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Institutional Capacity Development: Formulation of Management Systems and Policies
A Case Study of Tanzanian Church Hospital

A Research Paper presented by

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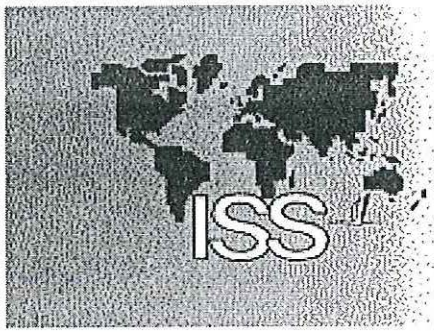

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Printed name: Musuto M.Chirangi

Signature:

The Hague, 18 November, 2000

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DEDICATION

This work is dedicated to the two beloved ladies: -

My Grandma, the late ***Pili Nyamurugwa wa Kafwenyi (1905-1985)***
-a jovial old lady who never tasted the flavours of formal education but had been always attesting that:
'Kosa Mali Upate Elimu'- a swahili statement implying that
'**education** is better than wealth',

and

My sister, the late ***Judy Owabariga (1960-1996)*** *for her incalculable* **hospitality** *and* ***support*** *to our family.*

ACKNOWLEDGEMENT

As the journey continues in the sea of intelligentsia, I wish to recognise and exalt first and fore most the presence and providence of *Jehova-Jireh.*

My deepest gratitude goes to my lovely wife Marja whose close unwavering support and love facilitated my smooth acclimatisation into the new Dutch culture. *Bedankt voor.*

I feel indebted for the joint resource mobilization by the Eastern Mennonite Mission (USA) through the Mennonite Church (Tanzania) and the Schoenmaker's family who made it possible for my studies and stay. My whole-heartedly thankfulness is to my employer Mugumu DDH and her workers for granting me a study leave.

For sure this work bears inputs of many scholars and experienced workers from different disciplines. Though it is not possible to mention all of them, I register my profound appreciations to my supervisors Frits Wills, Freek Schiphorst and other lecturers and the administrator in Labour and Employment Studies at ISS: -
I. Van Staveren, A. Abdelkarim, Roodal. M, J. Breman, H. Thomas and T.Kingdom.

Appreciations to all (ELS1999/2000) fellow participants for their constructive criticisms and ideas, without forgetting Cox, Elsa, Yanney and all Trade Unionists who treasure the lives of the working class.

My working experience and collection of data was very much enhanced by assistance from good individuals whom I owe gratitude, these include but not again limited to the list: -
Van Veen- ICCO (NL), Magiri.J- CBHPP Co-ordinator (TZ), J. Koot- Public Health Consultant (NL), Mtebe- General secretary CCT (TZ), Gelleja S.P- HRM consultant, (TZ), E. Lushakuzi- OD.Consultant (TZ), C. Bamanyisa- Health secretary MoH (TZ), Mugema S.K- Medical Practitioner (TZ), Nelson- MO I/c Mugumu (TZ), W. Flipse- CSSC Policy advisor (TZ), and my colleague E. Mpanda- ISS (PND) Participant.

Special thanks, to my close friends, relatives, brothers and sisters who have been supporting me in different ways, wishing me good health and sending words of encouragement. I herein wish to mention the families of uncle S. Muhongo, Lameck G., M. Kaare, Kongora K., my beloved sisters Grace and Joyce, my brothers who never let me down Godfrey and young man Bwire.

I treasure the silent but eloquent intercessory appeals by prayer- warriors, my inspirators, well-wishers like A. Mkamba, D. Sattimas and all others whose record is too long to dare enlisting.

As if I have forgotten them, *rata* Mutaragara *na mai* Nyabwire, my words will never match your caring and nurturing life-long project you undertook for me. You registered me at Nyakato Primary School (1974) where I was exposed to the basic education and knowledge; you took me to Musoma Sunday school (I can't remember when) where I was acculturated into Christianity- the life I have not regretted. I wish you could know my feelings at this moment as I sign-off.....

Wa- Chirangi
15th November 2000

ACRONMS

AMREF - African Medical and Research Foundation
CCT - Christian Council of Tanzania
CMBT- Christian medical Board of Tanzania
CORAT - Christian Organisation Research Advisory Trust
CSSC - Christian Social Services Commission
DDH - Designated District Hospital
DHMT -District Health Management Team
ELCT - Evangelical Lutheran Church of Tanzania
ESAMI-East and South Africa Management Institute
HMIS - Health Management Information System
HRD - Human Resource Development
HRM - Human Resource Management
HSR - Health Sector Reform
I/c - In charge
ICCO - Inter-church Organisation for Development Co-operation of the Netherlands
IDM - Institute of Development Management
ILO - International Labour Organization
IPD – Inpatient Department
KMT - Tanzanian Mennonite Church
MOI/c- Medical Officer In charge
MoH - Ministry of Health (Tanzania)
NGO - Non-Government Organisation
NIV - New International Version
NOI/c- Nursing Officer In charge
OPD – Outpatient department
PHC - Primary Health Care
RC - Roman Catholic (Tanzania)
SAP- Structural Adjustment Programme
SWOT- Strengths, weaknesses, Opportunities and Threats
TEC - Tanzania Episcopal Conference
TUGHE – Tanzania Union of Government and Health Employees
UNDP – United Nations Development programme
WCC - World Council of Churches
WHO - World Health Organisation

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CHAPTER 1. INTRODUCTION

1.1 Preamble – Evolution of the study

"If you don't know where you are going you will never get lost:
For wherever you are, you think to be in the right place"

This is a clear flashback voice of the late Jackson Mwano (1995), which never ceases to send cyclical waves into my tympanum. This brilliant Christian management consultant from AMREF– Kenya, while facilitating a management workshop[1], challenged Church health institutions' managers to visit their corporate goal to see whether they are heading into the right destination.

The Challenges to Church Hospitals

The twenty first century road to *offering quality and affordable health services for God' glory* by the Tanzanian non-for profit Church hospitals exhibits thorny challenges to their stakeholders especially managers and policy makers.

Church hospitals popular for their wide service coverage (44% of the national bed ownership) to complement Government services stand to face intricate emerging issues brought about by major global and national economical, social and political changes.

Firstly, it is evident from Christian Social Services Commission (CSSC) July 7-18 workshop's summary of proceedings (Mwanza); the 75 years of MEMISA[2] conference reader (5-6/10/2000 Rotterdam) and individual church and hospitals annual reports that these hospitals are experiencing less and less support in terms of grants, supplies and medical personnel from both outside (mission organisation) and inside (the ministry of health). Second, the ministry of health in implementing the public/private strategy as part of the health sector reform, has accepted market liberalization since the enactment of the Private Hospital Regulation Amendment Act (1991) to allow private practice even for profit in the country. In the same vein all private hospitals including Church ones are subjected to yearly accreditation system where their existence is to be determined by the way they abide to the government set standards and norms of quality assurance, for example having the required number of qualified personnel according to the health facility category. (MoH: *The Health Sector Reform Programme of Work July 1999-June 2002*).

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[1] Organised by the Tanzanian Christian Social Services (CSSC)- Capacity Building Project
[2] Dutch health missionary sending body

The expected questions following this one standard could be: Does the church have its own enough trained medical workers? (Bearing in mind the first change above). If yes, how attractive is the package offered (of course not only remuneration) to retain or attract others?

The third change has to do with globalisation and the way there is growing consensus of Universal Social Pillar where democracy, human rights, equity, and transparency are not only supposed to be preached but practiced. These and many others changes have had different implications to church hospitals management.

However, church hospitals are supported by poor management practices that cannot deal with these changes. One of the causes of this weakness is lack of appropriate management systems and policies in areas of financial and materials management, personnel policies, health information, strategic planning, discipline and conflict management, organization design and quality controlling.

This paper explores and analyses critically the proposed management tools, policies and systems discussed and developed by Church management managers in a series of CSSC-workshops where the author also participated. It specifically seeks to discover the management preparedness of church hospitals to face the above-mentioned changes.

Personal Experience and Involvement.

Knowing the challenges brought about by external environment alone, without a good grasp of the internal working environment as part of the corporate culture in these hospitals doesn't give one a full picture of the complexity of the problem.

Having served and being in-charge of administration and finance department in a Designated District Hospital [3]governed by both the church and the government for about six years, I have encountered many of those practical challenges which have sharpened my managerial, leadership skills and knowledge in health management.

I have also tested the real 'politics' of church leadership when I was elected and re-elected to be a servant (in a period of 5 years) at the capacity of the Diocesan assistant secretary.

During the years 1996 to 1998, I was one of the facilitators in a number of management workshops to church hospital managers from all over Tanzania under Capacity Building Project by CSSC. Subsequently, the workshops' ***outputs*** out of a participatory learning approach is one of the principle database of this paper.

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[3] Mugumu D.D.H-124 bed capacity with 180 employees is governed under a mutual operational agreement signed in 1980. The church is the owner while the government through the ministry of health is the main financier to the running expenses.

My overall personal involvement both in management practices and teaching in the realms of church environment has not been only inspiring but a noble privilege to be a witness of my own six senses (i.e. including spiritual) of what management tunes do church hospitals swing to. Who calls the tune? How resources are managed? What are the organisational norms and customs that compromise professionalisms or the biblical absolutes? How do we relate to each other as employees; how is the distribution of powers, authority and responsibilities in practice versus what we recite and believe in, and so on and so forth.

The (Artificial) Veil

This research parallel with the discussion of developing the appropriate management systems and policies, it endeavours to show how some values protected in the name of 'Christian culture' within the church work environment could inhibit church policy makers to see the real problems in the present systems and or hinder the smooth implementation of professional management.

Attestation

My interests at this point in time is to join other few writers of Church health management in bringing forth some practical suggestions on how we can improve management practices to enhance the quality of services to the community.

To conclude, I have undertaken this work not just to fulfil part of my academic requirements but as an ongoing participatory duty and responsibility for my people and the society at large. I attest that **capacity building** through **participatory learning approach** is one of the reliable versatile in establishing a powerful *non-Pharisaic*[1] critical mass to institute positive changes in church health institutions.

1.2 Research Problem Statement:

For many years in Tanzania, Church hospitals have been popular simply by outweighing (in terms of health service delivery) the government ones, which in most cases have been in shortage of supplies and drugs. Despite of wide service coverage and this recognition, Church hospitals demonstrate inefficient working and poor quality of services.

Management systems and policies Identified.

One of the major explanations of this weakness as found out by CSSC-survey[5] is ***a severe gap in Management Systems and Policies*** (henceforth referred as MSP) namely: - *management information system; performance appraisal system; disciplinary system; communication system; financial and materials management policies and regulations; quality assurance system; referral system; recruitment policy, human resource development policy; scheme of services, job descriptions, salary structures, incentive schemes, terminal benefits, organisational design and labour relations as part of personnel policies.*

Reasons for emerging challenges.

Recently in this era of health sector reform with market liberalization there is a shift from just giving health services to offering quality service in a competitive and standard-set environment with other private organisations. This situation together with the prevailing challenges of sustainability due to reduced resource-support (human, financial and materials) from both external agencies and internal by the ministry of health requires these hospitals to work effectively and efficiently.

Apparently, apart from the hospital managers (as in many other Church organisations) lack of the technical skills and experience to modern management, Church policy makers pause questions if not resistance to some modern managerial activities and policies in the name of preserving the '*Christian culture*'.

It is worthwhile at this juncture mentioning that few of the problems are caused by general weaknesses of the whole Tanzanian health system. Whereas some are specific to Church hospitals, others are Church based reasons to be discussed later.

Nature of the changes needed.

The principle problems (the severe gap) in those MSP are two fold.

Either the MSP are not yet in place therefore needed to be developed or if available, they are non-effective. The later can further be analysed into two explanations either they are not institutionalised or they are too old to be employed in today's era hence need to be reviewed.

Possible road ahead

The Christian Churches in Tanzania therefore face the **challenge** to change or institute appropriate MSP to their hospitals-a natural call for ***human capacity development.***

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[4] Free from hypocrisy, unwarranted prescriptions and burden to the society.

[5] Conducted by Christian Social Services Commission (CSSC) in hospitals of all 4 zones between 09th and 22nd July 1996.

A lot has been done to find out how church institutions can improve their services (Kenneth 2000:213; Stephen Overell 1998; Hehir 1995) but less has pointed out plainly the challenges and importance of instituting ***appropriate MSP versus the inherent 'Christian culture'*** for efficient working.

This gap is filled by the findings and critical analysis of management capacity development workshops' output to hospital management team members organised by Christian Social Services Commission (CSSC)-Tanzania (1996-1998).

Unless the church is willing to address this problem in a ***participatory approach*** while revisiting some of its organisational practices, the good image of its hospitals is at risk. Furthermore, the present era characterized with ***customer awareness to quality and high competition*** from within and without stands a better chance to officiate their (church hospitals') natural deaths. Eventually *health for all* shall remain a daydream.

1.3 Objectives and research questions

CSSC have been conducting management workshops by use of ***Participatory Learning Approach*** to church hospitals members of management teams between1996-1998 as part of human resource development and getting a forum to develop guidelines for MSP of church hospitals to bridge the management gap mentioned earlier.

Goal.

This **exploratory** qualitative research aims at unpacking the challenges and weaknesses of Church hospitals and give suggestions to different stakeholders for the purpose of instituting appropriate MSP. Hence the specific **objectives** in line to the goal shall be:

a) To explore the output of participants[6] in a series of CSSC- **eight** Capacity Building Management Workshops; **four** workshops convened outside work places in 10 days each and other **four** in specific hospitals (In-house workshops) for 5 days each.
b) To analyse and critically present the above-mentioned output.
c) To present recommendations gearing to improving MSP as part of enhancing quality health service delivery by church hospitals.

[6] Members of institutional management teams mainly Diocesan Medical Secretaries, Medical Officer in charges, Hospital Health Secretaries (Administrators), Nursing Officer in charges and Accountants.

The major ***guiding research question*** underlining the problem statement shall be:

How prepared is the church in making sure that its hospitals have appropriate management systems and policies for quality health service delivery?

A contested follow up question ***(FQ)*** shall be:

Do we (the church) continue to subscribe to the orthodox preserved values and practices? Like:

FQ1. We don't need a lot of regulations and policies; we are all responsible workers led by the Holy Spirit. The Bible and the church constitutions are sufficient.

FQ2. Competition is something to avoid, we are non-profit making organisations our work is to just give services.

FQ3. Trade Unionism should be discouraged if not avoided as it is secular and adversarial

FQ4. The ultimate responsibility of managing church institutions lies in the hands of Bishops. Hence they have to be Board Chairpersons and with the sole jurisdiction to appoint hospital Chief Executive Officers to defend 'the interests of the church'.

FQ5. Our goal is to restore one's soul hence the maximum disciplinary sanction you can give to the indiscipline worker is to shift him/her from one area to another or one department to another after praying for him/her to keep away Satan from visiting him/her again.

FQ6. Christian employees are *called to servant hood,* elaborate remuneration package and schemes are for *'wage workers'*

1.4 Units of analysis and logic linking of the Data to the research Question

The research inquiry tries to evaluate the level of preparedness of Church hospitals in acquiring modern suitable management organisation, policies and practices to enhance efficient health care services. This is achieved by analysing the present management situation and the possible road ahead.

Modern organisation theory focuses on organisational **processes** and the critical management function of **planning.** (Maureen P.S.1995: 13&115). Consequently, the units of analysis employed herein consist of three major elements: *(1) Management systems, (2) Management policies and (3) Strategic planning.* Below, each element is further expounded.

(1) Management systems

These are what D.A. Gillies (1994) and Hodge & Anthony (1984) call the *subsystems* of the larger complex hospital system. The data-category[7] *units of analysis* shall be: -

Management Information System, performance appraisal system, communication system, financial and material management systems, quality assurance, disciplinary system and referral system.

(2) Management policies

These are summary of general statements that spell out the direction for implementing desired objectives.

This element includes also (i) **management regulations**-specific statement of accepted 'dos' and 'don'ts', as control mechanisms towards attainment of a particular policy and (ii) **management tools** that are also part of the (sub) systems, employed to simplify or enable the processes to take place. Therefore management policies, regulations and tools - *units of analysis* shall include: -

Recruitment policy, training & development policy, financial regulation, organisational structure, workers organisation & social dialogue, job descriptions, scheme of services, salary structures, incentive schemes & terminal benefits,

(3) Strategic planning

This is a systematic critical exercise of joint efforts from all the subsystems. This work tries to bridge the gap between where the hospital is and where it wants to be. Strategies and activities are planned based on the SWOT analysis, what Philip N. Reeves (1988)[8] calls competence analysis of both the internal and external environment of the health institutions in question. The *units of analysis* here will be the planning process with interest in who participate in the exercise, how frequent, duration of the plan, the approving authority, and the information base.

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[7] As Ragin (1987) differentiated these from the theoretical category (*explanatory units*), which this paper categorize them as the **major areas of concern under study** outlined under research methodology and source of data

[8] In Simyar Farhad and Joseph Lloyd-Jones(ed) (1988), *Strategic Management in the Health Care Sector Towards the 2000.* Pg 65.

1.5 Research methodology and sources of data

This research has employed CSSC Capacity Building Project (CBP) in Tanzania as a reference **case study.** The study carries an in depth analysis of the eight CBP workshops outputs on development of MSP for church hospitals. The study uses a 'cocktail' of the following qualitative instruments (see further explanation in the source of Data):

a. Interviewing some church hospital stakeholders.

b. Institutional (hospitals) assessment by SWOT analysis

c. Content analysis of human resource management and the theology of work.

d. My personal observations in working with Churches and Para-church organisations.

e. Document analysis.

The major areas of concern under study (*explanatory units*) to analyse hospital MSP for quality heath service delivery are:

Organisation and managerial functions; financial policies and materials management; Health Management Information Systems; personnel policies, regulations and labour relations; and strategic planning.

☞ **The sources of data comprise of: -**

I. Primary data

a. Own observation during the workshops where I participated as one of the facilitators and six years experience (1994-1999) working and encounter with church organisations, leadership and culture.

b. A semi-structured interview ***(see appendix 1)*** to the identified key informants carried in Tanzania, Netherlands and Geneva (in June – September 2000). These included the following stakeholders (list of names and roles attached as ***appendix 2)***: -

2-CSSC officials, 2-Bishops, 2-Diocesan health secretaries, 3-members of hospital management team, 2-Trade Union (TUGHE) leaders, 1-Ministry of health representative, 1-pastor,

1-local authority representative, 1-workshop facilitators, 1-special advisor on socio-religious issues for ILO, 1-MEMISA official on behalf of the missionary sending bodies, 1-ICCO official on behalf of foreign Christian funding bodies, 2-experienced health management consultant, 2- Christian medical practitioners, 1- hospital board chairperson, 1- Hospital Board member.

Selection of interviewees

The interview was administered to selected individuals from a non-random *convenience*[9] group of people taking into consideration the key stakeholders of church health institutions. In the final analysis time and availability of people were also part of the determining factors.

II. Secondary data

1) **CSSC documents** i.e. Survey Report on MSP in Church Health Hospitals. (August 1996) and the summary of proceedings of the consecutive management workshops listed below:

Part A. Workshops on ***Development of MSP*** attended by Diocesan Medical Secretaries and church hospital Managers (Medical Officer In charges, Hospital Health secretaries, Nursing Officer In charges and hospital accountants) from all over Tanzania.

VENUE	REGION/ZONE	DATE
Makongoro Conference &Training Centre	Mwanza/Lake	07-18/07/1997
Masoka Training Centre	Kilimanjaro/North Eastern	14-28/10/1997
Mbagala Spiritual Centre	Dar-es-Salaam/Central Eastern	11-15/05/98
Iringa Centre	Iringa/ Southern	11-12/02/1997

Part B. In-house workshops on ***Strategic Planning*** attended by members of the management committees at the hospital or Diocese in the planning exercise.

VENUE	SERVICE AREA	TYPE OF ORGANISATION	DENOMINATION	DATE
Mugumu hospital	Serengeti	Designated District Hospital	Mennonite	28/9-02/10/1998
Sumbawanga Diocese	Rukwa and Mbeya	Diocesan Health Department	Catholic	23-27/111998
Wasso hospital	Ngorongoro	Designated District Hospital	Catholic	09-13/11/1998
Karatu hospital	Karatu	Voluntary Agency	Lutheran	02-06/11/1998

Sampling

Four out of six available summaries of proceedings from **'Part A'** were selected, while from **'Part B'** it is four out of five. This non-random sampling selection technique was based on representative criterions such as: -

- Geographical location as workshops were organised in zonal-kind of arrangements.
- Major denominations as health services providers
- Variety type of hospitals in strategic planning with different sizes, complexities and ownership, e.g. DDH, VA or Diocese.

[9] Described by Rudestam and Newton (1997) in '***Surviving Your Dissertation***', London: Sage.p.64.

2) Other **supporting sources** of information analysed and or cited are: -

- **Tanzanian Ministry of Health documents**: - The Health Sector Reform (HSR) Programme of Work (July 1999 – June 2000); Proposal for HSR (1994); Statistics for background information mainly from the Ministry of Health Tanzania; Health Statistics Abstract (1999) Volume 1&2 and from Bureau of Statistics Tanzania.
- Literature on related topics i.e. Capacity Building/Development, health policies, health management, strategic planning, theology of work, Christian managerialism and Human Resource Management as presented by the different authors and organisations like ECDPM publications, UNDP, WHO, CSSC, CCT/TEC, WCC, ILO, MEMISA etc.
- The Holy Bible (1995): New Revised Standard Version.
- Other literature, documents and websites related to the subject.

☞ **Data processing**

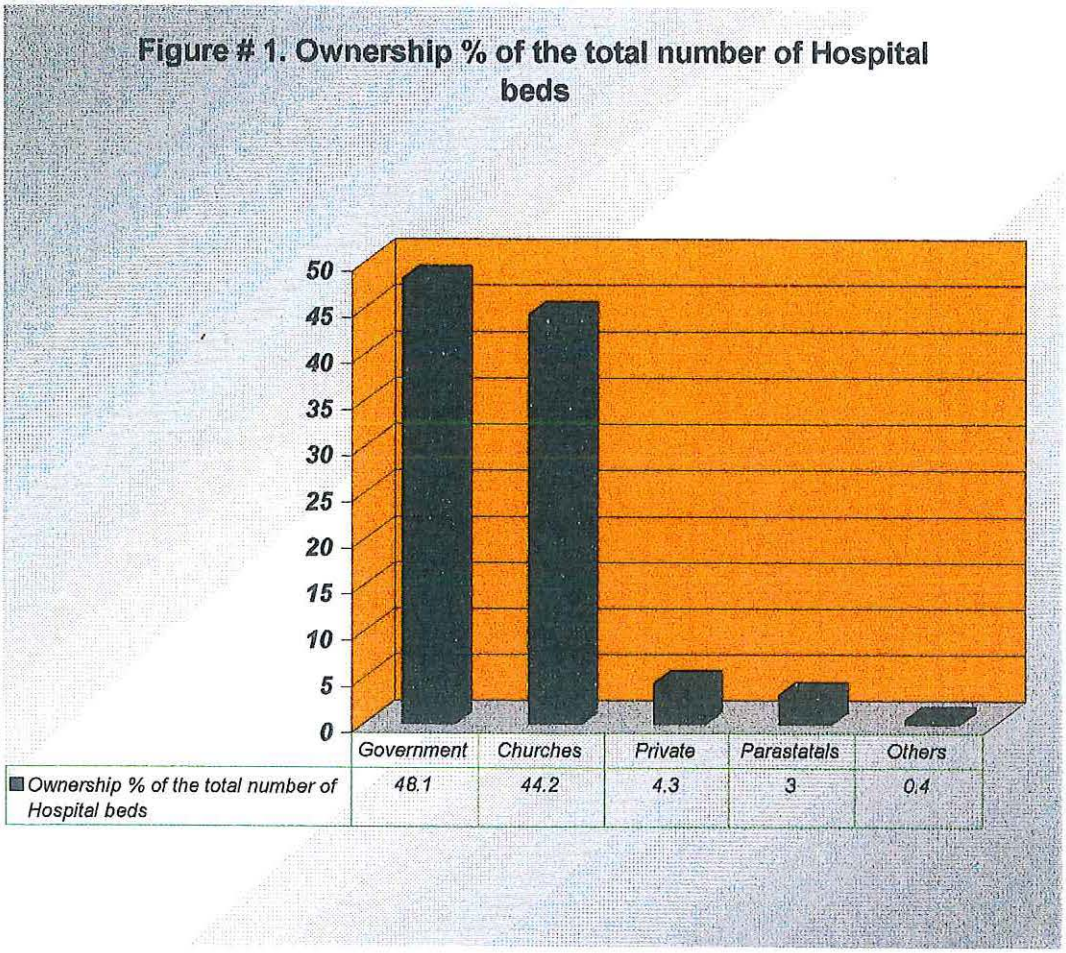
- The workshops' outputs (Part A & B) were analysed qualitatively, by critically observing notable differences and similarities with retention of most expressive and representative expressions. Weak and strong points of church hospitals and recommended general (generic) structures or policy guidelines were drawn.
- Significant and relevant elements for both Church authoritative writings and documents of the Ministry of health related to the research question were noted.
- Remarkable incidences of life experience (here in referred as ***case to ponder)*** witnessed by the author or told by interviewees were presented to relate and elaborate more the workshops' outputs.
- The Follow up Research Question has been codified as **FQ (1-6)** to be able to link it with the findings and analysis in a more simplistic but yet concrete manner.

1.6 Justification of study

General.

Apart from the government, the church is the greatest health services provider in Tanzania. The1999 Statistics[10] shows that the total number of Inpatient beds of church hospitals is 9980 this is about 85.2% of all non- government ones. (See also **figure # 1).**

[10] Health Statistics Abstract 1999 by Tanzanian Ministry of Health.



Source: Derived from the Tanzanian Ministry of Health; Health Statistics Abstract 1999Pg.1

Therefore the study of this *development agent* is worthwhile for the health of all Tanzanians who receive services disregard of their religious or political inclinations.

Each workshop under study had on average 25 participants from hospitals and health departments of Dioceses of different denominations all over the country except for the in-house workshops, whose participants were management team members from the same employer. This is a fair representative sample to draw notable findings if not educative conclusions.

Specific significance of the study.

The analysis is expected to show policy makers in the governments, churches and other non-governmental organisations with more or less similar problems, the preliminary impact of developing human capacity ***for identification of health management challenges*** towards viable solutions.

👍This open-ended exploration with flexibility of allowing new insights may at the end add to only little literature available on church health management.

👍Finally the paper also stands to provoke constructive discussions that might serve as a stepping-stone towards ***implementation*** of the appropriate MSP. This step can establish the relationship between capacity development and quality of health service delivery. It therefore implies the need to carry out a control research after implementation.

👍***The sanctity of Participatory Research (PR) Method***

The methodology employed when facilitating the workshops is a salient shift from conventional thoughts of *Subject – Object* relationship between the researcher and the community here in referred as Church hospitals in Tanzania. The researcher was considered as a facilitator and a conscious interpreter of complex and often competing stories. The research process and results were shared by both the facilitators and workshop participants. As Prasada (1995) puts it, PR has 'Authentic' participation towards self- responsibility.

1.7 Organisation of the paper

After introduction, this paper is organised in four further chapters as follows: -

📖Chapter 2

Gives a brief of the national health services status under Health Sector Reform (HSR) and Church hospitals health service delivery. The chapter further introduces the major national and international social, political and economical changes that have taken place but also presenting challenges and opportunities to Church hospitals. A description of Institutional Capacity Building Project conducted by CSSC- the central source of data under study is finally highlighted.

📖Chapter 3

Is devoted to theoretical and conceptual exposition. The modern organisational theory is used to show how Church hospitals as open systems are affected by both internal and external environments. Some concepts linking to theory are operationalized. These include hospital management systems and policies, institutional capacity development, quality health service delivery, Christian 'culture' versus contemporary work and labour related issues.

📖Chapter 4

Forms the main part of the research paper as it presents the findings with a critical analysis of their implications. The chapter begins by an overview of what the problems are in the present MSP in Church health institutions. The extent of each problem is classified, that is whether it is a general challenge to the whole Tanzanian health system, a problem imbedded in the owner (church system) or specific to church hospitals. The same overview mentions the underlying issues to each problem and the overall implications.

The workshops outputs and remarks (in grey boxes) with their appended few proposed generic management tools and policies are categorically presented and analysed under the six major subjects namely: -

Organisation and managerial functions; Personnel policies, regulations and labour relations; Financial and Materials Management; Health Management Information Systems and Strategic planning.

Cases to ponder (Italicised) are summarized true happenings to supplement both the findings and analysis. These special features in this chapter are meant to make information and inferences easily understood.

📖Chapter 5

Based on own experiences and consultancy from other proponents of professional health management practices, the chapter presents non-conclusive recommendations to different concerned stakeholders towards improvements of church hospital management in Tanzania. Future potential areas of further researches to ensure quality of service delivery in Church hospitals are highlighted too.

The chapter thereafter ends the paper by concluding remarks.

1.8 Scope and limitations of the study

1.8.1 Scope

The study mainly explores the primary impact of CSSS capacity building project in enhancing capabilities of Tanzanian church hospital managers. Covering a time framework of 1996 to 1999, it unpacks how boldly the said hospital leaders have been able to evaluate both the internal and external environment of their institutions and being able to develop generic policy guidelines and management tools for efficient working to face the major national and international social and economical changes.

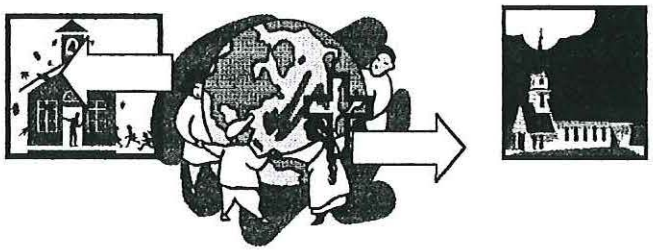
The analysis mentions few notable Christian values and practices that have direct relationship with management functions of Church hospitals.

1.8.2 Limitations

Without exception, the undertaking of this research has faced some limitations. Among the common notable problems were: -

a. Time constraint

While appreciating and make use of *alternative qualitative research methodology*, it is a felt opinion of the researcher that 3 weeks back in Tanzania was not sufficient. The travel logistics and inefficient management of information systems by government, churches and hospitals made it difficult both to meet as many interviewees as I anticipated and getting data from their offices. However this is balanced by my long time own experience in working with church hospital management. More over I have actively participated in the very CSSC – Capacity Building project from the time of developing a facilitators guide up to real work of facilitating the workshops.

b.  ***Diversity in Christianity***

Though at least all believe under the cross of Christ, there is diversity among Tanzanian Christian churches as it is everywhere due to differences in doctrines and *self-theologising*[11]. This makes it difficult in the first place to believe if there exists one 'Christian culture' as is difficult to get universal operational definitions of the theology of work. This is attributed to a great extent by different approaches in studying the Bible as summarized in ***appendix 3. Biblical hermeneutics in different theological paradigm***

c. Debatable controversial area

A study about managing church hospitals raises arguments due to different views in values, professional, ethical standards and interests. For example: -

[11] Other indicators under *contextualization of African Christianity* are self propagating, self managing, and self supporting,

✌Between a medical doctor who want to save lives of patients at any cost and a human resource manager who is keen in being effective with minimum wastage of resources.

Nevertheless, all these present rather a challenge than a problem to anyone aspiring to be a member of Intelligentsia especially in social sciences.

CHAPTER 2: CHURCH HEALTH SERVICES PROVISION AND CHALLENGES IN TANZANIA

2.1 Introduction: Health Sector Reform (HSR)

The government continues to rationalise its public sector objectives in order to make it more effective and productive. It is expected that the ministry will have a smaller structure, with its main role limited in policy formulation and regulation, creating an enabling environment to increase *private sector participation in the provision of Health services.*

The underlying HSR Programme of Work (1999-2002) outlines major agenda under reforms. Few affecting Church hospitals are summarized below.

AGENDA FOR REFORMS	*ISSUES*
Ideological reform	Government becomes a facilitator, private for profit is encouraged to take an active role
Organisational reforms	Making profession councils autonomous, and concentrate in developing guidelines, regulations and standards
Managerial reforms	District hospitals transferred to local government. The role of the District Medical Officer is to be reviewed
Human Resource Management	Staff to be considered for promotion under the district health boards
Financial reforms	Budget allocation based on population patterns, income distributions, and utilization of health services.
Public/Private mix reforms	Amendment on private practice registration. Introduction of accreditation system to both private and voluntary agencies

Source: Extract from MoH: *HSR Programme of Work (July 1999-June 2000).*

Table#1. Selected Health Management Indicators
Tanzania Mainland Regional Performances in percentage or rate

Region	Drugs	Visits	VHW	Equipment	MMR	Deliveries	Report
Arusha	39.7	57.8	*	*	*	*	36
Coast	9.4	55.9	80.6	7.1	375	34	34
Dar-es-Salaam	47.4	41.7	*	*	*	*	8
Dodoma	62.0	84.2	59.3	68.1	138	41.8	54
Iringa	48.5	81.1	94.1	33.9	210	60.8	71
Kagera	62.7	61.5	89.4	40.4	*	44.3	63
Kigoma	80.4	64.6	23.1	31.2	120	37.4	59
Kilimanjaro	62.9	77.8	39.8	28.6	69	54.3	44
Lindi	53.9	65.0	34.8	*	514	*	46
Mara	70.1	81.0	88.1	21.9	76	23.1	37
Mbeya	59.9	77.3	46.3	45.5	368	35.8	71
Morogoro	74.2	64.2	88.4	68.3	*	2.5	41
Mtwara	32.4	89.5	79.1	4.7	56	45.5	39
Mwanza	82.6	80.0	81.6	28.4	139	18.6	71
Rukwa	59.1	54.2	56.0	31.2	293	53.7	70
Ruvuma	28.1	77.6	93.9	54.7	190	71.6	65
Shinyanga	82.9	70.8	98.1	42.9	99	34.4	46
Singida	80.0	68.7	93.5	18.5	259	51.5	61
Tabora	62.8	52.7	13.5	23.4	176	38.2	38
Tanga	54.6	42.1	*	*	*	*	21
National/Average	***55.6***	***69.4***	***69.7***	***57.0***	***180***	***39.4***	

Source: MoH: ***Health Statistics Abstract 1999*** **Pg. 97-124**

KEY.
Drugs: % of Health Facility with Drug Kit Late
Visits: % Of Health Facility Visiting each Catchment Village once per Quarter
VHW: % of Communities with at Least one Village Health Worker
Equipment: % of non- functional Equipment Fixed/Replaced Within 3 Months of Reporting
MMR: Maternal Mortality rate per 100,000
Deliveries: % of deliveries at Health Facility or by Trained Traditional Birth Attendant
Report: % of Health Facility Response Rate (# of facts reported as a % of # of facts expected)
* Data missing /not reliable

Despite of all these good plans, the Tanzanian health sector faces some difficulties:

- The referral system is ineffective as it only favours those dwelling near the facility.
- The government still have a budget crisis both in the Recurrent and Development budgets. For instance out of the approved budget of Tshs.27.4 billion, only Tshs.156.2 million were disbursed in 1996/1997 (RPFB 1997/98-1999/2000). Though the government may be committed to help DDHs, financial constraints force her to prioritise the needs first. This could be a good reason to explain the inadequacy of drugs refer to the ***table # 1*** of management indicators where more than a half of all facilities, reported to have drug kit late. Issues of transportation and coordination only adds but not conclusive to the problem, (e.g. Mwanza though with Zonal Medical Store around had a score of 82.6).

It should be well recognised that though these hospitals get some income from the cost sharing scheme, the 1997/1998 statistics[12] show that the national total revenue was only 5.8% of total health expenditure or 13.4 % of total non salary recurrent expenditures.

👎 Health sector wide approach continues to be challenged, for example most of the government health projects are not coordinated and they are vertically run. Further, ***table # 1*** shows about 31% of villages not visited accordingly by the health facility management team.

👎 Access to health service is still a problem. Reasons given by the MoH include geographical barriers and ability to pay. The table shows that more than 60% of women deliver home without even a help of a trained birth attendant despite of a good percentage of villages with at least
a Village Health Workers(69.7%). Not amazingly we still have high maternal mortality rate 180/100,000

👎Overall speaking, a lot needs to be done to motivate people to see the importance of health management information. It is shameful that it is the big cities that have more educated people like Dar es Salaam and Arusha that have the least health facility reporting- rate (***table# 1***).

🛠In general all the above calls for overhaul of our systems, effective co-ordination and cooperation among all health providers and the communities.

2.2 Church health services delivery in Tanzania.

The church is the oldest government partner in provision of social services. The concept of holistic ministry was introduced since the coming of the missionaries to Tanzania. In a nutshell church planting went hand in hand with building schools, and health units.
Many of the health units at mission centres in the rural areas gradually developed into fully-fledged hospitals. Some of them later opened nurses and medical assistants training centres.
The partnership between the church and government in provision of health services was strengthened by the government's provision to mission hospitals under **the grant in Aid Regulation in 1944.** Apart from purely church run hospital known as Voluntary Agencies (VAs) scattered in urban and rural areas, there are 19 so called *Designated District Hospitals (DDHs)* out of total 60 district hospitals which though owned by churches they are financed mainly by the ministry of health grant.

[12] MoH: Health Abstact. Vol 1 1999 pg 125

These hospitals serves an average population of 250,000 each, more important under the HSR districts are given a greater role in provision of health care.

To date there are a number of churches providing health service. Some of them include Lutheran, Roman Catholic, Anglican, Moravian, Mennonite, Presbyterian and African Inland church just to mention a few. The updated available figures (1999) at the ministry of health show a substantial weight of churches as one of the major health providers. (See *table # 2*).

Table #2. The National total number of hospitals

Owner / Category	*Governmental*		*Non Governmental*			*Total*
	Government proper	Parastatals	Church	Private	Others	
Consultant hospitals	4	0	2	0	0	**6**
Regional hospitals	17	0	0	0	0	**17**
District hospitals	55	2	13	0	0	**70**
Other hospitals	2	6	56	20	2	**86**
Total	**78**	**8**	**71**	**20**	**2**	**179**

Source: Tanzanian Ministry of health; Health Statistics Abstract (1999) p.1

In a wider ***area of cooperation*** between the Church and the Government in health, the Church also runs a number of community health programmes and more actively in operating nursing, paramedical and medical training institutions. All these are more or less affected by the major changes discussed briefly in the next section.

2.3 Major changes affecting Church hospitals at a glance.

A. Less Support

Beginning the eighties mother churches and foreign mission organisations have been either handing over health facilities to local churches or reducing the budget (aids) gradually.

In the same light from MEMISA 75 year Jubilee Congress in Rotterdam[13], where the author was one of the participants, It was noted that the *medical mission period* is no more the same if not coming to an end.

Obviously, training and or sending medical personnel to Tanzanian Church hospitals by organisations like Memisa and Meducus (Dutch), Holy Ghost and White Fathers (USA), Eastern Mennonite Mission and Mennonite Central Committee (USA), German Centre for International Migration,

[13] On 'How popular is the Health Care?' conducted on 05-06th October 2000 in Rotterdam.

Danish Volunteer Service (MS), Netherlands Association of NGO for Personnel Services Oversees (PSO), German Technical Cooperation in Development (GTZ), Germany Catholic Association for Cooperation in Development (KZE), her Protestant equivalent (EZE) and many others are today at low scale as compared to the past (sixties to the eighties).

The reasons for this *bitter pill to swallow* action to Church hospitals include: -A shift of interest to other priority areas of concern e.g. relief for aid towards disaster management; questioning the undertaking (thinking of cost/benefits analysis); and internal policy changes.

The same trend has also been observed on the grant used to be sent to those hospitals from the Ministry of Health (MoH). All these imply reduced trained medical and paramedical personnel and less finance to meet daily running costs.

B. Globalisation and Health Sector Reforms

The shift to market liberalization, privatisation, decentralization to district authorities and increased consumerism call for a competitive service delivery, effective co-ordination, cooperation among providers, work reorganisation, strategic planning and quality assurance to meet the government set standards.

Since 1991 Tanzanians medical practitioners are (legally) allowed to run their own hospitals and dispensaries. Based on the survey findings of ELCT hospitals (1998) many outpatients prefer attending these private dispensaries to church (and government) hospitals. The number of patients at out patient department has decreased hence decreasing **potential income**. But the workload of in patient department, which constitutes the more **subsidised patients**, has remains almost unchanged.

Competition is more intensified as new private hospitals situated in towns have become more accessible by people who dwell in rural areas. This can be explained by both the increased awareness of good consumerism and the national improvement of roads and public private transports.

Though the government is equipped with organized institutions and people with various expertises, still a lot has been done in the last decade in terms of *economic reforms*[14] along side with capacity development and technical support.

How much more preparation is needed before church organisations fit into these (summarised below) inevitable challenges brought by dynamics of globalisation and health sector reforms.

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[14] A presentation at the ILO Technical Consultation on *Employment Promotion,* Dakar on 21-23 September 2000 by Wilfred Ndongko showed that reforms have not helped African countries into increased job creation, nor poverty reduction.

Dynamics	*Challenges to Church hospitals*
Informatization	The need to train people, acquire up to-date technological assets and installation of Health Management Information system.
Work organisation and human resource management	Giving flexibility, support and rewards to enhance entrepreneurship. Keeping only the optimal stock of drugs and allowing (temporary) employment contracts.
Free marketing	Increased competitions and decreased OPD patients.
Cost sharing	How to target and help the poor.
Privatisation	Registration and operation within the government set standards.
Decentralisation	Plan, organise, and manage health activities with district authorities.
Consumerism	Increased patient awareness to quality and medical- legal. The need to carry consumer surveys.

C. Consensus of Universal Social Pillar

There is a glowing recognition of the International Community towards democracy, human rights, equity and transparency. The 1998 Declaration on fundamental principle rights at work and its follow up does not exclude conformity by Church hospitals operating in Tanzania- a member state of ILO. The Church-working environment is at this juncture challenged by the following principles: -

- *Freedom of association and the effective recognition of the right to collective bargaining.* Do church hospital encourage or allow their workers to join trade unions or engage in social dialogue?
- *The elimination of discrimination in respect of employment and occupation.*

Though they are often the majority in the hospitals (especially in the nursing department), are women workers equally represented in decision-making bodies including managerial positions?

"Do what I say but not what I do" this was a repetitive[15] melancholic statement of Fr. Dominique Peccoud, the special advisor for socio-religious affairs at the ILO. He was reflecting what the church leaders preach (on human principle rights) but never practice them be it at Vatican or elsewhere and more serious such contravening life-style is in Dioceses.

D. A Breaking Traditional Social Security

Increased urbanisation, global communication network and escalating costs of living have weakened the Tanzanian traditional social structures. No more do we witness an automatic contribution towards health care from an 'extended' family member. The break down of this traditional social security means to a larger extent, a shift from dealing with a community to individual customers. Apparently, Individual customers (with limited resources), more than the community as a whole are very volatile and more sensitive to prices and the type of service you offer.

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[14] A presentation at the ILO Technical Consultation on *Employment Promotion,* Dakar on 21-23 September 2000 by Wilfred Ndongko showed that reforms have not helped African countries into increased job creation, nor poverty reduction.

[15] Fr. Peccoud reciting the Pharisees and Sadducees of Christ's time as he was responding to an interview by the author on human rights challenges related to Church organizations, work and employment on 28/09/2000, Geneva.

Today many patients are not capable to foot the bills on their own, but more also they are left unsupported! Any loophole in the system is quickly translated into added[16] absconded patients.
All these challenges calls for **Institutional Capacity Development**[17], a process in steps through which the Church and her institutions strengthen their ability to mobilize the resources needed to overcome economical, social and spiritual problems to pursue their mission.

E. Operating Under One Umbrella.

The establishment and functioning of CSSC (1992) by the Christian Council of Tanzania (Protestant churches) and the Tanzania Episcopal Conference (Catholic Church), is very viable in terms of opportunity for coordination and support especially in areas of health management and technical assistance. The body has also helped as a 'go between' the church and the government relations for example in securing opportunities for upgrading studies, participating and disseminating important decisions from the ministry of health to church hospitals, a new opportunity in areas of Church social services delivery.

"Additionally the history of relationship between the churches and government was not all that clear. For instance, Important Christian hospitals were nationalized in the beginning of the 70's and were returned to churches 20 years later in a very bad state" recalls Knauss (1978).[18]

Is there an opportunity for this national umbrella organisation to facilitate an effective ***networking*** among members? Why should two or more churches manage AIDS control programme projects independently in one area without cooperation?

Sustainability versus affordability

Due to challenges (A-D) mentioned above many church hospitals not only in Tanzania but also in all developing countries face severe management crisis. Hospitals need to continue operating for a long time without a major support from outside donors. Fully cost recovery from patient fee will result into excluding the poor because costs are increasing while the ability of rural and poor urban population to pay for the service is decreasing.

More challenging is the *absence or availability of unreliable sound data*[19] to make sound decisions on how to reconcile sustainability and affordability, which presently stand to be contradictory goals.

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[16] Hospitals get absconders due to many other factors including unsatisfactory service, mental disorders and other strong attached traditional beliefs.

[17] Whose goal is *to enhance ability to evaluate and address the crucial questions related to policy choices and modes of implementation among development options based on understanding of environment potentials and limits and of needs perceived by the people concerned.* (Capacity Building –Agenda 21st definition-Chapter 37 UNCED, 1992)

[18] H. Knauss (EZE) ***Conceptional Efforts in the Basic Health Care Sector in Tanzania***. Downloaded from http:/www.epo.de/2020/part3/knauss/knauss3.html. 3/7/2000 3:25PM.

2.4 CSSC- Institutional Capacity Building Project (ICBP)

A series of workshops for developing management systems and policies was organised by CSSC. This work, which took place in1996-1998 (refer to ***appendix4:*** *Gantt Chart for ICBP*) was the second phase of Capacity Building Project where all church hospital medical office in-charges; hospital secretaries; nursing officer in-charges, accountants and diocesan health directors participated. The main aim was to equip them with the necessary skills to be able to develop their own systems that suited their environment. Group assignments, plenary presentations and free discussions were part of the participatory learning approach.

Within the same period some hospitals on their own requests were aided with technical facilitation (in-house workshops) as they were carrying out their long term strategic planning.

The recent external project evaluation report[20] shows that so far according to incomplete statistics the project had already trained 207 out of 465 persons planned to be trained in four years time.

2.6 Concluding remark

Both for Government and Church hospitals, training of personnel is very much needed to be able to analyse the present situation and thereafter implement appropriate strategies in line of HSR.

CSSC –ICB project has been fruitful in development of management systems and policies, this however is not the ultimate goal of capacity development. Implementation of the changes is an on going assignment to church police makers and all workers.

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[18] H. Knauss (EZE) ***Conceptional Efforts in the Basic Health Care Sector in Tanzania***. Downloaded from http:/www.epo.de/2020/part3/knauss/knauss3.html. 3/7/2000 3:25PM.

[19] Steffen Flessa in his work (1998), *The Cost of Hospital Services: A Case study of Evangelical Lutheran Church Hospitals in Tanzania. Pg.398 speaks on this problem when he says,* " Perhaps the major problem of any researcher in Tanzania is lack of data, the almost complete unreliability of what data is available and the absence of any recent data...."

[20] Evaluation report of 16th November 1998 by Ms Teresa Obwaya (Kenya) and Dr. Jaap Koot (Netherlands)

CHAPTER 3. THEORETICAL REVIEW AND CONCEPTUAL FRAMEWORK

3.1 Introduction

Development of appropriate MSP to match the prevailing competitive environment for any organisation depends very much on how one identifies the root problems in the system. This chapter tries to use the system approach to show how both the external and internal environment affects church hospitals. A number of concepts like the theology of work, capacity development, and quality of health service delivery are operationalized to be able to discuss the research findings and eventually recommend practical steps.

3.2 Modern Organisational Theory: System Approach.

Classical Organisational Theory

Development of modern organisational theory starts with the ***classical organisational theory*** contributed by Max Weber (1864-1920) on the concept of *Bureaucracy,* Fredric Taylor (1856-1915) on theory of *Scientific Management* and Henry Fayol (1841-1925) on *Management Principles* recommended that bureaucratic structure with centralized authority is ideal for large organisations. For application in health care the theory emphasis is in tasks, efficient operation and individual productivity. These are to take place within the rigidity of managers, control of employees and strict obedience to authority.

Humanistic (Neoclassical) Organisational Theory

Studies made by researchers from Harvard University between 1927 and 1933 questioned the rigidity of the classical organisational structures and lack of concern for workers welfare.

The researchers concluded that various psychological and social factors in the work situation exert more influence on productivity than physical conditions (the Hawthorne effect).

Hence the focus in Humanistic theory is that increasing morale to workers results into increased productivity. In hospital set up the neo-classics would emphasis workers participation, group cohesion, and incentives (not only monetary).

Modern Organization Theory

Since 1960's up to now, we operate under modern organisation theory. Various researchers and theorists of the day view organisations as open, dynamic and complex systems.

Despite the emergence of diverse theories like technological theory, organic theory, information processing theory (not covered in this paper), ***a system framework*** is the common denominator to all proponents of modern organisation theory (Maureen P. 1995:13).

Under this theory an organisation is seen to consist *INPUT, PROCESS (THROUGHPUT), OUTPUT and FEEDBACK.*

The challenge to the role of management today is to make sure that there is effective communication, co-ordination, control, monitoring and constant review of structures and policies in every stage based on the feedback impulses.

3.3 A hospital as an open system

> *"Open systems have the characteristic of equifinality; i.e. objectives can be achieved with varying inputs and in different ways."*
> (D.A. Gillies: 1994, quoting Freemont Kast.)

A system is an orderly interconnected set(s) of parts/elements and their attributes that work together to accomplish specific objectives. (Ardnt and Huckabay, 1980)

Hospitals are open systems as they interact with their ***environment***[21] - the source and destination to their inputs. Their survivals depend on a continuous cycle of ***inputs, processes, output and feedback.***

The crucial concept to grasp here is that as environment continuously changes, automatically the feedback calls for appropriate changes in the input, process and or output.

One of the major criticisms of health care institutions have been their inability to rapidly respond as other business do to changes in the environment (Lehman, 1994). [22] However, he warns, *"A system that cannot respond from its feedback from its environment is doomed to extinction."*

Two salient characteristics of a system are as follows: -

a. It includes interconnected *subsystems* each of which has an objective that advances goals of the larger system. (Hodge and Anthony, 1984).

   In the case of a hospital, these subsystems could be, *nursing, clinical, pharmaceutical, financial, information, management systems and so on.* The study has presented only some ***management systems*** depending on the workshop participants' output.

a. Is capable of maintaining some degrees of organisation in the face of disturbing internal and external influences (D.A.Gillies, 1994).

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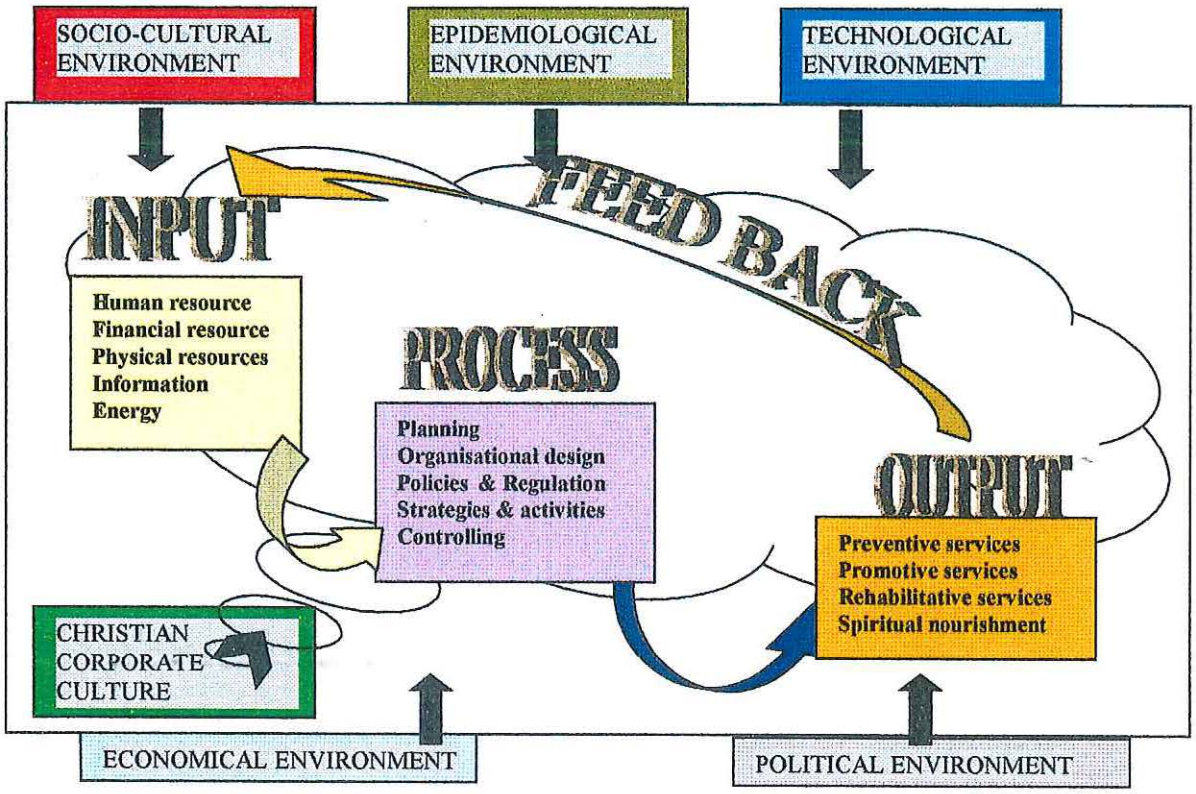
[21] Cultural, Social, Technological, Economical, Epidemiological etc.

[22] In Nursing Management Reference Desk Reference, Concepts, Skills and Strategies (1994) P.g 181.

The paper stresses the importance of management systems to face challenges of internal and external environment that have been explained earlier.

Diagram #1 by author below shows stages and examples of components of a church hospital as an open system affected both by external environment and internal environment (Christian corporate culture).

Diagram #1: An Open System



Example:

The emergence of HIV/AIDS is an epidemiological change, which has necessitated: -

➲ Changes in *inputs* (appointment of AIDS co-ordinators and counsellors, medical personnel to be trained about HIV infections, diagnosis, tests, more funds to take care of the victims and for purchasing HIV test kits)

➲Changes in the *processes* (new policies had been developed and institutionalised about blood donation, screening& result reporting, new (sub) systems (working groups, projects & programs) have been put in place in to foster preventions, care, reporting and advocacy to curb this killer disease. Consequently, these have come along with reorganisation in work schedule and job descriptions of some workers in the meta-system (hospitals).

➲Changes in the *outputs* (distribution of condoms, counselling services, pre-marriage tests, AIDS home –based care and so on. The Christian corporate culture (internal environment) in some cases has objected the distribution of condom.

Inferences

Synonymously to the above, economical, political and social changes discussed earlier, call for changes in all three stages of hospital system. The gist of this paper concentrates on the second stage referred (ie.the processes). The changes needed are practical MSP that will solve problem of *scarcity*-defined by Flessa (1996) as one or more of the following: -

Poor health in the community, insufficient medical supplies and drugs, inadequate staffs, financial constraints, lack of equipments, unskilled and less trained workers, unmotivated staff, lack of reliable data and so on.

Policies

These are guideline statements to certain actions in the (sub) systems. Linked to policies are organisations, developed regulations or standing orders, and working manuals as management tools for fulfilment and control of the adopted greed policy. Thence in a simplified explanation, policies are nothing other than the agreed upon clear statements to enhance efficiency and discipline in work places.

3.4 Institutional Capacity Development; a conceptual framework

Dr Philip Mpango on a workshop for Development of and Training on Approaches and Methods for National Capacity Building, Maastricht, 26-29 May 1998 describes Capacity to comprise of *human recourses, institutions and practices* that permit and enable a country to achieve its developmental goals.

According to the adopted definition by delegates from developing countries on a symposium held in 1991 by UNDP and International Institute for Hydraulic and Environmental Engineering, Capacity building is denoted to be much more than training and it includes the following: -

- ❖ Human resource development, the process of equipping individuals with the understanding, skills and access to information, knowledge and training that enables them to perform effectively.
- ❖ Organisational development, the elaboration of management structures, processes and procedures, not only within organisations but also the management of relationships between the different organisations and sectors (public, private and community).

- Institutional and legal frame work development, making legal and regulatory changes to enable organisations, institutes and agencies at all levels and in all sectors to enhance their capabilities.

Morgan (1993) defines capacity development as the ability of individuals, group, institutions, organisations and societies to identify and meet development challenges over time. He differentiates capacity development from the conventional capacity Building to emphasise the idea of on going process and not starting from the scratch.

Capacity development encompasses developing professionalism, institutional autonomy, and managerial effectiveness.[23]

The fundamental goal of capacity development is ***to enhance ability to evaluate and address the crucial question related to policy choices and modes of implementation among development options based on understanding of environment potentials and limits and of needs perceived by he people concerned.***[24]

Therefore, thinking of institutions, Institutional Capacity Development (ICD) seeks to:

Strengthen targeted human resource in a particular Institution and to provide that institution with means where human resource can be marshalled effectively to perform planning, policies formulation, implementation and evaluation.

In the Church context, I perceive (ICD), as a process through which the Church and her Institutions strengthen their ability to mobilize the resources needed to overcome economic, social and spiritual problems to pursue their mission (explained later in 3.6.2). Dennis Rondinelli[25], more widely defines ICD to include both sustainable organisations and widely accepted rules of behaviour.

Thence for the purpose of this paper while citing Berg's (1993) definition, ICD would refer to:

a. Hospital personnel skills enhancement (general and specific)
b. Organisational strengthening
c. Management procedural improvement (functional changes or system reforms) and
d. Adoption of sound policies and regulations.

[23] Tanzania National Capacity Assessment Team (1996), operational definition.
[24] Capacity Building – Agenda 21's definition (Chapter 37,UNCED, 1992)
[25] In '*Institutional and Market development: Capacity building for Economic and social transition'(1998).*

Implicit conclusion.

While reciting Mwano's flashback voice and UNDP definition, Capacity Development is required by church hospital workers and their organisations to improve their ability individually and collectively to efficiently perform functions and solve problems to achieve the ***set objectives***[26].

3.5 Quality health services delivery

The broad definition of health by WHO since 1946 forces all the governments to understand that health is one of the fundamental rights of every human being. That it is a condition of complete physical, mental, and social well-being and not merely the absence of diseases and infirmity.

One of the most widely cited recent definition hold that quality consists of the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consisted with current professional knowledge (Lohr et al., 1992; Lohr 1990). Donabedian, (1988) a leading figure in the theory and management of quality of care, has suggested that "several formulation are both possible and legitimate, depending on where we are located in the system of care and what the nature and extent of our responsibilities are." Different perspectives on, and definitions of quality will logically call for different approaches to its measurement and management.

Usually **quality** of health service is therefore reflected from the users satisfaction. This being the case then the assumption is that all customers are knowledgeable of some set standards. However this isn't the case always.

" *I like Y dispensary! I am satisfied with their service; it is not like X dispensary where they give you tablets instead of injection when you have malaria.* "[27]

See customer's inclination is not always right. But this study envisages holding that for any measure of quality attributes; Church hospitals have to observe some standards as agreed by the National Health Policy.

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[26] A measure against which you can recognize whether you are in the right place or not.

[27] One old mother attesting her views in Serengeti Tanzania Jan. 1999

These standard indicators are determined by: -

- Availability- do you have access to it?
- Affordability- are you able to pay for it?
- Reliability- can you trust it?
- Consistence- is it continuing to abide to sound principles?
- Timeliness- can you get it when you need it?
- Equitability- can you get it fairly without unjustifiable discriminations?
- Cost effectiveness[28] – does it have minimum wastage of resources? (Mostly not a concern of patients)

Patients as customers will at least be keen on the six mentioned obligatory elements. Not surprisingly all those can be enhanced by being effective as well as efficient. These obligation starts from the time a customer enters reception to the time of discharge be it '*from the front or the rear gate*'.[29]
Deming 85-15 Rule postulates that, 85% of what goes wrong in hospitals is with the system, individual workers account for the only remaining 15% (Walton 1990:20). Though this research doesn't try to test an hypothesis which links systems and policies to quality, Deming's argument forms a strong motivation to study management (sub) systems, guidelines, and tools which make the church hospital systems run either noisily, smoothly, and may be to a halt.
Despite of the raising costs, competition and regulatory constraints in all health care institutions, the dedication to quality improvement will ultimately bring Church hospitals to survival if not flourishing.

3.6 Christian culture versus contemporary work and labour related issues.

3.6.1 Theology of work.

Though many a times people cite the fall of Adam and Eve as the beginning of work, (toiling), God in Genesis had already given Adam the responsibility to ***till and Keep*** *(Genesis.2: 15)* the beautiful garden-Eden. God didn't want human beings to work anyhow for the sake of work but to be ***fruitful*** as he gave us all the authority over everything on earth *(Genesis1: 28-29)*. Work should therefore be considered as a duty rather than a punishment.

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[28] Routledge Dictionaty of Economics (1992) by Donald Turherford, defines it as the analyses of the cost of alternative programmes designed to meet a single objectives. That which costs less will be most cost effective.
[29] A Tanzanian hospital figurative expression denoting both possibilities of either leaving the hospital alive or as a corpse.

*"...being confident of this, that he who began a **good** work in **you** will carry it on to completion until the day of Christ Jesus" Philipians.1.6*

This also shows us that success is not in dependence of Pastors, Bishops or any prominent member of a Christian community but in HIM[30]. Again it has to be GOOD work! Business ethics is therefore the environment to be considered here.

For sure there a number of scriptures related to work. Saint Paul once denouncing 'He who doesn't work let him not eat' *(2Thesalonike 3.10)*, showing that we have to work if we want to live.

Though faith is often deeply expressed through our lives of work, workplaces remain laboratories of the spirit as people experience tension between their role as workers on one hand and as participants of the community of faith on the other. (Jan Wood 1999:9)

Today we hear sermons and read a lot on faith at work, being a Christian manager, Christian leadership and stewardship. I commend the work of Jan Wood (1999) *Christian at Work;* Ralph Mahoney (1996) called the *Shepherd Staff;* Dr. Donald R. Jacobs' Bulletin on *Christian leadership;* Alistair Mackenzie's Master of theology thesis (1999) on *Vocational, the theology of work and pastoral implication.* Other resource materials include those by Prof. Don Mathieson, *Extra care Needed-Christian at work,* an article from Affirm magazine summer 1997; Harold Turner's Orange Memorial Lecture (1992) on *a new mission to our post-Christian and largely pagan culture,* Dominic Beers' edited work (1995) *Christian Choices in Health Care* and many others. However most of these literatures: -

- Explore the difficulties and challenges individual Christian workers and not Christian organisations as such face in the world of work and business mostly on medical ethics.
- Discuss issues in context of Christians working in 'secular' organisations.
- Are more specific to the environment of the writers (mostly from the west), very few try to address some peculiar problems of African Christian workers and organisation leave alone Tanzania. In other words searching for materials on something like '*Contextualization of African Christian Managerialism* ends you in vain until one of us takes it as a de novo research project.

Whilst 'reclaiming the culture' may be appropriate in certain areas, Harold (1992) also should have thought of 'redefining the culture' and obviously some practical suggestion on how to cope with the prevailing contradictions in many issues that affect Christian workers and Christian organisations for example: -.

[30] God - the Omnipotent, Omniscient and Omnipresent.

a) A Christian manager leading nominal if not non-Christians.

Up to now many hospitals don't have sufficient qualified personnel. Should the management refuse to employ or second in a doctor who smokes or takes wine if that is against the norms?

b) Christian hospitals operating in a competitive business secular world with popular contemporary social and moral issues like: - Gene technology, euthanasia[31], body reclamations, induced abortions, surrogate motherhood, freedom of association and gender equality just to mention a few. This reminds me of one more touching incidence.

"When the morals of this church were in place, we could not have continued to work with all these nurses who have children out of wed locks." One hospital Chaplain reminds his administrator. *" In the actual fact those fatherless children should not get free medical services from us, neither on leave travel allowances nor assistance for their burials if they die. Their mothers need to look for other* ***alternatives.*** *"* He concludes in the name of reclaiming the original Christian culture.

Very quickly proponents of UN Convention on the rights of the child (1989) would pose a genuine query, *" Does Christian culture guarantee a breach of principle rights to children?"*

Just a common-sense follow up question will be *"which* ***alternatives****?"* mostly it will be from the community where the Chaplain also lives and must contribute in the African spirit of good neighbourhood. Now how do we justify the heavy punishment to the mother and the innocent fully developed embryo while the father is left free?

How do we justify dismissal of women nurses with children out of wedlock while the same male counterparts in the same situation remain untouched? As we reclaim the Christian culture, *engendering* of the corporate culture reclaims principle rights for mankind.

3.6.2 Church hospitals –points of departure from Government ones.

Though with the same aim of looking forward to seeing a healthy nation, there still exist some notable differences between Church hospitals and Government ones in ideological, organisational, value systems and therefore resulting into some differences in practices. This doesn't however try to suggest differences in classification of diagnoses, nursing care of burn cases and so on, but more in the way the church as a partner player visualizes beyond the visible (tangible) field. ***See appendix 5***: a diagram of Church hospitals as players in health service delivery and its interpretation by the author entitled, *"Playing Beyond the: - Referee's Eye, Goal Posts, Manager's Mouth, Supporters' Hands"*. The differences between Church hospitals (CHs) and Government hospitals (GHs) in Tanzania are: -

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[31] Andrew Fergusson (1995) in ***Christian Choices in Health Care*** *defines it as t*he intentional killing (voluntary, non voluntary and involuntary) by act or omission to a person whose life is felt to be not worth living.

a) Mission Statement

For CHs

To fulfil the call of Christ by preaching, healing, teaching and giving services to the community for God's glory.

For GHs

To fulfil the national health policy by providing health care for a given community according to and in line with the communities' objectives and subjective health needs.

b) Norms and practices

While CHs have devotional sessions as part of their duty, GHs don't.

CHs have Chaplaincy where pastoral counsellors serve for nourishment of spiritual development, GHs don't have. GHs have strong trade union but CH have weak affiliation to trade union, sometimes none. As GHs are managed by Regional /District Health Management Teams (RHMT/DHMT) and directives from the ministry of health, CHs though now established to meet set standards of the ministry of health, they are internally managed under diocesan health policies and circulars. There are also a lot of other values being hold by CHs that GHs don't or vice versa.

Some values had been held by different Churches in the name of a 'Christian values', which in my opinion has rather been misleading, and bringing confusions in places of work.

I am afraid that in most cases we have managed our institutions under *religious sits*[32] instead of *biblical absolutes* (see ***appendix 6***: Diagram revisiting the real foundation and focus of Church organisations***)***. Some of those stereotypic values (discovered by the author) are summarized and presented as the **sacred *six Rs*** that is *Reciprocity, Reticent, Resoluteness, Restoration, Restraining and Rewards* versus the **secular** ones (to be presented and discussed in chapter 4 and 5). These values referred herein cannot be simply described in the realms of the *Institutionalist theory of change* founded on the Veblenian dichotomy between instrumental values (based on reflection) versus ceremonial values (out of status, hierarchical order, beliefs and mores)[33]. The ***six Rs*** are neither in themselves resistant to change, nor seeking to preserve any existing class arrangement but more startling to note, is the way they are misinterpreted and applied in different situations.

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[32] People who hold high positions

[33] Explained by Tool (1993), *The Theory of Instrumental value: Extension, clarification.* And Gruchy (1972), *Contemporary Economic Thought: The contributions of neo institutional Economics.*

3.7 Concluding remark

Church hospitals are open systems affected by external environments. Capacity development is needed to develop ability of workers to meet and solve development challenges as the world is unfolding them. It is clear and commendable that management of Church hospitals incorporates Christian virtues. However misinterpretation of the Bible cannot be taken as an excuse to hamper professionalism and quality of health provision.

CHAPTER 4. MAJOR FINDINGS AND CRITICAL ANALYSIS

4.1 Introduction

A lot can be presented from the workshop outputs and interviews, herein I have summarised common aired views and suggestions on issues related to Church hospitals' management systems and policies in the light of improving the quality of health care delivery.

Special features appear in this section to make information easily understood.

The ***workshop remarks and outputs*** are in highlighted boxes to distinguish them from my personal ***analysis***. *Few* summarized, italicised ***Cases to Ponder*** presents true happenings as examples to supplement findings and analysis.

4.2 The agenda of the principle problems

4.2.1 The Orthodox Values

The findings and analysis try at the end to answer the major guiding research question.

'How prepared is the Church in making sure that its hospitals has appropriate management systems and policies for quality health services delivery?'

However its ***follow up question (FQ)***[34] as an antidote to unhealthy degree of preparedness sets precedence to the search of the principle base of the orthodox values and practices in church-working environment. The author suggests that the imbedded sacred values in the system (mentioned earlier as the **six Rs**) can explain to a great extent though not entirely both the originality of the existing principal problems and the response of Church hospitals to the prevailing challenges. The discovery of the six Rs comes out of life experience as a believer and as an employee in Church settings. Most of these values (though with different names) are expressed in Church constitutions (I have cited examples in the

[34] "Do we (the Church) continue to subscribe to the orthodox preserved values?"(Ref. Section 1.3)

findings and analysis), liturgical books, brief notes of employment contracts or Church doctrines sermons for example, '*abstaining from this world'* was the main theme of the then Rev. D. Mahemba on the day of my baptism[35].

The bona fide meanings in these values may not be bad at all but the problem arises when they are often wrongly interpreted to justify mistakes of omission (referred in table below as **secular values**) of important managerial activities, and therefore unconsciously alienating the systems (hospitals) from the necessary capacity to implement positive changes.

#	Sacred values	Reference	Key words	Secular values
R1	*Reciprocity*	Matthew10. 8	Freely you have received freely give	Setting targets and soliciting pledges in fund raising and cost sharing
R2	*Reticent*	James 4:11 Hebrew 13:17	Who are you to judge? Obey your leaders and submit to them	Being open and speaking against injustice. Allow flexibility to different opinions from those of authorities.
R3	*Resoluteness*	Hebrew 13:8	Jesus is the same yesterday, today and forever. Don't be carried away with strange teachings	Reorientation to new/modern knowledge and ventures
R4	*Restoration*	Matthew 6:12	Forgive us, as we forgive	Taking disciplinary measures and forwarding claims
R5	*Restraining*	John 15:19	You do not belong to the world but I have chosen you out of the world	Joining social groups and Trade Unions
R6	*Rewards*	Matthew 5:11-12	Blessed are you when people revile and persecute...Rejoice and be glad for your reward is great in heaven.	Having an elaborate remuneration package, scheme of services and other employees' rights.

4.2.2 Findings

The following summary portrays the general situation as identified and interpreted by the author based on participants' workshops outputs, interviews and from CSCC and MoH documentations. The columns from left to right show the type of system or policy item in question; its present status in church hospitals; the extent of the problems whether it is general to the Tanzanian government (**G**) or specific to Church (**C**) or Hospitals (**H**) and some possible underlying explanations; and the problem implications to the whole hospital system caused by either lacking or having inappropriate system or policy.

Note: Use the same key and heading in both tables.

Key: **G** - Government problem: **C** – Church problem: **H** – Church Hospitals' Problem

R (1-6) – Sacred values: **FQ** (1-6) – Follow up Question mentioned earlier in 1.3

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[34] "Do we (the Church) continue to subscribe to the orthodox preserved values?"(Ref. Section 1.3)

[35] On 12th Dec.1977 at Musoma KMT Tanzania.

Systems/Policies /Regulation/ Management tools	*Present Status*	*Extent (G, C or H) and Underlying Issues*	*Implications*
Organizational structures	Tall kind	Problem of **G, C&H.** Inherent from colonial authorities	Centralize authorities and delayed decision making
Communication system	Fosters mainly downward communication	Problem of **G, C & H.** **R2** calls for subordination in the case of church environment but the old public management & internal organisation in Govn't settings.	Innovations are hindered. Lack of effective feedback loop to improve quality.
Performance appraisal systems	Are of one-way; confidential annual reports by managers about their subordinates.	Problem of **G, C & H.** The old personnel management model with the aim of determining the future status of workers.	Missing discussion & analysis of success and failures with the view of improving the future performances.
Community financing system	Operating in seven Government Initiated pilot Districts i.e. Igunga, Nzega, Singida, Iramba, Hanang, Songea, Rural & Songea Urban Districts.	Problem of **G, C & H.** The whole idea of prepaying before service has not been common in Tanzanian social living. More advocacy and awareness campaign- activities need to be undertaken	Out of pocket-pay to service is not only expensive and with individual risks but doesn't address the problem of seasonability[36]- one of the features of poverty especially to the majority Tanzanians in rural areas.
Referral system	Ineffective pyramidal pattern is available in Government health system. Further more it isn't well linked to private or voluntary hospitals.	Problem of **G & H.** There is weak management logistics support system. Types and level s of services offered in different health facility categories (primary and secondary) need to be distinguished.	Only those living in the surrounding of tertiary referral hospitals benefit the services.
Strategic planning	Only short tern plans are carried by few individuals mainly management team	Problem of **C&H.** Critical decisions are to be approved by the Diocese. Lack of skills by other departmental heads, and Inefficient Information system makes strategic planning very difficult.	Management by crisis becomes the usual practice in dealing with critical issues. This is a costly undertaking due to emergence board meetings and frequent trips to the dioccse.
Quality assurance (QA) system	Very limited supervision, and monitoring of the services is done on the part of Government and DDH hospitals mainly through HMIS[37]. Less is done to other private health services.	Problem of **G & H.** There is weak linkage and control of private sector by the Government be it for health facilities, pharmaceutical shops, Laboratories and more completely uncontrolled traditional medicine practices.[38]	The Public/Private mix strategy # 7 (HSR programme of work) in the process endeavours to develop (in a participatory way) norms and standards for QA. The already implemented yearly accreditation system doesn't leave non-compliant church hospitals.
Organisations	Predominance of informal organisations and informal communication	Problem of **C&H.** The over assumption of and trust 'everybody is responsible'.	Increased rumours and misunderstandings perpetuated by grapevine.

[36]The lack of income during dry seasons and before harvests which causes financial barrier of obtaining of health care.

[37] Health Management Information System

[38] Private Medical Practitioners and Dentists operate under the re-introduction of private practice in 1991 as an amendment of the 1977 Act. The Pharmaceutical and Poisonous Act of 1978 empowers the Pharmacy Board to control importation, distribution and use of Pharmaceuticals. The same Act recognizes the Traditional medicine practices that are also mentioned under the Medical Practitioner and Dentists Ordinance Chapter 409, the Health Sector Reform (1996) and the National Health Policy (1990)

Workers organisation & social dialogues	Discouragement to join trade unions. Otherwise though acknowledge they are not institutionalised. Narrowly grasp of understanding the concept of hospital stakeholders.	Problem of **C**. **R5 & FQ3** create a base implicitly or explicitly for clear abstinence statement in Church constitutions & manuscripts.[39]	Infringing workers' fundamental rights. Missing the opportunity of involving workers in decision-making & problem solving. Failure to tap resources from local stakeholders
Job descriptions	Available for members of management committees	Problem of **C&H**. Lack of skills to develop them	Conflicting roles, and lack of performance indicators
Recruitment policies	Not in place	Problem of **C&H**. Legitimating hierarchical authority. Uprightness is overemphasized at the expense of professionalism	Few individuals' discretion instead of committees to appoint, hire, fire and shift. Allegations of nepotism and favouritism
Scheme of services, clear salary structures, Incentives & Terminal benefits	Not in place	Problem of **C&H**. Lack of skills to develop. **R6 & FQ6** neutralizes efforts towards implementation.	(Silent) questionable promotion and remuneration rates and procedures. Low employees morale, increasing labour turn- over & difficult to attract trained staffs. Increased industrial disputes where the church is accused of breaking mainly the Security of Employment Act No. 574 of (1964)
Disciplinary system	Unclear rules and procedures. Mostly shifting the undisciplined to another location	Problem of **C&H**. **R4 &FQ5** interfere the consistence in administering discipline.	Lack of behavioural change. Lowering performance of the receiving location.
Training & development policies	Not systematic with Training Need Analysis	Problem of **C & H**. **R3** has affected churches to some extent to concentrate in training people mainly in Theology & Bible, giving less attention to other disciplines. Financial constraints in churches and hospitals have also contributed greatly to poor Human resource Development.	Insufficient owned trained workforce. Churches are therefore highly dependant on seconded staffs from the MoH and Scholarship funds from abroad. This in turn becomes one of the major (human resource base) constraints to embark professionalisation. Continued situation means closure of hospitals.
Financial and materials management policies and regulations	Not in place	Problem of **C& H**. Lack of skills to develop them. **FQ 1** has been used especially where it was believed that just trustworthy accountants and storekeepers could be a perfect substitute to a working financial and materials management system. The weak culture of repair and maintenance is a general problem in the country. (refer management indicators)	Lack of accountability and preventable fraud are features of church institutions due to lack of effective checks and balances. Budgets deviate greatly from realities. Hospitals incur a lot of money to do major repairs or buy new equipment once the defect is beyond repair
Management Information System	While most Church hospitals still use Inefficient traditional routine data-led system, Gov't hospitals has adopted action-led HMIS[40]	**H** need to adopt and participate fully in HMIS. However the system needs review especially in the required books and sheets and registers for recording.	Without reliable and complete data **H** can't do strategic planning nor undertake informed decisions.

[39] For example pg 5, sect. III. E (*'Kujitenga na ulimwengu huu')* of the Tanzanian Mennonite Church (KMT) constitution (1992) stresses that we are not of this world. The same reason is used to restrain ordained workers from joining in government political posts: The ELCT (Northern Diocese) Employment Regulations and Rules, pg. 32, article # 11explain clearly that joining trade unions means automatic termination of employment.

4.3 Analysis

The following section is devoted to a bit elaborate critical analysis with examples of the situations in church hospital management. In every major area of concern under study (*explanatory units*), an analysis is given following the remarks and outputs by hospital managers as they tried to develop generic management systems and policies appropriate for their organisations.

4.3.1 Organisation and Managerial Functions

4.3.1.1 Organisational structure of hospitals

A. Workshop remarks and output.

- Majority of hospitals could present some kind of tall organisation structures. The existing ones are predominantly service based.
- Organisation structures were not conceived as important tools for indicating lines of authority, responsibility and communication flow be it vertical or horizontal.
- Organisation charts are displayed but not adhered to (implemented).
- Some indispensable lines of authorities and communications are only assumed without being shown in the chart for example position of the Chaplain, external auditor and so on.
- Generally relationships in the hospitals are dominated by informal organisations.
- Significantly, some expressed a tension of authority and position of MOI/c.

The workshop generated a generic hospital organisation structure. *(*Refer to ***appendix 7*** *– The Proposed Hospital Organogram)*

Analysis

- No longer hospitals look small and simple to manage. The health care in totality comprises of a team of people with different specialities. In as much as the chief executive officer needs to have some knowledge about health management, it however should not be an exclusive position for medical doctors. It is therefore illogical to expect any medical doctor to became the chief manager just by virtue of his/her position as a doctor. Nobody should reject them either just because they are medical doctors. In the actual fact what is much needed is a person with leadership qualities and managerial skills; she or he who with good interpersonal communication skills, knowledgeable in business administration, a self disciplined person with integrity and fidelity to common organisational interests and purpose. This can be a nursing officer, health secretary, a doctor, an economist, a pharmacist or whoever.
- There is no one best organisation structure to be emulated but they should be carefully developed by hospitals with flexibility to the prevailing organisational environment.

- Consideration to the size of the organisation, the corporate values, services offered and all the key positions identified are paramount. Many times no body has been assigning external ***auditor*** to carry transparent financial auditing. In Church hospitals, the excuse given by managers has been it is not our duty, it is the Governing board or it is the Diocesan health department. But neither the Board nor the Diocese had send one. This needs to be resolved. I have added my suggestion in the same proposed organogram.

4.3.1.2 Job descriptions (JD)

A. Workshops remarks and output

- Only heads of departments especially members of the management teams have job descriptions.
- It was noted that problems related to conflicting roles in managing different issues, are attributed by lack or misuse of job description.
- Many heads of departments or sections can't prepare job description with their subordinates due to lack of skills. If developed they will remain unmodified for ages.

Developed in the workshop, ***Appendix 8*** manifests an example of proposed Job Descriptions for the Diocesan Health secretary.

B. Analysis

- In as much as proponents of Human Resource Management (HRM) consider JD as archaic tool, which hinders flexibility and development, I still think that if well developed, JDs can still be used as guidelines and tools for performance appraisal. As also supported by Evan and Lorange,[41] **culture specific dimensions** need to be taken into consideration when transplanting or adopting HRM practices.

  Practices such as career development, performance appraisal, communication styles, reward systems, and job identifications are to great extent functions of different cultures.

  People in Tanzania want to be recognised according to their carrier choices and attainments. Workers (even for non professional cadres) feel offended when you try to make them 'junks of all trades'- today you are a cook in the kitchen tomorrow you will be a security guard, as for next week you don't know may be a mortuary attendant! In the actual fact it is not the titles, the tasks and promotion possibilities that only matters, workers in Tanzania and many other places are also committed to their jobs and all the attached personality and cultural values in it including the *artifacts*[42].

[41] In *their work (1990), The two logics behind HRM.* New York: St martin Press, pg 144-61

[42] The physical cultural symbols like clothes, offices, ornaments, signposts, name tags and so on.

A Case to ponder.

In their departmental meeting with the MOI/c, there is a 'big' applause by every clinical officer to the last speaker who has just finished his strong statement. " Look, how can you expect us to be effective, to work diligently while you don't motivate us. We don't ask for big things for example call allowances though we need them, but we want to see the hospital management respecting our work," he paused, " why do you in these days allow even nurses to put on our white clinical coats? Then let them do the clinical work."

This shows that while the style of Japanese management or the American McDonalds of all employees putting on the same uniforms may be motivating, the opposite is the case in Tanzania.

- JDs are not in any way permanent unaltered tools of management. They should be flexible enough to accommodate inevitable changes. A constant review is needed when any item becomes irrelevant or obsolete.

Caution: Trade Unions when in operation should be watchful when job descriptions and work schedules are reviewed especially for Nursing shifts to avoid what Ramaswamy and Schiphorst (1998)[43] unpacked when quoting Fucin and Fucin (1990) revealing that *"management might want nothing more than 57 seconds of peak performance out of every 60".*

4.3.1.3 Appointing authorities and exercise of power

A. Workshops remarks and output

- Generally authority was confined (concentrated) at the top and middle management levels. The workers at lower levels are just followers who receive orders and circulars on work assignments and behavioural requirements.
- About the appointing authorities, life at DDHs was better than at VAs. It was clear that in some hospitals one person (executive) at the diocese level and at times at hospital level has the discretion powers and authority to hire and fire. This practice has been a disgrace to human equity. It jeopardises any democratic move and any effort toward recruitment of potential candidate with the required personnel profile to match job specifications.
- With a lame reasoning of defending the 'interests' of the Church, Bishops remain to be considered as the 'owner' of the hospitals, and they also are the Board chairpersons in most cases.

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[43] Ramaswamy, E.A. and F.B. Schiphorst (1998), Working paper series No. 271 entitled *'Human Resource Management, Trade Unions and Empowerment: Two Cases from India.* The Hague: Institute of Social Studies. Pg. 16.

- The participants suggested that authority is to be distributed at all levels of management and that the church should STOP continuing entrusting all the authority and prerogatives of recruitment, selection, development and dismissal to personal biases of one leader despite of his/her credibility and position. Relevant committees need to be put in place or need to be honoured if they are there.

B. Analysis

Today we witness different governments of church leaders who **abuse authority** entrusted to them. This has been one of the major causes of discouragement and demoralization among workers in Christian institutions. The increasing conflicts, clashes, fights and 'sacred' religious disputes in 'secular' judicial bodies in the world today excluding not Tanzania are due to explosions from spiritual warfare bombs planted by irresponsible and selfish leaders.

Church hospitals just like any other Para-Church organisations have suffered greatly in what I call *'the Queen Bee Syndrome.'*[44] This has a lot to do with the way top leaders in their organisational environment exercise authority and powers. Consider the following 'distinct features' of the church hierarchy (blessed are those who don't have).

a. The constitutional obligations to elect new secretaries, directors, board members and others after a specific period (3-5years) but not Bishops because they have a life-long service constitutional right.

b. Workers like doctors, nurses, typists, teachers, administrators and even pastors can be easily shifted (by committees or individual heads) to new working places, but not Bishops.

c. Privatisation of crucial decision making in the hands of one of few individuals. You may be keen to know who has the last say in issues like floating tenders and disposal of church fixed assets. Delegation of authority is very minimal if not inconsistent.

[44] One of the distinct features of the Queen of the bees is her morphological make up -**'the figure of eight'**. It is believed that as long as she lives, the queen is always giving orders to her fierce body -guard bees to eliminate any young female bee that appears to have the same 'figure' whether or not she is interested in becoming a queen in future. The Queen is to remain the only one with distinct features and powers!

" *We are only delegated to do the tough and 'dirty' jobs in the villages, unlike them we don't have even bicycles but we are the ones who evangelise,*" complained one Evangelist in Arusha Tanzania (Nov.1998) as he was SWOT analysing the church.

A case to ponder.
The Bishop is the Board Chairman in not only the church hospitals in the Diocese but also schools, colleges and hostels in a Diocese. In his busy schedule the heads (Board secretaries) of 'his' institutions are trying to invite him in their important activities like, board meetings, graduation ceremonies, welcoming new entrants, and conferences. In most cases the (Bishop's) delegates attend the meetings as intermediaries or message carriers and not participants. It is regrettable that old agenda need to be clarified and or repeated to gain new momentum because the delegation keeps on changing from one person to another.
It is therefore not wise to continue keep this practice ***(FQ4).***

Thanks to foundations like the External Chair in Religion, Human Rights and Social Change established by a concerted efforts of World Conference on Religion and Peace (WCPRP), Cordaid and ICCO where the study of role of religion in addressing contemporary issues affecting human rights and social change is being promoted.

In her challenging inaugural address[45] entitled *Rats, Cockroaches and People Like Us,*

Dr.Gerrie ter Haar asserted that,

" For most people in the world, religion is an integral part of their existence, inseparable from the social and moral order and it defines their relations with other human being."

I therefore believe that religion still has a global momentous role to play in a successful enculturation of human rights. This however has to be seen practiced first within religious work organisations.

Many leaders emphasize also *reticent* ***(R2)*** - a habit of saying little or being silent either as a way of showing humbleness and submissiveness to leaders or trying to be seen as non-judgemental *(Hebrew.13: 17 & James 4:11)*. I think if you bow, smile and act indifferent to your corrupt leaders or lazy, idle workers, you are not less than a dangerous hypocrite
(Matthew 23:28). The Bible is never in contradiction with itself but the interpreters do. It is better always to remind ourselves 'submissive to what?' and 'for what purpose?'

I have witnessed many workers who were completely silent and look satisfied while they are still accommodated in the core level of the church (organisation) system. But the same people will quickly run and file cases against the church as soon as they are pushed at the peripheral.

A study on how and why churches and their organisations have been affected by loosing cases related to labour issues could be of interest.

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[45] Delivered by the External Professor of Religion, Human Rights and Social Change speaking at the ISS-the Netherlands on 13th April 2000

4.3.1.4 Stakeholders and social dialogue

A. Workshop remarks and outputs

- Being green as far as the concept and role of 'a local stakeholder' was confessed, and that this needs to be adequately clarified to church and hospital management members.
- The workshop identified their local stakeholders as all people and organisations that have interests at risk regarding the activities and outcomes of their hospitals. These include patients, workers, trade union, board members, Church leaders, CSSC, MoH, local governments, competitors (other health providers), development NGOs, suppliers and creditors and all the people in the communities around their service areas.
- Less effort has been put into establishing a stead partnership with all stakeholders. In some cases the Diocesan personnel policy would require restraining from joining some for example trade unions.

B. Analysis.

- For sure ***abstinence*** from a pool of either local experienced people in the business or potential sources of support is detrimental. This kind of life has left the Church and its hospitals continuing lamenting to mother churches abroad or former donors while singing of the 'old sweet days' in retrospect.
- ***Restraining*** from trade unions and social dialogue has no biblical base whatsoever. But some leaders from one-sided perspective feel that such gatherings lack humility and tranquillity. It is a plain truth that today trade unions need to reorient and revisit its membership and working strategies, however that cannot justify any move to shun away from them.
- Apparently, the adversarial approach is no longer a popular agenda. This is due to the present social and economical changes that have affected employment, work patterns and labour relations in different ways.

  When interviewing Bishops and Reverends, on the importance and role of trade unions and social dialogue in church organisations, most of them are not against the idea. But may be this kind of commitment need affirmative actions to actually support their operations in work places. Christians and non Christian workers working in church hospitals are tired of hearing and reading rhetoric statements that are never fulfilled.

[45] Delivered by the External Professor of Religion, Human Rights and Social Change speaking at the ISS-the Netherlands on 13th April 2000

A case to ponder

What message do we get after reading this passage directly quoted from RC Church authoritative manual[46]? Though some denominations hold different view on the same issue, the part I have underlined pause a serious question.

On Unions

"277. From the fact that human being are by nature social, there arises the right of assembly and association. They have also the right to give the societies of which they are members the form they consider most suitable for the aim they have in view, and to act within such societies on their own initiative and on their own responsibility in order to achieve their desired objectives."

Who then in the church has the RIGHT to deprive church workers from human basic RIGHTS? hope you have got the answer to **(FQ3)**

Another dimension in the name of *restraining from this corrupt world* ***(R5)*** has prompted some Church hospital managers to live in ignorance of labour laws and business laws an excuse that has not salvaged them from the pangs of court orders and injunctions.

Hebrews 13.8 talks about *restraining* as a value of being **in** this world but not **of** the world.

It is very strange the way we distort it to mean abstaining from the social life.

Appendix 9 summarizes what the participants viewed as the potential local stakeholders and ways of treating /involving them.

I believe if taken seriously by hospital management, a mutual cooperation with stakeholders is a treasure, which can't be disputed.

Note that in a wider sense the hospital management vested with the *steering powers* is also a stakeholder to be respected and cared for by all other stakeholders.

4.3.2 Personnel Policies, Regulations and Labour Relations

4.3.2.1 Recruitment and Discipline

A. Workshop remarks and output

- Lack of clearly stipulated recruitment and selection policies has led to employing staff with limited knowledge, skills and experience in Church health institutions.
- Where uprightness or committed church membership is looked upon as the yardstick, professional and technical procedures are seriously compromised.

[46] Rev. Sirico Robert, A. and Rev. Maciej Zieba, (eds) (1999), *The Social Agenda: A collection of Magisterial Texts.* Vatican: Citta Del Vaticano. Pg. 48,72 and 151

- Selection processes have to be handled in committees comprising church leaders and professionals. In many instances the Bishops and or General secretaries have posted people to hospitals without any selection procedure.
- Openness should be maintained through out the recruitment and selection process as to ensure engagement of staff with right qualification, attitude and aptitude.
- Employment contracts are inadequate as they lean more towards the employer; they are full of loopholes that can be taken advantage of.
- Disciplinary rules and procedure are not clear to hospital employees. Disciplinary sanctions are inconsistent.

The workshop developed an example of a policy statement on recruitment and selection for church hospitals (***appendix 10)***.

B. Analysis

- Depending on the size and complexity of organisations, it is advisable to have (as it is in some few cases) two or more categories of hospital employees from the point of view of their appointments:
  a. Those recruited and selected by the Hospital Board to include: -
  MOI/c, NOI/c, health secretary, chief accountant, doctors and assistant medical officers and
  b. All others who can be employed by the hospital management Committee.
  It is imperative that members of these appointing bodies are not affected by the *halo effect*[47] during selection.
- Agreeable as it is, the church is pictured as '*raising a **family**' (Ephesians.3: 15). Restoration **(R4)*** of everyone is a noble duty. But the answer to the follow up question ***(FQ5)*** is supposed to be no! Executing discipline should be seen as a way towards improved behaviour and not for persecution. All of us know that you spoil[48] the child if you completely abstain from disciplining him/her *(Proverbs.13.24)*. It is therefore better that sanctions are fairly exercised by a committee and not one individual. A provision of appeal must also be in place.
  Note. Shifting indiscipline people to one particular department/section creates in a long term a pool of potential organised destroyers in a polarised unit, dabbed punishing centre.
- The church should develop effective performance appraisal systems, where the employee has an opportunity to discuss with the employer to improve working.

[47] A term used in personnel management to denote a shortfall of interviewers when they wrongly think that an applicant is equally worthy in other areas for example (bookkeeping) just because he/she has one desirable quality (for example trustworthiness)

- This must be linked with a reward system. I don't agree with unpopular descriptions that salary is just a reward ***(R6)***, *also* ***(FQ6)*** or that we don't need much elaborate wages here as our rewards are in heaven (*Matthew 5:11)*. Exploiting workers (a comparative disadvantage) causes discontentment and continuous grumbling, which may cost them the heavenly reward you are promising them.

4.3.2.2 Human Resource Development (HRD)

A. Workshop remarks and output

- There is not what may amount to systematic training in church hospitals, so there is no training needs analysis among other elements.
- Necessity of training was seen to be due to: - inadequacy of trained personnel, expansion of the institution, upgrading to meet the demands of new positions.

The workshop identified *general problems facing HRD in hospitals and proposed solutions* ***(appendix 11a)***. They also proposed *HRD Policy statement* (***appendix 11b***).

B. Analysis

Education is the end and means to any development. The church as a whole need to put emphasis in human resource development not only in theology but also in all other fields. This is without forgetting the seemingly least in recognition but yet very important like, Epidemiological studies, Information and Technology and even Entrepreneurship. How can we be the *salt* of this world while we are ignorant of our environment?

'An intelligent mind acquires knowledge, and the ear of the wise seeks knowledge.'

(Proverbs.18: 15). Therefore there is no even a biblical base of not training people in other disciplines. I find illogical to base the trainee's contribution as suggested (*in appendix 9b*) to his/her gross salary. We are all aware of the difference in terms of costs depending on the type of training, the school he/she attends, the duration and many other factors. It would be fair and better to have a fixed percentage, not of the salary but of the cost of the training.

Referring to (X in *appendix 11a*), while self-reliance projects are accepted, this should not be the sole alternative. It is better to think of education insurance schemes and cost sharing by the trainee.

Referring to (Y in *appendix 11a*), it is better for any church to carry a sincere audit of her capacity to run effectively and in a sustainable manner all these institutions.

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[48] Making him/her a deviant and or useless member of a family

- We already are experiencing problems in running all the existing hospitals. May be it is better through CSSC, all churches to pull together resources to revitalize the already existing poorly run church training institutions than establishing new ones.

  It is also possible in this era of close cooperation with the Government to be given more vacancies if such a dialogue is initiated not by one individual church but through the umbrella organisations.

4.3.3 Financial Policies and Materials management

A. Workshops remarks and output

- Despite of all hospital making use of financial transaction documents and owning separate bank accounts, there is lack of approved financial regulation working manuals. Books of accounts like cashbooks, subsidiary ledgers, general ledgers, Stock ledgers, and Journal vouchers are neither maintained nor updated.
- The only reconciliation done though also not monthly is bank reconciliation. All others like stock –ledger reconciliation, subsidiary account and control account are rarely done. Trial balance properly maintained either.
- Few hospitals (mainly those forced by donors or the government for the case of DDHs) carry an external auditing yearly.
- There is lack of qualified staff in accounts sections.
- Hospitals have very unrealistic budgets (simple extrapolation of the past figures by a fixed factor to all items). More amusement, it is *one person's show* as the process doesn't originate from any head of other departments or section except from finance department.

B. Analysis.

- Both lack of statements of agreed accounting practice and systems of checks and balances in the realm of finances and other assets are major problems facing church hospitals.
- It makes a difference between hospitals with and without qualified accountants or health secretary. In the former, at least when there is a will, accountants and health secretaries have tried to observe and influence others on the fundamental accounting principles as stipulated in the Tanzania Statements of Standard Accounting Practice (TSSAP) by the National Board of Accountants and Auditors, under sec.39 of the Auditors and Accountants (Registration Act, 1972).
- To run hospitals without agreed accounting policies is to choose a road of inconsistency and loopholes that protrudes into confusions, unfairness and obviously theft by unscrupulous employees.

Just a few brief questions to consider.

How do the hospital treat the whole issue of valuation of inventories, provision for bad and doubtful debts, depreciation of fixed assets and methods of revenue recognition? What are the allowance rates? Useful life of fixed assets; the common answer to these was a witnessed silence.
Where do they place the gains on exchange? I mean not just in the statements of accounts but more physically where between the hospital safe and one 's wallet. Some will say, "It was my own initiative and bargaining power to get more from the Bureau of change". The same could be asked about the losses, but I am not sure if the answer will have consistency.

All these questions remain un-answered; otherwise you get many different opinions and not policy statements.

- The situation of operating without these guidelines can not be solved easily, firstly because the technical person supposed to help is also (in many cases) incapable- due to lack of the know how to develop and apply them. More hidden but still valid is even having Board members (especially from the church) side that are not knowledgeable enough in principles of accounts and financial management. Otherwise they would have pushed the managements to institute a system. They would have taken ample time to discuss the auditors report and budgets before endorsement.
- All these have been derived from the 'inherent' values the church has continued to embrace. Recalling the follow up questions ***(FQ1& FQ2)***, I don't think that having regulation and policies kicks away the Holy Spirit. We therefore need to train church workers also in other disciplines and install checks and balances to be able to control and utilize our scarce resources in the most possible efficient manner. *'Not for-profit'* hospitals cannot be taken to mean *'for-wastage'* hospitals.
- In as much as I would concur with Daniele Giusti[49] (1998) in '*Consequences for the NGO providers from the perspective of a National Co-ordinating Body'* when he affirms that stewardship cannot be substituted by professionally adequate management. I too attest the vice versa.
- Drugs, hospitals supplies, food, spares, and other consumables represent a very significant proportion of total assets. There is need for optimal levels of inventory for all stocks after consideration of costs, returns, risk of theft, damage and deterioration. Proper and transparent procedures of ordering, acquisition, distribution, and storage need to be employed.

[49] Executive Secretary of the health Commission of the Uganda catholic medical Bureau

4.3.4 Health Management Information System

A. Workshop remarks and Output

- Managers of church hospitals appreciated the new insight from the government from a mere *reporting system* to a *health management Information system (HMIS).* This is clarified by Sandiford (1992) when he ascertained that there are two major approaches to data collection: - **data-led,** which was the traditional way of collecting and reporting because it is requested by higher authority. The **action –led** in contrast is the one where only the data that are required for actionable management decisions are collected.
- With exception of referral hospitals and few DDHs, church hospitals don't put much effort on a sound Health Management Information System best known as MTUHA[50]. A need was expressed for church hospitals to also undergo an intensive training on how to use HMIS enormous registers and tally sheets.

B. Analysis.

- The responsible existing units called registry, record- keeping, or reception still reflects the narrow understanding of the whole concept. Still the way we keep records is tedious. These units are mostly staffed by attendants who can't analyse data to useful information.
- Sometimes the Church or government policy makers may get the right information they need, but this doesn't guarantee the use of that information to make decisions.
- Bruce B. Campbell (1997)[51] shows that HMIS is supposed to stimulate the increase number of informed decision. But still, presently health management decisions are mainly pulled or pushed by political reasons, experience and intuition.

A case to ponder

*"**I** promise timely report **this time**. As from now we will **push** all the departments, institutions and programmes **that receive grants** from you to avail **all the necessary reports** early before you begin **your** new financial year."*

Though you don't have the background information, think with me as I try to unpack this official statement delivered by one member of the Bishops' Council to the guest of honour, a humble messenger of the funding body from abroad.

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[50] A swahili abbreviation for **M**fumo wa **T**aarifa za **U**endeshaji **H**uduma za **A**fya.

[51] In his book of 1997,*Health Management Information Systems in Lower Income Countries.pg.13*

Words used	Possible meaning and or implications
I	One person's assignment and ability
This time	There were problems before (but no efforts had been taken to solve them)
Push	Employing power and coercion instead of dialogue
That receive grants	Others don't need to/ don't matter
All the necessary reports	Reports not specified (vagueness), confusion is about to emerge
Your	Reports prepared are not for them (church's financial year)

The ways we collect, organize, analyse and use data remains a challenge that need first of all a change of altitude. We need to see it as collected for us and not as a condition for receiving grants. Chambers (1983) concludes: -

"Much of the material remains unprocessed, or if processed, unanalysed, or if analysed not written up, and if written up, not read, or if read, not used or acted upon. Only a minuscule proportion, if any or the findings affect policy and they are usually a few simple totals"

4.3.5 Strategic Planning

A. Workshop remarks and output

- Most of the time, church hospitals plans have been for short time (not more that one year).
- The heads of departments from these hospitals were delighted to participate for the first time in planning for their own destiny. They felt a sense of ownership and commitment to the long-term plan (five years) they had produced.
- By undertaking a SWOT analysis of both the internal and external environments and there after resource assessment, the importance of having complete and reliable data/information was noted.
- Problem tree analyses were drawn. Though they differed from one hospital to another, the identified core problem '*poor health service delivery*' remained the same.

B. Analysis

- The implementation of the strategic plans in most cases called for an urgent need to formulate and institute appropriate policies and systems for example: - recruitment policies and financial policies. Here most hospitals managers face two problems namely: -
  (i) Lack of expertise thence assistance from local and external consultants need to be employed.
  (ii) Lack of mandate from church policy makers due to different or conflicting views based on the **six Rs.**
- I still believe that planning, as a whole is needed to give guidelines and sensible guesses of the future to managers. Most of the activities could be planned for short term e.g. repair and maintenance, short course training and acquisition of current assets. They don't need to wait for a five- year plan. Manpower requirements (the number of workers needed in a hospital) is a bit trick assignment that needs to be linked with the type and extent of services planned to be offered, the target population, capabilities of the workforce and of course the ability to remunerate them. The conversional idea of just doing simple comparison with the MoH proposed establishment (not to be confused with the minimum requirements) to government hospitals does not reflect the whole reality.
- My interview with hospital managers (especially VAs) disclosed that most of the financial matters are controlled at the Diocesan health department, hence causing bottlenecks in planning. Again decentralization becomes an agenda in this area.
- It is paramount for all heads of departments to grasp the importance of being sincere when carrying competence analysis. There is temptation of trying to evade the weakness in your sub-system, thinking that you are 'defending' the interest of your department. Plans become useful when endorsed by the right authority and plan of action (work) implemented.
- Memorandum of understanding/agreement between the Church and Government for DDHs stands to be obsolete as some major terms have either become irrelevant or cannot be fulfilled due to evident changes. Thanks to CSSC facilitation that now the Government is in discussion to review these long overdue-signed agreements with the DDHs owners.

  Some immediate changes to be tackled in the renewed agreements as part of the strategic planning could be:

  i. Government inability to assume fully responsibility for the recurrent expenditure and other related operational costs of the hospitals.

ii. The need for dioceses and hospitals to work closer to district local authorities than the MoH

4.4 Concluding remark

Based on the both primary and secondary data analysed, the major guiding research question,

"How prepared is the church in making sure that its hospitals have appropriate management system and policies for efficient quality health services delivery?"

Can be answered as follows: -

👎 The present situation manifests absence or ineffective management systems and policies for church hospitals to face the challenges brought about by economical, political and socio- cultural changes both from internal and external environments.

👍 Most hospital managers through a series of management workshops have been equipped with the knowledge and to greater extent skills to develop management systems and policies as appropriate to their environment.

☞ While most hospital managers have no problem in introducing the change (implementing the formulated management systems and policies), a lot needs to be done in terms of discussions, awareness raising, training, altitude and behavioural change for Church policy makers[52] and eventually to all workers on: -

a. Recognizing the importance of institutionalising these new managerial practices and tools.

b. How to reconcile and adapt appropriate Biblical hermeneutics to be able to interpret and accommodate inevitable changes without compromising to the authentic Christian virtues.

CHAPTER 5. RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

As a prelude to recommendations, it is worthwhile to emphasize three things:

- ☛ Though the paper has treated all church hospitals as one, due to differences in human resource capacity, economical status, church leadership and so on each hospital has been affected differently. Therefore the intervention package, pace, and sequence will automatically differ accordingly.

[52] Mostly Bishops, General secretaries, Diocesan health secretaries and (other) hospital board members.

- Frankly speaking, competition cannot be avoided (***FQ2).*** K.R.White (2000:221), urging Catholic hospitals to be equal in the market place in order to be able to compete with like organisations, he highlights the concept of *isomorphism* where organisations will imitate other organisations in their environment when they face the same set of environmental pressure. This should mean imitating *effectiveness* and not loosing their identity. This is very possible even in the realms of the Church itself. A practical example of the Church of England in an effort to halt its decline carried a management complete overall by introducing appropriate personnel management systems in 1998. Rev. Margaret Jackson (Ministerial education Secretary for Advisory Board of Ministry-UK)[53] in the same event said, *"effectiveness is in itself a witness to God".* Stephen Overell thereafter concludes that,

  > " *The Church can no longer hold out as a haven of bumbling decency while the rest of the world – schools, hospitals, even the army- focuses on outcomes, targets and quality."*

- Trying to solve the root problem doesn't mean turning everything by force in one day. Therefore this paper suggests gradual pragmatic changes starting with those issues where consensus or less disagreement exists among stakeholders like training. However in any case a welcoming ground is necessary as discussed in the next section.

5.2 Conducive environment.

An environment conducive for Capacity Development in Church hospitals includes: -

- ***Attitude and behavioural change***

This is the bone of contention in any struggle of human development. The way some Church decision makers look at issues and act has got to change in the direction of the Christians (the real owners) empowerment. Gone are the days when leaders got '*high blood pressure*' when they heard words like decentralization, privatisation, globalisation, workers participation and contracting. Everybody is to open up his/her mind[54] in order to understand and face new issues, we have never experienced before.

- ***The will and commitment***

A clear determination and dedication by both policy makers and implementers towards whatever good plans shall be the driving force to capacity development.

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[53] Quoted by Stephen Overell in *People Management: The Magazine of Professionals in Personnel Training and Management* of 1998, Vol.4. No.8, Pg. 34.

[54] Luke 24:45

- ***Participation***

  There should be a purposeful move to elicit participation from all stakeholders of Church hospitals. Hence improved communication and flexible organisational arrangements are very much needed from both the government and the Church sides.

- ***Resources***

  There is to be an effective mobilization of resources, be it finances, human, physical or information to implement the appropriate management systems and policies.

- ***Peace and tranquillity***

  Not least to mention, more than ever, today we have global and national conflicts and wars characterized as religious in nature such as in Bosnia, Algeria, Chechnya, Indonesia, Kashmir, and the recent Israel-Palestine in Jerusalem[55]. In Tanzania we have witnessed clashes, discords and lack of harmony within Christian denominations leave alone the fragile[56] Muslim Christian relations.
  The Tanzanian Mennonite Church for example, has been in a self-reconciliatory process for now more than ten years. Fund raising activities are being done here and then to make it possible for the leaders of both sides[57] attend the unfinished overdue case in Mwanza Court of Appeal.
  For sure this looks like *resource* misdirection, but that is the cost of having no peace. I have not analysed the time wasted, the deterioration of good will, acrimonious lives even within close relatives and sabotaging behaviours related to that case.
  In that situation institutionalisation of management systems becomes second to settling disputes.
  In a close meaning, a quest for peace in this work implies the way anybody will try to address issues without irritability, amplification nor underestimation.

5.3 Recommendations

The recommendations I have tabled herein should neither be regarded as conclusive panacea nor a set of prescribed policy to be practiced to the letter. These are to be considered together with other practical suggestions provided by other Christian practitioners and health management consultants while taking into consideration the prevailing situation in context.

As noted earlier the right actions at this stage are to be taken in joint efforts by the hospital management, employees, trade unions, and ministry of health, the church, the umbrella organisation, partner NGOs and the communities at large.

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[55] I am not sure if we should continue call it the Holy city while it is full of innocent blood shed

[56] As cited in the Annual Report on International Religious Freedom for 1999, released by the Bureau for Democracy, Human Rights, and Labour Washing, DC September 9, 1999 reports of an existence of a tension.

[57] Present recognised Mennonite leadership versus the split group of Mennonites

Some specific recommended areas of interests to be considered be as follows: -

5.3.1 To Church policy makers

- HRD should continue at both Church and hospital levels. CSSC is advised to continue with CBP, targeting mainly Church policy makers. Free discussion should be encouraged on different crucial issues raised in this paper. I recommend starting with those that has little or no criticism among different churches. e.g. Community financing, strategic planning, HRD policies, scheme of services and maintenance schedule. Issues that have to do with hermeneutics and power sharing should be tacked after a good grasp of their meanings and change of altitude, probably after some series of workshops.
- A feasible system for health quality assurance through routine self- assessment needs to be developed and instituted by the help of CSSC technical assistance. Indicators and processes are to be elaborated.

Some Church leaders[58] need to walk their talk as an example to be emulated by all other workers; otherwise this *spiritual schizophrenic* behaviour becomes a concrete blockade on the road of discipline and moral justice.

- Relevant constitutional Church conferences and general assemblies need to be used effectively to discuss and analyse annual reports, budgets and policy formulation for church Institutions.

Probably, we all know these days how those meetings have turned to be **political arenas** to gain favour from members especially when elections are around the corner.

- Beyond the *'traditional' glasses*[59]. *(Reorientation and not Resoluteness –**R3**)*

  ↷ Let the church work with local authorities and communities to establish Community Health Fund schemes (learning from the experience of Government pilot districts) where prepayment premiums are better than out of pocket pay to service. In fact this takes care of the problem always complained of by church hospital managers about how to cover the expenses of all ordained people and their dependants. They will just need to join this system, which ensures continuous service even when they have not received their monthly salaries/allowances. 'Alternative financing' is to be an on going agenda in church executive meetings. It is high time the church thinks and adopts more sustainable sources of financing by concretising plans and being more transparent on collections and pledges from members.

[58] This does imply that it is not a problem of all leaders.
[59] The old persistent one view of looking at issues. (determined not to change)

Most of Church already own income generating projects, the only problem is just the same; unless they are run according to modern professional management practices they will actually continue to be supported instead of supported other non-profit activities like health care.

- It is high time the church pays more attention to Primary Health Care (PHC) than thinking all the time to start institutional based services around them. It may be better to go back and refurbish, equip and reopen all the old dispensaries and health centres situated in the villages. The church needs to be near the community as possible, to learn even the socio-cultural barriers affecting health systems negatively. These can be issues on gender, dieting, traditional health care systems and so on. Efforts to capacity development should not only target the management of hospitals but also health centres, dispensaries and community-based programmes.
- The Church will have to accept subcontracting and at times to privatise some projects or part of the services they have been offering (e.g. catering services in the hospital, running Infusion Unit and so on). Important to note is that continuous monitoring and control mechanisms are to be in place lest the new providers exclude the poor.

The church now than ever needs businesspersons and entrepreneurs to manage with a Christian touch. Don't be deceived that heaven will be populated of spirits of poor people. After all God is the richest yet He identifies HIMSELF with the needy[60].

To condone all herbalists and traditional medicine in a blanket is like staggering in a colonial hang-hover. A desk/section on alternative traditional medicine under each department of health in Dioceses and within CSSC need to be developed. The responsible personnel will need to work in liaison with the government corresponding wings in quality assurance. I, personally see problems with three practical issues that may be also be questionable by churches: -

- Traditional doctors who appeal to spirits.
- Traditional doctors who claim to cure a lot (always with a long list on their sign posts) of chronic and incurable diseases like cancer, AIDS and so on. Who is a specialist of everything in this world?
- The way medicines are administered, especially the quantity and storage.

5.3.2 To CSSC, TEC and CCT

- Different Churches should work together in a co-ordinated way as suggested by Mr Cassels Andrew (1998) – the Guru of health Sector Reforms in 'a guide to sector wide approaches for health development. CSSC as an umbrella organisation should be mandated by CCT and TEC to carry out this mission of co-ordination and further research for instance testing an hypothesis which links management systems and policies to quality of services of church hospitals- the area that this paper was not able to reach.
- Considering Biblical hermeneutics

  What does the Bible say about certain behaviours and issues surfacing in the world and how we interpret them today are two major theological questions in our daily working life. I still believe that the Bible is holistic. The problem lies in how we interpret it in the subjectivity of humanity. All churches, CCT and TEC are hereby advised to discuss this area extensively to find out proper hermeneutics that takes into consideration the grammar, historical context of the verse or passage in question, but without loosing the real meaning. An example of my personal response to the six Rs is attached as

  Appendix 12 under the heading '*Artificial Veil between the Sacred and Secular Values*'

5.3.3 Non- Governmental Organisations

- While a lot of (technical, financial, materials and training) assistance already been given to our communities is being commended, there is a need for revitalized reorientation from donor-recipient view to *partnership*. This is based on mutual trust and reciprocity. It involves sharing of common vision and exchange of knowledge and experience in health care practice and research among partners. How many times have we heard NGOs replying to a community or a church that '*we can't support you into that area but we will support you in ... ...as that is in our priority area*'.
- Concerning the present discussion in the Netherlands and elsewhere in developed countries, on choosing better alternatives to help developing countries fight against poverty, illiteracy and ill health, I recommend dialogues with both partner countries and the sending organisations. Let International organisations not fall into slippery slopes of logic. For example the idea of giving topping up allowances to local doctors as a way of attracting them to live and work in rural areas sounds logic but is also not sustainable. Further more, how are you going to treat all other government workers like the teachers and so on, whose remuneration are not decent either?

5.3.4 To Workers and Trade Unions

- Trade unions have not been left unshaken by the global social and economical changes. They need to revisit their agenda in terms of membership and how they operate. Adversarial approaches are no more popular. They need to be aware of the global market changes. They have a great role to play in facilitating and educating the workers about new trends for instance the contradictions of *Human Resource Management* and the rhetoric of *participative management* (Marchington.1995)[61]. These newly (1980's) management models among other objectives they aim at taping brilliant ideas and information from workers rather than empowering them; helping management to justify their decisions than allowing workers in their departments to make any substantial changes to their quality of life in hospital they serve.

5.3.5 To the Hospital management Teams

- Good discipline is instilled upon cooperation between management and employees, also upon good environment to ensure that rules, procedures, regulations and policies are adhered to willingly. However, management should exercise its right to enforce obedience to the agreed way of working and relationship.
- As the management is introducing changes accepted by policy makers at any level, it is to apply an appropriate pace and sequence which doesn't cause havoc to bring everything to a halt. Experience has shown that gradual incremental change is better than 'shock therapy.'
- All management team members (MOI/c, NOI/c, HHS, and ACC)[62] should be equipped with skills of planning, controlling and execution of financial activities to be able to make sound decisions.

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[61] Pg.293 '*Involvement and Participation*' in *Human Resource Management: A Critical Text'. Edited by John Storey (1995).*

[62] Denotes Medical Office I/c, Nursing Officer I/c, Hospital Health Secretary and Accountant

5.3.6 To the Government

- As it remains to be the overall responsible to the health of the nation, the government should continue to create conducive environment, as the chief facilitator, information disseminator and supervisor over churches and all private providers.
- It is paramount for both the government and the church to honour any agreement whether signed before the lawyer or not as in the case of managing DDHs. This will increase trust and mutual respect.
- All health care activities have to be closely linked to development and poverty[63] alleviation strategies. Lack of good shelter, balanced diets, clean water, sanitation and problems of underemployment and unemployment are major hindrances to health.

5.4 Conclusions.

This research started by presenting the current global and national socio-cultural, economical and political changes that has taken place.

The system approach of modern organisation theory has been employed to show how both internal and external environment affect Church hospitals as open systems.

Reduced support (materials, finances, human resource etc) from mother churches and other donor agencies have forced Church hospitals to operate in an efficient manner if they are to continue existing.

Market liberalization has exposed church hospitals in an intense competition. Their existence is further shaken by the set standards they are required to meet for accreditation and operation as part of quality assurance in the national HSR strategies.

In modern management practices, they need appropriate MSP both for their sustainability and quality health service delivery-the hallmark of their mission.

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[63] The WHO **International Classification of Diseases** has accepted poverty as a separate disease.

By use of qualitative techniques of content analysis, life experience, semi structured interview to key informants and SWOT analysis, the author has discovered some values (six Rs) embedded in Tanzanian Christian corporate working environment. It has been shown that to some extent misinterpretation of these values stands as explanation to both the present management status and altitude towards new management practices.

The case study of CSSC management workshops has revealed that capacity building through *participatory learning approach* is a crucial tool towards identifying organisational problems, policy choices and skills acquisition to develop appropriate MSP.

However, the implementation of these changes needs an environment conducive to be created especially from the Church policy makers.

The research objectives were guided by the major research question and its follow up question,

'How prepared is the church in making sure that its hospitals have appropriate management systems and policies for quality health service delivery?

Whilst understanding and acquisition of skills (through a series of CSSC workshops) to develop management systems and policies by hospital managers appeared to have met with some success, the same could not be said about their implementation in work places.

The preparedness of Church in adopting the appropriate changes still needs more discussions, training, and awareness campaigns by all stakeholders, but more to church policy makers.

There is a need to adopt appropriate Biblical hermeneutics to be able to interpret and accommodate inevitable changes without compromising to the Christian virtues. This will ensure continuation of the noble mission of the Church- the dual ministry of both physical and spiritual healing without unnecessary hindrances.

Lastly the paper has tabled recommendations to different stakeholders with an emphasis of adopting situational intervention strategies in a gradual practical pace and sobriety, otherwise these systems running into entropy[64] starts to a popular agenda in Church hospital managing boards.

[64] A situation whereby a system dies naturally due to lack of inputs.

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Glossary of Terms Used.

The Church: Denotes all Christian Churches as one (universal) body of Christ.

Churches: Signify the diversity within Christians, also referred as denominations.

Christian Culture (adopted from Kroeber and Kluckohn (1952) definition)*:*
Consists of patterns, explicit and implicit of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievement of Christian groups, including their embodiment in artifacts, traditional ideas and their attached values.

Counselling: Assisting employer/ patient to recognise and accurately define his/her own problems, find solutions, or learn to live with the situation.

Diagnostics: activities, procedures, skills, and equipment employed to determine the nature of a disease. E.g. in laboratory, radiology department etc.

Ergonomics: analysis of the relationships between people and their physical environments and how the later can be used to meet human needs and wants.

Grapevine: An informal and unofficial communication that most of the times do spread rumours in and out of the organisation.

Halo effect: The situation where interviewers wrongly perceive that the applicant is worthy in other qualities just because he/she possesses one desirable quality.

HMIS: Health Management Information System.

Industrial relation: The practices, system and policies that govern the co-operation between management and organised labour.

Job Specification: A product of job analysis, which states exactly as possible what a job entails.

Labour Turn Over: The movement of workers in and out in the organisation. Can be measured as**:**
-

$$\text{Separation rate} = \frac{\text{Number of separation during the period}}{\text{Average number employed during the same period}}$$

Local stakeholder: person or organisation in the locality with an interest at stake, regarding the activities, outputs, and outcomes of a certain organisation.

Personnel conflicts: behaviour intended or unintended that obstruct the achievement of goals of other person(s) or any personnel divergence of interests between groups or individuals.

Personnel specification: A product of job analysis, which is a descriptive list of background, experience and ability, considered necessary for the performance of the job.

Terminal benefits: Is what an employee or next of kin gets from the employer when his/her employment is terminated. (Retirement, resign, dismissal, redundancy or death).

Appendix 1.

Major Sections and Guidelines to the Semi-Structured Interview

I. Organisation, Management Systems, and Policies

a. Policies & Regulations.

☞Availability/absence of management policies/regulations in the hospitals governing finances& Materials management; recruitment; Training & Development; Staff Regulations/Personnel working manual; disciplinary procedures.

☞If available: Categorize their origin, i.e. Hospital, Church, Ministry of Health/ Government. How well are they being communicated, interpreted and enforced?

☞If not available: Any reasons, problems encountered and or suggestions?

b. Systems.

☞Available/ absence of effective working systems in managing health data; Performance Appraisal; Ordering, procuring, distribution, storage and stock- taking of drugs, supplies, food, fixed assets. (How it is done, in each system?)

☞If internal and external financial auditing, Bank reconciliation is done, how often?

☞ What are the sources of funds and their general future prospects?

☞If there is a system/model for Quality Controlling of the services offered.

c. Management tools

☞Available/absence of Organisational structure, Job descriptions

Salary structure and scheme of services. (How they have been/are prepared).

☞General evaluation about these tools, whether they are good, burden, accepted, helpful or otherwise?

II. Employees Relations, Social Dialogue and Relationship with Stakeholders.

a. Available/absence of trade union (s) and why if absent.
b. Role of Trade Union to workers and to the organisation at large. Any challenges they encounter.
c. Any form of workers participation, participative management and general evaluation.
d. How is the relationship of management with the Church, Competitors, Ministry of health, Local authority, Community, Workers, Patients, Suppliers, (the how and why).

III. Human Resource Development and Human Capacity Assessment

a. Qualification of management team members and how the Hospital Governing Boards are formed. General assessment of workers' ability to perform their work efficiently.

b. Any continuous education programme in the hospital; upgrading course opportunities, seminars and workshops and their evaluation in terms of type, coverage, accessibility and applicability.

c. Ability to develop and institute the missing policies and systems with or without outside consultancy.

IV. Christian Culture

a. Any feelings and observations of operating differently from non-Christian hospitals by virtue of being Christian organisation.

b. Evaluate the points of departure.

c. Any Diocesan policy, circular or value added to the system that fosters/hinders development of professionalism or quality of services delivery.

e. What are the most crucial Christian values to be observed by workers in church organisations? Any relationship between any Christian held 'values' and failure to adopt from generic management systems and policies developed during CSSC management workshops or any modern management techniques.

V. Strategic Planning

a. Any systematic activity, which can accrue to be termed strategic planning. How often? Any challenges when undertaking the exercise.

b. What is the information base for planning?

c. Who does the planning? Who approves it before implementation of the activities?

VI. Open Issues

Opinions and suggestions on any other agenda related to the research paper.

NOTE:
Questions and discussions are to be adjusted to the background of the respondent and his/her constituency.

Appendix 2

Name-List of Persons Interviewed and Discussed with during Data Collection.

Name	Position/Role
Van Veen	Head of WOCA- Africa Team ICCO, NL.
Fr.Peccod	Advisor on socio-religious issues for ILO, Geneva
F. Van der Hoven	Health management Consultant, NL.
Rev. Jeremiah. Okidi	KMT General secretary, TZ.
A.Kolillah	Ag. Hospital Secretary, Wasso, DDH. TZ.
Dr. Mugema S. K	Mugumu Hospital T.Z
Dr. S. Haule	CSSC- CBP Co-ordinator,TZ.
Bishop J. Nyakyema	Chairperson, Lake Diocese of KMT, TZ
Hezbon Masirori	Chaiperson, TUGHE-Hospital Branch, TZ.
Magiri Jumanne	Co-ordinator Community Based Health Promotion Programme, Serengeti, TZ
Milton peter	District co-ordinator TUGHE, TZ
Sabina Gellejah	CSSC Management Workshop facilitator, TZ
Dr. Kaare	Member of the District Council Social Services Committee, TZ.
Dr. W Flipse *	Policy Advocacy Research advisor CSSC, TZ.
Bamanyisa C. *	Senior Health Secretary Ministry of Heath TZ.
Dr.Marja C.Schoenmaker	Medical practitioner, member of NVTG, NL.
Joyce Sagala	Diocesan Medical Secretary, Arusha, TZ
Rev. Daniel Sattima	Former member of hospital board, Musoma, TZ.
Amos Mutaragara	Chairman MDDH board, Musoma, Tz.
Rev. Christine Wever	Pastor Doopsgezinde Kerk, Leeuwarden, NL
Karamba Juma	Nursing Officer In charge MDDH, Mugumu, TZ
Rt. Rev. Alloysius Balina.	Bishop-Tanzania Episcopal Conference, TZ
Dr.Jaap Koot,	Public Health Consultant, Amsterdam, NL

* Contacted through E-mail

Appendix 3. Biblical Hermeneutics in Different Theological Paradigm

#	Theological paradigm	Approach to study the bible	Example of Theological proponents
1	Ecumenical grid	Use scientific, critical approach. Holy spirit is an advisor to the leader. This is euphemism to personal opinion.	Appiah Kubi, Schleiermacher, L.Newbigin, D.Tutu, Pobee, Parratt.
2	Evangelical missiological grid	Use linguistic approach, open mindedness is important. Holy spirit stimulates the leader.	C.H. Kraft, S.Murikwa, P.Hierbert, W.M.Smalley, Poghisio, A.R, Tippett,.,
3	Evangelical Academic grid	Use grammatico-historical approach. Dogmatic and systematic understanding is vital. The Holy spirits convicts the reader.	R. Gehman, T.Adeyemo, B.Katto, Fleming.
4	Evangelical Pastoral grid	Use an intuitive approach. Practical reasoning is necessary. The Holy spirit is at working different ways according to church traditions.	Denominational church leaders
5	Evangelical Kingdom grid	Use grammatico-historical approach, but open minded and less tied to theological and church traditions, which blinds one to the light of God. Holy spirit is at work, illuminating and stimulating the leader.	L.Niemeyer, H.Conn, H.Snynder, Jones.S.

Source: Derived from Larry L. Niemeyer (1993)

'A Kingdom Perspective on the four contemporary Theological Paradigms'. Nairobi: Daystar.

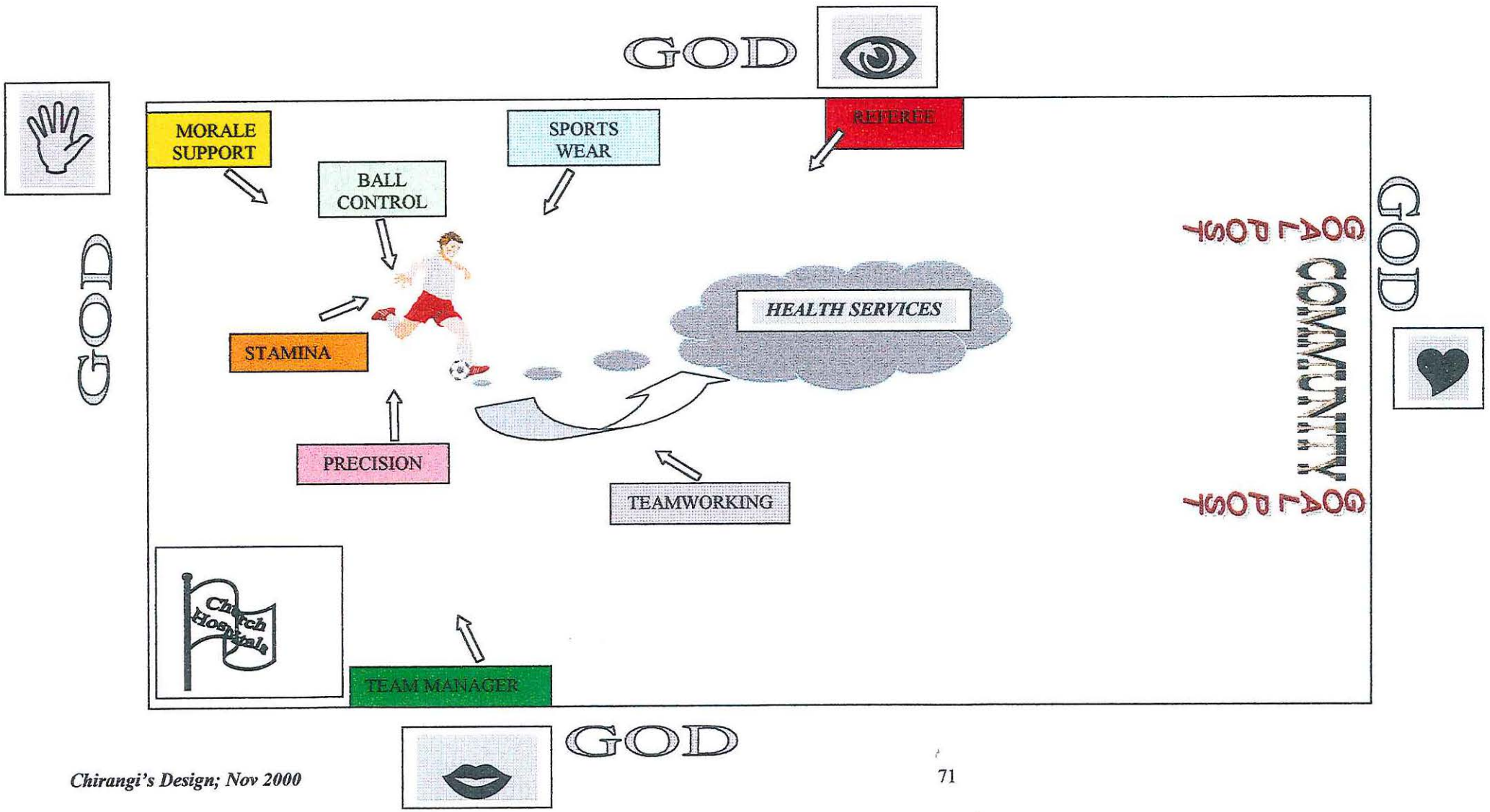
Appendix 4: Gantt Chart on CSSC Implementation Schedule of Management Systems Development.

<table>
<tr><td>Jan-Mar 1996</td><td>Apr-Jun 1996</td><td>July-Sep 1996</td><td>Oct-Dec 1996</td><td>Jan- Mar 1997</td><td>Apr-Jun 1997</td><td>July-Sep 1997</td><td>Oct- Dec 1997</td><td>Jan-Mar 1998</td><td>Apr- Jun 1998</td><td>July- Sept 1998</td></tr>
<tr><td></td><td colspan="4">Part 1: Survey of management Systems</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td>Pilot test</td><td>Survey in 12 hospitals</td><td>Review gap in 2 zones</td><td>Synthesis report on gaps</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td colspan="4">Part 2: Participatory Development of Systems</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>Facilitators guide developed</td><td>Developme nt workshop 3 zones</td><td>Development workshop 1 Zone</td><td>Synthesis report</td><td></td><td></td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td colspan="3">Part 3: Finalisation of guidelines</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Review by DHS. 1 meeting</td><td>Review by DHS. 2 meetings</td><td>Final document by CORAT</td></tr>
</table>

Legend:
DHS refers to Diocesan Health Secretary
Remarks:
The implementation of the project was done accordingly following the revised schedule of July 1997.

Appendix 5

Attachment: PLAYING BEYOND THE: - REFEREE'S EYE, GOAL POSTS, MANAGER'S MOUTH, SUPPORTER S'HANDS.



Chirangi's Design; Nov 2000

Interpretation of Playing Beyond the Visible Realm In Health Care.

Qualities for good playing	**Implied Meaning in Health Sector**	**Equivalent Environment for good health service delivery**	**Parallel Examples**
Stamina for Strength	Strength to acquire the required resources	Economical environment	Those with weak stamina can't play throughout 90 minutes: Drug kits in Tanzania don't suffice throughout the year.
Precision for targeting (in the desirable direction)	Ability to develop and adopt appropriate policies towards the desirable direction.	Political environment	Those without precision suffer in the penalty crisis: Rural women have suffered more because during economical crisis, we adopted cost sharing without targeting the poor.
Ball control for flexibility	How flexible are the social structures and values to adjust to global changes.	Socio- cultural environment	Flexible players turn quickly with the ball: A rigid society says woman circumcision is still a cultural value to preserve.
Sports wear for simplifying work	The practical medical hardware, software technology needed to simplify work & respond to the community needs	Technological environment	In official games, no one is allowed to play without sports gadgets: Without the minimum equipment and physical facilities needed a hospital cannot be allowed to practice medical care.
The rule of the game for fairness	Ethical standards and laws governing health service delivery	Ethical standards & legal environment	A credible player is self-disciplined even when the referee's eye is not able to see everything: Church hospitals go beyond the governmental regulatory framework. They subscribe to the Christian ethics.
Team-working for unity and efficiency	Effective communication and co-ordination for unified health sector wide approach.	Organizational environment	Teams, whose players don't pass ball quickly to each other, go out very exhausted as a result of energy loss. Poor community, inter-sectoral and private sector linkages cause resource wastages.
Morale support for motivation	How the surrounding support/affect the health services.	Geographical & Epidemiological environment	Having supporters (fans) is good but not sufficient to determine the winner/looser: The tropical geography is not a sufficient explanation for tropical diseases. Poverty is one of the major factors.

Concluding remark:

Being one of the key players in health care service, Church hospitals should endeavour to analyse their external and internal environment and find ways of dealing with weak or adverse factors that Hinder quality service delivery. Church hospitals avow that beyond the referee (regulatory bodies), there is an invisible God's **eye**- the indisputable quality assurance standard. We might loose the patient despite the entire medical and nursing care but beyond this defeat (in goal posts) is invisible victory in God's **love** in the life hereafter. God **speaks** to us (vision) beyond what our managers try to tell us. Our Not-for profit hospitals may not get many supporters in this competitive business world; however, Gods **hand** is far more than funs.

Redesigned by *Chirangi* from *Christian ClipArt*.

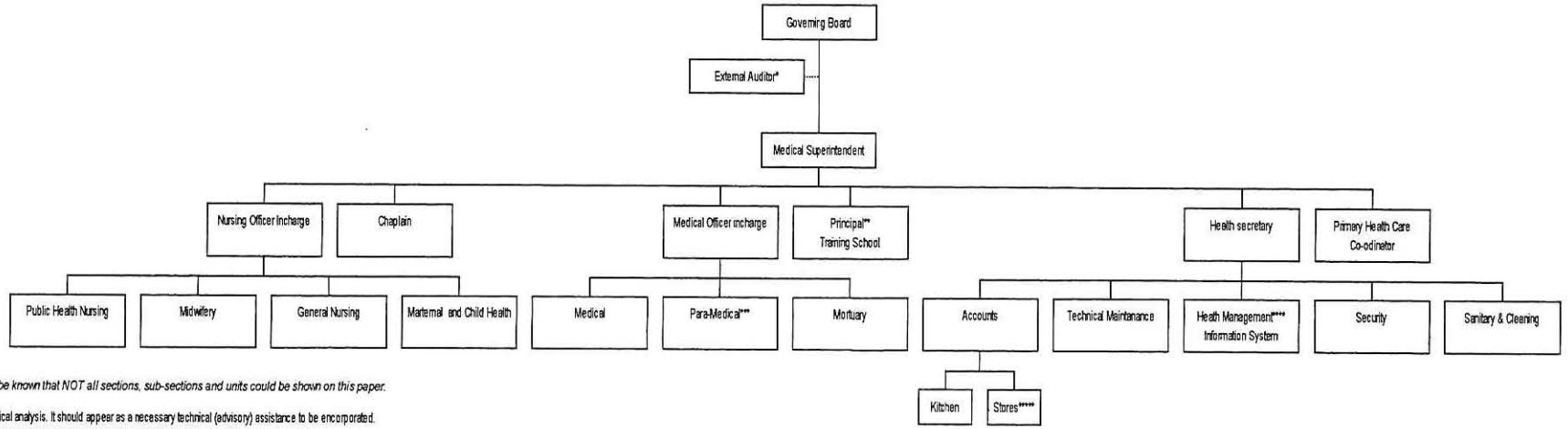
Appendix 6

Foundation & Focus

WHEN MANAGING CHURCH ORGANISATIONS

Appendix 7

Proposed Hospital Organogram



Key.

NOTE: It shoud be known that NOT all sections, sub-sections and units could be shown on this paper.

* Added as part of my critical analysis. It should appear as a necessary technical (advisory) assistance to be encorporated.

** Though the title is questionable, it includes radiography,Laboratory, Physiotherapy, Pharmacy, Anaesthesia

*** Also added. This is meant to be more than just Registry - the known narrow defined section to keep record.

**** Applicable to hospitals with attached trainning schools.

***** Looking it critically there are more than one kind of a store to be considered:
Think of stores for Pharmaceuticals, for food staffs, for cleaning, laundry and matresses, for fuel,
for technical tools and defected appliances to be repaired.

Appendix 8:

Example of proposed Job Descriptions for the Diocesan Health secretary

I. Identification
Name: _____
Title: Diocesan Health Secretary
Date of Issue: _____
Department: Health
Section: Administration
Allocation: Diocese
Number of employee: one
Job Code number: (If Applicable)

II. Relationships
Responsible to: The General secretary
Responsible for: Subordinate staff under health department

III. General job Summary
Establishes plans and co-ordinates smooth running of health facilities and programs

IV. Specific Duties and Responsibilities
Keeps meeting records for Diocesan health committee
Develops plans and project proposals for the diocesan health activities.
Consolidates and forwards health financial budget to the relevant committees and to the general secretaries
Develops training programmes for senior health staff
Co-ordinates all health related programmes and institutions through discussions, meetings and circulating important information
Carries out any other duties as assigned by the general secretary

V. Qualifications
At least an advanced diploma in health/public administration or the equivalent from a recognised institution.

VI. Job Change
According to the scheme of service

VII. Performance Indicator
Extent of achieving set goals in the duties listed in IV above

VIII. Date of Review

IX. Signatures
Employee_____
Employer_____

Appendix 9: The Potential of Stakeholders and Ways of involving them.

#	*LOCAL STAKE HOLDER*	*POWERS/INFLUENCE/ RESOURCES*	*TREATMENT/INVOLVEMENT*
1	Employees	▪ Collective power ▪ Knowledge, skills and ideas ▪ Direct influence in the way services are delivered	▪ Fair & decent work and remuneration ▪ Respect, humane & just management ▪ Participation in decision making and problem solving
2	Trade Union(s)	▪ Ability to mobilize employees ▪ Legal recognition as workers mouth-peace ▪ Most are aware of important labour laws ▪ Facilitate employees' co-operative projects (unions)	▪ Permission to have an office at workplace ▪ Allowed to conduct legitimate meetings ▪ Have representative in the hospital management committee ▪ Involved in employees' education & self reliant projects ▪ Involved in disciplinary matters and all major policy changes.
3	Customers	▪ Payment for service rendered ▪ Ability to evaluate and communicate your image to the public	▪ Satisfactory and affordable health service ▪ Enter into the hospital/community insurance scheme ▪ Involved in getting feedback of your service & Participate in cost sharing exercise.
4	Government and Community	▪ Powers of registration and permission to operate ▪ Money & other physical resources ▪ A pool of human resource ▪ Government machinery to enact and enforce Laws ▪ Source of data & Information	▪ Meet the minimum set standard ▪ Have substantial representation in the Hospital Governing Board. ▪ Employ/second staff from them. ▪ Involve them in fund raising and community Insurance scheme Involve in determining if one (unable to pay) is liable to exemption in cost sharing or Community Health Funding.

#	*LOCAL STAKE HOLDER*	*POWERS/INFLUENCE/ RESOURCES*	*TREATMENT/INVOLVEMENT*
5	Owner/Church	▪ Holds the mission of the hospital ▪ The powers for expansion, shrinking or closure ▪ Develop Diocesan policies which govern church institutions ▪ Finances ▪ The mandate to keep up the Christian culture.	▪ Allowed to make informed decisions on major policy issues in the Board and at the Diocese. The truth on all possible implications must be explained. ▪ Involved in fund raising from different sources ▪ Given chance to provide spiritual care to staff and Patients by appointing the chaplain ▪ Made aware of the social and economical Changes.
6	Competitors	▪ The experience in the Business ▪ The power to influence prices	▪ Exchange of ideas, information sharing, and socializing in gatherings and meetings ▪ Involve them in community health education
7	Suppliers, Contractors and Creditors	▪ Have financial and other physical resources	▪ Involve them in Fund raising ▪ Timely payment or informed delay of payment ▪ Enter with a clear contract to enhance quality service ▪ Continuous evaluation to what they offer.
8	NGOs	▪ Resources ▪ Some have community recognition	Those in the same line o Could be considered as collaborators and hence Co-ordinate together in the same community based health programmes

Appendix 10: *Example of a policy statement on recruitment and selection in church hospitals.*

1. Vacancy will be advertised to the workers from the institutions or the public specifying lead interval- 4 week
2. All application will be addressed to the medical superintendent of the hospital in the applicant's own handwriting and an attachment of relevant photocopies of certificate/ diploma etc.
3. All applications will be answered whether negatively or positively in the hospital designated forms.
4. There will be a selection committee to handle all matters related to selection of staff in the hospital.
5. Candidates will posses original awards/certificates on the date of interview.
6. Medical examination will be part and parcel of selection procedure.
7. The selection process will be as impartial as possible with no unfair discrimination.

Appendix 11a:

General problems facing HRD in hospitals and proposed solutions

PROBLEM	*SUGESSTED SOLUTIONS*
Lack of training policy	Development of training policy
Favouritism in selecting staff for training	Selection of candidates should be based on performance appraisal and aptitude tests done by selection committee.
i) Lack of funds for sponsorship (donor dependency) ii) Escalating costs of training.	i) Institutions should look for ways of generating funds through self-reliance projects, (referred in the analysis as **X**) ii) Prioritise training needs .
Lack of training vacancies in existing institutions	Establish church training institutions (referred in the analysis as **Y**)
Hospitals do not budget for training.	Budget allocation for training.
Many trained staff are not retained	i) Legal agreements/contracts to be signed by employees & employer before training ii) Up-grading / increase in skills, knowledge and qualification
On-job training is not perceived as beneficial by employees.	i) Employee should be educated on the importance of improving quality of service and their future. ii) Reward those who perform better
Poor training facilities	Training institution to improved both in terms of equipment and curriculum.
Inadequate staff to cover position of those who go for training.	Set budget for hiring staff to cover position left vacant

Appendix 11b.

Proposed policy for training and development in Church hospitals

1.The hospital will train and develop its employees according to the institution's needs and according their training plan/programme.
2.The primary objective of training and development will be to support the pursuit of the institutions goals.
3.Training in the hospital will be preceded by the training need assessment, which has to be handled to by the hospital management team.
4. The hospital may consider releasing an employee who on his/her own initiative has secured a training opportunity provided that training costs are paid by the employee concerned.
5. Any hospital sponsored employee who is discontinued from training because of misconduct, will be required to refund training costs incurred.
6.All hospital- sponsored employees will on successfully completion of training, sign a legal contract to work for the same institution to a period of 3-5 years depending on the length of training.
7.Original certificate of sponsored employees will be retained by the employer for the whole period of the bondage.
8. The employees in training will be required to contribute30% of their gross salary as individual contribution for training costs.
9.The employees undergoing training will have the same rights as others in consideration for promotions.
10.The employee will have completed not than three years continuous service before being considered for further training.
11.Training institutions will be obliged to fulfil the programmes, otherwise church health institutions will take legal actions against them.

Appendix 12

THE ARTIFICIAL VEIL BETWEEN THE 'SACRED' AND 'SECULAR' VALUES.

I. Introduction.

It is misleading when anybody proclaims directly or indirectly that after creation God became constricted in a small domain of existence known as the 'sacred'. In the same line we read how the death of Jesus Christ poured cold water to the priesthood of the day when the curtain separating the holy of the holiest was torn into pieces. (Matthews 27:51).

Many writers accept that the concept of secularization is very much a western construct.

Jan Wood (Director of Good news Associates, Seattle, Washington) declares[1]: -

"These artificial walls we in the west have erected between sacred and secular are bogus. The same love that solves problem s in the chapel solves problems in the boardrooms, on the factory floor, amid politics."

Dr. Murikwa, S. (once the departmental head of religious studies Daystar University, Nairobi) pointing the exclusiveness of African religious heritage as one of the weaknesses of African Christianity said:[2] -

"In African heritage, religion permeated every aspect of someone's life.... Many don't know this aspect and therefore make distinction between secular, and sacred activities."

II. Herein please find some few hints as personal response to the six **Rs** not questioning their intrinsic validity but rather on the way they are interpreted to exclude other important managerial activities dubbed as secular values.

#	'Sacred values'	'Secular values'	Counter arguments[3]
R1	*Reciprocity Mat.10: 8*	Setting targets and soliciting pledges in fund raising and ***cost sharing***	In the same chapter Mt.10: 14, it reads *'If anyone will not **welcome** you, shake off the dusts from your feet.* Welcoming which included hospitality was a reciprocal duty (pay) in kind expected from the recipients.
R2	*Reticent Jas 4: 11 Heb13: 17*	Being open and ***speaking against injustice.*** Allow flexibility to different opinions from those of authorities.	In Mt.23: 28, hypocrisy is condemned. The same 'woes' are given to those who act indifferent to injustice.
R3	*Resoluteness Heb13: 8*	Reorientation to new/***modern knowledge*** and ventures	*'An intelligent mind acquires knowledge, and the ear of the wise seeks wisdom'* (Prov.18: 15) King Solomon lifts the importance of having knowledge as a pre-requisite in making wise decisions.
R4	*Restoration Mt.6: 12*	***Taking disciplinary measures*** and forwarding claims	Organisations as families should think of the implied meaning in Prov.29: 19 *'By mere words servants are not disciplined, for though they understand they will not give heed.'* Also Prov.13: 24. It should be noted also that sins can be forgiven but the consequences of sins may remain like scars when wounds are healed.
R5	*Restraining Jn15: 19*	Joining social groups and Trade Unions	In Jn. 17:15 Jesus states that *'I am not asking to take them out of the world but to protect them from the evil one'*
R6	*Rewards Mt.5: 11-12*	Having an elaborate remuneration package, scheme of services and other employees' rights.	The same verse (Mt.5: 11) explains that the suffering should be on HIS[4] account. This actually stresses the opposite. E.g. being fired because you are asking for equitable and justly remuneration system in the firm.

[1] In *Christians at Work: Not Business as Usual.* (1999) Pg. 34

[2] Unpublished Paper on *Some Weaknesses of African Christianity* presented at Daystar University 1992. Pg.6

[3] Be aware that there are many other Biblical verses to challenge the same. The reference version used was the (1995) *Holy Bible: New Revised Standard Version.* Oxford: Oxford University Press.

[4] For the sake of Jesus and not for the sake of unorganised or exploiting managers.