MANAGING EmOC SERVICES: THE HUMAN FACTOR

Presented at the AMDD Program Conference
Marrakech, Morocco
February 19-21, 2001

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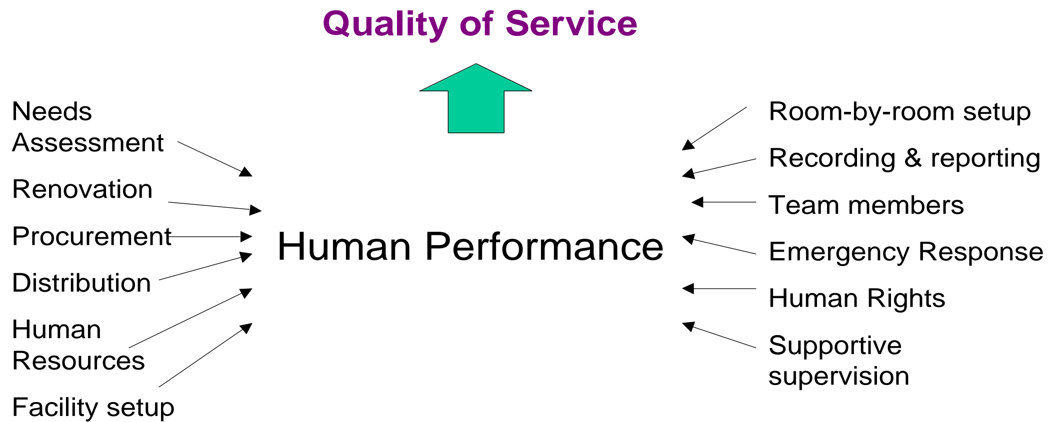
This morning, our discussion of management will focus on the human factor in delivering emergency obstetric care (EmOC). This means we will shift our thinking from physical and other inputs to the role human behavior—more precisely, the role provider performance plays in delivering quality EmOC so that more women's lives are saved.

What we are trying to do in this program is make hospitals work. So our projects are now tackling these issues at facilities. From the findings of the needs assessment, projects are supplying the necessary equipment and supplies, and making sorely needed renovations. And to improve staff performance, skills training is being carefully designed and in some cases, already being carried out.

My point today is that we can't stop here. If we look closely at what improves human performance and maintains high performance over time, we see that we need more than physical inputs and skills training. EmOC is different from other interventions in maternal health because quality care must be available 24 hours a day, 7 days a week. This means that a team of human beings must be capable, motivated and "ready" all the time. This is a huge management challenge. I will look at this challenge broadly—suggesting an approach to how management systems can improve and maintain human performance. The smaller discussion groups to follow will cover specific management issues and interventions.

The Human Factor



Here are the 12 essential components in the delivery of EmOC. If any one of these is weak or non-functioning, the likelihood is low that obstetric services will function effectively in an emergency. To improve each component, to make each one operational, requires inputs, and steps and procedures to be followed. To rephrase this from a management perspective, each component will be effective only if inputs are adequate and people do their job. It is the role of management to ensure that people are adequately supported in their individual and collective efforts. This results in lasting quality of service. In the figure above, the box that surrounds human performance is the management box.

The management question we need to ask is: How do we maximize human performance? As program planners and implementors, as policy- and decision-makers, as supervisors and managers, we need to understand what is known about human behavior, and then build management systems and design policy that reflect that understanding. Our goal is to strengthen management systems to support human performance critical to EmOC—at all levels of the health system. To do this, we need to put management systems in place specifically designed to support the work expected from each person at every level of the health system, from hospital staff and supervisors, to district officers, up to provincial and state officials.

How can we do this? There are many theories and beliefs about what drives human behavior, and I am not trying to convert you to any one of these. Rather, I am offering today a paradigm—not a belief system, but simply a paradigm based on behavioral science—that offers a structure for planning so that programs intended to maximize human performance will be more likely to reach that goal.

A B Cs of Behavior

- **A**ntecedents
  - – act as a signal or prepare people
- **B**ehavior
  - – the action itself
- **C**onsequences
  - – reaction to performance

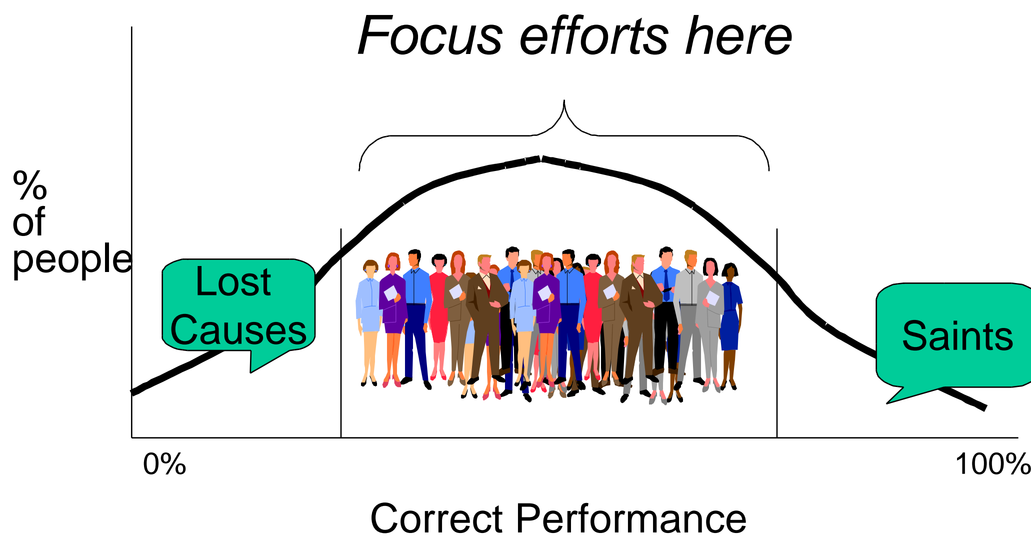
The structure I have found useful is based on the ABCs of behavior. Antecedents are events that come before a behavior and act as a signal or prepare people to act. Traffic lights tell us when to stop or go, and fever and sore throat tell us to see a doctor or take medicine. Next come the behaviors themselves. Behaviors can be analyzed for their feasibility—complexity and resources required; for their acceptability from a cultural, moral and ethical view; and for their familiarity—the degree to which people are already doing the behavior. And finally, consequences are the events that follow a behavior—the reaction a person gets from doing something. Reactions can come from within—such as feelings of guilt or satisfaction—or they can come from people or events in the environment—such as praise or a change in health status of a patient.

Consequences can be positive or negative, or equally influential on behavior, are those consequences when no reaction seems to have occurred at all. Positive consequences usually strengthen behavior—people are more likely to do something again if “it worked”. Negative consequences—often punishment—tend to suppress behavior. People usually stop doing that behavior and try an alternative. And when people feel their behavior got no reaction at all—ineffective treatment or “nobody cares”—they slowly become discouraged and eventually stop the behavior.

What do these concepts have to do with management? **A.** People are capable of learning skills. **B.** We can identify necessary skills for the management of EmOC. **C.** People must be supported to maintain their performance. Let’s look at each one of these

principles in detail. They may seem like mundane points, but they have important implications for structuring more effective management systems.

People are capable of learning skills



The first principle—the antecedent—is that people are capable of learning skills. If we took a hypothetical situation of all the people working in emergency obstetric care and plotted their level of performance, we would have some kind of a bell curve. At one end of the curve, we find a few people who perform correctly nearly 100% of the time despite bad conditions, obstacles, low pay, no matter what. We call them Saints. At the other end of the curve, we find a few people who perform badly, no matter how well paid and trained, with long vacations and easy postings. We call them Lost Causes.

Most people, however, fall in the middle. These are people who are affected by inputs, who are capable of improving their performance, and who need systems of support to maintain high quality performance. This is where we can make the most impact.

The next principle—the behavior—is that we can identify skills necessary for EmOC. As I said earlier, every component necessary for delivering emergency services takes people doing their job—using inputs, following guidelines, making good decisions and taking risks, whether they be nurses and midwives, managers, surgeons, drivers, lab technicians or cleaners. They all use some combination of technical (medical, surgical, equipment operation), social (interpersonal, ethical), management (supervisory, administrative) and other support skills (cleaning, transport, laboratory services).

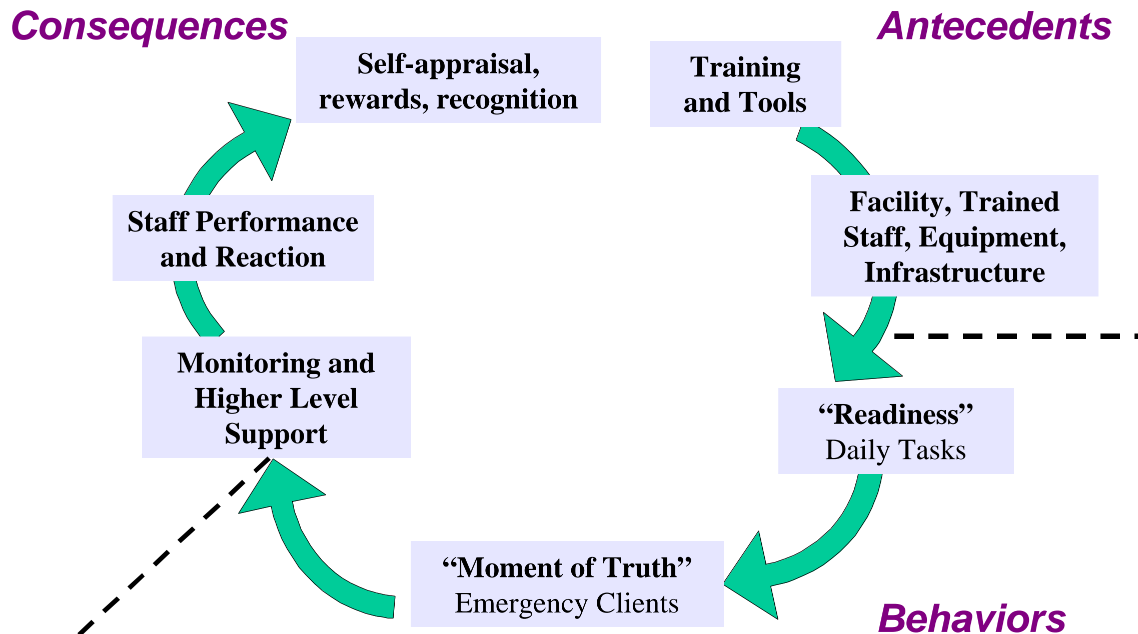
When we are designing management interventions for our projects, we need to ask: What do we want people to do? By clarifying what people need to do, we can focus management better to motivate and support people's efforts. Let's look at two examples from the 12 essential components of EmOC listed earlier.

Patients' rights: In rendering quality emergency service, it is important for providers to respect patients' rights. What does this mean? It means that providers will act in a certain way. Examples of behaviors that demonstrate respect for patients' rights are: examine in privacy, treat every patient, respond to patient's needs, and avoid displaying anger or impatience.

Supervision: Some people may already have natural leadership and managerial qualities, but most people can learn some of the skills good leaders and managers use. Some examples are: observe staff practices, acknowledge correct performance, correct poor performance, encourage lower level staff, lead by example, and call regular meetings. By identifying skills and behaviors, we clarify what management systems need to support.

Because I have listed behaviors here, this may appear as a top-down, dictatorial approach. I have done this only to illustrate a point. In practice, deciding on what will be focus behaviors is done by consensus.

The third principle—consequences—is that people must be supported to maintain their performance. Let's explore this question of support by using the example of a project that has decided to strengthen supervision at facilities as a strategy to improve quality of service.



First, let's look at a supervisor's job. It begins with training and tools for supervision. At the facility, we assume there are adequately trained staff, equipment and infrastructure. Then, the work begins. The supervisor is responsible for the state of readiness and for the emergency response, because supervision is critical to maintaining quality of care. As he or she does supervision, using what he learned, the supervisor gets reactions in the form of staff reactions and level of performance, support from higher levels of the health system, monitoring, self-appraisal, and rewards and recognition. These types of reactions can be supportive, punishing or they may not happen at all.

If you think about many management programs to strengthen supervision, they mostly concentrate on antecedents, preparing people with training and manuals on supervision, and then the person is expected to use supervisory skills to manage hospital staff (behaviors). The big question is, to what degree will supervisors use their skills and approach at their facility, day after day, month after month, year after year? A lot depends on the reaction they get—what are the consequences to their efforts to supervise? Do they get support from higher levels of the health system with monitoring and supervision? How do hospital staff react to the supervisor's efforts to correct and reinforce their performance? What rewards and recognition exist for a well-run

emergency service? Remember, there are three kinds of consequences: positive, negative and no reaction at all. All three have impact on performance.

What sort of consequence conditions currently exist for supervisors and managers? Generally, not very favorable. Desired performance is frequently ignored and in some instances, even punished! Management systems need to focus on and change consequence conditions so that long term use of skills is not left to chance. Management systems need to support what people have been trained to do. This does not mean adding follow-up visits to a training curriculum. Follow-up is an important component of good training, but it is not a long-term solution to maintaining quality performance.

What do I mean by support? There are two types of support a management system should provide. 1. System support for problem identification at the facility level. The management at the facility should have the authority and means to implement solutions that can be carried out at that level. 2. Other support in the form of recognition and rewards for quality performance (of a person or a facility) and taking risks. Such support can come in many forms and need not be limited to financial and other material rewards. In order to provide effective support, the management component of a project or a ministry program requires adequate amounts of time, expertise and resources.

Behavior—correct performance—needs to be supported at every level. Management systems therefore should be active at multiple levels of the health system to compliment each other. If there is no political will and leadership at higher levels, managers face unnecessary constraints at the facility. Yet, we must understand that antecedents and consequences influence the actions of officials at higher levels. The initiatives we ask them to take may not lead to a positive reaction from people and events in their work environment. We can supply the antecedents to their action (briefings, materials, workshops and conferences), but most of the consequences come from sources other than projects.

Following are examples of specific management interventions, one at the facility level (Quality Improvement Cycle) and one at the mid-level (strengthening the health information system) that follow the ABCs of behavior. We see how they are designed to be effective at maintaining optimal performance.

In using the Quality Improvement Cycle (QI) at a facility, the staff go through these four general steps:

- Team-lead assessment
- Information processing/action plan for improvement
- Implementation (of action plan)
- Progress review and feedback

From the standpoint of the ABCs of behavior, there are three important features of this process.

1. **It is a cycle.** The staff are constantly assessing and reviewing their own performance and assessing and reviewing facility readiness and emergency

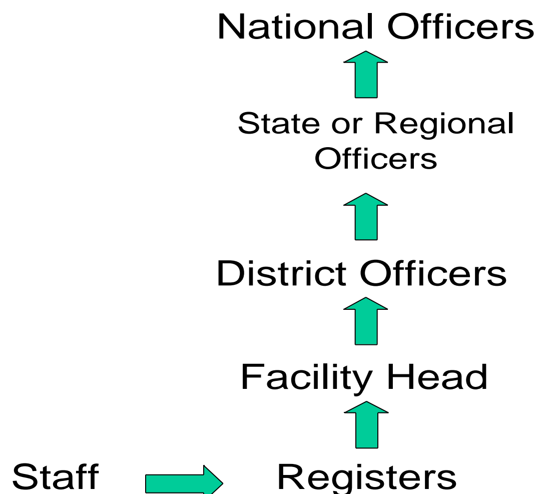
team response. The goal of QI is not to eliminate problems—emergency care must respond to highly variable and unpredictable circumstances all the time—but its goal is to provide a robust and ongoing cycle that deals constructively with problems and encourages correct performance.

2. **It clarifies expectations.** Both the team lead assessment and the action plan call for specifying actions and procedures—that exist and that must be changed or added—to improve quality of care.
3. **It generates feedback.** When staff track and review what they are doing, feedback is automatically generated. By allowing time in the cycle to recognize what worked and that progress is being made, gives people the constructive feedback and encouragement they need to continue.

If people see that their effort is making a difference and that they are recognized and rewarded in some way, they are more likely to continue their effort. This QI cycle is one way to provide these important events.

An example of a mid-level management system is the health information system (HIS) illustrated below. The typical HIS is structured so that a facility compiles data from the registers and sends this information to the district level. The head signs the report, but may or may not actually read it. The district officer then collects reports from all facilities in the district, fills out the report, signs it and sends it on. And so on up the health system. In general, the system doesn't work very well—reporting is sporadic or inaccurate—and people see no benefit from participating in the system. It certainly isn't serving as a management tool.

Example of a system to strengthen middle management: HIS



What are missing from the system are positive consequences. Right now, probably the most consistent consequence is some type of reprimand for NOT submitting the reports. There is rarely any benefit for participating. If however, people were encouraged to use the data they collected, they would learn more about their facility function or utilization, or they would see how services are operating throughout the district. They would identify what is working and where problems lie. More specifically, the head of a facility could analyze data from his registers, call the staff together and discuss what trends are there. The district officer could consolidate data and call heads of facilities together to discuss that the findings mean. And so on up the scale. If these insights lead to action, this could be a rewarding consequence, and the HIS system could function as an important input to management. This can be done without huge inputs of money or material.

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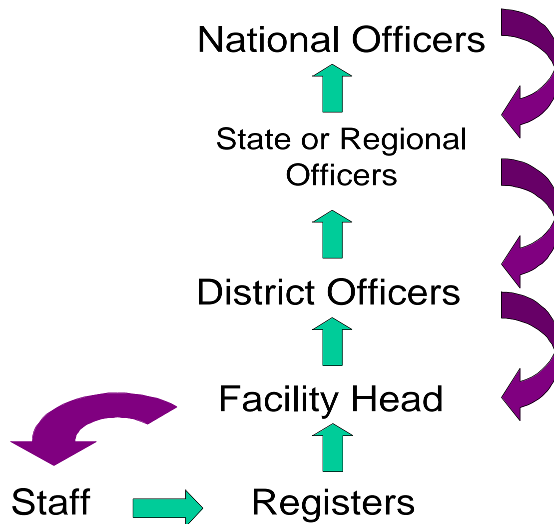

These are just two examples of management interventions that use the ABCs of behavior in their design, making them more responsive to providers' needs. In the management component of your projects, whether you decide to use QI, strengthen supervision, conduct audits or case reviews, use a HIS, engage facilities in appreciative inquiry, instill a monitoring system or run mid-level management meetings, you should look at each intervention to see if, as it functions, it will:

- establish a continuous process to:
    - Identify strengths and weaknesses
    - Generate constructive feedback
    - Promote problem solving and innovation
    - Acknowledge good performance, and
    - Support a team mentality.
- This process should occur at multiple levels of the health system in a coordinated fashion and consistently over time so that interventions reinforce each other.

By incorporating these elements into any of the management systems used in your district, or project, or facility, you increase the likelihood that management will more effectively improve human performance and maintain it over the long term.

In sum, the role of management from a behavioral perspective should establish clear expectations for correct performance, prepare people adequately, and support people to use their skills and resources optimally to provide quality emergency obstetric services.