Managerial Competency of Primary Healthcare Facility Managers in the Selected District Councils in Tanzania

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Abstract:
Understanding the managerial competency of healthcare managers is very important. However limited evidence exists on the managerial competency of primary healthcare facility managers in low- and middle-income countries. The purpose of this research was to examine the managerial competency of primary healthcare facility managers in the selected District Councils in Tanzania. This research is grounded on positivism philosophy, a

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cross-sectional survey descriptive research design, a complete enumeration sampling strategy and a survey used to collect primary data from 102 public primary healthcare facility managers located in Kondoa, Iramba and Sumbawanga District Councils in Tanzania. To examine the managerial competency of primary healthcare facility managers, the study adapted the MCAP framework and Statistical Package for Social Sciences (SPSS) version 25 used to analyze the data. For the communication and relationship management domain, 74.5% were competent while 25.5% were less than fully competent. Likewise, 65.68% of them were competent while 34.32% were less than competent in the knowledge of the healthcare environment domain. Equally, 62.74% and 37.26% of the primary healthcare facility managers were competent and less than competent respectively in operations, administration and resources management domains. Correspondingly, 67.65% and 32.35% of the primary healthcare facility managers were competent and less than competent respectively in evidence-informed decision-making. On the same token, 74.55% and 25.45% were competent and less than competent respectively in enabling and managing change. The study used primary data and contributed recently well-worth and highly demanded knowledge on the managerial competency of healthcare managers in the LMICs.

**Keywords:** Managerial Competency, Primary Healthcare Facility Managers, Tanzania.

**JEL Codes:** H1, M19.

1. Introduction

Measuring the managerial competency of primary healthcare facility managers in low- and middle-income countries (LMICs) is very important. This is because, measuring managerial competency is important for the continuous progress of quality in health care, ascertaining the best management practice, and management educations design (Santrić Milicevic, Bjegovic-Mikanovic, Terzic-Supić, & Vasic, 2010). Similarly, to enable primary care managers to provide excellent services to the public, there is a need to have extensive knowledge in their managerial competency (Mohd-Shamsudin & Chuttipattana, 2012). Thus, understanding the managerial competency of healthcare professionals is considered to be a priority for research to improve the provision of health services in primary healthcare (Dikic et al., 2020).

Different scholars established evidence-based management indicators for self-management, planning, organizing, directing, and managing the delivery of healthcare in light of the significance connected with evaluating
the managerial competency of health managers (Pillay, 2008; Khadka, Gurung and Chaulagain, 2014; Umbetghanova et al. (2014)). Most prior scholarly works that evaluated the management competencies of health managers used hospitals as the secondary level of healthcare delivery (Pillay, 2008; Kakemam, Janati, Mohaghegh, Gholizadeh, & Liang, 2021). These studies were disproportionately conducted in industrialized nations (Liang et al., 2018). Also, Mills et al., (2020) assessed the managerial competency of healthcare facility managers using superiors and subordinates as a source of information.

Previous scholarly works contributed limited evidence on the managerial competency of primary healthcare facility managers in LMICs (Kakemam & Dargahi, 2019; Dikic et al., 2020; Kakemam, Janati, Mohaghegh, Gholizadeh, & Liang, 2021). Similarly, other scholars reported that health facility management is among the under-researched area in many LMICs (Mabuchi et al., 2018; Mabuchi, Alonge, Tsugawa, & Bennett, 2020). This, reveals the limited empirical research on managerial competency-related issues at the primary healthcare level in developing countries (Mabuchi, Sesan, & Bennett, 2018; Macarayan et al., 2019). As a result, the managerial competency of primary healthcare facility managers is less well-known, questionable and open to discussion among researchers, policymakers and practitioners in the LMICs (MOH, 2018; Macarayan et al., 2019; Mabuchi, et al., 2020). This has led to substantial knowledge gaps on the managerial competency of health managers in the LMICs that need to be investigated (Bitton et al., 2019; Macarayan et al., 2019; Mabuchi, et al., 2020). Thus, reliable information is required to unveil the evidence of the managerial competency among primary healthcare facility managers in the LMICs including Tanzania (MOH, 2018; Mabuchi, et al., 2020).

The study intended to answer the questions on the managerial competency of primary healthcare facility managers and contribute to knowledge on the managerial competency of primary healthcare facility managers in the LMICs.

The paper is presented in the following order: starting with a literature review on the concept of measuring managerial competency, followed by methods used to conduct the study. The findings are then presented and discussed with the conclusions. Thereafter, the implications of the results, the limitations of the study, and potential future research areas were also reported.
2. Literature review

2.1. Managerial competency

Competence is a measurable behavioural feature of an individual that is linked to effective performance in a given job or organization. According to Boyatzis (1982), competency is a person's cognitive (skills and knowledge), affective (values and attitude), behavioural and motivational features and dispositions that enable an individual to perform successfully in a given situation. Different scholars define managerial competency based on multidimensional ideas. As defined by Boyatzis (1982), managerial competency consists of skills that are necessary for workers to have in order to accomplish certain tasks at the desired degree of success. Also, managerial competency is the person’s requisite knowledge, skills and abilities to accomplish his or her job (Quinn, Faerman, Thompson, & McGrath, 1990). Similarly, Whiddett and Hollyforde (2003) define managerial competency as individuals' behaviours that enable them to exhibit good task performance within the organization. Elsewhere, Krontorad and Trčka (2005) define managerial competency as employees who use a combination of knowledge, skills, talents, and behaviours in the course of doing their work, which is crucial in generating results that are consistent with the organization's strategic goals. Moreover, Veliu and Manxhari (2017) define managerial competency as prerequisite knowledge, skills, abilities and behaviours for successful job performance in managerial occupations. These divergent views lead to persistent difficulties in establishing the generally accepted definition of managerial competency (Russo, 2016; Kubeš, Spillerová, & Kurnický, 2004).

2.2. Measuring managerial competency

The concept of measuring managerial competency was initially introduced by David McClelland (McClelland, 1973). This is because, every manager must possess several abilities that will enable him or her to work properly and successfully at various managerial levels in the daily activities of the organisation (Veliu & Manxhari, 2017). Measuring managerial competency in health care attracts the attention of different stakeholders since it is understood to be essential in improving the delivery of quality healthcare services and ascertaining the best management practices (Santric Milicevic et al., 2010). The attention is based on the truth that, managers in the field of healthcare management face particular difficulties since they must combine
knowledge of clinical and healthcare procedures with contemporary commercial management techniques (Pillay, 2008).

Different scholars measured managerial competency in diverse ways in response to the emphasis given by various stakeholders to measure and understand the managerial competency of health managers. A study conducted in 2008 used a self-rating technique to measure the managerial competency of hospital managers (private and public) in South Africa (Pillay, 2008). The respondents were asked to score their ability to plan, organize, lead and control legal, ethical and self-management issues (Pillay, 2008). The ratings were given on a five-point Likert scale, with the lowest rating being very low and the highest being very high. According to the study, health managers perceived themselves to be relatively capable of planning, managing and leading, but least competent in specific healthcare skills. Also, the general lack of managerial competency identified in the public sector, project and knowledge management are the least developed competencies (Pillay, 2008).

Furthermore, in a study by Santrić Milicevic et al. (2010), the self-rating technique was used to assess the managerial competency of fourteen management teams from Belgrade primary healthcare centres. The study revealed the greatest competency gap among local health managers when it came to evaluating staff performance. A study by Khadka, Gurung and Chaulagain (2014), which was conducted in Nepal by using a self-rating technique, revealed that health managers were more competent in communication and knowledge and had honesty and integrity in service delivery, on the other hand, project and knowledge management was the least developed ability.

Moreover, Umbetzhanaeva et al. (2014) used a questionnaire developed by the EPOS health management group to assess the managing abilities of various levels of healthcare managers. About 61 managers from various levels of management were interviewed. According to comments, the lowest score was 57.2% among mid-level managers in the “information and financial management” sector (Umbetzhanaeva et al., 2014).

The current study acknowledges the contributions of seminal works in the area of measuring the managerial competency of health managers (Khadka et al., 2014; Pillay, 2008; Santrić Milicevic et al., 2010). However, the previous studies measured the managerial competency of health managers under the different educational systems, cultures, qualifications and the needed promotion procedures to the managerial position as well as measured at the secondary level of healthcare delivery. Thus, little evidence exists and thus more is needed on measuring the managerial competency of health
managers in the LMICs. This is because, there is no conclusive proof that primary care managers are effective and have the required skills in performing their managerial duties and responsibilities (Kak, Burkhalter, & Cooper, 2001; Mohd-Shamsudin & Chuttipattana, 2012). This goes together with the need of establishing an appropriate package of interventions to strengthen management capacity in the decentralized health context (Ng’ang’a et al., 2016). That substantiated the highly needed and demanded knowledge, and information on health managers, especially within the health systems in LMICs (Dikic et al., 2020). Similarly, there is a knowledge gap in understanding the managerial competency of the health managers in the LMICs and Tanzania in particular (Mabuchi et al., 2018; Ngowi, 2017; URT, 2018; Samky, 2019). In light of this limited empirical evidence on the managerial competency of primary health managers, there is a need of examining the managerial competency of primary healthcare facility managers in the public primary health facility in the Tanzanian context.

3. Methods

3.1. Study settings

The study was conducted in Kondoa, Iramba and Sumbawanga District Councils. These District Councils were purposively selected based on being in the high, middle and low star rating performance categories of health facilities in Tanzania (MOHCDGEC, 2018).

3.2. Research design

The study adopted a cross-sectional descriptive research design. In the cross-sectional part, the measurable data on the managerial competency of primary healthcare facility managers of public primary health facilities were collected at the same point in the same period. In the descriptive part, the statistical evidence describing the existing status as being perceived in a completely usual as well as unchanged natural environment of the variables of interest in the current study were analyzed (Aggarwal & Ranganathan, 2019). The descriptive research design selected to revealing accurately the characteristics of a particular group (Akhtar, 2016).

3.3. Framework for measuring managerial competency

In the current study, the Management Competency Assessment Project (MCAP) framework was adapted to measure the managerial
competency of primary health facility managers. In the MCAP framework managerial competency variables namely; interpersonal, communication qualities and relationship management based on relationship management and teamwork, communication management and personal quality management constructs. Also, knowledge of the healthcare environment is based on knowledge of the healthcare environment, knowledge of the organization and application of knowledge in legal and quality practices constructs. Additionally, evidence-informed decision-making built on evidence appraisal, evidence application and decision-making and evaluation of decision constructs were also measured. Moreover, enabling and managing change established on change preparation, change implementation and evaluation and leader quality in change constructs were used to measure managerial competency.

The MCAP framework had close-ended questions with a seven-point Likert scale, representing levels of managerial competency that ranged from (1) being not competent interpreted as the facility managers do not understanding the requirement and are not capable of applying it in their role. Also, (2) being at the level of basic or novice, implies that facility managers may be capable of demonstrating minor aspects of their role. Furthermore, (3) is an advanced beginner in which facility managers are capable of demonstrating in their role, but not in all required aspects. Additionally, (4) is competent with occasional guidance, which facility managers can generally demonstrate in their roles, but guidance is needed occasionally. Likewise, (5) falls into competent with no guidance, thus facility managers can generally demonstrate in their role independently, but have not had extensive experience. Similarly, (6) is proficient, that is to say, facility managers can always apply appropriately in their role and have extensive experience. Similarly, the last is (7), which is for superior expertise meaning that facility managers can always apply appropriately in their role with extensive experience gained from diverse management roles at the executive level and can transfer this competency to others.

Thereafter, the overall scale with two levels was further categorised and the scores from 1 to 4 (less than five) are considered less than fully competent and the scores from 5 to 7 (five or higher) are considered fully competent (Liang et al., 2018). The scale was selected in the current study because of its wide range of options providing facility managers more chances of assessing themselves in a wide range of competency levels. Also, the scale was successfully applied in assessing managerial competency levels of health managers in Iran, China and Australia (Kakemam & Dargahi, 2019; Liang et al., 2018).
3.4. Pilot study

Before the inception of the actual data collection process, the pilot study was conducted using a questionnaire. The pilot study allowed for the pre-test of the questionnaire on style and approach (Majid, Othman, Mohamad, & Lim, 2017; van Teijlingen & Hundley, 2001). The pre-testing also gives room to assess if the research tools can collect viable and reliable data that conform to the objective of the study. The questionnaire was pre-tested in ten primary health facilities. In pre-testing the questionnaire, it is adequate to use between (1% to 10%) of the sample size (Mugenda & Mugenda, 2012). Similarly, a range of (5% to 10%) of the sample size was also recommended (Paul & Saha, 2016).

3.5. Sampling and data collection

The complete enumeration sampling strategy was employed to select 102 public primary health facilities located in Kondoa, Iramba and Sumbawanga District Councils. Which PHFMs of public primary health facilities were contacted to participate in the study. In this study, data were collected between September and December 2020. The survey employed a questionnaire was used to collect quantitative primary data for the purpose of the current study, in achieving pre-stated objectives and answering the research question. In this study, the survey was conducted by administering the questionnaire to the primary healthcare facility managers of the public primary health facilities. The survey aimed at collecting information related to the managerial competency of primary healthcare facility managers. The survey research was a useful and legitimate approach to research that has clear benefits in helping to describe and explore variables and constructs of interest (Ponto, 2015).

3.6. Data analysis

The quantitative data were descriptively analysed by using Statistical Package for Socio Sciences (SPSS) version 25. Descriptive statistics including means and standard deviations were used to present the findings on the managerial competency of the primary health facility managers.

3.7. Ethical consideration

Ethical permission was granted by the University of Dodoma, which has been given the mandate to issue research clearance to its staff and students.
on behalf of the Government of Tanzania and the Tanzania Commission for Science and Technology. The clearance was presented to the Kongwa, Kondoa, Iramba and Sumbawanga District Councils who approved the study in their administrative areas. Verbal consent was sought from the primary healthcare facility managers. Respondents were informed that participation is voluntary, and they have the right to withdraw from the study at any time they wish to do so without any consequences. They were also assured of the confidentiality of any information deemed necessary to be treated so anonymity in this study was also adhered to (Fouka & Mantzorou, 2011).

4. Results and discussion

Generally, the findings revealed that primary healthcare facility managers exhibited different levels of managerial competency ranging from not being competent to be competent across all investigated domains. The results for managerial competency of PHFMs based on Interpersonal Communication Qualities and Relationship Management (ICQRM), Knowledge of Healthcare Environment (KHE), Operations and Administration Resources Management (OARM), Evidence-Informed Decision Making (EIDM), Leading People and Organization (LPO) as well as Enabling and Managing Change (EMC) were presented in (Table 1).

Table 1. Managerial Competency of Primary Healthcare Facility Managers

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not competent</th>
<th>Basic/ novice</th>
<th>Adv beginner</th>
<th>Comp, guidance</th>
<th>Comp, no guidance</th>
<th>Proficient</th>
<th>Super Expert</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICQRM</td>
<td>(0.00)</td>
<td>(0.00)</td>
<td>(5.88)</td>
<td>(19.61)</td>
<td>(31.37)</td>
<td>(37.25)</td>
<td>(5.88)</td>
<td>5.17</td>
</tr>
<tr>
<td>KHE</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>24</td>
<td>35</td>
<td>28</td>
<td>7</td>
<td>5.02</td>
</tr>
<tr>
<td>OARM</td>
<td>(0.00)</td>
<td>(0.00)</td>
<td>(7.84)</td>
<td>(23.53)</td>
<td>(34.31)</td>
<td>(27.45)</td>
<td>(6.86)</td>
<td>4.93</td>
</tr>
<tr>
<td>EIDM</td>
<td>(0.00)</td>
<td>(0.98)</td>
<td>(2.94)</td>
<td>(33.33)</td>
<td>(31.37)</td>
<td>(27.45)</td>
<td>(3.92)</td>
<td>4.90</td>
</tr>
<tr>
<td>LPO</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>16</td>
<td>32</td>
<td>26</td>
<td>4</td>
<td>4.90</td>
</tr>
<tr>
<td>EMC</td>
<td>(0.00)</td>
<td>(0.98)</td>
<td>(8.82)</td>
<td>(22.55)</td>
<td>(38.24)</td>
<td>(25.49)</td>
<td>(3.92)</td>
<td>4.90</td>
</tr>
<tr>
<td>Overall</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>23</td>
<td>35</td>
<td>36</td>
<td>5</td>
<td>5.17</td>
</tr>
<tr>
<td>MC</td>
<td>(0.00)</td>
<td>(0.00)</td>
<td>(2.94)</td>
<td>(22.55)</td>
<td>(34.31)</td>
<td>(35.29)</td>
<td>(4.90)</td>
<td>(0.93)</td>
</tr>
</tbody>
</table>

Source: Prepared by the authors based on SPSS V 25 output.
4.1. Interpersonal communication qualities and relationship management

Based on the interpersonal communication qualities and relationship management domain 74.5% were competent while 25.5% were less than fully competent (Table 1). These findings demonstrate a high competency level of ‘interpersonal, communication qualities and relationship management’ which can be attributed to its long-term identification as an important competency for health managers (Liang & Howard, 2010). Comparable results are reported by Lopes, Narattharaksa, Siripornpibul, & Briggs, (2019) who revealed that primary healthcare managers were found competent in communicating effectively. Similarly, 91% of the participating primary managers positioned themselves as fully competent in interpersonal communication qualities and relationship management (Liang et al., 2018). Similarly, the primary healthcare managers in Timor-Leste were observed as competent in communicating effectively (Lopes et al., 2019). Analogous results are reported among the head nurses working with specialized and primary healthcare organizations and the social care sector in Finland (Kantanen et al., 2017).

4.2. Knowledge of the healthcare environment

Likewise, 65.68% of the PHFMs were competent while 34.32% were less than competent in the knowledge of the healthcare environment domain (Table 1). Comparable results are reported by Lopes et al. (2019) who revealed that primary healthcare managers were found not competent in professionalism in the workplace entailing knowledge of the healthcare environment. Likewise, health managers in Iran were also not capable of accomplishing their managerial duties and responsibilities (Kaushik & Walsh, 2019; Kuhlmann & von Knorring, 2014). These findings are similar to those reported by Kakemam and Dargahi, (2019) that Iranian hospital managers have the highest level of competency in ethical issues, planning and service provision management. Likewise, 18% of the participating primary managers positioned themselves as less than fully competent in knowledge of the healthcare environment (Liang et al., 2018). Similar information was presented by Lopes et al. (2019), that primary healthcare managers were found to be not competent in knowing the organization in Timor-Leste, findings which were consistent with the findings of a study by of Al-Momani, (2018). Regarding the findings above, similar results are reported in a study by Hamidi and Eivazi, (2010) that, the level of professional skills (technical) was moderate (56%) among managers of health centres in Iran.
4.3. Operations administration and resources management

Similarly, 62.74% and 37.26% of the PHFM were competent and less than competent respectively in operations, administration and resources management domains (Table 1). Comparable results are reported by Lopes et al. (2019) who revealed that primary healthcare managers were found not competent in financial management and knowing the organization both of which are parts of operations management. Likewise, health managers in Iran were also observed as not capable of accomplishing their managerial duties and responsibilities (Kaushik & Walsh, 2019; Kuhlmann & von Knorring, 2014). Similarly, the evidence revealed that between 18% and 24% of the participating primary managers positioned themselves as less than fully competent in operations, administration and resources management (Liang et al., 2018). In the same regard, it was concluded that participants were less competent in the management of people and finances (thus, operations) as well as in change management (Harris, 2016).

A similar observation was made about nurse managers working with the selected public hospitals in KwaZulu-Natal province, South Africa. These were reported as not having the necessary financial management skills and competencies to manage the current healthcare financial situation, thus making them require additional training to gain more knowledge and skills (Naranjee et al., 2019). Similarly, findings reported in the mean score of the management competency in human resource management among managers at different levels in the general hospitals in Iran was found to be 3.44 (Kakemam et al., 2017).

Again, in Finland among both head nurses and directors of nursing, the mean competency score of human resource management was quite good at 1.95 and 1.81 respectively (Kantanen et al., 2017). Furthermore, in South Africa, the overall clinic nursing managers rated themselves as high on staff management with a mean competency score of 8.75 (Munyewende et al., 2016). Likewise, a study by Al-Momani, (2018) revealed that health managers scored the highest ratings on ‘delegating some important decisions to staff’ (mean=4.24). Furthermore, Lopes et al. (2019), indicated that the primary healthcare managers in Timor-Leste were competent in managing human resources. Similar findings reported that the overall operational management competence among directors of nursing was estimated as better (Kantanen et al., 2017).

On the other hand, other studies reported conflicting findings among hospital managers in Tehran, Iran who considered themselves least proficient in the category of managing people with a mean competency score of 2.99
(Kakemam & Dargahi, 2019). This difference could be that the managerial skills between the two groups vary according to the characteristics of the respondents (Al-Momani, 2018). Similar findings were reported in a study by Hamidi and Eivazi, (2010) indicating that, the level of professional skills (human) was moderate at (56%) among managers of health centres in Iran.

4.4. Evidence-informed decision making

Equally, 67.65% and 32.35% of the primary healthcare facility managers were competent and less than competent respectively in evidence-informed decision-making (Table 1). Similarly, more than 12% of health service managers were reported as not being capable of demonstrating competency in ‘evidence-informed decision-making’ (Liang et al., 2018). The findings reflected those reported by Kakemam and Dargahi, (2019) that Iranian hospital managers lacked management knowledge and skills in the area of problem analysis/solving. Having a high proportion of primary healthcare facility managers needing assistance in evidence-informed decision-making could probably be contributed through the limited use of the available evidence which is pertinent to the management and organisational practices among health managers (Kovner & Rundall, 2006; Liang et al., 2012). Also, it could be related to the recent inclusion of evidence-informed decision-making managerial competency as it is believed to be an essential competency for health service managers (Isouard, Martins, & Friedman, 2015; Liang & Howard, 2010). This shows that almost one-third of primary healthcare facility managers were not capable of demonstrating competency in the indicators of evidence application and decision-making constructs. This might be caused by the actual limited use of the available evidence for organizational practices and management (Kovner & Rundall, 2006; Liang, Howard, Leggat, & Murphy, 2012).

Likewise, the newness of evidence-informed decision-making in the list of managerial competencies was thought to be essential to health managers (Isouard et al., 2015; Liang & Howard, 2010). The other evidence reported that respondents felt they were least proficient in the category of problem-solving and analysis in Iran (having a mean competency score of 3.09 (Kakemam & Dargahi, 2019). Likewise, some of the primary healthcare managers in Timor-Leste were revealed not to be competent in problem-solving on financial management in their jobs (Lopes et al., 2019). The low score in critically appraising the validity and relevance of evidence competency could be attributed to the low use of evidence in making managerial decisions in healthcare (Liang, Howard, & Wollersheim, 2017). This could be caused by the actual limited use of the available evidence to
make a pertinent decision relevant to organizational practices and management (Kovner & Rundall, 2006; Liang et al., 2018). Furthermore, the newness of evidence-informed decision-making in the list of MC although it is essential to health managers (Isouard et al., 2015; Liang & Howard, 2010).

On the other hand, contradictory findings were reported in a study by Liang et al. (2018) that only around (12%) of middle-level health service managers working with public hospitals in Victoria, Australia were unable to demonstrate competency in ‘evidence-informed decision-making.’ The possible explanation for this could be that the managerial skills between the two groups differed according to the characteristics of the respondents (Al-Momani, 2018).

4.5. Leading people and organization

Regarding the leading people and organisation domain, 24.52% are less than competent while 75.48% are competent (Table 1). Similar findings are reported by Lopes et al. (2019) that, primary healthcare managers were found to be incompetent in problem-solving as part of leadership management competency. These findings are consistent with the findings reported in a study by Pillay, (2008) that the maximum average competency was related to strategic planning. Related findings were observed among both the head nurses and directors working in Finland with specialized primary healthcare organizations and the social care sector of nursing whose mean competency score of leadership and management competencies was quite good at 2.11 and 1.93 respectively (Kantanan et al., 2017). On the other hand, conflicting findings show that those who were educated primarily as clinical experts and healthcare managers frequently lack the core competencies of leaders (Al-Maqbali, 2019). In Iran, the mean score of management competency in leadership in general hospitals was found to be good at 3.49 (E. Kakemam et al., 2017). Likewise, in South Africa, the clinic nursing managers working in Gauteng (an urban province) and Free State (a mixed urban-rural province) overall rated themselves high on leadership and management with a mean score competency of 8.67 (Munyewende et al., 2016). Equally, clinic nursing managers rated themselves high in planning and priority settings (8.6) (Munyewende et al., 2016).

4.6. Enabling and managing change

Concerning enabling and managing change, 74.55% and 25.45% of the primary healthcare facility managers were observed to be competent and less than competent respectively (Table 1). A similar finding is reported
indicating health service managers demonstrate competency in enabling and managing change (Liang et al., 2018). Similar findings were revealed in a study by Kakemam and Dargahi (2019) that, hospital managers from Tehran, Iran were found most competent in terms of change management. Likewise, Liang et al. (2018) affirmed that only around 4% of the health service managers in Victoria Australia were unable to demonstrate the competency of ‘enabling and managing change’. This result correlates with what was reported by Kakemam et al. (2017) that, in Iran, the mean score of management competency in change management at different levels in general hospitals was found to be 3.26. However, contrastive findings were reported by Harris (2016) that, participants had fewer competencies in change management. Furthermore, Liang et al. (2018) reported that only 4% of health service managers were unable to demonstrate competency in enabling and managing change. This resulted in many managers to disengaged and struggle when leading their organizations through changes (Al-Maqbali, 2019). This could be attributed to the reason that, managerial skills between the two groups differed according to the characteristics of the respondents (Al-Momani, 2018). Moreover, the low score in change management competency may be attributed to the reality that most mid-level healthcare managers are not well prepared to drive results.

5. Conclusion, implication, limitation, and recommendation

5.1. Conclusion

Primary healthcare facility managers, on the one hand, demonstrated being more competent meaning that they did not need assistance in performing their managerial duties and responsibilities in leading people and organizations 84.54% and interpersonal communication qualities and relationship management 76.37%. This is followed by enabling and managing change 76.01%, operations, administration and resources management 73.64%, knowledge of the healthcare environment 69.99% and the least evidence-informed decision making 69.09%. On the other hand, primary health facility managers demonstrate being less than competent, meaning that they needed occasional guidance in performing their managerial duties related to evidence-informed decision making 30.91%, followed by knowledge of the healthcare environment 30.01%. Others included subsequently, operations, administration and resources management 26.36% enabling and managing change 23.64% followed by interpersonal communication qualities and relationship management 23.63% and the least was leading people and organizations constituted 15.46%.
5.2. Implications of the study

5.2.1. Practical implications

Primary healthcare facility managers need on-the-job training related to hospitals and healthcare management for them to have appropriate knowledge skills and abilities for effectiveness and efficiency in performing their managerial duties and responsibilities. The results of this study highlight the important practical implications by initiating the apparent need for improvement to strengthen the managerial competency of primary healthcare facility managers in all investigated domains as has been confirmed by the findings from this study. This is confirmed by having primary healthcare facility managers who are less than competent and need occasional guidance in performing their managerial duties and responsibilities.

5.2.2. Policy implications

Leaders in the areas of human resources development have a duty to advocate investments in managerial competency and prioritise management development (WHO, 2005; United Nations Children’s Fund, 2018). Also, globally the findings of the current study have a policy implication as part of growing evidence that demand the need to conduct more researches to measure facility management. This is to inform the needed critical improvement and achieve the delivery of quality primary healthcare that would be necessary for effective universal health coverage (World Health Organization, 1978).

5.2.3. Theoretical implications

The findings of this study confirm that the MCAP framework can be applied in healthcare settings in LMICs. The implication is based on the way the study was designed by adapting variables stipulated in the MCAP framework to examine the managerial competency of primary healthcare facility managers. This implies that adapting the variables from the MCAP framework, shows that the research has taken care of the essential contributor to the managerial competency of the primary healthcare facilities management literature.
5.2.4. Managerial implications

From the managerial perspective, the findings imply that primary healthcare facility managers are required to pay considerable attention to both developing and improving their managerial competency.

5.2.5. Implication to academicians and researchers

Academicians, especially those in business and management schools, have the potential of contemplating the role they might play in improving the managerial competency of primary healthcare facility managers. This could be very easy for the academicians in these business schools because they are in a position to do so and there is a gap and the need of doing so. The other area that might have an opportunity is the dissemination and application of new findings in management practices.

5.3. Limitations of the study

In the process of data collection specifically on access to health facilities, the study was limited by the onset of the rainy season, which was addressed by opting for the researcher to have on-and-off exercise in visiting the health facilities during the convenient weather. Also, there were several non-operating health facilities which created a gap and lowered the total number of the proposed sample, thus lowering the statistical power of the results. This was addressed by trying to reach operating health facilities despite the geographical challenges. Additionally, due to the limited time of the proposed assignment, that is six months for data collection, it was not possible to undertake a longitudinal study, thus the cross-sectional design was employed instead and this limited the advantages that could have been gained using longitudinal research design.

Furthermore, the study was limited to only public-owned primary health facilities due to their being available, thus limiting the generalisability of the findings to private, faith-based, private-public owned health facilities, thus limiting the diversity of the contributed knowledge. In addition, the availability of limited empirical evidence on the managerial competency of primary healthcare facility managers in the LMICs prevents direct comparison (Mabuchi et al., 2020). Thus, this led the study findings to be mostly compared with those in a similar setting only.

Despite the aforementioned limitations and beyond any reasonable doubt, the study contributed to the needed empirical knowledge geared to inspire future investigation that would necessitate understanding the
managerial competency of the primary healthcare facility managers in the LMICs.

5.4. Recommendations

Based on the findings that a proportion of primary healthcare facility managers evidenced to perform their managerial duties and responsibilities at the level of being less than competent. This study recommends that primary healthcare facility managers in the LMICs should be given training related to management. This is very crucial based on the truth that, on the one hand, primary healthcare facility managers in the studied areas have been performing managerial duties and responsibilities related to hospitals and healthcare management. Also, they are expected to be managerially competent and perform their managerial duties and responsibilities efficiently and effectively. On the other hand, these primary healthcare facility managers are less than competent to perform their managerial duties and responsibilities, which can negatively affect their performance.

The empirical knowledge contributed by the current study is limited to cross-sectional data, thus the current study proposes that longitudinal studies be conducted to have additional benefits (Bradley et al., 2015; Macarayan et al., 2019). The longitudinal investigation is expected to have the advantage of effectively tracking and determining variable patterns over time.

Additionally, it is suggested that future research include health managers and health facilities from the categories of specialized hospitals, national and regional hospitals, district-designated hospitals, teaching hospitals, privately owned health facilities, and faith-based organizations in order to increase the study's heterogeneous population. Thus, taking care of the diversity in managerial competency. The inclusion of diverse types of health facilities ought to have the advantages of understanding more and generalizing descriptive characteristics to managerial competency. Thus informing different decisions in policy and programme (Burchett et al., 2012). Furthermore, due to the reality that, the current study is limited to the primary level of healthcare delivery, thus the proposed secondary and tertiary levels of care do warrant such studies in the future.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.
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