Towards a healthy district

Organizing and managing district health systems based on primary health care

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Preface

In many parts of the world, progress towards the goal of health for all by the year 2000 is slow and uncertain. While most countries have formulated broad policies, strategies and plans for achieving the goal, the implementation of these plans is often weak. The current efforts of numerous agencies and sectors to extend health care will succeed only if each district can identify its own priorities and target the available resources to the individuals, families, communities, and other population groups who are underserved or at risk. The need to adopt a population approach and to identify the target groups for health programmes is the point of departure of the present publication.

The ideas presented here are based on a number of years' experience as a district health manager, as well as on extensive discussions and consultations with colleagues both within and outside WHO. I am particularly grateful to Dr G. Fowkes, Department of Community Medicine, University of Edinburgh, Edinburgh, Scotland, and Dr Asamoah Baah, Ministry of Health, Accra, Ghana, for their helpful suggestions, as well as to the many individuals who commented on the early drafts of this book.

E. Tarimo

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Introduction

In May 1977, the Member States of the World Health Organization adopted the goal of "Health for all by the year 2000". If this goal is to be achieved, the people who do not currently have access to appropriate health care—those still missing from the "all" in "health for all"—must be identified, and services must be developed to meet their needs. The most practical unit for doing this is the district, where—given coordination by means of good planning and management—health professionals, auxiliaries, workers from other sectors, and community members can assume collective responsibility for the health of the community. Unfortunately, this team potential is seldom realized. District plans are often poorly formulated or non-existent, targets are vague, and efficiency, effectiveness, and quality of services are seldom considered. The activities of various programmes and institutions continue to be piecemeal and poorly coordinated, while health services are concentrated in particular areas, leaving large population groups with little or no access to health care.

This publication is concerned primarily with orienting health care workers in district health systems in developing countries to ways and means of overcoming problems, and describes briefly how district health systems can be improved. It is not meant to be a comprehensive or detailed manual, but rather a stimulus to action and to the acquisition of skills for the improvement of district health systems.

It is addressed primarily to those directly concerned with improving health within a defined population, and particularly to members of district health management teams. It should also be relevant to provincial, national, and international institutions concerned with the role of primary health care in improving health. In examining the organization and management of district health systems, the book focuses on nine issues, each of which is an integral part of a district planning cycle (Fig. 1), and which address the following sets of questions:

- Does the country have national policies, strategies and plans of action for health for all? Are support and guidance provided to districts?

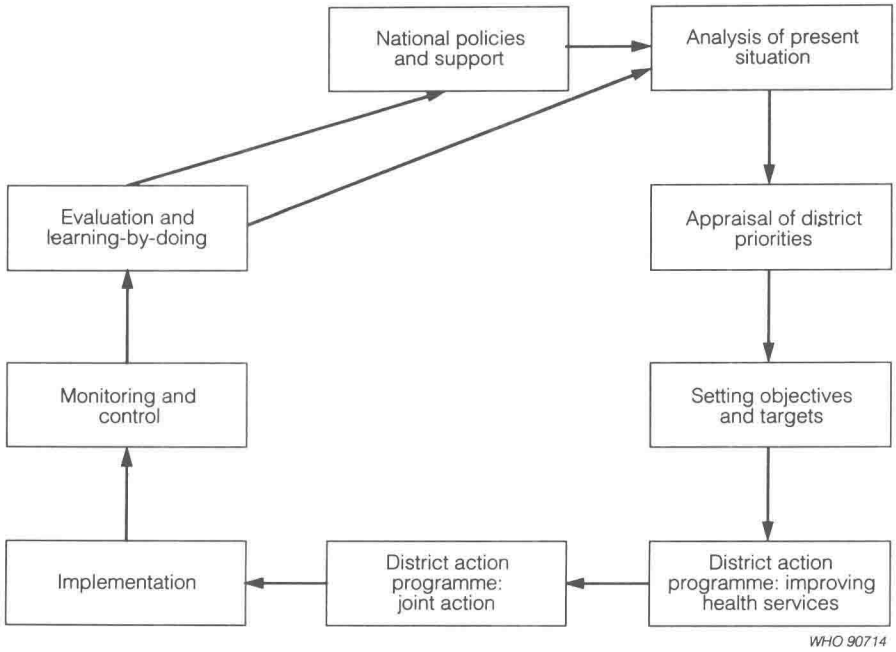

Fig. 1. The district planning cycle

- Are basic data on the characteristics of the population, level of health, major health problems and coverage with essential health care readily available in the district?
- Have district priorities been appraised?
- Have objectives and targets for health and health care been set?
- Does the district have an action plan for important programmes such as health promotion, maternal and child health, school health, environmental sanitation, occupational health, control of diseases and curative services?
- Are there effective mechanisms to get everyone — communities, health-related sectors, nongovernmental organizations and the various health programmes — to work together?
- Are there adequate resources, incentives, logistics and organizational arrangements to ensure prompt implementation of programmes?
- Are activities monitored and controlled regularly? Is there a mechanism for quality assurance?

A health worker in the Philippines adds another piece to the jigsaw of a nation's health. *Photo WHO/Zafar (19938)*

- Is periodic evaluation carried out? Are efforts made to find solutions to problems encountered?

If the answer to most of these questions is "yes" for a given district, it is already well on the way towards becoming a healthy district. If not, this book provides suggestions and pointers as to what could be done to improve the situation.

Some definitions

What is a district?

The district is the most peripheral fully organized unit of local government and administration. It differs greatly from country to country in size and degree of autonomy, and population may vary from less than 50 000 to over 300 000.

It is geographically compact and every part of it can normally be reached within a day. As a unit, it is small enough for the staff to understand the major problems and constraints of socioeconomic and health development, and for

health and other workers to know each other and be more humane in their approach. It is also a large enough unit for the development of the technical and managerial skills essential for planning and management. There is usually a central administrative point where the main government sectors are represented. The district is often the natural meeting-point for "bottom-up" planning and organization and "top-down" planning and support and is, therefore, a place where community needs and national priorities can be reconciled.

The district offers great opportunities for effective intersectoral action, since it is an area within which bodies such as development committees and district councils can very easily plan and act in unison. At district level, away from rigid central divisions and bureaucracies, different sectors have always tended to work together and people find it easy to collaborate on specific issues. The constitutional, legal, political, and administrative structures will determine the degree to which responsibilities will be decentralized. These structures also influence the amount of community participation through, for example, representative assemblies or other established mechanisms for the involvement of citizens in public matters.

What is a health system?

"A health system is the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychosocial environment and the health and related sectors" (*1*).

What is a district health system?

A district health system based on primary health care is a more or less self-contained segment of the national health system. It comprises first and foremost "a well-defined population living within a clearly delineated administrative and geographical area. It includes all the relevant health care activities in the area, whether governmental or otherwise. It therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, communities, the health sector, and related social and economic sectors. It includes self-care and all health care personnel and facilities, whether governmental or nongovernmental, up to and including the hospital at the first referral level, and the appropriate support services, such as laboratory, diagnostic, and logistic support. It will be most effective if coordinated by an appropriately trained health officer working to ensure as comprehensive a range as possible of promotive, preventive, curative, and rehabilitative health activities (*2*).

The network of manpower and facilities providing health care at district level varies greatly from country to country. At the most peripheral level of contact between the community and the organized health service, there are health units bearing different names in different countries: dispensary, clinic, health post, health centre, health subcentre, general practitioner's office, etc. Somewhere in the district, usually in the main town, there is a district hospital. There may also be other hospitals, often belonging to nongovernmental organizations, such as missions and societies. Within the community itself, there may be community health workers. Also, many individuals, families, groupings within communities, and other sectors will be involved in health care activities.

What is primary health care?

The expression "primary health care" has traditionally been used to mean the first-level contact between patients or communities and organized health care. In this sense, it includes the services provided by peripheral health workers, including general practitioners, nurses, and health auxiliaries. The International Conference on Primary Health Care, held at Alma-Ata in 1978, used the expression to convey two other meanings: essential health care consisting of at least eight elements (see Fig. 2), and an approach to the provision of health care that is characterized by equity, intersectoral action, and community participation. It is essentially to these two last meanings that the expression now commonly refers.

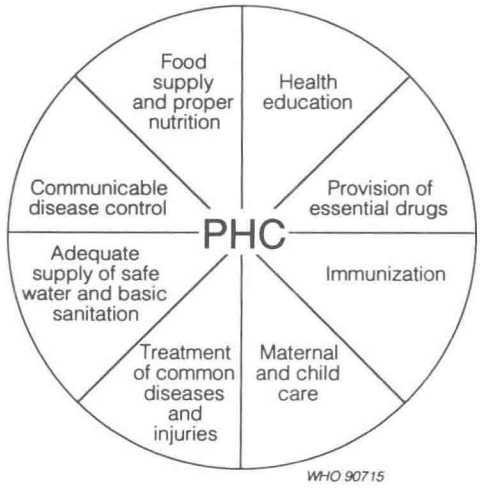

Fig. 2. The eight elements of primary health care (PHC)

CHAPTER 1

National policies and support

There remain many decisions to be taken and activities to be carried out by governments to bring about necessary changes in district health care. Inequities in health and health care still prevail in many parts of the world. In spite of being committed to the goal of health for all, some countries have not as yet defined the relevant policies and plans of action, while others have produced quite inadequate ones. National plans of action must institute a fair distribution of resources and programmes throughout the country, with preferential allocation to underserved districts. They should also provide a framework for districts so that their action programmes meet their needs.

The objectives of primary health care can only be achieved if each sector makes an appropriate contribution. For this to happen effectively, a mechanism for intersectoral coordination and cooperation must be established, and this is where the central government comes in. The minister of health could, for instance, prepare a document for the cabinet suggesting possible ways and means of ensuring the desired coordination. These might include, at central level, a subcommittee of the cabinet and, at district level, a subcommittee of the district development committee. Legislation may be required to set up such mechanisms at government level.

The existence in the ministry of health of a high-level committee or focal point for the support of primary health care can bring about more general support, and an increasing number of countries are developing high-level coordinating networks to support the implementation of primary health care. These have different names in different countries, for example, national primary health care implementation committee, national health council, etc. These networks bring together representatives of nongovernmental organizations, professional associations, and technical institutions. Collaborative networks involving technical institutes, such as universities, social science institutes, and management and administration centres, might be set up for the same purpose.

In countries where the administrative system has been decentralized to district level, the development of district health systems is greatly facilitated. Elsewhere, progressive decentralization should be targeted—so many districts by 1992, so many by 1993, etc.

Financial delegation to the district is the key factor in providing opportunities for change to be initiated within the district according to local

circumstances. Decentralization without delegation of appropriate financial decisions does not work. There is also a need to ensure political commitment inside districts to fiscally and socially responsible management.

Decentralization requires, first, better trained health managers at district level, secondly, a health team approach, and thirdly, planning support from the central authority in the form of guidelines and advisory staff.

Political commitment will have to be buttressed by economic support. Government expenditure on health programmes in many developing countries seldom exceeds 2% of the gross national product. The small sum spent per capita is an important contributory factor in the poor coverage of public health services. Efforts will have to be made to gain the backing of economic planners at both central and district levels. To this effect, it will be necessary to prepare a properly costed financial master-plan. Where further increases are not possible, alternative ways of financing district health systems, including cost-sharing, have to be considered.

In order to improve district health systems, a managerial process will have to be established and used at both central and district levels. In the districts, this process should be sensitive and responsive to epidemiological patterns in the community, as well as to local cultural habits pertaining to health.

The medical officer in charge of provincial health services meets with village elders in Thailand. *Photo WHO/A. S. Kochar* (18549)

What type of support can the district management team expect from the national level?

The ministry of health should produce guidelines or protocols on district health systems which define national policies and provide planning norms for adaptation by health teams. Specific support should be offered by the central level in the following areas.

Planning and management

Central authorities can:

- set out clearly how national health objectives and health service targets may be translated into district objectives and targets and vice versa, thus helping district staff to set their own objectives more easily;
- identify the priority areas to which extra resources should be allocated, thus assisting the district staff in their own determination of priorities;
- provide experts in demography, epidemiology, etc. on a short-term basis to assist district staff in analysing and setting priorities until they have gained the numerical and other skills required to conduct a situational analysis (such expertise should be provided only until local staff are proficient in the relevant tasks);
- initiate training programmes in planning at district level, for example, short courses held at a national centre or locally, or in-service training while district staff are in the process of planning future activities (the aim should be to enable staff to make competent district plans without the assistance of outside experts);
- provide extra resources for these initiatives, or attempt to obtain them, on behalf of districts, from nongovernmental and other sources;
- provide examples of simple indicators and methods of recording, aggregating and analysing data to obtain useful information;
- provide guidelines on budgeting, cost analysis, and cost control;
- provide guidelines on technical issues, including appropriate ways of controlling important diseases.

Joint action

In addition to forming national coordinating committees, central authorities can encourage community participation, intersectoral collaboration, and the integration of vertical programmes in districts by:

- organizing more joint action at the national level, because this often leads to similar joint ventures lower down the system;
- providing earmarked resources at district level to encourage joint action;
- attempting to change the attitudes of health service staff and the general public regarding primary health care—for example through the mass media.

Community-based health workers are part of the primary health care strategy. Good health is not something that can be imposed from the outside. In this Indian village the entire community has gathered to discuss attitudes and appropriate action. *Photo WHO/UN (19135)*

CHAPTER 2

Analysis of the present situation

District planning is crucial if primary health care is to be improved. Because the population and geographical area of a district are of a manageable size, the information needed for planning will be relatively easy to obtain. In addition, communication and change will be easier because staff within the district will often know one another personally.

For an analysis of the present situation in the district, data on the following are required: population; health indicators; deployment of resources; and coverage. This information, which is the basis for appraising district priorities, setting programme objectives and targets, and specifying the measures to be taken, should provide an insight into overall health needs and make it possible to ascertain the strengths and weaknesses of the existing district health system and how it can be improved. Data can be gathered from routine information collected by health workers in their day-to-day work, reports of studies previously carried out in the area, and census data. Local data rather than national statistics should be used as much as possible. Incomplete data should not be discarded since they may prove useful if "enriched" and carefully interpreted. Special surveys may provide more accurate information (for example, on disease incidence and prevalence), but they are expensive and time-consuming. They should be resorted to only where better estimates are likely to lead to a change in policies and plans.

The district health team should assess in some detail the major health problems in the district and the extent to which care programmes are overcoming them. Both "strong" and "deprived" areas of the district should be identified.

Population

Where do the people live? Is this likely to affect health care coverage and utilization? How big are various population groups, i.e., the under-fives, children aged 5–14, women of childbearing age (15–44 years)? Table 1 shows how such information can be summarized.

Variations in population size between subdistricts will show what areas may need additional health facilities. The age structure of the population will help in determining the types of service required. The extent of urbanization

Table 1. Presentation of information on a district's population, by subdistrict and age group [a]

	19.. (five years ago)		19.. (current year)		Projections for 19.. (in 5 years' time)	
	No.	%	No.	%	No.	%
Total	86 000		100 000		111 000	
Subdistrict						
A	34 000	40	42 000	42	52 000	47
B	21 800	25	21 500	21.5	21 000	19
C	30 200	35	36 500	36.5	38 000	34
Urban	17 200	20	24 000	24	31 000	28
Rural	68 800	80	76 000	76	80 000	72
Age						
0–11 months	3 000	3.5	3 600	3.6	4 000	3.6
1–4 years	12 500	14.5	14 400	14.4	16 000	14.4
5–14 years	23 000	27	27 000	27	30 000	27
15–49 years (females)	19 000	22	22 000	22	24 500	22

[a] The figures given are for purposes of illustration only.

will indicate whether there is a need to develop urban-oriented primary health care (*3*).

Data on socioeconomic factors such as income, occupation, and educational level, which have a strong bearing on health status and health service utilization, should also be included.

Information on the following should be obtained for selected years: crude birth rate (CBR), expected annual number of births (CBR × total population), crude death rate, and population growth rate. Further parameters are given in Table 2.

Health indicators

The types of data listed in Table 2 can provide important information for comparative purposes, but are frequently not available at the district level. It is useful, therefore, to obtain approximate figures or, at least, to discover whether rates are higher or lower than the national averages. At the local level, there are usually sources of data that can be consulted, e.g., morbidity data can be obtained from hospital or health centre registers. The infant mortality rate (number of deaths of children under one year of age per 1000