

MODULE 1

District Health Management Team
Training Modules

Health Sector Reform and District Health Systems

AFR/DHS/03.01

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World Health Organization
Regional Office for Africa
Brazzaville

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Foreword

Health systems in Africa are undergoing considerable change, often in a context of ongoing health sector reforms. In most countries, decentralization of health services is very central to these changes, and consequently there is a need to prepare and empower those working at the district level for their new responsibilities and tasks. Many countries have requested WHO/AFRO to support them in the implementation of the change processes at the district level, and the Regional Office is giving special attention to these requests. Apart from the technical support that WHO can provide to the countries concerned, several support tools, modules and frameworks have been and are being developed to support the strengthening of district health systems.

The training modules are intended for use by district health management teams (DHMTs) with the objective of developing the capacity to address the problem areas identified from the assessment of district health systems operationality. In addition, the modules could also be used during basic training of health personnel. Tools for the assessment of district health systems operationality are already available to the countries.

Countries should make use of these training modules so as to enhance the effectiveness of the priority programmes they are implementing in order to improve the performance of their health systems. It is clear that the success of health systems largely depends on the performance of the health system at implementation levels, namely district and community. The training modules address practical issues critical for the improvement of health systems at those levels.

I hope that countries and especially district health management teams in the Region will make optimal use of the training modules in order to enhance their capacity to address the priority health problems that we are facing every day.



Dr Ebrahim Malick Samba
Regional Director

March 2003

Acknowledgements

This publication is an effort to respond to the different needs for capacity building in management and implementation of health programmes and delivery of essential services. It reflects the thinking acquired from experience working with health sector reforms being implemented in the African Region.

The District Health Management Training modules are meant to be used as generic materials which may need to be adapted to country-specific situations. They cover the principles that are applicable across the Region and are meant to guide and strengthen the management capacity of district health management teams.

We would like to express our sincere gratitude to all those who have contributed to the development and review of the previous versions of the modules. Dr Sam Nyaywa, working with colleagues in the Division of Health Systems and Services Development (WHO/AFRO), provided the first draft in 1997. Special thanks also go to the Institute of Primary Health Care in Iringa and the Centre for Education and Development in Health, Arusha (CEDHA), both in Tanzania, which participated in the testing and revision of the modules. We also would like to express our appreciation to the Zimbabwe team who reviewed the modules and the WHO Tanzania Country Office team for their support.

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List of Abbreviations

AFRO	Regional Office for Africa (of the WHO)
AIDS	Acquired Immunodeficiency Syndrome
BI	Bamako Initiative
CBD	Community-Based Distributor
CEDHA	Centre for Education and Development in Health, Arusha
CHC	Community Health Committee
CoC	Code of Conduct
DHB	District Health Board
DHMT	District Health Management Team
DHS	District Health System
DMO	District Medical Officer
EHP	Essential Health Package
EIP	Evidence and Information for Policy
FPP	Family Planning Programme
GPE	Global Programme on Evidence
HFA	Health-for-All
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HMT	Hospital Management Team
HQ	Headquarters
HRH	Human Resources for Health
KSA	Knowledge, Skills and Attitudes
MCH	Maternal and Child Health
MOH	Ministry of Health
MoU	Memorandum of Understanding
NGO	Non-Governmental Organization
OAU	Organization of African Unity
OSD	Organization and Services Department
PHC	Primary Health Care
PoW	Programme of Work
PPAp	Project by Project Approach
RC	Regional Committee
SWAp	Sector Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
TH	Traditional Healer
UNICEF	United Nations Children's Fund
UNSI	United Nations System-wide Special Initiative on Africa
VHW	Village Health Worker
WHO	World Health Organization

Overall Introduction To The Modules

This is one of a set of four management training modules aimed at District Health Management Teams in the countries of the African Region.

There have been considerable achievements in African countries as a result of implementation of the Primary Health Care (PHC) strategy. However, health problems and ill-health continue to exist despite these laudable initiatives; for example, inequity in health care delivery still exists. Health systems and programmes are often blamed for inefficiency and ineffectiveness, putting them under pressure to be re-orientated and re-organized.

The setbacks have been partly attributed to the continuing economic crisis and lack of resources. However, much has to do with poor management, especially in the organization of district health systems and the difficulties faced in translating PHC principles and Health Sector Reform proposals into practice.

These problems can be attributed to lack of appropriate knowledge, skills and capacities among those who are responsible for managing district health systems and programmes. The gap which exists between training of district health managers and what they are called upon to do, poses one of the major issues to be addressed for the achievement of health sector reform objectives as well as the goal of Health-for-All.

Training of DHMTs in health management has been going on for some time. Different institutions have developed training materials; however, these materials are usually not based on the current thinking of practical health management requirements in the recently or impending decentralized districts.

The ongoing health sector reforms in African countries focus on the district health system. New and heavy responsibilities are placed on the shoulders of the District Health Management Teams who are the main implementers of national health policies and strategies. The Division of Health Systems and Services Development of the World Health Organization Regional Office for Africa therefore developed this set of training modules that addresses the knowledge, skills and attitudes required of District Health Management Teams to cope with their challenging new roles and tasks.

It is acknowledged that circumstances differ widely among countries in the African Region. The modules are therefore meant to be generic and should be adapted to country-specific circumstances as required. It is further recognized that learner needs of different district health management teams in countries can differ from one another; even learning needs among members within a particular team can differ. The course that is offered is therefore explicitly modular: it is not necessary that everyone study every unit in every module at the same level of detail. Although the modules were developed for DHMTs, they are also potentially useful for district-based managers of health programmes and other “extended” DHMT members. Furthermore, countries with regional or provincial health teams can benefit from the modular course by acquiring a common understanding with the DHMTs. This would strengthen their support function capacity.

With this understanding, the main developmental objective of the modular course is:

To have in place DHMT members with adequate managerial skills and capacities for the implementation of Health Sector Reforms.

The district health management training modules have been developed to cover four major areas. Modules 1 through 3 should take a week each. At least two weeks should be set aside for module 4.

Module 1: Health Sector Reforms and District Health Systems

- Unit 1 Health Policy, Strategies and Reform
- Unit 2 District Health Systems

Module 2: Management, Leadership and Partnership for District Health

- Unit 1 Important Management and Leadership Concepts
- Unit 2 Team Work
- Unit 3 Multisectoral Collaboration: Partnership in Health Care
- Unit 4 Partnership Between Organizations
- Unit 5 Community Participation, Partnership Between Organizations and the Community

Module 3: Management of Health Resources

- Unit 1 Management of Human Resources
- Unit 2 Management of Finances and Accounts
- Unit 3 Management of Logistics
- Unit 4 Management of Physical Infrastructure
- Unit 5 Management of Drugs
- Unit 6 Management of Time and Space
- Unit 7 Management of Information

Module 4: Planning and Implementation of District Health Services

- Unit 1 Basic Concepts of District Health Planning
- Unit 2 Preparation for Planning
- Unit 3 Health Systems Research
- Unit 4 Steps in the Planning Process
- Unit 5 Essential Health Package
- Unit 6 Disaster Preparedness

Introduction To Module 1

HEALTH SECTOR REFORMS AND DISTRICT HEALTH SYSTEMS

The district is the level where health policies and health sector reforms are interpreted and implemented. In the whole policy and reform process, success or failure depends on the ability of district health management teams (DHMTs) to interpret and implement what is required. Too often the members of DHMTs are already overloaded with work while trying to cope with the day-to-day requirements of their technical work as well as their management and administrative tasks. A DHMT member needs to understand the context within which she/he operates in order to function as a better manager. This module has been developed to assist each team member to work as a leader and manager in leading health development in the district. It is also an introduction to the other modules (two to four).

The main objectives of this module are to ensure that DHMT members will be able to:

- Function better within the prevailing and changing policy and reform context;
- Play an active and proactive role in pursuing Health-for-All objectives in their districts;
- Strengthen their performance as leaders, managers and team members in managing a district health system.

This module introduces the policy development process; it will introduce some of the important health policies of the recent past and highlight the main health policy and strategic issues, including Health-for-All, Primary Health Care (PHC), health sector reforms and the sector-wide approaches (SWAPs). The District Health System will be discussed, and the assessment of the operationality of individual district health systems will be introduced. The module is structured in two units:

1. Health Policy, Strategies and Reforms
2. District Health Systems

Unit 1: Health Policy, Strategies and Reform

Introduction

The District Health Management Team is a technical team that manages health services in the district. DHMT members are commonly very busy people; they often have to take care of patients, environmental health, nursing issues and other technical tasks along with administrative duties, resource management, supervision, problem-solving and crisis management. Why then bother about policies, reforms and other seemingly remote issues?

There are various reasons why it is important for DHMT members to know the principles of policy formulation and the prevailing policies themselves. First of all, it is possible that members have been or will be consulted at one or more stages during the policy formulation process. Secondly, it will be expected that the DHMT will implement the national policies at district level. It is even further possible that DHMT jobs or job descriptions depend on reform measures which originate in policies and policy decisions. Retrenchment, rationalization of services, decentralization and different methods of reporting are all the result of policy changes. DHMT members should know about them to be better prepared for their roles as leaders in health development.

This unit explains about health policies, how they have evolved over time and how they have been and still are implemented through various strategies such as PHC health sector reforms and SWAps. Special attention will be given to the renewal of the Health-for-All policy commitment into the 21st century and its emphasis on poverty reduction and the specific African goal of eliminating diseases of poverty, exclusion and ignorance by the year 2020.

Objectives

The objectives of the unit are to:

- Introduce the development and evolution processes of policies
- Explain important health policies and strategies.

Expected Outcomes

At the end of the unit, participants should be able to:

- Explain and outline how (health) policies develop and evolve;
- Appreciate the importance of the policy context for their day-to-day work;
- Recall the main elements of PHC as a strategy toward achieving Health-for-All;
- Identify strengths and weaknesses in the implementation of PHC/HFA in their districts;
- List the main health policy and health sector reform issues on their own national agenda;
- Identify and appreciate how these reform issues will affect their own work;
- Prepare themselves to cope with the day-to-day work and policy demands.

1.1 Policy and Policy Development

1.1.1 Basic concepts

In this module, the term *policy* refers to a clear-cut statement of aims and objectives, about what is to be achieved (Box 1).

BOX 1: DEFINITION OF POLICY

A policy is a set of clear statements and decisions defining priorities and main directions for attaining a goal.

Policies must be clear, concise and precise. They should be general enough to remain valid for a considerable period of time and yet be specific enough to clearly indicate policy-makers' aims and priorities. Policy is concerned with what is to be done (content); strategy is how to do it. A good policy gives a broad agenda and framework for action; it provides direction without unduly limiting implementers. It is important that a policy be made available as a written document with official status adhered to by high authorities; for instance, in the case of a national health policy, usually the authority is the Parliament. A health policy is a set of clear statements and decisions defining priorities and main directions for improving health and health care in a country.

Some reasons why it is important for a Ministry of Health to have a widely accepted health policy include:

- It gives a vision on how to solve health problems.
- It gives a ground for planning implementation strategies.
- It creates uniformity and focus in health development.
- It enhances processes for monitoring and evaluation of strategies for accomplishing policy goals.

Having a health policy further assists authorities with decision-making; for instance, if the policy indicates a preference for supporting community-based health care, a Training Committee may decide to use a grant for an applicant who wishes to develop in this direction rather than for a request concerning training for clinical super specialization.

Finally, having a clearly stated policy will help to attract donor support and strengthen the position of government in the face of individual donor agenda. Once a government has stated what it wants and what it stands for, it is in a much better negotiating position than a government that has no clear health policy.

Policy development

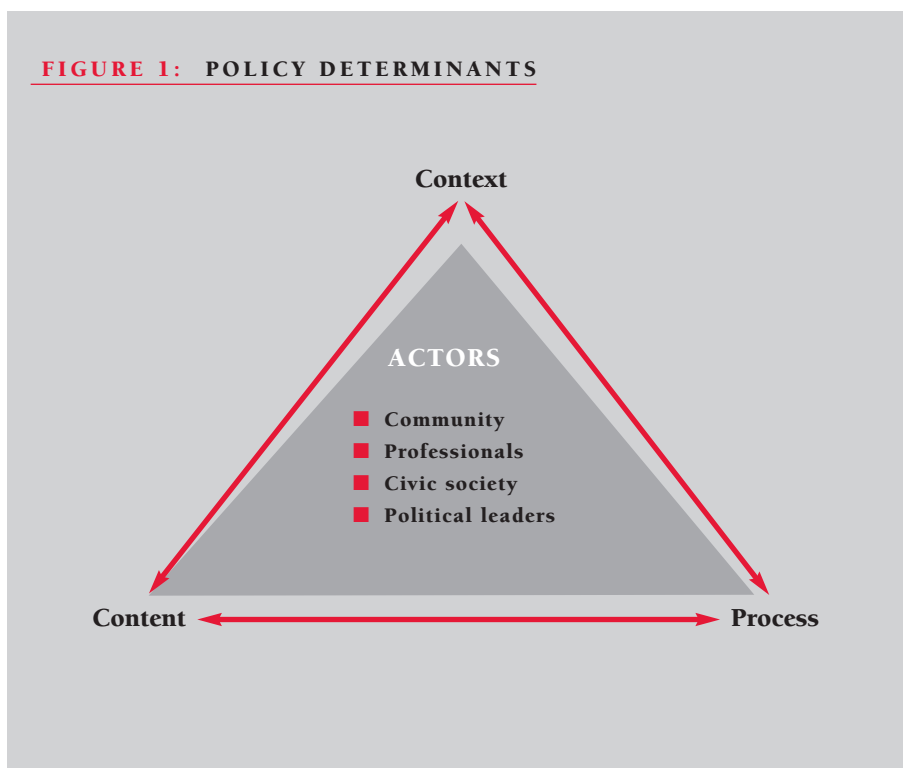
Policies should never be static; in order to remain relevant, they should be adapted and sometimes completely revised in line with developments and changing circumstances locally in countries and internationally.

Policies are only useful if they are implemented. It is therefore important that politicians, the public and the implementers support policies. This has its implications for the policy development process. To

get support, a good policy has to be developed through wide consultation. Usually, policy development goes through various phases:

- Development of the policy agenda according to identified needs and discussions to determine the important issues to include
- Decisions about which agenda issues to address and which to drop
- Implementation of policy decisions
- Review of successes and failures, restarting of the process.

In practice, this process is never as neat and linear as depicted; political factors such as elections or appointment of a new Minister of Health may influence the process in unpredicted ways, either facilitating or blocking the development or implementation of policies in a certain direction. Therefore, policies may be “shelved” if the political climate (context) is not favourable, while on the other hand policies that have almost been forgotten may become relevant again when circumstances change. Implementers may also fail to implement a particular policy if they do not believe in it or if they do not know how to handle it. In summary, the fate of a policy proposal depends on content, process and context (Figure 1).



Adapted from: *Health Policy and Systems Development: An agenda for research.* WHO/SHS/NHP/96.1, WHO, Geneva, 1996

In particular, acceptance of a policy is determined by:

- how the agenda was formulated, how it defines the problems and what solutions it offers;
- whether midlevel technocrats and bureaucrats who are responsible for translating policy into programmes were involved in the formulation of the agenda;
- how well advocacy, facts and evidence-based information were used to influence decision-makers and other stakeholders;
- political climate;
- availability and mobilization of resources required to achieve the desired policy outcomes.

ACTIVITY 1

- Discuss a policy agenda for your district.
- Study your national health policy, identifying points that are of importance to you and your district.
- Formulate your comment on these policy points; are they desirable, can they be implemented, what role does any DHMT member have to play in its implementation?

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MODULE 1

1.1.2 Evolution of international health policies

Policies should be dynamic and change with time to adapt to new circumstances and challenges. Health policies are no exception. Health policy development is no longer an issue that is limited to national boundaries. Health and disease know no borders, and the need to address health issues through international fora has long been recognized. On 7 April 1948 the World Health Organization was founded. The date is still commemorated as World Health Day.

In 1978, a joint WHO/UNICEF international conference in Alma-Ata adopted a Declaration on Primary Health Care as the key to attaining the goal of Health-for-All by the year 2000. In 1985, the African Member States adopted the three-phase African health development scenario under which the district became the focus for health development. Another important landmark was the Ottawa Charter for Health Promotion from the first International Conference on Health Promotion, Ottawa, 1986. In 1987, ministers of health from the African Region adopted a resolution during the thirty-seventh session of the Regional Committee in Bamako, entitled “Women and children’s health through the funding and management of essential drugs at community level”. This resolution became widely known as the “Bamako Initiative”. The year 1988 marked the ten-year anniversary of the “Alma Ata Declaration” with a conference in Riga, where successes and failures of the PHC strategy were discussed and the Health for All goal was reaffirmed to be extended into the 21st century.

Following the United Nations General Assembly resolution on the report of the International Conference on Population and Development, the WHO Regional Office for Africa adopted a Reproductive Health Strategy for the African Region 1998–2007. In 1995, WHO produced a consultation document entitled “Renewing the Health-for-All Strategy”, with guiding principles and essential issues for the elaboration of a policy for equity, solidarity and health. During its session in May 1998, the World Health Assembly endorsed the new global health policy, “Health for all in the 21st Century”. The

United Nations Special Initiative on Africa (UNSI), launched in March 1996, supports health sector reforms in Africa through SWApS which aim to ensure adequate access to an essential health package at an affordable rate and on a sustainable basis. In September 1999, in Windhoek, Namibia, the WHO African Regional Committee confirmed the relevance of the principles and values underpinning the PHC approach to the implementation of the Health-for-All policy and the fact that they are a source of inspiration for African countries.

In July 2000, a WHO-AFRO Regional Consultation on Poverty and Health took place in Harare. The link between health and poverty is presently very high on the African health policy agenda. The general objective of the proposed core health intervention is to reduce the disease burden, particularly among the poor and other vulnerable groups, and consequently break the vicious cycle and linkage between poverty and ill-health. At its meeting in Ouagadougou in September 2000, the Regional Committee adopted the “Regional Health-for-All Policy for the 21st Century: Agenda 2020” with the vision of “Overcoming diseases related to poverty, exclusion and ignorance in the context of good governance and autonomous development of a proactive health system for a decent and worthwhile living”.

Such policy developments take place in regular consultation with ministries of health and other important stakeholders (such as religious organizations and other NGOs). Communications have made the world a small place, sometimes referred to as a “Global Village”; therefore, events taking place in one part of the world easily influence events in other parts of it. Health policy development takes place at global, regional and national level. Many nations are simultaneously struggling with similar issues. Therefore, a policy decision taken at an international forum will affect individuals, communities, DHMTs and districts.

ACTIVITY 2

- Read two of the more recent regional policy papers such as Health and Poverty Reduction, HFA for the 21st Century and Health-for-All Policy for the 21st Century in the African Region: Agenda 2020.
- Discuss what implications these international policies may have for your own work and work situation in the district.

1.2 Elaboration on Important Health Policies and Strategies

1.2.1 Primary Health Care

Introduction

In 1978, the Alma-Ata conference formulated the Primary Health Care (PHC) strategy to achieve “Health-for-All by the year 2000” on a global basis. The conference, which was organized by WHO and UNICEF, greatly influenced national policies in improving and expanding health services. The Alma-Ata Declaration defined PHC as: “Essential health care based on practical scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation; and at a cost that the community and country can afford to main-

tain at every stage of their development, in the spirit of self-reliance and self-determination” (WHO 1978).

Essential health care

One important notion which arises from the definition of PHC is that it provides “essential health care”. In its broadest sense essential health care may refer to all concerns, issues or elements which are absolutely necessary or indispensable in the process of ensuring people’s well-being (health) and development. PHC can also be referred to as basic or fundamental care. The exact content of what this essential health care entails differs from country to country, but includes, according to the Alma-Ata Declaration:

Education concerning prevailing health problems and the methods of preventing and controlling them, Promotion of food supply and proper nutrition, Adequate supply of safe water and basic sanitation, Maternal and child health care including family planning, Immunization against the major infectious diseases, Prevention and control of locally endemic diseases, Appropriate treatment of common diseases and injuries as well as provision of Essential Drugs (WHO 1981).

Three prerequisites for successful Primary Health Care were identified as:

- A multisectoral approach
- Community involvement and participation
- Appropriate technology.

A multisectoral approach

A multisectoral approach or intersectoral collaboration is a principle of linking health provision to other aspects of socioeconomic development that are closely related to health. Health is often determined by other sectors; for instance, nutritional status is related to agriculture and income. Education, in particular education of girls and women, is often a very important determinant of family health. Sectors dealing with water, sanitation and housing are obviously important for health. On the other hand, health is an important factor for development. The HIV/AIDS epidemic continues to have a disastrous effect on the economically active section of the population and is therefore a serious threat to development.

Health is the concern of everybody: providers of health services, providers of non-health services or consumers. However, the various sectors that have a role to play should do so in a coordinated, efficient manner. To achieve such integration is not an easy task. The main enhancing factors in the collaboration process are:

- readiness and willingness of the authorities to take up the challenge;
- changes in organizational and political structure;
- participation of the people in social decision-making;
- distribution of power and income to allow equal access to resources;
- a multiple dimensional approach to health issues;
- improvement of accountability for health.

Community involvement and participation

WHO describes community involvement as an active involvement of people in the society in the planning, operation and control of PHC (see also Unit 5 of Module 2 of this series). It identifies community involvement as existing when individuals and families assume an active role for their health and welfare and develop the capacity to contribute to their own and the community’s development. This implies that

health services are a client service, integrating people's views, traditions and actions in every stage of development. Involving people in the decision-making, implementation, monitoring and evaluation of health services facilitates liberalization and transformation towards self-reliance and development.

One of the main sub-principles of community involvement is that "PHC cannot be handled from high up" (WHO/UNICEF 1978). This means that providers of health services should be made accountable to the community they serve rather than to a distant ministry of health.

Appropriate technology

PHC depends on practical, scientifically sound and socially acceptable methods and technology. This is often referred to as *appropriate technology*, a kind of technology that best fits the local situation in all respects. Appropriate technology is not always cheaper than modern technologies; neither is it "second rate". A Health Technology Policy Proposal for the African Region (WHO AFRO 1999) recognizes the need for countries to formulate health technology policies to ensure that technology choices are driven by country needs. **Health Technology Assessment** is an important concept mentioned in this context.

Studies have further shown that traditional health practices (including traditional practice and other services such as those rendered by TBAs) may be much more acceptable in some communities than modern health services. This calls for the integration of traditional health practices within the district health system.

Health-for-All Policies for the 21st Century

A lot has happened since the launching of Health-for-All by the Year 2000 and the adoption of the PHC strategy to achieve it. A lot of progress was made and many health indicators have improved. However, Health-for-All is still far from reality. In the African Region, it is recognized that there is still a lot of ill-health that is related to diseases of poverty and ignorance. Of the six WHO regions in the world, the African Region bears the heaviest burden of disease. The outbreak of HIV infection and AIDS in the early 1980s drastically changed the epidemiological profile in many African countries. Because of HIV, life expectancies at birth have started to decrease in some African countries. Due to the AIDS pandemic, the incidence of TB is increasing. Malaria is still one of the leading causes of morbidity and mortality on the continent. Pregnancy-related health problems are still rampant while acute respiratory infections, diarrhoeal diseases, malnutrition and malaria are still the main causes of child morbidity and mortality. Meanwhile, the burden of noncommunicable diseases in the Region has been rising. Armed conflicts, wars and other complex emergency situations have added to the burden.

Several factors contribute to the occurrence of various illnesses in Africa, including man-made environmental hazards, political instability and insufficient policy attention to health. Poverty assumes tragic dimensions in some cases and may be coupled with population pressure, sociocultural factors and vulnerability to promotion of harmful practices by deceitful advertising.

An African Regional Health-for-All Policy for the 21st Century has a vision of health development in Africa by the year 2020 (see Box 2). The realization of this vision calls for health development policies that are centered on the following values and principles:

- solidarity based on partnership, transparency and shared responsibility,
- equity based on universal access to health care, including individual care, and on the need to guarantee universal access to health,
- ethics based on achievement of and contribution to global and national progress in health,
- cultural identity which respects ethnic differences and specificities of conditions,

- gender equity which ensures equity between women and men in decision-making and utilization of health services.

**BOX 2: VISION OF THE HEALTH-FOR-ALL POLICY
FOR THE 21ST CENTURY IN THE AFRICAN REGION**

“Overcoming diseases of poverty, exclusion and ignorance in a context of good governance and autonomous development of a proactive and efficient health system for a decent and worthwhile living” (WHO/AFRO 2000).

To achieve Health-for-All in the 21st Century in the African Region, the following four strategic directions were adopted:

- creation and management of enabling environments for health,
- undertaking health system reform by drawing upon PHC principles,
- empowerment and support at individual, family and community levels,
- creation of the conditions that will enable women to participate, benefit and lead in health development.

The need to place health on the socioeconomic development agenda is recognized while even more emphasis is placed on full community participation and equity. Equity is taken even further than originally envisaged in Alma-Ata, and efforts have been initiated to assess the fairness of health sector reforms and focus policy attention on the link between health and poverty reduction. In connection with the latter, poverty leads to ill-health, and ill-health breeds poverty. It is important to view this bi-directional relationship between ill-health and poverty as equally important in breaking this vicious cycle permanently.

Various core health interventions for poverty reduction are discussed in other modules of this series. They focus on:

- Equity and access with gender sensitiveness and awareness
- Quality and relevance
- Sustainability, efficiency and cost-effectiveness in dealing with the burden of disease
- Intersectoral collaboration, partnership and involvement of the people.

Equity in Health

Equity is probably the most fundamental principle underlying PHC. It is the principle that emphasizes that health should be for all people and not just for the few privileged ones. Equity in health is not easy to define, and people consider it in different concepts and contexts. However, it is possible to discuss equity with the understanding (WHO/ARA/98.2) that health inequities exist when there are inequalities in health status, risk factors or health service utilization between individuals, or groups, that are unnecessary, avoidable and unfair.

Inequity in health exists in many ways; for ease of discussion, they can be classified as inequities related to:

- health determinants
- health status
- health care resource allocation
- health care utilization.

Inequities related to health determinants

It is well established that the poor have much lower life expectancy and other health indicators than the rich. There are gross inequalities in wealth among countries, within countries and even within communities, and these inequalities determine inequality in health.

Inequality in the level of education, in particular the level of education of women and girls, is another example of a determinant which implies inequality in health. Inequality in access to safe water and sanitation is another important example of a determinant with a strong health impact.

Inequities in health status

There are many examples and possible ways of demonstrating inequality in health status. There are differences in life expectancy at birth, infant and child mortality, nutrition status (for instance the prevalence of stunting), maternal mortality and age-specific adult mortality. Inequalities can also be demonstrated in the occurrence of disease. For instance, in 1999 of the 34 million people in the world who were living with AIDS, 22 million were from sub-Saharan Africa.

Inequities related to health resource allocation

Among inequalities in the allocation of health care resources, the per capita distribution of specific categories of fully qualified health personnel is probably the most obvious. Even between countries within one sub-region, doctor-population ratios may range from one per 1,000 to one per more than 30,000. The inequality is also obvious in countries where qualified doctors and registered nurses tend to cluster in urban centres, leaving the communities in what is perceived as “hardship” areas virtually un-served. Other differences exist in distribution of service facilities of various levels.

Much attention has been given to the inequalities in availability of health finances. It is not uncommon that a quarter or more of a country’s total health budget is allocated to one tertiary teaching hospital. There is an obvious contradiction when the health spending in some countries is compared with the burden of disease.

Inequities related to health care utilization

Inequalities in health care utilization are evident for instance in differences in immunization coverage, antenatal coverage, percentage of births attended by a qualified attendant or use of contraceptives.

Moving toward Equity

After the adoption by the global community of the Health-for-All objectives and the Alma-Ata Declaration in 1978, many sub-Saharan African countries were confronted in the 1980s with economic problems which resulted in a gradual decline in the delivery of services in the health sector. It then became neces-

sary to find an appropriate strategy to limit the pernicious effects of the deterioration of health systems on the population.

Thus during the thirty-seventh session of the WHO Regional Committee, held in Mali in September 1987, health ministers of the African countries adopted resolution **AFR/RC37/R6**, better known as the “Bamako Initiative” which subsequently was approved by the OAU Heads of State and Government. This resolution was a follow-up to a WHO and UNICEF proposal aimed at revitalizing district health systems, with the ultimate goal of effectively implementing PHC and reducing maternal and infant mortality.

The goal of the Bamako Initiative (BI) was to ensure access to essential health services and restore confidence in public health systems by improving the quality of care and promoting community participation. The BI was considered as one of the most important approaches for strengthening health systems at the peripheral level through community co-management and co-financing mechanisms, with a view to improving the delivery and efficacy of health care as well as the sustainability of essential health services in Africa. It emphasized four major developments: the promotion and implementation of a minimum package of care, the constant availability of drugs at affordable cost, the sharing of costs between the various actors of the health systems including users, and the effective participation of the community in the local management of the health system.

Health financing is a major concern in health sector reform and will be discussed in detail in Module 3. A risk of various cost-sharing initiatives is that they may actually affect equity by denying access to the poor who cannot afford the charges. The problem is complicated by inadequate exemption and waiver mechanisms to protect the poor because most countries have weak administrative mechanisms and therefore fail to apply the exemption and waiver policies.

Promotion of equity is high and getting higher on the Health-for-All priority lists. At district level the following should be possible for a DHMT:

- Put efforts toward equity explicitly on the district health development agenda; include it in district health plans and consider it among the highest priority responsibilities of the District Health Management Team.
- Assign the responsibility for monitoring progress toward equity to specific DHMT members who have to report back to the full DHMT on a regular basis. Those so assigned should read available literature on pursuance of equity and fairness in health and seek to become experts in the field.
- Among the important things a DHMT should do is to show inequities and bring them to the attention of those who are in a position to do something about them.
- Progress toward achieving equity should be monitored with the use of appropriate indicators (see Box 3 below, adjust to local requirements as appropriate). Too often health information yields figures that are hiding important detailed differences between groups. A DHMT should be able to detect among the poorer sections of the population those who are desperately poor. For example, among pregnant women they should detect those who cannot afford a facility-based delivery.
- Fair and effective exemption and waiver mechanisms should be put in place. Exemptions apply to whole groups or categories of service that are given freely (for instance, immunization for under-fives). Waivers apply to individuals who are treated at a reduced rate or without payment based on judgments of their specific circumstances.
- In most countries exemption and waiver policies and guidelines exist. DHMT members should ensure that such policies and guidelines are widely known and implemented.

- Empowerment of communities, establishment of community health funds and making local health services accountable to the community (principles arising from the Bamako Initiative) are other measures that may reduce inequity if well implemented.

**BOX 3: INDICATORS MEASURING
DIFFERENCES BETWEEN POPULATION GROUPS**

- 1: Health determinant indicators
 - Prevalence and level of poverty
 - Education levels
 - Adequate water and sanitation coverage
- 2: Health status indicators
 - Infant mortality rate
 - 1-4 year old mortality rate
 - Prevalence of child stunting
 - Maternal mortality
 - Life expectancy at birth
 - Occurrence of relevant infectious diseases
- 3: Health care resource allocation indicators (per capita)
 - Distribution of qualified health personnel categories
 - Distribution of health services at primary, secondary and tertiary level
 - Distribution of health expenditure on personnel, supplies and facilities
- 4: Health care utilization indicators
 - Immunization coverage
 - Antenatal coverage
 - Percentage of births attended by a skilled attendant
 - Current use of contraception

ACTIVITY 3

- Using the health status indicators, discuss ten related priority activities to be included in your district health plan as part of the strategy to promote equity in your district.

ACTIVITY 4

- Identify what essential elements of PHC are included in the health policy in your country.
- Identify examples of inappropriate technology that you have encountered in your district. Analyse why this inappropriate technology was introduced and list its undesirable effects. Discuss how you will correct these.
- Identify existing inequities in health that exist in your district. Make an action plan with indicators to address these inequities.

1.2.2 Health Sector Reform**Background and Rationale**

After two decades of significant socioeconomic growth in most independent African countries, the 1980s ushered in a period of world economic recession that negatively impacted on the economies of most African countries of the WHO African Region. They began experiencing declining and even negative economic growth rates. This changing socioeconomic environment called for various types of economic reforms, some of which had unfavourable consequences in the health sector. The health care delivery systems of many countries were so weakened that they were unable to cope with the increasing health challenges. This adverse socioeconomic environment called for urgent and thorough reform of the health sector.

Definition of Health Sector Reform

National health sector reform has been defined as a sustained process of fundamental change in national policy and institutional arrangements led by government and designed to improve the functioning and performance of the health sector and ultimately the health status of the population (WHO/SHS/96.1). The countries of Africa differ considerably in their historical, economic and political contexts, though they also share a number of important problems and specific policy instruments in approaching health sector reform. Therefore, there is no single formula, recipe or agenda for national health sector reform. However, it is clear that economic and political circumstances as well as good leadership are most important for a reform movement and the implementation of change.

Characteristics of Health Sector Reform

The words *national* and *sector* in the definition of health sector reform include the entire health care system in a country, that is, preventive, curative, promotive and rehabilitative services; the public and private sub-sectors; and primary, secondary and tertiary care. Health sector reform is a problem-solving as well as a learning process. It seeks solutions to major problems related to a country's health policy and health care system and involves many actors, institutions and stakeholders. It is country-specific and calls for local and national government ownership and commitment rather than domination by external forces.

Health sector reform is a deliberate and planned undertaking intended to bring about lasting change. It is not an ad hoc or emergency action and is not a “project”. It is a process which should go beyond redefinition of policy objectives and discussion on the ideological orientation of the health care system to structural changes of existing organizational and management structures as well as financing systems. It is also a political process; therefore, consensus of all stakeholders is very crucial. Successful consensus-building on every aspect of the reform process will facilitate implementation of the reform agenda even in a situation of political change. Principal actors or stakeholders include the Ministry of Health, other sectors (e.g. ministries of local government, housing, water, education etc), local governments, the population (individuals, households, civil society), service providers (government, NGO, private), resource institutions (university/research institutions etc), institutional buyers (insurance funds, district health institutions etc) and key donors (bilateral and multilateral).

Health sector reform complements PHC by re-emphasizing principles of equity, collaboration, community involvement and decentralization. A very important principle in the health sector reform process is that decisions are evidence-based; this applies to decisions about organization and managerial processes, financing, choice of health priorities and health care packages. The reforms therefore rely heavily on health systems research and health information. Donor/government relationships are clearly defined in the context of the reform process and have in place coordination mechanisms (donor/government coordination) to minimize duplication of efforts and harmonize health finances in support of a national health budget. Sector wide approaches (SWAps, see below) have been adopted in a number of countries in the region to facilitate donor/government relationship in support of reforms. Health sector reforms in Africa have addressed various areas, including organization and management of health systems, financing of health care, decentralization in the health sector, and human resource development and management.

Role of DHMTs in the reform process

Most countries have identified the district as the production unit in the reform process. The district is the level that provides services and measures reform outputs with appropriate indicators. Therefore, the DHMTs will assume an important central role in the implementation of reforms by fulfilling the following:

- performing comprehensive **district health planning** (refer to Module 4 on Planning process and steps), including the formulation of essential health services packages and as much as possible integration of vertical programmes through incorporation in district plans and budgets;
- identification of areas for **operational research and information** requirements; conducting research in collaboration with research institutions; collecting, compiling, analysing, using and disseminating district health information (refer to Module 3); operating a dynamic district health resource centre (library) which is linked with national and international information networks; seeking and sharing reform experiences with other districts within and without the region or province;
- **management** of health resources, organizations and services, including the supervision of monitoring and evaluation in implementation of a district health plan;
- promotion of **partnership and coordination** of various initiatives in the districts: government, NGO, private for profit and non-profit, donors, civil society, communities and others (refer to Module 2);
- promotion of **public/private mix** (Module 2);

- **advocacy on reforms** to all stakeholders; linkage of health reforms with other related reforms in the district, e.g. local government reforms, civil service reforms etc.;
- advising District Health Boards or other equivalent governing structures on all matters pertaining to health in the district;
- **mobilization of health resources** in support of reform strategies (from government, donor, private sector, community etc.); facilitation and management of alternative health financing schemes, e.g. cost-sharing (user fees), community pre-payment schemes, e.g. community health fund;
- assessing **Human Resources for Health (HRH) capacities** within DHS and planning for capacity-building with in-service seminars and continuing education; recommending minimum incentive packages for district HRH to the concerned higher authorities; establishing appropriate staff levels and mix for each health facility to match the provision of essential health services and ultimate workload.

Expected Outcome and Objectives of Health Sector Reform

Main expected outcome

The main expected outcome of health sector reform is health improvement or health gain.

Objectives

To achieve the main outcome, health sector reform is concerned with achieving the following:

- Improved equity in health and health care services
- Increased and better management of health resources
- Improved performance of health systems and quality of care
- Greater satisfaction of consumers and providers of health care.

Strategies

In order to achieve these objectives, health sector reform programmes have commonly focused on the following three strategic issues:

- Organization, management and decentralization
- Financing of health services
- Health service delivery.

Organization, management and decentralization

Changes in the organization and management of health services have been closely linked to wider **civil service reforms** involving streamlining of ministerial structures and trimming down the number of civil service personnel. Commonly, social services (including health) have been decentralized to the districts as part of **local government reforms**. The roles of various levels in the national health care system are being redefined; hospitals are successively becoming autonomous. New management structures are therefore generally put in place at each level (for instance, district health management boards and various steering committees). The government is no longer seen as the sole or main provider of health care; a definite important role is allocated to the **private and NGO sector**, with the ministries of health taking on roles in policy-making and regulation rather than implementation. This implies changes in struc-

tures and functions of ministries of health. Many of these changes require new laws or by-laws. Legislation review is therefore a common aspect of health sector reform. In many cases, implementation of reform requires specific efforts to train and build capacity to manage the new organizational structures. At the same time, strong **advocacy** is required to inform and communicate with the public and partners about the new organization, procedures and developments. Management of resources commonly features on the reform agenda as part of efforts to improve the performance of the health service organization. Concern for resource management also includes management of information and logistic support systems: transport, essential drugs and supplies, technology and infrastructure.

Human resource planning and management deserve special attention. They usually consume between 70% and 80% of the recurrent health budget while huge sums, time and effort are also devoted to basic education and training. Nevertheless, deployment, motivation, supervision and maintenance of knowledge and skills are often grossly neglected. Human resource planning requires special skills in the use of computerized projection models and requires surveys and integration with information systems to establish their distribution and mix (WHO has developed a set of projection models that are available on diskette from WHO Country Offices). Planning of human resources should be in line with PHC and reform objectives; planning should also take into account future sustainability at an acceptable remuneration level, while leaving sufficient projected recurrent finances for non-personnel operational expenses. In addition, HRH planning should be linked with civil service pay reforms that are likely to take place alongside national health sector reforms. Initially, planning can be based on appropriately defined staffing levels and skill mixes to deliver the identified health service packages at each level. Gradually, however, as health management information systems improve, HRH planning should shift from fixed staffing standards to workloads. Programmes should be initiated to build management capacity for the implementation of reforms at each level. There is further need for curricula review and re-training in line with reforms.

Health financing

Health sector reform concentrates on two main factors with relation to health finances. The first is mobilization of more finances and the second is better and more efficient use of available funds. Mobilization of resources includes the establishing of alternative health financing schemes such as cost-sharing, pre-paid schemes or national health insurance. It also includes negotiating with donors on the basis of policies, programmes of work and district health plans. Promotion of public/private mix in health services provision is yet another way of mobilizing resources from the private sector (for profit and not for profit), at the same time strengthening the public sector to maintain equity and accessibility. To ensure that funds are actually used as intended, reforms in many countries deal with improved accounting and the building of accounting capacity. Also, in negotiations between governments and donors, there is a search for new funding mechanisms through pooling of funds and provision of budget support. Fairer and more equitable allocation of health finances has already been discussed under equity and will be further discussed in Module 3 (Unit 2, Management of Finances and Accounts).

Equitable provision of essential health services

Improving health services in the interest of all is the main purpose of health sector reform. Improving services in a comprehensive way requires an approach which views these services at various levels as a system geared towards tackling health priorities. It is necessary to determine how many levels of health provision are giving most value for money. For each level, costed minimum standard essential health

service packages need to be defined as local health priorities. Linkages between the various levels should also be taken into consideration to ensure that there are workable referral and supervision mechanisms. Reform also means integration of vertical programmes where this will lead to better and more efficient health care. However, to ensure that all this will actually improve the service, specific quality assurance mechanisms or a system of quality improvement needs to be put in place. At the same time, adequate attention should be given to logistic support, transport, essential drugs and other medical supplies.

Expected outcomes of the reform process

Health sector reform agendas vary from country to country since they are dependent on a country's specific health problems and needs. The health sector reform process (Figure 2) is, therefore, a generic one. Three aspects of the process are worthy of emphasis: It is non-linear; all stakeholders must be involved in the various phases of the process; monitoring and evaluation, continuing education, advocacy and consensus building are central to the process.

There are linkages (Figure 3) between health sector reform and its ultimate goal, health status improvement. Health sector reform leads to changes in health policy, health systems and health services. These changes, in turn, should lead to health system development and strengthening, which are prerequisites for improving the performance of health systems and services, which in turn necessitate health sector reform. Improvement in the performance of health systems and services leads to greater access and better utilization of quality health services which are produced and provided in a more efficient, equitable and sustainable way. Ultimately, improvements in the performance of health systems and services should lead to improved health status which is measured by such impact indicators as infant and child mortality, maternal mortality and life expectancy at birth.

ACTIVITY 5

- Study Figure 2 and Figure 3 individually and carefully. Note any aspect that you do not fully understand, and write down any questions that you have.
- Discuss the figures in a group and try jointly to understand them and answer your questions.
- Discuss the results of your group work in plenary session with the facilitator.

FIGURE 2: HEALTH SECTOR REFORM: PROCESS AND STAKEHOLDERS

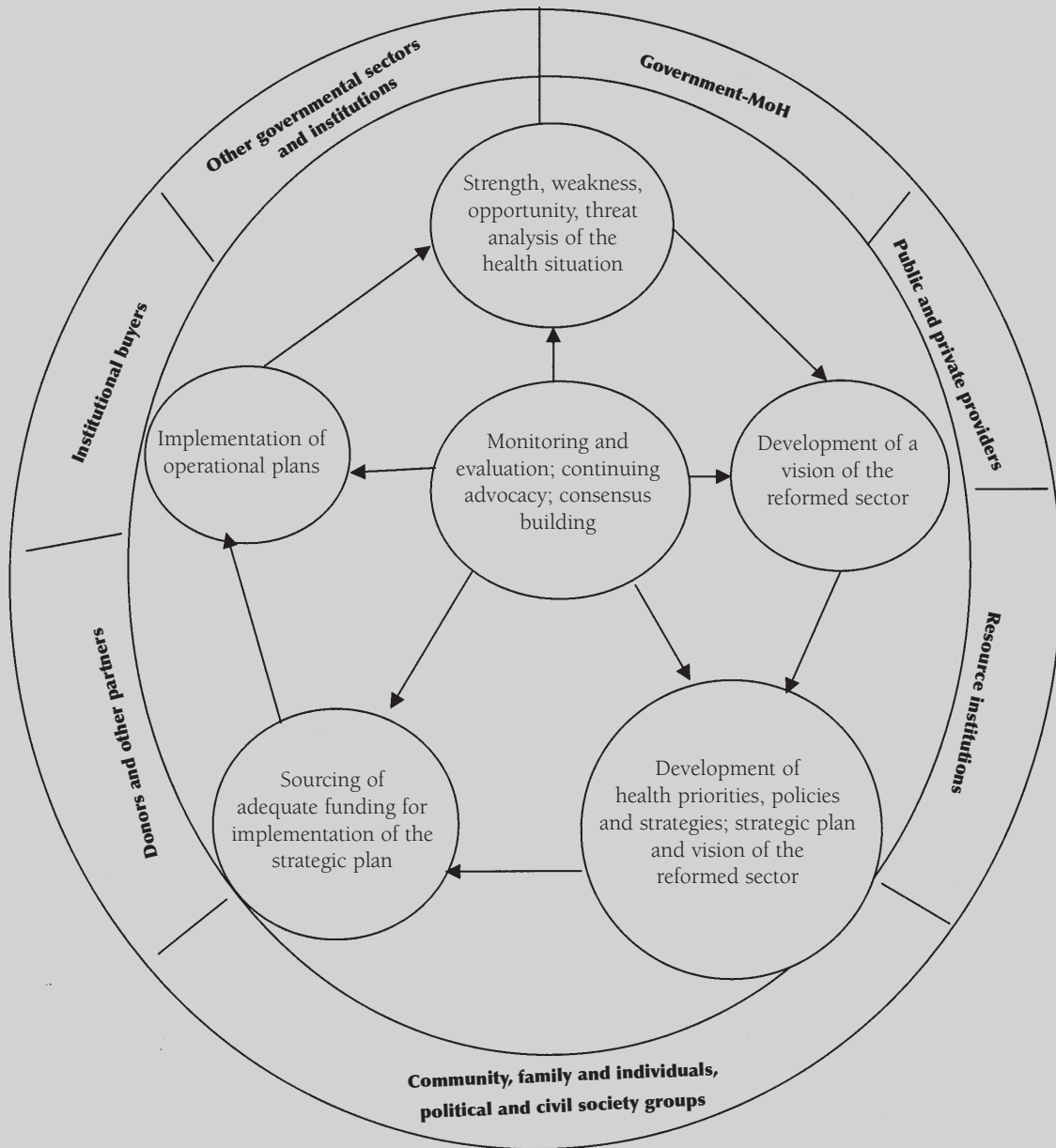
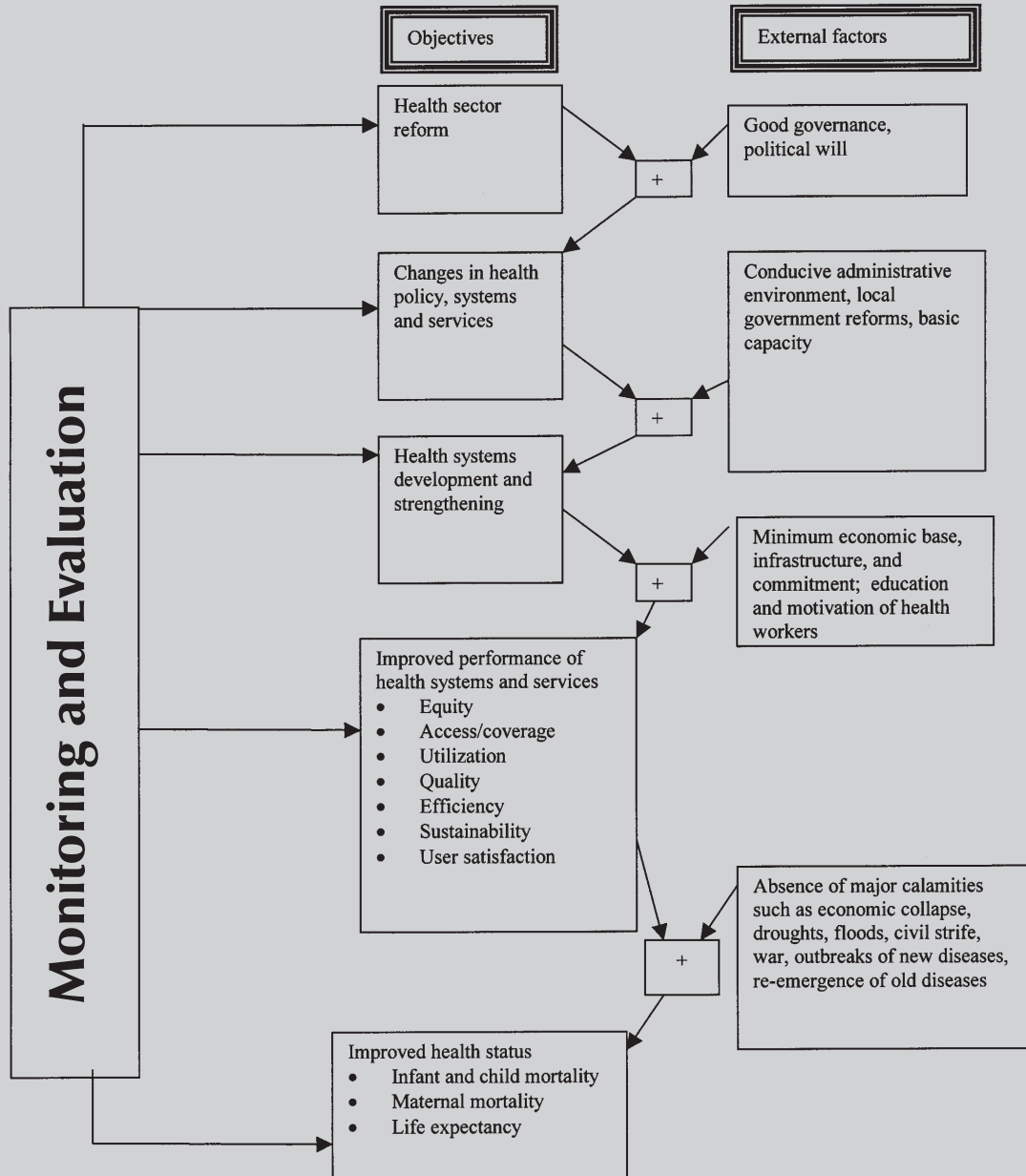


FIGURE 3: FRAMEWORK FOR LINKING HEALTH SECTOR REFORM TO HEALTH STATUS IMPROVEMENTS



1.2.3 Sector wide approaches

In the context of health sector reform, sector wide approaches (SWAs) have been developed and implemented as a method of working between government and donors organized around a negotiated programme of work (PoW) for the sector. Many countries in the African Region depend on donor support to implement their health policies. This support is still given in a fragmented, uncoordinated way through a confusing number of projects and programmes. SWAs should achieve coordination of donor efforts and strengthen partnerships in sustainable health development.

Definition

In the health sector context, a SWAp is a sustained partnership led by national authorities involving civil society and external partners with the goal of improving people's health and contributing to national development. This is achieved through a collaborative PoW with established structures and processes for negotiating strategic and management issues and reviewing sectoral performance against jointly agreed milestones and targets.

The components of the collaborative PoW are concerned with sectoral policy and strategy development; resource projections, spending and financing plans; institutional development and capacity building. They are defined in terms of development objectives, that is, an agreement on what is to be achieved over time, rather than a set of prerequisites. Also, components of the PoW should be implemented at a pace which is suitable for national concerns and priorities.

In addition to the PoW, the development and implementation of SWAs require the establishment of structures and processes for negotiation of strategic and management issues and for review of sectoral performance against previously agreed milestones and targets. Sound macro-economic policies are also favourable to the development and implementation of SWAs.

Origin

SWAs have evolved from two main directions. First there has been the interest of macro-economists wishing to improve the budget process, capturing all funding sources and expenditures (government and non-government) and fitting health sector plans within a rolling medium-term budget to ensure that allocation decisions are made in line with overall national priorities. Secondly, interests in SWAs also emerged from health professionals concerned that donor-driven projects have tended to absorb scarce human and financial resources, sometimes with limited coverage, often with unsustainable standards and insufficient building of local capacity.

Aims

SWAs aim to achieve sustained improvements in people's health by establishing long-term partnerships in which donor assistance and national resources are used to support a single national health policy and its strategies. SWAp supports the sector as a whole as opposed to the Project by Project Approach (PPAp) which may lead to fragmentation, inconsistencies between national and donor funding, conflicting systems, and duplication or overlapping of efforts. SWAs further aim at adopting common approaches across the sector relying on government procedures to disburse and account for all funds. There is need to build confidence and trust between partners with the strengthening of national institutional capacity mainly in planning, budgeting, accounting and auditing.

Some key operational issues

SWAps development and implementation will deal with some operational issues which are critical for success. These include:

- Definition of health sector which helps to better identify the main actors
- Allocation of funds to priority health programmes
- Addressing poverty and health of the poor population
- Ownership by government and incentives for SWAps
- Definition of components of the collaborative Programme of Work
- Partnership agreements and working arrangements.

The dual purpose of SWAps is therefore to:

- Ensure that policies, budgets and institutional arrangement are ultimately geared toward improvement in service quality and health outcomes; and
- Facilitate a different form of interaction between government and donors.

SWAps for health development stress the need for strong national leadership and ownership as opposed to donor dominance. It should be emphasized that SWAp is an approach, not a specific aid instrument. It must be able to accommodate the private sector and plurality in general, rather than creating a massive public sector programme.

Partnership agreements and working arrangements in SWAps

The implications of a SWAp include the commitment to shared goals and the negotiation of strategies rather than planning of projects. SWAps allow a phased introduction of common management arrangements with regard to monitoring performance, financial management and procurement of goods and services.

In order to harmonize the whole process, partnership agreements and working arrangements will be required at country level. These will include:

- a joint statement of intent to proceed with SWAps;
- a collaborative PoW with performance objectives and milestones for each of the main components;
- a detailed Memorandum of Understanding (MoU) between partners that specifies the roles of actors in the health sector, etc;
- an agreed code of conduct (CoC) that will cover other issues relating to behaviour of donors and government that are not included in the MoU.

BOX 4: LESSONS AND EXPERIENCES FROM SWAPs

- Consensus on the policy framework between government and donor partners is crucial to enhance real partnership
- There is need for time and patience to build capacity, consensus on policy and a sense of local ownership without pushing too hard. Avoid a top-down process and adopt a broader dialogue involving all stakeholders at all levels
- Those who implement SWAPs should understand what is required of them, and have incentives to act accordingly.
- SWAPs need to be designed to tackle major health problems
- Timely disbursement of funds should go hand in hand with asking implementers to sign performance agreements, specifying the outputs they will deliver with the financial resources for which they are responsible.
- Efforts should be made to operate SWAPs via a decentralized system by provision of clear national policy priorities and clear definition of the services which local governments are expected to provide.

BOX 5: KEY FACTORS FOR SUCCESSFUL REFORMS AND SWAPs

- Sound government leadership (Ministry of Health) throughout the reform process.
- Sustained political stability and will.
- Sustained consensus building among all stakeholders.
- Availability of financial resources, largely from internal sources.
- Effective management of the process of change.
- Sound macro-economic performance.
- Clear and commonly shared long-term vision to guide the reform process.
- Adequate capacity (administrative, technical, managerial and institutional).
- Comprehensive health sector development.
- Adequate in-built flexibility, adaptation, monitoring and phasing.
- Effective coordination of all donor support to the reform programme.
- Comprehensive policy and strategy on human resources for health.

ACTIVITY 6

- List your hopes and fears in connection with health reform and SWAps.
- As a member of DHMT, write a memorandum to express them in the next reform meeting with higher authorities.

ACTIVITY 7

- Carefully study the health reform policy and strategies in your country. Then identify major changes or interventions required in your district in order to implement the reform policy and plan.
- Discuss how you will incorporate the changes in the next District Health Plan.

Unit 2: District Health Systems

Introduction

This unit introduces the concept of a district health system. The unit presents various components of a district health system, essentials of teamwork and various sources that make the district health system function properly and how they interrelate with each other.

Objectives

The objectives of this unit are to:

- Introduce the concept of a district health system;
- Describe the district health structures and their functions;
- Explain the relationship between national and district health systems;
- Provide an overview of the assessment of the operability of district health systems.

Expected Outcomes

It is expected that by the end of this unit, participants shall be able to:

- define a district health system and its components;
- understand the functions of various bodies in the district health system;
- differentiate roles of a district health system and those of a national health system;
- understand the referral system and how it is expected to function in the reformed health sector;
- understand and apply principles of assessing the operability of a district health system.

2.1 Definitions

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 300,000.¹ It comprises first and foremost “a well-defined population living within a clearly delineated administrative and geographical area”.

A district health system includes the interrelated elements in the district that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychosocial environment.² A district health system based on PHC is a self-contained segment of the national health system. It includes all the relevant health care activities in the area, whether governmental or otherwise. It includes self-care and all health care personnel and facilities, whether governmental or non-governmental, up to and including the hospital at the first referral level and the appropriate support services (laboratory, diagnostic and logistic support). It will be most effective if coordinated by an

1 E.Tarimo, *Towards a healthy district: Organizing and managing district health systems based on Primary Health Care*, Geneva, World Health Organization, 1991.

2 Glossary of terms used in the “Health for All” series No. 1–9, Geneva, World Health Organization, 1984.

appropriately trained DHMT and DHM Team Leader/Organization Manager, working to ensure as comprehensive a range as possible of promotive, preventive, curative and rehabilitative health activities.³

The following are some of the components of a district health system:

- district health office;
- district hospital or hospitals;
- health centres;
- community, neighbourhoods and households;
- private health sector, NGOs and mission health services.

2.2 Characteristics of a District Health System

A district health system is **large enough** to justify the costs involved for investment in and management of health services, particularly where hospitals are concerned (favourable cost-benefit ratio). It is **small enough** to know and take account of the demographic and socio-economic situation. Both top-down and bottom-up **planning approaches** can easily be coordinated because of direct contact at all levels. **Communication** with the target population and its participation in planning and organization are fairly easy to handle. **Management** (e.g. supervision) is more transparent and reliable. **Coordination** is easy to achieve between the various programmes and services at different levels. **Intersectoral** cooperation can take place (e.g. with agriculture, education, water, sanitation and housing sectors).

2.3 Conditions for a Functioning District Health System

A DHS can only function on a target-oriented basis when political decisions create the required framework. The decentralization of the health system must be legalized and implemented by means of regulations and legislation. The necessary financial and human resources must be mobilized. Health service institutions and providers must have autonomy in the use of physical and human resources, and income generated by health services must remain at their disposal. Sufficient personnel, qualified in planning and management activities, must be available.

2.4 Some Major District Structures

The following district structures are meant to serve as examples and a basis of discussion because the situation may differ from country to country.

The District Council is a form of local legal administrative body or government authority in the district. It is composed of councillors who are elected according to the legislation prevailing in a country. The chief executive officer (CEO) conducts the day-to-day business of the council which employs workers in various disciplines. The CEO also manages a group of technical experts in various fields like agriculture, water, public works and health.

The district council usually has legal status and powers, a defined geographical area under its jurisdiction and powers to collect and review revenue. The district council also manages its own budget, makes development plans and provides economic and social services in its area of jurisdiction.

³ Eighth General Programme of Work covering the period 1990–1995, Geneva, World Health Organization, 1987.

The District Health Board (DHB) is a policy body consisting of elected or appointed members drawn from both public and health sectors in the district. Members serve for a fixed term as stipulated by law. The DHB ensures that the District Health Management Team provides quality, cost-effective and equitable district health services. Members should understand main health and management issues in the district and contribute to the development of appropriate health policies in accordance with national policies. The DHB should further support the DHMT to carry out administrative and professional activities. Its concrete functions include:

- approval of health development plans, annual plans, budgets, quarterly progress reports and all initiatives for local resource generation;
- monitoring and evaluation of progress of health activities and taking appropriate decisions;
- ensuring internal and external audit of all assets, equipment, financial and human resources in the district;
- attending to appeals, petitions, complaints etc. from the public and from staff;
- ensuring intersectoral cooperation in the district with relevant government departments and private health sector;
- initiating mechanisms for sustainability of community involvement in planning, implementing, monitoring and evaluation;
- ensuring involvement of the community in health care management of local facilities at community level;
- facilitating establishment of committees that promote PHC operations at all levels.

The District Health Office manages, administers and coordinates district health matters and serves as a link between the district and higher levels: regional, provincial and national. It is managed by a multidisciplinary team usually referred to as the District Health Management Team (DHMT). The District Health Office is headed by the Public Health Physician/Officer, District Medical Officer or District Health Director, depending on the system that operates in a country. The District Health Office could be answerable to either the District Council/Assembly or local Health Board. The responsibilities of the District Health Office are to:

- ensure the equitable delivery of high quality, cost-effective district health services;
- assist the District Health Board or any equivalent policy structure at the district to understand the main health and management issues in the district so that they are able to assist the DHMT better;
- provide the District Health Board with relevant and updated information on national health policies;
- account to the DHB for the performance of the district health system in accordance with the health action plan;
- work closely with the Provincial Health Office and other districts on matters related to general management of district health services.

The District Health Management Team is responsible for the day-to-day management of the district health system. Common DHMT functions include planning, supervision, budgeting and finance control as well as problem-solving and crisis management. The DHMT is answerable to the District Health Board for day-to-day management of the district health system. The DHMT leader is commonly the District Medical Officer, District Health Officer or District Director of Health Services. Other core

members usually include the District Nursing Officer or Matron, District Environmental Health Officer, District Pharmacist and District Health Administrator. The composition differs from country to country. In some countries, DHMTs are being reviewed and tested to match health sector reform strategies and components. DHMT composition may include the District Officer for Organization and Management, the District Officer for Health Financing, the District Officer for HRH Planning and Development and District Officer for Essential Health Services (including logistics, essential medical supplies, communicable and noncommunicable diseases, etc). Co-opted members tend to include representatives from NGOs and private health providers, training institutions and important public health programmes.

The DHMT has the responsibility of reviewing all health development plans in the district (including private, NGOs, missions, etc.). The team should translate the national health policies into comprehensive annual district health plans in accordance with local situations. This involves consultation with all stakeholders, including health centre staff, health centre committees and committees at community level. The plans and budget should be submitted to the DHB for approval and funding. The DHMT should then ensure that health services are provided by different levels of health care on basis of district health plans and in accordance with national rules and regulations.

Other tasks of the DHMT include:

- initiation and promotion of partnerships with other health providers and other sectors to enhance collaboration and communication at all levels in the district, establishing functional committees to enhance community participation and supporting all initiatives for local mobilization of resources;
- strengthening provision, management and use of health information and health systems research to support evidence-based planning and appropriate choice of health interventions;
- human resource management involving recruitment, deployment, supervision, counselling, conflict resolution, disciplinary action, identification of district training needs, staff development planning, career development and coordination of in-service training;
- regular management of budgetary resources (personnel, drugs, vaccines and medical supplies etc.);
- monitoring of all health performance in the district and taking corrective action where required.

ACTIVITY 8

- The DMO or other DHMT Leader sits with the District Health Administrator to prepare the agenda for the next weekly meeting of the DHMT. The other DHMT members observe the process and make notes but do not participate in the discussion. Once the task is completed, the observers give their comments on both the process and content of the agenda.
- Among the various agendas prepared by the different groups, choose one or two with interesting contents. In a “fish bowl exercise” one group should conduct the meeting while the others sit around, observe and make notes. Your facilitator will explain the details. If there are enough participants, the same agenda can be discussed by two different groups, one with a formal chairperson and secretary, the other one without.
- In a variant of this exercise, a suitable group member can be instructed to attempt to become the informal leader of the group by constantly challenging the chair.

The Hospital Management Team (HMT) is answerable to the DHMT, and the head of the hospital (Hospital Director) is the chairman. Preferably the hospital administrator should be the secretary. Other members usually include heads of departments according to the organization of the hospital. The Hospital Management Team should:

- ensure that the hospital provides appropriate quality diagnostic clinical services (including referral services), technical support (including training in clinical care to peripheral health institutions), monitoring, evaluation and corrective action as required;
- take care of day-to-day management of the hospital and PHC in the catchment area;
- oversee all expenditures for the hospital according to existing regulations;
- prepare and submit quarterly and annual plans, budgets and reports;
- hold regular staff meetings and involve hospital departmental staff in budgetary planning and sometimes allocation of recurrent budget for use in service areas.

Health Facility Committees may include the Health Centre Committee, Dispensary Committee or Clinic Committee as applicable to the situation in different countries. Committees at the community level have a big role to play in view of the importance of health centres, dispensaries and clinics in district health development activities.

Health Facility Committees are expected to:

- mobilize and support community involvement at all stages of health care provision;
- consolidate and prioritize community health needs to be included in the district plan and budget;
- initiate and participate actively in health-related activities at household and community level;

- give support to community-based health care volunteers (TBAs, VHW) and THs;
- support all local health development activities, in particular initiate and participate actively in health-related activities at household and community level;
- mobilize and account for resources and contribute to preventive maintenance and security of the health facility;
- monitor and evaluate progress made in implementation of activities in health facility catchment areas, and consolidate, analyse, use and disseminate data;
- initiate formal and non-formal health education activities in the community with more emphasis on women and child health.

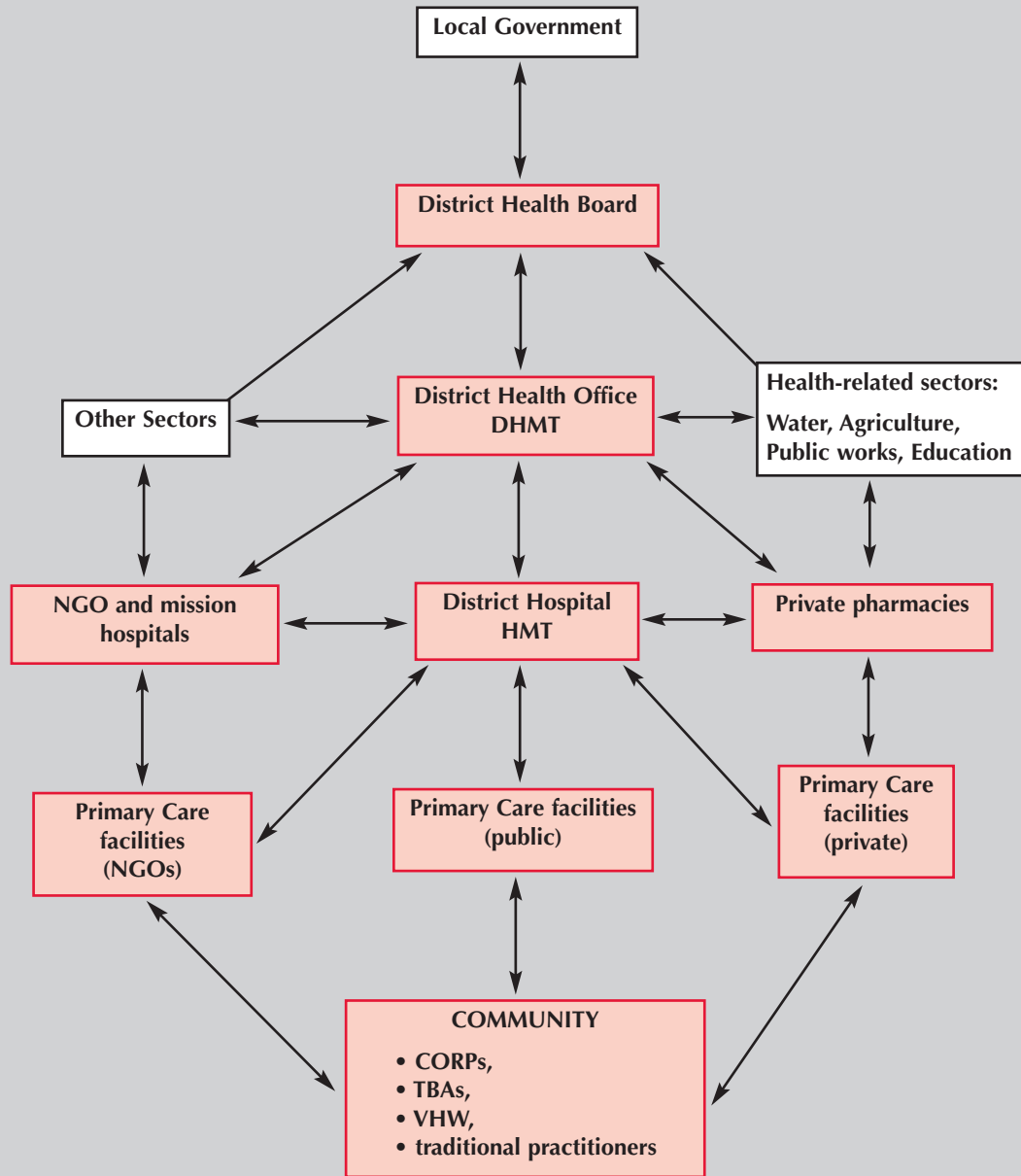
Composition of health facility committees varies according to the circumstances in each country. It is recommended that they be composed of representatives from the community, health facility and other community development structures. The committee elects its own chairman. The head of the health facility is the secretary to the committee. Preferably at least half the composition of the committee should be women, and youth should be represented.

The Community Health Committee (CHC) is answerable to the health facility committee. However, in some countries, there is a village development committee which is responsible for all development in the village. Such a committee will also be responsible for specific health activities. Community Health Committees should:

- identify community needs and integrate these into the health facility action plan;
- act as a link between community and health facility staff;
- initiate and participate actively in health-related activities at household and community level (for example, community transport for patients);
- develop mechanisms for sustainability of community-based health care workers and community own resource persons (CORPs);
- initiate and strengthen all local health development initiatives with other government sectors;
- collect vital community-based health data;
- mobilize and account for local resources;
- initiate formal and non formal education in healthy life styles.

Figure 4 depicts the hypothetical model of a district health system showing the various linkages with other structures in the district.

FIGURE 4: DISTRICT HEALTH SYSTEM AND ITS LINKAGE TO OTHER DISTRICT STRUCTURES (HYPOTHETICAL MODEL)



Note: The shaded boxes represent the structures of the District Health System.

2.5 Role of the Province or Region

Experiences from countries where decentralization has been introduced have shown the necessity of redefining the role of provinces or regions. It is important that the roles of the province in a strengthened district set-up are clearly defined.

Some of the possible roles of a redefined province or regional health office could be:

- monitoring performance of district health systems;
- monitoring financial performance in the districts;
- assisting in development of a health management information system;
- assisting in human resources development in districts;
- assisting in development of a quality assurance policy in districts;
- providing technical, consultancy and training services to the districts;
- conveying central health policies.

ACTIVITY 9

- Role-play a situation where a DHMT visits a health centre where it meets a representative of the Health Centre Committee. The committee members have collected money and now intend to build an extension to the facility, expecting that the DHMT will provide three more nursing staff. It is a difficult situation because (a) extension of facilities is not in the district health plan and not considered a priority, and (b) providing extra staff to this facility is not possible within the budget. Role-play this situation and then discuss.
- Role-play a DHMT visiting a health centre and meeting a representative of the Health Centre Committee. There is a conflict situation. Members of the committee have raised serious complaints and want to get rid of one of the health workers who you know as technically excellent, competent and dedicated; however, he is not from this part of the country.
- Further role-play any “real life” problems that exist in the functioning of health facility committees in your district.

2.6 Relationship between National and District Health Systems

It is important to understand the relationship between district health systems and national health systems (Table 1).

TABLE 1: FUNCTIONS OF HEALTH SYSTEMS

HEALTH SYSTEM FUNCTION	NATIONAL SYSTEM	DISTRICT SYSTEM
Stewardship	<ul style="list-style-type: none"> Regulatory functions 	<ul style="list-style-type: none"> Implement and enforce regulations
	<ul style="list-style-type: none"> Policy formulation 	<ul style="list-style-type: none"> Interpret and implement policies, e.g. Essential health packages
	<ul style="list-style-type: none"> Setting standards 	<ul style="list-style-type: none"> Interpret and enforce standards
	<ul style="list-style-type: none"> Liaison with bilateral and multilateral agencies 	<ul style="list-style-type: none"> Partnership establishment and sustenance through private/public mix, community involvement and multisectoral approach (planning, monitoring and evaluation)
	<ul style="list-style-type: none"> Formulation of strategic research priorities and plans 	<ul style="list-style-type: none"> Conduct health system research Take part in national surveys Take part in piloting interventions of national priority Involve NGOs in health systems research Conduct cost-effective public health intervention
	<ul style="list-style-type: none"> Establish HMIS 	<ul style="list-style-type: none"> Put HMIS into operation by collecting, processing and analysing data Use information for evidence-based comprehensive health planning Link HMIS data for research
Resource generation	<ul style="list-style-type: none"> Development of a national human resource development strategy and plan Training of high and middle level health workers Development of national health infrastructure development and maintenance plan Development of a national equipment policy Policy development on procurement and rational use of essential supplies, including drugs 	<ul style="list-style-type: none"> Assessment of local human resource needs Rational deployment and utilization of HRH Continuing education for health workers Training and orientation of CORPs for health (TBAs, VHWs, traditional practitioners, CBDs) Identifying physical infrastructure and equipment needs Routine maintenance of physical infrastructure and equipment Identifying drug and other essential supply requirements and placing orders Proper storage, distribution and use of essential supplies
Service delivery	<ul style="list-style-type: none"> Tertiary health care services Technical back-up and support supervision Setting standards Quality assurance Monitoring and evaluation Provision of incentives for service organizations and providers 	<ul style="list-style-type: none"> Identification of health care needs and prioritization of health services Provision of identified and prioritized health care packages in an integrated continuous and comprehensive manner Encourage community-based care Identification and involvement of all stakeholders Development and implementation of action plans Ensuring customer/client satisfaction
Financing	<ul style="list-style-type: none"> Budgeting Financing strategies Donor coordination Development of pooling mechanisms (e.g. insurance and prepayment schemes) Development and use of purchasing mechanisms (e.g. contracting) Maintenance of national health accounts 	<ul style="list-style-type: none"> Budgeting Allocation of funds to activities Implementation of insurance and prepayment schemes Implementation of exemptions Provision of proper accountabilities Implementation of co-financing schemes

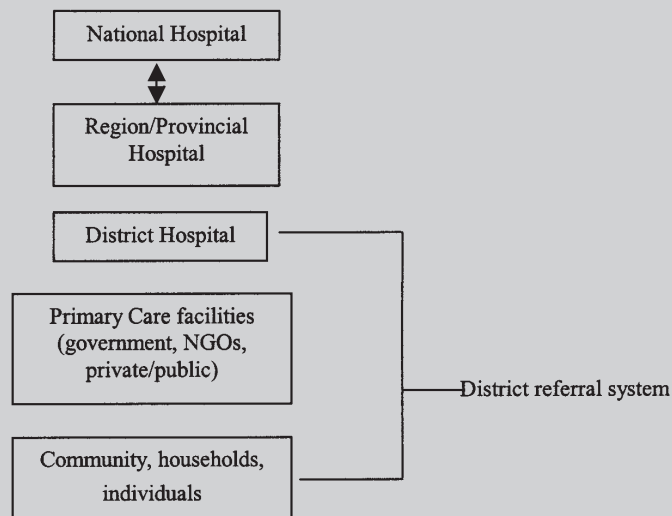
ACTIVITY 10

- Using newsprint paper, chalkboard or other large drawing surface, draw a diagram of the present communication lines between your district health system and the higher levels in the hierarchy of the national health system. Discuss which lines function well and which lines require change or improvement. Then draw an “ideal communication structure”. Compare the results with the reform proposals.

2.7 Levels of Health Care Referral

The different levels of health facilities in the district are referred to as the “Referral system” or “Health pyramid”. The flow in the referral system is shown in Figure 5. Note that the flow is in two directions.

FIGURE 5: HEALTH REFERRAL SYSTEM



The type of services and staff available at each level will differ from country to country but become more sophisticated the higher the level. Some countries have already made progress developing “Essential Health Services Packages” with or without accompanying health systems research. Where such service packages have been defined, they should be used. Different types of skills are required at the different levels. The services at various levels should be complementary. When required, a lower level facility should refer a patient to the next level for a service that cannot be provided at the lower level. This needs to be done in a coordinated manner in full consultation with the patient. The staff member at the lower level facility writes a referral note to send a patient to the next level. Likewise, after giving the service, feedback should be provided to the lower level from where the patient was referred.

ACTIVITY 11

- As DHMT, make a table with three columns as shown below; in the left column indicate the facilities at different levels, in the middle column indicate the services needed at each level and in the right column list the knowledge, skills and attitudes (KSA) required to provide the necessary services.
- Discuss the ideal personnel mix that together has the required KSA. Compare this with the present staffing pattern. Develop this into a recommendation to your Ministry of Health.

Level	Services needed	Required KSA
Community		
Dispensary		
Health Centre		

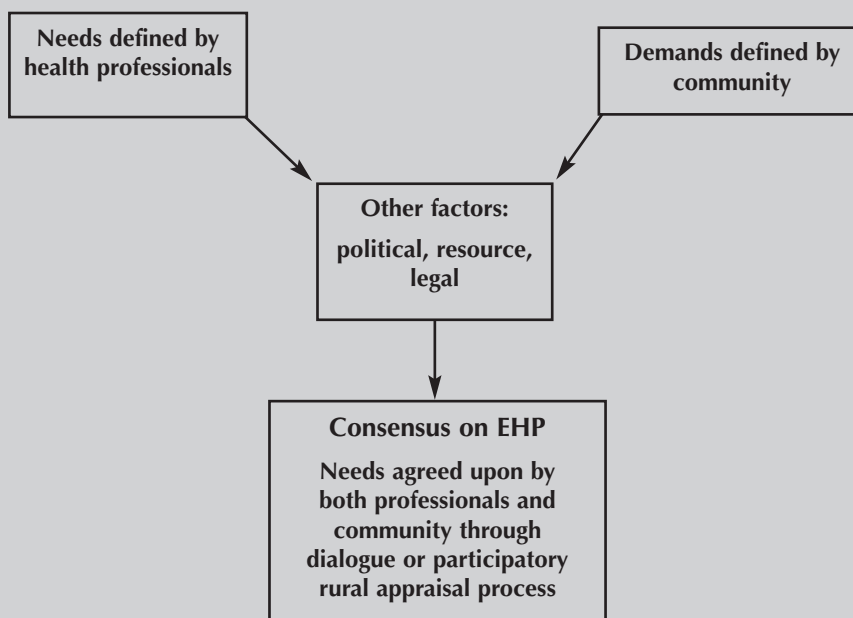
At community level accessibility is influenced by health promotion activities by community members like TBAs, village health workers, traditional practitioners and community-based contraceptive distributors.

Community-based health care can detect and care for patients with chronic illnesses such as AIDS and tuberculosis. Community-based initiatives can also include prevention such as use of impregnated mosquito nets. The community should be involved in mobilization of resources to meet health care costs of a referral patient, whether for referral from community level to a higher level or for “reverse referral” of a patient who has undergone a health intervention at higher level and then requires continued care and support at home. Such resource mobilization could be through community health funds in line with the Bamako Initiative which ensures availability of essential drugs. The community has the right to

demand quality health care services and should also participate in identifying essential health care packages. Vulnerable groups like women and children should be given special consideration.

At health facility level health workers shall improve quality of care by ensuring improved geographical accessibility so that people will not have to walk long distances to primary care facilities. Technical accessibility should also ensure standard quality health care. Health care services shall be made affordable through various methods of health financing such as a community health fund, the Bamako Initiative or health insurance schemes. In the latter, communities “pool risks” and give necessary exemptions to the most vulnerable groups, e.g. pregnant women and children. The community will be involved in the management of funds and setting of prices for health care services. Communities will demand that health facilities provide quality services based on “Essential Health Packages” which have been developed jointly by health workers and Community Health Committee representatives (Figure 6). Health facility workers will ensure continuity of health care services which are set according to the needs and resources of the immediate communities they serve. Health services will have to go beyond the borders of health facilities to ensure the phenomenon of “**from home to health facility and from health facility to home**” is a reality.

FIGURE 6: DEVELOPMENT OF ESSENTIAL HEALTH PACKAGE



The district hospital is the referral apex in the district where patients are referred from other health facilities. Being part of the DHS the hospital is also expected to provide identified and prioritized essential health packages. The hospital generally should not compete with primary care facilities or get too involved with solving community health problems. Instead, it should concentrate on providing the level of technological medical care that lower levels cannot provide.

Minimally the district hospital is expected to offer the following as part of the district essential health package:

- outpatient care for those who can be managed on ambulatory basis;
- supportive medical care of critically-ill patients who are hospitalized;
- diagnostic services such as laboratory, radiology and ultrasound;
- continuing education for health workers within the hospital and from primary care facilities;
- conducting of research, both operational and intervention studies;
- reverse referral of patients to continue with follow-up care in their local health care facilities;
- referral of patients to consultant (tertiary) hospitals.

2.8 Assessing the Operability of District Health Systems

One of the major functions of the DHMT is to assess the operability of the district health system. This should be done periodically to provide necessary information (District Health Profile) for the planning, monitoring and evaluation of district health services (a specific assessment tool for DHS operability has been developed by WHO/AFRO).

Assessment of the operability is defined as the review of the organization and management of a health system in terms of structures, managerial processes, priority health activities, community participation and the availability and management of resources. It does not include the assessment of performance which would entail the measurement of achievements such as health improvement of population, fair access, effective delivery of appropriate health care, efficiency and patient satisfaction. In sum, assessment of the operability of a district health system is a component of the monitoring and evaluation processes in a health district.

The objectives of the assessment of the operability of a district health system are to:

- identify the strengths and weaknesses in the organizational structures, the managerial process, the provision of priority health activities, community participation and empowerment, and the management of resources in the district health system;
- develop a plan of action to improve the operability of the district health system, on the basis of the results of the assessment and in collaboration with all parties involved in health development in the district;
- strengthen the DHMT through a self-assessment process.

**BOX 6: CRITERIA FOR ASSESSING THE
OPERATIONALITY OF DISTRICT HEALTH SYSTEMS**

Functioning district health management structures

- District Development Committee
- District Health Committee
- District Health Management Team

Established managerial processes

- Operational plans
- Guidelines, standards and norms
- Supervisory activities and monitoring of progress

Health facility activities

- Public health interventions
- Basic health care
- Health related interventions

Community health initiatives

- Functioning community structures
- Community activities
- Community funds

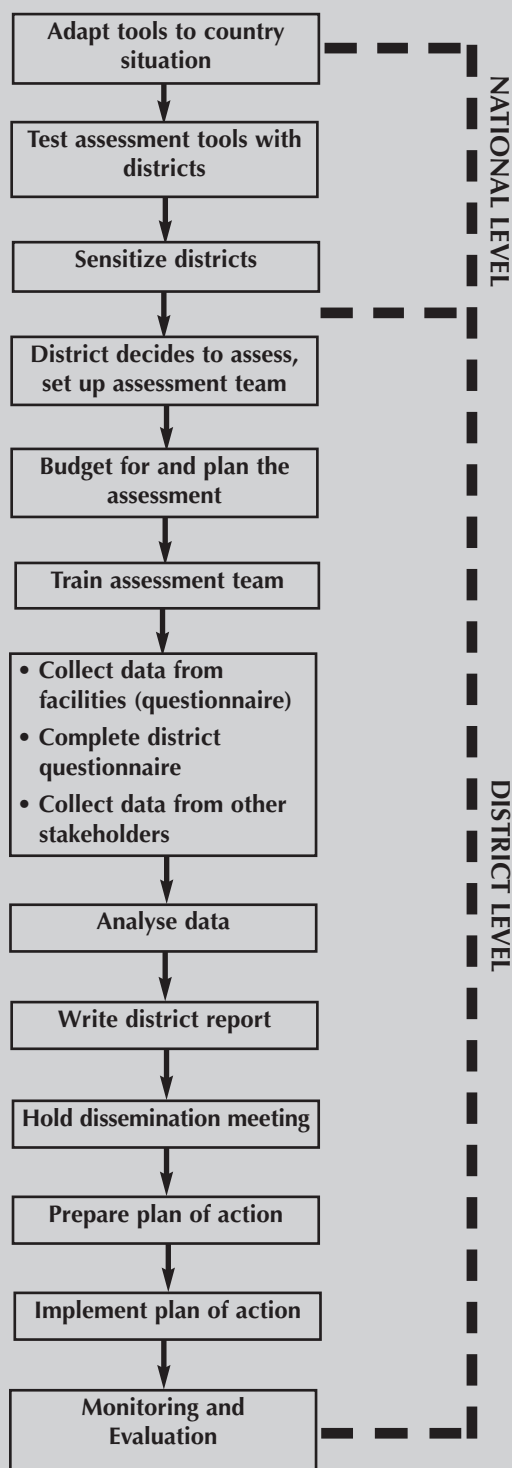
Availability of locally-managed health and health-related resources

- Funds
- Human resources
- Equipment, drugs and supplies

Source: Tools for Assessment of the Operationality of District Health Systems: Guidelines, WHO/AFRO.

At the central level of the health system the results of the district self-assessments could be used to guide policy development, planning and resource allocation for strengthening the country's district health systems. Figure 7 gives steps in the assessment process which should take place at national and district levels.

FIGURE 7: STEPS IN THE ASSESSMENT PROCESS



Source: *Tools for Assessment of the Operability of District Health Systems: Guidelines*, WHO/AFRO.

Since the assessment is generally the responsibility of the DHMT, the tools have been developed as *self-assessment* tools. The methodology can be used to establish the evidence base for both operational and strategic planning processes for improving the operability of the district system. Supervision and monitoring using the health management information system should be integrated into routine district management in order to facilitate regular assessments. Comparison with results from neighbouring districts could be the basis for a structured exchange of experiences and solutions.

ACTIVITY 12

- DHMTs are advised to make use of detailed assessment tools and guidelines developed by WHO/AFRO in collaboration with Member countries. Tools for assessing the operability of district health systems include: Guidelines, district questionnaire, health facility questionnaire.
- Ask your MOH or WHO Country Office for these documents.

Suggestions for Further Reading

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