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HEALTH SYSTEMS STRENGTHENING: IMPROVING DISTRICT HEALTH SERVICE DELIVERY, AND COMMUNITY OWNERSHIP AND PARTICIPATION

Report of the Regional Director

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BACKGROUND

1. The World Health Organization defines a health system as all organizations, people and actions whose primary intent is to promote, restore and maintain health.[1] It has six interrelated building blocks, namely, service delivery; health workforce; information; medical products, vaccines and technologies including infrastructure; financing; and leadership or governance. Improvements in service delivery require simultaneous improvements in the other building blocks at all levels of implementation including the district.

2. A district is defined as "a clearly defined administrative area covering a population at which some form of local government or administration takes over many responsibilities from central government departments".[2] It translates central government aspirations, policies, strategic directions and road maps into district-level action and forges a mutually accountable partnership between people and government. A health district is the part of local government that takes over the responsibilities of the central ministry of health. It is large enough to justify the investment and management costs and small enough to be familiar with the relevant demographic and socioeconomic factors. It is normally equal to the administrative district and serves approximately 50 000 to 300 000 people.[3]

3. The effectiveness of the organization and management of service delivery in the district depends, among others, on the competence and number of members of the district health management team as well as relevant management teams in health centres, health posts and communities. These teams coordinate the planning, implementation, monitoring and evaluation of health service delivery.

4. The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa,[4] the Addis Ababa Declaration on Community Health,[5] the World Health Report 2008 on Primary Health Care[6] and other related documents[7] outline the principles and approaches for strengthening health systems. They emphasize the role of communities and partners in health development.

5. Communities are defined as "social groups of any size, whose members reside in a specific locality, share government, and often have a common cultural and historical heritage".[8] Many countries have set up community structures to work with health workers especially at the first level of the formal health system. In some countries, such community structures determine how health services are organized and operated. Where communities are closely involved, service

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1 WHO. Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, World Health Organization, 2007.

2 WHO. Operational support for Primary Health Care: the role of the district level in accelerating health for all 2000 for all Africans. Brazzaville, World Health Organization, Regional Office for Africa, 1987 (AFR/RC37/TD/1, AFR/HFA/2).

3 Where districts have many more inhabitants, they should be divided. Gorgen Helmit et al. The District Health Systems – Experiences and prospects in Africa, Manual for Public Health Practitioners, Deutsche Gesellschaft für, Postfach 5180.65726 Eschborn, Germany, 2004, page 32.

4 WHO. Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. Brazzaville, World Health Organization, Regional Office for Africa, 2008.

5 WHO, Addis Ababa Declaration on Community Health in the African Region, Brazzaville, World Health Organization, Regional Office for Africa, 2006.

6 WHO. The World Health Report 2008–Primary Health Care: now more than ever. Geneva, World Health Organization, 2008.

7 For example: WHO, Framework for the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: achieving better health for Africa in the new millennium. Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/4).

8 www.sustainablemeasures.com/Training/.../Cmmunty.html, accessed on 18/02/2010.

utilization rates are higher.[9] One successful example is the Onchocerciasis Control Programme's community-directed treatment with ivermectin.

6. The African Region has made progress in promoting and strengthening community involvement in health development.[10] However, there is still a weak interface between communities and the formal health care delivery system. It is necessary to promote and protect community ownership and participation to enable communities to benefit from global advances in medical technology. Communities need to participate in ensuring universal coverage, comprehensiveness, continuity and people-centred health services to improve health outcomes including the health Millennium Development Goals (MDGs).

7. Progress towards achieving the MDGs is slower than expected. Only six countries (Algeria, Cape Verde, Eritrea, Malawi, Mauritius, Seychelles) are on track to achieve MDG No. 4.[11] While the average annual reduction rate needed to achieve MDG No. 5 in the Region is at least 5.5%, it was only 0.1% annually between 1990 and 2005.[12] The prevalence of noncommunicable diseases such as cancer, cardiovascular diseases and road traffic accidents is also rising.[13]

8. This document highlights issues and challenges and proposes actions to improve health service delivery and community involvement.

ISSUES AND CHALLENGES

9. Districts are the hubs for the coordination and management of planning, implementation, monitoring and evaluation of central government policies. These actions require a district health management team that is competent in leadership and governance. However, in most countries in the African Region, there is a paucity of competent teams at district level. There are no formal approaches to develop leadership and governance competencies or to improve the adequacy, qualitatively and quantitatively, of members of district management teams.

10. In the African Region, the coverage of essential health interventions is inequitable and not universally accessible. Less than 50% of people with common illnesses obtain the required treatment. For example, only 38% of those needing treatment for pneumonia and diarrhoea are actually treated. Only 40% of those with malaria are treated and, on average, only 3% use artemisinin-based combination therapy, with rates ranging from <1% to 13%.[14] Only 29.5% of mothers exclusively breastfeed their babies in their first six months.[15] In addition, resource allocation favours curative services at high cost while neglecting primary prevention and health promotion which could prevent up to 70% of the disease burden.[16] This is due to ineffective priority setting mechanisms, poor integration and lack of harmonization and alignment to a single national strategic health plan.

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[9] WHO. Community health in the African Region. In: Proceedings of the joint UNAIDS, UNICEF, World Bank and WHO International Conference on Community Health, Addis Ababa, 20–22 November 2006, page viii.

[10] WHO, Addis Ababa Declaration on Community Health in the African Region, Brazzaville, World Health Organization, Regional Office for Africa, 2006.

[11] WHO. Towards reaching the health-related Millennium Development Goals: progress report and the way forward. Brazzaville, World Health Organization, Regional Office for Africa, 2009 (AFR/RC59/3).

[12] UN. The Millennium Development Goals report. New York, United Nations, 2007.

[13] WHO. The world health report 2008–Primary Health Care: now more than ever. Geneva, World Health Organization, 2008, page 8.

[14] UNICEF. Countdown to 2015: tracking progress in maternal, newborn and child survival: the 2008 report. New York, United Nations Children's Fund, 2008.

[15] WHO. 2009 world health statistics. Geneva, World Health Organization, 2009.

[16] WHO. The world health report 2008–Primary Health Care: now more than ever. Geneva, World Health Organization, 2008, page 53.

11. Health services are expected to be people-centred, i.e. based, holistically, on people's health needs, including physical, emotional and social concerns beyond disease categories. They should be comprehensive, including health promotion, prevention, diagnosis, treatment, referral, long-term care and social health services. They should also be continuous, applying coherent management until the problem is resolved or the risk factor has disappeared.[17] In most districts, services are still not people-centred, continuous or comprehensive. There is no institutionalization of the concept of primary care as the hub for coordination of health services for well-defined communities within the district. In addition, there is no decentralization of financial and other resources for management by a primary care team at this level.

12. The organization of service delivery requires focused and coordinated efforts. Health services including referral systems in most countries of the Region are not organized in a manner ensuring the continuum of care, efficient utilization of resources and reduction of hospital visits. For example, there is insufficient coordination of the continuum of care regarding HIV testing and counselling; prevention of mother-to-child transmission of HIV; necessary additional HIV laboratory work; and treatment with antiretroviral medicines. This weak coordination makes it difficult to improve the quality and quantity of integrated supervision even among related services.

13. An estimated 63% of countries facing the human resources for health (HRH) crisis worldwide are in the African Region.[18] The Region manages 24% of the total global disease burden using only 2.3% of the total global health workforce.[19] There is inadequate scaling up of the production of health workers and insufficient incentives to recruit, retain, develop and appropriately and equitably deploy personnel to offset the impact of the HRH crisis.

14. If universal coverage of essential health services is to be achieved, health financing must be in the form of prepayment in order to eliminate barriers to access, social protection must be organized, and inequalities must be shown and the un-reached populations must be reached.[20] Many countries are yet to institutionalize robust prepayment systems that eliminate impoverishment of families due to out of pocket expenditure at the point of service.

15. Health infrastructure, medicines and health technologies are vital in the provision of comprehensive and quality health services. The challenge is to develop and effectively manage an efficient procurement system; equitable distribution; and rational use of health infrastructure, medicines and other health technologies to improve the quality of services provided at district and lower levels.

16. At district level, it is very important to measure progress towards attainment of the MDGs and other national and international goals. The current measurements for these goals are mostly retrospective and are thus too late for districts to make any necessary corrections for improvement. For example, the 2008 countdown report on the attainment of MDGs by 2015 used 2005 maternal mortality data.[21] There are inadequate mechanisms to strengthen health information management systems such that districts are unable to detect, during the first month of implementation, the level of progress towards the attainment of annual or longer term goals. In addition, there is inadequate data gathering and analysis for timely and effective decision-making.

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[17] WHO. The world health report 2008–Primary Health Care: now more than ever. Geneva, World Health Organization, 2008, pages 46, 48 and 49.
[18] WHO. The world health report 2006–Working together for health. Geneva, World Health Organization, 2006, page 12.
[19] WHO. The world health report 2006–Working together for health. Geneva, World Health Organization, 2006, page 8.
[20] WHO. The world health report 2008–Primary Health Care: now more than ever. Geneva, World Health Organization, 2008, page 25.
[21] UNICEF. Countdown to 2015: tracking progress in maternal, newborn and child survival: the 2008 report. New York, United Nations Children's Fund, 2008.

17. The success of service delivery and improvement in district health systems are measured through the health status of the communities within the district. Communities have a dual role: ensuring that their health needs are met by local government, and contributing effectively towards health development by living responsible lives that emphasize family values for health promotion and disease prevention. Many communities do not have enabling environments; others are mainly passive partners in health development because they are detached from national development agendas.

18. Districts perform well when they are fully decentralized in the form of devolution. However, in many countries, districts do not have full financial autonomy and the responsibility for staff recruitment and development. In addition, the necessary technical, political and administrative conditions do not exist at the level to which authority is to be transferred.[22] As a result, there is minimal benefit of decentralization at district level, such as participatory planning and organization; effective communication with communities; effective management and coordination of programmes and services at all levels; adequate intersectoral collaboration particularly with the agricultural, education, water supply and waste disposal sectors; and improved services in terms of relevance, quality, availability, accessibility and acceptance on the part of the users.

ACTIONS PROPOSED

19. All the actions proposed are meant to be implemented at district level with guidance and support from the central level and involvement of the local assembly. Each community should be a strong partner in visualizing, planning, implementing, monitoring and evaluating these actions.

20. **Strengthen the leadership of district health management teams:** There is need to ensure that district health systems have technically-competent health management teams that lead governance at the district health office, district hospitals, health centres, health posts and communities. District health management teams should provide outstanding leadership in service delivery, health financing, information, health technologies and HRH management. Teams should be developed using formal and sustainable capacity-building programmes.

21. **Implement a comprehensive package of essential health services:** The comprehensive health services package should be based on population health needs, barriers to equitable expansion of access to services and available resources. The package needs to be considered as the minimum that can be provided during a specified time frame. There is need to consider the complementary capacities of the different levels of care and the necessary balance among promotive, preventive, curative and rehabilitative services.

22. **Improve organization and management of health service delivery:** In order to ensure availability, quality and continuum of care and to reduce the frequency of hospital visits by patients, there is need to use effective service delivery models that promote efficient referral systems and integration of services, e.g. Integrated Management of Childhood Illness. There is need to improve the quality and quantity of integrated supervision to ensure continuity of quality health care.

23. **Institutionalize the concept of primary care as the hub of coordination:** People-centred, comprehensive and continuous health services require a hub of coordination close to a well-defined community. The hub comprises a primary care team that is responsible for all the health needs, including referral, of the community. Decentralization of necessary financial and other

[22] Gorgen Helmit et al. The District Health Systems – Experiences and prospects in Africa, Manual for Public Health Practitioners, Deutsche Gesellschaft für, Postfach 5180.65726 Eschborn, Germany, 2004, page 43.

resources to this hub is a prerequisite for ensuring accountability for results and efficiency in resource allocation and use.[23]

24. **Improve the adequacy of HRH and introduce a team approach in performance assessment:** There is need to invest in the production, recruitment and retention of HRH and to use standards to distribute personnel equitably across the public, private and nongovernmental health facilities based on service needs while implementing an incentive package especially for rural-based health workforce. A team approach in assessing performance should be one of the means to motivate staff and improve their competence, responsiveness and productivity. Development and implementation of algorithms, mentoring and supervision of HRH should be promoted and guided by a strong regulatory framework to ensure adherence to HRH norms and standards, good quality and continuum of service.

25. **Develop prepayment mechanisms such as social health insurance and tax-based financing of health care:** In order to ensure universal coverage, there is need to eliminate the impoverishment resulting from catastrophic out-of-pocket expenditure at the point of service by institutionalizing prepayment mechanisms. Funds should be pooled regardless of their sources. Financial management skills of staff should be strengthened by promoting transparency, accountability and accuracy.

26. **Strengthen procurement, supply and distribution processes and minimize commodity wastage:** Countries should use transparent procurement procedures to achieve value for money. There is need to institutionalize regular inventories and improve supply management procedures to ensure regular availability of essential medical products and rational use of essential medicines, commodities, equipment and to invest in infrastructure development and maintenance.

27. **Clarify district responsibility in achieving national, international and millennium development goals:** Annual national targets should be reflected in each district and community on a monthly basis taking into account the catchment population. This is especially helpful for assessing progress during the first month of implementation and taking corrective measures on time. In addition, data gathering and analysis should be improved to institutionalize evidence-based decision-making.

28. **Empower communities (including women, the elderly, children and other disadvantaged groups) to take appropriate actions for the promotion of their own health:** As a true partner in health, communities need to be involved in the planning, organization, management and implementation and monitoring of health service delivery. They should advocate for better health services from government including health information, skills and financial and other resources to ease their participation. The focus of community-based interventions should be at individual and family levels.

29. **Create an enabling environment for devolution of health sector responsibilities to the districts:** The local assembly and the 'health districts' should have adequate capacity to ensure smooth transfer of central level responsibilities to the districts so that they can attain full financial autonomy and take up responsibility for staff recruitment and development. The political and administrative conditions should be strengthened to ensure effective institutionalization of participatory planning and organization; effective communication with communities; effective management and coordination of programmes, services and partners including the private sector at all levels; and coordination of intersectoral collaboration particularly with the agricultural, education, water supply and waste disposal sectors.

30. The Regional Committee is invited to examine this document and endorse the actions proposed.

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[23] WHO. The world health report 2008–Primary Health Care: now more than ever. Geneva, World Health Organization, 2008, page 55.