

53987

WHO/SHS/DHS/95.1
Original: ENGLISH
Distr: Limited

DISTRICT HEALTH SYSTEMS:

GLOBAL AND REGIONAL REVIEW

BASED ON

EXPERIENCE IN VARIOUS COUNTRIES

World Health Organization
Division of Strengthening of Health Services
District Health Systems Unit

1995

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DISTRICT HEALTH SYSTEMS: A REVIEW

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PREFACE

During the first eight years of the implementation of the Declaration of Alma-Ata (1978), little emphasis was placed on strengthening district health systems. However, in May 1986, the World Health Assembly adopted a resolution calling on Member States and WHO to place much more emphasis on district health systems for primary health care. Since that time, the main challenge for countries and WHO has been how to turn the district and local health system into one truly based on primary health care and able to function to maximum effect. This document presents successes and shortcomings experienced in attempts to develop population-based operational health systems in both rural and urban areas.

We are grateful to Dr Françoise Barten, Dr T. Heikens, Dr Mya Tu and Dr Elizabeth Quamina for their valuable assistance in the development and analysis of this document.

The contributions of our colleagues in the Regional Offices of WHO and the District Health Systems unit in headquarters (Dr G. Dorros, Dr H. M. Kahssay, Mr Ole Teglgard, Dr F. Siem Tjam, and Mrs Carole Riley) are also much appreciated.

Dr I. Tabibzadeh
Chief, District Health Systems
Division of Strengthening of
Health Services
WHO headquarters, Geneva

DISTRICT HEALTH SYSTEMS: A REVIEW

INTRODUCTION

Since its inception in 1978, the concept of the district health system has come to be accepted as a valid one and, in addition to the WHO headquarters Programme on Strengthening District Health Systems based on Primary Health Care, there have been the many activities of the WHO Regional Offices in support of the strengthening of district health systems in the countries of their respective regions. A number of international, multilateral, and bilateral aid agencies have also supported the development and strengthening of district health systems, either through the WHO programme mentioned above or through direct bilateral support to countries.

This review aims at covering the development of district health systems in general, and not just the activities of the programme administered by WHO headquarters.

Admittedly, details of activities by other aid agencies supporting countries directly and bilaterally are not always forthcoming, but an attempt has been made to incorporate such information as is available.

The components of district health systems include the overall organization, planning, and management of resources, as well as the technical implementation of the elements of primary health care (such as immunization, maternal and child health, etc.). This review however, is concerned only with the organizational and managerial aspects and with the institutions dealing with the components of primary health care. The technical aspects of the implementation of the elements of primary health care are covered in a separate review. Moreover, although health systems research is one of the approaches used in the development and strengthening of district health systems, this review does not describe the results of such research separately, but incorporates them into the relevant sections of the review.

This document reviews the development and strengthening of district health systems in countries as a result of the support provided by the WHO Programme of Strengthening District Health Systems based on Primary Health Care, the WHO Regional Office's Programmes on District Health Systems, and by international, multilateral, and bilateral aid agencies. It analyses and assesses the development of the different components and institutions within the systems.

On the basis of such reviews and analyses, it outlines issues and challenges for the further development and strengthening of district health systems based on primary health care.

Section I traces the concept and development of the district health system initiative in the context of the goal of Health for All by the Year 2000 with primary health care as the key approach, and defines the district health system. It then describes the initiation of the WHO Programme of Strengthening

District Health Systems based on Primary Health Care, its objectives, and its approaches.

Section II is a global review of the various aspects of district health systems that have been emphasized and supported.

Section III reviews the activities of the WHO Regional Offices in implementing district health systems, and of international aid agencies in supporting district health systems.

Section IV outlines some of the major issues and challenges involved in the strengthening of district health systems.

SECTION I

BACKGROUND

Health for All by the Year 2000

1. The ultimate objective of the World Health Organization, as defined in Article 1 of its Constitution, is the attainment by all peoples of the highest possible level of health. Also enunciated in the Constitution is the principle that health is one of the fundamental rights of every human being.

2. Yet, when the world health situation was reviewed by the World Health Assembly in 1977, the magnitude of the health problems in most of its member countries was indeed alarming, and this was coupled with the inadequate and inequitable distribution of health resources throughout the world. Faced with the urgent need to improve the situation, the World Health Assembly passed a resolution (WHA 30.43) in which it decided that the main social target of governments and of WHO in the coming decades should be the attainment of all the people of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life.

The Alma-Ata Declaration

3. Subsequently, the International Conference on Primary Health Care, which was held in Alma-Ata in the former USSR in 1978, issued the Alma-Ata Declaration endorsing the goal of Health for All by the Year 2000, and clearly stating that primary health care is the key to its attainment.

Implementation of Primary Health Care in the Eighties

4. Much progress has been made in primary health care since the Alma-Ata Conference, but this has been either at the national level in the development of policy, management capability, and training capacity, or at the local level in the organization of community action, training, and the utilization of community health workers. Weakness in national efforts to pursue the goal of Health for All has been due to problems of organization and management at the district level, as well as lack of adaptability to change and the changes faced by Ministries of Health at the policy level.

5. The decade of the 1980s was characterized by the international debt crisis, the application of structural adjustment policies in many developing countries and a reverse flow of resources between North and South. This resulted in a slowing-down of health development efforts in these countries.

The World Health Assembly Resolution on District Health Systems

6. In May 1986, the Thirty-Ninth World Health Assembly reviewed the Global Report on the Evaluation of the Strategy for Health for All, based on reports by Member States, and the Seventh Report on the World Health Situation. The review revealed that, while in some countries impressive progress had been made in strengthening health infrastructures, and in coverage by health services, in a large number of countries there had been a diffuse expansion of the health infrastructure which resulted in formidable managerial and financial problems in trying to provide for even the essential elements of primary health care. The planning and management of primary health care programmes were still carried out at the central level with little understanding of the problems and constraints at the community level.

7. On the basis of this review, the Thirty-Ninth World Health Assembly adopted a resolution (WHA39.7) in May 1986 in which it urged countries to strengthen further the health system infrastructure based on primary health care, laying particular emphasis on district health systems based on primary health care, and defining targets for the integrated delivery of essential elements of primary health care until all districts and all elements were covered. It also called on WHO to intensify support for countries in this regard.

8. It was in the light of this that WHO proposed an intensification and targeting of national action programmes for primary health care, focusing on manageable units within countries - i.e., geographical areas small enough to permit effective and efficient management, yet large enough to make it feasible to include all the ingredients required for self-reliant health care. These organizational units were called "districts", but are known by various names in different countries, e.g., areas, blocks, *thanas*, municipalities, etc.

Definition of District Health Systems

9. In order to facilitate a common understanding, the WHO Global Programme Committee in 1986 defined the district health system based on primary health care as "a self-contained segment of the national health system comprised of a well-defined population living within a clearly delineated administrative and geographical area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative and rehabilitative health activities".

10. The district, which is the peripheral organizational unit of national health systems, is particularly suitable as a channel for services to communities, and as a link with more central policies and support systems. It is at district level that the health needs of the population can best be matched with the resources to be allocated.

The District Health System Initiative

11. District health systems are not a new idea. Decentralization and central control have long been important political and organizational strategies. The management of health services for defined geographical areas from regional, provincial, or district centres has been a common feature of most health systems in developing and developed countries alike. The district health initiative represents a renewed effort to implement primary health care and to strengthen the intermediate level of the health system in order to provide the necessary support and stimulus. To succeed, primary health care must have as its cornerstone a clear and firm national policy and unwavering support from the top. It is at the district level that "top-down" and "bottom-up" approaches meet. Much depends, however on the people in the district who are charged with the management and implementation of primary health care strategies.

12. Yet, it is precisely in this area of organization and management at the district level that many countries are weak. Often, an existing centralized, vertical management of health programmes has led to wastage of resources and under-utilization of community resources and manpower. A related problem encountered in promoting primary health care at the district level has been the difficulty of integrating vertical programmes into comprehensive plans of action at district level.

13. The district health system initiative and approach were therefore designed to help countries implement their primary health care strategies more effectively, the district being the most appropriate level for coordinating "top-down" and "bottom-up" planning, organizing community involvement in planning and implementation, supporting health care workers, and improving coordination between the government and private health sectors. In addition, many key development sectors are represented at this level, thereby facilitating intersectoral cooperation and management of services across a broad front.

Initiation of the WHO Programme on Strengthening District Health Systems based on Primary Health Care

14. WHO's Division of Strengthening of Health Services therefore initiated its district health system programme on the basis of the above considerations.

Development Objectives

15. With regard to development, the objectives of the WHO Programme on Strengthening District Health Systems are to improve the quality of life and reduce mortality and morbidity by strengthening the effective implementation of primary health care in participating countries, with due consideration to equity, effectiveness,

efficiency, and flexibility within the context of national, regional, and global strategies for reaching the goal of Health for All.

Objectives and Approaches of the Programme

16. The immediate programme objectives were:

- (1) to develop and test processes for initiating more effective and sustainable health action in selected districts, in order to enhance and accelerate their implementation of primary health care and to improve health care and the health status of their populations, using an action research approach;
- (2) to promote and support the adaptation and country-wide adoption of both the strategies developed for improving district-level functioning and the processes employed for initiating and managing change, through promotion, training, and information support, and through resource mobilization;
- (3) to promote the adaptation and adoption on a global scale of strategies developed and tested in specific districts and countries.

The approaches adopted in pursuit of the objectives of the programme were:

- (1) support for country-wide action for district development;
- (2) support for "learning-by-doing" research and development in selected district;
- (3) promotion, training, and information support (including preparation of guidelines and tools); and
- (4) resource mobilization.

SECTION II

ASPECTS AND CRITICAL AREAS OF DISTRICT HEALTH SYSTEMS SUPPORTED IN VARIOUS COUNTRIES

17. This section reviews the development of district health systems as a whole and covers those activities supported by the WHO Headquarters Programme of Strengthening District Health Systems, the WHO Regional Office programmes, and the activities supported by international, multilateral, and bilateral aid agencies.

Critical areas

18. Since the introduction of the WHO programme, a number of areas of critical importance for the success of a primary health care strategy at the district level have been discerned. These are: district level. These are:

- organization, planning, and management,
- finance and resource allocation,
- information,
- community involvement in health,
- intersectoral action crucial for the sustainability of primary health care in the district,
- capacity-building,
- institutional strengthening:
 - (a) health centres,
 - (b) district hospital,
- urban district health systems,
- quality assurance.

Organization, Planning, and Management

19. The establishment and functioning of effective, efficient, and equitable district health systems, and the implementation of the primary care strategy itself, require the full participation of the population and a wide range of organizations and institutions. Many different participators and potential partners in health development are present in the district; individuals, families, communities, and public and private health organizations, many of them involved in health care development. Some of them are involved in the health sector programme, or in running services and/or owning health facilities, while some are involved in intersectoral activities. The district health systems aim at integrating these participators into one adaptive system, and strengthening primary health care strategies through concerted action.

20. While the political arm of the district health systems is the district council or local government body that empowers the system with resources and authority, responsibility for technical executive tasks and daily management rests with the district health management teams.

21. In order to strengthen the organization, planning and management capabilities of the district health management teams in the various countries, several approaches were employed:

- in Ethiopia, support was provided for research on the development of management information systems and improved financial and planning management at the district level;
- support was provided to Pakistan for the production of case studies on information systems for primary health care;
- in Ghana, a national meeting was held to discuss the problems facing the health management team including those caused by strong vertical programmes dominating other health initiatives;
- training has been part of all the programmes for strengthening the district health management system and for strengthening the implementation of primary health care; training-related activities included training of medical graduates in Ethiopia for leadership roles in district management through a two-year Master of Science programme;
- in Oman, the Wilayat (district) health system focuses on improving the managerial capabilities of its Directors of Health Affairs. Baseline data for planning purposes were generated all over the various Wilayats.

22. In all the countries covered, the support activities have brought, in varying degrees, new ideas and visible improvements, mainly in planning and management, but there are still many weak areas.

23. Comparative studies on the structure of district health systems have been carried out in diverse countries (Colombia, Indonesia, Jamaica, Nigeria, Philippines, Senegal, Sudan, and Yemen), using different approaches. Many countries have reported the existence of various types of committee dealing with health and health issues. The studies describe and analyse health development structures within district health systems and assess their contribution to health. The results should enable WHO to provide national authorities with technical advice and support on various aspects of health development structures in district health systems.

24. Vertical programmes have become an entrenched tradition with the relevant power structures, transport rights, etc. To date, the coordination of the many separate programmes (maternal and child health, immunization, AIDS, leprosy etc.,) has been only partially successful. However, the WHO Programme has been successful in achieving active communication between the various services that compose the district health system. This collaboration has led to many improvements, including the shared use of resources like transport.

25. Experience in integrated health care delivery in different countries was reviewed and discussed at an interregional consultation meeting held in Bandung in August 1993. In addition, a review of experience in various vertical programmes such as immunization, malaria eradication, diarrhoeal disease control, etc., was conducted.

26. A closely related activity is the research and development project in Chipinge District, Manicaland Province, Zimbabwe. In this project, which started in October 1992, the community of Chinymukwakwa has initiated health development activities and community mechanisms for planning and monitoring them. At the same time, the health centre continues to train local community development workers and local healers to refer cases of malaria and other communicable diseases. The District Health Nurse acts as a catalyst in stimulating intersectoral activities in the project area. She attends meetings of the Rural Development Council, as the district health representative.

27. The district health systems in the countries being supported have, up to now, not yet addressed the problem of the quality of care, and this has to a certain extent contributed to the "bypass" phenomenon. Where services are inadequate, because of absence of personnel or lack of skills or supplies, the community soon learns to bypass lower-level services and go directly to the district hospital or one at an even higher level. In Saudi Arabia, however, manuals on quality of care at the health centre level have been developed, focusing on operational aspects.

28. The coordination of the many components of the comprehensive district health system is an important function of the district health management team which is often composed of only government health personnel. The development of a network harnessing the contributions of the private sector (physicians, nurses, midwives, pharmacies, drug stores) nongovernmental organizations, traditional healers, and environmental sanitation services can have a positive impact on the accessibility and availability of appropriate health care. The responsibility of the district health team should therefore be to coordinate the total delivery of health care within the district and to explore mechanisms for achieving this.

29. Countries continue to face enormous and difficult tasks in bringing about the necessary improvement in the management of district health systems. A variety of approaches that have been field tested will therefore need to be made available to the countries. Support will need to include strategies designed to sustain the strengthened system through maintenance of staff morale and community involvement, based upon full participation and education.

Finance and Resource Allocation

30. The need to improve district financial planning and management is evident. Yet experience in Ethiopia suggested that most district health managers consider this to have low priority among management concerns. Moreover, few managers at any level are given the flexibility needed for the planning, allocation, and management of financial and human resources. In addition, managers have no incentive for seeking to manage their overall resources better. For these reasons, it was concluded that,

rather than attempting to generate and force activities in the area of financial management, it would be best to incorporate them within existing managerial activities or initiatives.

31. It was observed that, in some countries, there was administrative inability or unwillingness on the part of the central authority to delegate financial responsibility to regional and district bodies.

32. Where the strengthening of district health systems has been active, budgeting is at the district level. The various health services of the district prepare budgetary proposals which are, as in the cases of Ghana, Indonesia, and Tanzania, discussed by the District Health Management Team and sent in their final version sent to the region. The region collates all district budgets for forwarding, together with the regional budget, to the Ministry of Health. In past years, government funds have not increased in line with the needs and population: when cuts are made, the district is hardly ever informed of their extent. In Sudan, four districts were selected where there are Health Management Area Teams to provide technical support to communities and help them identify health priorities. Those teams have used the methodology developed by WHO under the name of District Team Problem-Solving Technique.

33. The managements of district health systems frequently have to curtail planned and necessary activities, at very short notice, owing to the failure of budgeted funds to arrive. This has done nothing to improve the reputation of the systems in the eyes of the population.

34. For the district health team to respond to needs promptly, reduce wastage, and extend the life of equipment by timely maintenance, it is necessary for the district to be given control over financial allocations from all sources. This may require changes in central government policy and financial regulations. Improvement in financial management at district level should result in greater competence in accounting and expenditure control. This is an area in which there is considerable room for improvement. Countries should be supported in their efforts to analyse existing national policies and procedures and take measures to facilitate the delegation of financial management to the districts. With support from WHO, Libya is reviewing its national health system with a view to its further reorientation towards primary health care.

Information

35. The effective decentralization of planning, budgeting, and decision-making is dependent upon a sound information base. The development of a health information system at district level is therefore, an important component of activities aimed at improving management.

36. Support has therefore been provided for strengthening health management information systems in the districts. Critical issues include: the use made of information already being produced; the quality of the available information; data

collection and reporting formats and procedures; and the production and use of information on financial resources.

37. Information proceeds typically from the lowest-level health centres via the district and regional levels to the Ministry of Health. The "vital horoscope" health information system of Iran is valuable for monitoring progress and as a management tool. Unfortunately, in most countries, information systems are not so well developed and the conclusions drawn from information received are not fed back to the original source.

38. In most instances, the forms to be filled in at the lower levels are cumbersome and time-consuming: standardized simplified forms that can be quickly evaluated are definitely needed. These should take into consideration the limited nature of the information available, particularly in respect of morbidity and mortality. Epidemiologically useful information is at present very limited.

Community Involvement in Health

39. Community involvement in health has received widespread support and has been accepted as fundamental to health development.

40. The WHO programme has supported the development of a "canalization" model in Guatemala for establishing links between health centres and communities. This has led to improved community participation and development, as well as encouraging a two-way flow of health services to the people and of people to the health centres.

41. Case studies on community involvement within district health systems were conducted in Bolivia, Nepal, and Senegal, to provide examples of practice in different countries. An analysis of these, together with guidelines for assessing progress in community involvement in the context of district health systems, has been produced for use by district health systems.

42. There has been widespread use of community health workers who come from the community and are selected by and remunerated by the community. A research and development project on ways of strengthening the performance of community health workers was supported in 13 countries. An interregional meeting held in November 1990 to assess the results achieved and the lessons learned, highlighted three areas for further consideration: attitudes of health personnel towards community health workers; the structure and organization of district health systems in support of community health worker programmes, and the cost and financing of such programmes at district level. With regard to the last point, case studies in Jamaica and Thailand, revealed that, while the cost of specific aspects of community health workers programmes in districts, such as training and drug supply, were well known and more or less provided for, the cost to the health services providing referral and technical support to these programmes was substantial, but has not been accounted for so far.

43. However, despite numerous activities and extensive rhetoric on the subject in the past decade, widespread and effective community involvement in health is still a long way off and its overall development has been slow. However, comprehensive programmes of integrated and sustainable development based on self-reliance and self-management by the community, have been launched, under the name of Basic Minimum Needs, in Egypt, Jordan, Somalia, Sudan, and Yemen. This approach emphasizes community organization, community capacity development and financing.

44. Despite many years of international assistance programmes, villages without potable water, latrines, or electricity are still legion. In these villages, often dependent on subsistence economies, energies curbed by disease are soon exhausted, and there is little room for anything else but the battle just to subsist. Generating funds in these communities is difficult. If the service is of poor quality, which it so often is at the village and health post level, the farmer is not willing to contribute. Payments to village health workers are mostly irregular, sometimes in small amounts of cash or in kind, and certainly provide little motivation.

45. The economic difficulties of the 1980s, which continue to have an adverse effect on health development, may have contributed to the slow development of community involvement. However, a more fundamental reason could be that the changes and efforts required to achieve it have been underestimated or even misunderstood.

46. In the majority of countries, community involvement in health is still mostly considered mainly as the mobilization of community resources to support an externally determined programme or activity. Most countries have yet to commit themselves to a more active approach, particularly in the area of decision-making.

47. There is universal recognition that sustained development in health will be achieved only when there is partnership with the community. It has also been recognized that decentralized district or local health systems are necessary for effective community participation in health development. Necessary, but not sufficient, District Medical Officers and their teams often do not appreciate the value of community involvement and are not sufficiently motivated or skilled to facilitate and support it. A decentralized district health system based on the primary health care approach is one that resolves the contradiction between the authoritative orientation and structure of most health services and the conditions necessary for participation.

Intersectoral Action

48. Sustained improvement in the health status of populations can only be achieved through the concerted efforts of other social and economic sectors. While multisectoral action has been recognized from the beginning as a key strategy for achieving Health for All, putting it into practice has proved to be the most challenging and difficult of tasks at all levels.

49. The traditional approach to intersectoral coordination has been concerned mainly with linkages within the government sectors dealing with education and

agriculture, and the agencies responsible for water supply and housing. In practice, such linkages have been demonstrated to be far more effective at the district than at the central level and must be pursued. Other intersectoral efforts should be explored at district level: for example, collaboration with private business enterprises, local media, and providers of public transport. The development of leadership and advocacy skills among health personnel is an important factor in achieving success in this aspect of district health system development.

50. District development committees provide an important opportunity for coordinated socioeconomic development in which all sectors, including health, can play a part and for the promotion of activities in other sectors that will benefit health. Adequate use of this opportunity is rare. Individual sectoral priorities and different administrative structures often prevent the pooling and sharing of resources between sectors.

51. The development of local government health plans at the district level has proved to be one way of securing higher priority for health concerns on the agenda of district development and helping each sector to define its role in health activities within the district.

Capacity-building

52. The development of human resources and capacity-building has been among the major activities supported in a large number of countries. It has been carried out through courses, workshops, and seminars on management, and has certainly created an awareness of management and working as a team. Apart from management training, there is a need for more technical training for health personnel. Many field health workers (medical assistants, auxiliary nurses, auxiliary laboratory technicians, and others) have not had any continuing training courses in years. Manuals have been produced but are not sufficiently known at district level.

53. One important area that has been supported is the development of integrated learning materials. Training of health workers at the district level has been left, in many countries, to the vertical health programmes. This has resulted in duplication of materials, fragmentation of training resources, inadequate training of the majority of health workers, and institutionalized disincentives for the delivery of integrated health care.

54. To address this issue, a project was undertaken for the purpose of developing a decentralized system for training and learning at the district level. Integrated learning materials based on technical and managerial information available in WHO have been developed in three lots: the first is for facilitators, the second contains training material for health workers, and the third is concerned with providing essential health care at the local level through an integrated approach. The materials are being field-tested in a number of countries.

55. Extensive research is needed on the human resources required at the district level. The establishment of realistic health personnel requirements, in order to achieve the most efficient use of resources, is another priority. In-service training

relevant to local health problems is recognized as one means of improving the morale of the staff by increasing their abilities, confidence and job satisfaction. This must be linked to more efficient management of district health personnel including their appropriate deployment.

Institutional Strengthening

(a) Health centres

56. The term "health centre" covers all health facilities other than hospitals. It is usually the facility at the first-contact level, and has a unique potential, as well as responsibility, for increasing people's ability to solve their own problems with confidence. It provides a full range of health promotion and preventive services, as well as curative care limited mainly to ambulatory patients. It has a multidisciplinary team capable of providing the range of services mentioned above.

57. A Working Group on The Role and Functions of Health Centres in District Health Systems met in Geneva from 12 to 16 July 1993, with participants from Dominica, Indonesia, Nigeria, Philippines, and Senegal. It reviewed and extensively revised a draft document entitled "The health centre in district health systems", reviewed research proposals from each of the participating countries and prepared the global framework/design for a multicountry research and development project, including research strategies and a timetable. Mongolia and Uganda were added to the list of participating countries later.

58. At present the following two versions of the health centre concept exist.

- The **generic health centre** is a self-contained segment of the national health system guided by the district health service of which it is a part. It comprises a variety of interrelated components that contribute to health in homes, schools, workplaces, and the community including support for self-care administered at home. These components are supported by a professional staff, together with appropriate diagnostic, laboratory, and logistical services, and coordinated in a dedicated management structure.
- The **reference health centre** differs from the generic health centre in that it is a functional concept that can be realized by strengthening one or more health centres to improve referral within the health system in urban areas. Thus, in addition to its generic health centre functions, it provides essential surgical, maternity, and medical care, as well as carrying out preventive and promotive activities in the neighbourhood it serves. The reference health centre lightens the burden of the first-referral hospital by taking over certain routine interventions, at the same time bringing appropriate care closer to the population at only a fraction of the cost of similar operations performed in local hospitals. Health centres, including reference health centres and hospitals, are components of a health care system, each playing a different but complementary role.

59. Despite the fact that there have been several studies documenting the linkages between health centres and the community, little information is available on the cost-effectiveness and successful functioning of the health centre in the referral system or on its specific role, as distinct from the hospital, in the decentralization of national and district health systems. The potential role of the health centre as an additional growing nucleus for specialized community care needs to be explored. Health centres could certainly take on a larger share of health service provision in the district.

(b) District hospitals

60. While the hospital is universally accepted as the facility where the sick are treated, its role in the health system has changed over the last several decades in response to national socioeconomic and political influences, professional pressure, and technological advances in the field of health and medical services.

61. The district hospital in this context connotes all hospitals at the first-referral level, whether in metropolitan or in rural districts. Within the same district other hospitals may function - for example, a regional or provincial hospital representing the next step in the referral system, or even a teaching hospital, coincidentally located in the same geographical area. Similarly there may be profit-making, non-profit, or specialist hospitals in the area.

62. Although activities in support of district hospitals under the District Health Systems Programme have been few (e.g., a study on increasing their effectiveness in Zambia), a large number of studies on various aspects of the district hospital have been carried out by individual institutions and agencies. These have been incorporated in a review, available from WHO.¹

63. Studies of hospital functions have been undertaken, in urban as well as rural districts, both for district hospitals and the larger teaching or central hospitals. A number of national studies and position papers have been commissioned and collected to identify trends and opportunities in Chile, Colombia, Egypt, Indonesia, Nigeria, Philippines, Tanzania, and Viet Nam.

64. A Regional Consultation on the Profile of District Hospitals in WHO's African Region, was held in Brazzaville from 30 May to 3 June 1994.

65. Studies have shown that hospitals at the district level in a number of countries e.g., Guatemala, Thailand, sub-Saharan countries, also provide services that are typical of facilities at the first-contact level i.e., the health centres. Such involvement of the hospital in primary health care activities has a number of undesirable consequences, the most important of which is that it forces the hospital to work below its potential by overloading it with work that would be more appropriate for a health centre.

¹ The role of the hospital in the district. Current concerns.
Geneva 1992, SHS Paper No 2, (WHO/SHS/CC/90.2)

66. The district hospital is the health facility at first-referral level, and has a defined area of responsibility within which there may be a number of additional health centres or units. The distribution of tasks between the peripheral community-based health facilities and the hospital should therefore be unambiguous and unequivocal.

Urban Health Systems

67. Rapid urbanization and a corresponding increase in the number of urban slum-dwellers, living in conditions of extreme poverty, particularly in the developing countries, has now become an increasingly important issue for health and municipal authorities. Support has been provided to a number of countries for analysis of the situation and action to improve the health of this high-risk group. This support also involves the reform and strengthening of local government, as well as steps to improve coordination between the local government and the national health services.

68. In urban as in rural areas, the name applied to the "district" varies from one country to another (upazila, arrondissement, township, ward, etc.,). The urban district health system should be clearly demarcated according to administrative boundaries and cover a defined area and population. A special challenge for urban health systems is that, in almost all instances in well-defined areas, two very different communities coexist: the well-to-do with relatively few health problems (apart from those created by lifestyle), and the poor with the full range of health problems (diseases due to poverty as well as lifestyle).

69. WHO studies on this subject have reached two clear conclusions: first, that primary health care is as relevant to the situation of urban areas as it is to that of rural areas; second, that the very real problems of access and intersectoral cooperation seem to stand a good chance of being tackled, only when there is a credible local facility with real roots in the community and good links to first- and second-level referral care. It is in this context that intermediate health units to be known as "reference health centres" are proposed.

70. Both these conclusions place the subject squarely in the realm of district health systems based on primary health care, with the prospect that one-half at least of the population to be cared for will be urbanites. This prospect requires that this programme should henceforth devote particular attention to the urban district variant within the generic district health system.

71. In some cities, there is a tendency to strengthen and upgrade one health centre in each urban district as a reference health centre which will function broadly, regulate referral systems, support other centres, and seek to decongest hospitals. These developments were analysed by a WHO Study Group in 1992 and its report was discussed by the WHO Executive Board in 1993. It was decided to undertake further studies in conjunction with the development of urban health systems.

72. In addition, the following studies have been supported in a number of cities in different parts of the world:

- referral systems between health units, health centres and hospitals in a low-income area (Bangkok, Thailand);
- functioning of reference health centres (Cairo, Egypt; Jakarta, Indonesia);
- functioning of a community reference infirmary (Manila, Philippines);
- functioning of a health centre connected with a medical college (Delhi and Bombay, India).

73. The magnitude and complexity of urbanization as a social phenomenon and its impact on health bring out the need to go beyond a narrow sectoral approach and to develop multisectoral collaboration as the only way of dealing the health problems of the urban poor at their roots and to solving them in a lasting manner. Building upon existing structures, partnerships between local governments, community-based organizations, nongovernmental organizations, private firms, universities, and health care professionals are strengthened in order to facilitate an integrated approach to urban health. The multiplicity of participators presents an important challenge, indicating as it does, the need for integration, rather than mere coordination or collaboration.

74. Real and effective urban capacity-building demands an emphasis on capacity assessment at community level as well as assessment of needs; it should involve all participators simultaneously and should be carried out as a continuous process. Universities and public health schools within the cities involved are important resources for research and development activities, including identification and assessment of the options, for implementation by the local and district urban authorities. Clarification of the role of government, reorientation of bureaucratic structures and personnel, and location of the interface between government services and community action are needed.

Quality Assurance

75. Quality assurance is an approach that has proved highly effective in improving the quality and efficiency of health care.

76. In deciding to introduce the quality assurance concept in primary health care, WHO clearly distinguishes quality assurance from quality control and assessment. Quality assurance is a continuous process, whereas quality control is a rather imperative and hierarchical action not dissimilar from assessment, which is often a unique activity.

77. A number of meetings on quality assurance have taken place during the last five years, in Maastricht, Pyongyang, and Shanghai, under the auspices of WHO's Regional Offices for South-East Asia and the Western Pacific, together with the District Health Systems unit of the Organization's Division of Strengthening of Health Services. Quality assurance is a rather new issue in the domain of district health systems and has so far, been mostly confined to the most obvious components in such

systems viz., hospital activities, though the Pyongyang meeting also addressed the issue of quality assurance of primary health care activities such as maternal and child health.

78. Concerns about the quality of primary health care made the World Health Assembly decide in 1989 to include quality assurance in the Eighth General Programme of Work of WHO, emphasizing "... the need to improve the quality... of support.. from the district to the community".

79. While quality assurance is gradually being introduced in the facility-bound, in-patient type of activity, there is at present little experience of its use in ambulatory care, and hardly any of its use in health promotion and preventive activities. As such, quality assurance remains a matter of assessing services or provision of care. In this area little use has been made of the strategies essential to primary health care, e.g., achieving equity, intersectoral collaboration, and community participation, and what is most important, the empowerment of communities to take their health in their own hands.

SECTION III

ACTIVITIES OF WHO REGIONAL OFFICES AND INTERNATIONAL AID AGENCIES

African Region

80. In its mid-term plans, WHO's Regional Office for Africa strongly stresses the restructuring and improvement of health service systems, in the light of the rapidly changing socioeconomic, epidemiological and demographic situation. While the concept of district health systems based on primary health care is an accepted one in the Region, less emphasis is given at the present stage to social participation in health development. In some areas of the Region no correspondence yet exists between an administrative district and a health district. Here, the district-focused concept is related to development of institutional performance, health care packages, and interventions in the context of priority areas for primary health care. In 1989 a study was undertaken, which used a set of criteria, such as existing health committees, district management teams, identification of priority technical activities, community participation, and funds available to meet minimum requirements for district programmes. This study found that over 50% of district health systems in the African Region were operational according to the above criteria.

81. Although the district health service concept has been adopted, its full implementation as envisaged in the Harare Declaration is still limited. Initial priority is given to reorienting service structures towards primary health care in order to improve coverage and the quality of care. In further support of the goal of Health for all Africans, a "new health care financing programme" at district level is being developed, on the basis of previous studies. The main features of the programme are:

- (a) a "social dialogue" between members of the community, "experts", and other parties and organizations concerned with health;
- (b) transparent and accountable multisectoral bodies/institutions at the district or provincial level stimulating a "social dialogue" based on national policies; and
- (c) the formation of national and intercountry coordinating committees to manage programmes and compare reports on experience in different countries of the Region.

82. Much of the present plans appear to hinge on technical and expert advice, allowing little room for communities to develop their own solutions and district health systems. The present regional programme for improving the level of services at the first contact level (the health centre) and the first-referral level (the district hospital) offers, if the generic district health system concept is explored, a good start to the task of expanding the role of these institutions in primary health care, as advocated in the guidelines issued by AFRO for operational support for primary health care, and the role of the district in accelerating Health for All by the Year 2000.

Region of the Americas

83. In the Region of the Americas, district health systems are known as local health systems or SILOS (Sistemas Locales de Salud). A recent analysis of the development of local health systems in 34 countries revealed that 31 of them (91.2 %) had formulated strategies and were applying them. Decentralization and delegation of authority, as well as democratization, are the main driving forces behind local health systems.

84. Bolivia, Colombia, Ecuador, Peru, and Venezuela, which are members of the Andean Initiative, have adopted, without exception, explicit policies for the development of local health systems, all having a legal foundation. Almost all the countries have strategies for decentralization or deconcentration, incentives for community participation and the development of local administrations, training for the human resources involved in these processes, and projects which mobilize internal and external resources. Of the 1615 local health systems planned by the Andean countries, 197 are in the development stage (12.2%) and have begun to apply the policies and strategies adopted by the governments.

85. All Central American countries but one have devised explicit policies and strategies for the development of local health systems, with policy lines ranging from the deconcentration of Ministries of Health to decentralization as a part of a general process of government reform, as well as policy decisions backed by general laws that affect the entire public administration, as part of national health plans or as internal directives of the Ministry of Health. The common strategies adopted to implement the policies envisage the development of the managerial capacity of local levels, interinstitutional and intersectoral coordination, the development of local planning, and support for and promotion of community participation.

86. The countries of the English-speaking Caribbean have planned 177 local health systems. Most countries have defined policies on the development of such systems and except in one country, strategies are being carried out to implement them. Policy is based either on administrative development at local levels as a sectoral effort, with decentralization as the method for developing the local health system. In one country an explicit undertaking to decentralize the health system appears in the constitution. Strategies envisage the establishment or redefinition of regionalization, an explicit definition of the roles and functions of the health team at the local level, stimulus for local planning, administration, and management capacity, support for community participation, and the appointment of an official at the central level to oversee the process at the local level.

87. Canada, Cuba, the Dominican Republic, Haiti, Mexico, and the USA have, without exception, formulated explicit policies for the development of local health systems and are carrying out specific strategies in this regard. In every case, the policies envisage decentralization. They are often backed by constitutional mandates, especially in the federated countries. The strategies adopted include the strengthening of interinstitutional and intersectoral coordination and cooperation, community participation, health promotion, the strengthening of local administrative capacity, and the adoption of general targets such as "healthy cities/districts".

88. Social participation in health has received specific emphasis. The participation of nongovernmental organizations in strengthening local health systems in the Region has been remarkable. However, reports indicate mixed degrees of success in implementing the local health systems approach and attaining social participation. The Region's health systems remain predominantly medical and curative. An integrated, social, and intersectoral focus on health is still generally lacking, and community participation still tends to be limited to utilization and collaboration. A large number of projects for the development of local health systems are being supported with external cooperation and resources, or through international lending operations.

Eastern Mediterranean Region

89. Several countries in the Region have embarked on district health system development, though with different experiences and levels of progress.

90. The significant differences between countries in the Region, economically and geographically, have considerable effects on health needs, structures, health economics, etc. This heterogeneity influences the development of district health systems, as they have to be adapted to prevailing local conditions.

91. A number of countries have started decentralization to the level of the provinces and regions, but little beyond that. However, in most districts, there already exists some type of administrative health structure. The district is conceived mostly as an administrative entity which, among other things, is due to the lack of managerial skills at district levels. A major challenge is to change the districts into functional self-sustained systems, comprising all local health-related elements (health and other sectors, public and private mix, district leadership, life of communities, etc.). Thus, districts should be active in coordinating the mobilization, allocation, and management of resources, and in opening up possibilities for active community participation, equity, and self-reliance.

92. Some countries have emphasized the health information system as a spearhead. One country has reviewed the organizational structure and job description at each level of health care. Another country has focused on the catchment areas of health posts as the planning and organizational units for the promotion of primary health care. In general, the health centres have evolved into an important source of support for other levels of care and health development structure. Their role is being expanded to cope with additional tasks pertaining to environmental health and support for the training of development workers.

93. The district health system concept has been strengthened through improved structuring of the district health team and training it in management and analysis of progress (Morocco), through creating a "District Health Directorate" (Egypt) or "Board", with members from local bodies, in addition to the "District Health Officer" (Pakistan), through developing the regional district health information system (Oman), through paying more attention to the role of the private sector, which may be encouraged with incentives/loans to build health institutions (Pakistan). The district health system in the Islamic Republic of Iran is based on a network of rural

health houses and health centres in both urban and rural areas. The efficiency and effectiveness of the health network is justified by the improvement in health indicators between 1984 and 1993, e.g., rural infant mortality per 1000 from 71 to 44 and maternal morbidity per 1000 000 live births from 230 to 80.

94. Although progress has been made, a number of obstacles in the development of the district health system concept continue to exist, e.g., areas with weak political commitment, lack of trained staff, pressure groups favouring costly curative care (Cyprus), vertical programmes which resist integrated health care as aimed in the district health system (Sudan), over-use of free health services, especially if they are easily accessible (Qatar, Tunisia), keeping decentralization as a principle but with minimal implementation (Morocco), etc.

European Region

95. *"Health for All" targets: primary health care and local health care delivery.* In September 1978, most European Member States already had quite well-developed health care systems. The Declaration of Alma-Ata came, therefore, as a challenge for change. 1980 saw the approval by the Regional Committee of the first common health policy, the European strategy for attaining Health for All (unpublished document EUR/RC30/R8 Rev.2). Targets 26 to 31 of this strategy deal with appropriate care and underscore the importance of basing health care systems on primary health care, supported by secondary and tertiary care. The characteristics and principles of primary health care, as well as issues relating to human resources, management, and service quality are also addressed. By introducing indicators to monitor the progress made by Member States, the European Region provided an essential tool for surveying health policy implementation. Since then, many countries have developed their own health policy documents. Some of them have gone further, targeting health achievements at regional or local level; this often involves setting indicators relating to the content of primary health care and the use of resources for the services included.

96. *Healthy cities: health promotion and disease prevention at the local level.* In 1986, the Regional Office tried to mobilize individual cities to bring the Health for All message down to the local level at which people live, work, and play. The Healthy Cities project began with the nomination of a handful of cities that wanted to improve the physical, mental, social, and environmental well-being of their inhabitants by putting health high on municipal political agendas, by ensuring organizational and financial measures to make the desired health improvements possible, and by designing and implementing concrete, multisectoral programmes for local action. Today, the project has grown to include a network of 35 European cities and 19 national networks (incorporating 500 cities and towns), committed to building support for a new kind of public health, based on the willingness of all sectors to adopt health-promoting policies. The Healthy Cities project has given the Regional Office a wider understanding of health and its determinants at the local level, increased its involvement, and highlighted the need to overcome sectoral separation in order to respond to new health challenges. In particular, it has confirmed the need to involve partners throughout the city in health activities, above all the citizens themselves.

97. *Trends in health service systems at regional or local level.* In a number of countries (e.g., the Scandinavian countries and the United Kingdom), health service delivery was organized at a regional or local level long before 1978. An increasing number of countries have been decentralizing their health service structure since the late 1980s and this trend is catching on in the central and eastern countries and the newly independent States of the Region. The degree of decentralization of different services varies; for example, one may find countries where the nursing and midwifery services are a communal responsibility, whereas the first-contact medical practitioner is accountable at the district level. In other countries, these services may go together at either level. In yet others, the regions are assigned responsibility for organizing health care delivery at all levels for their inhabitants. Another important issue is that of what is being decentralized and how it works. The transfer of responsibility for providing services is not always accompanied by the ability to allocate resources of all kinds nor by the decision-making capacity needed in order to obtain these resources. Increased health awareness on the part of the population, the growing notion of quality health care as something to which the public (who want to exercise a choice and have their voices heard) are entitled, socioeconomic constraints due to other, concurrent priorities, and the introduction of trading concepts to the health care scene are some of the key factors that will shape health care delivery in the European Region for the next decade or so. Vigilance is necessary to ensure the preservation of equity, ethics, and need-related availability of services in the present new and quickly changing social environment.

South-East Asia Region

98. The Forty-first Session of the Regional Committee for South-East Asia, held in 1988, passed a resolution requesting Member States to develop and strengthen district health systems within the context of national plans and strategies for Health for All.

99. In 1991 the WHO Regional Office for South-East Asia launched an intercountry project on the intensification of action programme for primary health care, covering two or three districts from each of its eleven Member States. The project aimed at intensifying and accelerating action in four main areas: immunization, control of diarrhoeal disease, control of acute respiratory infections, and provision of essential drugs through existing health infrastructures. The project was intended to reach the disadvantaged and vulnerable groups of the population and strengthen the management capabilities of district health workers.

100. The final evaluation undertaken by the participating countries showed that considerable progress had been made in strengthening health care coverage, increasing the effectiveness and efficiency of health programmes, improving immunization coverage, and reducing child and maternal morbidity and mortality rates. These successes have encouraged the national authorities to support decentralization at district level. Experience in project activities in the districts selected indicated that improvements in the management of the district health service system could bring about better health coverage and improved health status among underserved populations.

101. District health systems are now being developed in all countries of the Region and their progress has been documented and analysed. Many successful examples of health development are emerging such as: decentralized management; community health financing; drug cooperatives; innovative workshops on district team problem-solving; and new approaches in health care financing, including the introduction of social security, health insurance schemes, drug revolving funds, cost-sharing, health cooperatives, user charges etc.

102. While district health systems have been developed and strengthened in varying degrees, a number of critical issues and problems remain: thus the main emphasis has been on coverage, and quality of performance has been neglected; policy guidelines are inadequate to support planning and implementation at district level; decentralization is rare; the roles, responsibilities, and procedures of district health staff are poorly defined and their leadership and management expertise is usually weak; the integration of vertical programmes is still facing difficulties, and uni-purpose workers, who have been trained as multipurpose workers, continue to give preference to their earlier programmes; there are deficiencies in collaboration within the health sector, and between the vertical programmes and the general health services; much of the information generated at district level is neither for the district health managers, nor required for decision-making, monitoring, and evaluation at district level, but only for transmission to the upper echelons, from which feedback is rarely provided; community involvement in health is weak and attempts to foster leadership capability in the community are inadequate; in district development committees, insufficient attention is paid to identifying health problems that require intersectoral action, and individual sectoral priorities and different administrative structures often prevent the pooling and sharing of resources between sectors; and finally there are not enough financial or skilled human resources, at the district level, and those that are available are usually neither equitably distributed nor efficiently used.

Western Pacific Region

103. In the countries of the Western Pacific Region, the concept of "district" is applied in a variety of ways. For instance, in large countries such as China, Korea, Laos, Malaysia, Philippines, and Viet-Nam, districts were developed according to criteria quite different from those used in the small island nations in the Pacific. The driving force of the district approach also appears to vary. For instance in Hong Kong, New Zealand and Singapore, where coverage was complete, rising cost was the driving force behind the implementation of a primary health care approach. In countries such as Laos and Papua New Guinea, there is a tendency to recentralize.

104. Urban health problems in various countries are noticeably increasing, particularly those arising from the aging of the population, and from the combination of chronic and communicable diseases in slum areas. Health infrastructure and primary health care development have been neglected in most large countries of the Region. The rise of privatization and competition is leading to increased inequity. Urban primary health care is particularly important in the Western Pacific Region in view of the fact that already some 52 % of the population (1990 figure) are living in urban areas.

105. A project on district health care systems in support of primary health care was carried out in six large countries in the Region from 1987 to 1992. It dealt with key problems in the implementation of health care at the district level. While the question of improvement in the financial management system at the district level was addressed in a number of countries, problems relating to improvements in personnel management and supervision, the drug supply system, the preparation of learning materials, procedural manuals etc., were addressed by all of them. Community participation and intersectoral collaboration were regarded by all the countries as difficult to achieve, and much consistent effort will be required to ensure progress in these important areas.

International Aid Agencies supporting WHO Global and Interregional Programme on Strengthening District Health Systems

106. Strong international support has been received for this programme. UNDP was the first major donor and, in addition to the global programme, has given support to some high-quality regional projects, as well as activities at country level. Other agencies that have supported various aspects of the programme in several countries, either through WHO or through direct bilateral support, are: Canadian International Development Agency (CIDA), Danish International Development Agency (DANIDA), Finnish International Development Agency (FINNIDA), International Development Research Centre (IDRC), Japanese International Cooperation Agency (JICA), Norwegian Agency for International Development (NORAD), Overseas Development Administration (ODA), Swedish International Development Authority (SIDA), Swedish Agency for Research Cooperation (SAREC), as well as Austria, Italy, and McGill University (Table I).

Table I. District Health Systems: summary of selected interventions in different countries and sources of funds ^a

Country by Region	Interventions	Sources of funds
AFRO		
Ethiopia	<ul style="list-style-type: none"> - training health officers to establish district health systems - research and development activities dealing with functions and constraints in three districts - developing health information system for districts 	WHO IDRC UNICEF UNDP DANIDA
Ghana	<ul style="list-style-type: none"> - to strengthen the role of regions in support of district health systems development - developing effective team work - improving the coordination of vertical programmes - restructuring of Ministry of Health to support decentralization 	WHO ODA UNDP NORAD World Bank FINNIDA
Guinea Bissau	<ul style="list-style-type: none"> - strengthening the role of regions in management of health care - intensive training in management and epidemiological surveillance 	WHO UNDP SIDA
Kenya	<ul style="list-style-type: none"> - developing planning and management skills in District Health Management Teams - increasing effectiveness of district hospitals in supporting primary health care 	WHO UNDP
Nigeria	<ul style="list-style-type: none"> - Research and development activities in five local government areas with a view to improving planning and management, introducing health systems research, strengthening laboratory systems in the areas 	WHO UNDP FINNIDA
Senegal	<ul style="list-style-type: none"> - conducting case studies on community involvement in a district in Dakar 	WHO UNDP
Tanzania	<ul style="list-style-type: none"> - strengthening primary health care implementation by training district teams - developing and applying tools for allocating manpower to districts and health centres - Institute of Primary Health Care development - formulating district planning guidelines 	WHO UNDP DANIDA SIDA/ SAREC
Zambia	<ul style="list-style-type: none"> - improving district health system management through district hospitals, initiated with two, expanded to nine - Primary health care management systems audit 	WHO UNDP DANIDA FINNIDA
Zimbabwe	<ul style="list-style-type: none"> - improving district health management - integration of health care delivery in two districts - Primary health care management systems audit 	WHO DANIDA

Table I contd.

Country by Region	Interventions	Sources of funds
AMRO		
Bolivia	- study on community involvement and preparation of plan of action for training in community involvement for health development (and document)	WHO UNDP
Guatemala	- support for outreach activities through "canalization" approach	WHO UNDP
EMRO		
Egypt	- developing community-based information systems for managing health development - training health personnel to manage and provide urban health services - experimenting with ways to maximize community involvement	WHO FINNIDA
Pakistan	- develop case studies and models for district health service information systems (Aga Khan University urban/rural health units)	WHO UNDP
SEARO		
Bangladesh	- management development in <u>upazilas</u> , improving information systems and collaboration with health-related sectors	WHO DANIDA
Indonesia	- reviewing and revising stratification as a tool for improving health centre and district performance	WHO FINNIDA
Nepal	- developing a strategy for improving district health planning	WHO FINNIDA
WPRO		
Laos	- management development at provincial and district level - policy and situation analysis of problems of coordination, finance, and manpower development	WHO FINNIDA

^a In addition, several country, interregional, and global activities dealing with urban health development and performance of community health workers have been carried out with funding from the Italian Government and AGFUND respectively.

Also, during 1987-1991, case studies on community health workers were conducted in other countries, such as Thailand and Jamaica, with AGFUND support.

Activities after 1991 are reflected in the global review in Section II.

107. The policies of the various agencies, with regard to primary health care and district health systems vary, likewise the area emphasised and the support provided.
108. **CIDA/IDRC (Canada).** The principal targets are rural villages and urban slums. This agency sponsors many community projects to improve water and sanitation and to promote better nutrition, particularly for pregnant women, babies, and school-age children.
109. **DANIDA (Denmark).** DANIDA endorses the primary health care/district health system approach, and is supporting the WHO programme in this area, emphasizing the strengthening of basic health care aimed at improving rural health services. Increased priority is being given to population policy and family planning.
110. **FINNIDA (Finland).** FINNIDA emphasizes the importance of the primary health care concept, and its support in this area, mainly directed at the least developed countries, is concerned with women and children, family planning as an integrated part of primary health care programmes, and community mobilization and involvement.
111. **GTZ (Germany).** This aid agency addresses in particular key areas in primary health care in which a relatively high degree of success can be achieved with a relatively low input of resources. It is supporting the development of a number of district health system projects, emphasizing managerial aspects, further training of health personnel, and integration of family planning.
112. **JICA (Japan).** Japan provides support by training individuals, supplying equipment, improving infrastructure, and educating individuals on family planning concepts. It emphasizes the need for cooperation in order to treat and prevent diseases and to disseminate information about sanitation, and supports research on disease prevention, diagnosis, and treatment, as well as community health development.
113. **DGIS (Netherlands).** The Dutch policy aims at achieving more comprehensive primary health care through different approaches: first, by concentrating on long-term cooperation, in multisectoral settings in urban areas, with maternal and child health as the central component; second, by concentrating on a limited number of priority and/or national programmes in support of primary health care; third, by increasing the efficiency of the overall health care delivery system in order to promote reallocation in favour of the primary health care levels.
114. **NORAD (Norway).** The emphasis of Norway's aid for the health sector is on primary health care facilities in rural areas. It includes the upgrading of health centres, referral hospitals, and rehabilitation centres for the physically handicapped, as well as population and family planning.

115. **SIDA/SAREC (Sweden).** Sweden's health programme focuses on primary health care, including family planning. Health assistance has shifted from the provision of infrastructure to the strengthening of particular components such as immunization, maternity care, health education, and training.

SECTION IV

MAJOR ISSUES AND CHALLENGES IN DISTRICT HEALTH SYSTEMS

District Operational Planning

116. The concept of district health systems came into existence because it was clearly realized that primary health care activities cannot be determined, planned, and organized from the central level. District operational planning is therefore an indispensable tool for the implementation of these activities. It is a participatory process and facilitates the execution of activities at the most appropriate level and closest to the target group.

117. Strategic plans are needed to coordinate both diverse sectoral health development efforts and external inputs in support of health development. The preparation of a strategic district health plan requires the involvement of all the participants in the district health system in defining key issues, setting priorities, analysing opportunities, allocating scarce resources, planning strategic action, and implementing and evaluating activities.

118. Goals, roles, and procedures at the district level need to be clearly defined and organization, planning, and managerial expertise in the district strengthened. The major constraints remain the level at which decisions are made and the amount of financial resources available in the district for planning in health, whether these are redistributed from the national level or raised locally.

119. The current tendency to emphasize managerial skills, almost to the exclusion of all others, could result in a body of senior personnel who lack both the technical knowledge needed to formulate sound policies and the operational experience to develop plans that can be implemented.

120. District operational planning should aim at intersectoral programmes for health which are mostly determined by aspects outside the realm of the actual health services. However, like vertical health programmes, intersectoral programmes often compete for the same resources as the regular public health programmes and become competitors in the district, as has happened in the case of Tanzania.

121. There is a great need for further exploration of ways of encouraging and strengthening intersectoral action to improve health status and promote and protect the health of the community.

122. District operational planning should avoid building up mini-bureaucracies at the district level. There is also the risk of district offices centralizing power, rather than delegating and sharing it.

123. Countries should consider the suggestions of the World Bank,² that redirecting resources from interventions that have a high cost per DALY (disability-adjusted life year) gained to interventions that cost little could dramatically reduce the burden of disease without increasing expenditure. It proposes that a limited package of public health measures and essential clinical interventions should be developed as a top priority for government financing.

Integration

124. The usual global response to the emergence of new diseases or threats to health or the resurgence of old ones has been to develop a new programme.

125. There are, therefore, vertical programmes for malaria eradication, immunization, family planning and AIDS and many more. Some vertical programmes deal with specific aspects of health care delivery such as the Essential Drugs Programme. Donor agencies found this approach attractive at first in that it facilitates accountability and results are usually quantifiable with a degree of precision.

126. Experience over the years, however, has cast some doubt on this approach as a sustainable, cost-effective mechanism for improving the health of communities. Moreover, even when there has been marked success (though not the complete success of the smallpox programme) hard-won gains have been dissipated when the resources available to a vertical programme have had to be reduced because of changing priorities.

127. The integration of programmes facilitates comprehensive planning and programme development, resulting in a maximization of the use of resources without loss of accountability. Work plans for coordinated, supervisory visits not only provide additional support, training, and motivation for health personnel, but reduce transport costs and allow more time for supervisory contact. Not to be overlooked is the synergistic effect of integrated programmes.

128. The district health system is the most appropriate effective level at which vertical programmes can be integrated. At this operational level, maternal and child health and family planning, nutrition, immunization, and control of diarrhoeal diseases and acute respiratory infection have long been packaged together in health posts and health centres. The transition from vertical management to an integrated approach to programme planning and budgeting, integrated supervision, and an integrated reporting system is readily achieved at district level. The first step towards achieving any, or all, of this is that the staff concerned must have training in integrated programme techniques.

129. At district level, high-risk groups and local needs can be identified. Improved coverage can then be secured by making the necessary operational modifications.

² World development report, 1993; Oxford University Press.

130. Finally, the participation of both community and health personnel in the district health system offers an effective approach for achieving sustainable health care.

131. In recent years, interest among health planners and managers in the integration of vertical health programmes into a comprehensive programme for health care services has grown. Three special areas that invite attention and action at district level, are integrated programme planning and budgeting, integrated supervision, and integrated training.

Optimal Use of Resources in Districts

132. Essential to the efficient running of health services and programmes are good district health management and an optimal integration of activities and participators. Many courses to improve the management capacities of health staff have been developed and implemented. However, successful integration and management of these activities and participators are both conditioned by a number of critical issues which are largely determined by the political will of health care professionals and politicians to share power and establish partnerships with the members of interested groups in the community.

133. The economic crisis and the initial programmes for structural adjustment of the economy have had a significant impact upon the health sector in many developing countries, resulting in contracted health budgets and services, which have in turn stimulated experiments in the financing of health services. Alternative financing mechanisms, therefore, need to be examined at national and/or district levels as part of the strategy to maintain the level of services. However, it is up to the district team to evaluate, most carefully, mechanisms for providing additional resources, in order to foresee and protect the community from, or minimize, any deleterious effects. Indeed the introduction of user charges can have a positive outcome if these can be retained at district level and utilized on behalf of the community to improve the quality of services.

134. There is an increased emphasis on resource acquisition close to the users of health services, which is a relatively new concept in many developing countries. Cost-recovery based on the sale of essential drugs has become more common since the Bamako Initiative, which has led to the creation of community financing systems in several countries, while others have modified the idea and developed a cash-and-carry system. Some countries now have experience of private health provision in public facilities, which in some cases may mean additional finance for the public sector. Intramural private-sector financing is another initiative. Contracting out in the public sector (to the private sector) is yet another, and is usually done to finance support services such as cleaning, laundry, security, etc. Several countries have now changed their legislation to open up the market for these private services.

135. The major challenge for WHO as regards the financing district health systems is to develop, jointly with national governments, financing systems befitting the mandate of the district. It is evident that the introduction of changes in any health financing system requires a strong national governmental office.

136. It is also of great importance that both private-sector and nongovernment resources efficiently complement and support district health systems and primary health care objectives. To improve the use of available financial resources and to maximize those that could be mobilized, district health planners and managers must be able to manage the public/private mix in a coordinated way. Experience with such approaches as the contracting out or privatization of services will be explored, and guidelines produced.

137. Decentralization is essential if resources at the district level are to be used and managed to the best effect.

138. Decentralization commonly involves the delegation of managerial functions and financial authority to regional, district, and municipal levels. Many countries are facing difficulties in implementing the reforms and organizational changes required for decentralization. In this connection, a review and analysis of the process and an assessment the achievements and setbacks experienced with decentralization will need to be undertaken and guidelines developed.

139. While decentralization is of foremost importance in financing district health systems, it is crucially important first to establish the national objectives and values of any health financing system and set priorities at the national level to begin with, and subsequently at the district level.

140. Operational studies will need to be undertaken and supported in various countries to review and analyse the process of decentralization and to assess achievements and setbacks, developing guidelines to facilitate this process in other countries.

Capacity-building

141. Capacity-building is not about adequate staff or appropriate training. These requirements lie within the realm of human resource development, which is one of the key strategies of the district health system.

142. The purpose of capacity-building is not only to learn and adapt, but also to create and continue self-sustaining processes in government, institutions, and community life.

143. Translated into the relatively modest setting of district health systems based on primary health care, some aspects of the complex concept and practice of capacity-building may be stated in simple terms just to facilitate monitoring and measurement of performance.

144. Treating the district health system as a part of the larger scene of national capacity-building, three aspects of capacity-building may be noted by way of illustration.

145. There is need for a determination at national level to endow the district health mechanism with not only the managerial authority, but also the financial means, to

acquire its own true personality as a self-sufficient and self-sustaining entity. It is understood that this would exist within the orderly structure of a national government, with a series of the checks and balances, audits, and controls necessary to maintain coherent national management and ultimate central authority.

146. Within the scope of the district health unit itself, a capacity to respond to the distinctive needs of each locality must be developed. Clearly, there is no mechanism whereby national governments or international agencies can supply guidance for every situation confronting the district. The internal capacity for problem-solving must satisfy its own needs. It must respond to the unique requirements of each district, and adapt known remedies or introduce new ones.

147. Third, the community it serves must use and re-use the district health system, adapting and shaping it to serve communal needs and purposes. This real-life interaction is mutually reinforcing. The only way to guarantee that a health unit will be self-sustaining is to ensure that its capabilities match the demands of its environment. The community must have confidence in it. Otherwise, it will wither away from disuse.

148. No universal and uniformly applicable prescriptions for capacity-building can be attempted. Capacity-building must be observed as a constant goal in promoting district health systems worldwide, and should be measured in future in terms of the contribution made toward national capacity-building, or at least attempted.

149. While capacity-building is a process involving a variety of cadres and individuals at the district level, institutional development is a process of strengthening, already existing institutions, and enabling them to participate fully in the process of health reform.

150. The development of human resources and institutional strengthening are directed by the need to increase the transparency and improve the performance of the organization(s) at the district level. Management skills should contribute to this process.

151. Much emphasis has been placed on the development of human resources but little on their management. Career structures, bonding, differential salaries, and secondary benefits or allowances, as well as other staff entitlements, have too often been neglected in the development of a sustainable and equitably spread system of well-balanced health service facilities.

Strengthening of Health Services

(a) *Health centres*

152. The performance of health centres (and hospitals) needs to be improved through task analysis, assignment of roles and responsibilities, and development of work plans.

153. The tasks included in the work schedules of health staff should be developed according to the health needs of the local population.

154. There is an evident need to upgrade organizational arrangements, as well as staff management and development, at the district level.

(b) Hospitals

155. The district hospital has a role that is central to the concept and practice of primary health care. It should be an integral part of the district health system.

156. Today, the district hospital should serve as a base for technical support to the health centres and posts within the district health system. It should certainly not compete with the other primary health care institutions, but work with them. It is the first basic hospital of the referral system, which, in addition to patient referrals, may cover referrals for logistical and management support and requests for technical education.

157. The outpatient department of the district hospital should accept only referred patients or genuine emergencies. The referral system should be developed in consultation with the potential users, namely the health care providers and consumers. It should be reviewed from time to time. Referral is a two-way process, and patients should be referred back to the source of referral with full information for the health care provider.

158. During the past few years curative medicine has been second in importance to prevention. In consequence, and with increasing financial constraints, the district hospitals have suffered in many ways from benign neglect except in one respect: they are overstaffed!

159. The doctors in the district hospital should have experience of public health work. In this respect medical schools should include a public health/epidemiology component in the undergraduate curriculum to ensure practical competence in line with the real needs of the health care system.

160. The increase in the number of cars on the road results in more and more traffic accidents. Caring adequately for the victims is a challenge for the district hospital. The more the Maternal Health and Safe Motherhood Programme is accepted by the rural women in a hospital's catchment area, the greater the need for competent management of pregnancies and deliveries. Complications are frequent, in the order of about 10%, requiring urgent, usually life-saving, surgery for which district hospitals should be equipped and staffed. The acceptance of a district hospital by the public may be measured in terms of occupancy rate, length of stay, number of complicated deliveries, and maternal and perinatal mortality rates. An overcrowded hospital outpatient service may indicate ineffective, unacceptable primary health care; an empty hospital reflects the community's rejection of its services.

161. Since the basic laboratory at the health centre level offers only limited diagnostic facilities, the district hospital must be in a position to perform a number of specific laboratory tests as well as simple routine X-ray investigations.

162. A well-managed district hospital can greatly contribute to effective primary health care through improved diagnosis and drug-saving, disease-specific therapy.

Urban Health Systems

163. Rapid urbanization is occurring everywhere and is expected to have major implications for integrated primary health care in the coming decades. In cities around the world the living conditions of hundreds of millions of people threaten their health and have potentially catastrophic social consequences. The scale of unmet needs and urban health problems is such that the cities of the 1990s - especially in the South - demand specific approaches to the problem. The district health systems approach is particularly promising in urban areas, given the many opportunities cities also offer for decentralization, integrated primary health care, and health development.

164. There is a certain inevitability in what social scientists say about the movement of humanity from rural to urban areas. The world is becoming predominantly urban. In 1800, only 3% of the world's population lived in urban areas; in 1950 the proportion was 29%, and soon after the year 2000, it will be over 50%.

165. The inevitability of these changes stems from the fact that economic opportunity lies in the mega-cities which generate, in some instances, 80-85% of their gross national budget. And it is there that people will move inevitably, rich and poor alike. Sadly, the rich get even richer in the cities and the poor even poorer. Once the rural migrant is trapped within the city he or she is vulnerable to three health hazards simultaneously and perhaps synergistically. The *first* is economic in origin and due to low income, poor education, inadequate diet, overcrowding, and unsanitary conditions. The *second*, caused by the man-made urban environment stems from industrialization, pollution, traffic hazards, stress, and alienation. The *third* results from social instability and insecurity, giving rise to promiscuity, alcohol and drug abuse, prostitution, child labour, and sexually transmitted diseases.

166. Within the present decade, therefore, most of the constituency of the district health system will come to have its location in the cities. Its majority, as urban poor, will be even more vulnerable to disease and danger than it is today. The situation is not confined only to the vast mega-cities. A WHO panel on urbanization reports that there are 440 cities with a population of over one million. Almost every country in the world has one or more of them.

167. Painstaking research, a vast amount of literature, and mighty promises have been lavished on every aspect of urbanization. But, surprisingly, the International Institute of Environment and Development has disclosed that today most aid agencies and development banks allocate less than 15% of their funds to projects to meet basic needs in urban areas, and less than 20% to all other urban development projects.

168. In due course, growing awareness of the realities of urban poverty will, it is hoped, unlock the flow of development resources. By that time, this programme to strengthening the district health system should have assembled field-tested information to reinforce sound investment plans in favour of the health and welfare of the urban poor. All its future work plans must therefore include an urban component.

Community Involvement

169. The involvement of communities in the development of appropriate health services has been one of the more difficult strategies for primary health care to sustain. In many instances, success has been achieved by encouraging greater involvement by representatives of local nongovernmental organizations. Many of these organizations have an interest in a particular disease or are for women. Indeed, women have played a fundamental role in community organizations and action for health in many countries. Sometimes, too, community involvement has revolved around the enthusiasm and commitment of a health worker resident in the community.

170. Very often the representatives of the community have strong political affiliations, which can be divisive unless they are appropriately contained.

171. The benefits to health status resulting from improving the educational level of the community, and particularly of women, are well known. Persuading the district educators to participate in educating both the community and the school population (boys and girls alike) on family health issues would ensure the development of a more informed community, ready not only to participate in decision-making on the subject of health, but also to provide health care at family level.

172. Also influencing community involvement are the skills demonstrated by health workers in motivating and facilitating true participation. This task often requires putting aside "health" priorities and dealing with other social problems identified by the community. Health workers need to become skilled in promoting attitudes and behaviour favourable to community participation and overcoming their own basic resistance to the involvement of the community in planning and management issues.

Quality Assurance in Health Development in the District

173. Quality problems are commonplace in health centres and district hospitals, and the quality of health service delivery at these facilities will need to be improved. A methodology for quality assurance will need to be developed and tested, allowing the district management team to recognize quality problems promptly and take remedial action. This would cover: aspects of care delivery, suitable indicators, data collection, standard-setting, analysis of shortfalls in quality, implementation of appropriate measures, and training.
