Reading

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District Health Systems

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Strengthening the backbone of primary health care

This article discusses how to increase the effectiveness of district health systems, with particular reference to the setting of priorities and targets, the realization of various forms of joint action, and the improvement of management and other skills.

Since the Alma-Ata Declaration in 1978 a keen awareness has developed of shortcomings in health services and of the need for policies and programmes which reflect people's requirements to an increased degree. Most countries have expressed a commitment to primary health care by signing charters, making declarations, and publishing policy statements, and many have set national goals and described programmes for the organization and management of their health systems on this basis. About three-quarters of developing countries have national plans indicating how their health infrastructures may be extended and reoriented to achieve the goals of primary health care.

Improvements in health services and health status are, however, the real signs of progress. There has undoubtedly been a considerable increase in health facilities, manpower and services since 1978. Advances have taken place in the provision of immunization, safe water supplies, maternal and child health care, and so on. Also, there is evidence of some betterment of health. The infant mortality rate, for example, has fallen in most countries, although rates of 200 or more infant deaths per 1000 live births still occur in many.

But success in improving health has been limited, partly because of the difficulties in developing primary health care. One important problem has been the unrealistic expectations of international organizations and donor agencies, which have been eager to show improvements in health within a short time after projects have been started. This has led to a constant search for short cuts in implementing programmes and to little time or attention being paid to local cultural factors; donor participation is often substituted for community participation. As a result the development of primary health care has tended to be hindered rather than helped.

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Economic support for primary health care has been inadequate. The percentage of gross national product devoted to health remains low in many developing countries; it is less than 2% in half the countries of Africa. According to the global strategy for health for all (1), ministries of health should review the distribution of their health budgets and, in particular, their allocations to central and peripheral levels, urban and rural areas, and specific underserved groups, and resources should then be reallocated according to need. This is more easily said than done. Hospitals are under great pressure, and a shift of resources in the short term has proved to be practically impossible. Few countries have been able to find additional funds. Thus, a shortage of drugs and essential equipment is a common feature of health services in many developing countries. Shortages of spare parts have turned many countries into graveyards of unusable equipment from the North.

But even if additional funds were found or better distribution achieved, there would still be little hope of reducing inequities in health because only a limited reorientation towards community care and prevention has taken place. While health personnel may be better distributed geographically, they often remain insensitive to local needs. Also, health programmes remain facility-orientated in that hospitals, health centres and dispensaries are concerned with providing health care for people who go to them. Who cares about patients who, for financial, cultural or other reasons, cannot avail themselves of services? Who cares about the time it takes for patients to return to work after episodes of sickness? What proportion of health centre staff know how many children they fail to vaccinate each year? Most ministries of health in developing countries have considered it better to attend properly to those who manage to come to health facilities than to go out in search of disease in the community.

An equally serious problem in the development of primary health care is the piecemeal approach to the provision of health programmes: the programmes for control of tuberculosis, leprosy and malaria, and the Expanded Programme on Immunization attract funds, may organize “vertical” services, and produce results, yet are more convenient to the providers of care than to the consumers. A mother who has to walk eight miles for antenatal care one day and take a child the same distance for immunization the next, rather than receiving both services on the same day, is not getting the best possible attention. Inadequate consideration has been given to the creation of functional units in which health services are integrated and at the same time coordinated with the activities of other sectors.

In response to these deficiencies, the district is increasingly being recognized as the “implementation unit” for an integrated assault on health problems. It is the most peripheral fully organized unit of government, varying greatly from country to country in size and degree of autonomy, and being designated by many different names. The population is usually between 100 000 and 300 000.
The district health system is the backbone of primary health care. At the community level there are activities for individuals, families, and community groups to improve their health; there may also be community health workers. The peripheral units vary in size and function, and are known as dispensaries, clinics, health posts, subcentres, general practitioners' offices or health centres. There is usually a district hospital in the main town, and often there are also other hospitals belonging to nongovernmental organizations. In addition to the health service, several health-related sectors, particularly agriculture, education, and water and sanitation, play major roles in improving health.

Focusing action on the district has the following advantages (2).

- The district is geographically compact and all parts of it are usually accessible, often within one day.
- It is an administratively defined unit, replicated in all parts of the country.
- It is managed by a few key officers, thus facilitating liaison and coordination between the local representatives of different government departments and associated nongovernmental organizations.
- It often has one main town that is a focus of communications and trade, with associated roads and transport and other important services.
- It has a small enough population to facilitate the coordination and management of the available health services.
- It is usually large enough to have specialized supporting technical and managerial staff, sufficiently skilled to allow substantial delegation of decision-making from national or regional management.

These factors make the district the best unit at which to introduce changes in the health system.

In attempting to strengthen primary health care in a district, the following issues need to be addressed:

- priorities for action;
- health objectives, coverage targets and service goals;
- joint action;
- management and training.

Priorities

An appraisal of the state of health and health services makes it possible to decide which problems should receive special attention. Priorities are often set on the basis of the disease situation. Epidemiological information and scoring systems have been used to assist in deciding which diseases should receive priority. The points considered include their prevalence and severity, and the effectiveness of low-cost technology. Despite limitations in the availability of data, most countries are able to proceed in this way with some degree of reliability. But this approach, which leads to the selection of a few diseases for concerted action, is unsuitable for people working in districts. If leprosy or tuberculosis are not picked as priority diseases, should no effort and resources go to improving programmes for their control? Should patients with these diseases be told to return after two years in the hope that the scoring system may then give them priority?

Another serious deficiency of this approach is that separate infrastructures consisting of
The backbone of primary health care

Joint action

People with limited practical experience often ask how to put together the elements of primary health care. Decisions are required on the organizational structure of the health system and on the grouping and allocation of tasks. Although each country has to evolve the structure best suited to its needs, the main principles of joint action can be applied universally: integration of vertical programmes, intersectoral action, and community participation.

Integration implies as much fusion of the provision of care as possible, particularly at the points of contact with the user. In contrast to vertical programmes with distinct management and organizational structures, integration requires that one authority decide on and direct the delivery of health care. It should be recognized, however, that between integration and vertical organization there can be various degrees of cooperation. At the level of collaboration there may be considerable communication and sharing of facilities between, for example, programmes for maternal and child health and immunization, while at the level of affiliation joint clinics may be held. Such integration can be encouraged by giving the district health team complete control of the budget for operational activities, without earmarking funds for certain vertical programmes.

Health objectives, coverage targets, and service goals

When a situation has been assessed and priorities have been formulated, a decision needs to be made on the extent of desired health improvements, the service coverage, and changes in the service to be achieved in a given time. Many district health teams will readily indicate targets for new health facilities but few will have set:

- health improvement objectives, such as reductions in specified mortality and morbidity rates;

  coverage targets for various programmes, such as an increase in the percentage of households with clean water or eligible children immunized;

  specific goals for improvements in the functioning of the infrastructure in given times.

Setting such objectives and targets is relatively easy, but they should be realistic and achievable within specified periods. They can then be used as the basis for deciding who should do what and how services and tasks should be organized.

District health systems cannot be strengthened in isolation; the development of the whole system is essential to the functioning of the different parts.
Intersectoral collaboration. The health sector alone cannot achieve significant improvements in the health of populations. Other sectors, such as industry, agriculture, and education, in trying to achieve their sectoral objectives, may exert a powerful influence on health. In order to optimize the positive influences, intersectoral collaboration is essential. At district level it is extremely difficult but may be encouraged by, for example, focusing on risk factors for health and not just health problems. This may lead to intersectoral action, because the reduction of risk factors does not obviously fall within the duties of the health sector. The improvement of water supplies is a responsibility of the district council services or utilities department; reducing the dangers of smoking may be tackled jointly by the education and health sectors.

Intersectoral collaboration may also be encouraged by giving emphasis to the reduction of inequities in health which are very closely related to inequities of income, nutrition, water supply, sanitation, education, and so forth. Administratively, intersectoral collaboration may be promoted by the formation of district intersectoral boards.

Community participation in primary health care may involve individuals and families (e.g., adopting healthy life-styles), community groups (e.g., voluntary organizations constructing health facilities), and community health workers (e.g., providing first-line care). The main initial difficulty lies not in deciding what the community can do but in implementing the process of participation. Health service staff have to accept greater community involvement and are required to work collaboratively beyond the confines of the health service. Furthermore, it is necessary to convince the local people of the benefits of participation. Given the right attitudes of health service staff and members of the community, an organizational structure can be devised to initiate community-based projects. Inevitably, a committee or board will include senior, respected members of the community. The eventual aim is that the community participate to some degree in the management of all aspects of the health service. The community also needs to be kept informed of how its actions are contributing to the achievement of district objectives and targets, and how progress compares with that in other communities.

Management and training

The improvement of management is essential for the strengthening of district primary health care. One of the first steps is to ensure that there is an appropriate district management team, perhaps comprising the district medical officer, district health officer, public health nurse, public health administrator, finance officer and a senior lay member of the community.

In addition to long-term planning and the setting of priorities and objectives, the team will be concerned with operational management including the allocation of duties, delegation and supervision of staff, monitoring and control, provision of supplies, logistics, maintenance of facilities and equipment, and financial management. Some management expertise is essential and further education of staff may therefore be required.

It is important to ensure that manpower and skills are matched with the tasks to be carried out and distributed appropriately throughout the district health system. Manpower levels are now adequate in many countries but further training may be
required in order to strengthen primary health care. Many health workers, particularly in peripheral units, are isolated. Some may not have attended refresher courses since qualifying, perhaps 20 years previously. Their skills may have declined to the point where they are not only useless but also hazardous. Sometimes workers are overtrained. A plan of action for the reorientation of health staff may need to be developed. The potentials of activity-based learning and distance learning need to be exploited much more.

The district is the frontline unit for planning, organizing and managing primary health care. Programmes have to be devised by governments, the voluntary sector, and communities, all planning and working together. While considerable decentralization of authority is called for, overall national guidance and monitoring have to be provided by government. District health systems cannot be strengthened in isolation; the development of the whole system is essential to the functioning of the different parts.

This holistic approach to health care will not work without determination and bold enlightened leadership. Unfortunately, there are increasing pressures to organize resources for health along traditional, vertical lines and to pursue goals and programmes in isolation. The organization of health systems based on the comprehensive objectives of primary health care is difficult, and practical experience in this area remains limited, particularly in international organizations. The sceptics who claim that the district approach is woolly and unmanageable should become more closely acquainted with what is going on in the field and should help to encourage joint action. Those working at government level in developing countries should be aware that the giving of special attention to primary health care in the district is a logical step towards health for all.

References
2. Vaughan, P. et al. District health planning and management. London School of Hygiene and Tropical Medicine, 1984 (Evaluation and Planning Centre Publication No. 2).