
1. The Concept of the District Health System (DHS)

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Geographical accessibility continues to be a major problem, particularly in rural areas (Rwanda)

1. Relevance of the District Health System

More than 25 years after the 1978 Alma-Ata International Conference on Primary Health Care¹, PHC remains central to the health policy of most African countries. This is true even though the WHO's ambitious goal of 'Health for all by 2000', which was to be achieved with the help of PHC, has long since been shelved. Despite the difficulties of translating the PHC strategy into practice, the fact remains that in the current socioeconomic circumstances there is simply no realistic alternative if the whole population is to be provided with basic health care, especially in rural areas. As a matter of public interest, governments remain in charge of organising an affordable health system, which offers a wide range of services of an acceptable quality (rather than merely vertical special-focus programmes). This health care system needs to be accessible to the entire population, including the destitute, for whom special rules should apply.

Major efforts have been undertaken by the international community to implement the PHC strategy, with numerous projects and vertical programmes. Yet, within a few years, most of these proved to be inefficient, non-sustainable, and in some cases even counter-productive to the efficiency of the local horizontal health services. Finally, it became clear that selective vertical approaches (i.e. focusing on one specific disease or on family planning) resulted in short-term successes only. They were unable to ensure the sustainable implementation of the PHC strategy. The concept of primary health care calls for services to cover the entire spectrum of preventive and curative medicine. This can only be provided within the framework of an integrated health care system, an objective that cannot be achieved overnight, but offers far more sustainability than any fast-track programme.

The district health system provides the best chances of implementing PHC as laid down in the Declaration of Alma-Ata. This finding was incorporated in the 1987 Harare Declaration, signed by representatives of 22 African countries, which is as valid today as on the day it was adopted.

¹ The primary health care (PHC) strategy was adopted worldwide in 1978 under the aegis of the WHO.

Primary Health Care means:

Community involvement and the use of local human and physical resources to provide a range of curative and preventive services and health promotion measures that are both accessible to and affordable for the local population.

Primary Health Care embraces eight elements:

- Health education
- Food supply
- Drinking water supply and sanitation
- Maternal and child care, including family planning
- Vaccinations
- Endemic diseases
- Miscellaneous diseases and injuries
- Essential drugs supply.

Primary Health Care is geared to the following guiding principles:

- Maximum accessibility
- Utilisation of local resources
- Involvement of the target population in planning and implementation
- Integration of preventive and curative services
- Rationalisation of the health services (appropriate technology, financing and management).
- Inter-sectoral cooperation.

Primary Health Care is not limited to:

- Simple measures (e.g. rehydration and preventive measures)
- Promotion of village health workers and community development
- Activities at the lowest level of health care (dispensaries, etc.).

Primary Health Care also includes the referral hospital.

One may object that in recent years “Poverty Reduction” and “Millenium Development Goals” have been the overarching strategies for health care. However, the analysis of these strategies points out that they are fully in line with the concepts and principles of



WHO's slogan 'Health for all by the year 2000' – modified in a particular way (Benin)

PHC; to some extent they are adjusted to current expectations and perspectives.

Critics of the district approach point, not without justification, to the persistently poor quality of many health services, especially state services, in most countries of sub-Saharan Africa. However, the reasons for this tend not to be technical or conceptual in nature. The shortcomings of the systems are rather a reflection of the challenges faced by the society in which they operate: socioeconomic crises, political mismanagement and corruption at every level of society. In public services in particular, and the health service is no exception, these factors have led to appalling mismanagement and lack of commitment resulting in a drastic drop in the quality of services provided.

Given these circumstances and the limited success of the wide range of public health activities carried out to date, the discussion returns time after time to shifting the focus back to hospital-based care. If attention were focused on hospitals it would be possible, goes the argument, to achieve an acceptable level of health care in one (large) institution at least.

Experience shows, however, that hospitals that serve a large number of outpatients and thus have to operate as large-scale health centres become inefficient as staff and other resources must increasingly be dedicated to tasks that a hospital should not normally be expected to undertake. As a result the hospital's core tasks are performed with ever decreasing efficiency. At the same time, the peripheral services are used less and less frequently, and are actually weakened rather than being strengthened from the district and/or regional level levels. In the final analysis it is particularly the rural population, which often accounts for between 60 and 80 per cent of the total population, that loses out. This is totally unacceptable in terms of strategy and health policy.

There is no realistic way of replacing the comprehensive, integrated district health system (DHS). What is needed to ensure the desperately needed qualitative improvements to the DHS, is an integrative, inter-sectoral reform policy for the system as a whole.

Another approach might be to encourage non-state service providers as an alternative to the crumbling public services. Such an approach would appear to be expedient, since there is little hope that the state services will be able to master the current crisis in the foreseeable future. It is worth noting here that many more developed countries, in particular industrialised countries, have put their primary health care services mainly in the hand of non-state service providers.

For many years now it has been clear that centralised health systems are no longer in a position to provide even the minimum of care required at all levels, and that major planning and managerial authority should be delegated to decentralised bodies. The district level has a vital part to play in this new structure.

The integrated district health system offers the following major advantages over a centralised system:

- It is *large enough* (in business terms) to justify the investment and management costs, especially in hospitals (good cost-benefit ratio).
- It is *small enough* to be familiar with the relevant demographic and socioeconomic factors, and able to take these into account.
- *Participatory planning and organisation* are more feasible at this level.
- *Communication* with target groups is easier because of the geographical proximity.

- *Management* (e.g. supervision) is less complex and thus more effective.
- It is easier to *coordinate* various programmes and services at different levels.
- *Inter-sectoral cooperation* is easier, in particular with the agricultural, education, water and waste disposal sectors.

Like every other health care system, the DHS can be assessed using a grid and a logical approach which are widely used in planning and evaluation exercises.

Criteria when assessing a health system for coherence²

- **Relevance** of the services in terms of quantity, technical level and problems experienced by the target groups
- **Availability** of resources to provide appropriate health care
- **Accessibility** of the services (geographical accessibility and affordability)
- **Quality** of the health care in the eyes of the experts and of the population
- **Acceptance** of the services offered on the part of users

2. Structure of the Integrated DHS

The DHS is part of the National Health System and generally covers one district – an administrative unit that is home to between 50,000 and 300,000 people³. The Head of District is usually appointed by the Government, whereas the members of the district council are, for the most part, elected representatives of the community. Depending on the degree of decentralisation, the district council may be wholly responsible for health care in the district.

Within the administrative structure of most African countries there is a regional level above the district level. Depending on the colonial history of the country, this level is sometimes known as provinces, departments or prefectures. One region consists of several districts. Formerly, the regional administration was superior to the district council in all matters, but gradually, in the course of

² After T. Tanahashi, WHO, Division of Strengthening of Health Services (1978).

³ Where districts have many more inhabitants (e.g. in Rwanda), they should be subdivided.

Support services to be provided by the regional administration to support DHS

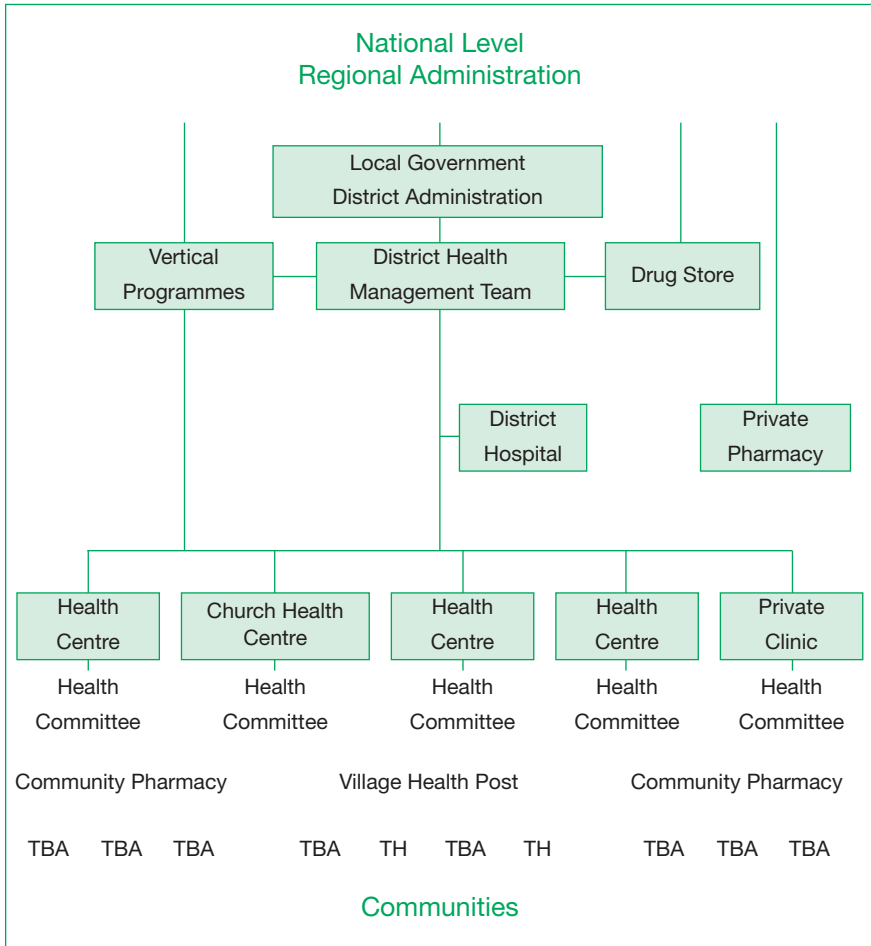
- Assigning personnel to districts of the region to overcome the urban-rural inequities
- Staff training and running a regional or zonal training centre
- Human and institutional capacity-building for decentralisation
- Quality management
- Introduction of sustainable maintenance systems
- Disaster preparedness programmes
- HIV/AIDS control
- Operational research

decentralisation, the district level was granted significant decision-making authority. However, the regional level retains a major role in the implementation of national health policy, quality control as well as coordination and support of the districts, even if it is no longer solely responsible for the budget. Strong districts are unquestionably an important element of decentralisation. Nonetheless, it should be noted that many tasks can be managed more effectively and more efficiently at the regional level. For instance, it makes more sense to organise programmes such as staff training, maintenance or HIV/AIDS control at this level (for further details see Box 'Support Services provided by the Regional Administration'). The DHS embraces all the facilities and individuals in a district involved in providing health care at various levels of intervention, not only state providers, but also church, community and private providers. In principle, traditional healers are also part of the system, although there are few instances of cooperation between them and the other parts of the DHS as a result of their widely divergent views on the causes of diseases and how best to treat them⁴.

⁴ In general terms, traditional medicine is based on a very different philosophy of sickness that distinguishes it from "modern" scientific theory. According to traditional medicine, sickness is mainly a result of the (mis)conduct of the patient and his/her relations to others, rather than being connected to micro-organisms in the environment. Traditional healers, who consider supernatural factors to be responsible for most health problems, are generally consulted first when someone falls ill. The effectiveness of the treatment of major health challenges they provide (e.g. malaria or complications during childbirth) is, however, dubious.

1 The Concept of the District Health System (DHS)

Figure 1: The district health system. Lines designate functional links (not hierarchy). This is only one possible structure, and many variations are conceivable. TBA = Traditional birth attendant, TH = Traditional healer



The DHS is responsible for providing primary health care, i.e. organising a minimum package of curative and preventive services in line with national health policy to respond to the health problems and needs of the local population.

Within the DHS we distinguish between the primary and secondary levels that have to be supervised, coordinated and sup-

ported by a management body. However, the system also comprises village and community-level activities as well as vertical programmes, thus rendering the overall structure significantly more complicated and complex.

The primary level comprises all health centres, dispensaries and similar facilities in the communities with qualified staff such as nurses and midwives, but no doctors.

The secondary level refers to all first referral hospitals (for all services at primary level). Generally, there is an official district hospital, and sometimes smaller, mostly non-governmental hospitals. Unfortunately it is rare to find any organised form of cooperation between the hospitals in a district⁵.

The referral system is intended to ensure an operational link between the two levels, which demands advanced logistics (vehicles, communications technology such as radios, telephones or mobile phones and an appropriate reporting system). The enormous cost of maintaining this system is generally prohibitive, and indeed, when resources are so scarce, the system can only be justified if effective controls (e.g. by the community council) ensure that ambulances, for instance, are used for their intended purpose.

The costs of transporting patients from one facility to another are often extremely high, and if the patient is charged for the full amount it is likely that he/she will either refuse to be transferred or that loss of time over the resolution of the payment issue results in the patient's life being put at risk. Subsidies or cost-sharing schemes are needed to avert this danger. Ideally, health insurance schemes should cover the costs.

Primary-level health services transfer patients whose condition demands technology or skills not available at primary level to the referral hospital. Under optimum conditions, however, up to 85% of all patients can be treated at primary level. A very small number (some 4%) of the 15% referred to a hospital subsequently require special treatment available only in special hospitals at national level⁶.

⁵ In Tanzania, the state worked together with the church to develop a promising joint programme ('Sharing Responsibilities') – see report CSSC 2002.

⁶ Percentages are based on estimates made in Kasongo, Zaire (Project of the Antwerp Tropical Institute) and in various GTZ-assisted projects.



Mother-and-child-related health problems account for 70% of all health care provisions (Tanzania)

At village and community level there are often health-related initiatives (e.g. village health posts, village health workers, traditional birth attendants, health committees, youth and social centres and alongside these the traditional healers), which require the support of the nearest health centres and dispensaries.

In spite of the negative experiences that many countries have had with village health posts and workers, it may be useful to continue this approach in areas without health facilities where the local community is committed to support community-based initiatives.

In some countries (e.g. Malawi with its health surveillance assistants) specially-trained staff are responsible for outreach work, such as vaccination programmes, water supply and sanitation measures and hygiene education. The commitment of community members is vital if programmes of this kind are to be successful.

The district health management team (DHMT) should always be headed by a doctor with public health qualifications⁷ and

⁷ The most appropriate training available is a one-year Master of Public Health course.

should comprise at least one administrator, one experienced nurse and the senior physician from the district hospital. Representatives of non-governmental organisations working in the district should also be part of the team. (For more details see the chapter on “Planning and Management” below). The DHMT plans and budgets for the activities needed to manage, control, coordinate and support all health services in the district on a year-to-year basis. Although extremely difficult, it is of paramount importance that this process considers all sources of funding and all district activities – especially externally-funded projects and institutions – to provide transparency and prevent unnecessary duplication.

All non-governmental health services including pharmacies should be involved in the planning process and in all support activities whether they are church, community or private providers.

Vertically-organised health programmes such as vaccination programmes, family planning, and AIDS, TB and malaria control tend to be organised and conducted nationwide. Given the high costs and lack of sustainability of many vertical programmes, it seems undoubtedly useful to integrate them into “horizontal” health services, provided adequate logistic and financial preconditions exist and appropriately trained staff are available. However, forced integration of vertical programmes can be disastrous, as demonstrated by the considerable drops in previously high vaccination rates in some countries (e.g. Tanzania). It is therefore reasonable to retain vertical programmes if it seems improbable that conditions at district level can be significantly improved in the foreseeable future.

On the other hand, better equipped vertical services should never become competitors of worse-equipped primary and secondary care facilities. If this happens it always indicates a misallocation of resources, which calls for immediate correction.

3. Facts, Figures and Standards

There is an optimum size for a well-functioning district health system. Given the huge rates of population growth, these figures should be known and taken into account in political, planning and managerial decisions.

Table 1: Planning data on the basis of average figures for a health district. The figures have been taken from different projects, and deviations are possible on the ground. The data given here should serve only as an example.

Scope

- Hospital: 1 bed per 1,000 inhabitants of the health district
- 1 health centre/dispensary per 6,000 inhabitants in rural areas, and per 10,000 inhabitants in urban areas.

Accessibility

The distance to the closest health centre/dispensary should not exceed 5 km (or 10 km in particularly difficult regions).

Personnel (minimum)

- Hospital (200 beds): minimum of 3 doctors, nursing staff ratio of 3:1 (beds: nursing staff), administrators (1 accountant), 1 trained hospital technician
- Health centre/dispensary: 1 nursing officer (with 4-year training) as team leader, 1 midwife (with 3-year training), 1 nurse attendant or social worker, 1–2 auxiliary staff members
- District health management team: 1 doctor trained in public health as the team leader, 1 top-level nursing staff member, hospital director, 1 person for mother and child matters, 1 accountant.

Utilisation

- Outpatient care: 1 case treated per patient per annum
- Occupancy rate of hospital beds: 70–80%
- Percentage vaccination coverage: more than 80% (extended vaccination programme for young children)
- Utilisation of modern methods of family planning: 40% or more in the medium term
- Percentage deliveries with medical assistance: over 60%

Expected workload per annum (e.g. health centre/dispensary serving a population of 6,000)

- 6,000 new cases (general outpatient care) per health centre/dispensary (assuming one case treated per capita per annum, rate of utilisation: 1.0)
- 135 deliveries with health service assistance (assuming a birth rate of 45/1,000, 50% home deliveries)
- More than 600 antenatal consultations (assuming a mortality rate of 10%, an average of 3 consultations per pregnancy, rate of utilisation: 0.8%)
- More than 900 consultations for babies/vaccinations in infants' first year of life (assuming five consultations/vaccinations)
- 504 consultations on family planning issues (assuming 40% of all women aged between 15 and 49 consult the services, i.e. = $6,000 \times 0.21 \times 0.4$).

Weekly workload of a health centre/dispensary

Assuming a utilisation rate of 50% (curative treatment), 80% (antenatal care), 20% (family planning):

58 new cases	($6,000 \times 0.5 : 52$)
14 antenatal consultations	($900 \times 0.8 : 52$)
26 infant development checks	($300 - 10\% = 270 \times 5 : 52$)
5 family planning consultations	($6,000 \times 0.21 \times 0.2 : 52$)

The optimum district health system serves a population of between 200,000 and 300,000⁸. When planning a DHS on this basis, planners must take into account the fact that in most African countries the population of a given area will rise by about 50% over a 15-year period.

Given a target population of this size, the district hospital should have a minimum of 200 beds. A reasonable ratio is one bed per 1,000 inhabitants⁹. Hence, in this example, a second, smaller hospital with 100–150 beds would also be justified.

There should be between 20 and 50 health centres at primary level, depending on the human resources available and on the population density.

4. Sharing of Responsibility within the DHS

To ensure the provision of optimum care by using resources as rationally as possible and by avoiding unnecessary duplication it is vital to specify the responsibilities of the various facilities and levels of care.

A smoothly functioning referral system is the precondition for cooperation between the various levels of the health system (community initiatives – health centres – district hospital).

A detailed job description should be available for every position, and each member of staff should be given a copy of their own job description.

Also, standardised diagnosis and treatment guidelines should be implemented, laying down criteria for the referral of patients to the next level of care (e.g. a child with a serious infection or severe malnutrition).

A distinction can be made between the following duties:

⁸ All following figures refer to this optimum size of a district health system.

⁹ These figures are based on the work of Dr. Pridie, Chief Medical Officer in the British Colonial Office in London, who made far-reaching proposals for the health services in the colonies as far back as 1949.

Health Centre/Dispensary

- Curative care of acute and chronically sick patients who do not require a doctor (ideally up to 85% of all cases)
- Antenatal care
- Obstetrics
- Family planning
- Infant care including vaccinations and development checks
- Community development (primary disease prevention in particular as regards drinking water, disposal of solid waste and waste water, medical back-up for traditional birth attendants, village health workers, social workers, youth initiatives)

District Hospital

- Treatment of outpatients and management of emergencies
- Surgery (moderately complex surgery in the fields of obstetrics, general surgery, traumatology, urology)
- Treatment of serious internal and pediatric cases
- Technically complex diagnostics (radiology, ultrasound, laboratory)
- Training and upgrading (especially for other district staff)
- Collaboration on both clinical and public health studies and operational research
- Collaboration on the supervision of health centres/dispensaries
- Technical services and maintenance (for the entire district)

District Health Management Team

- Planning and management of the DHS including financial planning
- Personnel assignment and further training
- Management of physical resources including procurement of drugs, medical supplies and equipment
- Organisation of supervision
- Responsibility for the uninterrupted supply of drugs
- Coordination of studies and operational research
- Inter-sectoral cooperation

5. Decentralisation

For several years now it has been the declared reform policy of low-income countries to decentralise the administration in most sectors¹⁰. This political u-turn away from a more centralised system is in part a response to the past failures of centralised government decision-making, which has all too often gone hand in hand with corruption. It is hoped that further-reaching decentralisation of decision-making authority in the health sector, as in other areas, will increase citizen involvement resulting in greater social justice and a more effective health care system.

Quite apart from the aspect of democratisation, it is assumed that the breakdown of the national health sector into operational sub-units (health districts) will boost quality and bring efficiency gains. As budgets shrink there is much to recommend this approach.

- Decentralised financial planning is more efficient, since precise information on the resources required (e.g. staff, drugs, transport, renovation work, etc.) is more easily available at local level. By contrast, in a centralised system the districts are seen as homogeneous units and too little attention is paid to their specific geographic, cultural and economic characteristics. As a result many resources are wasted.
- The proximity of the control body allows for improved financial control and budgetary management, making it easier to prevent the misuse of resources.
- Performance improves when the supply of necessary inputs is reliable, and when both controls and technical support services are stepped up thanks to greater proximity.
- Finally, increased client focus has been shown to improve the performance of the health system, which in turn pushes up the demand for services. The resulting boost to the revenue of the health services helps to underpin the sustainability of improvements.

At present, no convincing factual arguments speak against this sectoral reform. Resistance to decentralisation is thus mostly polit-

¹⁰ The pressure exerted by international financing institutions and development cooperation on national governments, which are often more than reluctant about decentralisation, cannot be denied.

ical in nature, since decentralisation always means a shift in power from national to regional level. This resistance, especially on the part of the ministries affected (Ministry of Finance, Ministry of Health and the Ministry responsible for administration, as well as the Ministry for local government) frequently takes the form of delays in the process of legalisation. Endless revisions can result in the reform being watered down to such an extent that all that is left is deconcentration, rather than the originally intended devolution.

It is, however, important to recognise that often the technical, political and administrative preconditions do not exist at the level to which authority is to be transferred. If the human resources capacity, management expertise and genuine involvement of the population must first be created at the lower level, a premature transfer of decision-making authority can prove to the detriment of all parties involved.

One crucial factor is the quality of the new regulations and instruments of decentralised administration (i.e. their scope and effectiveness); another is the speed of implementation in terms of the requisite human resources and their ability to perform their new tasks competently and reliably.

The competence and the commitment of the local government are of absolutely paramount importance to the success of decentralisation. It can do much to accelerate the process by conducting

What do the four “D”s mean?

Decentralisation is the transfer of central government powers, i.e. decision-making authority in the fields of planning and management, to a lower level. Three distinct forms can be identified:

- **Deconcentration:** The transfer of central administrative functions but not of decision-making authority to the periphery or lower levels.
- **Devolution:** The transfer of important decision-making sovereignty to lower levels of government (e.g. a community council).
- **Delegation:** The transfer of managerial responsibilities of government to an independent controlling body, such as an NGO.



Decentralisation: district authorities need to understand the new tasks and responsibilities (Tanzania)

solid education work and training staff members affected within the district and local administrations, the health services and the district council.

Decentralisation within the district means first and foremost greater community involvement in the organisation and financing of the health services in the community in question. Relevant regulations are essential, and can be drawn up by a management committee. The community should then implement them rigorously, with the support of the DHMT or a competent NGO, where appropriate.

6. Integrating the Private Sector

The district health system comprises all actors and all initiatives aiming to preserve good health and to treat diseases irrespective of the provider's institutional character or the scope of the services offered. Due to the move towards decentralisation, the private

sector plays an increasingly important role in the provision of services.

The private sector includes all non-state providers of health-related services: hospitals, health centres, private medical practitioners, private clinics and pharmacies, laboratories and blood banks, etc. Also included are companies that are contracted to perform certain functions such as laundry or cleaning (outsourcing). Traditional healers and birth attendants are obviously also non-state providers, but they need to be categorised differently (see below for further details). The number of all these providers in the overall health system has continuously risen in recent years, especially in urban areas.

Private providers comprise:

- church organisations
- not-for-profit organisations (e.g. cooperation partners)
- profit-oriented institutions and individuals
- medical services of companies.

The integration of all health services into the district health system (irrespective of the agency in charge) is logical and makes sense if all potential services are to be fully exploited. However, there is still resistance (albeit decreasing) on the part of the government and on the part of private-sector providers. Generally, historically old conflicts between the state and the church are at the root of this resistance. These conflicts intensified during the struggle for independence and have only started to abate in recent years as a result of the reform movement. Nonetheless, in most cases current conflicts are equally shaped by mutual accusations¹¹.

The first step on the way to integrating private health services into the DHS is to include them in the information system, and to ensure their appropriate participation in planning and management of the district resources as well as in quality control. This in turn presupposes that the non-state services accept the need for openness as regards their income and expenditure, which, on the part of the churches, is met with limited enthusiasm.

¹¹ It was and is a question of power. The government dislikes the relative independence of churches with their external support, while the churches refuse to let themselves be “annexed” by the state. The authorities accuse the churches of failing to disclose and share their resources, while the churches accuse the authorities of mismanagement and unreliability. As a result both claim for themselves the right to refuse to share.



Learning from history

In Tanzania, an illustrative poster exhibition on the history of health care in the country was organised. It provides background information on the development of the Tanzanian health care system, which helps better understanding of the currently implemented health sector reforms. The exhibition also points out the main health problems and highlights the efforts the system has undertaken so far to tackle them.

The development of modern and traditional medicine, the German and British colonial period and the modern health care system is shown, as well as the contributions of missions and churches in setting up the health system.

With independence in 1962, Tanzania started building a health system according to standards of the industrialised world. However, the country was affected by a long-lasting period of continuous political and economic decline resulting in the dilapidation of the health care system.

Finally, in the 1990s fundamental structural and administrative reforms of the health sector started. Looking back in history to study how reforms were planned and implemented in the past might offer useful lessons for today.

(Photo: Tanzania, 1929, in D.Clyde: History of medical services in Tanganyika)

It is generally accepted that the guidelines and provisions of state policy are binding for all health facilities across the board. However, non-state services must be granted a measure of independence to enable them to decide on their specific orientation and specialisation. For it is the very variety of funding bodies and providers which allows the health service to respond to the many different cultures found within the target population, and their divergent needs.

It is important to acknowledge that private health facilities have no external source of funding and must therefore ensure that their income covers costs if they are to survive. Revenue is generally raised by charging user fees, although this means that less affluent patients are automatically excluded from these facilities. Limited access is not acceptable from the point of view of overall planning, and a solution to this equity problem must be found within the district. The DHMT needs to contribute to the development of practicable solutions such as exceptions, subsidies or alternative modes of payment.

The integration of private pharmacies in the health system means that they have to accept the principle of supplying essential drugs in the form of generic drugs. This, understandably, causes resistance, not only because it affects the individual commercial interests of pharmacists, but also those of the entire pharmacy sector in the country and the international pharmaceutical industry that stands behind it. Compromises are needed to ensure the continued availability of essential drugs in their generic form on the one hand, while allowing the sale of branded drugs on the other. This is another task for the district health management team (and of course for higher levels).

The role of traditional healers and traditional birth attendants is very different from that of private providers, since they are an organic part of the community and of their own specific ethnic culture. It is thus difficult and of questionable value to integrate them into the "modern" health care system and its administration.

In the interests of patient care, however, efforts should be made to contact these groups and even to work with them on certain health problems (e.g. hygiene or HIV/AIDS). Only mutual recognition of the strengths and weaknesses of both health care systems can form the basis for fruitful cooperation.

7. Inter-sectoral Cooperation

In every country, society is broken down into sectors for administrative and political reasons, but no thought is generally given to the fact that people do not think in terms of sectors. Although it is found time and time again that inter-sectoral cooperation is vital for development, its implementation never meets people's expectations. This open reluctance or inability to practice inter-sectoral cooperation can be seen at all levels, from the community to the ministries. The reform movement of recent years has made new attempts to bring different sectors together, but when discussions

District response to HIV-AIDS

The fight against HIV/AIDS is considered to be more effective based on an inter-sectoral approach at district level rather than a national vertical programme. Furthermore, including all districts of a region in one regional programme will increase efficiency and the impact of the programme.

Health services are of crucial importance for health communication, diagnosis and therapy. However, successful prevention of the disease is achieved only if couples practice safe sexual behaviour. For this purpose, all sectors of society, and "education" in particular, have to be involved.

The coordination of various stakeholders requires inter-sectoral committees at regional and district level. Relevant institutions and initiatives of the civil society should be included accordingly. Politicians need to be aware of the magnitude and dynamics of the disease as well as the priority measures to be organised in their zone of influence.

The main programme activities should include

- STD control
- Health promotion, advocacy and resource mobilisation
- Voluntary counselling and testing (VCT)
- Counselling and home-based care (PLPHA, orphans)
- Prevention of mother-to-child transmission (PMTCT)
- HIV/STD laboratory support
- Safety in health services
- HIV and STD surveillance
- Treatment with anti-retroviral drugs (ART)

address the issue of funding, almost insurmountable difficulties emerge yet again.

Inter-sectoral cooperation for the health sector covers in particular the fields of social affairs, education, water supply, sanitation and agriculture. Spontaneous forms of cooperation of varying degrees can be observed fairly often, but they do not generally stand the test of time.

The efforts in many countries to improve cooperation among all partners in development using Sector Wide Approaches (SWAp)¹² raises the question as to whether the focus on one sector – in this case the health sector – is in itself an obstacle to inter-sectoral approaches.

Institutionalised forms such as inter-sectoral committees at district level are important platforms for exchanging information and implementing joint projects. It is possible that the inter-sectoral HIV/AIDS committees set up in many countries might provide the impetus needed to tackle this epidemic.

Competent and reliable leadership by the district health management team is crucial in this respect. Specific cooperation between two sectors (e.g. health and education) is very useful and is being implemented successfully in some places.

Further Reading

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¹² It should be stressed that SWAp is a strategic approach rather than a programme or a new method to pool donor funds. SWAp aims specifically to strengthen the cooperation between development partners in support of government-led policies and increasingly relies on government for management, implementation and funding procedures. It calls for a new relationship in which the government has to develop strong ownership of the health reforms and the development agencies have to move away from previously fragmented implementation and management systems (see bibliography).

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