DISTRICT HEALTH SYSTEMS

Decentralizing for greater equity

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There is much talk these days of the need to develop the district health system. The idea is to decentralize services in order to make them more responsive to the health needs of the people, and particularly to the poorest in rural districts and urban slums and shanty towns. A stronger and more integrated system of services at the district level would certainly increase the chances of successful implementation of primary health care (PHC).

However, we introduce the issue with a certain amount of caution. Firstly, this is because evidence of a major national success story of decentralization to the district is hard to come by. Despite the fact that the reform of the National Health Service in the UK is often cited as an example, there is no clear evidence of the impact of the changes. Although the reforms offer possibilities for strengthening public health and community involvement, says Dr Peter Bellamy, a former CMC commissioner working with the South Birmingham Health Authority, the reality often appears to be different.

Another problem is the current "market mechanism" ethos, and the powerful influence of the World Bank which is offering loans for the health sector. This atmosphere highlights reliance on the private sector and the introduction of user charges, and it clouds the importance of state responsibility for social services and the needs of the poor. In the health care reform taking place in Zambia, for example, as much as 20% of the population may not be able to afford the charges. WHO officials looking into the effects of the introduction of fees for services found that many of these people would not be entitled to state assistance. Only 5% of the population might be able to receive support as "destitutes".

There are also the financial and administrative realities of the current situation. Today, there is less money available for health, and the proportion for PHC is therefore even smaller. Central governments want to control the limited resources available and may feel tempted to delegate responsibilities without handing over the authority and the necessary funding to the district authorities. At the same time, the administrative structure at the district level may not be able to cope. Effective management of expanded structures can only be built slowly. Rapid reform in the Philippines has led to cases of health workers being deprived of their salaries for up to six months.

Last but not least, the reforms require a change in thinking about health care provision which some experts find difficult to make. Much more community involvement is needed if health needs are to be met more efficiently. Yet, World Bank experts and medical professionals often have little practical experience in negotiating with communities. They may even find the process threatening.

However, we did decide to take up the issue because of the enormous potential that decentralization offers for community-based PHC. Given the political will to make decentralization work, community health initiatives, non-governmental organizations and groups, including church hospitals, would have more chance to influence, and more opportunity to support, the formal structure. There would be new opportunities for intersectoral collaboration on housing, child-care, transport and so on – all areas that can have a crucial impact on health.

Having taken this decision, we would like to know what you think about decentralization and the development of the district health system. Do write to us with your comments and your experiences – both good and bad. We look forward to hearing from you.
WHAT IS THE DISTRICT HEALTH SYSTEM?

According to the World Health Organization, the district health system is the generally recognized organizational and operational vehicle of primary health care. It is the most peripheral, fully organized unit of local government and administration. It is generally small enough to be manageable and for the staff to understand local problems and large enough to be capable of serious planning and management. At this level, "top down" and "upward" (bottom up) planning can find a meeting point, national and local priorities can be reconciled, health problems are not distorted by disciplinary or sectoral considerations, and intersectoral articulation becomes real and effective.

The district health system is a more or less self-contained segment of the national health system. Its population is well defined and lives within a clearly delineated administrative and geographical area. It includes all the relevant health care activities in the area, whether governmental or private. It therefore comprises a variety of interrelated elements that contribute to health in the home, the school, the workplace, and the community. These are the responsibility of the health sector and related social and economic sector. It encompasses self-care and all health care personnel and facilities, whether governmental or nongovernmental, up to and including the first-referral hospital. It will be most effective if coordinated by an appropriately trained director of public health working to provide a comprehensive range of promotive, preventive, curative, and rehabilitative health activities.

The ultimate objective of a district health system is to make essential health and health-related services available and accessible to the people in a defined area, irrespective of social position. Such a system should be built on the available infrastructure and ensure adequate involvement of the community, especially women, and investment in manpower development. An equitable quality of the services should be assured for all social levels, and the importance of this should be understood by the public, the professionals, and those financing the system. To this end it is necessary to institute process and outcome measures and evaluation procedures. Evaluation must be a concern of all the agencies, groups, and individuals delivering the services although the ultimate responsibility for coordinating these activities and taking stock of the quality of what is being done will remain with the director of public health.

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The establishment or strengthening of health districts and the organization of district health systems are in progress in several cities and countries. One example is Manila, capital of the Philippines. The city is divided into six political districts. Each district is divided into barangays, which are the smallest political subdivision. The links between the health centres and the community (outreach services) are ensured by the barangay health worker assisted by the barangay health volunteer. Cases beyond their competence are referred to the health centre or to the community reference infirmary. An evaluation over a 10-year period in four barangays in subdistrict Pandacan shows a number of improvements, including a reorganization of the Manila Health Department, the strengthening of the health centres, the establishment of community reference infirmaries and manpower development programmes, and the revision of the university medical curriculum. Other functions, such as that of intersectoral coordination, are still deficient and will be given increased attention.

Reorganizing district and city health departments
Health development and the reorientation of services to meet the needs of vulnerable and under-served groups will not happen without determination and effort. Leadership, organization, and management are needed, as well as an ability to obtain political and professional support, mobilize resources, and bring together into a functioning network all possible participants and contributors. For this, district and city health departments should be strengthened and continual efforts made to bring about a change in attitude throughout these departments involving a fundamental shift of values, leading to new strategies and approaches.

Capacity-building
The tasks facing governments involved in the reorientation and strengthening of rural and urban district health systems are often disproportionate to the available knowledge and skills. Capacity-building is therefore a priority and must be carried out at all levels simultaneously and continuously. It is a complex endeavour that goes far beyond the training and retraining of professional personnel and community health workers. It involves the delicate task of re-educating political leaders and high-level managers as part of an awareness-raising process of fundamental importance. The process includes the provision of information to the public as a prerequisite for their participation, and this calls for the involvement of mass media and the mobilization of all
agencies directly or indirectly active in the field of health. It also entails the development of methods and procedures to establish baseline data and evaluate results on a continuing basis as well as the carrying out of action-oriented research as and when needed. In this respect, universities and other research and training institutions, which represent an enormous investment in capacity-building, must be linked with the local communities.

Conclusion

It would be rewarding to be able to conclude on a note of optimism, but experience in the poor districts of the world, mainly but not exclusively in developing countries, does not engender optimism. In applying the concepts and strategy of primary health care to the poor, there is still a long way to go. Vulnerable groups such as women, certain categories of workers, the elderly, and the handicapped still receive inadequate attention. Many of the most vulnerable live in countries with stagnating economies, high debt levels, and low investment in social services.

Nevertheless, one positive conclusion is possible. Certain important, interrelated concepts that are accepted as fundamental in international organizations and cooperation agencies are finally being considered and debated locally and seem to be receiving increasing attention. Some of these concepts are:

- decentralization, the development of self-reliance, and local capacity building,
- democratic accountability and responsibility, leading to increased efficiency,
- sustaining of only those initiatives that deserve to be sustained, and
- equity in the provision of service and care.

DEVELOPING THE DISTRICT: FOR WHOM?

Decentralizing to the district level is vital if decisions about health priorities are to involve more people. However, given the current political and economic environment, there are certain risks involved in embarking on the process, according to Peruvian doctor Eugenio Villar of the Division of Intensified Cooperation (ICO), World Health Organization.

First, much of the present pressure on governments for decentralization comes from the international financial institutions as part of Structural Adjustment Programmes (SAPs), rather than from within the countries. The danger is therefore that the only objectives of decentralization are cost-cutting and "efficiency" at the expense of equity and the needs of the poor. Take the example of Zambia. While there is evidence that, due to incentives, more doctors are moving out of the cities to work in rural areas, decentralization plans also include reducing the number of health centres nationwide from the present 900 to 400. Dr Villar says that he is not arguing that a health facilities should never be closed. He says that for example it may be necessary to close facilities in oversupplied areas in order to achieve a better distribution. "What I wish to affirm is that decentralization should aim to put primary health care into practice in an equitable way," he says.

The second danger is that decentralization to the districts may take place without the necessary changes in attitudes towards improving health. Dr Villar says that those implementing the changes have to be convinced of the central role of the community in the promotion of health. However, World Bank officials and medical professionals working in central government may find it difficult to give up their idea of health services as suppliers of medical technology. Both sets of experts need to accept that gathering "information intelligence" from the communities which are already managing their own health problems is the priority for development planning. Such an approach would reveal the need for other district administrations, such as agriculture and housing, to be involved in planning if health conditions are to improve.

Once it is recognized that decentralization has "health for all" as its objective, and community involvement and collaboration between economic sectors as major priorities, the processes involved in decentralizing become more obvious.

First, there is the need for central government to redefine its role in favour of the district. In a responsible way, it has to gradually transfer not only responsibilities to the district but also financial resources and authority.

Second, the capacity of the health sector within the district, particularly the managerial skills, have to be strengthened.

Thirdly, links between the district administrations and the community have to be built. Community-based health projects, youth and women's health networks, employee health organizations and so on, have to be involved in the decision-making of the health system. Although the views of these groups may be different, and may sometimes appear threatening to those in power, it is only by involving these community organizations in health structures that the best choices for health development will be made.
THE DISTRICT HEALTH SYSTEMS APPROACH

Many of the approaches to introducing primary health care have not worked well. Matomora K S Matomora, MD MPH, Institute of Tropical Hygiene and Public Health, Heidelberg University, Germany, introduces Contact readers to the "District Health Systems" approach, and explains why it is important for church hospitals to become part of such a system.

Since the 1978 Primary Health Care (PHC) Declaration in Alma Ata, Kazakhstan, various implementation approaches have been tried. They have ranged from the more "selective PHC" programmes to more community mobilization approaches. Most of the approaches have tended to be operated independently of the existing health infrastructure. The multi-tier health system has often been perceived as being complex, centralized, and inefficient. Meanwhile, most people depend on the system's lower, resource-starved tiers (health posts, clinics, dispensaries, health centres and so on) run by inadequately trained and poorly motivated staff.

The district health systems (DHS) approach to implementing PHC is about decentralization of health planning and decision-making to a more manageable and autonomous district level. The size and complexity of the district is determined on the one hand by the need to be large enough as to allow some concentration of technical and human resources, which can effectively support PHC, and on the other hand by the need to be small and flexible enough as to allow for communication with, and the participation of, the population.

The objective of this paper is to analyze the tenets (principles) of the District Health Systems approach, and in particular, to consider the importance of the involvement of church hospitals in it. The involvement of church hospitals is considered to be important not only in order to share the immense workload at hand, but also in order to enrich the approach through sharing the church's special experience with community-based health care (CBHC) support activities. On the other hand without the District Health Systems frame, CBHC work appears to dissipate (disappear). It is hardly sustainable nor can it achieve significant coverage. The frame function of the District Health Systems approach is illustrated by the AIDS and Safe Motherhood programmes (see pages 12

The considerable potential contribution of church hospitals is their track record in facilitating and supporting CBHC.
and 13). Both case studies show why it is important that all health services have the support of the district level.

**The District Health Systems approach**

The district is the level where top-down and bottom-up planning processes converge. The district health system is defined by WHO as “a more or less self-contained segment of the national health system which comprises a well-defined population living within a clearly defined administrative and geographical area, either rural or urban, and all institutions and sectors whose activities contribute to improved health”. It consists of a complex of related and coordinated health facilities, which are organized as a whole and which together assume the responsibility for the health of a defined population. Such an integrated system must cover all situations and avoid “gaps” such as giving an injection of chloroquine to patients who could more simply and more appropriately take the drug orally.

Elements of a system are not distinguished by levels of care but rather by their different functions. The different elements of the system must fulfill level-specific roles and so avoid “overlap”. Thus, for example, “primary” functions are best performed at the health centre, where the staff are trained to provide a wide range of integrated services and continuity and comprehensiveness of care are best guaranteed. Within the system internal “barriers” must be minimized in order to facilitate referrals and transfers. For example, there should be no additional payments for referrals.

In its most simplified and most manageable form the District Health Systems is a two-tier system which consists of a network of primary health units and a central hospital.

**The health centre**

The health centre is a comprehensive primary health unit. It is a small, decentralized and permanent structure which has a few (3-5) trained, locally-resident polyvalent (multi-skilled) staff, who deliver to a defined population integrated, comprehensive and continuous care, which cannot be given by the community itself, that is, through mothers, community health workers, traditional birth attendants, etc. The specific function of the health centre is to be the “universal entry point” and “point of interaction” between the service and a defined community. Its most important role is the establishment of human relationships with the population and the promotion of a continuous dialogue and community participation. As such it is the most logical level for initiating and supporting community-based health care (CBHC) activities and for ensuring their wider coverage. In its delivery of technical care the health centre can meet up to 90% of the health care needs of the population it serves and reduce overall hospital admission rates by up to 50% (1).

In the past urban health centres have not been common. Instead, hospitals have been forced to serve as highly congested urban dispensaries. As a result, they have usually been grossly undermined in their district functions. The need for a dense network of urban health centres is being increasingly recognized. These do not have to be costly new buildings. Existing maternal and child health (MCH) clinics, social centres or even low-cost rented apartments can be converted into health centres. Then, after reorienting, existing hospital outpatient staff are decentralized to the health centres. Direct access to the hospital is slowly restricted. This is achieved either through a compulsory referral system, and/or raised consultation fees and/or an appointment system.
As a result doctors have more time for supervision and for organization of the district.

The district hospital
Rather than being an independent entity, the hospital is redefined as a complementary part of the health centre's service. The hospital concentrates scarce resources (equipment, staff and drugs) and acts as a referral centre for patients who require expertise and treatment not available at the health centre. Moreover, hospitals are meeting places for district decision makers. They plan and conduct training, health centre evaluations and epidemiological surveys. The clinicians evaluate the referral process with health centre staff during supervision.

A study of the hospital-health centre relationship in the Kasongo health district of Zaire showed that children who were covered by a health centre had a shorter mean duration of hospital stay than those who were not covered. The number of hospitalizations per inhabitant for areas with health centres was almost half that of areas not covered (2). The health centre staff have sufficient prestige to persuade people not to go to the hospital when they do not need to; and to ensure that they do go, even if they are living in remote areas, when they do need hospital care.

The district health office and management team
The district concept assumes a fairly high level of autonomy and the existence of a competent district health management team led by the district medical officer (DMO). The district medical officer's responsibilities include management and motivation of the team members, training of health centre staff in technical and social skills, as well as supervision and administrative control of the health centre and the hospital. The district health management team plans and coordinates the health infrastructures and activities, and manages the hospital (referral) clinic and the medical operational research. It also maintains multisectoral contacts, with departments of education and agriculture, for example. The performance of a district health management teams can be evaluated through such indicators as frequency of meetings, frequency of supervision of health centres, attrition rates (loss of staff to other employment), analysis of work-time and non-existence of a private practice inside the public service. In reality, however, most district health management teams have little power and very limited resources. Their members are inappropriately trained and are often absorbed in routine activities.

Traditionally, District Health Systems are organized alongside the administrative districts. Apart from their lack of real autonomy and power such districts may in many cases be too large to make District Health Systems manageable.
The large size may be in terms of area, such as in Kenya, or in terms of difficult terrain as in Zaire or Lesotho, or in terms of large populations, such as in India. It may also be in terms of large numbers of primary health units as in Tanzania. The District Health Systems usually involve only government hospitals. Other hospitals, such as non-governmental private hospitals and church hospitals, are rarely incorporated into this organization despite the fact that they could share the work of the administrative district.

CHURCH HOSPITALS AND THE DHS APPROACH

In developing countries, church health services form a major resource. In 1971, Protestant churches and missions alone operated medical programmes in 81 nations, including over 1,200 hospitals. In sub-Saharan Africa, church hospitals provide 43% of medical work in Tanzania, 40% in Malawi, 34% in Ghana, and 9% in Zaire. In Asia, the figures are 26% for Taiwan, 15% for India (where there are over 200 church hospitals), 13% for Bangladesh, and 12% for Indonesia (3). WHO advises governments to facilitate the integration of both governmental and non-governmental hospitals and to establish integrated District Health Systems. There are good reasons to integrate church hospitals. They have a good track record in supporting community-based health care activities. Other qualities include stability and low staff turnover, freedom from a rigid bureaucracy, proximity to communities, preference to serve and support the underserved and high staff motivation following a voluntary and informed decision to work in church services.

Sharing district functions
The importance of sharing district functions among government and NGO health services may be illustrated by the example of Tanzania. The country is divided into 106 administrative districts. There are 175 hospitals, of which 80 are church owned. At the primary level are 3,370 health centres, more than 3,000 of which are called dispensaries. In principle, church hospitals, including the so-called designated district hospitals, do not have district functions. These district functions are the sole responsibility of the district medical officer. However, calculations show that by assigning all hospitals such “district functions” in their catchment areas, total supervision costs would be reduced by between a quarter and a third. The workload for each supervising centre (covering different areas in a particular administrative district) would be much more manageable and the quality and frequency of supervision could be much improved (4).

Reluctance to share district functions stems from greed for power and control on both sides. The church hospitals fear loss of identity, autonomy and flexibility. Governments do not want to let go of any of their power. Moreover, while the importance of hospitals in PHC was strongly emphasized by Mahler (1981), then Director General of WHO (5), in practice their involvement, especially that of church hospitals, was limited to such activities as running mobile maternal and child health (MCH) clinics,
training and supervision of village health workers and traditional birth attendants (TBAs), and support of community-based health care (CBHC) activities in a small number of selected villages. Neither government nor church hospitals took systematic and regular support of a network of health centres in their catchment area as their priority role.

Back to the roots
Organizing a network of primary units around a hospital which supervises them is an old idea. Even before Independence in Africa “Medical work of doctors...consisted ‘mostly of intensive travelling from one dispensary to another, some of them 50-80 miles walking distance apart.’ The idea of establishing a central hospital with small dispensaries... (supervised) at frequent intervals by the medical officers.” (6) These mainly curative oriented dispensaries were later to be replaced by health centres, which integrated curative with preventive care. A conference in Harare in 1987 was an important step “back to the roots.” It defined the district health system approach as the best means of implementing PHC. Subsequent international meetings and resolutions have reiterated the important role of hospitals in referral and in the logistic and managerial support of health centres.

Involvement of church hospitals in running health districts in Africa has best been realized in Zaire and Lesotho. There, health districts have been defined as follows: “Each functioning hospital, regardless of affiliation, is responsible for the technical organization and supervision of all of the health activities in its catchment areas.” (7) Among the 306 Health Zones in Zaire (34 million population), 50% are managed by or in collaboration with NGOs. In Lesotho (1.9 million population) nine of the 19 “Health Service Areas” are run by church hospitals. Similarly, in Ghana, hospitals which are centrally-situated within particular districts have been declared district hospitals, independent of their affiliation, and one of their doctors is appointed district medical officer. In Brong Ahafo region of Ghana, for example, six of the 12 district hospitals are church owned (8). As a result of the cooperation and sharing achieved in these countries, they can boast some of the most tenacious and resilient health districts (for example, Kasongo, Vanga, and Bwamanda in Zaire, and Scott in Lesotho) reported in literature. Similar cooperation takes place in Nepal, Haiti and the Philippines (9).

The considerable potential contribution of church and other non-governmental (NGO) hospitals for the District Health Systems approach is their track record in facilitating and supporting community initiatives and community-based health care (CBHC). However, the framework in which this activity has taken place has not been well defined. Thus the multiplication and spread of CBHC initiatives in the 1980s has been slower than had been expected. In fact, at the beginning of the decade, Werner (1980) (10), after reviewing over 40 Latin American rural CBHC programmes, wondered “if and how such activity can be replicated to reach more people.” Similarly, Mburu and Boerma (1989) described CBHC as being “inextricably small-sized and characteristically short lived... Few benefits, if any will emerge in the foreseeable future.” (11) The involvement of the church hospitals in the development of health districts has the potential of making CBHC more sustainable and of achieving greater coverage.
AIDS PROGRAMMES AND THE DHS APPROACH

AIDS is a major blow for developing countries, and especially for Africa. In late 1993, cumulative HIV infections in adults were estimated to be nine million in sub-Saharan Africa, two million in South and South East Asia, 1.5 million in Latin America and the Caribbean and 1.7 million in the rest of the world (12). Two-thirds of all HIV-positive persons in the world are in sub-Saharan Africa, where only 9% of the world’s population lives. Being mainly heterosexually transmitted, AIDS in Africa is very largely a family problem involving men, women and children.

The three main objectives of the global AIDS strategy are to prevent infection, to reduce personal and social impact and to mobilize and unify national and international efforts against AIDS. In order to achieve these objectives, greater attention is being given to care, better treatment for other sexually transmitted diseases (STDs), and a stronger focus is being placed on preventing HIV infection by improving women’s health, education and status as well as the promotion of a more supportive environment for prevention programmes.

Hospital-supported home care
AIDS home care, with support from the hospital level, has been tried in several places. For example, since 1987, the Chikankata Salvation Army Hospital, 240 beds, in Zambia has been developing an admirable model of hospital backed, home-based AIDS care. By 1990, the team consisted of 12 staff including two doctors. The programme consists of patient diagnosis, counselling, treatment, contact tracing, home-based care and hospital care as well as AIDS educational activities with family members, community groups and schools. In Rakai area, Uganda a similar approach has been reported. WHO has recently (1993) published an AIDS home care handbook. Home care takes advantage of the effectiveness of family support, the need to decentralize care, the educational effect and the preference of the terminally ill to die at home (13).

Such innovative programmes contribute important lessons. However, with the increasing prevalence of HIV/AIDS on the one hand, and with declining resources on the other, hospital-backed home-based care can hardly be sustainable nor can it achieve more significant coverage. In 1990, the team consisted of 12 staff including two doctors. As Williams has stated “it will never be possible for Chikankata AIDS team to meet with more than a handful of individuals, families and community groups.” Moreover, the high initial resource input limits the replication of the approach in other districts. Those involved in the project have concluded that the solution may be through greater integration with the formal health structure. They hoped that in the future, “it may be possible to work more closely with rural health centres and community health workers.” (14)

AIDS care within the DHS approach
The value of the District Health Systems approach is well-illustrated by the AIDS epidemic in sub-Saharan Africa. Home visits and follow-up of chronic patients is part of the minimum package of activities of health centres. The role of the hospital is in logistics and training support, enabling and motivating health centres to follow-up AIDS patients and their families more seriously and systematically.
The increasing demand for AIDS medical and nursing care as well as for counseling and health promotion requires a network of health centres within a functional district health system. The health centres have the advantage of being physically closer to the patients than the hospital. They are also likely to be less impersonal, and more sensitive to local cultural considerations, such as what would be considered appropriate clinic opening times. Teamwork is also better in smaller units, and with polyvalent workers there, a patient can be helped by any of the four or five staff members.

Unlike outreach services, the health centre is a permanent structure which, theoretically, would provide a 24-hour service. Integration, which is defined as the acceptance and assumption of responsibility for all aspects of the care, is especially important for AIDS management and control programmes. Because AIDS affects every aspect of community life, intersectoral action is crucial. This is best realized at the district level where decisions can be translated into sustainable action among the same population.

SAFE MOTHERHOOD PROGRAMMES AND THE DHS APPROACH

The gap between health statistics for women in developed countries and those in developing countries is dramatic. Ninety-nine per cent of the estimated 500,000 maternal deaths worldwide take place in developing countries where only 75% of the women live. Africa, for its part, experiences 30% of all maternal deaths although only 11% of women live there. The estimated lifetime risk of maternal death in northern Europe is one in 9,850 compared with one in 21 for Africa, one in 54 for Asia and one in 73 for South America. For each maternal death, there are estimated to be five to six times as many cases of maternal morbidity as a result of obstetric complications.

The need for a working District Health System
Much of the obstetric morbidity and mortality is technically preventable. The demand for service is extremely high. From experience in developed countries, it is known that high standards of obstetric care, whether domiciliary (Netherlands) or hospital-based (USA), plus safe and legal abortion services, reduce maternal mortality. From the experience of a US community which chooses not to use medical services, it is also known that general development alone does not reduce maternal mortality. Among the women followers of this religious sect who refuse all hospital care, maternal mortality is 100 times higher than in the rest of the US and similar to that of rural India (15).

A top priority in reducing maternal mortality is prompt access to a functioning emergency obstetric care service, involving safe blood transfusion and surgery. Immediate medical causes of maternal deaths are 28% haemorrhage, 19% induced abortion, 17% hypertension, 11% obstructed labour/uterine rupture, 11% infection and 15% other causes (15). The second priority is to reduce exposure to the risks of unwanted pregnancies. This is achieved with the help of family planning which reduces

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Cesarian section in the general surgery room at the Base Hospital, Matara, Sri Lanka.
L. Casher/WHO

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the number of pregnancies and the proportion of high risk pregnancies. The third is the establishment and improvement of other maternal services, including the early recognition of complications, the organization of transport for emergencies and conveniently-located "maternity waiting homes", antenatal clinics and TBA training.

Antenatal care helps all (not only pregnant) women to obtain prompt treatment for complications and for existing problems (eg anaemia and malaria). However, the predictive value of antenatal care screening may be low. Postpartum haemorrhage and infection are not always predictable. Two-thirds of cases of obstructed labour cannot be predicted. This shows that the need for prompt access to obstetric emergency hospital services is independent of the risk status. However, this does not mean that all deliveries must be carried out in hospitals. What it does mean is that the District Health System has to ensure that health centre staff and their communities need to be able to recognize obstetric complications early and make arrangements for transport. In anticipation of such situations, special "transport funds" need to be arranged and self-administered "maternity waiting homes", near the hospitals or beside the main roads, need to be developed. Exactly which options are chosen and who organizes the arrangements can be decided locally, with the PHC team initiating discussions with TBAs and household elders, for example.

Conclusion
The District Health Systems approach gives the best organizational base for implementing PHC more coherently. Such important programmes as AIDS control and the Safe Motherhood Initiative can best be operationalized within the context of a functioning district system. The involvement of church hospitals even to the extent, as in Zaire and Lesotho, of defining "health districts" around all functioning hospitals of a country, strengthens the District Health Systems approach. It ensures that the church continues to motivate and support community initiatives in health and development within a sustainable framework and to larger populations, much in line with the CMC mandate to facilitate "the development of compassionate, just and sustainable health care." (16).

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Life in Angola: water and housing conditions are crucial aspects of an integrated approach to district health care. Peter Williams/WHO
BRAZIL: WOMEN PARTICIPATE IN SHAPING DISTRICT HEALTH POLICY

The active participation of community organizations, including women’s groups, in district health structures can play an important part in shaping local health policy. Although many women’s health organizations have experienced frustrations in this process, there have been successes. For example, represented on a district health committee, a feminist group in Brazil has helped to build an understanding of the social causes of maternal mortality.

In 1989, a national seminar on maternal mortality and morbidity was organized by the Coletivo Feminista Sexualidade e Saude (Feminist Collective on Sexuality and Health), Geledes - Instituto da Mulher Negra (Geledes - Black Women’s Institute) and Margareth Arilha, a feminist working with a health and education NGO. Those taking part included the women’s health activists, researchers and public health professionals who play crucial roles in implementing women’s health initiatives at the national level in Brazil. Participants rapidly agreed on the urgency of reducing the high rate of maternal deaths and morbidity in the country. Discussion then turned to creating the necessary strategies. Three main strategies emerged:

- developing concepts of ethical practice for both individuals and institutions.
- to encourage the collection of more precise data about maternal deaths;
- to increase the number of maternal mortality committees, and
- to include the participation of women’s health activists on these committees.

This was not the first time that women’s health activists had spoken about the need for maternal mortality committees. They argued that such committees would not only work towards reducing maternal mortality and morbidity but could also help to improve the health conditions of the population and the quality of patient care. They also argued that the committees might be able to help to fight the indifference that can be characteristic of the public health services.

A woman living in a favela in Brazil.
Peter Williams/WHO

The deaths of all women between the ages of 10 and 49 years should be investigated.
City and district representation
In 1991, during the administration of the Partido dos Trabalhadores (Workers' Party) and while there was a woman mayor, a committee on maternal health was set up in the municipality of São Paulo. Called the Principal Committee on Maternal Health, its members included medical professionals, women's health and community health movement representatives, including members of the Feminist Collective on Sexuality and Health.

One of the rules set by the committee was that the deaths of all women aged between 10 and 49 years old should be investigated. Working with the municipal government programme which gathers information on deaths in the city, the committee decided that when the cause of death was uncertain, health and statistical records should be examined, medical professionals interviewed and the families of the women who had died should be visited.

During the first six-month period, members of the committee identified 59 deaths as "maternal". Of these maternal deaths, 15 had required detailed investigation. Members of the committee had looked into how, where and why the deaths had occurred and what had caused them. They discovered a great deal of information about the situations of the women themselves. Most of the women were from the most deprived parts of the city. They also established that most of the deaths could have been avoided if there had been access to antenatal care and to timely treatment.

On the basis of this investigation, the São Paulo municipality enacted legislation on the investigation of all maternal deaths of women between 10-49 years, and the principal committee set up 10 sub-committees in different administrative districts of the city. These sub-committees would look into the actual conditions of the most vulnerable women, and assess what could be done to prevent the deaths. As well as participating in the principal committee, the Feminist Collective was represented on the sub-committee for the administrative district #2 - West Zone of São Paulo.

The experience of the work of these committees in São Paulo has been shared by health authorities and women's networks throughout Brazil. In some cases, the information has stimulated similar developments in other states. Unfortunately, because of a change of government in São Paulo, the Collective is no longer represented on the principal committee in São Paulo. However, it continues to be represented on the West zone district committee.

Becoming part of the health structures in Brazil has provided women's organizations in Brazil with an opportunity to begin to shape policy. At the same time, the government structure benefits from networks of committed community members.

Source: Campaigning for integrated programmes, policy and planning committees, Women's Groups, NGOs and Safe Motherhood by Marge Berer, Maternal Health and Safe Motherhood Programme, Division of Family Health, World Health Organization, Geneva, and personal communication with Maria José Arajo, a member of Colletivo Feminista Sexualidade Saude and former coordinator of the Program of Integral Assistance to Women’s Health (PAISM) in the municipal health department of São Paulo.
CHRISTIAN NETWORKING IN SANTE FÉ

For more than 10 years, seven Christian organizations have been working together as a network in a vast area in the north of Argentina, writes Nilda Favit of Institute for Popular Culture (INCUPO).

It was the situation of the poorest of the poor which led us gradually towards combining our efforts. That way, we could make the best use of our resources, she says. We pool our ideas and carry out joint evaluation and planning.

The area is in the north of Santa Fé province and covers some 77,000 square kilometres with a population of around 280,000. The population we work with is predominantly rural and comprises indigenous communities of the Mocovi and Toba tribes. The people work mainly as peasant farmers, small producers, casual labourers, crop pickers, traditional fishermen, forestry workers, domestic employees and other similar occupations.

How does the network operate?

The work is divided into geographical zones, some along the banks of the River Parana and others in the forest areas. The field work is coordinated by two, three or more organizations working together, and a "coordinating board" made up of representatives of all seven organizations meets every month. Every three months, there is a meeting with the work teams. These are occasions for training, planning and evaluation, and also for the pooling of the work plans of the seven organizations involved. Once a year there is a gathering of about 100 representatives of all the local groups.

Examples of field work

In the Parana River zone, groups of women work to improve nutrition by introducing foods based on forest plants. They also keep a kitchen garden with vegetables for food and medicinal plants from which they prepare plant-based remedies. They keep a check of their children's weight, noting it down in "the good development notebook" which we have produced for them. They also organize popular entertainment providing health information.

All the activities contribute to "integral health" - an integrated approach to health based on a wide vision of health. Many of those involved do not specifically belong in the field of health. The indigenous communities have formed a provincial organization through which they have succeeded in lobbying for a recognition of their rights in a provincial law. This group was also active in the convention which recently reformed the national constitution. They pressed for the revised text to include recognition of their status as original peoples.

In the northern zone, there are groups working on alternative energy sources (gas production). Some of the members now work processing coal in a plant adapted for greater health and safety. They have regular dealings with the public health authorities.

Network members

- Asociación Amigos del Aborigén, Pueyrredón 1348, 3560 Reconquista, Santa Fé, Argentina. Tel: 0482 22096
- Caritas Promotion Department
- Foundation for Development in Justice and Peace (FUNDAPAZ)

The mothers are responsible for checking the growth of the children in the community.

The situation of the poorest of the poor led us gradually towards combining our efforts.
ENCYCICAL ON ABORTION

The World Council of Churches (WCC) has responded to Evangelium Vitae, the recent papal encyclical on abortion, contraception and euthanasia. Konrad Raiser, WCC’s General Secretary, says that although the encyclical did not go beyond earlier pontifical statements on these pressing moral issues, its formulation posed difficulties for ecumenical discussion and made "it nearly impossible to elaborate shared pastoral concern and guidelines".

The encyclical addressed moral questions with a degree of isolation from those who have to make moral choices, Raiser said. While women "are the ones who carry the main burden" in making decisions about abortions, they are hardly mentioned, Raiser said. He said that this showed a "striking lack of appreciation" and an "underestimation" of the ability of women to make their own ethical judgements.

The WCC had a “different methodology” in developing judgements on ethical questions to that of the encyclical. Unlike the Roman Catholic Church, the WCC did not have a “teaching office”. Instead, WCC was an intermediary or broker between churches in reaching ethical judgements and an intermediary for concerns which affect the unity of churches. Raiser said that Vatican officials had agreed with some of the individual points raised by the WCC delegation.

A VACCINE FOR MALARIA?

A trial of the Colombian “SPf66” malaria vaccine has shown a 30% reduction in the risk of clinical malaria in Tanzanian children, according to the World Health Organization (WHO). This trial follows a smaller one in February 1994 which showed that the vaccine was “safe and induced antibodies” in the Tanzanian children involved.

Although the result of the trial is very encouraging, WHO believes that it does not warrant widespread use of the vaccine at the present time. Many questions still need to be addressed. For example, how safe and effective is this vaccine in other high risk groups and in other malarious areas? Is it likely to be more effective than the 6–8 other Plasmodium falciparum malaria vaccines expected to enter clinical trials over the next 2-4 years?

Colombian doctor Manuel Patarroyo, who developed the SPf66 vaccine, offered to donate its full licence rights to WHO two years ago. Negotiations on these matters are still in progress.
The theme of this year's World Health Day was "A World without Polio" - once again, the focus is on immunization. This element of primary health care (PHC) takes the major share of external aid and concern in most poor countries. There are good reasons for this trend, one being the high cost-effectiveness rate. However, other elements of PHC need to be addressed, for example, nutrition. In Tanzania, PEM (Protein Energy Malnutrition) is a major cause of morbidity and mortality in under fives. Data show that its prevalence has been doubling within the past 27 years. In the country, PEM is dealt with mostly by external agencies or non-governmental organizations (NGOs) with a project/programme approach like CSPD (Child Survival Protection Development) operated by Unicef in half of the 20 regions of Tanzania.

In my opinion, the maternal and child health (MCH) national service, which is well-spread throughout the country (one unit for every 2.5 villages) should instead deal with PEM. Community-based nutrition rehabilitation with good commitment from the health staff and full involvement of the local leaders has proved to be an adequate approach. Hospital wards are certainly not the right answer to the problem, as has been repeatedly underlined. There is a need for a reorientation in the service rendered by the MCH system, from central to peripheral level. At present vaccination and prescription of drugs take the major share of the daily activities in a typical village health unit. It is true that malnutrition is a global problem and requires a multisectoral approach, but it is also true that the health sector ALONE could do much to reduce the fatality rate, to raise awareness among the population and to educate women on proper utilization of whatever food is available.

Massimo Serventi
Paediatrician
Dodoma General Hospital
Tanzania

As an obstetrician with a reproductive and maternal-perinatal health programme in Peru, I always find it useful to know what ecumenism is doing about health. I was particularly interested to read about your work and testimony with regard to the International Conference on Population and Development which took place in Cairo last year. In Peru, a mainly Catholic country, there have been major debates on this theme. Unfortunately, some senior members of the Roman Catholic Church have tried to block the analysis of the problem of women’s health. These members of the Catholic hierarchy were anxious that the Cairo conference would approve abortion, closing their eyes to the fact that in reality abortion is a public health problem. For our part, we are planning strategies to raise awareness about health, especially among adolescent girls in the schools.

Name withheld
Regional coordinator
Reproductive health, DRSA
Ministry of Health
Peru

Ecumenism and women’s health

USEFUL PUBLICATIONS

This list includes some useful books on the district health system. Unless otherwise stated, these publications are available in English only. Addresses of distributors are provided in the Address box (on next page).

A new agenda for medical missions by D Merrill Ewert is available as a MAP International Monograph 1990.

District health care by R Amonoo-Lartson, G J Ebrahim, H J Löwel and J P Ranken is intended for those involved in planning, administration and evaluation of health services at the district level. ELBS version available from TALC at price £2.20 per copy.

Library packages to support district health services are available from TALC. The scheme offers three small libraries of vital medical and health books.

The largest package is for the District Hospital Library, containing 17 books at a price of £85 including surface mail (£106.85 for airmail delivery).

A second package, which costs £60 (£76.20 airmail), is intended for the Health Centre Library. Both packages contain a copy of "Where there is no doctor", a revised book on nutrition and a book on obstetric emergencies.

The third, the Pharmacy Library, is new and available at an introductory price of £32.00, (£47.00 airmail). This library pack contains a range of publications and materials which support the effective management of essential drugs in hospitals and health centres.

Medical administration for front-line doctors by C Andrew Pearson is a practical guide to the management of district level hospitals, from money to maintenance and primary health care outreach. A new edition is available from TALC at £5.80 per copy.


The role of the hospital in the district, delivering or supporting primary health care? By W Van Lerberghe and Y Lafort, WHO/SHS/CC/80.2.


ANNOUNCEMENTS

Pepsi feeding bottles
US company Munchkin has irresponsibly launched a "soda series" of infant feeding bottles. Advertised with the slogan "You got the right one baby" and "You gotta have it", the bottles feature the logos of soft drinks, such as Pepsi, Diet Pepsi, 7UP, Slice and Dr Pepper. On seeing these bottles, those taking care of children might think that it was safe to feed children soda. Included under the promotion on the package, there is a warning section. This warning mentions the "severe tooth decay" that can result from prolonged contact with liquids containing sugar, but it does not warn parents specifically not to use soda to feed their infants. The feeding bottles have been found on sale in the USA, Canada, Mexico, Malaysia and Singapore.

In a letter to PepsiCo, staff members of Wellstart, a non-profit organization dedicated to promoting infant health and well-being, urged the company to agree that the "Pepsi baby bottle series is a potentially dangerous product which should be taken off the shelves and discontinued."

Contact always welcomes letters to the editor, especially those which challenge or add to arguments of articles appearing in the magazine. Publication of letters will be at the discretion of the editor and the editorial committee. Unsigned letters and letters without the writer's address will NOT be published, but in some cases, and always on request, Contact will withhold the name of the author.

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Contact deals with varied aspects of the community's involvement in health and seeks to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to: Contact, the publication of CMC- Churches' Action for Health, WCC.

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