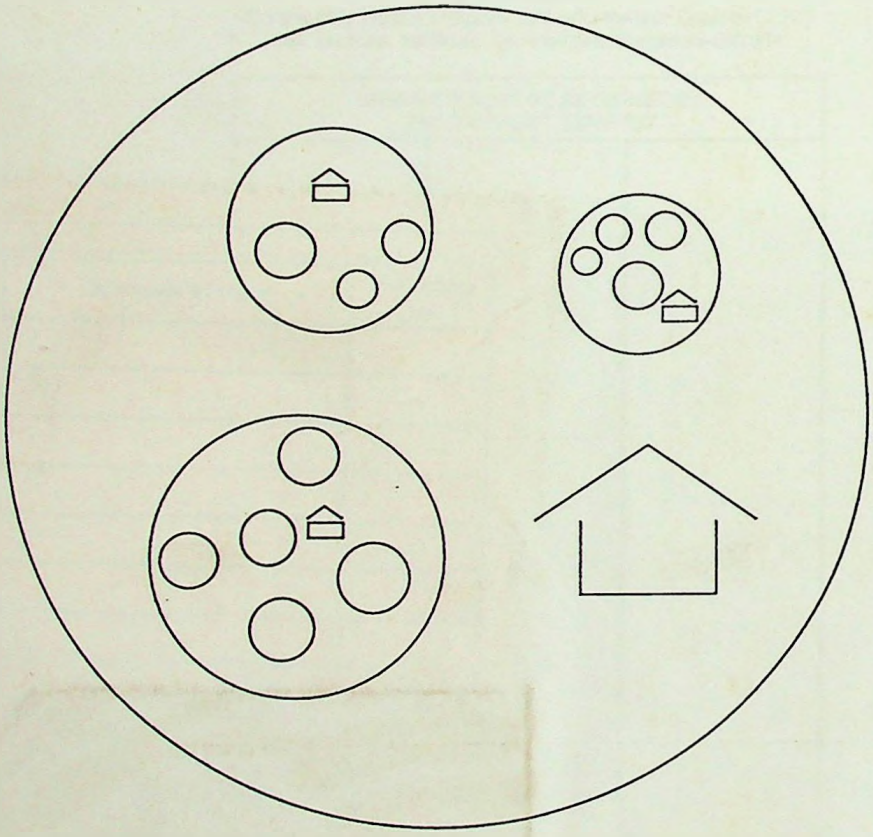
Management
of Health Districts
by Non Governmental Organizations.

How can it be achieved?



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Marieke Verhallen

Management Involvement of Non Governmental Organizations in Health Care Districts

How can it be achieved?

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Marieke Verhallen

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INTRODUCTION:

At present many developing countries are undertaking health system reforms for a variety of reasons. The envisaged reforms have stimulated a new debate on the role and place of health care providers of church-related or social local non governmental organizations. (NGO's) Only too often their facilities are not an integral part of the public health care system.
The adopted 'District Health Care System' has to be a coherent and comprehensive delivery system capable of answering the needs of a well defined population in the context of Primary Health Care. [1,2] To achieve this all non-profit health care providers/facilities in the district have to be part of the system.
The need for close cooperation between governmental and NGO providers and integration of NGO facilities, in the context of the district health care system, has been well argumented in all documents on the issue. [1 to 11] However, experiences show that achieving the cooperation needed to establish a coherent district system, is not easy to realize. Governments are still trying to manage and implement all health services while they are inadequately equipped and badly placed to do this. NGO health facilities have the technical capacities to take more responsibilities in a district but they are rarely being given these duties nor are they taking them. [3,4,5,6,7]
Though both parties see the need for close cooperation, they are not finding the ways to effectuate it. Up till now very little research has been done to determine how to install an effective cooperation and which conditions can enable NGO facilities to take responsibility for running (all) aspects of a health district or sub district. [4,7]

This paper lays out the need for health systems research into feasible strategies for Government - NGO cooperation to assist policy makers, of both parties, in ensuring optimal use of all available capacities and capabilities to strengthen the district health care delivery system.
I will first try to define the problem more clearly as I think that, at least, part of the difficulties stem from unclear views on what the aim should be. At present the issue is considered merely in the light of integration of the NGO facilities into the public delivery system. This raises fundamental hesitations on both sides.
Subsequently I will study the obstacles as they pose themselves to a particular NGO hospital. In chapter three I will try to determine the conditions that can remove the obstacles and enable both parties to effectively share responsibilities and resources. In the conclusions and recommendations I hope to give my ideas on how we can continue on this road.
The information and experiences, which form the basis of this study, mainly stem from Sub-Saharan Africa as my own experience lies there. The role of the NGO hospital in the district is my main focus as it gives more opportunities to illustrate the issues at stake. But much of what is being said is also applicable to peripheral units and sub districts.

1. PROBLEM DEFINITION:

1.1. Background:

At independence most new Sub-Saharan African governments (and their international partners) interpreted their responsibility for health care delivery in such a way that they saw it as their obligation to provide and manage all the services needed. This meant that non-governmental providers were seen as temporary, or ignored and not integrated into the system.

Depending on the country or region, the NGO's now own and operate between 25 to 60% of the available health facilities.

In some countries attempts have been undertaken, in the past, to integrate NGO health care providers into the Governmental health care system, with limited success. The failures have strengthened feelings of competition in many instances, and have sometimes even fostered mistrust and hostility.

At present the issue is on the agenda again as a result of various changes in international and national views regarding solutions for the problems of developing countries.

1.2. The District Health System:

The main concern of the Primary Health Care concept (PHC) and the ensuing 'Health For All by the year 2000' strategy (HFA) is to ensure that prevention of disease and promotion of health should get as much attention, if not more, as curative care. It's revolutionary idea lies in insisting that the population should be directly involved in shaping it's own health and health care. [1,2,8,11] *

The concept and the strategy is now the basis of health care programs and activities of Governments and NGO's in most Sub-Saharan countries

To facilitate community involvement and responsiveness to local health needs a reorganization of the health care delivery system into health districts has been elaborated:

" A district can be defined in very general terms, as the functional unit of a decentralized health care organization for a defined population".** Its optimum size is the result of two opposing requirements: economy of scales and community participation.

In its simplest form the district health system (DHS) is an integrated three-tier system:

(1) community health care activities supported by (2) a first line health facility (dispensary or health center) which in its turn is supported by (3) a district hospital.

In summary: the first line unit is the pivot of the health service delivery system. (curative care, prevention and promotion) The district hospital provides referral care and support to the first

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* This policy was inspired by the work of three NGO hospitals.

** Abbreviated definition as used by MMI in 5; see 2 for more extensive definitions.

line units. The District Health Management Team is responsible for the management, strengthening and coordination of all services in close cooperation with the district health governing board and the hospital staff. *
This concept facilitates the division of tasks and responsibilities between health professionals, representatives of the population and all other parties concerned.[2,4,6,8,9,10]

1.3. Interests and hesitations towards cooperation:

1.3.1. The Government's perspective:

The governments of the Sub-Saharan countries are going through a transition phase. Under national and international pressure political changes towards democracy are being initiated. The Structural Adjustment Programs of the International Monetary Fund and the World Bank favour a different view on the role of government. Governments should not want to cater for everything but restrict themselves to setting policy guidelines, ensuring access to social services for the poor, regulation and research. [3,11]
This means the government has to delegate the execution of tasks and duties to other parties. Privatization and decentralization are strategies envisaged to achieve this aim.

In health care governments face enormous budgetary constraints, lack of capacity and capabilities as well as organizational problems. The World Bank and WHO stimulate governments to concentrate on: [3]
- financing and implementing public health interventions;
- financing and ensuring delivery of a package of essential clinical services;
- improving cost-effectiveness.

Private providers can ensure clinical services for the wealthy and might contribute to cost-effectiveness and quality of services through competition. Public health tasks and access for the poor will only be taken on by private providers if special subsidy measures are taken by the government. [12] In many areas, the population has no choice of providers as no other health facility is available. Privatization can thus not contribute to comprehensive and equitable PHC.
The district health system, as a form of decentralization, aims at ensuring equal access while delegating the responsibility for execution of essential clinical services and public health tasks to local authorities and parties.

The international policies, and their translations by individual governments, are not clear with regard to the role and place of NGO's in these strategies. [3,13]

- As private providers and competitioners, their contribution to alleviating the

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* Annex 1 shows the national public health system and annex 2 the organization of the district.

governments burdens can only be quite limited. In practice some governments seem to favour this option as it retains their complete authority and autonomy to determine policies and control the execution of public duties from the central level down to peripheral workfloor.

- As part of the district system, a solution has to be sought, to ensure that the NGO's can take up the appropriate district tasks and responsibilities. Integration is often proposed [2,4,5,6,7,8] but most governments appear to shy away from it. The probable reason is that it would increase governmental responsibilities instead of diminishing them.

Delegation of tasks gives the government the possibility to diminish its executive responsibilities while retaining its constitutional obligation to ensure access to health care. This option is new to most governments. Some are studying the implications, advantages and disadvantages.

Most of the proposed changes still have to be translated into the laws and bylaws of the countries but also into guidelines for local implementation. Experience within governmental bodies, at all levels, to share decision making and to share responsibilities with- or delegate tasks to non governmental parties is minimal. There is a reluctance to shed direct control and current unfamiliarity with the NGO's together with past rivalries give rise to resistance to such cooperation.

1.3.2. The Non-Governmental Organization's perspective:

The NGO's, thought of here, are autonomous local organizations. Their original aim is to support the poor. They mostly finance their running costs from local income. (fees for services and contributions) Dependence on international support is mainly for investment costs.

The developments at national level provide new challenges to contribute in other ways to the improvement of services. They also open up possibilities to support popular movements in search of a more just society. [4,15]

In health care the NGO's present isolation from the system limits their possibilities to provide comprehensive PHC. Their financial constraints limit their possibilities to realize their commitment to the poor, particularly in situations where they are not sharing in public funding. NGO's are often quite aware of the needs and have the capabilities and experience to assist in strengthening the existing health care system. [3,5,6] Their assets are: an important network of facilities; experience in community involvement and experience in providing health care under economical constraints. Most NGO facilities are either first line centers or first line referral hospitals. Overall geographical coverage can be largely improved if they are included in the DHS.

On the other hand the tasks, that they have taken in the course of the years, are often wider or

more restricted then proposed in the DHS. Moreover, as they have to ensure their own running costs, their fees may be higher than those of the surrounding governmental facilities.

The district health system offers, in their perception, great advantages for improvement of the health care provision and to solve the inadequacies and duplications existing at present between the various parties. [5,6,7]
Full integration of the NGO facilities into the district health system is often seen as the most suitable approach. [5,6,8] However many NGO's feel that, by definition, this would mean that they become one with the government system and thus loose their identity. It is felt to be in contradiction with their wish for autonomy and independence. In their opinion these guarantee their freedom to act in line with their original aim and retain their community based character. [6,14,15,16]
Their hesitations are strengthened by past experiences with government nationalization policies. [18,19] The fact, that most NGO's have not yet developed consistent policies in face of the new challenges, complicates matters still further. [7,14,15]

If NGO's want to remain faithful to their original aims and play a positive role in society building, they need to know what is at stake at community level as well as have influence at policy formulating and implementing level to promote such interests. Remaining autonomous and accepting delegated responsibilities in the district health system, as partner of the government, would give them both. But it will also give obligations as their activities and policies (for ex. essential drugs, cost sharing etc.) will have to be aligned. Inevitably this entails a certain loss of independence but the advantages outweigh this price, according to NGO's considering this option.

1.4. The Key Question:

The principles of PHC and the definition of the DHS implies that the district has to be an entity with a coherent system of participative management and an equitable financing system (including user-charges). Each health facility/provider has to be part of the system to ensure its cohesion and comprehensiveness.
The definition does not imply that there has to be unilateral ownership. The responsibilities and tasks for providers/ facilities are clearly defined/definable. This means they can be divided amongst the parties, present, on the basis of location and capabilities.
The government has to remain responsible for ensuring that the population has access to the health care it needs and that each person benefits to an equal share of the national health care resources. Under the new policies it can delegate responsibilities and grant access to such resources to other parties.

The NGO's want to keep their autonomy while contributing to the improvement of health care delivery to the same population to which they have close links.
Full integration does then not serve the interests of either party concerned.
The key question therefore should be: 'how to share responsibilities and resources in such a way that government and NGO's complement one and other to achieve optimal functioning of the district health system' Or: 'how can the government delegate responsibility and the corresponding resources to the NGO's and how can the NGO's take them up?'

2. THE OBSTACLES TO SHARING RESPONSIBILITIES IN DISTRICT HEALTH - THE CASE OF TANGUIETA.

Policy guidelines, regarding how to achieve the sharing of responsibilities by Governments and NGO's, are lacking all around. [4,7] To find solutions I propose to look at the obstacles as they are perceived by a NGO which is invited to take on responsibilities in a health district. The example chosen is exceptional in that little to no cooperation existed between the hospital and the government in the past. It allows to show more clearly which issues need to be addressed.

St. John of God Hospital is situated in north Benin. It is geographically and functionally well placed to take the role of district hospital for the Tanguieta district. It is owned by the catholic diocese of Natitingou and run by the congregation of the Brothers of Saint John of God of the African Province.
The Atacora Health department and the administration of the bilateral 'Dutch Support to Primary Health Care Project' want St. John of God hospital to take the role of district hospital. The ultimate aim is that the diocese and congregation provide for the management of the district by leading the District Health Management Team. (DHMT) [16]
I will limit myself here to the main obstacles. [16,17] *

2.1. The actual obstacles:

The obstacles can be regrouped in four categories: political and legal constraints; organizational and structural constraints; resource constraints and constraints related to attitudes, orientations and training.

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* For an overview of the background information please be referred to annex 3, 4 and 5.
The case information stems from:
a) the report of a study to determine whether and how the proposed reorganization could be achieved. The study was commissioned by the Atacora Health department and the management of the Dutch Support to PHC Care Project and executed by the independant consultant Dr. F. de Paepe, see 16.
b) the reports on the Round Table Consultation regarding the Health Sector, held under the auspices of the Ministries of Health and Economic Planning, see 17.

2.1.1. Political and legal constraints:

- The legal context for the installation and functioning of a health district still has to be elaborated. The mandates of the district governing bodies, to determine local policy and resource allocation, have not yet been set. The private non-profit health facilities are not legally recognized. Combined these legal obstacles mean that the execution of public duties by the NGO, in the district, will have no legal basis. A law to recognize NGO's is being proposed but it does not mention delegation of public tasks to NGO's.
- There are serious inconsistencies between the ministry's policy statements and actions. Even at present the implementation of activities and interventions from central level to peripheral level often bypass the regional and district authorities. In addition the interpretations of the role of a district hospital differ between local level (referral care and strengthening of first line units) and the ministry (only referral care). Determining the actual responsibilities is thus hampered.

2.1.2. Organizational and structural constraints:

- There is no regional development plan all parties can refer to. A platform for consultation within the health sector and with related sectors does not exist. The regional health department is not yet taking the lead in organizing dialogue between all parties.
- Community involvement at all levels still needs to be realized as well as coordination between the operational levels and the main actors in public health.

The health system elements are not well interlinked. The district medical officer is not part of the hospital management and the hospital management is not part of the DHMT.

The health information system is deficient and the referral system is not operational.

- The present services of the hospital need to be reoriented but this can only be done if the surrounding facilities become fully operational: first line tasks for the population of the town have to be taken over by a first line unit in the vicinity; second line referral care has to be ensured by the Atacora regional hospital.

2.1.3. Resource constraints:

Financial:

- The budget allocated by the government to health services, is very limited in comparison to the needs of the population and the problems the health system faces. There are also inefficiencies in the allocation of resources.
- The funding of running costs and motivational allowances by the bilateral development agency endangers the sustainability, after the project period, and may prevent the mobilization of local resources. The same goes for the high degree of dependency on outside support of the hospital.

- The hospital's high fees already raise fears regarding the actual accessibility for the poor. If these have to increase, to fund new activities, the access for the poor to referral care may become even more compromised.

Personnel:

- The region has a great lack of competent and motivated staff for all the intervention levels. On top of this staff management problems, like unwarranted absences and low performance rates, result in under utilization of first line units. It is not yet clear where, under who's responsibility, staff management will be placed in the district health system.
- The hospital lacks staff that is capable of initiating and guiding operational integration and structural cooperation (for ex. a public health officer). Its staff lacks recent experience in PHC supervision of first line units.

2.1.4. Constraints related to attitudes, orientations and training:

- The communities are not yet well informed on the changes in policy and lack understanding of its objectives. The various committees, in which they should be involved, are only just being installed. Health authorities and staff have little experience with participatory management. (for ex. the communities have not been consulted regarding the role of St. John of God hospital.)
- As the private social sector was never officially recognized and structural subsidies were never allocated the NGO facilities operate in relative isolation. This and events in the past have given rise to mutual mistrust and even hostility. The hospital and NGO fear loosing their autonomy when becoming part of the district system. The health authorities are unsure of the allegiances of the NGO: to the people or to the donor organizations.

The health authorities do not recognize the value of the NGO's achievements, nor of the contributions they can offer to the health care system.

The fact that, the dialogue between the two parties has and is instigated and organized by donors instead of the Ministry of Health, does not facilitate the establishment of an equal working relationship.

- At the level of the institutions there is a resistance to change: after such a long period of central planning and management local staff have the habit of limiting their activities to daily management and avoiding changes. At regional and district governmental level there is a significant lack of management and planning capabilities. Together this strengthens dependency on central level and outside support for determining the Public Health Policy.

3. DISCUSSION:

The obstacles for the transfer of public duties to the NGO are numerous.

In order to enable St. John of God hospital to take the role of district hospital, at least, the

following issues need to be addressed:
- the legal embedding;
- clarification of tasks and responsibilities;
- operational relations with the DHMT and the regional health department;
- the health information and referral system;
- the funding of delegated tasks.

To enable the diocese/congregation to accept the responsibility to manage the district the most important obstacles are:
- the inconsistencies in the policies;
- absence of a legal context;
- the absence of clear mandates for the governing and managing structures.

Decentralization has to be a well thought through policy: decentralization of functions without the necessary resources and strengthening of the local management capacity will lead to failure, frustration and discouragement at community level. [13]

From the policy documents [17] it is not clear whether this government sees involving NGO's in district health in the perspective of decentralization or as a form of privatization. [14]

It is only on the basis of a correct interpretation of decentralization and delegation of public tasks that the political, legal and financial constraints, can be addressed adequately.

Confidence in one and other can not be dictated but it can be stimulated by recognition and guidelines/regulations based on mutual respect.

However there are experiences that prove that more can be achieved:

The third mail survey of Medicus Mundi Internationalis, regarding NGO hospital's involvement in the district health system, shows that important improvements are gained in districts where the hospital is represented in the DHMT, the DHMT in the management of the hospital and district authorities in the Board of Governors of the hospital. [6]

Examples can also be found, among these hospitals, where very successful cooperation has been established, due to personal motivation and interests of individuals at government and NGO level. The effects of changes in staff show how fragile these successes are. [18,19]

In the Brong-Ahafo region of Ghana, the NGO facilities have become an integral part of the district health system, while remaining autonomous. [19] This can be clearly attributed to:
- deliberate policies on both sides combined with clear implementation guidelines;
- delegation of the district medical officer function to the NGO hospitals;
- well qualified and highly motivated staff on both sides;
- staff allocation and an important financial incentive in the form of payment of seconded staff;
- a policy of regular auditing.

Zaire's policy on district health is one of the clearest and simplest. The hospital, that is in or near the district capital, of what ever denomination, is designated district hospital and its owner is invited to become responsible for managing the district, including the financial responsibility. The DHMT and the district health office are situated on the hospital compound the DMO is part of the hospital team. NGO's find this a useful basis to take up the responsibility. It should be realized though, that, the present socio-economic crisis in Zaire, does give all parties a high degree of autonomy as well as very important constraints. [20,21]

Which essential issues need to be addressed:

The obstacles and experiences show that, in order to improve cooperation between governmental and NGO health care providers, in district health, the following issues need to be addressed:

A.) Policy formulating:

For the government and the NGO's, the first step to an effective cooperation in social services, is the elaboration of deliberate policies on the extent and forms of the cooperation. If the government wants to delegate public duties it should also specify the criteria, conditions and possible contributions they foresee. In turn the NGO's. should specify their criteria, conditions and contributions.

On the basis of these positions a dialogue can be undertaken to come to consensus in the specific fields. In case no consensus can be reached each party has to clarify the implications this entails for their relationship and the activities/services being considered.

The government has to formulate its policies on decentralization and privatization as well as specify the operational consequences in such a way that they are consistent with the aims and the interpretation indisputable.

The policy on district health also needs to be consistent and clear. Its translation into guidelines and mandates for local implementation have to be practical and transparent. Certainly the mandates regarding local responsibility for strategy, staff management, material and financial resource allocation have to be consistent with the aims of decentralization.

To delegate tasks and responsibilities, to NGO providers, the organizational structure of the district should be chosen in such away that decision mandates and actual execution of activities remain close together. Also communication lines should be kept short and access to information optimal. The Zairian or Ghanaian structure seem, to me, the more appropriate.

The issue of community participation, participation of NGO's and other health related sectors in the health districts governing bodies still needs consistent and practical translation in to the policy and guidelines in most countries.

On the basis of the government's district health policy and their own aims the NGO's should establish their own policy towards district health and the role they can play in it. They need to determine under which conditions they are willing to take on responsibilities, to what extent and how these can best be implemented.
This deliberate policy can then be the basis for a dialogue with the district, regional and national authorities to arrive at a strategic agreement.

In any case all policy documents and guidelines need to be made public and circulated widely so that all concerned are well informed and well aware of what is expected of each party and actor.

B.) Legislation:

If cooperation, between governmental authorities and NGO's, is desired official recognition of the NGO's in the general laws of each country is necessary. Specific criteria can be set to determine which NGO's warrant recognition.

All the above mentioned government policies and those determined in dialogue with other providers need to be reflected by clear and consistent legislation, bylaws and regulations.
Contracts between government and NGO's regarding delegation of tasks, responsibilities and resources have to be drafted carefully and based on the general legislative frame work and upon the published regulations. (such contracts are currently virtually non existent in the countries concerned.)

All laws and regulations should be clear regarding litigation procedures. These have to ensure independent and fair judgment.

C.) Organization and structure of the district management:

The first step to be taken, here, is that members of the management team of the hospital become member of the DHMT and the district medical officer becomes member of the hospital management team. The district health governing board and the hospital governing board should include representatives of one and other. Both have to invite the communities to elect representatives to join them.
The functional links between the district bodies/facilities and the regional health authorities have to be clearly defined and operationalized.

The second step should be, the development and implementation of the health information system, in a close cooperation between the government and the NGO's. The third step is to

devise the two-way referral system together.
These two information systems are key elements for the assessment of needs and functioning of facilities and thus form the basis for planning of services and activities.
The cooperation enables the staff of both parties get to know each other and have access to feedback information to evaluate and adapt their functioning in line with the needs.

The next step should be the district diagnosis and the development of the district health plan together with all parties concerned. The gradual transfer of tasks and responsibilities, to NGO's, if relevant, has to be part of this district health plan. The process should be well planned and phased, certainly if the gap between the prevailing situation and the desired district health system is large. The ultimate goal has to be clearly defined and understood by all concerned, from the beginning, and their participation ensured and maintained during the entire process.

The business world uses an effective way to share tasks and responsibilities, between two or more autonomous organizations, to realize a certain objective: subcontracting. An agreement is signed between the parties determining which services or goods are to be delivered by one party against which compensation of the other party.
In analogy, the government can contract NGO's to execute specific tasks or deliver specific services and/or to be responsible for areas or sectors of public duties against certain compensations.
The PHC approach demands that such contracts are agreements between the population, the local government and the NGO. The contract should be drafted with care and in detail. It has to fit into the policies and prevailing laws and bylaws as well as into the district health plan.

D) Resources:

Allocation of responsibilities should go together with resource allocation. If governments wish to delegate tasks and responsibilities to NGO's they will need to provide financial compensation. Various forms of resource provision are possible but whatever form is chosen equality between 'NGO districts' and similar districts run by the local/district government should be ensured.
These resource allocations should, on the other hand, not imply that the NGO's diminish their contributions: in the partnership their resources have to be entered towards the common goal.

Personnel is an even more crucial resource for an effective functioning of the district health care system. The district health board and the DHMT have to be allocated the necessary mandates to ensure effective personnel management. Thus, if the NGO carries a leading responsibility for

the district, it should have a relevant responsibility for the management of staff at hospital and first line units.
NGO's often work with a minimal number of staff to keep running costs low. If they are to realize, additional, delegated duties the government has to allocate the necessary personnel or the funds to employ them.

E.) Attitudes, orientations and training:

Communication and training are important tools to achieve the desired district health care. They can also be important instruments to establish effective cooperation.
Each partner should invest in adequate exchange of information on its policies and activities both formally and informally. The district health information and referral system are starting points.
The district health system demands both new and different management capacities of health staff. A management training program is an effective way to start the reorganization towards a district health care approach. Staff of the public sector and the NGO's should undergo the training together. This shared experience and the inevitable exchange of views will certainly contribute to changing attitudes and fostering cooperation.

Experience has proved that interest and motivation of key staff members can be conclusive in establishing effective cooperation. Both the government and the NGO should select staff accordingly. At coordinating positions staff should be willing and capable of open communication, building bridges and undertaking innovative approaches.

F.) Support structure:

The actual delegation of tasks to achieve a coherent district health system has to be implemented at district level between NGO, local authorities and communities. But to develop policy and implementation guidelines the regional and national authorities need an interlocutor at these levels. The NGO's in a country should organize themselves in such a way that they can be a dialogue partner for the government and support each other at these levels.
These regional and national coordinating bodies should aim at harmonizing policies and facilitating local implementation.
In case of disputes between a NGO and local authorities the regional or national body should be enabled to play a mediating role.

4 CONCLUSIONS AND RECOMMENDATIONS:

All Governmental and NGO health care providers recognize the possibilities and challenges that the district health care approach represent towards improving the delivery of comprehensive Primary Health Care. The basic willingness to cooperate to achieve the essential aims is present.

However integrating the NGO health care providers into the governmental system is not a feasible strategy. It ignores the right to a basic form of autonomy of the NGO's and adds to the burdens of the government instead of diminishing them. It also ignores the value of continuous dialogue between equal partners of different origin to shaping a democratic society.
Approaching the subject in the perspective of delegation of public duties and partnership between Government and NGO's respects , as much as possible, the autonomy of all partners. More importantly it facilitates determining the extent, the conditions and methods required to establish the necessary cohesion and comprehensiveness at district level.
In order to respect the autonomy of NGO providers and use their technical capabilities optimally, delegation of the responsibility to manage a district or sub district seems the most appropriate strategy.

The case study shows that there are important obstacles, for a NGO hospital to becoming recognized district hospital and for the NGO to become responsible for the management of a district. Removing these constraints will not be easy and demands important efforts of all parties.

The rare examples of effective delegation of tasks and responsibilities and positive cooperation show that it is possible.
Particularly the approach of subcontracting seems very promising as a way to effectuate delegation of tasks and responsibilities against an appropriate compensation. The government can thus improve access to clinical care and public health interventions for the population while retaining its influence and regulation power to meet its political obligation.
This approach needs to be tested in practice under close research conditions so that its merits can be clarified and practical implementation details can be elaborated. Also research into different forms of subcontracting should be initiated.

Further operational research is required to establish appropriate ways, to create all conditions, in full consideration of the wishes of the communities and the local situation.
Specific subjects are:

- in-depth analysis of positive experiences in public-private cooperation, in district health, to establish the conditions which are decisive in ensuring this cooperation and to investigate whether and how these conditions can be created elsewhere;
- how to translate transfer of public duties to NGO's in the context of local democratic policy and decision taking;
- how to ensure community involvement in the decision making with regard to the actual transfer and in the gradual implementation and control there-of;
- investigate alternative staff management and training strategies to improve effectiveness of health service delivery and the necessary support to the communities while taking the different origins of the staff into consideration.

The origin, extent and the influence of negative attitudes towards cooperation should also be researched, in each country, so that they can be taken into account and addressed in the implementation strategies.

The district health system should not be made a goal in it self. It certainly cannot solve all the problems in health care.
However it is, at present, the most promising means to achieve the goal: health for all in cooperation with the communities.
This paper shows that there is still a lot to do to ensure clear translation into government policies and implementation guidelines. Research and cooperation efforts should be concentrated on this at present.

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Annex 1.

The National Health System.

National Public Health System

Levels		Health Structures			Intersectoral Structures
Administrative	Health	Management Sturctures	Health Services	Training and Research	
National	National	MOH	National Hospital(s)	University Nursing Schools etc.	Ministry of Planning Ministry of Local Government Others
Provincial	Provincial	Prov. Dir. Health	Provincial Hospital(s)	Strengthening District Health Services	Sectoral Delegations
District	District	DHMT	District Hospital, Other (NGO) Hospitals	Strengthening First line Units	District Council NGO's Sectoral Programs
Sub-District	Sub-District Health zone	Health Centre Committee	Health Centre, Health Post	Strengthening Communittee Based Health Care	NGO's Sectoral Programs
Village		Village Health committee	TBAs, VHW, Other Health Care Providers		Village Development committee

Annex 2.

Organization of the District Health System.

Tasks and responsibilities of the health facilities:

First Line Centers:
The first line health institutes (dispensaries/health centers etc) role towards the communities in their catchment area (service area or health ward = sub district) is:
- Providing first line curative and rehabilitative care and/or referring the patient to the next most suitable level of professional care;
- Implementing prevention and promotion activities both on site as through outreach activities at the level of the community and it's institutions (homes, schools and workplaces);
- Supporting the health activities of the communities through health information/education, stimulating promotion activities, training and supervision of village volunteers.

The first referral level: the district hospital:
The district hospital has two main functions:
- Providing referral curative and rehabilitative care/services for patients sent in by the first line centers and referring patients back or to second or third line referral centers;
- Strengthening the functioning of the first lines centers through:
  * ensuring the two way referral system;
  * ensuring the functioning of the health information system;
  * training and supervision;
  * management, procurement, transport and administration support.

Tasks and responsibilities of the management structures :

The Village Health Committee:
Representatives of the community and it's health care volunteers (village health workers and traditional birth attenders) plan and manage their village health activities. They can call on the health center staff to assist them.

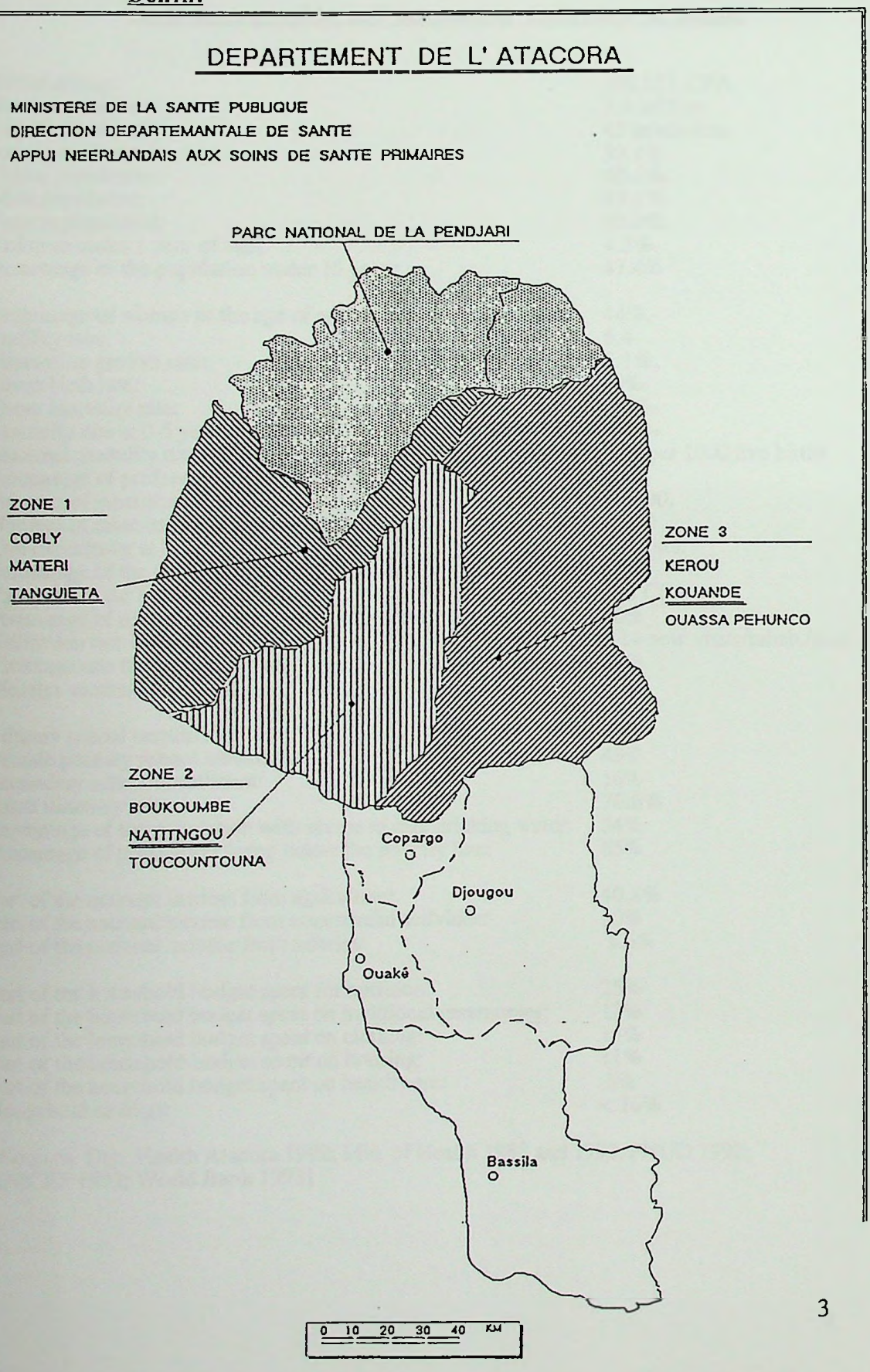
The Health Center Committee:
Representatives of the communities in the catchment area of the health center together with the staff of the health center plan and manage the activities of the health center.

The District Health Management Team (DHMT):
This team should be formed by the district health staff and representatives of the district hospital. It is headed by the district medical officer (DMO). It's basic responsibility is to plan, coordinate and manage the district health care program and representing the interests of the district towards other sectors and higher echelons in the country's system.

The District Health Governing Board:
This council ensures policy formulating, decision taking, budget allocation and control for the district. It is formed by the DHMT, representatives of the hospital, of the community, of non governmental organizations active in health, of related sectors, and representatives of local authority.

Annex 3.

Benin.



Annex 4.

Socio-demographic and economical Indicators of Benin.

BP/inhabitant:	109.221 CFA.
Total population:	5.0 million.
Population density:	45 inhab./km2
Rural population:	59.4%.
Urban population:	40.6%.
Male population:	49.1%.
Female population:	50.9%.
Children under 1 year of age:	4.5%.
Percentage of the population under 15 years:	47.4%
Percentage of women in the age of procreation:	44%.
Fertility rate:	6.4
Population growth rate:	3.1%.
Gross birth rate:	49‰
Gross mortality rate:	138‰
Mortality rate at 0-5 years	147‰
Maternal mortality rate:	11.7 per 1000 live births
Percentage of professionally assisted births:	35%
Number of inhabitants per doctor:	16.600.
Number of inhabitants per paramedical:	1.750.
Life expectancy at birth:	47 years.
Percentage of the national budget used for health:	4.9%
Expenditure for health per inhabitant:	528 CFA.
Percentage of the health budget spent on salaries:	80%
Utilization rate of services:	0.14 new visits/inhab./year.
Coverage rate for ante natal care:	47%
Measles vaccination coverage:	79%
Primary school enrollment:	52%
Female primary school attendance:	43%
Secondary school enrollment:	16%
Adult illiteracy rate:	76.6%
Percentage of the population with access to safe drinking water:	54%
Percentage of population living below the poverty line:	65%
Part of the national income from agriculture:	40.8%
Part of the national income from commercial activities:	50%
Part of the national income from salaries:	5.6%
Part of the household budget spent for nutrition:	25%
Part of the household budget spent on traditional ceremonies:	17%
Part of the household budget spent on clothing:	15%
Part of the household budget spent on housing:	11%
Part of the household budget spent on health care:	5%
Household savings:	< 10%

[Sources: Dep. Health Atacora 1992; Min. of Health 1988 and 1993; PNUD 1992; UNICEF 1992; World Bank 1993]

Annex 5.

Background to the Case of Tanguieta.

1. Country situation:

The hospital in question is situated in the northwest of Benin.
Benin is a French speaking Sub-Saharan African country.
The problems that the health care providers are facing are largely identical to those of most developing countries.
The former government was communist inspired. This meant a high degree of centralization and no recognition for other social service providers.
Since 1989 Benin has undertaken a Structural Adjustment Program with the help of the International Monetary Fund, the World Bank and it's other international development partners. This was followed in 1990 by political changes favoring democratization.[16,17]
A new policy for health care has been devised in this period. The main aim is to improve health care for the rural population through strengthening Primary Health Care, decentralization and allowing private providers to practice. Cost sharing is being introduced under the implementation of the Bamako Initiative [22,23].
Relations between the government and the NGO's are coloured by the past. The NGO's covered their own running and investment costs by asking fees and raising donations from their European counterparts. Mistakes and failures on both sides have given rise to mutual distrust and sometimes even hostility.
The degree of organization among the NGO's is limited. The catholic church has a small coordinating office. The 7 NGO hospitals of all denominations have formed an association to harmonize their policies and facilitate their dialogue with the Ministry of Health. Recently this association was invited to participate at a round table conference to discuss the country's health care decentralization policy. The invitation was instigated by the international donors of Benin.[17]

2. The Atacora Region:

This is the northwestern region.[16] In comparison to the other regions it is the least developed region. Living conditions are harsh and communications difficult. This means that well trained staff does not want to work here.
There are three hospitals in the region, two NGO and one governmental. Apart from the NGO hospitals the various institutes function far below their capacity.
A Dutch governmental development program has been active in the Atacora since 1983. It started as a program to strengthen Community Based Health Care by improving Village Health Worker performance. In the second and third phase of the program it became apparent that the community activities needed to be supported by a well functioning health care system. Therefore the fourth phase is directed at reorganizing and improving the performance of the health care services. The approach chosen is to develop a district health care system.
For this reason the region will be divided into several districts each comprising three sub districts. A district health team will be appointed for each district.

3. Tanguieta district and Tanguieta Hospital

Tanguieta is one of these districts. This district counts about 150.000 people. It comprises 54 village health posts together with 54 village health committees; 13 first line centers and one NGO hospital in Tanguieta town: St. John of God hospital.
The utilization of the first line centers is low (0.15 visits pp/py). The units have serious staffing problems both in actual shortage as due to frequent absences. Supervision has been irregular up till now.
The Saint John of God hospital at Tanguieta is geographically and functionally well placed to take the role of district hospital. It is owned by the catholic diocese of Natitingou and managed

by the congregation of the Brothers of Saint John of God (Fatebenefratelli) of the African Province.
The diocese and the congregation have the basic capability to take the responsibility to manage the district.

From 1970 to 1994 St. John of God hospital grew out to a be a 190 bed hospital. At present it considers the population of at least five surrounding sub districts as it's target population. (± 200.000) For this population the hospital provides first line, first and second level referral care. It has taken on all these functions in answer to the team's views on care for the poor and in response to deficiencies in the surrounding region. Patients have a considerable confidence in the hospital they come from all over the region and the surrounding countries. (bed occupancy is 70%)
The financing of the running costs is covered for 33% by patient fees. The remaining part is contributed by the Milan province of the congregation. This is a high rate of outside dependency. (in most other countries the level of outside support ranges around 20% mainly for investments) The congregation wants to retain accessibility for the poor in this way. At present it feels that the outside support can not be increased any more. At the same time the devaluation of the CFA is driving up costs. The hospital is therefore forced to increase fees.
The hospital is well staffed with personnel [92] from the region and for the larger part trained on site. The management is still totally in the hands of the expatriate members [6] of the congregation. The population is not involved in the hospital board.
In the past the hospital had started two peripheral centers and outreach preventive activities. These were handed over to the regional health authorities around 1987.

4. What does the hospital have to offer the district?

The St. John of God hospital has much to offer to ensure the functioning of the district of Tanguieta.
To ensure quality of care it has a large experience in management, permanent well qualified staff and a stable supply of equipment and medicines.
The motivation and commitment of the staff, their listening attitude and their special interest in the vulnerable are great assets towards acceptability by the communities. In order to stimulate participation of the communities, it has the people's confidence. Also, due to it's long and stable presence, it has accumulated a good knowledge of the actual field situation and the social context.
It's assets towards fostering responsibility at all levels are:
- a great interest and sufficient capabilities for training personnel and volunteers also beyond the mere technical aspects;
- access to feed back information and the capacity to coordinate a health information system;
- the possibilities to install direct supervision;
- a basic willingness and experience to ensure progressive handing over of responsibilities to key staff and other personnel.

St John of God hospital sees the following advantages in becoming district hospital:
It offers the opportunity to take charge of all the health related problems of a well determined population.
First of all this will increase the possibilities to reach the poor. Secondly it will be able to plan the activities in a comprehensive way so that it can improve delegation of tasks among staff, optimize the use of resources and improve efficiency. Furthermore, supervision of first line centers together with a key role in installing and maintaining a two-way referral system, give the team much more scope to ensure continuity in care and services.
Due to the hospital's financial restrictions and in view of equity it hopes that taking the responsibility for the district will give it access to government subsidy.
The leadership role and the subsidy will enable it to install more rational fee systems.

For the government the advantages of St. John of God Hospital as district hospital for Tanguieta district correspond largely to those mentioned above. The ultimate aim, that the diocese and the congregation become responsible for the management of the district and thus for the running of the first line units, would constitute a considerable alleviation of the responsibilities of the regional health department.