

# Towards universal health coverage: reforming the neglected district health system in Africa

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## ABSTRACT

In most African countries, the district sphere of governance is a colonial creation for harnessing resources from the communities that are located far away from the centre with the assistance of minimally skilled personnel who are subordinate to the central authority with respect to decision-making and initiative. Unfortunately, postcolonial reforms of district governance have retained the hierarchical structure of the local government. Anchored to such a district arrangement, the (district) health system (DHS) is too weak and impoverished to function in spite of enormous knowledge and natural resources for a seamless implementation of universal health coverage (UHC). Sadly, the quick-fix projects of the 1990s with the laudable intention to reduce the burden of disease within a specified time-point dealt the fatal blow on the DHS administration by diminishing it to a stop-post and a warehouse for commodities (such as bednets and vaccines) destined for the communities. We reviewed the situation of the district in sub-Saharan African countries and identified five attributes that are critical for developing a UHC-friendly DHS. In this analytical paper, we discuss decision-making authority, coordination, resource control, development initiative and management skills as critical factors. We highlight the required strategic shifts and recommend a dialogue for charting an African regional course for a reformed DHS for UHC. Further examination of these factors and perhaps other ancillary criteria will be useful for developing a checklist for assessing the suitability of a DHS for the UHC that Africa deserves.

## BACKGROUND

The administrative structure in almost all African countries was inherited from the European colonial administration. The structure was made to benefit the colonising authorities. The district system is the closest administrative level to the community and the people and was subordinate to the province (or region as the case may be), which, in turn, looked up to the maximum authority at the central government. The district administration was dependent on, and took directives from the centre or the province and ensured that the communities within it conform to

## Summary

- ▶ African countries have adopted Primary Health care (PHC) approaches in their national plans and strategies to improve health outcomes, and recognise the central position of the district health system (DHS) in its delivery.
- ▶ The current district (health) system is the closest administrative level to the people that was created by the colonialists to be completely subordinate to the central government to the extent that it is unable to effectively anchor a universal health coverage (UHC).
- ▶ A UHC-friendly DHS must have authority to make informed decisions, set its priorities, develop management capacity, and control and channel its resources towards the development of UHC that is equitable and accessible.

colonial regulations and processes (that may be in conflict with tradition) and deliver resources for export. In exchange, the district officials were rewarded and the communities provided with the most basic health services to prevent epidemics that may spread and jeopardise central government interests. The relationship between the district government, the community and the people were, therefore, testy, founded on exploitation and suspicion and completely incongruous with the tenets of local government, which belonged to the people. At independence, despite representative governance, the position of the district and the contact between its operators and communities remained unsavoury unidirectional with minimal if any community input into district decision-making. The opportunity to participate was tokenistic, and periodic to serve specific ends that benefited service providers. It is, therefore, not surprising that community health projects are difficult to communicate to a community by a district health administration that lacks local knowledge. Yet, the quality of delivery of universal health coverage (UHC) depends heavily on

the district health system (DHS) being the closest administrative organ to the community.<sup>1</sup>

It is gladdening that proceedings from recent conferences indicate that the critical role of the DHS in PHC delivery is receiving more attention and the consensus that it is the route towards the delivery of PHC and the realisation of the UHC.<sup>1-4</sup> Perhaps an understanding of the typical African district system will be useful for appraising the anomaly in the current district governance and its capacity to anchor the HS that will deliver UHC.

The African equivalent of district governance before colonial administration would be a collection of communities that are contiguous, related to a common ancestor, speaking the same dialect, with similar values, norms, rituals and taboos to the exclusion of others. The African district system is often referred to as a clan. Such a traditional district had rules and processes of enforcement and was a coordinate to others, not subordinate to them. In spite of the African community becoming a global one, some of the features are self-evident in urban towns in form of communal neighbourhood security watch, access road-making, garbage and gutter cleaning. These attributes are important considerations in reforming the current district system before it can be expedient for the implementation of UHC.

Our article is an analytical appraisal of the district (health) system in colonial times, its current relevance and usage in many sub-Saharan African countries and an examination of the necessary attributes for a UHC-friendly district system.

### UNPLEASANT ORIGIN, RELEVANCE AND NEGLECT OF THE DISTRICT (HEALTH) SYSTEM

As mentioned earlier, the district system is not typical to African traditional state administration.<sup>5</sup> The district system preceded the colonies and was only formalised during the colonial administration.<sup>6</sup> The district is probably the first in the slave supply chain management process, where captured slaves were assembled and counted before movement to the coastal towns and shipment. Most of these departure centre-points later served as national headquarters for the colonial administration. The origin of the district system unto which UHC rests has, therefore, not been pleasant to the communities and the population and until it is reformed, the vestiges of the exploitative nature of its original design will continue to dog the steps of PHC delivery.

As the peripheral end at the chain of authority, the district government has never had the autonomy to decide or plan. The only freedom the district administration ever had was the liberty to agree with 'orders from above' that must be carried out with diligence and minimal regard to the local knowledge. Another colonial feature of the district that had subsisted was the irony of taking resources from the district and then allocating left-over from the central, and the provincial administration to it.<sup>7</sup> It was convenient for the postcolonial administrations

to keep the structure while attempting to reform it by conceding token authorities to it in the guise of decentralisation and federalism but retaining the authority to harness the resources to the centre, returning pittance to the district but expecting them to effectively implement policies. And when this fails, the alternative is to bypass the district for a quick-fix strategy, which further weakens the system.

In most countries, the districts (or local governments) *sensu stricto*, is the level in the health system (HS) where policies that the central government formulates are operationalised. The DHS is responsible for the PHC services provided through health facilities and coordinating community health-related activities through outreach services.<sup>8</sup> Although at the bottom of the pie in resource allocation, the district remains at the top of the pyramid in terms of its relevance to health service delivery.

The Millennium Development Goals (MDGs) that aimed at radically diminishing the health impact of specific diseases, such as HIV/AIDS, and address maternal and child health conditions reduced the district to a stop-post to the communities and a warehouse for commodities. The DHS lost its relevance with respect to planning healthcare service provision. As the district descended to a state of neglect by central authorities, it dragged the DHS down with it. Campaigns replaced routine health facility-based service provision (as health-workers' salaries were unpaid for months on end), seasonal health evangelism for such services as cataract removal became the norm, just as health education, advocacy and community mobilisation by itinerant provincial city-based personnel replaced the village health teams in local knowledge advisory. Central-based and province-based personnel made 'training' of peripheral health personnel a continuing and ready excuse for earning extra income from funding agencies. No wonder then that the MDGs, although, deep and far-reaching were not deep-seated enough to sustain beyond the project cycle.<sup>9 10</sup> The district administration and its HS, finally, collapsed and is currently in need of resurrection.

The historical vestiges of top-down control inherited from colonial traditions have been maintained, and are a far cry from the required horizontally networked DHS that is required for UHC.<sup>11</sup> A professionally managed DHS will attract private sector investment by its performance.<sup>12</sup>

The success of the Sustainable Development Goals will depend on its tenacity and root within the community and its firm rooting in the DHS. UHC that is planned atop of a neglected district (health) system is bound to fail from the onset. The district government that will carry through an effective UHC will have specific sustainability features and attributes for decision-making authority, coordination, resource control, development initiative and managerial skills, which we briefly discuss in the following sections.

### Decision-making authority

The subordinate nature of the district and its HS must give a way to a district administration that is able to use data collected from the district to make decisions. The local government should be the primary level of not just data collection as is the case presently but of decision-making based on the evidence, it has collected. The personnel that are employed at the local government should be as qualified as those working at any other sphere of government in terms of skills and competence to make evidence-informed decisions. Such an arrangement will require investment in district personnel to enable skills for defining health problems, data collection and analysis, and designing programmes. This will contribute to the development of a surveillance technique that can generate evidence that will be well understood to the extent that any emergency will be prevented at this level before it draws global attention. The current arrangement where the authority to plan, procure, store and distribute is made outside the district will be antithesis to a health-care that is universal, that is, equitable and that harnesses all resources for healthcare including the traditional healthcare practitioners. African countries must accord the district the autonomy to decide on the fundamental issues of the community, and avoid the current order of professional precedence in health. Unfortunately, the current state of affairs is varying capacity at the decentralised levels and even for national-level to provide an effective stewardship function of oversight and support, particularly in contexts of mushrooming numbers of districts (an increasing feature in many countries, often for political reasons). In order to realise this, a skilled and equipped district health team, which embodies, public health, surveillance, epidemiology, health management, planning, environmental health and administration skills, needs to be in place. Consideration for the required skills could be addressed through recruitment, provision of tools and guides, on job training, supportive supervision and mentoring approaches, which model resourcefulness and reflexive practice.<sup>13</sup> Additionally, close collaboration needs to be fostered between ministries of health and training schools to ensure that the required skills are well addressed in preservice training.

A proactive, liberalised, participatory and community-oriented problem-solving and innovation process will make the districts to deliver.<sup>14-17</sup> Unfortunately, the voice of communities has been little heard. Active collaboration between communities and programme staff needs to be promoted to the extent that they are not mere recipients of services but play a significant role in the planning, resource mobilisation and implementation of the programme of which they are also beneficiaries. While policies guiding community participation do exist, in practice, there appears to be little implementation. The role of community participation appears to be limited to the provision of information to research and programmes, or even labour in building facilities; rarely is this participation extended towards shaping policy

meaningfully.<sup>18</sup> Among the reasons that partly explain this anomaly is predominance of ‘expert’ perspectives of policy-makers, managers and frontline staff guiding the influence on PHC delivery,<sup>19</sup> the lack of recognition of community structures and how they interface with the formalised HS, insufficient resources allocated to community-based accountability initiatives, as well as lack of community capacities to hold service providers to account.<sup>20 21</sup> Some of the prerequisites for effective participation of communities include the existence of community structures, allocation of resources (funds and time) to allow for participation and relationships built on mutual trust between health managers and providers with formal and informal community leaders.<sup>21</sup> Indeed, experiences from Zimbabwe have demonstrated better performance on PHC in a set of clinics where community interests were well represented.<sup>22</sup>

### Coordination, penetration and sustainability

The neglect of the district and the subordinate relationship with the central and provincial administration has led to diminutive input into the development of local communities. The complete dependence of district officials on provincial authorities for decisions in itself has weakened the provinces since data for development are collected at the district where they are hardly used for decision-making. A UHC-friendly district will have its development agenda independent but in coordination with the other districts and in harmony with the province.

A UHC-friendly district (health) system will provide complementary coordinate services rather than subordinate to another administrative system. It will provide the platform for assessing the extent to which policy is aligned with intervention. The DHS will serve as a platform for a coherent and cooperative partnership hub where all health programmes coalesce into activities that could be integrated and co-complemented as a district health package. The district is uniquely positioned to mobilise for intersectoral action and to serve as a platform for training, assessing performance and testing initiatives. Its accessible bureaucracy infuses in it the ability to resolve UHC-related issues including emergencies and to prevent them from becoming nationwide problems. Further, the ownership that is anchored in UHC-friendly DHS is favourable to realising sustainability of health programmes, which has been a challenge, especially in donor-supported projects.

### Resource control

The most critical factor in the district system is the limited capacity to mobilise resources locally and the absence of control over its resources. It is at the core of the administrative decentralisation in Zambia that led to a moderate transfer of decision-space from national to district level,<sup>23</sup> while in Kenya, rapid devolution of authority led to decentralised decision-making to the district resulting in implementation challenges.<sup>24</sup> In Ghana, however, centralised decision-making, coupled

with incomplete fiscal decentralisation concentrated health decision-making authority at the centre with the district as a mere appendage.<sup>16</sup> In many African countries, it is politically expedient to decentralise, and often to split districts to small entities with little definition of responsibilities or the means for carrying such responsibilities through, thus, further weakening the system. It may not, therefore, be enough to decentralise the structure, more important is to legislate the relationship between the district and the centre. The decision to devolve power to the periphery is always contentious in all countries as politics, power distribution and ethno-religious factors play a role. Yet, UHC can only succeed when the district system is allowed to take the centre stage in its own health service delivery. A UHC-friendly DHS will have the autonomy to harness local knowledge and skills for institutionalised health service delivery that is inclusive and equitable and to develop the human resource base that aligns with its health and administrative needs. The supply chain management will reflect the health needs of the district population. In as much as it will be idealistic to propose complete retention of the district's resources for the development of the district including health, it is realistic to expect a district to retain a proportion of its revenues for its development plans.<sup>25-27</sup>

Examples from Nigeria, Kenya and Ghana<sup>28-29</sup> demonstrate the detriment to the district service delivery when domestic budget allocation to the district only pays the personnel salaries, while development partners fund core activities for which the districts exist. The external funders have the liberty to select what activities to fund to the exclusion of others no matter how critical.<sup>30-31</sup>

### Development initiative

While perceptions of weaknesses in district-level leadership have prompted calls to strengthen these capacities,<sup>32</sup> limited attention has been given to the systemic reasons behind these weaknesses. The approach to DHS management and leadership capacity strengthening to date has been predominantly on increasing sufficient numbers and competencies of district managers. What is needed is a typology of leadership, which is focused on creative actions to promote development,<sup>14</sup> can embrace novelty and uncertainty, network-building and systems thinking. It is not only individual competencies, but leadership patterns that are integrally linked to the overall organisation of the system.<sup>26</sup> Alongside, there is a need to address the systemic weaknesses that impact on the management capacity of district health managers so as to engender creativity and promote innovation and learning.<sup>14</sup>

### Management skills

Highly skilled managers are required for local government administration but unfortunately, transfers to or employment by the local government are seen as punitive, yet the implementation of the most complex health programmes is done at the district. Skilful managers will harness resources, define priorities and plan how

resources will be allocated to achieve maximum benefit. A UHC-friendly DHS will be competitive with the other spheres of government in attracting highly skilled professionals to its workforce. The DHS should have the capacity to manage the supply chain, social communication and marketing, evidence-based decision-making, resource management and accountability process.

- a. The current system of warehousing health commodities in some provincial store is contributory to lack of access. Every district should manage its supply chain system in coordination and not in subordination to the other spheres of administration. This approach will enable a UHC, which is responsive and localised enough, to be accessible to the local population. The current approach of a central procurement system for all districts has the negative effect of creating a uniform problem, such as the shortage of the same commodity nationwide, making accessibility an issue and UHC a mirage.
- b. Social communication and marketing skills are becoming popular for communicating health messages. The district should have the skills to manage its communication system for marketing its resources (tourism, utilities and relative advantage) including health education, mobilisation and advocacy. A district should be able to market to the world that 'for the past 5 years, there has not been a single cholera episode in our district because 90% of taxable adults paid their tax and the district authorities use it for water provision'. The present arrangement does not allow the districts to speak for themselves but to rely on the central government to speak on their behalf. The inability of several countries to increase the enrolment rate into the community health insurance scheme is partly due to an inability to communicate and market the scheme. Concepts of equity take a different meaning if not conveyed appropriately to the audience.
- c. Evidence-based decision-making ability should be at the service of the local government HS. The DHS provides opportunities for learning about policy performance that is made at the centre and passed down to the district for implementation. At the moment personnel often swarm the local government at specific seasons or for the specific purpose of data collection, incorporating field assistants from local government as guides and enumerators. The data are then centrally collated, analysed and interpreted to suit authorities outside the district. The district should have adequate skills for collecting, retrieving and using data for decision-making and serving as a repository of the district health data. Database for district planning should remain in the district.
- d. Transparency and accountability are a commonly cited local government problem. An empowered district provides social accountability mechanisms for performance. Performance is easily noticed and impact on community immediately visible. Integrated people-centred healthcare means putting the needs

of people and communities, not diseases, at the forefront, and enabling them to take charge of their own health. The UHC-friendly DHS will seek a balance between being accountable to the superordinate HS (ie, national to regional to district structures), and social accountability to the community. These two modes of accountability naturally oppose one another because bureaucratic accountability is an 'accountability for control' (focused upwards on compliance, standards and sanctions), whereas social accountability tends to be an 'accountability for improvement' (ie, focused downwards on learning and feedback).<sup>33</sup> A linear implementation, which is the hallmark of the closed systems, is giving way to a more participatory approach. However, the pull towards benchmarking and uniformity constitute a major drawback.<sup>34</sup> Programmes often sacrifice process sustainability for results-driven global health agendas that are dependent on checks and balances of monitoring financial inputs.<sup>35</sup>

e. Training and capacity-strengthening initiatives have never been sustainable. Case studies from Niger, Zimbabwe and Guinea<sup>17 36</sup> have shown the limited success of managerial capacity strengthening interventions when programmes are vertically introduced, with toolbox approaches, even while programme achievements are recorded in the short-term. Furthermore, hierarchical, top-down practices and behaviours get reproduced by managers and frontline staff towards patients (such as ordering people, rudeness and impatience)<sup>37</sup> all of which are incongruous with DHS but as mentioned earlier the origin of the district administration was neither consultative nor service-oriented. However, restructuring it is essential to enable it to function optimally to the benefit of UHC.

Sub-Saharan Africa can take a cue from Thailand that, in spite of its low gross national income per capita, took the bold step in the 1970s to reform its district system as a prelude to UHC in later years. Thailand invested in district-level infrastructure through deliberate policy to train the district health workforce, recruit and distribute all cadres of personnel. Following this, targeted insurance schemes were introduced to ensure equitable access to healthcare until UHC was implemented in 2002.<sup>38 39</sup>

## CONCLUSION

The current DHS that served the colonial administration's mobilisation of the resource from the hinterland to the central government is too authoritarian and ill-equipped to anchor UHC. A reform that takes into consideration the characteristics, powers and functions of the district system, as, for example, articulated in the South Africa Local Government administration<sup>40</sup> is likely to be an effective system for anchoring UHC. DHS at the local level should be built around communities of people who share the same ecological environment, disease and cultural epidemiology and therefore, have evolved a common response to reducing its deleterious effect on

their health. Three strategic shifts would be beneficial namely (1) reconceiving accountability and putting the needs of the people and communities at the fore front, (2) engendering adaptive leadership and restructuring the district governance to have autonomy to grow and control resources and (3) authority to enforce compliance with local expressions of needs and norms that are non-repugnant to social justice and the constitution. A critical aspect will be to rebalance the tensions between the bureaucratic accountability, which exists within the formalised organisation of the HS (ie, national to regional to district structures), and the social accountability, which exists to the community.

A UHC-friendly district will serve as a coordinate service provision sphere rather than a subordinate system to the provinces. However, the political, economic and power interest in district reform is so contentious that a neutral body as the WHO will be in the best position to initiate a regional dialogue to reform the district system for UHC implementation.

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