Does health district system fit with humanitarian crisis situation? The African Great Lakes experience

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Health districts are usually implemented in a long lasting development perspective.

The objective of the study is to look at the operational feasibility of implementing and supporting health district systems in crisis conditions.
Rutshuru Health District (RHD - Eastern DRC)

- 215,000 inhabitants
- surface: 3 389 km²
- 15 health centres + 1 reference hospital (111 beds)
- medical and administrative staff
- 3 doctors and about 60 nurses
- management committee

RHD faced severe security constraints with 4 major war like events between 1992 and 1998
Rwanda is a small country in central Africa
27 000 km² with about 8 million inhabitants
In 1994, War & Genocide

- Administrative apparatus destroyed
- Health system completely dismantled
- Human resource greatly reduced

Opportunity exists for profound health sector reform
Support project funded by Belgian Co-operation

From 1991 onwards:
no more expatriates
EU and Belgian Co-operation support managed by local health professionnals

Follow up of 12 indicators for about 17 years

Routine health information system related to the whole district and specific data collection related to obstetrical activities at hospital level
Decentralisation / Health district implementation

Integrated local health services

Community participation
  -> management decision making
  -> financing (alternative options, e.g. “mutuelle”)

Quality of care improvement

Public - private mix

Health information system (HIS)
HIS as a key component of the health sector reform

HIS was redesigned in 1997 (all levels involved) and was implemented in 1998

Computerised monthly information related to diseases, activities, resources and administration

Completeness rate was very high: 85%

Data provided by health centres

1st level of the health system; public and not-for-profit;

n = 340
In addition to that:

- surveillance of interest diseases (WHO)
- socio-demographic survey (UNFPA)
- public expenditure review (DFID, WHO)
- national health accounts (USAID, WHO)
- demography and health survey (USAID)

Integration at the central level of the MoH
Findings (1)

Activities in RHD

Year

Percent

NC / inhab / yr

Curative care

DTC3

Measles

Curative care
Findings (2)

Activities in RHD

Assisted deliveries

Deliveries at hospital

Caeserean sections among deliveries at hospital
## Findings (3)

### Activities in Rwanda

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<tbody>
<tr>
<td>Curative care</td>
<td>0.34</td>
<td>0.28</td>
<td>0.25</td>
<td>0.25</td>
<td>0.24</td>
<td>0.28</td>
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<tr>
<td>Obstetrical coverage</td>
<td>10.2</td>
<td>10.7</td>
<td>10.2</td>
<td>10.0</td>
<td>n.a.</td>
<td>n.a.</td>
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<tr>
<td>Antenatal care coverage</td>
<td>54.6</td>
<td>58.4</td>
<td>68.1</td>
<td>76.4</td>
<td>n.a.</td>
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<tr>
<td>BCG immunisation rate</td>
<td>61.6</td>
<td>41.9</td>
<td>56.8</td>
<td>65.5</td>
<td>73.0</td>
<td>93.2</td>
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<tr>
<td>Measles immunisation rate</td>
<td>53.2</td>
<td>36.3</td>
<td>36.7</td>
<td>52.1</td>
<td>70.0</td>
<td>64.4</td>
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<td>1997</td>
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<td>MoH budget as a share of national budget (%)</td>
<td>2.2</td>
<td>3.1</td>
<td>4.2</td>
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<td>Domestic rec. expend. at the district level (USD/inh/yr)</td>
<td>0.28</td>
<td>0.39</td>
<td>0.44</td>
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<tr>
<td>External rec. Expend. at the district level (USD/inh/yr)</td>
<td>2.93</td>
<td>2.2</td>
<td>1.59</td>
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<td>Infrastructure coverage (Health centres / 10 000 inh.)</td>
<td>0.43 §</td>
<td>0.44</td>
<td>0.42</td>
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<td>Human resource coverage (med. doctor / 10 000 inh.)</td>
<td>0.18 °</td>
<td>0.18</td>
<td>0.18</td>
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§: 0.18 in 1994
°: 0.07 in 1994

Source: PER 1999 and MoH
Performances in both settings yield arguments in favour of health district systems support and implementation in crisis conditions.

This should be complementary to emergency interventions.

The basic conditions for health district system’s success are:
- a clear health policy
- a political will which is able to “drive” external intervention towards district facilities.
Future directions (2)

Policy implications

- Health system and peripheral facilities performances should be rewarded through health information analysis
- Simple data analysis should be used to improve health system knowledge and understanding at all level of the system
- Scientific basis for health services delivery and organisation roots in HIS, but there is a need to develop methodology and capacities according to available resources in developing countries
Future directions (2)

Policy implications

- Extension to management including more sophisticated databases related to personnel, equipment and infrastructures
  => on going process to design “sanitary mapping”

- The methodology should be strengthen in the extent to which “vertical” approaches are becoming prominent with initiatives such as Global Health Fund
There is a complementarity between routine HIS and more specific surveys.

There is a need to strengthen health services research methodology that could be better suited to resources and information available in developing countries.

Evidence “assisted” management and decision making is a key element in the international research agenda for health systems in developing countries.