Health Systems

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Smaller health areas for a better service

An analysis of Sudan’s health system revealed a lack of sound leadership for village-level providers. The district-based peripheral health system was failing to meet an increased demand for leadership and management support. Some of the principal factors explaining this state of affairs were population growth, increased numbers of health units, long distances and transport difficulties. With a view to solving these problems, the country was divided into smaller health areas around rural hospitals and similar physician-led facilities. A decentralized system based on the principles of primary care was established in these areas under health area management teams. Setbacks encountered in giving effect to the policy have led to proposals for a new implementation strategy.

Sudan is committed to the health-for-all strategy and primary health care. Programmes established by the Ministry of Health have led to:

— increased coverage by basic services,
  particularly at the periphery where

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community health workers have played a key role;
— the introduction of new activities, most notably those concerned with child survival;
— the initiation of training for primary health care workers;
— the securing of resources from international donors to assist the health sector during a period of general economic decline, so as to strengthen the Ministry of Health’s capabilities in management, transport and communication.

However, there are still serious deficiencies in the population’s health status; for
instance, the estimated infant and under-five mortality rates for 1990 were 107 and 181 per 1000 respectively \((t)\). Only 51% of the population lives within five kilometres of health service facilities; a potable water supply is available to only 21%; only 20% of women in labour are attended by trained health personnel; and only 53% of children under one year are covered by the immunization service. The situation is worse in rural than in urban areas. Although economic difficulties and civil unrest have undoubtedly been partly responsible for these unsatisfactory figures, intrinsic problems of the health system may have been more directly and significantly to blame.

The principal factors explaining these inadequacies in the health service in general and primary health care in particular have been identified \(2, 3\).

- There was a failure to adjust to the tasks associated with the primary care strategy. The organizational structure inherited from the colonial authorities in the 1950s was retained, with the exception of certain changes consequent upon regionalization in the late 1970s.
- Budgetary priorities remained unchanged, most financial resources being tied to salaries and the rest going largely to hospital-based facilities.

- There was poor leadership, supervision and management support for health workers at village level.
- The top-down planning of activities and the absence of management skills at the implementation level led to poor results and deterioration of the whole health infrastructure.
- Vertical programmes were adopted as the easy way to produce results in the short term but meant inefficient resource use and uncertainty about the sustainability of activities.
- Village health workers neglected promotive and preventive tasks and concentrated on financially more rewarding curative work, in the absence of supervision and support from the authorities.
- There was too little community participation and too much dependence on official and outside funding for primary care activities.

Possibly the most important of these factors was the failure to provide leadership and management support for the people working at village level. The organization of the health system was originally based on the administrative districts and there was an absolute separation of curative and preventive services. The leadership of each district health service was in the hands of a medical inspector, who was assisted by three or four health personnel supervisors. The implementation of regionalization and of primary care policies in the late 1970s dealt the final blow to the district-based health system, which was already failing to cope with the rapid expansion of services. The factors behind the failure of the district-based system were as follows.

- District populations increased over a 30-year period from 250,000 to an
average of 750,000 people who were scattered in numerous small rural communities. This, and the drive to increase primary care coverage, produced such a large rise in the number of basic health units that they became unmanageable from a single centre.

- Transport problems were caused by the immense size of the districts, sharp increases in fuel prices, and high maintenance costs, and consequently effective supervision and communication were almost impossible.

- A succession of local government laws created new rural and urban councils that removed from district health teams the advantage of being close to administrative and decision-making centres.

- The separation of preventive and curative services was made more pronounced by a law giving administrative and financial responsibility for primary care units to the local government authorities while hospitals continued to come under the Ministry of Health.

- The financial resources available to the health services diminished owing to a decline in the national economy and a reduction in the political priority given to expenditure on health. At the periphery the situation was exacerbated by the inability of the new health sector to compete with education and other sectors for local government finance. Inadequate financing was reflected in particular on service activities with operative and recurrent costs.

- The trend towards specialization among doctors meant that reduced numbers wished to be district medical inspectors or rural hospital doctors. In 1985, 64% of the country’s doctors were working in the capital and another 27% were working in

- three of the eight remaining regions (4). The duration of rural hospital assignments fell to only six months on average. The rural health service was thus left with an unwilling and insufficiently skilled administrative and technical leadership.

**Health area policy**

A health area policy was developed through joint efforts made by the Ministry of Health and Gezira University to overcome the major shortcomings identified in the district-based peripheral health delivery system. The main purpose of the new policy is to create a peripheral organization providing sound leadership and management support for village-level providers from a reasonable distance. The rural hospital was chosen as the site for the development of leadership and management capabilities. A feasibility study and a training programme were initiated by Gezira University and New York’s Columbia University. An expanded role for rural hospitals and a new job description for rural medical officers, emphasizing leadership support for primary care services, were adopted by the Ministry of Health in 1985 (5, 6). Rural medical officers were trained to undertake the new roles. Follow-up observations indicated the need to develop teamwork; health area management teams eventually came into being. The new policy was adopted by the National Council for Health in December 1987.
The health area policy calls for the division of the country into decentralized administrative units, basically comprising geographical zones around rural hospitals or health centres serving defined populations, each with a health team headed by a doctor. In each area a health area management team is to be made responsible for all leadership and management functions. The new system is to replace, at the periphery, the old district-based organization of the health service and is to be founded on:

- the principles of primary health care, with maximum coverage by basic services, equity of distribution, and community participation;

- decentralization such that decision-making is delegated to the health area where appropriate;

- unity of health area management in the interest of integrated planning, implementation and evaluation of activities, including those associated with vertical programmes generated nationally for primary care;

- accountability to the community and intersectoral cooperation, facilitated through the formation of area health councils, whose members are to include representatives of the community and of various government sectors and are to have the final say on health plans and their implementation.

- the establishment of sound managerial processes and the development of essential management skills by health area management teams and other health personnel.

The intended organizational structure of the health delivery system in the regions is shown in the table, while the proposed administrative and referral relationships are indicated in the figure on page 36.

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<th>Management bodies in the health area system</th>
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<tr>
<td><strong>Executive body</strong></td>
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<td><strong>Region</strong></td>
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<td><strong>Province</strong></td>
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<td><strong>Health area</strong></td>
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<td><strong>Village</strong></td>
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The proper formation and functioning of the health area management team is essential for the success of the system. The team, headed by a doctor who acts as health area medical inspector, includes heads of services, usually senior paramedical staff, among them the officer responsible for environmental health. The team represents the Ministry of Health and exercises authority in the health area; it is separate from the board of directors of the rural hospital. Although collective responsibility is exercised, there should be some division of labour among the team members in accordance with their technical skills. The overall functions of the team in the health area comprise:

- responsibility for administrative, technical and financial affairs of all health services and personnel;

- local planning, implementation, evaluation and management support of all health activities;

- supervision of health workers and provision of support and training;

- organization of logistical support and delivery of drugs and other supplies to units;
— improvement of coverage by services and introduction of new services, starting with elements of primary care which are still lacking;
— integration of service components, including those delivered by national vertical programmes, and intersectoral cooperation with other government departments and agencies engaged in development activities;
— promotion of community organization and community participation in all stages of service delivery;
— establishment of an information system to aid decision-making by the team and to supply data to higher levels.

**Policy implementation**

Soon after the adoption of the new policy, 175 health areas were created. Unfortunately, this was not followed by a well-defined national implementation plan. The main burden fell on the regional health authorities, which received no additional resources, and the results were variable. As judged by the number of health areas where a substantive implementation of the whole policy was achieved, the overall outcome was poor.

However, important lessons can be learnt. Some major problems were identified and need to be resolved before successful implementation of the new policy can be contemplated. At the same time an alternative implementation strategy has to be sought which takes these problems into account. The main obstacles to implementation are outlined below.

• The Ministry of Health failed to give a clear explanation of the new policy to the regional and lower levels of the health system. This, and the absence of a conspicuous model of successful implementation, reinforced bureaucratic resistance to change among health administrators at the periphery.

• In the absence of support from above, the health area management teams were unable to initiate and maintain activities required by the new policy. Thus the supportive linkage between the rural hospital and village facilities in the form of regular supervisory visits, the delivery of supplies and the training of health workers was inadequate except in few areas where international non-governmental organizations provided assistance.

• The administrative separation of facilities run by the Ministry of Health and those controlled by local government was not resolved before the implementation of the new policy began. The supervision of village-level facilities by health area management teams was thus rendered less effective than it might have been.

• The uneven distribution of rural hospitals led to variations in the sizes of health areas. The immense size of some areas made their management by a single team stationed in a rural hospital almost impossible.

*The new policy should be applied in two or three selected areas in each region as a first step.*

• There was a shortage of managerial skills among key personnel, who were in any case scarce because of the imbalance in manpower distribution between rural and urban services.
New strategy

The health area policy aims to improve primary care, particularly in rural Sudan. It is based on a sound analysis of the previous health service delivery system and promises to correct its major deficiencies. The policy is compatible with the international movement for strengthening primary care through the development of district health systems. However, three years of unplanned attempts to implement the policy made little impact. This experience and the limited resources make it inadvisable to plunge into
a new process of implementation embracing the whole country. Instead, the new policy should be applied in two or three selected areas in each region as a first step. This would allow the pooling of resources and expertise from central government, academic institutions, international agencies and local sources so as to establish a functioning system. Locally appropriate solutions to problems of implementation should be adopted in each region. The lessons learnt in this phase would help later expansion at a pace compatible with the capacity of the new system, and the Ministry would discover how much help was needed in each region and where its support could best be utilized.

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References


The urban crisis

The world is at a turning point. It is faced both by the massive degradation of the natural environment and by the accelerating decline in the quality of life of many of those who live in the built environment of cities. The two crises are related. The consequences of urbanization make a major contribution to the global environmental changes that threaten the very existence of life in the future, while changes in the biosphere increasingly affect health and social conditions in the cities. Dealing with this twofold crisis calls for unprecedented cooperation among the people of the world and their governments.