What really improves the quality of primary health care?

A review of local and international experience

Initiative for Sub-District Support
Technical Report #3
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What really improves the quality of primary health care?

A REVIEW OF EXPERIENCE

- Health care reform has put in place the administrative structures necessary to support the District Health System. However, that administrative reform must translate into improvements in service delivery.

- ISDS, working in selected areas, aims to identify obstacles to delivery of high quality primary health care and to help address these factors in a systematic and sustained way.

- Although ISDS uses the sub-district as the focus for evaluation of support strategies, interventions will target a number of levels.

- ISDS brings together two models of health reform, namely district development and quality assurance. Although sharing much in common, these approaches have elsewhere tended to develop along separate lines.

The district has been identified the organisational unit for the reorganisation and transformation of health care provision in South Africa.

For the District Health System to achieve its aim of providing high quality health services which are accessible to all South Africans, health care system reform will need to take place at a variety of levels. Although progress has been uneven across provinces, in many areas the necessary administrative structures for implementation of the district health system are in now in place. The challenge is to now “translate provincial commitment and administrative reorganisation into real improvements in health care delivery at local level”\(^1\).

Quality within health care has been defined as “the success of the health services in meeting the health related needs of the population in a manner that is consistent with local goals, national goals and resource constraints”\(^2\). Although a political commitment to providing
high quality primary health care is an important initial step, experience has shown that there is often a gap between the intended role of primary health care services and their real capacity to deliver - chiefly as a result of lack of resources and management capacity.²

By focusing at the sub-district level, and through the introduction of a deliberate and systematic programme of support, ISDS aims to kick-start a process which, by addressing factors which are amenable to change in the short- to medium term, hopes to turn sub-district health teams into agents of change and local health care reform.

ISDS differs from many other initiatives in that, despite the narrow spatial focus (the sub-district), the range of interventions is wide. But more importantly, it seeks to address obstacles at whatever level they occur, whether at the level of individual patient-carer interaction, at primary health care facilities, at district level or at regional and provincial level.

In this way, the initiative brings together two strands of health reform which elsewhere have tended to develop along separate lines. The process of district development has focused on low-income countries with an emphasis on building management and administrative capacity. On the other hand, the quality assurance movement, using methods imported from more developed countries, has focused at a more individual level with an emphasis on facilities and health workers. Little information is collected or available about quality at a district level.³

This review aims to:

- Review the current understanding of district health systems and district strengthening programmes, with emphasis on factors facilitating and constraining progress.
- Review the role of the quality assurance process within primary health care and district health systems
- Identify and review initiatives which like the ISDS have aimed to improve the standard of health care provision through the introduction of a range of support strategies.
- Specifically, review initiatives aimed at enhancing the capacity of community members to participate in health care governance, management and service delivery, as a means of enhancing quality.
METHOD

MEDLINE and POPLINE searches were undertaken which identified all articles dealing with quality of care and district development which have appeared in the published literature since 1990. In addition certain key journals were reviewed. Articles with relevance to ISDS were identified and are reviewed below.

Problems with this methodology include:

- While most published literature could be identified, much relevant information is contained within the so-called “grey” literature in the form of reports published by governments or non-governmental organisations. Although some unpublished reports are included in this review, it was frequently difficult or impossible to obtain the reports or papers. The Initiative for Sub-District Support would appreciate further contributions to this review.

- Projects are generally reported on by those responsible for their design and implementation. The authors may therefore have a vested interest in the success of the project and may gloss over or fail to adequately understand or document the reasons for the success or failure of the initiative or aspects thereof.

- Quality of care is a concept which has chiefly arisen in developed countries, often in the context of highly sophisticated and specialised units. Only literature which has some relevance to primary health care is included here.
THE DISTRICT HEALTH SYSTEM

- The District Health System is recognised as the most appropriate vehicle for the delivery of primary health care.
- National policy decisions and administration can be integrated with local conditions and needs within the District.
- The District Health Team represents the prime vehicle for change in the District.
- The pillars of the District Health System have been identified as:
  - Organisation, planning and management
  - Financing and resource allocation
  - Intersectoral action
  - Community Involvement
  - Development of Human Resources
- Following review of the international experience the WHO has identified key problems within each area and identified potential solutions to many of these problems.
- Most district development initiatives make use of the management and planning cycle approach.

Strong backing for the DHS

Internationally there is wide support for the district health system as the appropriate organisational framework for strengthening primary health care provision.

The strengths of the District Health System can be regarded as:
- The district is a focus for decentralisation of political power
- The district is the natural meeting point for “bottom-up” planning and organization and “top-down” planning and support
- The district contains sufficient public service infrastructure for service delivery whilst the focus is near enough to communities to allow a certain transparency of community-wide problems and constraints
Most health problems can be addressed at a district level. This is particularly true as increasing emphasis is placed on addressing causes of diseases and disease prevention.

Health workers require sustained support which can best be provided within the district.

Many key development sectors are represented at the district, thus facilitating intersectoral co-operation and the management of services across a broad front.

The co-ordination and integration of services and vertical programmes allows for increased efficiency.

The World Health Organisation has identified the main pillars of the district health system as:

- Organisation, planning and management
- Financing and resource allocation
- Intersectoral action
- Community Involvement
- Development of Human Resources

A system struggling to meet its potential

Despite widespread support for the district health system, there is no doubt that it has failed to achieve much of its perceived potential. Following a review of the international experience, the World Health Organisation, proposed a set of critical considerations that need to be addressed in the development, implementation and evaluation of strategies adopted for strengthening district health systems based on primary health care.

These are:

Decentralisation and National support

National governments need to adopt policies that support the development of district health systems. These policies need to allow flexibility for local action while ensuring equity between districts.

Health ministries need to develop broad guidelines that specify the role and responsibilities of the centre, the region and the district.
Districts should have sufficient authority to enable them to manage financial and human resources allocated to or raised by them.

Organization, planning and management

- Districts need to develop a planning process to define objectives and set targets with emphasis on those families and communities most at risk.
- District health teams need to review roles, goals and procedures at regular intervals.
- The role and function of the district hospitals in the context of Primary Health Care should be reviewed and redefined, and hospital staff orientated accordingly.
- District health information systems need to be developed to provide data for monitoring health problems and resource utilisation.
- Problem-orientated research needs to become an integral part of district health management.

Resource allocation and Finance

- Financial planning and management need to be strengthened in an effort to improve use of available limited resources.
- Allocation of resources needs to be reviewed at both district and national level.
- Options for financing health services should be considered.

Intersectoral action

- Mechanisms need to be created which give health concerns higher priority on the agenda of district development and assist each sector to define its role in health activities.

Community Involvement

- Education, orientation and training for community involvement should be directed at decision-makers and professional staff; community level health workers; and community leaders.
- National governments need to demonstrate the political will to support community involvement in health and to promote self-reliance by strengthening the knowledge and skills of communities for solving health and development problems.
Development of Human resources

- Districts need to take an active role in determining training and staff development strategies and schedules.
- Continuing education for rural health workers needs to move from the current emphasis on workshops and seminars or training in the workplace through supportive supervision.
- District leadership for Primary Health Care should be developed through orientation, training and continuing education of key individuals.

Strategies critical to making the DHS work

The key strategies advocated for achieving these goals are:

- policy action
- action research
- management systems review and development
- activity-based learning
- leadership training

The district health system has focused on the District Health Team as the vehicle of change. Much district development is based on the management and planning cycle approach. The cycle consists of a number of consequential steps, namely:

- situational analysis
- priority setting
- option appraisal
- programming and budgeting
- implementation
- monitoring and evaluation

A well-functioning district health team would automatically move through this cycle of defining objectives, designing processes to meet objectives, measuring performance, comparing the actual to the expected and analysing reasons for performance gaps.

The above approach can be seen to be based on what Green has labelled as the “rational planning” approach, which assumes that
“decisions about the future require a series of logical steps, from analysing the nature and extent of the current problem, deciding on aims and targets, delineating the various alternative routes to achieving these, choosing the most appropriate option, and then the actions required to implement it”.

Furthermore this model makes further assumptions which are frequently not met. These include that:

- the district health services are working towards predetermined national goals which are based on assessment of health need and attuned to the primary health care approach.
- organisational culture is geared towards achieving policy goals and that organisational values will not hinder the implementation of agreed policy directions.
- resources are firstly available and secondly can be allocated to priority areas.
- the model underplays the conflict of interest between and within various interest groups.

Bearing in mind that these preconditions are in reality seldom present, the authors then identify some approaches or models which may enhance the ability of programmes to impact more positively in the process of district development.

1. An emphasis which enables district managers to look more broadly at how political factors shape the planning process.

2. An emphasis on enabling health workers experiencing problems in the district to identify and implement solutions using local resources.

3. An emphasis which enables an understanding of how organisations work can provide a basis for decision-making, and improvements in organisational performance.
QUALITY ASSURANCE IN PRIMARY HEALTH CARE

- Concepts within the quality assurance are derived from industry.
- Quality assurance methodology tend to focus on technical aspects and the interpersonal components of health service provision.
- Many concepts developed within this paradigm are consistent with the aims of primary health care, although issues such as equity and accessibility need to be incorporated.
- Critics argue that quality assurance programmes run the risk of channelling resources into processes which focus on narrow outcomes rather than on building the health system as a whole.
- The quality assurance movement is growing in South Africa. Much of the work in South Africa has focused on developing norms and standards as well as accreditation.

Historically, the quality of public services in developing countries has been neglected with little attention being paid to the quality of primary health care provided. In the years following the Alma Ata declaration, access was equated with adequate primary health care provision and priority was given to extending coverage by health care services. Considerations of the quality of care provided formed little or none of the primary health care or health systems discourse.

During the 1980s concerns regarding the quality of care being provided emerged. The perceived lack of ability of primary health care workers to adequately treat common childhood illnesses such as diarrhoeal disease and acute respiratory infections, provided the impetus for a process whereby quality assurance methods were applied to developing countries.

The concepts of continuous quality improvement and total quality management emerged from America and Japan during the 1950s and 1960s. Quality experts helped Japan rebuild its industrial capability by applying ideas of process control, worker involvement in search of
causes of quality problems and a systems approach to preventing quality problems. Organisations which embraced the philosophy of total quality management introduced a process whereby every organisational unit, and every worker in the organisation, regularly and systematically used quality assurance tools and methods to improve their work.9

Widtfeldt summarised continuous quality management assumptions about an industry or service as such.10

➤ The system is the source of the majority of quality problems.
➤ An outcome/product will be free of defects if the correct process or systems are in place at the inception.
➤ Quality improvement is a never-ending process.
➤ Measurement tools must be used to continuously improve quality and productivity.
➤ Customer satisfaction is vital for success.

Although the quality assurance movement was developed in highly industrialised nations, Sukati argues that the associated management approach complements the PHC strategy of health care delivery in a wide range of areas.11 These include:

➤ the involvement of consumers or customers in decision making
➤ emphasis on effective, efficient and affordable health services
➤ the need for management capability to support changes necessary for acceptable health care delivery
➤ the need to strengthen information systems that will facilitate the monitoring and evaluation of health services with a view to improve the delivery of health care.

Proponents of quality assurance have argued that a process of quality assurance should be conducted regularly at every level in a health care system, from the national to the community level and within institutional units and subunits.

A critique of quality assurance

Although no-one can argue that improvements in the quality of care provided are desirable, the approach and methods used in the process have drawn criticism.12, 13 These criticisms include the following issues:
• **Why measure quality?**

The deficiencies of health care provision are well documented in many developing countries. Some critics argue that resources should rather be channelled into addressing these issues, rather than on further documentation of shortfalls.

• **Lack of concern about access and equity**

Access and equity which are central principles of primary health care form no part of traditional quality assurance discourse. Within the manufacturing sector, customers are involved in decision making only in the sense that they choose whether or not to buy a particular product. The rise of quality assurance movement has for the most part developed within a milieu which encourages health care to be regarded as a commodity which should be regulated by market forces.

Adequate means of building issues surrounding access and equity into quality assurance tools have not been developed.

• **Who defines what quality is?**

Different interest groups within the health services such as individual clients, service providers, managers, and donors may define quality differently.\(^{14}\)

While client satisfaction has formed a strong component of quality assurance in developed countries, it has received scant attention in developing countries. One study undertaken in the Democratic Republic of the Congo (formerly Zaire) showed that patients valued the availability of drugs and good interpersonal skills of nurses above renovated health centres or technical competence on the part of the staff.\(^{15}\) Following the Bamako Initiative, attempts in Sub-Saharan Africa to improve the quality of health services have been linked to a desire to increase people’s willingness to pay for the services provided.\(^{16}\)

• **How is quality measured?**

Cabral differentiates between “quality of care” which relates to the meeting of qualitative standards in the processes of health care delivery and “performance” which relates more to the quantitative (and cost-efficient) response to the health needs of the served communities. Performance viewed this way can then be measured in a quantitative method against a set of norms and standards.\(^{3}\)
In high income countries, such standards are increasingly based on assessment of the effectiveness of carefully-defined health interventions, undertaken through clinical trials. Although transfer of medical knowledge to low and middle income countries has been accompanied by some development of standards appropriate to the context and needs of individual countries, objective assessment of effectiveness has rarely been undertaken.¹⁷

While such a set of minimum standards can be useful in that they ensure uniformity, they can come to define a minimum rather than an optimum level of acceptable performance; in use, the minimal becomes the optimal and standards end up defining adequacy rather than excellence.¹⁸

Quality assurance programmes run the risk that “health personnel can become dependent on check lists at the expense of dynamic, creative monitoring of health workers performance”.¹⁹

Quality Assurance in South Africa

Zwarenstein identifies several large scale initiatives undertaken in South Africa which aim at quantifying quality or developing methods of quality assurance.¹⁸

These are:

1. The development of norms and standards undertaken by the Centre for Health Policy. He suggests that both the methods used and the results obtained may provide a model for quality assessment at primary level.¹⁹

2. A hospital accreditation programme established under the auspices of the Council for Health Service Accreditation. Standards have been developed for both clinical services and general support services. The standards are implemented in participating facilities through a participative management approach based on continuous quality improvement techniques. Accreditation is granted once an organisation has the necessary systems in place to substantially comply with the standards.²

3. Development of clinical guidelines including the implementation of the Essential Drugs List.

In addition various tools for assessment of quality of care for specific services are being developed. Such tools may involve a number of
key components: observation of care management, interviews with clients, interviews with health personnel, checklists for assessing facilities and supplies, and review of clinical records. In the past, these assessments have tended to focus on technical aspects and the interpersonal components of the quality of services have tended to be ignored or underestimated by planners - despite the fact that these are the most resistant to change.

The National Progressive Primary Health Care Network has begun to use the development of a Patients’ Charter as a quality assurance tool. The Chartering process involves a negotiation between providers and users with a view to reaching agreement on a common set of standards for health services at the national, provincial, district and facility level.\textsuperscript{20}
There is little published literature which looks at providing multiple support strategies within contained geographical areas.

An intervention using the process of district action research and education in Tanzania showed that constraints could be identified and to some extent overcome in the absence of additional resources being allocated to the sub-district.

A two year initiative in the Kabarole district of Uganda focused on planning and management, support and supervision and community participation. Indicators showed significant gains in the standard of health service provision.

Identification of the lack of basic district management skills as a major constraint to PHC implementation led to a “management strengthening project” in the Gambia. District teams became more effective management units with increased motivation and improved planning skills, particularly with regard to resource management.

A number of initiatives aimed at building the capacity of districts to provide high quality services have been undertaken in South Africa. These include the District Health Management Development Programme undertaken in Kwazulu-Natal and North West, and a project in Agincourt, Mpumalanga.

Although the success of focused interventions aimed at improving aspects of health care provision or health management is well documented, there is little published literature regarding the success or otherwise of initiatives which aim to provide multi-pronged support. A number of initiatives which have focused specifically on the sub-district are reviewed below.

Tanzania

In 1990 an effort was made to identify obstacles to health care delivery which could be tackled with existing resources through district action-research and education in the Dodoma Region of Tanzania.²¹
The urban district identified staff motivation as their major problem, while the rural district focused on supervision. District health management teams identified the underlying causes of their respective problems and suggested solutions. A plan of action for one year was developed and implemented in each district. The plan of action for the urban district concentrated on increasing the availability of continuing education for health workers, establishing a library, preparing guidelines for good performance, and developing a system to recognize and reward the best workers. The plan for the rural district focused on improving the preparation and follow-up of supervisory activities through a workshop, morning sessions, and monthly meetings involving members of the district health management team.

At the end of the period it was shown that some gains had been realized. Staff motivation, which was used as the only indicator in this study, had improved somewhat but was constrained by the fact that major grievances surrounded deficiencies in salaries and other benefits which were not within the ability of the district to change. “Nevertheless, by using the process of district action research and education, both of the district health management teams strengthened their capacities and developed positive problem-solving attitudes.”21

Uganda

A project undertaken in the Kabarole district of Western Uganda documented the advantage of using a systems analysis approach to establish baseline information and then evaluate project results using the same methodology.22 A baseline survey undertaken in 1989 showed that health services were generally functioning poorly.

Discussion with the health authorities lead to identification of certain areas for intervention. These were supervision, planning and management, basic knowledge and skills, and, on the community side, involvement of the community in health-related activities.

Indicators used in the assessment of the health system and based on the main areas of intervention were drawn up. A scoring system was used and each health unit scored using the following indicators:

1. **Indicator Aggregates**
   - Physical infrastructure
   - Staffing
Staff presence
Availability of drugs
Planning and management
Supportive supervision
Basic skill
Basic knowledge
Community involvement
Immunisation coverage

2. **Health service utilisation**
   Health services utilisation (visits to health facility per person per year)
   Antenatal visits per pregnancy
   Pre-school child visits per year

3. **Planning and management of peripheral health units**
   Health units with more than 50% of staff having written job descriptions
   Availability of treatment schedules for specific diseases
   Availability of weekly or monthly workplans and regular staff meetings
   Staff physically present
   Health Units reporting regularly
   Availability and quality of record system
   Availability and maintenance of equipment
   Availability of transport
   Health units with more than 80% of staff receiving salaries promptly

4. **Indicators for supportive supervision**
   Centres supervised at least once during previous month
   Heads of health units considering supervisory useful
   Health Units receiving copies of supervisory reports for the last supervisory visit
   Health Units reporting that supervisors usually help staff solve management problems
Health Units reporting that supervisors usually provide continuing education during the visit

5. **Indicators for community involvement**

   Community participates with delivery of health services
   Health Units where communities participate in water source improvement
   Health Units with community involved in building and repair of health units
   Health Units with trained CHW or TBA in catchment area
   Health Units where staff participated in community meetings within last 6 months
   Households which have and use a latrine

Physical aspects of the community environment

Following further discussion and planning meetings, a programme was introduced which targeted a number of areas:

**Planning and management**

Minimum standards for a functioning infrastructure at the local health unit level, and mechanisms to deliver supplies and carry out inventories were established.

**Training and Supervision**

This included training programmes for all levels of health care workers aimed at improving basic knowledge and skills. A regular supportive supervision structure was put in place. Management seminars were held in each area.

**Community participation**

This was encouraged through the organisation of community seminars in each area.

The same evaluation was undertaken after two years and showed an improvement in score for almost all indicators. The largest changes occurred in supportive supervision, planning and management, community involvement and basic skills. No attempts to measure any changes in health outcome were undertaken.
Although the authors are positive about the method used, they identify a number of problems with the approach. Political and economic influences on the health care system were not included in the analysis (primarily because of time constraints). No control area was included and the improvement in socio-economic conditions which occurred during the two year period may have accounted for some of the positive changes.

Furthermore the role of the Ministry of Health was not analysed in depth. Most of the impetus for change was generated from an outside agency which raises questions of sustainability.

Nevertheless this study shows that significant gains could be made without major changes in infrastructure. Issues related to transferability and reproducibility were not considered.

The Gambia

A project undertaken in The Gambia identified the lack of basic management skills of district-level health teams as a major constraint to the implementation of primary health care. A “management strengthening project” using a problem-solving and participatory strategy was introduced. Although the project did not specifically look at service delivery, it shared much in terms of aim and methodology with the ISDS project.²³

Characteristics in common with the ISDS

These include:

➢ The project was undertaken at a time where decentralisation of decision making and resource allocation was occurring.
➢ The project made use of a problem-solving and action-orientated approach.
➢ The district health team (or equivalent) was identified as the focus of intervention. A process whereby the DHT were drawn into a process whereby they developed a plan of action for their district. The action plans were required to be realistic in terms of the financial and human resources available.
➢ The project strategy was not rigidly defined, but was allowed to evolve over time with inputs from local staff. The objectives were useful for setting work priorities and evaluating progress, but at
the same time were broad enough to give teams flexibility in implementation.

- There was a strong commitment to work within and strengthen government structures. In the Gambia donors have tended to support improvements in the technical skills of health workers, and provide capital for vehicles, equipment and buildings in the context of vertical programmes. Little attention has been paid to health systems management development. Some NGOs have developed parallel structures for management of projects. Not only are competent staff drawn away from government health services, but it is difficult for district health teams to plan and deliver services in an integrated and efficient way. Health management capacity building was regarded as a priority.

- Individual members of the district health teams were encouraged to relate to their peers in the district rather than to their superiors at a national level.

- The analysis of data about health service delivery by the district health team on a monthly basis came to be seen as a priority.

- There was a commitment to providing technical support to health care workers.

The project was assessed as having made some gains in that district health teams had become more effective management units with increased motivation and improved planning skills. Of particular note was a marked improvement in control and management of resources such as transport. At the time of publication no indicators for evaluating the effectiveness of the project had been identified.

Factors which facilitated progress

The authors identified the following factors as facilitating the effectiveness of the project.

- A growing awareness amongst team members that they could benefit from management changes.

- Leadership within the district health teams was supportive of the project and process.

- The problem-solving, “learning by doing” approach of the project was found to be appropriate in facilitating changes in management practice.
As the project progressed, team members recognised the importance of the collection and analysis of data.

Factors limiting progress

The following factors were identified as limiting the effectiveness of the project.

- Despite a commitment to decentralisation, resources, especially budgets and staff, were still managed centrally. This limited the ability of the district team to channel resources into local priority areas.
- Decentralisation and management reform require a critical mass of skilled managers at a national level to design and implement changes. In the Gambia the national level managers did not have the necessary time, skills, information and authority to manage the changes.
- Donor policy and practice had a considerable impact on the way services were delivered in the Gambia. Team working time was often dominated by programme-centred training rather than on core functions such as planning and supervision.
- The DHT failed to recognise or identify certain problems. These areas were therefore neglected.

It should be noted that no efforts were made to assess the impact of the management changes on the quality of health services provided or on the health status of the population.

South Africa

A number of projects in South Africa are also forerunners of the current sub-district support project.

The District Health Management Development Programme

The District Health Management Development Programme undertaken in Kwazulu-Natal and run by the Centre for Health and Social Studies (CHESS) aimed to “develop the delivery and management capacity of primary health care managers, administrators and service providers at the district level.” It was run in eight districts. Team members were drawn from health and other sectors. The programme took the team members through a process whereby a priority health issue was
identified and then strategies for tackling the problems were identified.

The project was judged to have been successful despite some constraints. These included the lack of clarity and development of the district system, fragmentation of health services and lack of resources. Political insecurity and violence also limited the ability of the programme to achieve its full potential.

The programme has now been implemented throughout the provinces of North West and Mpumalanga.

Agincourt Community Practice Project

The Agincourt sub-district of Mpumalanga province was the site of a project which aimed to develop a demonstration district health system and was a joint venture between the Health Systems Development Unit, the relevant Health Service and the Agincourt communities. As in the previous project, the district chosen had suffered from underdevelopment and fragmentation of health services in the past.

Quality shortfalls were categorised as follows:

- Lack of basic infrastructure
- Staff shortfalls and inadequate professional skills
- Poor management systems and lack of supportive supervision
- Low staff morale, demotivation and poor attitudes
- Poor access due to geographic, organisational and cultural barriers
- Little community participation
- Lack of information for planning with no system of monitoring and evaluation.

Quality of care in clinics

A further project undertaken by the Centre for Health Policy has looked specifically at improving performance and quality care delivered by first line primary health care facilities. This study is grounded in the quality assurance paradigm, whereby weaknesses in the delivery of PHC in the selected facilities will be identified and a plan of action will be developed and implemented. It is envisaged that this plan will include, at least, training of staff and managers, introduction of clinical management protocols and continuous assessment of quality of care.
Following a rapid appraisal of four primary health care facilities, the following areas were identified as potential areas for action on quality:

- **Improving the availability of basic resources**
  
  A checklist of essential infrastructure and equipment was devised and each facility “scored” as to the availability of these basic resources. These included buildings, supplies, staff and equipment.

- **Addressing the “process” of care in facilities**
  
  A number of criteria were used to assess the quality of the care being provided. These included:
  
  - Whether facilities provided integrated daily care
  - Appropriate patient flows
  - The percentage of TB patients who completed treatment
  - The quality of care for other chronic diseases, in particular diabetes
  - The quality of child care services
  - Interactions between staff and patients

- **Meeting the needs of users**

- **Improving management and support systems**
COMMUNITY PARTICIPATION

A commitment to community participation is an intrinsic part of primary health care and district development, but translating this commitment into practical strategies has proven difficult.

Factors contributing to this failure include:

- Preconditions for meaningful community involvement are absent
- Community involvement is viewed as a means of legitimating programmes
- Lack of clarity as to what community participation is aiming to achieve
- Failure to specify what level of community participation is anticipated
- In a given context, the reasons for community participation must be specified, the form of anticipated participation defined and specific strategies identified. Sufficient resources to sustain the desired form of participation must be available and accessible.

A commitment to community participation remains a cornerstone of primary health care.

Why involve communities?

The rationale for advocating community involvement in health are well documented. They include:

1. Community participation is in line with achieving public health interventions that stress prevention rather than cure.
2. If community members are involved in planning, development and implementation of health services, then services are more likely to address real needs and less likely to be misused.
3. Communities possess untapped resources that can be used to strengthen the capacity of health services.
4. People have the right to be involved in decisions about activities that affect their daily lives - community participation gives practical
force to the idea of health as a human rights and social justice issue.

5. Amongst the disadvantaged and the under-served, community participation provides a basis for increasing the self-confidence and self-reliance of individuals and the community as a whole. Translating the goal of community involvement into reality has proved elusive and numerous papers have documented the failure of meaningful community participation.

Reasons for poor community involvement

Possible reasons for failure include:

- Preconditions for meaningful community involvement are absent. These include:
  - Political commitment to the ideal of community involvement
  - Bureaucratic reorientation towards community participation
  - Development of self-management capabilities of local communities
  - Minimum basic health structure and coverage

A re-orientation on the part of health care workers is also often a prerequisite for meaningful community participation. However “methodologies for re-educating and re-orientating health staff towards community involvement have not been very effective. Although health care workers have been trained and can repeat the “right words”, their basic attitude remains unchanged.”

- Community involvement is viewed as a means of legitimating programmes

Stone points to a contradiction which exists within the primary health care approach. It is supposed to foster community participation and wherever possible assist local communities to define their own health needs and initiate ways of meeting them. At the same time primary health care has set some parameters around the both the needs of the people and the range of possible means of meeting them. Programmes with strong agendas of their own, may use community involvement simply as a means of legitimating their own presence in a community.
Lack of clarity as to what community participation is aiming to achieve.

Community involvement may have a variety of aims. It may be regarded as a means of improving efficacy of the services i.e. as a managerial technique which aims to benefit both the consumer and provider. Under these circumstances, the results of participation in terms of the predetermined targets are considered more important than the act of participation. An alternative view is to see participation as an end in itself. The emphasis here is on the process rather than on achieving specific actions. In the long term, the process may be of greater importance than the outcome, particularly if this is measured in terms of specific actions such as committee meetings.29

Moser and Sollis describe a participatory PHC project in Ecuador and look at the criteria which were used to evaluate it. Although the project failed to meet all of its objectives, it was a success from a social development perspective. The local community regarded the project as a success in that it empowered community leaders to improve organisational capacity and initiate actions on their own.30

Failure to specify what level of community participation is anticipated

Rifkin identifies five levels at which community participation can be said to occur:27

- People can participate in the benefits of a health project by receiving health care.
- People can participate in programme activities through contributions of time, money or other resources.
- Local people assume managerial responsibilities in a program and decide how certain activities are to be conducted.
- Program monitoring and evaluation.
- People from the community decide what health programs they think should be undertaken and ask for expert knowledge and resources to enable the activities to be pursued.

Advocacy groups which participate through confrontation with state structures, can be regarded as a further level of participation.31
It is crucial that a programme specify what level of community participation it is aiming for. “It is important to identify what participation is supposed to achieve, what motivates it, and how it should be organised so that it is systematic, flexible and productive.”

- Failure to earmark resources for community involvement

If community participation is to be anything more than tokenism, then it is crucial that it is adequately resourced. Brownlea identifies power, knowledge and skills as crucial resources for participation, but does not elaborate as to how these resources can be made available to community members.

In response to the difficulties of achieving community participation, a number of authors have attempted to identify specific strategies for ensuring the involvement of the community.

Rifkin identifies “background factors” to community involvement. These include local cultural, social, economic, political and historical factors as well as the degree to which the government policies respond to local needs. Although it is often not possible to change any of these factors, they should be recognized so that cognisance can be taken of them during project implementation.

The term “action factors” refers to things that can actually be done to achieve the objective of “community involvement”. With these factors it is probably more important to consider how things are done, as opposed to what is done.

Action factors are:

- assessment of needs
- community organisation
- programme management
- attention to the needs of the poor

Bracht and Tsouras identify four major strategies. These are that:

- the community are involved in defining what ‘health” means to them, recognising that the concept will change over time.
- the community is involved in the process of identifying and prioritising its own health needs
• a process exists whereby resources are made available to assist communities in establishing strategies and working towards meeting their health needs.

• the interface between the health authority and local government and the health authority and the community receives due attention.33

IMPLICATIONS FOR ISDS

The ISDS is innovative in that it aims to simultaneously address factors which prevent provision of health care. Although the participatory and problem-solving approach adopted has been shown to be able to achieve success in similar initiatives, these projects have been more limited in their scope. The ISDS project aims not only to improve the health services in specific areas but to kick-start a process which strengthens the development of district health systems throughout the country.

The provision of quality primary health care depends on:

• The presence of a minimum level of service provision. This includes physical infrastructure, staffing and supplies. Adequate access must likewise be assured. The services should at least meet a nationally accepted norm.

• The presence of adequate management systems to support the health services.

• A commitment to the provision of high quality services. The meaning and measurement of the desired quality may vary between areas and should reflect the priority health issues in the area.

Community involvement in health and health care provision remains a challenge. Achievable goals should be set and efforts made to document the reasons for successes and failures. Despite a recognition that community involvement requires resources, the nature of these resources and how they can be made available to community members, is not clear.
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