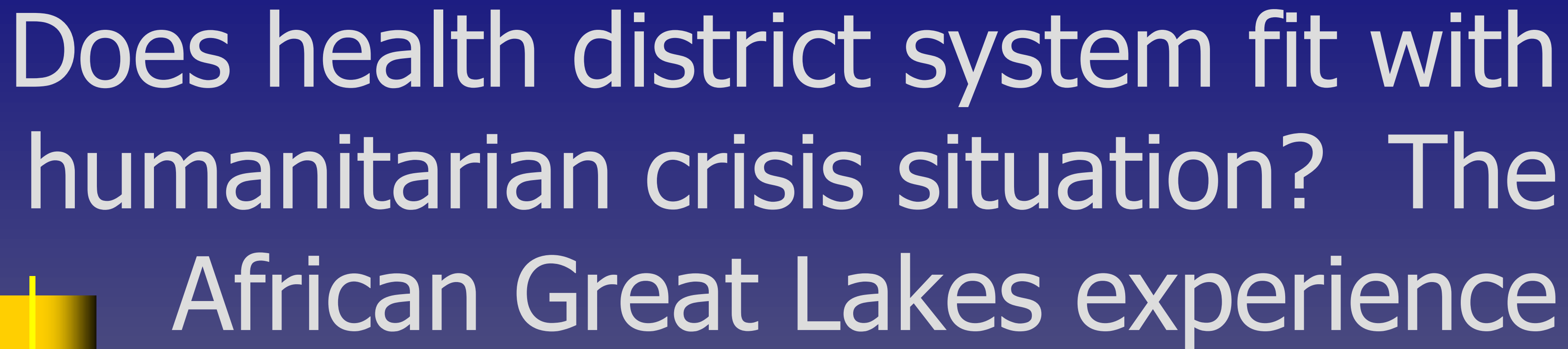


Does health district system fit with humanitarian crisis situation? The African Great Lakes experience

Porignon D [1], Bucagu M [2], Mitangala P [3], Dujardin B [1], Dramaix M [1], Hennart P [1]

[1] School of Public Health, Université libre de Bruxelles, Brussels

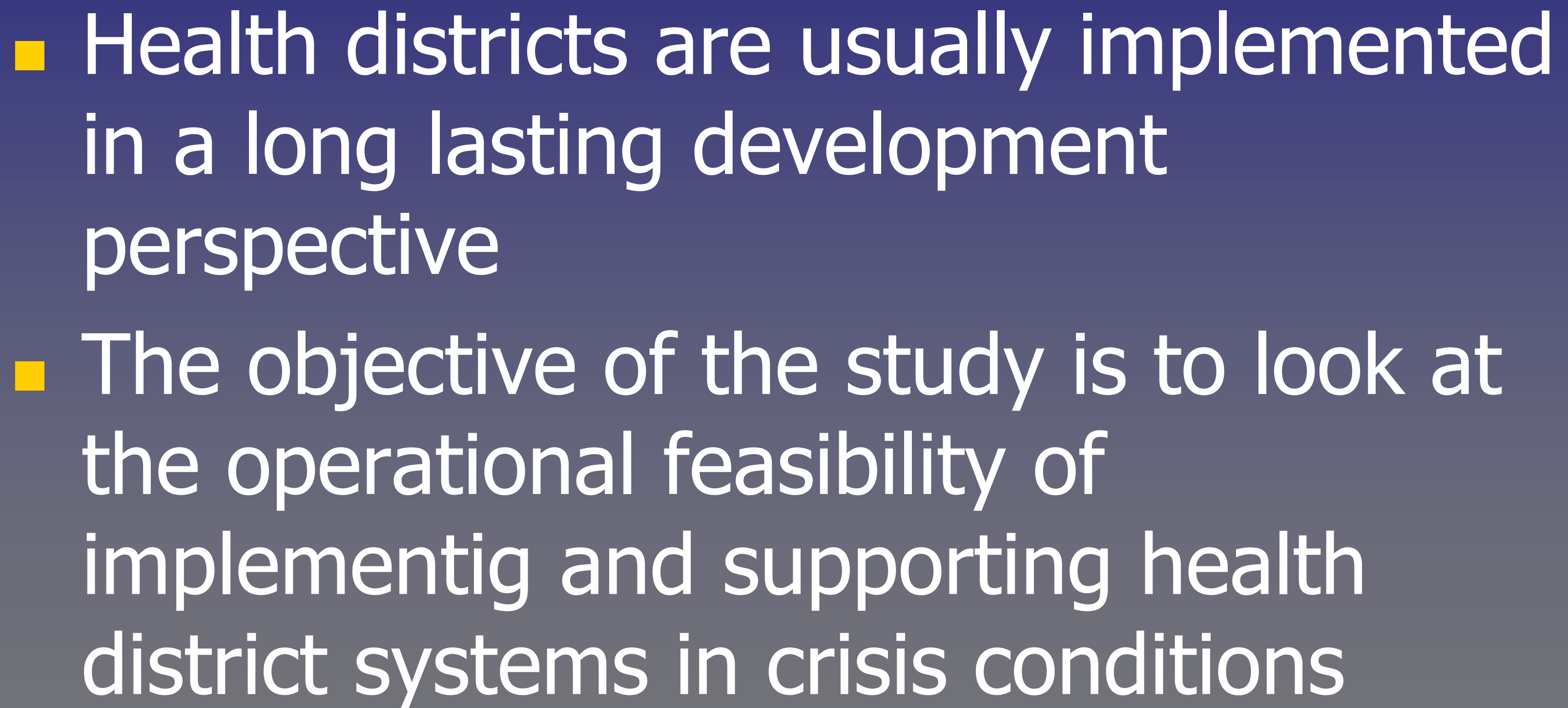
[2] School of Public Health, National University of Rwanda, Butare

[3] CEMUBAC, School of Public Health, Free University of Brussels, Belgium

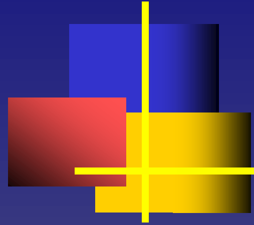
10th International Congress on Public Health

WFPHA, 19-22 April 2004, Brighton, UK.

Introduction (3)



Introduction (Setting 1)

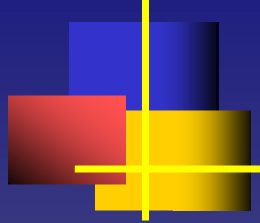


- Rutshuru Health District (RHD - Eastern DRC)

- 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

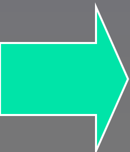
RHD faced severe security constraints with
4 major war like events between 1992 and 1998

Introduction (Setting 2)



- 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

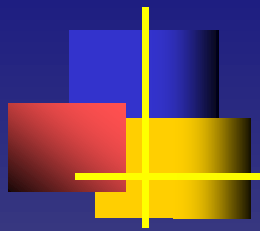


Opportunity exists for profound health sector reform

cemubac:

Approach (1)

RHD: from 1985 until 2001

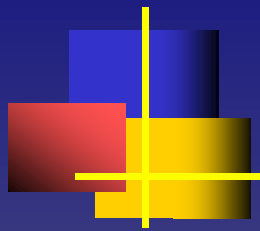


- Support project funded by Belgian Co-operation
- From 1991 onwards :
  no more expatriates
  EU and Belgian Co-operation support managed by local health professionnals
- Follow up of 12 indicators for about 17 years
- Routine health information system related to the whole district and specific data collection related to obstetrical activities at hospital level

cemubac:

Approach (2)

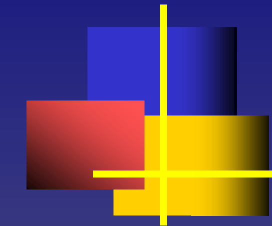
Health sector reform in Rwanda



- 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)

Approach (2)

Health information system in Rwanda



- 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

Approach (3)

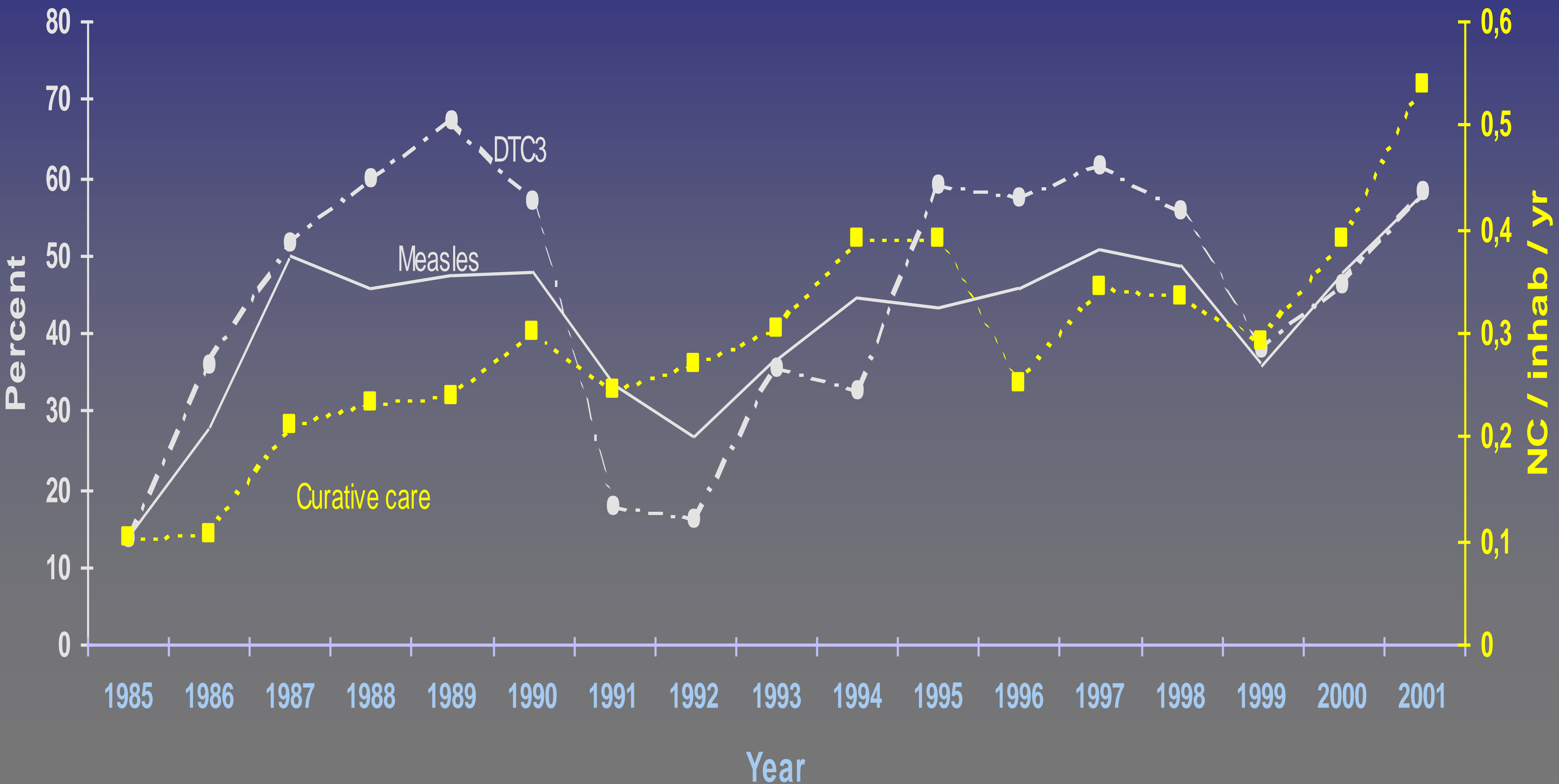
Additionnal information in Rwanda

- 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

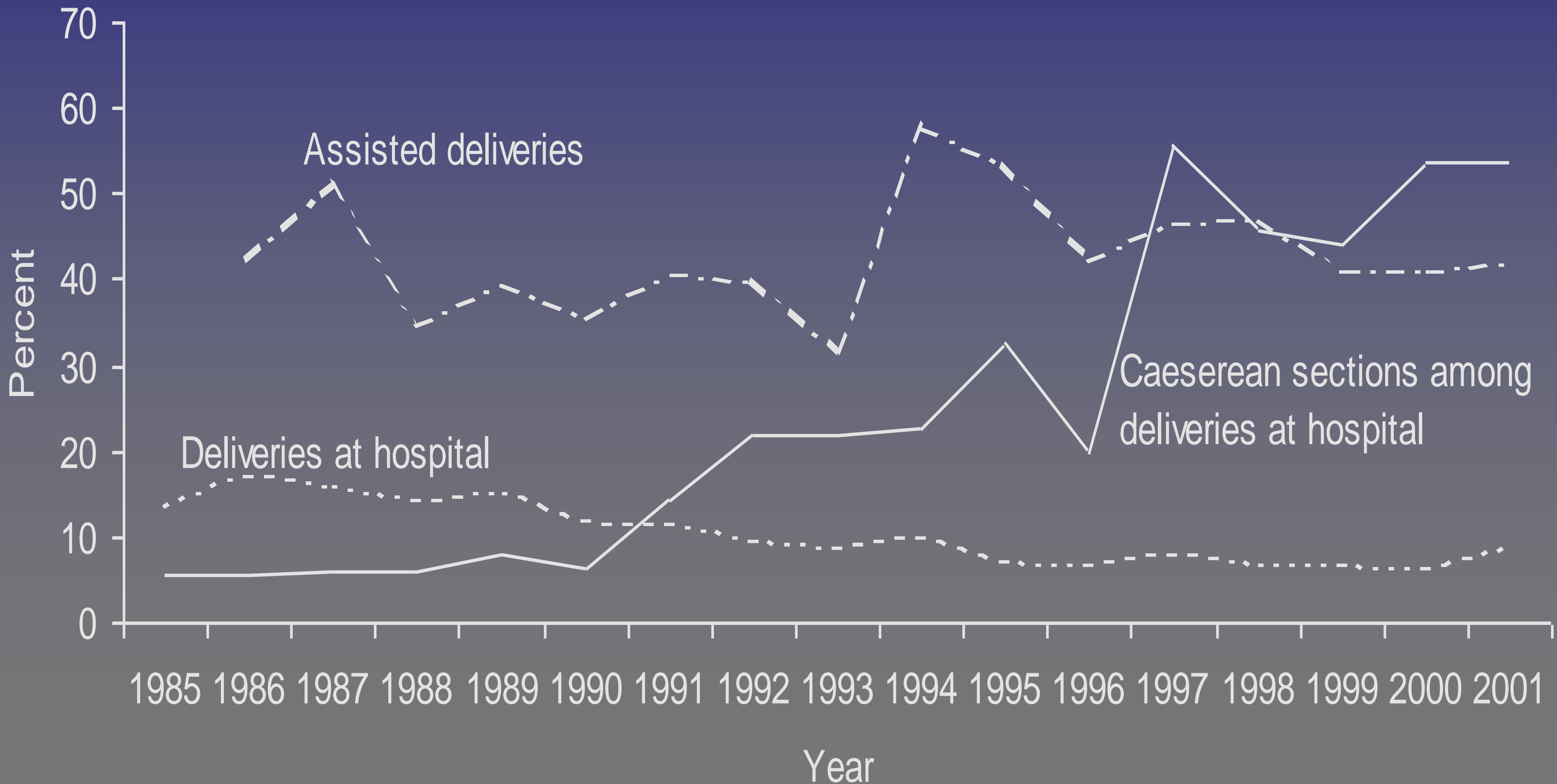
Findings (1)

Activities in RHD



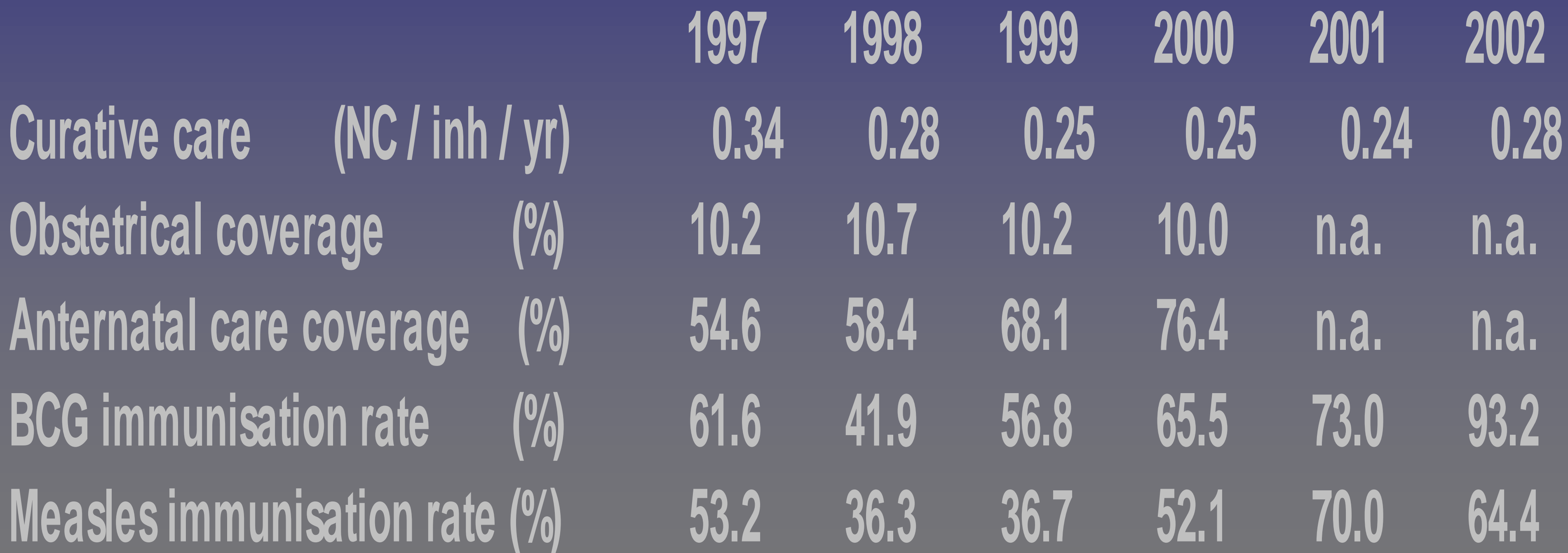
Findings (2)

Activities in RHD



Findings (3)

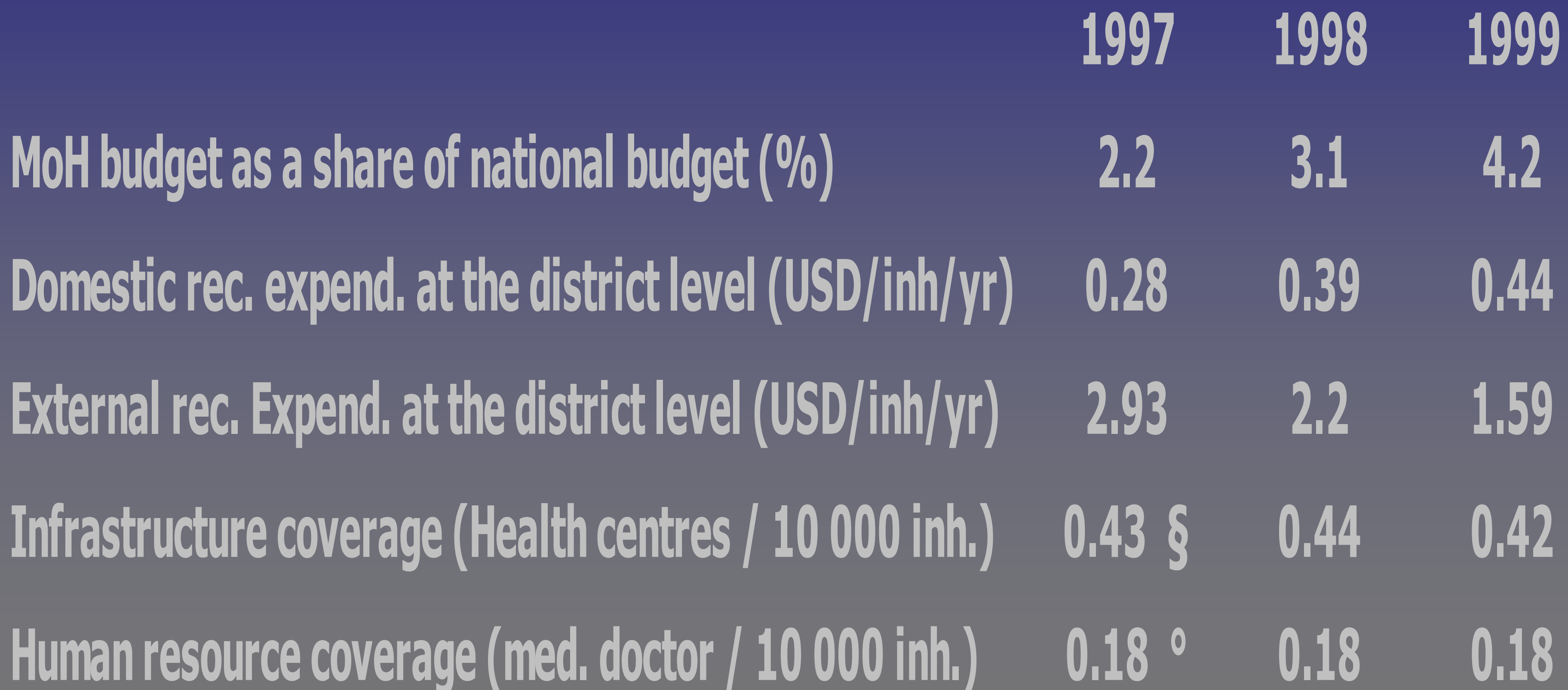
Activities in Rwanda



		1997	1998	1999	2000	2001	2002
Curative care	(NC / inh / yr)	0.34	0.28	0.25	0.25	0.24	0.28
Obstetrical coverage	(%)	10.2	10.7	10.2	10.0	n.a.	n.a.
Anternatal care coverage	(%)	54.6	58.4	68.1	76.4	n.a.	n.a.
BCG immunisation rate	(%)	61.6	41.9	56.8	65.5	73.0	93.2
Measles immunisation rate	(%)	53.2	36.3	36.7	52.1	70.0	64.4

Findings (4)

Resources



	1997	1998	1999
MoH budget as a share of national budget (%)	2.2	3.1	4.2
Domestic rec. expend. at the district level (USD/inh/yr)	0.28	0.39	0.44
External rec. Expend. at the district level (USD/inh/yr)	2.93	2.2	1.59
Infrastructure coverage (Health centres / 10 000 inh.)	0.43 §	0.44	0.42
Human resource coverage (med. doctor / 10 000 inh.)	0.18 °	0.18	0.18

§ : 0.18 in 1994 *° 0.07 in 1994*

Source: PER 1999 and MoH

Future directions (1)

Policy implications

- Performances in both settings yield arguments in favour of health district systems support and implementaton 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
- Scienctific 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

Conclusion