NATIONAL OPEN UNIVERSITY OF NIGERIA

SCHOOL OF MANAGEMENT SCIENCES

COURSE CODE: MPA 874

COURSE TITLE: PLANNING HEALTH FACILITIES AND MANAGEMENT DEVELOPMENT PROCESS

COURSE GUIDE

MPA 874
PLANNING HEALTH FACILITIES AND MANAGEMENT DEVELOPMENT PROCESS

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CONTENTS **PAGE**

INTRODUCTION

Scientific planning is crucial to the attainment of health goals- as managers need to plan health activities to produce positive results that will meet the needs of health consumers. This course will afford you the opportunity to be exposed to the following- health planning and management, planning health services, health planning and planning techniques, implementing health activities, healthcare of the community, the millennium development goals, health status and health problems and quality management in healthcare.

This course guide gives you an idea of what to expect as you study this course. Tutor-marked assignments are provided at the end of each unit. The course is expected to expose you to communication for health education, health information and basic statistics, managing health information units and usefulness of information technology in programme planning and implementation. This knowledge is crucial in order to prepare you for the modern trends and management of information in hospital services.

WHAT YOU WILL LEARN IN THIS COURSE

This course is expected to expose you to how to plan health facilities and process of management development, implementing health activities, evaluating health activities, healthcare of the community, the Millennium Development Goals(MDGs), health status and health problems, health information system and quality management in health care.

COURSE AIMS

This course aims at exposing you to the basic concepts in health planning and management, implementing health activities, healthcare of the community, the millennium development goals, health status and health problems and quality management in healthcare. The aim of the course will be achieved by:

- introducing you to the basics of planning health facilities
- exposing you to the nitty-gritty of implementing health activities
- focusing on issues of health status and health problems, health information system and quality management in health care.

COURSE OBJECTIVES

After studying all the units of this course, you should be able to:

- explain health planning and management
- discuss how health services are planned
- describe the process of planning health services
- outline how to evaluate health activities
- describe the healthcare of the community
- discuss the concept of Millennium Development Goals, especially how it affects health services
- describe the health status and health problem of a community
- briefly explain the relevance of health information system to planning and development of healthcare facilities
- explain how quality management in healthcare can be achieved.

WORKING THROUGH THIS COURSE

To complete this course, you are required to read the course units, books and other materials provided by the National Open University of Nigeria (NOUN). Each unit contains tutor-marked assignment and at the end of the course is a final examination. It is advisable you devote qualitative time for thorough studying of the course.

STUDY UNITS

The course contains the following units.

Module 1

Unit 1 Health Planning and Management
Unit 2 Planning Health Services I
Unit 3 Planning Health Services II
Unit 4 Implementing Health Activities

Module 2

Unit 1 Healthcare of the Community
Unit 2 Millennium Development Goals
Unit 3 Health Status and Health Problems
Unit 4 Quality Management in Healthcare

TEXTBOOKS AND REFERENCES

There are also textbooks, listed under the reference section. They are meant to give you additional information, if only you can lay your hands on any of them. You are advised to practice the self-assessment exercises and tutor-marked assignment questions for greater understanding of the course. By so doing, the stated learning objectives of the course will be achieved.

ASSESSMENT

There are two aspects to the assessment of the course, i.e. the tutor-marked assignment and a written examination at the end of the course. The assignments are expected to be submitted to your facilitator in accordance with the deadlines stated by the university authority. The assignment carries 40% of your course mark; while at the end of the course you will be expected to write a final written examination which carries 60%.

TUTOR-MARKED ASSIGNMENTS

Each unit of the course contains tutor-marked assignments. You need to submit the assignments to your Facilitator through your counselor, at the prescribed time.

FINAL EXAMINATION AND GRADING

The final examination for this course has a value of 60% of the total course grade or as may be decided by the university. The examination will cover all the units of the course, so it is important you spend time to study all the units.

COURSE MARKING SCHEME

The following shows the breakdown of the course marking scheme.

Tutor-marked assignments	= 40%
Final Examination	= 60%
Total	**= 100%**

HOW TO GET THE MOST FROM THIS COURSE

No doubt, distance learning programme is different from the conventional type; you can do your study at your pace and time and place that suit you best. The units are well laid out for ease of understanding; and it is expected that as you thoroughly go through

them, you will surely learn a great deal. As well, you should be able to apply the knowledge in your day to day activities. Ensure you work within the specified time so that you can cover all the units before the final examination.

FACILITATORS/TUTORS AND TUTORIALS

There are many ways of learning as an open distant learner. You learn when you interact with the content in your course material just as a student interacts with the teacher in a conventional institution. You also learn when you are guided through the course. Though you are not taught the course, your course material is however your teacher; and as such, you will not be able to get answers to any questions which may arise from your study of the material. For this reason, apart from the course material which you have received, the delivery of this course is aided by tutorial, facilitation and counselling support services. These services are not compulsory but you are encouraged to, maximally, take advantage of them.

A number of hours have been scheduled for this course, and they form a part of your learning process; you also have an opportunity to receive face-to-face interaction with your informal facilitator and to receive answers to questions or classifications which you may have. Also, you may contact your tutorial facilitator by telephone or e-mail. As an open and distant learner, you are expected to prepare ahead of time by studying relevant study units, write your questions so as to gain maximum benefit from tutorial sessions. Information about the location and time schedule for facilitation will be available at your study centre.

Note that tutorial sessions are flexible arrangements between you and your tutorial facilitator. You will need to contact your study centre to arrange the time schedule for the sessions. You will also need to obtain your tutorial facilitator's phone number and e-mail address. Tutorial sessions are optional, however; participating in them provides tremendous benefits because they provide a forum for interaction and group discussions which will maximise the isolation you may experience as an open and distant learner. Your tutorial facilitator guides you by doing the following things.

i. Providing answers to your questions during tutorial sessions on phone or by e-mail
ii. Coordinating group discussions
iii. Providing feedback on your assignments
iv. Posing questions to confirm learning outcomes
v. Coordinating, marking and recording your assignments/examination score(s)
vi. Monitoring your progress.

Information about the location and time of facilitation will be available at your study course. This is a flexible arrangement between you and your tutorial facilitator. You should contact your tutorial facilitator whenever:

i. you do not understand any part of the study unit
ii. you have difficulty with the self assessment exercises
iii. you have a question or a problem with an assignment, or your tutorial facilitator's comments on an assignment or with the grading of an assignment.

SUMMARY

This course will equip you with the knowledge needed to make you a proficient health worker. You will be given sufficient ground to achieve this. We wish you success in your studies.

MAIN COURSE

CONTENTS **PAGE**

MODULE 1

UNIT 1 HEALTH PLANNING AND MANAGEMENT

CONTENTS

1.0 INTRODUCTION

Planning and management are, relatively, crucial subject areas. Planning is for tomorrow and management is for today. These subjects have acquired great importance during the past two decades. The purpose of planning is:

1. to match limited resources with many problems
2. to eliminate wasteful expenditure or duplication of expenditure
3. to develop the best course of action to accomplish a defined objective. As a result of the increasing demand for medical and health care services, planning and management are considered essential, if higher standards of health and health care are to be achieved.

Planning, in its broadest sense, includes three steps:

(a) plan formulation
(b) execution and
(c) evolution

Planning is a matter of team work and consultation. The planning team consists of, not only specialists within the health field, but also specialists in the fields of economics, statistics, sociology, management, etc.

Development Planning

Every country has its own plan for national development. The purpose of national planning is to achieve rapid, balanced economic and social development of the country as a whole. The National Development Plan(NDP) of a country is a combination of sectoral plans which comprise the following sectors, namely- food and agriculture, education, health and family planning, manufacturing, transport and communications, housing, power, social welfare, etc. All these sectors compete for national resources.

In this context, national development planning has been defined as a continuous, systematic and coordinated planning for the investment of the resources of a country (men, money and materials) in programmes aimed at achieving the most rapid economic and social development possible.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define health planning and management
- discuss the goals of health planning
- describe the planning cycle
- outline management methods and techniques.

3.0 MAIN CONTENT

3.1 Health Planning

Health planning is a recent concept. It is part of national development planning which is necessary for the economic utilisation of materials, manpower and financial resources. The purpose of health planning is to improve health services. In this context, national health planning has been defined as the process of identifying community health problems and un-met needs, “surveying the resources to meet them, establishing priority goals that are realistic and feasible and projecting administrative action to accomplish the purpose of the proposed programme”.

3.1.1 Health Needs and Demands

The purpose of health planning is to meet the health needs and demands of the people. Health needs have been defined as “deficiencies in health that call for preventive, curative control or eradication measures”. The need for medical care, safe water supply, adequate nutrition, immunisation, and family planning are all community health needs. It may be mentioned that the health needs as seen by the people are not, exactly, the same as seen by experts. Some needs may not be perceived at all; others may be vaguely perceived, and still, others are awakening only on contact with new ways of life. People’s needs are conditioned by their aspirations. In a democratic society, people’s needs may be presented as demands.

Resources

The term resources are widely used in health planning. It implies the manpower, money, materials, skills, knowledge, techniques and time needed or available for the performance or support of action directed towards specified objective. The resources can be readily wasted if there is no proper planning and management.

Objectives, targets and goals

A number of words are used to describe the end - results of planning- objective, target- these words are drawn from military and sports terminology. An important element of planning is the setting of clear-cut objectives, targets and goals. Let us consider the meaning of these words.

i. An **objective** (point) is precise- it is either achieved or not achieved. It is a planned end-point of all activities. A TARGET often refers to discrete activity such as the number of blood films collected or vasectomies done. It permits the concept of degree of achievement; whereas objectives are concerned, directly, with the problem itself.

ii. **Goal** is defined as the ultimate desired state towards which objectives and resources are directed. Unlike objectives and targets, goals are not constrained by existing resources nor are they, necessarily, attainable. Goals formulated at the highest level are, generally, broad. A goal is, usually, described in terms of:

1. what is to be attained
2. the extent to which it is to be attained
3. the population or section of the environment involved
4. the geographic area in which the proposed programme will operate and
5. the length of time required for attaining the goal.

iii. **Plan -** Planning results in the formulation of a plan. A "plan" is a blue print for taking action. It consists of five major elements; objectives, policies, programmes, schedules and budget.

iv. A "programme'' is a sequence of activities designed to implement policies and accomplish objectives. A programme gives a step- by-step approach to guide the action necessary to reach a predetermined goal. Programmes must be closely integrated with objectives.

v. A "schedule" is a set of rules for carrying out work which, when observed by all, helps to ensure the maximum use of the resources and efforts. "Policies" are the guiding principles stated as an expectation, not as a commandment.

vi. **Pre- planning -** Pre- planning is preparation for planning. The important preconditions are as listed below.

(a) **Government interest**- any plan for the health and welfare of a country must be based on a strong political will, as manifested by clear directives or policies given by the political authority

(b) **Legislation**- the social and health policies formulated may have to be translated- for instance, the medical termination of Pregnancy Act, 1971, by the Indian parliament to protect the health of mothers.

(c) **Organisation for planning**- there should be an organisation which should be composed of technical experts in various fields to advise government at the centre on issues of health.

(d) **Administrative capacity**- one of the essential pre-conditions of planning is administrative capacity for proper coordination of activities and implementation of the plan at all levels. For the health plan, administrative capacity is vested in the central and state ministries of health.

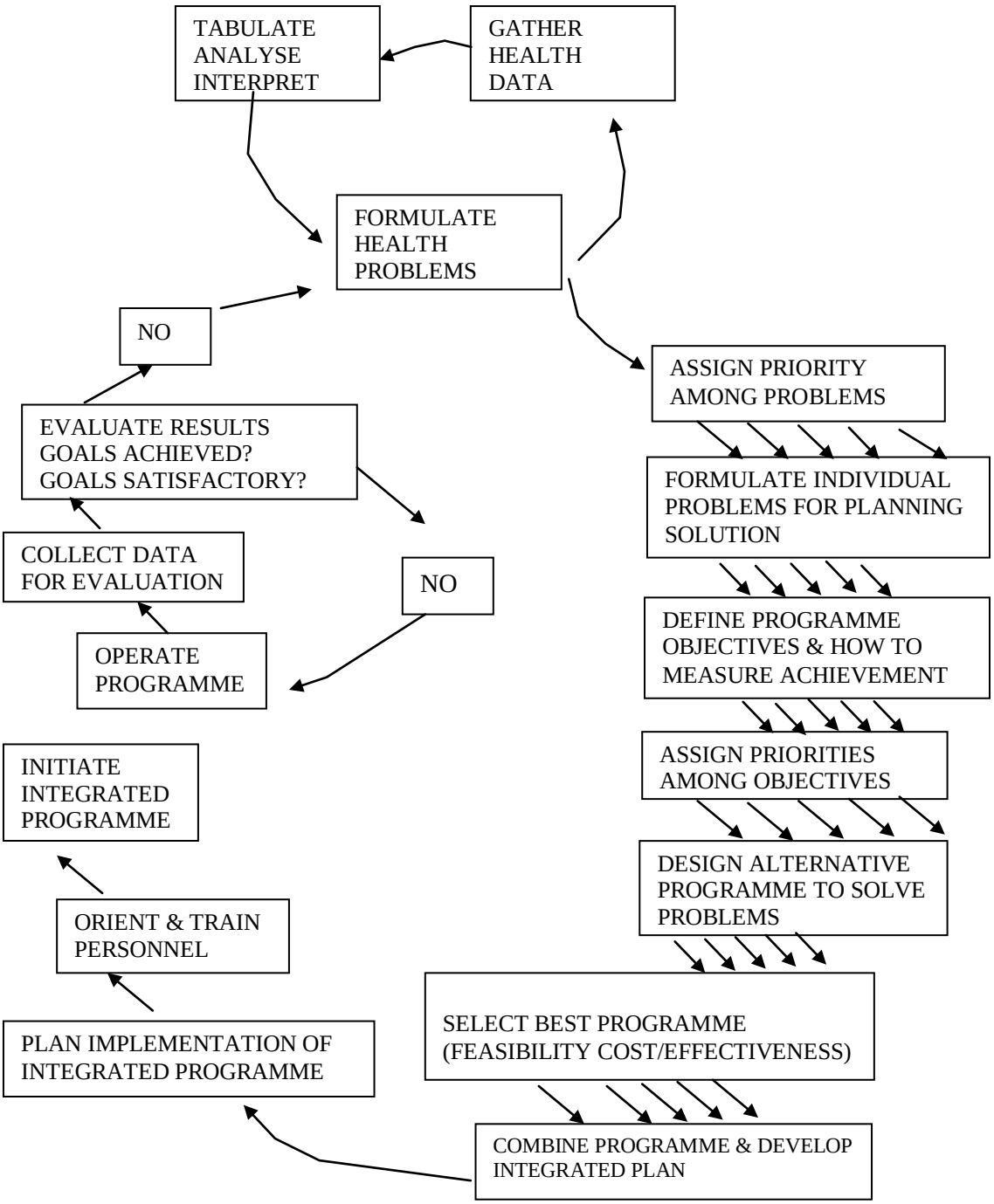

Fig. 1.1

3.2 Planning Cycle

Planning is the broad foundation on which much of management is based. Planning may be defined as a process of analysing a system, or defining a problem, assessing the extent to which the problem exist as a need. It is a process of formulating goals and objectives to alleviate or ameliorate those identified needs; examining and choosing from among alternative intervention strategies; initiating the necessary action for its implementation. It also involves monitoring the system to ensure proper

implementation of the plan and evaluating the result of intervention in the light of stated objectives. Planning, thus, involves a succession of steps. These are as shown in the diagram above.

3.2.1 Analysis of the Situation of Health

The first step in health planning is analysis of the health situation. It involves the collection, assessment and interpretation of information in such a way as to provide a clear picture of the health situation. The following items of data are the minimum essential requirements for health planning.

a. The population, its age and sex structure
b. Statistics of morbidity and mortality
c. The epidemiology and geographical distribution of different diseases
d. Medical care facilities such as hospitals, health centers, and other health agencies(both public and private)
e. The technical manpower of various categories
f. Training facilities available
g. Attitudes and beliefs of the population towards disease, its cure and prevention.

The analysis and interpretation of the above data brings out the health problems, the health needs and health demands of the population.

Establishment of objectives and goals

Objectives and goals are needed to guide efforts. Unless objectives are established, there is likely to be haphazard activity, un- economical use of funds and poor performance. Objectives must be established at all levels, down to the smallest organisational unit. At the upper level, they become more specified and detailed. The objectives may be short term or long term. In setting these objectives, time and resources are important factors. Objectives are not only a guide to action but also a yardstick to measure work, after it is done. Modern management techniques such as “cost- benefit” analysis and input- output study of health services are used for defining goals, objectives and targets in more definite term than hitherto.

Assessment of resources

The term resources imply the manpower, money, materials, skills, knowledge and techniques available for the implementation of health programmes. These resources are assessed, and a balance is struck between what is required and what is available, or likely to be available.

Fixing priorities

Once the problems, resources and objectives have been determined, the next important step in planning is establishment of priorities in order of importance or magnitude, since the resources always fall short of the total requirement. In fixing priorities, attention is paid to financial constraints, mortality data, diseases which can be prevented at low cost, saving the younger people in whom there has been considerable social investment; and also political and community interests and pressures.

Once priorities have been established, alternative plan for achieving them are also formulated and assessed, in order to determine whether they are practicable and feasible. Alternate plans with greater effectiveness are chosen.

Write-up formulated plan

The next major step in the planning process is the preparation of the detailed plan or plans. The plan must be complete in all respects for the execution of a project. For each proposed health programme, the resources (inputs) required are related to the result (outputs) expected. Each stage of the plan is defined (with appropriate financial estimates); and the time needed to implement is specified. The plan must contain working guidance to all those responsible for execution. It must also contain a built- in system of evaluation. It will be left to the central planning authority and the government to consider modifications of the plan in relation to allocation of resources.

Programming and implementation

Once the health plan has been selected and approved by the policy making authorities, programming and implementation commence. Plan execution depends upon the existence of effective organisation. The organisational structure must incorporate well- defined procedures to be followed, as well as the job responsibility of different workers for achieving the predetermined objectives during the period prescribed. It is at the implementation stage that shortcomings often appear in practice. Many well considered plans run into hitches at the implementation stage because of delays in critical supplies, inappropriate staffing, and similar factors. The main considerations and tasks at the implementation stage include:

(a) definition of roles and tasks
(b) selection, training, motivation and supervision of the manpower involved
(c) organisation and communication
(d) the efficiency of individual institutions such as hospitals or health centres.

Monitoring

Monitoring is the day-to-day follow-up of activities during implementation, to ensure that they are proceeding as planned and according to schedule. It is a continuous process of observing, recording, and reporting on the activities of the organisation or project. Monitoring, thus, consists of keeping track of the course of activities and identifying deviations and taking corrective action, if excessive deviations occur.

Evaluation

The purpose of evaluation is to assess the achievement of the stated objective of a programme, its adequacy, its efficiency and its acceptance by all parties involved. While monitoring is confined to daily ongoing operations, evaluation is mostly concerned with the final outcome and with factors associated with it. Good planning will have built-in evaluation to measure performance and effectiveness, thus providing feed-back to correct deficiencies or fill up gaps discovered during implementation. In the opinion of the *WHO* expert committee on national health planning in developing countries, evaluation measures the degree to which objectives and targets are fulfilled and the quality of the results obtained. It measures the productivity of available resources in achieving clearly- defined objectives. It measures how much output or cost-effectiveness is achieved. It makes possible the re-allocation of priorities and resources on the basis of changing health needs.

3.3 Management

The term "management" is used in many senses. It is sometimes confused with administration- sometimes, with organisation. Some equate the term management with administration. Others view management as "the purposeful and effective use of resources- manpower, material and finances–for fulfilling a pre-determined objective." In theory, management consists of four basic activities:

- **Planning**- determining what is to be done
- **Organising**- setting up the framework or apparatus and making it possible for groups to do the work
- **Communicating**- motivating people to do the work
- **Monitoring (controlling)-** checking to make sure the work is progressing, satisfactorily.

Management techniques are familiar in business, industry, defence and other fields. The current emphasis by *WHO* and many governments is on improving the efficiency of health care delivery systems through the application of modern management methods and techniques.

Management methods and techniques

Management techniques are many. They are based on principles derived from the behavioural sciences, as well as quantitative methods. These techniques have been developed by experts of management science to help managers of many organisations to achieve their stated goals. These techniques are now becoming more popular (in terms of application) in the health field. A brief account of these techniques is given below.

a. Methods based on the behavioural sciences

1. **Organisation design** - Poor organisation results in waste of resources. It is a theory of management that ensures that an organisation must be suited to its current situation and the needs to be serviced. The organisation of health services should, therefore, be designed so as to meet the health needs and demands of the people. Furthermore, the organisational design should be reviewed every few years because of changing problems and changing technology. Efficient delivery of health service depends upon the existence of an effective organisation.

2. **Personnel management** - This is skilful use of human resources. This has to do with proper methods of selection, training and motivation; division of responsibility; distribution of roles; elimination of square pegs in round holes (i.e. professional staff not suited to administration, either through training, selection or natural inclination, should not be entrusted with administrative and management burdens). Also, incentive for better work; opportunities for promotion and professional advancement; effective design of health teams are all fundamental techniques of personnel management which could contribute to the efficiency of health service delivery.

3. **Communication** - Better communication contributes to effective functioning of an organisation. Communication roadblocks exist at various levels- between the doctor and the patient; the doctor and nurse; between the senior officials and junior official; between the directorate and the health ministry; between the health ministry and other ministries, etc. Communication barriers are responsible for delays in regular reporting and notification; delays in the compilation of statistics, delays in the supplies, and delays in salaries. Delays are some of the major weaknesses in health agencies/ministries; and the task of health management is to

solve the communication problems by establishing suitable vertical and horizontal communication channels.

4. **Information system** - Information is needed for day- to- day management of the health system. Information comes from many sources- both formal and informal. The information system should be tailored according to the management needs of the individual health services. The functions of information system consist of collection, classification, transmission, storage, retrieval, and display of information. A good information system provides data for monitoring and evaluation of health programmes and gives the requisite feed back to health administrators and planners at all levels. Computers can play a great role in improving the health information system.

5. **Management by Objectives (MBO)** - Objectives are set for different units and sub-units, each of which prepares its plan of action- usually, on a short term basis. This helps in achieving the results more effectively and smoothly.

b. Quantitative methods

Quantitative methods are derived from the field of economics. Operations research and budgeting are some of these techniques that have great role in the management of health services.

1. **Cost- benefit analysis** - This is a management technique which has attracted the widest attention (in terms of application) in the health field. The economic benefits of any programme are compared with the cost of that programme. The benefits are expressed in monetary terms to determine whether a given programme is, economically, sound, and to select the best out of several alternative programmes. The main drawback with this technique is that the benefit of a particular programme in the heath field cannot always be expressed in monetary terms. We, generally, express the benefit in terms of births or deaths prevented, or illnesses avoided or overcome. Hence, the scope of applying this method is rather vague.

2. **Cost- effective analysis** - This is a more promising tool (for application) in the health field than cost- benefit analysis except that benefit- instead of being expressed in monetary terms, is expressed in terms of result achieved, e. g. number of lives saved or the number of days free from disease. However, even cost-effective analysis is not possible in many cases.

3. **Cost accounting** - It provides basic data on cost structure of any programme. Financial records are kept in a manner permitting costs to be associated with purpose for which they are incurred. Cost accounting has three important purpose in health services, namely- (a) cost control; (b) planning and allocation of people and financial resources; and (c) pricing of cost reimbursement.

4. **Input- output -** Input-output analysis is an economic technique. In the health field, "input" refers to all health service activities which consume resources (manpower, money, materials and time). 'Output", on the other hand, refers to such useful outcomes as cases treated, lives saved or inoculations performed. An input-output table shows how much of each "input" is needed to produce a unit amount of each 'output". It enables calculations to be made of the effects of changing inputs.

5. **Model** - Model is a basic concept of management science. It is an aid to understand how the factors in a situation affect one another. It is an abstraction of the reality, not the reality itself. The decision process includes the use of a model.

6. **System analysis** - The purpose of system analysis is to help the decision maker to choose an appropriate course of action by investigating his/her problem, searching out objectives, finding out alternative solutions, evaluation of the alternative in terms of cost effectiveness and re-examination of the objective. Systems analysis is, essentially, finding the cost- effectiveness of the available alternatives. The system can be hospital supply system, an information system, a total community health service system, an outpatient clinic or any other system with problem of management. A system may be made up of independent subsystems.

7. **Network analysis** - A network is a graphic plan of all events and activities to be completed in order to reach an end objective. It brings greater discipline in planning. The two common types of network techniques are- (a) *PERT* and (b) *CPM*.

   (a) PERT (Programme Evaluation and Review Technique) - is a management technique which makes possible more detailed planning and more comprehensive supervision. Every housewife who plans a meal so that each part of the menu is completed at the same time is using the basic technique of *PERT*.

   The essence of *PERT* is to construct an arrow diagram (as in *fig.1.2* below).The diagram represents the logical sequence in

which events must take place. It is possible with such a diagram to calculate the time by which each activity must be completed and to identity those activities that are critical. This simple technique provides a basic discipline by which all concerned in a project can know what is expected of them and to minimise any delay or crises in the implementation of the plan.

PERT is a useful management technique which can be applied to a great variety of projects. It aids in planning, scheduling and monitoring the project; it allows better communication between the various levels of management. Also, it identifies potential problems; it makes continuous, timely progress reports possible; it forms a solid foundation upon which to build an evaluation and checking system.

(b) Critical Path Method (CPM) - the longest path of the network is called "critical path". If any activity along the critical path is delayed, the entire project will be delayed.

8. **Planning Programming- Budgeting System (PPBS)** - The Planning Programming- Budgeting System (PPBS) is, primarily, a system to help decision makers to allocate resources so that the available resources of an organisation are used in the most effective way in achieving its objectives.

The *PPBS* does not call for changes in the existing organisation. It calls for grouping of activities into programmes related to each objective. Another approach is known as the 'Zero Budget Approach"- i.e. all budgets start at zero and no one gets any budget that he cannot specifically justify on a year- to- year basis.

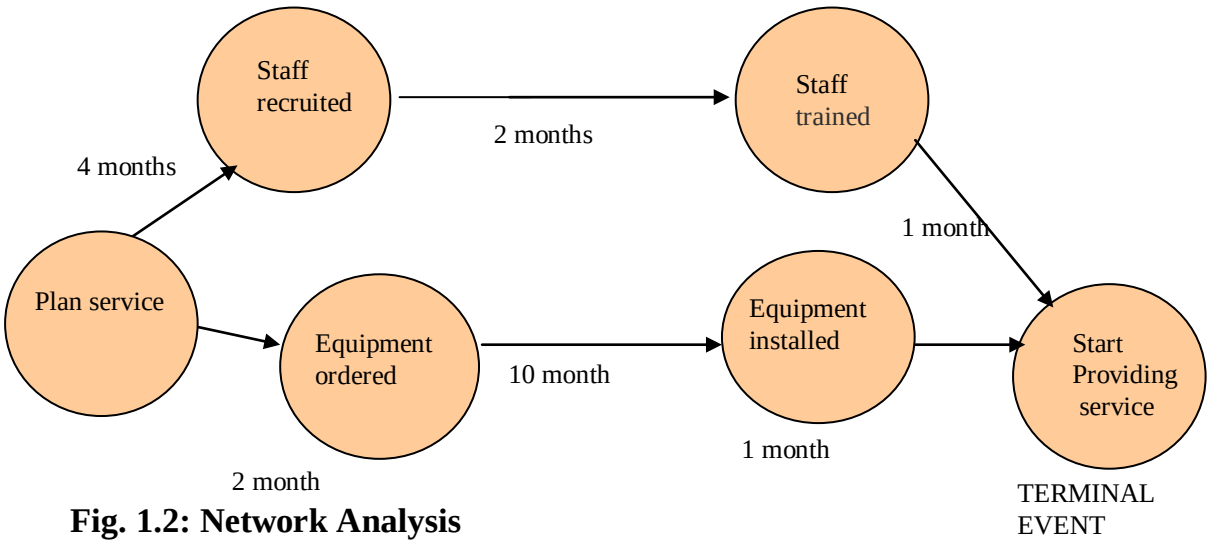

Fig. 1.2: Network Analysis

9. **Work sampling** - This is the systematic observation and recording of activities of one or more individuals, carried out at predetermined or random intervals. It provides quantities measurement of the various activities. The major parameters that are analysed are the type of activities performed and the time needed to do specified jobs. Work sampling studies have been done on doctors, nurses, pharmacists and laboratory technicians. Work sampling permits judgments to the appropriateness of current staff, job description and training. It helps in standardising the methods of performing jobs and determining the manpower needs in any organisation.

10. **Decision making** - Decision making is just like the basic discipline of differential diagnosis in medical practice. Decisions should not be made with incomplete data. In the health sector, decisions have to be made about development of resources, optimum work load for medical and paramedical workers, strategies for providing health care, etc.

SELF-ASSESSMENT EXERCISE

Describe various methods and techniques of management mentioned in this unit.

3.4 National Health Policy - 2002

The ministry of health and family welfare, govt. of India, evolved a National health policy in 1983- keeping in view the national commitment to attain the goal of health for all by the year 2000. Since then, it has been relating to the health sector, necessitating revision of the policy, and a new National Health policy -2002 was evolved.

The main objective of this policy is to achieve an acceptable standard of good health amongst the general population of the country. The approach will be to increase access to decentralised public health system by establishing new infrastructure in the existing institutions. Emphasis should be on ensuring a more equitable access of the country; priority will be given to preventive and first line curative initiatives at the primary health level. The policy is focused on those diseases which are, principally, contributing to disease burden such as tuberculosis, malaria, blindness and HIV/AIDS. Emphasis will be laid on rational use of drugs within the allopathic system. To translate the above objectives into reality, the health policy has laid down specific goals to be achieved by year 2005, 2007, 2010 and 2015. These are as given in the table below. Steps are already under way to implement the policy.

Table 1.1: National Health Policy of India- 2002
(Goals to be achieved by 2015)

Eradicate polio and yaws	2005
Eliminate leprosy	2005
Eliminate Kala-azar	2010
Eliminate lymphatic filariasis	2015
Achieve zero level growth of HIV/ AIDS	2007
Reduce mortality by 50% on account of *TB*, malaria and other vector and water borne diseases	2010
Reduce prevalence of blindness to 0. 5%	2010
Reduce IMR to 30/100 and MMR to 100/ Lakh	2010
Increase utilisation of public health facilities from current level of < 20 % to > 75 %	2010
Establish an integrated system of surveillance, national health account and health statistics.	2005
Increase health expenditure by government as a % ofGDP from the existing 0.9 % to 2.0 %	2010
Increase share of central grants to constitute at least 25% of total health spending	2010
Increase of the sector health spending from 5.5% to 7% of the budget	2005
Further increase to 8% of the budget	2010

4.0 CONCLUSION

Planning is a matter of team work and consultation, the planning team consists of not only specialists within the health field but also specialists in other fields like economics, statistics, sociology, management to mention but a few.

5.0 SUMMARY

In this introductory unit, you have been exposed to what management methods and techniques entail, in the health sector. This is expected to boost your understanding of other concepts that you are going to come across.

6.0 TUTOR-MARKED ASSIGNMENT

Discuss the planning cycle of health management.

7.0 REFERENCES/FURTHER READING

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UNIT 2 PLANNING HEALTH SERVICES I

CONTENTS

1.0 INTRODUCTION

Planning begins as an idea, or because attention has been drawn to a particular situation. Planning a programme can take place at any level of a system. Usually however, the general policies and guideline of a health system are laid down by the ministry of health. The rule of the middle-level system is to interpret policies at local level, plan their implementation, and see that they are implemented.

During the daily round of work, planning takes place continually. Planning methods can be applied to a large programme such as a national malaria programme, or to a small one such as health education in a village.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define planning
- list the steps in planning health activities
- describe steps one to three of planning health activities.

3.0 MAIN CONTENT

3.1 Steps in Planning Health Activities

There are five planning steps, as follows:

1. look at the situation-collect the facts
2. select the important problems
3. set objectives and targets
4. review obstacles and limitations
5. prepare the plan.

Step 1 - Looking at the situation

For purposes of health, planning information is required about:

- health, diseases and illnesses
- the community (population, births and deaths, age groups, housing, schools, leaders, organisation, etc.)
- health staff
- other resources.

Some of the information needed for health planning is obtained from other sectors such as the education or agriculture ministry. Management information must be:

- of the right kind (relevant to the purpose)
- in the right amount (enough and not too such)

Much of the information needed can be obtained from records and reports. This is, usually, formal or official or published information. A second type of information-informal information-is obtained from the community, not from official sources; but this informal information is, probably, the most useful at the middle level of a health system. It is, particularly, important when planning health programme. One can learn much from contact with different groups-community leaders, teachers, traditional health workers, women's groups.

These are resource persons who can indicate a community's needs and often uncover the underlying cause of a problem that may not always be apparent to the health worker. For example, if they fail to practice what they have learned; the reason may be that the grandmothers, who are often heads of households, have a strong traditional approach to childrearing and feeding.

Methods of gathering information are:

- listening and observing in the community
- discussing with community leaders
- talking with other development workers, teachers, religious leaders, agricultural workers
- talking with traditional healers or other health workers
- reading the records of clinics or health centers
- studying maps, census figures, district figures, special reports or programme reports.

The following table shows the types and sources of information that may need to be collected about a community and its health problems and needs.

Table 2.1: Types and Sources of Information

INFORMATION FROM THE COMMUNITY ON PEOPLE'S HEALTH TYPES	SOURCE
Why problems have occurred	Listening and observing in the community
The kinds of traditional health care available	talking with people.
Attitudes and customs concerning health and illness.	
ON HEALTH WORK BEING DONE	
What the people feel about the work.	Listening to the community, Particularly the leaders. Talking with other community development workers.
TYPES ON THE COMMUNITY	SOURCE
Attitudes and customs relating to matters other than health, e.g. community. Who are the leaders in the community? Who are the workers. Talking with teachers and makes decisions and how are decisions made?	Listening to and talking with people in the community. Reading material, if available communication between leaders and people. Talking with other health and development Religious leaders.
Are there traditional health workers such as birth attendants, healers, a medicine-men?	
Other health and health-related agencies	
Geographical features	
Transport facilities	
Public facilities: water, sanitation, market, School, farming, food production. Map of area.	

INFORMATION FROM RECORDS	
TO IDENTIFY PEOPLE	
Name, age, sex, address	Registration cards Health centre records Community survey.
ON PEOPLE'S HEALTH	
Kinds of health problems and when Problems occurred.	Monthly reports. Outpatients records.
Number of expectant mothers attending Antenatal clinics	Clinic records
Number of births each month or each year (live and stillbirths) and sex number of mother	Clinic records or survey of children under one year in the community
Who died from childbirth in past year.	Clinic records or direct questioning
Number of deaths by sex, age and Presumed cause.	in the villages. Possibly, health Centre records or through Community officials.
ON HEALTH WORK BEING DONE	
Number of people seen each month and why. Treatment given, kinds of health problems. Special campaigns held.	Monthly report.
ON MATERIALS USED FOR HEALTH WORK	
Drugs supplied. Drugs used. Other supplies. Latinate of supplies needed for a period at time.	Stock ledger and inventory.

Collecting baseline information

Baselines information should be collected when health services are to be provided, for the first time in a community. It enables management to decide what kinds of health activities are needed and to calculate the number of people who should receive different kind of health services. Also, it enables progress to be measured at intervals after services have been introduced.

Such baseline information will include:

- people's names, sex and addresses
- birth date or approximate age
- occupation
- length of time living in the village
- number in family and their relationships

- number of births in the past year
- number of infant deaths/stillbirths in the past year
- probable causes of deaths
- most common communicable diseases
- whom people call or consult when they are sick
- geography of the area
- water supply sources
- excreta disposal practices
- foods available and used, and the methods of preparation and storage
- infant feeding and care practices.

This information may be collected in different ways. Village leaders may be able to give some information, but a survey of the people in the area may be necessary to find out all is needed.

A survey may be made by talking with the people in each house within the area- or, if this will take too much time, it may be in every fourth or fifth house. Volunteers from a village are often used by health workers to assist in collecting information. The volunteers must be told why and how the survey is being done, and which information to collect. The village leader may advise on the choice of volunteers.

Information about resources

It is important to collect information about resources. A resource may be thought of as anything that can be used to carry out activities to achieve an objective. Resources are not only money. For example, in gardening, the climate is a resource; in building a hotel for tourists, the situation or the view is a resource. When choosing a course of action, all types of resources must be reviewed, systematically, one by one. The main types of resources are listed below.

1. People- trained people, skilled people, or others who are concerned with health care services
2. Buildings e.g., dispensaries, health centres, rural hospitals
3. Equipment, material, transport
4. Information- books and methods manuals, records and reports, community studies, surveys
5. Social and other environmental factors- public opinion, government support, technical resources (e.g., electricity), climate
6. Money- this is needed to obtain other resources (such as equipment or transport)
7. Time- there must be enough time to operate the plan.

Collecting information to explain the cause of a problem

Information may have to be collected in other ways to help in understanding why a problem occurred. Thus, a supervisory visit may be needed to see why there is an increase in diarrhea, as shown by the monthly report. Questions like the ones below may need to be considered.

- Do the people understand the reason for good hygiene and sanitation?
- Are there attitudes and customs that would cause the problems?
- Is the water supply safe? If not, why not?
- Are the people using the latrines that have been built? If not, why not?

Answers will give information that would lead to a more accurate interpretation of the data found in records. From information gathered, the health worker-in-charge can plan ways to solve the problems or to modify programmes.

Looking at the health work being done

It is useful to make a list of targets that have been achieved (e.g., the number of children immunised), as well as those that have not been met. The opinion of the community should be noted. Are the people participating fully in certain programmes? Are they satisfied with the work being done? Are they applying what they learn- what the health worker teaches? What are the obstacles? Can obstacles be removed or reduced? Should targets be changed?

Recording cumulative information by tabulation

Information collected daily can be accumulated by adding the data for each month, throughout the year. In this way a health worker can see, continuously, how each programme is progressing, and where and why targets are not being met. This information is very useful in making the health plan for the area for the following year.

Analysing information

It is not enough to collect information. It must be analysed and digested. Information must be selected so that only useful information is considered, arranged in such a way that it can be compared with other information (standardised), recorded so that it can be remembered and found again when needed, and communicated to others who need the information.

Step 2 Selecting important problems

What is a problem?
Here are two useful definitions of a problem:

- a problem is a difficulty or obstacle seen to exist between a present situation and a desired future objective
- a problem is a perceived gap between what is and what should be.

It is important to recognise that people look at (perceive) problems differently. For Example:

'*a village has a contaminated water supply, which may be resulting in outbreaks of diarrhea'*.

That is a situation. If the villagers do not recognise that the water is contaminated or that it is responsible for diarrhea, then, to the villagers, this situation is not a problem. However, the health worker 'sees' or 'perceives' the gap between what is and what could be. This gap is a problem, to the health worker.

It is important to define a problem clearly; otherwise an attempted solution may be wrong. Many health problems have several causes. It is easy to mistake a cause for a problem; then, one cause may be removed without solving the problem. Consider the following.

1. *Many people have diarrhea*
2. *The well-water is contaminated*
3. *There are too many flies*
4. *The sanitation is poor*
5. *The people need health education*

Which of the above is the problem?

The problem is '*many people have diarrhoea'*. Statements 2, 3 and 4 are possible causes of the problem. If the problem is stated as 'sanitation is poor', and the effort at solving the problem is concerned only with improved sanitation, the diarrhea will **not** disappear. It may be spread by flies or contaminated water.

In analysing problems, define what the problem is, and find all possible causes of the problem; then, look for ways to remove causes. To select important problems, it is useful to group all the problems under the following headings.

Diseases or health problems
e.g., malaria, malnutrition, respiratory diseases, diarrhea.

Health service problems
e.g., insufficient drugs, lack of qualified personnel, difficulty in visiting outlying areas.

Community problems
e.g., inadequate water supply, no primary education, people have to go a long distance for health care, poor harvest, male population leaving the land to work in industry.

The health worker is always faced with more than one problem at a time and cannot solve all of them at once. So the problems are studied and the most important are given priority, i.e., these problems will be tackled first. Resources will be used mainly for these problems.

When attempting **to select priority problems** one must look, carefully, for the real causes, especially for purposes of health programme planning; many health problems could best be cured by balanced diet, clean water, education, and clean environment. When seeking information, it is important to look also outside the health field.

One way to determine problem priorities is to set criteria. A criterion is a principle or a standard by which one can measure or judge something. A set of criteria may be listed to form a **check-list** such as the following; does the problem:

- affect large numbers of people, e.g., malaria, leprosy
- cause high infant mortality, e.g., malnutrition, neonatal terms
- affect maternal health, e.g., complications of pregnancy, multiple pregnancies, post-partum hemorrhage?
- affect children and young persons, e.g., blindness, trachoma, home accidents?
- cause chronic conditions and handicap, e.g., blindness, trachoma poliomyelitis?
- affect rural development, e.g., river blindness, sleeping Sickness?
- cause worry to the community?

If the answer to any of the above questions is *YES*, the problem is a priority one. A problem may receive priority attention also if there is a simply way to deal with it.

Example of a list of community problems (applying step 2)
After reviewing all the information available a number of problems will emerge. A typical list can look like the list below.

Diseases and health problems

Malaria	Low birth weights of infants
Respiratory infections	leprosy
Diarrhea	tuberculosis
Complications of pregnancy and hepatitis	
Labour	skin infections
Eye infection	ear infections
Insect and snake bites	malnutrition

(and so on, according to the area)

Other problems that may emerge-

Communications

Bad roads	inadequate transport
Seasonal bad weather	flooding

Health services

Health personnel do not go out to the community	insufficient staff
Lack of material for dressings and treatments	insufficient drugs
	inadequate working condition
	lack of transport.

Other problems affecting health-

Illiteracy	rodents and animals roaming freely
Lack of sanitation	drought
Contaminated water supply	unemployment
Bad/overcrowded housing.	

To choose priority problems from the above list, apply the selection criteria mentioned earlier on, the more important problems will become obvious, consider the following examples.

Health problems

Complications of labour
Low birth weight of infants
Malnutrition

Health service problems

Insufficient visits to the community
Lack of transport.

Community problems

Lack of sanitation.

Note- many problems are outside the health sector but are important because they affect health. The health worker can make giving the people health education a priority, to inform them about those problems and teach them how to prevent and overcome them. He/she may cooperate with the teacher in the school, or take advantage of the literacy programme, to prepare material so that people can learn about health, at the same time as they learn to read.

Contaminated water, or, in some areas, lack of water are not problems the health worker can tackle alone. He/she can get in touch with the appropriate authority and cooperate with them. He/she must consider all this when making a plan of work. This may include, for instance, educating the community in a latrine-building programme or water conservation in the home.

SELF-ASSESSMENT EXERCISE

Briefly explain the steps involved in planning health activities.

4.0 CONCLUSION

Proper planning is crucial to the attainment of health goals, as health activities must be well organised in order to achieve a result. Planning that is scientific and thorough will, definitely, produce positive results as it will be goal directed.

5.0 SUMMARY

In this unit, you learnt about what a problem is, the importance of defining problems, selection of important problems, criteria for selecting important problems and setting objectives and targets.

6.0 TUTOR-MARKED ASSIGNMENT

How can a health manager gather information for decision making?

7.0 REFERENCES/FURTHER READING

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UNIT 3 PLANNING HEALTH SERVICES II

CONTENTS

1.0 INTRODUCTION

This unit is a concluding part of planning health services activities; the focus of this unit will be on reviewing of obstacles and limitations, and finally, preparing the blue print of the plan to be executed.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- discuss reviewing of obstacles as a step in planning health activities
- describe how to write the plan of health activities.

3.0 MAIN CONTENT

3.1 Reviewing Obstacle

Having selected priority problems, and taken into consideration the resources available (i.e. people, equipment, drug and material), the next step is to decide how the problem can be reduced or whether they can be solved. Many health problems cannot be solved quickly. They need several combined activist to deal with them.

Setting objectives is a positive step towards improving health. An objective may be defined as the intended result of a programme or activity. There are two important reasons for setting objectives. One is that a clear objective is essential to a definite plan. For instance, if you say- *"I am going to shanghai"*- then a travel plan can be drawn up; e.g. bus from village to town, rail from town to port, then from port to shanghai.

You may say- *"we will improve health"*, but no definite plan can be made from that; but if you say- *"we will extend health care to cover the total population by 1985"*- then a plan can be drawn up to try to achieve that goal. Long term objectives such as control or eradication of a communicable disease (e.g. measles), or reduction of infant motility rate require that a number of intermediate objectives necessary to achieve the main objective must be stated. Short term objectives to be achieved by a specific data as a step towards a long term objective are sometime called operational objectives.

The other reason for setting objectives is to enable results to be evaluated. Thus, if the objective of a child health programme is to decrease infant mortality within a given period, then to evaluate the programme, it will be necessary to measure the degree of reduction of the infant mortality rate within a determined period. If the objective is to reduce the number of cases of measles by 50%, the result can be measured as the number of cases of measles in the population in 1980 can be compared with the number of cases in each of the previous five years. Objectives are usually time-bound, i.e. to be achieved in x weeks, months or years.

Characteristics of useful objective

Objectives must satisfy four criteria. They must be relevant, feasible and observable or measurable. An objective is relevant if it either fits in with the general policy or helps to solve the problem it is meant to solve. It is feasible when it is possible to achieve it- i.e. the resources are available and the obstacles can be overcome.

An objective is observable when the result can be clearly seen or known. If a building is erected or a worker is in a new skill- this is a result which can be seen. An objective is measurable when the result can be reflected in numbers. For example, malnutrition will be reduced to 1% is measurable. At the end of the year the number of babies born and the number vaccinated can be compared- i.e., programme towards achieving the objective can be measured.

Objectives may be stated at different levels of the health system

1. "At the end of five years, just less than 4% of children under three years of age will be malnourished"- (below 60% weight for age on standard growth chart)"- is an example of an objective set by a ministry of health at national level.

2. At the middle level of the health system, an objective is expressed as a number of operational targets, and standard instructions are written for village health workers for actions they must take to

reach the targets (e.g. on nutritional care- instructions on health education, buying local foods for children, rehabilitation of children with malnutrition). The following are examples of operational targets and their corresponding rehabilitation activities at the middle level:

a. to identify children of ages one day to three years with malnutrition, according to stated nutritional criteria (state village to be covered and number of children)
b. to train village health workers to identify malnutrition accordingly (state the number of village health workers to be trained)
c. to plan a (definite) number of training sessions
d. to provide care for identified children according to standard instructions (the quality of care can be assessed).

3. At village level an operational target would be: Identify among the child population of ages one day to three years of age all children with malnutrition, according to the specific criteria, and provide care to them according to the standard instructions.

In defining hoe village health work apply the criteria (e.g, action is improve nutrition) standardising instructions are expressed as activities of the programme, i.e, what health workers should do. The result will be evaluated at laterals to judge progress and finally at the end of a period, e.g., after five years to if the objective has been achieved.

Reviewing obstacles and limitations

Having set objectives, the question must be asked- are there any reasons why these objective could not be attained? Are there limitations or obstacles?

Types of obstacles and limitations

The limitations of an activity may be, simply, the absence of resources; and these can be discovered during a review of resources. For example, consider the list below.

- People are not interested; or they feel they have other more important needs, or there are no trained people.
- Equipment is not available or cannot be bought or is expensive.
- Information is hard to find; there are no books and advisers are not available.
- Time- no one has time to start the plan or to supervise it.
- There may be special environmental obstacles; and when making a plan the environment should be reviewed to see if it presents any special difficulties such as the ones stated below.

- **Geographical problem-** which should be considered in building roads, marketing goods, or transporting patients; it is crucial to delivering adequate health service in some areas.
- **Climate**- which may influence types of building, transport, gardening, nature of health problems, etc.
- **Technical** difficulties related to the level of technological advancement of the society.
- **Social factors-** which are the most serious obstacles. There may be customs or taboos that operate against the plan. People may have prejudices against new ideas; or there may be laws or regulations (good or bad) that prevent certain activities.

Finally, having reviewed and classified the obstacles and limitations, the health worker looks again at the objectives and modifies them as necessary. Then they become the objectives and targets to be achieved. The output of this step will be an analysis of obstacles and limitations and a final list of objectives and targets.

Using the obstacles

A simple method is to list the objective, write down the obstacles and actions for each one, and then group them under three headings as follows.

- Obstacles that can be removed- i.e., a solution has been found. For example, *"provide and improve maternity care"*. The obstacle is a shortage of qualified hands. The suggested solution is to train traditional attendants, supervision provide by midwives.

- Obstacles that can be modified or reduced. For example, a group of villages want children to be educated. They set as targets to build a school and recruit teachers; they find their resources are insufficient. So they erect a simple tent, at least, to serve as protection from sun and rain. This permits them to offer a house to the teacher as an incentive to come to a rural area. A teacher can teach without a building; but a building, however well equipped, is useless without a teacher.

- Obstacles that cannot be removed. In health planning, an objective may, sometimes, be replaced. For example, if the plan is to employ a midwife- supervisor, and there is none available, the goal may be changed so as to have an experienced, trained Traditional Birth Attendants (TBA) who will support and help others.

Making the Plan

Once the objectives and targets have been set, the health team and the community most now plan how these objectives and targets may be achieved. There may be several different strategies for achieving them, or only one way. Activities to meet objectives and target is sometimes called "strategy". The term strategy is a military one and means planning and resources in the way that gives the best chance of success. Before planning activities, it is necessary to:

- look at different possible ways of achieving the objectives
- balance resources and needs
- choose the best action plan, then
- write detailed activities, based on the chosen plan of action.

Balancing resources and needs

To assist in deciding on a plan of action, it is helpful to draw up a table to list the different possibilities, noting what is needed and what available or can be provided. Reviewing resources include the community's own resources- and that means people, materials. It also includes building such as a community meeting- house, where health activities can be carried out. Others include materials such as a boat, animals, and the local bus service.

The community should participate in planning by means of an area representative at the middle level, and the village leader and others designated by him at the village level. A plan must be drawn up within the limits of available resources even if at first some activities have to be modified. Look at the priorities and consider which resources can be used for the maximum benefit of the whole population. One may have to think of alternative ways of using resources, or using less resource. For example, using oral dehydration therapy at the village level is an alternative to sending children to a health centre-this will eliminate cost of transportation etc.

The advantage of planning like this, is that it ensures that some change takes place; and then, progress will be made achieving targets. Only when all available local resources have been allocated should requests for extra resources be made. Sometimes, certain plans rely on donations or government funds. If resources are not granted, the plan fails. Health services management uses this method of taking resources into consideration; also, programme planning is a major factor. It is a basic step in preparing a schedule of activities.

People are the important resources for a programme. When discussing obstacles and how they may be overcome, representatives from the community participate. The can indicate what the people can do for

themselves. Community participation also ensures that what is being planned is what the people want and need. All members of the health team should also participate and agree on the choice of action

Choosing the best action plan

The choice of action, in any country, district or area depends on circumstances. For example, are there traditional birth attendants in the area? How much money is available? Which alternative does the community prefer- which will give the greatest coverage in the long time? In many cases, more than one choice could be made. For, example, traditional birth attendants could be trained and, meanwhile, a long-term plan for a future clinic could be started. The traditional birth attendants can deal with normal deliveries, and the clinic will deal with referred complications.

Writing an outline plan

A plan can be written in many ways. The order in which it is written depends on its main user or purpose. Sometimes, government or councils require plans in a specific form- especially if they are submitted to request for funds or other resources. In other cases, the order of headings used in writing a plan is less important; but it is very important to write up the plan under some system of headings so that nothing is forgotten.

It is useful to write a brief summary of the whole plan and then put details such as list of equipment. These details are necessary so that the health worker who is responsible for managing the programme has full control of implementation. A plan can be written using the seven guideline words- Why, *what, how, which, where, and when*. It is followed by example of detailed lists of time- targets, requirements and budget items for an antenatal care and maternity programme, for example.

4.0 CONCLUSION

For scientific planning to take place, the health manager needs to have adequate information about an identified problem, formulate objectives and targets, choose his strategies and activities identify resources needed and available, organise and control the required activities.

5.0 SUMMARY

In this unit, you have been taken through reviewing obstacle and writing health plans. Hopefully, the knowledge acquired in this unit will be of help to you (as a health manager) in the area of effective services delivery.

6.0 TUTOR-MARKED ASSIGNMENT

Discuss the importance of writing health plans in the management of health care activities.

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UNIT 4 IMPLEMENTING HEALTH ACTIVITIES

CONTENTS

1.0 INTRODUCTION

With the formulation of the plan, the most difficult part of the process is reached to out the plan into action. Planning is designed to help implementation. The plan is a check list and a guide. It is not something developed in isolation from existing activities.

A programme is a grouping or series of continuing and related activities designed to achieve a definite purpose or objective. It is a course of action to implement a plan or part of a plan. Stage by stage, the activities necessary to fulfill the plan are implemented so that gradually the work is completed, changes take place and are integrated into existing programme or becomes the beginning of a new programme.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define coordination-in relation to heath work
- discuss monitoring and redirecting a programme of activities.

3.0 MAIN CONTENT

3.1 Coordinating the Work of the Health Team

a. Coordination is easier if there is a clear organisational chart describing the relationship of each member of the team. For example, consider the figure below.

Medical assistant	Public health nurse
Dispenser	Community nurse
Village health worker	Traditional birth

Fig. 4.1

b. Clear job descriptions help people to work together, harmoniously. The relationship between staff is strengthened if each one has a clear job and knows the officer to whom he/she is accountable. However, the job description must be seen as a guide. It must not be used as an excuse for not participating in activity not, specifically, stated in the description.
c. Sharing objectives and targets is another important factor in bringing together (but this is a reason for coordination)
d. Organisational structure determines how communication takes place between the different levels of a system, for the purpose of coordinating a programme and activities of a health team. It specifies.
    - who instruct others and what they are to do, at each level of the organisation
    - Whom each person reports to on job progress or problems.

It is important to remember that only the structure of the organised health services is shown. The health system includes the unorganised or informal care given within families and that given by other people in the community such as healers or neighbors. The health worker/midwife must understand the structure of the health system and know what her responsibilities are in relation to the *TBA(s)*. She must also know she is accountable to the health worker who has management functions at the middle level and through her to the community.

Coordinating the activities

It is not enough to list the activities necessary to the plan. The list must be put into a timetable or schedule. The schedule must state the time for beginning and completing each activity and who is responsible to see that it is done. The next management function is to coordinate the *what, how, and how much*- in order to meet the *when requirements* of the programme. To do this, there must be a clear understanding of why activities must be carried out.

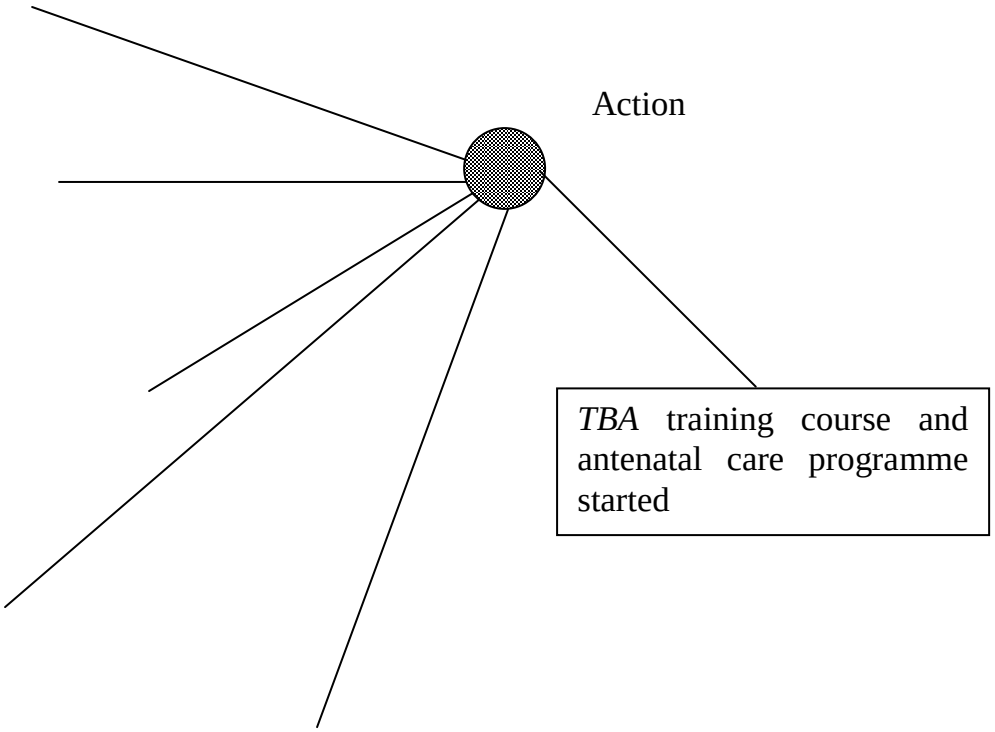

Fig. 4.2

Step 1: List activities

Health-worker time Secured
People participate in discussion and decisions
Training arranged and clinic space and furniture obtained in village

Equipment and supplies obtained

Transport and duty travel fund obtained.

Step 2: Identify main activities that will lead to achievement of the objectives.

Based on the list of detailed activities, the major activities to achieve the gal are then identified.

Step 3: Indicate time lines for each of the detailed activities listed

Step 4: Identify workers who will be responsible for each of the detailed implementing activities.

Staff will be assigned for each of the activities listed, on the basis of their job descriptions.

Communicating the discussions
However well the planned activities are scheduled, and the organisational chart and job descriptions written, coordination will not succeed until these work directives are communicated and understood by all members of the team. An organisational chart may be reviewed and discussed with the members. Each health worker should have an individual job description in writing. The activities schedule should be discussed with the team and with the community to see if the time-targets are feasible and realistic.

3.2 Monitoring and Redirecting a Programme

Many health activities are taking place at once. The supervisor, who cannot be everywhere at once, needs some tools to "watch or monitor" the work. The purpose of this management activity is to maintain work standards.

Maintaining work standards
The supervisor of health workers must be able to:

- use check lists to observe performance and identify deficiency in standard, outputs and procedures.
- trace the causes of work deficiencies. Why are targets not being achieved? The reason may be personal, technical administrative or organisational.

The usefulness of a checklist, notably, to select priority problems has been previously discussed. The checklist functions as a set of criteria. A checklist can be prepared to assist in supervising. It is a record or reminder of what is happening. It can b used as a basis for planning future activities and for following up progress.

The causes of work deficiency are to be found in many areas. Targets are assessed periodically (so that defence can be put right and problems solved before they become too serious). Sometimes, the cause of a deficiency may be a technical fault in an important part of equipment such as a jet injector or a typewriter; or it may be a fault of the organisation- e.g. a nurse may be overworked and unable to meet all the demands on him/her. Meanwhile, training a rural health worker for certain tasks could solve the problem.

A deficiency may be found in the staff or in administration. For example, transports may not arrive at the health center on time, or at all. Sometimes a work-deficiency can be remedied by retraining. A supervisor who is monitoring is continually checking the health service

activities- whether the programme/service is operating as intended? For example, the following are given due consideration.

Do the health units receive adequate drug supplies?
Are the leprosy clinics being held regularly?
Do the midwives complete the *MCH* cards correctly?
Is the referral system being used as intended?

Methods of monitoring
A supervisor monitor by:

- continually observing
- checking supplies against inventories an stock-lists
- examining records, and
- discussing with staff and the community.

Using information from records for monitoring
Information will be used for identification of problems, daily, as well as for yearly planning of the health work for the area. It will be necessary to know what the information means whether it is correct. Records must be reviewed at regular intervals and information must be verified.

Redirecting activities
The purpose of monitoring is to maintain work standards. Information which comes from monitoring guides health activities. If work deficiencies are found or targets are not met, the causes must be sought. Changes are made in the programme, according to information recorded; these changes are, sometimes, called 'redirecting'.

When it is found that targets are not being met, it is often necessary to redirect the programme- sometimes the goals must be modified. For example, management finds that antenatal care targets are not being met, and that the reason is that some *TBAs* are hostile to the training programme. They do not give antenatal care. The women they deliver do not wish to attend the group clinic.

This can be overcome; the nurse/midwives think, through a group approach. That is, first, she discusses the problem with the midwife; then, they will see community leaders, and finally, they talk with all the *TBAs*, especially those who have not yet participated, fully, in the training and antenatal programmes. Meanwhile, the midwife will spend an extra day each month, devoting more time to work with the *TBAs* and the pregnant women.

Time, therefore, is an important element. The midwife must adjust her timetable and activities. The nurse/midwife must adjust her timetable to

permit her to spend more time for a month or two, visiting health sector *A* to support the midwife, and help her to consolidate the antenatal programme. This will be a model- if successful, for other villages in the area.

3.3 Supervising in Action

There are three styles of supervising, namely- autocratic, *marchic* and democratic. Whatever style is adopted, the activities of supervision remain similar. Some of these activities are discussed here.

Making a supervisory schedule
There may be one or several health workers assigned to different village in a health area. In either case a supervisory plan must be made for each year. How often monthly visits are to be made will depend on the local situation, the state ad stage of the programme, and he availability of transport and personnel.

Planning the schedule for supervisory visit includes:

- checking the health worker in charge of the job description for the frequency of required supervisory visits
- listing all programmes
- reviewing previous reports
- identifying needs for extra control
- noting in which health area special assistance is required.

Step 1: Listing where supervision is most needed
A listing such as shown in the following example enables a health worker supervisor to see reason for more frequent visits, and thus, to plan of them in order to maintain the control needed to reach programme goals.

Step 2: Reviewing other timetables
The next step in scheduling is to arrange a timetable of the supervisory visits.

Two things are needed for this:

(i) the plan made for the year. This shows that definite dates during the year that are allocated to fixed events
(ii) the health unit timetable schedule. This timetable tells the day during the week that are allocated to activities that are scheduled regularly

Step 3: Making a yearly scheduled for supervisory visits

The yearly schedule for supervisory visits is then planned as shown in the example below, considering:

- minimum needs for supervisory visits
- programme needs for more frequent supervisory visits
- fixed dates in the annual plan
- fixed activities that happen regularly each week.

The visits outside the health center are planned so as to keep the fourth week of each month free to allow time to complete required monthly reports. After the supervision schedule is made, health workers in the areas to be visited should be to be the date of the visits so that they will available. The village leaders should also be informed as they, or the people, may wish to talk with the health worker responsible for visits. When the yearly scheduled for supervisory visits is prepared, the arrangements must be made to have any transport needed available in the days the villages will be visited.

Planning a supervisory visit

Before making a supervisory visit, a review of records should be made so that the responsible health worker will be aware of the following, for example:

- local targets to achieve the goals
- what the health worker activities are, in the programme that are going to be observed
- what progress the programme has made to date in relating to targets that have been set
- what problems have arisen in implementing the programme
- what supplies are needed.

Routine supervisory activities, in accordance with the supervisory plan, will be to look at records to see if they are well kept are if they agree with monthly reports.

- Observe how the health worker caries out the activities listed in his job description, such as ways of cleaning equipment a stories supplies use of opportunities to teach people about health, and giving care to the sick and injured.
- Talk with the village leader and other people in the community. Do they understand and want the programmes that are being implemented? Do they feel they need other help? Encourage them to talk about their needs as they see them and how they feel these might be met.

- At the end of the visits, discuss with the health worker what has been found: good points (health centers is clean, supplies are safely stored) as well as need for improvement (wash hands before and after caring for sick people, tell them what to do to stay well) and how improvement might be made.
- Remind the health worker of the date of the next supervisory visit to the area.

All the observations made should be noted on the supervisory check list or in the note book, for follow up (as needed) when the supervisor returns to his/her area health center. Plans need to be made for the items that have been noted for follow up so that information or a solution to the problem may be found before the next planned visit.

4.0 CONCLUSION

In order to coordinate the work effectively, the health manager must coordinate people so that they work together harmoniously, arrange activities and schedules, and then communicate decision to all concerned.

5.0 SUMMARY

In this unit, you have been exposed to coordinating the work of the health team, monitoring and redirecting a programme of activities on health and supervising in action.

6.0 TUTOR-MARKED ASSIGNMENT

Describe the purpose of coordinating, controlling and supervising health care activities in a comprehensive health center- as a health care manager.

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MODULE 2

UNIT 1 HEALTH CARE OF THE COMMUNITY

CONTENTS

1.0 INTRODUCTION

This unit focuses on the health care of the community and such areas like concepts of health care, levels of health care, changing concepts of health elements of primary health care, principles of primary health care and the concept of health for all. Your understanding of this unit will improve your health service delivery to the society.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the concept of health care
- state the levels of health care
- list the changing concept of health
- enumerate the elements of primary health care
- describe the principles of primary health care
- discuss the concept of health for all.

3.0 MAIN CONTENT

3.1 Levels of Health Care

It is customary to describe health care services at 3 levels, namely- primary, secondary and tertiary care. These levels represent different types of care involving varying degrees of complexity

a. Primary care level

It is the first level of contact of individuals, the family and community with the national health system, where "primary health care" ("essential" health care) is provided. As a level of problems, it is close to the people, where most of their health problems can be dealt with and resolve. It is at this level that health care will be most effective within the context of the area's need and limitations.

In the Indian context, primary health care is provided by the complex of primary health centers and their sub-centers through the agency of multipurpose health workers, village health guides and trained dais. Besides providing primary health care, the village "health teams" bridge the cultural and communication gap between the rural people and organised health sector. Since India opted for "Health for all" by 2000 AD, the primary health care system has been reorganised and strengthened to make the primary health care system more effective.

b. Secondary care level

The next higher level of care is the secondary (intermediate) health care level. At this level, more complex problems are dealt with. In Indian, this kind of care is, generally, provided in district hospitals and community health centers which also serves as the first referral level.

c. Tertiary care level

The tertiary level is a more specialised level than secondary care level; it requires specific facilities and attention of highly specialised health workers. This care is provided by the regional or central level institutions; for instance in Nigeria, we have teaching hospitals, specialist hospitals, and so on.

A fundamental and necessary function of health care system is to provide a sound referral system. It must be a two-way exchange of information and returning parties to those who referred them for follow-up care. It will ensure continuity of care and inspire confidence of the consumer in the system. For a large majority of developing countries (including India) this aspect of the health system remains very weak.

3.2 Changing Concepts

With political independence, there was a national commitment to improve health in developing countries. Against this background, different approaches of providing health care came into existence. These are considered below.

1. Comprehensive health care

The term "comprehensive health care" was first used by the Bhore committee in 1946. By comprehensive services, the Bhore committee meant provision of integrated preventive, curative and promotion health services from "womb to tomb" to every individual residing in a defined geographic area. The Bhore committee defined comprehensive health care as having the following criteria:

a. provide adequate preventive curative and primitive health services
b. be as close to the beneficiaries as possible
c. has the widest cooperation between the people, the services and the profession
d. is available to all irrespective of their ability to pay
e. look after specifically the vulnerable and weaker sections of the community and
f. create and maintain a healthy environment both in homes, as well as working places.

The Bhore committee suggested that comprehensive health care should replace the policy of providing more medical care. This concept formed the basis of national health planning in India and held to the establishment of a network of primary health centers and sub-centers.

The government of India, during the successive 5 years has built up a vast infrastructure of rural health services based on primary health centers and sub-centers. However, experience during the past 50 years has indicated that the primary health centers were not able to effectively cover the whole population under their jurisdiction and their sphere of services did not extend beyond a 2-5 km radius. These facilities often did not enjoy the confidence of the people medicines they were understaffed and poorly supplied with medicines equipment; as a result, there was growing dissatisfaction with the delivery of health services.

2. Basic health services

In 1965, the term “basic health services” was used by *UNICEF/WHO* in their joint health policy. They defined the term as:

> *a network of coordinated, peripheral ad intermediate health units capable of performing effectively a selected group of functions essential to the health of an area and assuring the availability of competent professional and auxiliary personnel to perform these functions.*

The change in terminology from comprehensive to basic health services did not affect materially the quality or content of health services. The handicaps or drawbacks of the basic health services are those shared by the comprehensive health care services, viz lack of community participation, lack of intersectional coordination and dissociation from the socio-economic aspect of health.

3. Primacy health care

A new approach to health care came into existence in 1978, following an international conference at Alma-Ata (USSR). This is known as “primary health care”. It has all the hallmarks of a primary health care delivery, first proposed by the Bhore Committee in 1946, and now espoused world-wide by international agencies and national governments.

Before Alma-Ata, primary health care was regard as synonymous with “basic health services” first contact care” “easily accessible care”, “services provided by generalist”, etc. The Alma-Ata international conference gave primary health care a wider meaning. The Alma-Ata conference defined primary health care as follows:

> *Primary health care is essential health care made universally accessible to individuals and acceptable to them. Through their full participation and at a cost the community and country can afford.*

Primary health care is, equally, valid for all counties, although it takes varying forms in each of them. The concept of primary health care has been accepted by all countries as the key to the attainment of health for all by, 2000 AD. It has also been accepted as an integral part of healthcare system, worldwide.

3.3 Elements of primary health care

Although specific service provided will vary in different countries and communities, the Alma-Ata declaration has outlined eight essential components of primary health care.

1. Education concerning prevailing health problems and the methods of preventing and controlling them
2. Promotion of food supply and proper nutrition
3. Adequate supply of safe water and basic sanitation
4. Maternal and child health care, including family planning
5. Immunisation against major infectious diseases
6. Prevention and control of locally endemic diseases
7. Appropriate treatment of common diseases and injuries and
8. Provision of essential drugs.

3.4 Principles of Primary Health Care

Let us consider some of the principles.

1. Equitable distribution

The first key principle in the primary health care strategy is equity or equitable distribution of health services, i.e health services must be shared equally, by all people irrespective of their ability to pay, and all (rich or poor, urban or rural) must have access to health services. At present, health services are mainly concentrated in the major towns and cities resulting in inequality of care to the people in rural. The worst hits are the needy and vulnerable groups of the population in rural areas and urban slums. This has been termed as social injustice.

The failure to reach the majority of the people is usually due to inaccessibility. Primary health care aims to redress this imbalance by shifting the center of gravity of the health care system from cities (where three quarters of the health budget is spent to the rural areas (where three quarters of the people live), and bring these services as near people's homes as possible.

2. Community participation

Notwithstanding the overall responsibility of the central and state government, the involvement of individuals, families, ad communities in promotion of their own health and welfare, is an essential ingredient of primary health care. Countries are now conscious of the fact that universal coverage by primary health care cannot be achieved without the involvement of the local community. There must be continuity in the planning, implantation

and maintenance of health services, besides maximum reliance on local resources such as manpower, money and materials.

In short, primary health care must be built on the principle of community participation (or involvement). One approach that has been tried successfully in India is the use of village health guides and trained dials. They are selected by the local community and trained locally in the delivery of primary health care to the community they belong, free of charge.

By overcoming cultural and communication barriers, they provide primary health care in ways that are acceptable to the community. It is now considered that "health guides and trained dials are an essential feature of primary health is in India. These concepts are revolutionary. They have been greatly influenced by experience in China where community participation in the form for bare foot doctors took place on an unprecedented scale.

3. Intersectoral coordination

There is an increasing realisation of the fact that the components of primary health care cannot be provided by the health sector alone. The declaration of Alma-Ata states that primary health care involves aspects of national and community development, in particular- agriculture, animal husbandry, food, industry, education, housing, public works communication and others sector. To achieve such cooperation, countries may have to review their administrative system, reallocate their resources and introduce suitable legislation to ensure that coordination can take place. This requires strong political will to translate values into action. An important element of intersectoral approach is planning-planning with other sector to avoid unnecessary duplication of activities.

4. Appropriate technology

Appropriate technology has been defined as:

> *…technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and those for whom it is used, and that can be maintained by the people themselves in keeping with the principles of self reliance with the resources the community and country can afford.*

The term "appropriate" is emphasised because in some countries, large, luxurious hospitals that are totally inappropriate to the local needs are built which absorb a major part of the national health

budget, effectively blocking any improvement in general health services. This also applies to using costly equipment, procedures and techniques when cheaper, scientifically valid and acceptable ones are available.

It will be seen from the above discussion that primary care is, qualitatively, a different approach to deal with the health problems of a community. Unlike the previous approaches (e.g. basic health services, integrated health care) primary health care approach starts with the people themselves. This approach signifies a new dynamism in health care and has been described as health by the people, placing people's health in people's hands.

The ends of the primary health care approach are the same as those of earlier approaches (i.e. attainment of an acceptable level of health by every individual) but the means adopted are different; that is more equitable distribution and nationwide coverage, more intersectoral coordination and more community involvement in health related matters. In short, primary health care goes beyond the conventional health services. It forms part of the larger concept of human resources and Development.

3.5 Health for All

In 1977, it was decided in the world health assembly to launch a movement known as "health for all by the year 2000". The fundamental principle of HFA strategy is equity; that is, an equal health status for people and countries, ensured by an equitable distribution of health resources. The member countries of WHO, at the 30th World Health Assembly define Health for All (HFA) as "attainment of a level of health, that will enable every individual to lead a, socially and economically productive life".

The Alma-Ata International conference on primary health care reaffirmed health for all as the major social goal of governments; and stated that the best approach to achieve the goal of HFA is by providing primary health care, especially to the vast majority of underserved rural people and urban poor. It was envisaged that by the year 2000, at least essential health care should be accessible to all individuals and families in an acceptable and affordable way with their full participation.

The Alma-Ata conference called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a national health system. It is left to each country to develop its norms and indicators for providing primary health care according to its own circumstance. In 1981, a global strategy for

HFA was evolved by WHO. The global strategy provides a global framework that is broad enough to apply to all member states and flexible enough to be adapted to national and regional variations of conditions and requirements.

This was followed by individual countries developing their own strategies for achieving HFA, and synthesis of national strategies for developing regional strategies. The WHO has established 12 global indicators as the basic point of references for assessing the progress towards HFA, as for example, a minimum life expectancy of 60 years and maximum IMR of 50 per 1000 live births.

National strategy for HFA/2000

As a signatory to the Alma-Ata Declaration in 1978, the government of India was committed to taking steps to provide HFA to its citizens by 2000 AD. In pursuance of this objective various attempts were made to evolve suitable strategies and approaches. In this connection, two important reports appeared- (i) report of the study group on "Health for All-an alternative strategy", sponsored by ICSSR and ICMR, and (ii) report of the working group of "Health for All by 2000 AD" sponsored by the ministry of health and family welfare, government of India. Both groups considered, in great details, the various issues involved in providing primary health care in the India context. These reports formed the basis of the national health policy formulated by the ministry of health and family welfare, government of India to the achievement of HFA.

The national health policy echoes the WHO'*s* call for HFA and the Alma-Ata declaration. It had laid down specific goals in respect of the various health indicators by different dates such as 1990 and 2000 AD. Foremost among the goals to be achieved by 2000 AD include the following.

1. Reduction of infant mortality from the level of 125 (1878) to below 60
2. To raise the expectation of life at birth from the level of 52 years to 64.
3. To reduce the crude death rate from the level of 14 per 1000 population to 9 per 100
4. To reduce the crude birth rate from the level of 33 per 1000 population to 21.
5. To achieve a net reproduction rate of one
6. To provide potable water to the entire rural population.

4.0 CONCLUSION

Community participation is now recognised a major component in the approach to the whole system of health care treatment, promotion and prevention. The stress is on the provision of these services to the people representing a shift from medical care to health care and from urban population to rural population.

5.0 SUMMARY

We have studied the subject of health care of the community especially the concept of health care, levels of health care changing concepts of health, elements of primary health care, principles of primary health care and concept of health for all.

6.0 TUTOR-MARKED ASSIGNMENT

i. Discuss the principles of primary health care.
ii. Suggests why you think, primary health care is the solution to world made health problems.

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UNIT 2 MILLENNIUM DEVELOPMENT GOALS

CONTENTS

1.0 INTRODUCTION

More recently in September 2000, representative from 189 counties met are the millennium summit in New York, to adopt the United Nations millennium declaration. The goals in the areas of development and poverty eradication are now widely referred to as Millennium Development Goals (MDGs). The MDGs place health at the heart of development and represent commitment by government throughout the world to do more to reduce poverty and hunger and to tackle ill-health; gender inequality lack of education access to clean water and environmental degradation. They are an integral part of the road map towards the implementation of the UN millennium declaration.

Three of the 8 goals, 8 of the targets required to achieve them, and 18 of the 48 indicators of progress, are health related. They assist in the development of national policies focusing on poor, and help track the performance of health programmes and system. Although, the MDGs do not cover the whole range of public health domains a broad interpretation of the goal provide an opportunity to tackle important cross cutting issues and key constraints to health and development. Government have set a date of 2015 by which they would meet the MDGs, i.e. eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality; improve maternal health; combat HIV/AIDS, malaria and other communicable disease; ensure environmental sustainability and develop a global partnership for development.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- explain the concept of millennium development goals
- state the indicators of millennium development goals
- discuss heath care delivery system.

3.0 MAIN CONTENT

3.1 Concepts and Definitions of MDG

The concepts and definitions of MDGs are as follows (G,T and I written in parenthesis are pertaining to goal number, target number and indicator number of UN declaration).

Prevalence of underweight children (under five years of age (G1. T2.I4): Promotion of children of under-five years with low weight for age, as measured by percentage of children with moderate and severe malnutrition those falling below 80% of the median weight for reference value of below two standard deviation of national or international references populations, such as growth, charts of the US national center for health statistics.

Proportion (%) of population below minimum level of dietary energy consumption (G1. T2.I5): Since there is no specific data available, proxy indicator “proportion of population undernourished” is used. It is the proportion in percentage of persons whose food intake falls below the minimum requirement or food intake that is insufficient to meet dietary energy requirements continuously.

Under-five mortality rate (G4.T5.I13): Probability of ding between birth and exactly five year of age expressed per 1,000 live births.

Proportion (%) of one year old children immunised for measles (G4.T5.I15): The percentage of infant reaching their first birthday fully immunised against measles (1 dose).

Maternal mortality ratio (G5. T6.I16): Annual number of maternal deaths per 100,000 live-births. A maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, from cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

Proportion (%) of births attended by skilled health persons (G5.T6.I17): The proportion in percentage of births attended by skilled personnel per 100 live births. Skilled health example, doctors, nurse, midwives) who

have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose or refer obstetric complications. Traditional birth attended trained or untrained, are not included in this category.

HIV prevalence among young people (G6.T7.I18): Since the relevant data is not available, the proxy indicator as proposed by UNAIDS/WHO is used. The proxy indicator is "HIV prevalence among 15-24 years old by sex" which is the estimated number of young people (15-24 years old) living with HIV/AIDS as per proportion of the same population and sex. These country specific estimates are expressed as a range generated by regional modeling. The other proxy indicator is HIV prevalence rate among population 15-49 years of age.

Condom use in high risk population (G6.T7.I19): Since the data is not available, it has been proposed to use "condom-use among 15-24 old by sex". This is the percentage of young men and women of age 15-24 years who said that they used a condom the last time they had sex with a non-marital. Non-cohabiting partner of those who have had sex such a partner in the last 12 months.

Ratio of children orphaned/non-orphaned in schools (G6.T7.I20): Since the data is not available, the proxy indicator I used as "AIDS orphans currently living" which is the estimated number of children (0-14) in a given year, having lost their mother or both parents to AIDS.

Malaria death rate per 100,000 in children (0-4 years of age) (G6.T8.I21): proportion of children (0-4 years of age) died due to malaria in a given year.

Malaria death rate per 100,000 in all age groups (G6.T8.I21): Proportion of people of all age groups died due to malaria in a given year. It is malaria crude death rate.

Malaria prevalence rate per 100,000 population (G6.T8.I21): Proportion of notified or reported cases of malaria per 100,000 population in a given year. It is malaria crude prevalence rate.

Proportion (%) of population under ages five in areas with high risk of catching malaria by using insecticide treated bed nets (G6.T8.I22): The percentage of children under five years of age who are using insecticide treated beds net among the same population living in malaria risk area, in a given year.

Tuberculosis death rate per 100,000 (G6.T8.I23): Proportion of people of all age groups died due t tuberculosis in a given year.

Tuberculosis prevalence rate per 100,000 (G6.T8.I23): Proportion of tuberculosis cases detected and out directly observed treated short-course (DOTS) (G6.T8.I24): Since the baseline data is not available, WHO proposed to use “DOTS detection rate”.

Proportion (%) of smear-positive pulmonary tuberculosis cases detected cured under directly observed treatment short course (DOTS) (G6.T8.I24: Since the base line date is not available WHO proposed to “DOTS cure rate” which implies treatment success rate that is treatment completion rate and cure rate.

Proportion (%) of population using bio-mass fuel (G6.T8.I29): Bio-Mass fuel is nay material derived from plants or animals, deliberately burnt by human for example, wood, animal dung, crop residues and coal. Since the baseline data is not available the proxy indicator is proposed as “percentage of population using sold fuels”.

Proportion (%) of population with sustainable access to an improved water source, rural (G7.T10.I30): Since the base line data is not available, the proxy indicator “percentage of population with access to improved drinking water sources, rural, is used. “Improved” water sources means household connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection. Access means the availability of, at least, 20 liters of water per person, per day from a source within one kilometer of the user’s dwelling place.

Proportion (%) of population with suitable access to an improved water source, urban (G7.T10.I30): Since the baseline data is not available, the proxy indicator “percentage of population with access to improved drinking water sources, urban” is used. Improved” water source mean household connection, public standpipe, borehole, protected dug well, protected spring, rainwater collection. “Access” means the availability of at least 20 liters water per person per day from a source within one kilometer of the user’s dwelling.

Proportion (%) of population with access to improve sanitation (G7.T11.I31): “Improved” sanitation means: connection to a public sewer, connection to septic system, pour-lush latrine, simple pit latrine, or ventilated improved pit latrine. The excreta disposal system is considered adequate if it is private or shared (but not public), and if hygienically, separates human excreta from human contact.

Proportion (%) of population with access to affordable essential drugs on a sustainable basis (G8.T17.I46): Since the base line data is not available, the proxy indicator “percentage of population with access to

essential drugs", which WHO routinely report for international comparison, is used. Every year, in order to estimate the level of access to essential drugs, WHO Global Action Programme on Essential Drugs interviews relevant experts in each country about the pharmaceutical situation. The interviews can choose from four levels of access by the population to essential drugs: less than 50%; between 50-80%; 80-95%; and above 95%. They indicate which category is most appropriate for their country. Essential drugs are those drugs that satisfy the health care needs of the majority of the population.

3.2 Health Care Delivery

The challenge that exists, today, in many counties is to reach the whole population with adequate health care services and to ensure their utilisation. The large hospital which was chosen, hitherto, for the delivery of health services has failed; in the sense that it serves only a small part of the population. Therefore it has been aptly said that these large hospitals are more ivory towers of diseases than centers for the delivery of comprehensive health care services. Rising cost in the maintenance of these large hospitals and their failure to meet the total health needs of the community have led many countries to seek 'alternative' models of health care delivery with a view to provide health care services that are reasonably inexpensive, and have the basic essential required by rural population.

3.2.1 The Model

A number of models have been developed for the delivery of health care services. One of the simplest models is shown hereunder. In actual practice, the model is more detailed and complex. The INPUTS are the health status of health problems of the community; they represent the health needs and health demands of the community. Since resources to meet the many health needs are always limited, priorities have to be set. This envisages proper planning, so that resources are not wasted. An account of health planning has already been given in the preceding units.

Health care services are designed to meet the health needs of the community, through the use of available knowledge and resources. The services provided should be comprehensive and community based, the resources must be distributed according to the needs of the community. The health care system is intended to deliver the health care services; in other words, it constitutes the management sector, and involves organisational matters. The final outcomes or the **output** is the charged health status is not improved health status of the community which is expressed in terms of lives.

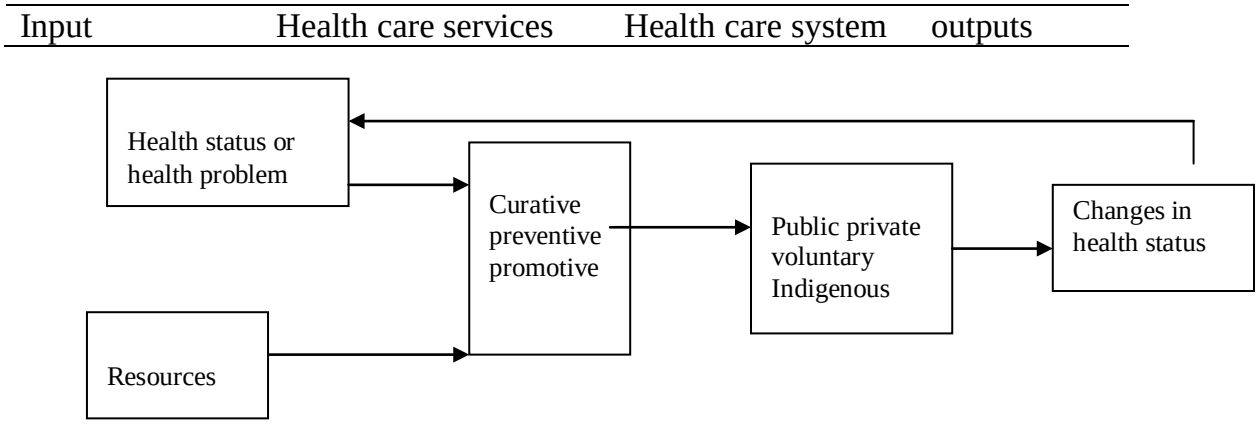

Fig. 2.1: Model of a Health Care System

4.0 CONCLUSION

Millennium development goals initiative is enriching and all-embracing; the initiative is, no doubt, a way forward to meeting the health problem of citizens, but it requires the commitment of all and sundry.

5.0 SUMMARY

Concepts and definition of millennium development goals and health care delivery have been dealt with in this unit; the MDG is an initiative geared towards fostering better quality of life for mankind.

6.0 TUTOR-MARKED ASSIGNMENT

Relate the concept of the Millennium Development Goal is to meet the health problems of developing counties of the world.

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UNIT 3 HEALTH STATUS AND HEALTH PROBLEMS

CONTENTS

1.0 INTRODUCTION

This unit is looking at health status and health problems, resources available to meet the vast health needs of a community. The irony here is that, while health problems are rising astronomically daily, the basic resources for providing health care are failing greatly and speedily; hence the global confusion in meeting the needs of her citizens.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define community diagnosis
- discuss the concept of health problems
- explain the basic resources for providing health care
- state the purpose of health care services.

3.0 MAIN CONTENT

3.1 Health Status

An assessment of health status and health problem is the first requites for any planned effort to develop health care; the data required for analysing health situation and for defining health problems comprises the following.

1. Morbidity and mortality statistics
2. Demographic conditions of the population
3. Environmental conditions- which have a bearing on health
4. Socio-economic factors- which have a direct effect on health
5. Cultural background, attitudes, beliefs and practices- which affect health
6. Medical and health services available

7. Others services available.

An analysis of the health situation in the light of the above data will bring the health problem and health needs of the community into perspective. These problems are then ranked according to priority or urgency for allocation of recourses. A brief description of current demographic and mortality profile and the health problem of India are given in the following pages

1. Demographic profile

A major concern today is population explosion. The demographic profile is characterised by:

a. large population base
b. high fertility both in terms of birth rate and family size
c. low or declining mortality
d. "young" population (about 35.35 per cent of the population) below the age of 15 years.
e. the proportion of illiterate population is close to 34.62 percent- this explains why the decline in birth rate has been so slow.
f. dependency ratio of 62 per 100- that is, every economically productive member has to support almost one dependant.

Table 3.1 below summarises the most recent demographic information available.

Table 3.1: India: Demographic Profile

Total population (2004)	1087 million
Crude birth rate (2004)	24.1
Crude death rate (2004)	7.5
Annual f\growth rate % (2004)	1.7
Population doubling line (at current growth rate)	30 years
Population rural % (2002)	72
Adult literacy rate % (2001)	65.38
Density of population per sq.km (2001)	325
Sex ratio female per 1000 male (2001)	933
Population below 15 years % (2003)	32.3
Population above 60 years % (2003)	7.2
Average family size (2003)	3.0
Age at marriage, female (2003)	20.1 years
Annual per capital GNP (at current prices 2004-05)	Rs. 23241

the health status of the population. Death rate has steadily declined from 21 (1965) to 7.5 (2004). Life expectancy, at birth, has gone up considerably

since 1951, recording an estimated 65.3 years during 2001-02. The mortality rates for a number of infectious and communicable diseases have also registered a decline (e.g. cholera, tuberculosis, malaria). However, a deeper study reveals distressing situation; Indian's health standards are still low compared to those in developed countries. While in the world as a whole, the *IMR* is about 54 per 1000 live births and in the developed countries as low as five, in India it is as high as 58.

3.2 Health Problems

The Health problem of India may be conveniently grouped as follows:

1. communicable disease problems
2. nutritional Problems
3. environmental Sanitation Problems
4. medical Care Problems
5. population Problems

1. Communicable disease problems

Communicable diseases continue to be a major problem in India. Diseases considered to be of great threat today are as follows.

(a) **Malaria**- malaria continues to be a major health problem in India. With the implementation of modified plan of operations in 1977, the upsurge of malaria cases dropped down from 6.75 million cases in 1976 to 2.1 million cases in 19844. Since then, the epidemiological situation has not shown any improvement. Although total malaria cases have declined compared to previous years, the proportion of *P. falciparum* has increased. Malaria cases have increased in Goa, Madhya Pradesh and Orissa. During 2005 there were 940 reported malaria deaths in the country. The reported incidence is about 1.8 million cases with slide positivity rate of about 2.32%. There appears little prospect of malaria eradication in the foreseeable future.

(b) **Tuberculosis-** tuberculosis is another leading public health problem in India. About 30 per cent of the total population is infected (tuberculin positive). 1.5 percent have radiologically active disease of the lungs of which 0.4 per cent are sputum-positive cases. According to official estimates, India has nearly 12 million cases of pulmonary tuberculosis of which about 3.4 million are sputum-positive. The number of deaths is estimated to be nearly 400,000 every year.

(c) **Diarrheal diseases-** diarrheal diseases constitute one of the major causes of morbidity and mortality, especially in children below five years of age. Outbreaks of diarrheal

diseases (including cholera) continue to occur in India due to poor environmental condition.

(d) ***ARI*-** acute respiratory diseases are one of the major causes of mortality and morbidity in children below five years of age. It is estimated that about 13.6 percent hospital admissions and 13 percent in-patient deaths in pediatric wards are due to *ARI*.

(e) **Leprosy-** leprosy is another major public health problem in India, for instance. During the year 2003-2004, a total of 2.20% new cases were detected, out of which child cases were 14.91% and deformity grade 11 and above was 1.8%. 35.26 per cent of these cases are estimated to be multi-bacillary. All the states and union territories report cases of leprosy. However, there are considerable variations not only between one state and another, but also between one district and another. The prevalent rate of leprosy is about 2.3 per 10,000 population. The proportion of infectious cases varies between 6-8 percent. In short, India accounts for about 60% of the leprosy cases in the world.

(f) **Filaria-** the problem is increasing in magnitude every year-having risen from 25 million at risk in 1953 to 553 million, presently. Of these, 109 million are living in urban areas and the rest are in rural areas. There are estimated to be at least 6 million attacks of acute filaria disease per year, and at least 45 million persons currently have one or more chronic filarial lesions.

(g) ***AIDS*-** the problem of *AIDS* is increasing in magnitude every year. Since *AIDS* was first detected in the year 1986, the cumulative number of *AIDS* cases has risen to 124,995 by the end of August 2006. It is estimated that by the end of year 2005 there were about 5.7 million *HIV* positive cases in the country.

(h) **Others-** *Kala-azar*, meningitis, viral hepatitis, Japanese encephalitis, enteric fever and helminthic infections are among the other important communicable disease problems in India. The tragedy is that most of these diseases can be either easily prevented or treated with minimum input of resources. In fact most of the developed countries of the world have overcome many of these problems by such measures as manipulation of environment, practice of preventive medicine and improvement of standards of living.

2. Nutritional problems

From the nutritional point of view, the Indian society is a dual society, consisting of a small group of well fed and a very large

group of undernourished. The high income groups are showing diseases of affluence which one finds in developed countries. The specific nutritional problem in the country is Protein-**Energy Malnutrition (PEM);** "food gap'- appears to be the chief cause of *PEM*, which is a major health problem, particularly, in the first years of life. The great majority of cases of *PEM*, nearly 80 per cent are mild and moderate cases. The incidence of severe cases is one to two percent in pre-school age children. The problem exists in all the states and the nutritional marasmus is more frequent than kwashiorkor.

(b) **Nutrition anemia-** India has, probably, the highest prevalence of nutritional anaemia in women and children. About one-half of non-pregnant women and young children are estimated to suffer from anaemia. 60 to 80 percent of pregnant women are aneamic. 20 to 40 percent of maternal deaths are attributed to anaemia. By far the most frequent cause of anaemia is iron deficiency.

(c) **Low birth weight-** this is a major public health problem in many low birth weight (less than 2.5 kg), as compared to about 4 percent in some developed countries. Maternal malnutrition and anaemia are mainly responsible for this condition.

(d) **Xerophthalmia (nutritional blindness)-** about 0.04 percent of total blindness in India is attributed to a deficiency of vitamin A. Sub clinical deficiency of vitamin A is also widespread and is associated with increased morbidity and mortality from respiratory and gastro-intestinal infections.

(e) **Iodine deficiency disorders-** goiter and other Iodine Deficiency Disorders (IDD) have been known to be highly endemic in sub-Himalayan regions, for instance. Re-assessment of the magnitude of the problem by the Indian Council of Medical Research showed that the problem is not restricted to the 'goiter belt" as was thought earlier, but is extremely prevalent in other parts of India as well. Studies showed that the prevalence rate in some parts of Himachal Pradesh was 28.7 percent (in Sirmor) and 34.4 percent in Champaran, Bihar; 35.6 percent in Darjeeling, West Bengal; and 27 percent in Arunachal Pradesh. (f) **Others-** other nutritional problems are lathyrism and endemic fluorosis in certain parts of the country. To these must be added the widespread adulteration of foodstuffs.

3. Environmental sanitation problem

The most difficult problem to tackle in this country is perhaps the environmental sanitation problem, which is multi-faceted and

multi-factorial. The great sanitary awakening which took place in England in 1840's is yet to be born. The twin problems of environmental sanitation are lack of safe water in many areas of the country and primitive methods of excreta disposal. Beside these, there has been a growing concern about the impact of "new" problems resulting from population explosion, urbanisation and industrialisation leading to hazards to human health in the air, in water and in the food chain.

At the United Nations Water Conference in Argentina, in 1977, it was recommended that priority should be given to the provision of safe water supply and sanitation services for all by the year 1990, and the period 1981-1990 was designated as the 'International Water Supply and Sanitation Decade". As at year 2000, safe water was available to most urban and 85 per cent of rural population; and adequate facilities for waste disposal was available to 29 percent of the urban and two percent of the rural population. The problem is great.

4. Medical care problems

India has a national health policy. It does not have a national health service. The financial resources are considered inadequate to furnish the costs of running such a service. The existing hospital-based, disease-oriented health care model has provided health benefits, mainly, to the urban elite. Approximately 80 percent of health facilities are concentrated in urban areas. Even in urban areas, there is an uneven distribution of doctors. With high rate of migration from rural to urban areas, urban health problems have been aggravated. These problems included overcrowding in hospitals, inadequate staffing and scarcity of certain essential drugs and medicines.

In the rural areas, nearly 74 percent of the population does not enjoy the benefits of the modern curative and preventive health services. Many villages rely on traditional systems of health care. Thus, the major medical care problem in India is inequitable distribution of available health resources between urban and rural areas, and lack of penetration of health services to the social periphery. The *HFA*/2000movement and the primary health care approach which lay emphasis on equity, intersectional coordination and community participation seek to redress these imbalances.

5. Population problem

The population problem is one of the biggest problems facing the country, with its inevitable consequences on all aspects of

development, especially employment, education, housing, health care, sanitation and environment. The country's population has already reached one billion mark, by the turn of the century.

The government has set a goal of 1 percent population growth rate by the year 2000 (which was not attained); currently, the country's growth rate is 1.93 percent. This calls for the "two child family norm". The population size and structure represent the most important single factor in health and manpower planning in India today- where the law of diminishing returns, among other factors, plays an important role in the economic development of the country.

3.3 Resources

Resources are needed to meet the vast health needs of a community. No nation, however rich, has enough resources to meet all the needs for all health care. Therefore, an assessment of the available resources, their proper allocation and efficient utilisation are important considerations for providing efficient health care service. The basic resources for providing health care are:

- health manpower
- money and material and
- time.

Health manpower

The term "health manpower" includes both professional and auxiliary health personnel, who are needed to provide health care. An auxiliary is defined by *WHO* as "technical worker in a certain field with less than full professional training." Health manpower requirements of a country are based on- (i) health needs and demands of the population and (ii) desired outputs. The health needs, in turn, are based on the health situation and health problems and aspirations of the people.

Health manpower planning is an important aspect of community health planning; it is based on a series of accepted ratios such as doctor-population ratio, nurse-population ratio etc.

Table 3.2: Suggested Norms for Health Personnel

Category of personnel	Norms suggested

1.	Doctors	1 per 3,500 population
2.	Nurses	1 per 5,000 population
3.	Health worker female and male	1 per 5,000 population in plain area and 3000 population in tribal and hilly areas.
4.	Trained TBA	One in each village
5.	Health assistant (male and female)	1 per 30,000 populations in plain area and 20000 populations in tribal and hilly area.
6.	Health assistant (male and female)	Provides supportive supervision to 6 health workers (male/female)
7.	Pharmacist	1 per 10,000 population
8.	Lab technicians	1 per 10,000 population

Although the averages are satisfactory on a national basis, they vary widely within the country. There is also mis-distribution of health manpower between rural and urban areas. Studies in India have shown that there is a concentration of doctors (up to 73.6 percent) in urban areas where only 26.4 percent of population live. This misdistribution is attributed to absence of amenities in rural areas, lack of job satisfactory, professional isolation, lack of rural experience and inability to adjust to rural life. The national averages of doctor-population ratio, population bed ratio, and nurse to doctor ratio, in some countries are shown in table 3.3.

Table 3.3

Country	Doctors Per 1000 Population population	Beds per 1000 population	Nurse per 1000 population	Midwives per 1000
India	0.7	8.9	0.8	0.47
Nepal	0.21	1.5	0.22	0.24
Bangladesh	0.26	3.36	0.14	0.18
Sri Lanka	0.55	29	1.58	0.16
Thailand	0.37	22.3	2.82	0.01
Myanmar	0.36	6.3	0.38	0.60

Health manpower requirements are subject to change (both qualitatively and quantitatively) as new programmes, projects and philosophies are introduced into the health care system. For example, there has been a

change from uni-purpose to multipurpose strategy, in recent years; then came the goal of health for all. In addition, national health programmes such as tuberculosis control, leprosy eradication and control of blindness needed more trained workers and technicians. Thus, during the past decade many new categories of health manpower have been introduced. They include village health guides, multipurpose workers, technicians, ophthalmic assistants, etc. Table 3.4 gives the total health manpower current stock under the "rural health scheme".

Table 3.4: Health Man-Power in Rural India as at Sept. 2005

Category	**In position**
1. ANM	133194
2. MPW (Male)	61907
3. Health Assistant (Female)/LHV	17371
4. Health Assistant (Male)	20181
5. Doctors in PHCs	20308
6. Specialists:	
a. Surgeon	1207
b. Gynaecologists and obstetrician	1251
c. Physician	884
d. Paediatrician	675
7. Radiographer	3550
8. Phamarcist	1337
9. Lab. Technician	12284
10. Nurse Midwife	28930
11. BEE	2645

Money and material

Money is an important resource for providing health services. Scarcity of money affects all parts of the health delivery system. In most developed countries, government expenditure for health lies between six to 12 percent of *GNP*. In underdeveloped countries, it is less than one percent of the *GNP* and it seldom exceed two percent of the *GNP*. This translates into an average of a few dollars per person, per year in the underdeveloped ones. To make matters worse, much of the spending is for services that reach only a small fraction of the population.

To achieve Health for All, *WHO* has set as a goal the expenditure of five percent of each country's *GNP* on health care. At present, India is spending about three percent of *GNP* on health and family welfare development. Since money and material are always scare resources they must be put to the most effective use, with an eye on maximum output

of result for investment. Management techniques such as cost effectiveness and cost benefit analysis are now being used for allocation of resources in community health.

Time

'Time is money'; it is an important dimension of health care services. Administrative delays in sanctioning health projects imply loss of time. Proper use of man-hours is also an important time factor. For example, a survey by *WHO* has shown that an auxiliary nurse/midwife spends 45 percent of her time in giving medical care, 40 percent in traveling five percent on paper work; and only 10 percent in performing duties for which she has been trained. Such studies may be extended to other categories of health personnel with a view to promote better utilisation of time.

Resources are needed to meet the many health needs of a community. However, resources are inadequate in the health sector, in all poor countries. What is important is to employ suitable strategies to get the best out of limited resources

3.4 Health Care Services

The purpose of health care services is to improve the health status of the population. In the light the goal of health for all, the goals to be achieved have been fixed in terms of mortality and morbidity reduction, increase in expectation of life, decrease in population growth rate, improvements in nutritional status, provision of basic sanitation, health manpower requirements and resources development and certain other parameters such as food production, literacy rate, reduced levels of poverty, etc.

The scope of health services varies widely from country to country and it is influenced by general and ever changing national, state and local health problems, need and attitudes as well as the available resources to provide these services. A comprehensive list of health services may be found in the report of the *WHO* Expert Committee (1961) on "Planning of the Public Health Services". There is now broad agreement that health services should:

(a) be comprehensive
(b) be accessible
(c) be acceptable
(d) provide scope for community participation, and
(e) be available at a cost the community and country can afford. These are the essential ingredients of primary health care which forms an integral part of the country's health system of which it is the central function and main agent for delivering health care.

4.0 CONCLUSION

In order to provide necessary health services for a community, health personnel must be able to identify prevailing health problems and determine their priority. Rather than just providing prototype services, it is better to continually reassess the health problems of the community and plan services appropriate to the priority health problems of the area.

5.0 SUMMARY

This unit has looked into health status and health problems and resources available in meeting these health problems. No doubt the health status of a community or nation has been direct effect on their productivity (economy).

6.0 TUTOR-MARKED ASSIGNMENT

Discuss the health status of Nigerians in relation to the national economy.

7.0 REFERENCES/FURTHER READING

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UNIT 4 QUALITY MANAGEMENT IN HEALTH CARE

CONTENTS

1.0 INTRODUCTION

In recent years, the quality of health care has assumed a high profile on the health care agenda throughout the world. In the West African sub-region in particular, the quality of health care has dropped, noticeably, in many countries as a result of the economic decline, political instability and emigration of a large number of health professionals. In the developed world, serious attention has been given during the 90s to the concept of quality in health care including quality assessments, quality control, quality assurance and total quality management (TQM). Unfortunately, quality management has not received enough attention in most of the developing world; the most common excuses being that it is expensive and technically difficult. This is most unfortunate as services of poor quality, invariably, lead to wastage of resources.

In this unit, quality is defined in the context of health care. The relevance of quality management and its various dimensions are discussed. The processes for assessment and management of the quality of the services provided in a health service organisation or a health facility are explained.

2.0 OBJECTIVES

At the end of this unit, you should be able to:

- define “quality”, and explain its relevance and various dimensions in the context of health care
- explain the concept of quality management and describe its evolution
- describe how to assess the quality of health care in various setting
- describe how to manage the quality of the services of a health service organisation or a health facility.

3.0 MAIN CONTENT

3.1 Brief Historical Review

According to Goings (1995), it was Florence Nightingale who- by her activities, during the Crimean war about 100 years ago- first drew attention to the benefits of good quality health care. The modern concept of quality management was developed in Japan and in the USA in the early 1940s. The concept was adopted and applied in health care in the USA, and Europe in the 1970s. In USA, interest in quality care was provided by different institutions- even at high cost. These concerns led to the establishment of the Professional Standards Review Organisation (PSRO) which encouraged peer reviews e.g. medical audit, utilisation review, etc. Recent trends include Total Quality Management (TQM) and Continuous Quality Management (CQM).

TQM owes its development to the ideas of Deming, Juran, Crosby and Feigenbaum, who each made unique contributions to its development. Deming (1982), the father of the quality movement stressed that quality does not cost anything extra. He was the author of the Deming chain reaction which showed that when quality is improved by improving process rather than by merely increasing inspection, productivity improves, leading to decreased costs, lower prices, increased sales and thus, a greater return on investment.

Juran (1964) believed that management could achieve a higher productivity by pre-empting problems before they occur, rather than by depending on the use of the control function to correct deviations from the norm. Crosby (1979) drew attention to the importance of developing the commitment of employees to the concept of *TQM*. Feigenbaum (1983) was pre- occupied with devising methods of keeping the costs of quality management to a minimum. A common thread in the contributions of these eminent persons is that a restructuring of attitudes a necessary at all levels of any organisation which desires to manage the quality of its services

3.2 Quality

According to the Chambers mini-dictionary, quality is the “degree of worth”. The Oxford English dictionary defines it as “the degree of excellence” and the “relative nature or kind of character”. It is also defined as “fitness for purpose” (Juran, 1964) and “conformance to specifications” (Crosby, 1979). The British Standard Institute defines quality as “the totality of feature and characteristics of a product or service that bear on its ability to satisfy stated or implied needs”. According to Goings (1995) a quality service is one in which the

guiding principle is “doing the right thing right, right away”, i.e. doing the correct thing correctly, without delay. Obviously, from these various definitions, quality is a multifaceted concept with many dimensions.

Dimension of Quality

Donabedian (1980) and Maxwell (1984) have taken a holistic approach to the concept of quality and have identified several dimensions of quality including the following.

1. **Technical (professional) competence-** this refers to the skills capability and performance of care providers, managers and support staff, e.g. clinical acumen, diagnostic ability, etc.
2. **Client’s satisfaction-** this expresses client’s perception of the response of the health service to his/her felt needs; opinions are, usually, based on the outcome of care, interpersonal relationships, amenities of care, etc.
3. **Accessibility of care** in terms of absence of barriers to health care, i.e. geographic, economic, social, cultural, linguistic barriers (availability, affordability, acceptability of care, etc.).
4. **Coverage-** percentage of the community who should receive a service- who actually receive it.
5. **Effectiveness-** are the desired results actually obtained? Is the treatment given the most appropriate for the given situation?
6. **Efficiency-** is optimum care being given at minimal cost possible? Is unnecessary treatment given?
7. **Interpersonal relationships-** what is the interaction between providers and clients, between managers and providers, between the health team and the community? Good interpersonal relationship is expressed through mutual respect, courtesy, confidentiality, responsiveness, empathy which all lead to trust, and strengthen credibility.
8. **Continuity of care-** Is the complete range of preventive, curative and rehabilitative care available on an on-going basis without undue interruptions? Is there timely referral for more specialised services?
9. **Safety-** are the risks of injury, infection, side-effects etc., to both clients and providers minimal? This dimension of quality has assumed greater importance in view of the threat of diseases such as *AIDS* and viral hepatitis.
10. **Amenities-** the physical appearances of facilities, cleanliness, comfort and privacy for patients – in what state are these amenities? Do they encourage the client to return for a follow-up visit?
11. **Utilisation of health services-** what is the rate of utilisation of the services?

All these suggest that there are many perspectives on quality and that quality health care responds to the needs of its clients and demands not only sound technical skills but also excellent interpersonal skills. The various perspectives on qualities are discussed in the next section.

Perspectives of Quality

Quality means different things to:

- the clients – patients and the community
- care providers
- managers.

A. The clients – patients and the community are concerned with whether the service:
   - addresses perceived needs
   - is delivered courteously
   - is concerned with effectiveness, accessibility, interpersonal relation, continuity, amenities.

B. Care providers focus on:
   - professional skills,
   - effectiveness
   - availability of resources
   - safety.

   1. *What laboratory services are available?*
   2. *How accurate and reliable are they?*
   3. *What referral systems are available?*
   4. *What are physical working conditions?*

C. Managers focus on all the various dimensions of quality, since they are, ultimately, responsible for quality assurance and total quality management. Both of these terms will be discussed in subsequent sections.

3.3 Total Quality Management (TQM)

TQM has been defined by Collard, Sivyer and Deloitte (1990) as "a cost-effective system for integrating the continue as improvement efforts of people at all levels, in an organisation to deliver products and services which ensure customer satisfaction." They emphasise that *TQM* is a continuous process. *TQM* represents a total cultural shift from management based on error detection and correction, to management

based on error prevention with a focus on the satisfaction of the consumers needs. *TQM* seeks to create a culture of constant examination and improvement of work, so as to respond to changing consumer requirements.

There are three elements of TQM, namely:

- a focus on service to customers
- teamwork- involving everyone in the organisation
- a scientific approach to decision-making based on data collection and analysis.

This implies that *TQM* is directed at meeting the needs and expectations of clients, patients and community. It is directed at the development of an organisational culture in which every member of staff works as a member of a problem solving team, dedicated to satisfying changing consumer demands. In other words, all concerned members of the term are involved- including managers, professional and ancillary staff. *TQM* encourages a team approach to problem-solving, thereby reducing resistance to change.

Problem-solving is based on, scientifically, collected data, the goal being *excellence and perfection*. Data is needed at all stages of the problem-solving process to define the problem, identify its causes and to monitor the effect of the solutions. These are, usually, simple quantitative data such as waiting time in clinics etc. It is important to note that *TQM* focuses on the improvement of work processes. In *TQM* the process for improvement never ends. *TQM* is the responsibility of senior and top management as it is a very potent means for the enhancement of the reputation of an organisation.

Development of *TQM* programmes

According to Morgan (1994), most *TQM* programmes develop, sequentially, through the following four stages- inspection, quality control, quality assurance and total quality management.

(a) Inspection- the assessment of a product or service to assess its conformity with specified requirement.
(b) Quality control - the continuous monitoring of a process to detect causes of quality problems so as to meet the requirements of customers.
(c) Quality Assurance (QA) - all the arrangements made to safeguard, maintain and promote the quality of care (Donabedian, 1980). In *QA* there is a shift from detection of causes of quality deficiencies to prevention. *QA* is a more comprehensive process than quality

control and included the creation and maintenance of a quality system and audit of the system's operation.

(d) Total quality management- involves the application of the process to all branches and levels of the organisation.

3.4 Stages of Awareness of Quality Management

Crosby (1979) has identified five stages of awareness of quality managements. These are the stages of uncertainty, awakening enlightenment, wisdom and certainty. These form a continuum from a situation where management has no knowledge of the use of quality management as a tool and deals with problems as they occur without analysing the cause of the problems to a situation where quality improvement through prevention of problems is a normal and continuous activity. In the West African sub-region, most health service organisations are in the stage of uncertainty.

3.5 Building a Quality Management Programme

This requires commitment and dedication at all levels. There are two approaches to building a quality management programme:

a. comprehensive *QA* strategy, i.e. total quality management
b. problem-oriented approach which emphasises small-scale activities and produces incremental improvement in quality.

This later approach is recommended in sub-Saharan Africa where death of skilled personnel makes the adoption of *TQM* rather impractical. It is also recommended that the programme should include the following elements:

1. training of all employees towards the acquisition of problem-solving and orientation on the nature and methods of *QA*, emphasising self-appraisal
2. teamwork rather than individual efforts should be emphasised
3. a supportive administrative structure originating from the top and extending down throughout the organisation. A *QA* committee should be established to provide information, guidance and monitoring. A *QA* officer should be appointed in each department.
4. statistical control and measurement of quality based on accurate statistical data and methods. A statistical unit should be created if none already exists.

Key activities to be carried out, according to Franco et al (1993), include deliberate action to:

a. foster commitment to quality
b. conduct preliminary review of *QA* activities
c. develop the purpose and vision for *QA*
d. determine the level and scope of activities
e. assign responsibility for *QA*
f. allocate resources for *QA*
g. develop a written *QA* plan
h. strengthen *QA* skills
i. disseminate *QA* activities
j. manage the change.

3.6 The Quality Management Process

Based on experience gained from successful *QM* programmes in several countries, the process consists basically of establishing standards, monitoring their implementation and pre-empting and overcoming problems. There are 10 steps, grouped into 3 sets of activities namely:

- Designing
- Monitoring quality
- Problem-solving and improvement of processes.

Each department should be allowed to proceed at its own pace, paying attention to a few problems at a time to start with and gradually increasing its scope and proceeding through the stages of inspection, quality control, quality assurance, and hopefully, and total quality management. These efforts should result in a gradual, but steady improvement in the quality of care provided.

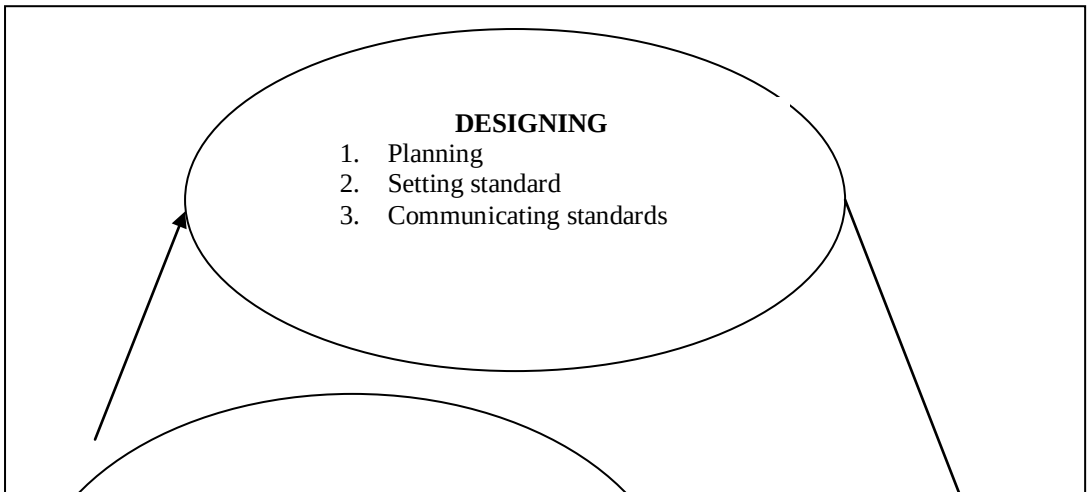

Fig. 4.1: The Quality Management Process (Franco Newman, Murphy and Mariam; USAID, 1995)

4.0 CONCLUSION

In the context of health care, quality expresses the degree of excellence of the services provided, its fitness for the purpose for which it was established and its conformance to planned specifications. A good quality health services is one in which the correct services are provided correctly without delay. Quality is a multifaceted concept and can be viewed from several perspectives the most important of which are perspectives of the clients of the health service.

5.0 SUMMARY

Quality management focuses on the satisfaction of the needs of the clients, emphasises teamwork, self-appraisal and a scientific approach to problem-solving based on the collection of data. Every health institution should establish a quality management programme using an incremental problem-oriented approach. Activities should be department-based and should be directed at establishing standards, all employees towards the acquisition of problem solving skills as well as a supportive administrative structure originating from the top and extending to all levels of the institution.

6.0 TUTOR-MARKED ASSIGNMENT

Describe how to assess the quality of health care in various setting.

7.0 REFERENCES/FURTHER READING

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