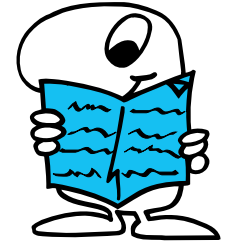


Initiative for Sub-District Support



Kwik-Skwiz
#9

The role of the District Hospital in the DHS

The issue

The District Hospital serves three critical roles in a well-functioning district health system, namely to:

- provide **support** to health workers in clinics and community services, both in terms of clinical care and public health expertise
- provide **first level hospital care** for the district
- be the place of **referral** from clinics and/or community health centres, and be responsible for referring patients to higher levels of care, when necessary.

In the past, some District Hospitals have served all three roles very effectively, and also played the added role of overall district management - often to good effect. This was particularly the case in some of the ex-homeland areas, where some "health wards" had many of the characteristics of a well-functioning district. In other places, first level hospitals operated independently of clinic and community services, and it was this problem that needed to be addressed through a District Health System. But valid concerns are now being expressed that the pendulum has swung too far the other way, and that some people have understood the district office to have replaced many of the functions of the District Hospital - in particular, support to clinic and community services. The national Department of Health has clearly stated that the district hospital is an integral part of the district health system. But it's a message that needs to be reinforced as the District Health System is implemented: The responsibilities of a district hospital, as outlined above, are critical to a well-functioning district.

Defining the problem

"The role of District Hospitals has been downgraded in the process of DHS development. To many people, the DHS is equated with Primary Health Care, and Primary Health Care is equated with primary level services. Some people do not see the importance of District Hospitals in the delivery of comprehensive PHC and in the support of primary level services. There should be a drive to bring hospitals and clinics closer together, not to separate them". - Former Medical Officer, rural Kwazulu

That perspective may be a bit provocative, but it gets to the heart of the matter. National health policies are based on the principles of the Primary Health Care (PHC) Approach, and are designed to create a health service that is more appropriate, equitable, less hospital-based, and more promotive and preventative. The District Health System has been adopted as the vehicle to deliver PHC in South Africa.²

Primary Health Care in this context includes all services *up to and including District Hospitals*. But in practice there has been a tendency to isolate the District Hospital from the other components of health care delivery within the DHS, which threatens the integrity of the health district and the benefits of the DHS. Dr Ian Couper, the Medical Superintendent from Manguzi Hospital in northern Kwazulu-Natal explains:

"The implementation of the DHS has taken some areas backwards, especially the push to separate 'hospitals' from 'districts'. While I understand that there is a need to correct the imbalances of the past in many areas, for most of us working in District Hospitals in northern Kwazulu, the hospital

has been the launching pad to serve the district. It was the central point of the district that provided expertise and resources for PHC rather than taking them away (as has happened elsewhere). It was the natural meeting point for staff, patients and community members. It acted as the bed-rock for the support of multi-sectoral health care activities. District hospital staff together with our communities are saying very strongly that we want to continue this way. Community members do not see the reason to separate off the hospital, because they already feel they “own” the hospital. Unfortunately, this does not fit in with the way things are developing. I do not feel this problem is a fault of the DHS, but of the way it is being implemented and interpreted”.

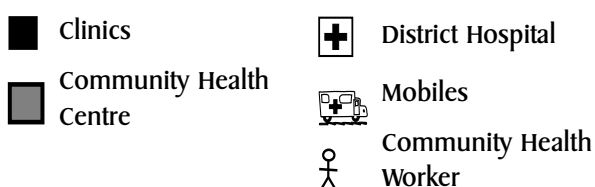
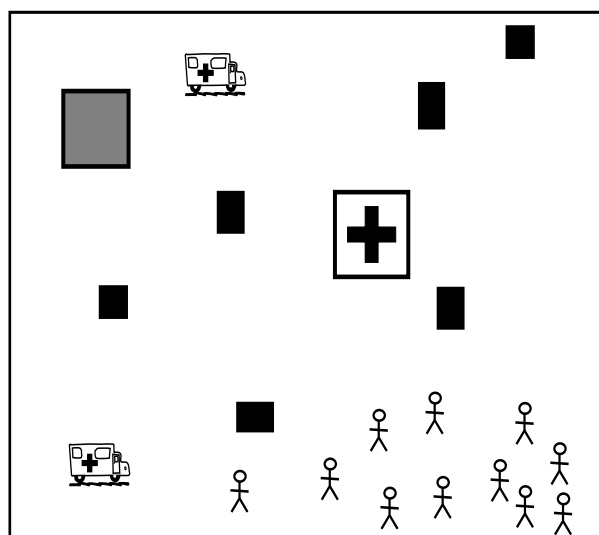


Diagram: District Hospitals, community health centres, clinics, mobile services and community-based health care providers (such as CHWs) are different components of one functional unit for the delivery of Primary Health Care.

Ten Features of a Good District Hospital

The World Health Organisation has defined and described the District Hospital in a number of technical documents.¹ ISDS has adapted WHO recommendations to put forward the following ten features of a well functioning District Hospital.

- An essential component of the health district;

- Provides certain Level 1 hospital services that cannot usually be delivered at a clinic or health centre (see Box 1);
- Has the following clinical departments: emergency care, medicine, surgery, obstetrics, paediatrics, psychiatry and outpatient services;
- Provides a 24 hour service and has more than 30 beds;
- Provides in-service training and support to PHC services and facilities in the district;
- Ensures the maintenance of good clinical standards in the district;
- Provides comprehensive (preventative, promotive, curative and rehabilitative) care, and is an integral part of all district health programmes;
- Staffed by generalist doctors who receive support from secondary and tertiary level hospitals;
- Should render primary level services to the local surrounding population, such as immunisation, growth monitoring and STD treatment (preferably through a separate PHC centre or OPD within the grounds of the hospital); and
- Has the capacity to interact with the community and with other sectors.

Integrating the District Hospital into the DHS

District-wide support function of the District Hospital

In addition to the services listed in Box 1, the District Hospital should be able to provide technical support to PHC in the district as a whole. An example of such a hospital is Hlabisa Hospital in Kwazulu, as explained by the following quote:

“In our health ward, the TB programme achieved a compliance rate of over 80% despite being in a difficult and remote rural area. The TB programme was managed from the District Hospital which provided the necessary medical, public health and logistical expertise. The hospital worked in tandem with the clinic sisters, community outreach officers, the transport department and the community in achieving this success. At no time was there any competition between hospital and clinics for the same resources because they were all part of one system responsible for the health of the same

Box 1: Basic Conditions and Procedures Managed in a District Hospital

Amputations (below-knee, digits)
Anaesthesia (general and regional), intubation, and management of complications of anaesthesia.
Anal fissures and fistulae - basic surgical management
Ascitic taps, pleural taps, bladder puncture and hydrocelectomy
Acute severe malnutrition: Inpatient care and rehabilitation
Basic emergency medicine: fluid and electrolyte balance; management and investigation of coma; status epilepticus; nebulisation and intensive care of acute severe asthma; heart failure; eclampsia; cardio-pulmonary resuscitation.
Biopsies (eg. lymph nodes, cervix, pleural, skin)
Circumcision
Colostomy
Control of epistaxis
Debridement and care of wounds
Deliveries - normal vaginal, assisted vaginal, caesarean sections and symphysiotomy.
Extraction of teeth
First Aid management of multiple trauma victims
Gastric ulcers: medical management
Gynaecology: termination of pregnancy; dilatation and curettage; female sterilisation; evacuation of uterine cavity; insertion and removal of IUCDs
Incision and drainage of abscesses
Laparotomy: for intestinal obstruction, intussusception, perforated intestines, ectopic pregnancy, etc.
Male sterilisation
Manipulation, reduction and plastering of common fractures (eg. Colles fractures, supra-condylar fractures)
Meningitis (diagnosis and management)
Obstetric emergencies: management of cord prolapse, ruptured uterus, APH, PPH and eclampsia
Ophthalmology: basic management of refractive disorders, acute red eye
Psychiatric illness - basic in-patient care and rehabilitation
Removal of foreign bodies from ear
Reduction of dislocations
Split skin grafting for simple and small third degree burns
Snakebite - administration of anti-venom
Traction
Volvulus

Note: This list of conditions or procedures are based on a World Health Organisation list, and should be used as a guide. The exact basket of services to be delivered at a District Hospital should depend on the demographic and epidemiological profile of the district, the resources available and the proximity of a regional hospital.³

population. It was like this with our maternal health service where the hospital and the clinics would hold joint perinatal mortality meetings to work out how the health system as a whole (including the communications system and the laboratory service) could function more effectively to improve health and reduce mortality. One of the senior Hospital Midwives was instrumental in providing in-service training to clinic staff on antenatal and intra-partum care.”

Relationship between Hospital and District Management

The integration of the District Hospital with other district health services often remains poorly defined. Linkages for coordination and support are often unspecified, leaving the relationship between hospital management and the management of other aspects of PHC ambiguous. The role of a DMT is to provide these linkages and ensure coordination. Any separation of the District Hospital from the other district health services without a DHMT to pull the different services

together will lead to inefficiencies, fragmentation within the district, and will mean that the District Hospital is unable to realise its full potential for supporting PHC and developing the DHS.

In many health districts therefore, especially the rural and under-resourced ones, provided that the district management team can see to the needs of the whole district and resist being dominated by curative hospital services, the best solution is to locate the District Office within the grounds of the District Hospital. In one ISDS district, the District Office was located in a different town from the District Hospital, resulting in problems and inefficiencies:

The District Hospital lies 75 km away from the District Office. With the difficulties of poor transport and communications, this decision has been a costly one for the people of the district. Managers and coordinators spend almost an hour commuting in each direction every day. Transport, communication and management systems have been hampered as a result, and there is little sharing of resources. Hospital staff who can contribute to broader district development can't, even if they want to. For example, the Hospital has a Dietitian who would prove invaluable to the development of the nutrition programme. However, the nutrition programme coordinator and the dietitian work so far apart from each other that this kind of collaboration is not easy.

By having the District Office closer to the hospital, resources (especially people and skills) can be shared, and the District Office will be on hand to ensure that this hospital provides a health service that is integrated into and supportive of the primary level services.

Many District Hospitals also have resources and skills that should be used to develop effective District Health Management. For example, in many places, the administrative skills around human resource management, accounting and provisioning are located within hospitals. These hospital-based skills should be utilised to support the DHMT by encouraging hospital

administrative and management staff to become more district-orientated. If the perceptions and orientation of hospital staff are based on the DHS concept, the District Hospital can and should be one of the key supports of primary level care and PHC.

Areas for consideration

National, provincial and district managers need to give particular consideration to the following questions:

- What is the role of the District Hospital in the DHS, and the district health planning process?
- How can we integrate District Hospitals into other activities within the DHS.
- How and when should hospital personnel be involved in primary health care outside the hospital, and how can we develop orientation and training programmes to strengthen this?
- How can we develop methods for resource allocation within districts that may best meet the needs of the entire population?
- How can clinical referral systems can be made to function more effectively?
- How can District Hospitals support peripheral health units, and increase the confidence of the community in them?

This brief was prepared by David McCoy, ISDS facilitator for the Eastern Cape.

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Comments or criticism?

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