THE DISTRICT HEALTH SERVICES MANAGEMENT PROJECT

TSHOLOTSHO DISTRICT
MATABELELAND NORTH PROVINCE
ZIMBABWE

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CHAPTER 1. THE DISTRICT HEALTH SERVICES MANAGEMENT PROJECT IN TSHOLOTSHO: OBJECTIVES AND METHODS

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The DHSM project is a research project that was launched in Murewa district (Mashonaland East province) in 1991 and in Tsholotsho district (Matabeleland North province) in 1992. The project is funded by the DGVIII of the European Commission. This funding ended in May 1999. Since its inception, the project was operationalised by the Ministry of Health and Child Welfare and by the Belgian non-governmental organisation *Medicus Mundi Belgium.*

The objectives of the project are:

- to improve the management expertise, and hence management practice, at district level;
- to disseminate research methods and results to other districts in the province and the country;
- to strengthen local institutional research capacities, more specifically the Health Systems Research and Technology unit of Blair Research.

There basically are three institutional partners in the research: the District Health Executive (DHE), the Provincial Health Executive (PHE), and the External Research Team. In the case of DHSM, this External Research Team is constituted by the *tandem* Institute of Tropical Medicine, Antwerp (Belgium) and Health Systems Research and Technology Unit, Harare.

The research methodology is centred round decision-making. Decisions are taken in order to solve problems[1]. In the case of DHSM, management decisions are considered as hypotheses to be tested by action. Figure 1 illustrates the process. Decisions taken in the field of organisation of health services are not taken at random, nor are they taken in a vacuum. They are in fact influenced and shaped –

[1] For instance: overcrowding of the hospital outpatient department; inappropriate use of referral services; lack of staff motivation; inadequate coverage in first line health services; limited community involvement in decision-making; etc.

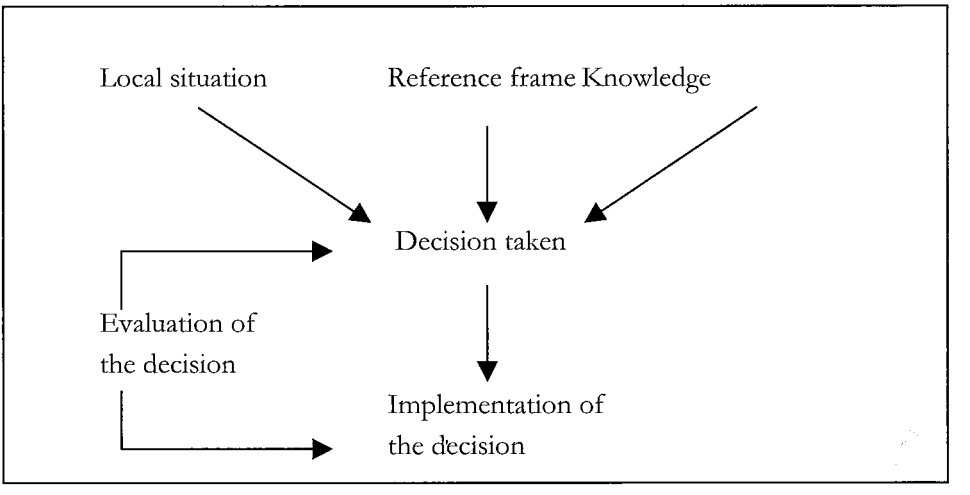
although rarely on a explicit basis - by a series of practical and theoretical considerations. We can distinguish three types of considerations:

- first, the characteristics of the local situation (which may need to be described more extensively in a pre-action or pre-operational phase);
- second, the knowledge, insight and experience managers already possess (or to which they can have access) on how to deal with a given problem;
- third, the kind of health care delivery system the district manager would like to establish: i.e. a conceptual reference frame of a health care delivery system. Every manager has such a reference in mind, although it is rarely thoroughly explicitated. It is obvious that such a reference frame is not value-free.

It appears thus that management decisions are not necessarily based on solid scientific evidence that would, a priori, prove and guarantee that the decisions are the most appropriate ones. Hence the denomination *empirical* decisions.

Once the decision is taken, practical measures need to be implemented in order to implement the decision in the field situation. Eventually, the decision needs to be evaluated: in other words, the managers need to assess whether, and to what extent, the initial problem was solved. It is obviously possible that a new, and hopefully more appropriate, decision is then taken. In turn, this last decision also needs to be evaluated, and so the cycle goes on...

The DHSM project precisely is about reflecting, explicitating and documenting in a systematic and rigorous way the different steps of this management cycle. Proper documentation enables other managers to use these experiences in their own setting, since others also encounter similar problems. The main actors in the entire process are thus the very district managers themselves. It is clear that such a process is quite demanding in terms of time.



- Figure 1: DHSM research methodology -

Admittedly, the use of the word "research" in the DHSM project is somewhat misleading and it has also lead to some misunderstanding in both Tsholotsho and Murewa. There are in my view at least two reasons for this situation.

First, there is the fact that the DHSM methodology, apparently, does not add much new to what many managers already do in their routine work. To a certain extent this is correct. What is new, however, is a critical *attitude* to what one does in terms of management and decision-making. Such an attitude implies that managers are willing to explicitate what they are doing and why they are doing it. And, eventually, that they accept that the results of their decisions are thoroughly evaluated. The research activity in DHSM thus consists of actually testing in a rigorous manner the appropriateness of the decision. Hence the need for implementing and evaluating the decision, i.e. a need for *action*. Such a process, definitely, does not fit the prevailing conception of health care managers on what "research" is (or is to be). The denomination "critical management" or "scientific management" rather then "research" may perhaps prevent such misconceptions. Remains the nude fact that such a culture of critical or scientific management is insufficiently developed among health care managers– be it in Zimbabwe or elsewhere.

Second, I think there is the fact that many district managers (be it nurses, doctors or environmental health workers) have no problems with considering research as something dissociated from day-to-day management. Research is largely seen as some kind of specialised activity that is carried out on an *ad hoc* basis and in parallel to routine management. The link with the reality on the field is overlooked thereby jeopardising the relevance of the research.

The way Health Systems Research (HSR) is considered and promoted in Zimbabwe may perhaps have contributed to perpetuate the dichotomy between "research" and action. One example illustrates this. The classical HSR in Zimbabwe remains largely *descriptive* and limits itself in most cases to an analysis (albeit thorough) of an existing situation: it does however not test action. The research exercise generally ends with the establishment of a list of well-intentioned recommendations – some of them quite relevant, others *gratuit* or irrealistic. This is not felt as a problem by the researchers because they do not consider the test of the recommendations (through their implementation) as part of the "research" activity. The exercise thus remains neutral and does not enhance the capacity of district managers to become themselves agents of change.

In the DHSM-methodology, the description of the situation in which the problem evolves is not more than a (more or less necessary) input in the decision-making cycle (see again figure 1). Such a situation analysis is thus an investment with a cost that needs to be optimised. By no means, however, can this situation analysis be considered as the very product of the "research" process. The real product can only be appreciated in terms of change! Table 1 highlights the main specifics of the methodological process followed in the DHSM project. It also points to the main difficulties encountered in the process.

Specifics of DHSM methodology	Difficulties encountered
The management team (DHE) is at the same time the research team	Conflicts with prevailing perception on research as an *ad hoc* activity separate from day-to-day management
The identification of problems is integral part of the routine management process	Id.
Single problems are analysed and tackled in a systems perspective (efforts are made to identify and monitor the positive and negative system effects of a given action)	Such a comprehensive and encompassing approach creates a perception of "vagueness" and of long-term remoteness of palpable results*
The process implies the use by the management team of a common reference frame of health care delivery for own decision-making purposes**	The use of a reference frame conflicts with the prevailing culture among many district managers of obedient and passive implementation of decisions taken by others at higher levels in the health system
The process is action-oriented	Implies a more long-term perspective beyond a merely descriptive phase
Except for external scientific support, other inputs remain limited notwithstanding the considerable amount of (staff)time that is needed in the process	Conflicts with the managers expectations of material benefits (seminars, per diems, etc.): research being also seen as a potentially "lucrative" exercise that allows staff to increase revenue and attend out-of-service training sessions

* The latter, as a matter of fact, is often correct

** For instance, the patient-centred approach advocated in the Primary Health Care strategy would be one of the important features of such a reference frame. In structural terms, this implies a model of health services organisation whereby the health centre, rather then the hospital, occupies the central position in the District Health System (see annex 1).

- Table 1: Specifics and difficulties encountered in the DHSM project -

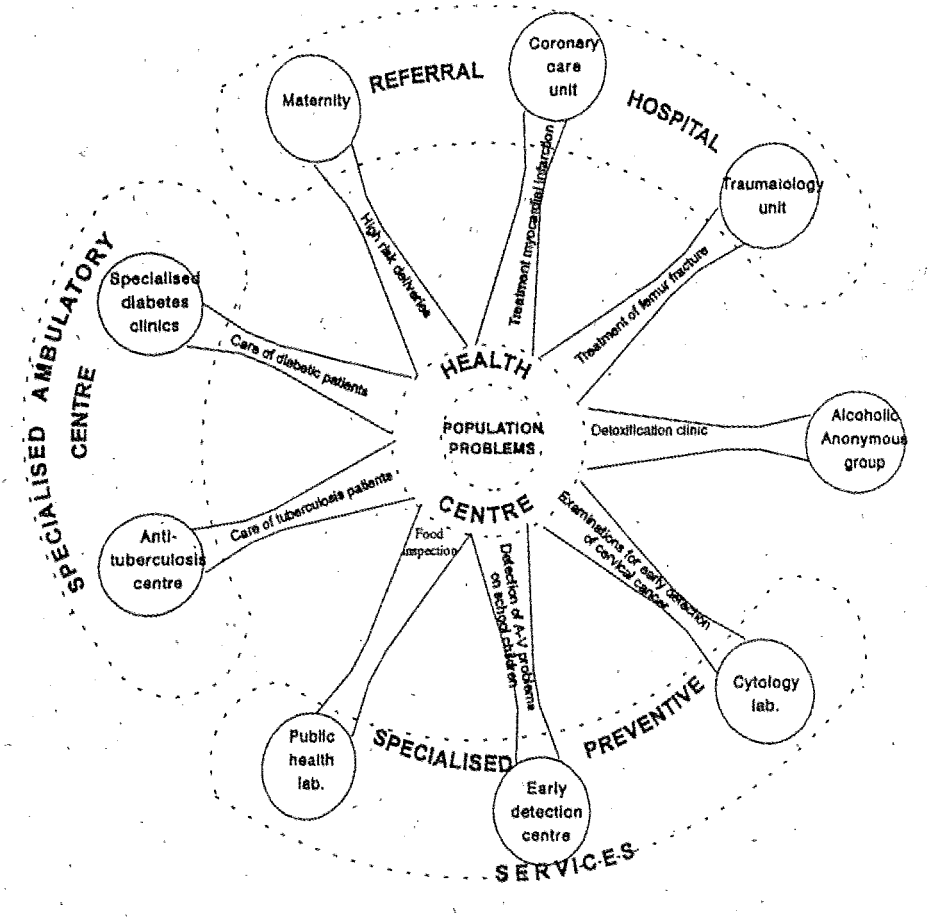
Let me conclude on the following issue: who can learn what from the DHSM project?

Each of the three institutional partners in the research has its specific inputs in the process, and each of them can draw specific benefits from it.

The main inputs provided by the DHE are its time and its knowledge of the local situation and people. The DHE may benefit through the provision of a better service to the community and through the in-service training opportunities the research process creates.

The inputs of the External Research Team (Antwerp and Blair) are its expertise in terms of methods and its knowledge of similar experiences conducted in other countries. The project is an opportunity for the ERT to enhance its expertise in the field of management of health services. Finally, the involvement of the PHE allows to create an environment that is conducive for research. The PHE also guarantees that the action taken in the course of the project fits the larger frame of health care policies as defined at the political level. It is expected that DHSM provides the PHE with relevant information, insight and knowledge that can be used in other districts within the same province.

Annex 1: The health centre at the core of the system



Source: Groupe d'Etude pour une Reforme de la Médicine, Pour une politique de la santé, *La Revue Nouvelle 1971, Bruxelles, p.97.*