Topic 4. How to make a district diagnosis?

A hand out from the project on "Integrated management of public health programmes at district level"

This project was developed by incorporating ideas, suggestions and contribution from an interactive participatory process of dialogue and consultation involving public health and multidisciplinary resource network drawn primarily from mainstream institutions and the civil society network in India.

A draft manual evolved covering concepts and values Roles, Skills and Challenges and an Integrated Paradigm for the Public Health Management at District level. It also elaboarates on, making a district diagnosis; organizing a health management information system; evolving a district plan; organizing an epidemiological surveillance system; responding to an epidemic and managing an outbreak; managing health programmes; managing human resources; organizing materials management; monitoring and evaluation; leading and building a health team; promoting, communicating and advocating for health; promoting and sustaining community partnerships; and building and sustaining partnerships with the educational sector; civil society, private sector and promoting an inter-sectoral collaboration.

Developed by
Centre for Public Health and Equity, and its associates, for the Society for Community Health Awareness Research and Action, Bangalore.

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Preface

This document is intended to serve as an evolving conceptual **framework for district level public health managers** in the health systems of the South East Asian countries. These managers, their knowledge, skills, attitudes, and openness to new challenges and new paradigms will remain one of the key determinants of the success of countries in reaching the **"Health For All"(HFA) vision** and the ***Millennium Development Goals(MDG's)***.

This document is a practical do it yourself workbook that draws upon some of the wealth of experience and resources in the past and present and tries to help district level managers address the complexities of today's challenging global, national and local health situation and the emergence of new challenges and reemergence of older ones.

Readers are adviced not to treat this document as a comprehensive manual but as **an evolving compilation of concepts in public health management**. This conceptual framework contains suggestions to tackle some of the problems, that the district level public health managers meet in their daily life as they lead, assess, respond, evaluate and learn from numerous health systems challenges. Where possible and feasible it directs the managers to other resources and materials that will provide them additional perspective and details **(*see CD accompanying the manua*l)**

The authors/ facilitators have extensively worked in the community and have had decades of experience in supporting capacity building for public health/ community health in the main stream and civil society linked alternatives sector. They have also tried to draw upon the experience and the field-oriented perspectives of a network of public health capacity builders and trainers from the mainstream public health institutions and civil society training centers ***(see list of contributors).***

This is ***a work in progress.*** The conceptual framework will, we expect, evolve into a guidebook that gets used and adapted by district level public health managers, trainers and supervisors of district level public health programmes. The document is expected to continue to eveolve with the feedback from users making it more relevant, responsive, context specific and focused.

We see this document as the beginning of a new journey - ***a journey of strengthening district level public health management***.

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4. How to make a district diagnosis?

Every District Public Health Manager needs to spend some time every year, every month and whenever possible to understand the problems and challenges in her/ his specific district, so that the health systems and health programmes can be adapted to be more responsive to this reality and to this evolving / changing situation.

All managers are expected to collect, supervise, tabulate, analyse and report a large amount of data from the Health Management Information Systems which may be operating within their district system and which may be a part of a more organized National / Country level and State level HMIS. However, often this reporting becomes a routine ritual or activity geared towards supplying data for another level, another manager. This chapter highlights that the primary significance of all data, information, evidence collected at the district / sub-district level as part of an HMIS or as part of routine public health programme activity is primarily to help the Manager make a District Diagnosis which includes sub-district and community diagnosis.

Knowing your own district and all the components related to it – including development situation, demographic situation, health situation, health system situation, local self government, potential partners and everything about the communities you serve – with their diversity and plurality is the first step of the District Diagnosis.

4.1. Preliminary Information To Make A District Diagnosis

In this manual we are suggesting a set of general questions that each district level public health manager must ask his team and in order to get the answer or the basic evidence to evolve the answer. Some further details of components and sub questions are also included. These are not exhaustive but indicative. They are adapted from four well known sources. [1,2 ,3 & 4] Depending on the country / state / and local situation additional questions may be relevant and should be added to the list.

a) Knowing your community

It is possible that the District Public Health Manager does not know everything about every community that is available in the whole district – but it must be his / her endeavour find out as much as possible and to make every health team member aware of the need to make a basic 'community diagnosis' of all the communities, sub-communities, clusters of people living in areas under their defined geographical and jurisdictional areas so that from this multiple community diagnosis – the identification of priority groups whose access, utilization and service satisfaction may be made possible by

focused initiatives and actions in every programme and functional area of the district and sub-district health systems.

The community diagnosis must specially focus on

a. the type of community based on geography – rural, urban, hilly, forest dwellers;
b. The type of community based on caste, class, gender and ethnicity with focus on plurality, health seeking behaviours and access and uilization of health programes;
c. The religious, cultural, political divides that need to be kept in mind so that community building activities to address these divides can be built into the health programmes.
d. The presence, status and special challenges of smaller marginalized or socially excluded groups within and outside the mainstream community. (These need to be reached, addressed, involved and supported by special activities and focused measures.)

   Eg., women, working children – child labour and street children, school dropouts, people with disability, people with mental ill health, elderly, those who are socially excluded due to social status (dalit and adivasi) and stigma (leprosy, HIV-AIDS, sexual minorities, sex workers)

It is only with such inclusive information that the health system can live upto its mandate to equity in access to health care for all the peoples in the sistrict.

b) What do you know about your own district?

Before focusing on health problems and health systems it is important for the District Public Health manager to know more about the social, economic, political, cutural and ecological characteristics of the district.

a) The geography of the district including its plurality in terms of urban / rural, hilly, forest regions and its physical geography – including water resources.
b) The economic geography of the district which includes the main economic activities – agriculture, industry and other rural / urban occupations; wages and income – averages and ranges;
c) The literacy levels of the population and the educational resources and opportunities in the area – schools, colleges and vocational training facilities and also non-formal educational initiatves.
d) The general development levels of the district – roads and accessibility of regions, electricity and telecommunication; water sources and supplies and sanitation; markets and commercial activities.
e) The social development levels of your district – the social institutions, cooperatives, clubs and societies, the libraries, the availability of media – folk and radio / television and telecommunication.

f) The cultural development of the district in terms of cultures, ethnicities, minority groups, indigenous people and their development and interactions. Also resource for folk and formal cultural communication – art, music, dance, theatre and informal education including jatha, fairs and festivals.
g) The political situation of the district in terms of leaderships, designations and role of important supervisors, chain of reporting etc
h) Various partners in Health and Development sector present in your district
i) Public transport and access. Timing ? Access at night?

C) Understanding ill-health of your district:

Some questions to find answers for:

a) Which age groups contain most people and which age group is increasing fastest? - demographic date by age groups and sex.
b) Who gets sick? Who dies? In the community? In the centres / hospitals? – age and sex specific mortality with causes of death? Morbidity with causes of death by age and sex?
c) Who needs maternity care? - - fertility, live births,still births, infertility.
d) What are the health problems in the area?
    1. What does the dispensary / health centre / hospital / statistics say?
    2. What do the people in the community report when they meet health workers?
e) When does ill health occur? Which months? Which seasons?
f) Why does ill health occur?
    1. nutritional status
    2. physical factors in the community
    3. social and cultural determinants / environment
    4. economic and political determinants
g) Are these health problems specific to certain socially marginalized groups in the district
    1. women
    2. aged / elderly
    3. people with disability
    4. working children / street children/ child labour
    5. dalits, adivasis, sexual minorities
    6. stigmatized by illness – leprosy? / HIV-AIDS?
h) Water supply and sanitation
    1. Source (Protected well, unprotected wells, river, pond, piped water etc)
    2. Toilets, sanitary latrines, fields etc
    3. Village sanitation
i) Disease vectors (mosquitos, flies, sandflies etc)

d) What is right/wrong with the existing district health systems?

a) What are the government linked health systems in the district?
    1. at the district level
    2. at the sub-district level
    3. at the community level
    4. at the family level (first level of contact)

b) How are the services coping or performing?
    1. From the health team point of view
    2. From the community leaders point of view
    3. From the community / people point of view

c) Are all the people utilizing the services? If not, why not? Who is not?

d) Is the services covering or reaching all the parts of the district? If not, why not? Where is it not reaching?

e) Are any particular groups in the community considered specially 'at risk' of ill health and is this concept being used in any of the health services and health programmes?

f) Is there a deficit in the:
    1. Quantity of care for district needs?
    2. Is there a quality concept for different services?

g) Is staff morale high? Is health team concept and practice strong?

h) Do staff interact well with the community, patients and each other?

i) Is the health system regularly monitored and evaluated?

e) What Are The Additional Local Resources ? Who Are Your Potential Partners?

a) Who is providing Health Care? Of what type and or how?
(who do people go to for advice? Where? When? At what cost?)
    1. Traditional birth attendants
    2. Traditional healers
    3. Indigenous system/ other system practitioners
    4. General practitioners
    5. NGOs and mission institutions
    6. Private sector.
    7. Government health care institutions

b) Where are the health care providers located in your district ?
(Mapping the different resources on a map to understand spread and outreach and areas that are underserved or in inaccessible terrain will be useful. Where possible include the concept of 'chronobars' ie time taken from villages and clusters to reach the nearest health care facility and referral units)

c) Who are the people other than health workers who also are potential resources for health action?
    1. schools, teachers and children
    2. college, teachers and students
    3. rural development agencies and NGOs

4. community organizations including farmers' clubs and cooperatives; women's clubs and self-help groups; youth organizations; other community based organizations.,
5. professional and non-professional literate people, groups, networks
6. other training institutions
7. other governmental and non-governmental agencies for development, education, rural industry, other sectors which impinge on health.

d) What are the material resources, skills, capacities and local resources (including labour) available from the communities in your district?

e) What are the financial resources that can be tapped to complement / supplement the health programmes under your care?
   1. cooperatives and local banks
   2. local self government institutions and their health budgets
   3. economic activity that can be tapped for contribution / donations, etc.

4.2. Making a District Diagnosis

a) From the categories of information highlighted in the exercise above a description of the following five features of the district will be available:
   1. Type of communities in district
   2. Social, economic, political, cultural and ecological characteristics of the district
   3. Overview of Ill-health in the district
   4. Overview of government health systems
   5. Overview of local resources and potential partners

b) From this collected evidence **a district diagnosis** can be made which would include:
   a) population priorities
   b) health priorities (health indicators)
   c) health care priorities over the year, keeping seasonality in mind
   d) challenges for deployment of resources to ensure coverage of district
   e) sources and quantum of finances and other resources and supplementary / complementary options
   f) special challenges or priorities for the district other than (a) to (f).

c) Since this information collation and diagnosis will be available at sub-district levels at first, the priority health problems and challenges can be identified through a brainstorming with the whole district team and relevant experts. This will help to make an **overall district diagnosis** and explore the programmatic and system responses needed to respond to this diagnosis.

d) ***A district Action Plan*** *can then be drawn up on an annual basis drawn, from all the above exercises and data/evidence collection mentioned earlier. The Action Plan will then consist of a series of action initiatives /*

elements that need to be then translated into programmes of activity within the context of the multilevel health system in the district and availability of human, material, financial and time resources

e) Over the years, with more and more decentralization of health system management and health information gathering and decision making, this process of district diagnosis will no longer be a 'top down' process but a series of 'bottoms up' exercises that begin at the village and community level. Each village or community will initiate this process in coordination with representatives of the local self government structures (constitutionally mandated to manage the most decentralized health functions and programmes) and evolve **village plans**. Multiple village plans will then need to be integrated or compiled into clusters for each sub-district area and finally gradually amalgamated through a series of similar exercises into a District Action plan. An interactive dialogue between stakeholders and participants at each level will add value to this exercise.

f) Additional **Sources of data for district diagnosis and planning** in different countries of the region. There will be additional sources of data, routinely collected or through special surveys which can provide district and sub-district level disaggregated data which will help this diagnosis and planning exercise. These may include.
   - Population and household census
   - Vital events register – records of vital events such as births, deaths, marriages and divorces
   - Routine health services data dealing with morbidity and mortality data; immunization, disease treatment, out-patient attendance and admissions
   - Epidemiological surveillance data - including immunization records and notifiable diseases
   - Disease registers for specific morbidity and mortality
   - Community surveys undertaken by Government agencies, International agencies, Non-Governmental Organizations, research groups, etc
   - Research studies by academics

g) Towards a focus on **Qualitative data**
   Traditionally the focus of data / evidence gathering for district planning has relied heavily on health systems data be it from an organized HMIS or from monthly reports, clinic and health centre records, stock registers and inventory, survey records and registers maintained and analysed by health team members, - all of which is usually quantitative.

   Nowadays it is considered important that all this quantitative data must be supplemented by active qualitative data / evidence gathering which is through listening, observing and talking to community, community leaders, workers and supervisors. These qualitative evidence must include community / beneficiary / consumer / participant feedback as

also health team / care provider / supervisor / system managers feedback. Many process, values and other significant qualitative challenges in public health management can be identified and addressed only through such qualitative information seen in the context of the qualitative data from the area.

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Further reading

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