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Developing primary health care in Thailand

Innovation in the use of socio-economic determinants, Sustainable Development Goals and the district health strategy

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Abstract

Purpose – The purpose of this paper is to describe progress in an across sectorial approach to primary health care at the district health service (DHS) level in Thailand in response to recent innovative national public policy directions which have been enshrined in constitutional doctrine and publicly endorsed by the Prime Minister. This paper describes one response to the Prime Minister's challenge for Thailand to become the centre of learning in the sub-region in health management.

Design/methodology/approach – The authors utilised a descriptive case study approach utilising an analysis of the Naresuan University initiative of establishing the College of Health Systems Management (NUCHSM). Within that case study, there is a focus on challenges relevant to the socio-economic determinants of health (SOED) and an emphasis on utilising Sustainable Development Goals (SDGs) within the DHS structure.

Findings – The findings describe the establishment of the NUCHSM. A Master of Science (Health Systems Management) by research and a PhD degree have been created and supported by an international faculty. The Thailand International Cooperation Agency recognised NUCHSM by providing scholarships. International students are from Bangladesh, Bhutan, Kenya, Malawi and Timor Leste. Research consultancy projects include two in Lao People's Democratic Republic; plus, a prototype DHS management system responsive to SDG attainment; and a project to establish a sustainable Ageing Society philosophy for a Thai municipality.

Originality/value – The case study on NUCHSM and its antecedents in its development have demonstrated originality in a long-standing international collaboration, and it has been recognised by the national government to provide scholarships to citizens of the countries in the sub-region to undertake postgraduate studies in health management. The concept of learning from each other and together, simultaneously as a group, through action research projects funded to enhance the evolution of DHSs is innovative.

Keywords Primary health care, Sustainable Development Goals, District health services, Socio-economic determinants of health, Health reform

Paper type Research paper

Introduction

According to the World Bank (2017) Thailand "is one of the great development success stories. Due to smart economic policies, it has become an upper middle-income economy and is making progress towards meeting the Sustainable Development Goals". Figure 1 provides an overview of Thailand's performance and the most recent data are available at www.worldbank.org/en/country/thailand. A wider discussion of Thailand's health system in the broader Southeast Asia context is available from Chongsuvivatwong *et al.* (2011).

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- Population 68.86 million
- GNI per capita $ 5,640 (UMIC)
- Health status
  - Life expectancy 78 (F)/72 (M)/74.6 (T)
  - U5MR 12.0/1,000 LB
  - MMR 20/100,000 LB
- Skilled birth attendance 99.6% (2012)
- UHC achieved by 2002 with comprehensive package, almost zero co-payment
- Health Expenditure (2014)
  - THE 4.1% GDP, $ 227 per capita
  - Public source
    - 56% THE, 1.9% GDP (2001) prior UHC
    - 78% THE, 3.2% GDP (2014) post UHC
  - GGHE, 13.3% of GGE (2014)
  - Out of pocket 11.9% of THE (2014)

Sources: http://thailandmap.facts.co/thailandmapof/thailandmap.php; World Bank: www.worldbank.org/en/country/thailand

Figure 1. Thailand at a glance 2016

Of significant importance in our understanding of Thailand is that its population has recently changed from one that has predominantly been typified as having a majority rural and poor population to one that is almost equally balanced between urban and rural populations. The population more than 68m is also ageing with those over 60 years of age at 11.9 per cent in 2010,

and this part of Thai society will become 25 per cent in 2030. Service utilisation of older people is already greater than 2.3 times that of the general population. Health challenges increasingly faced by the under-developed nations are such as non-communicable diseases (NCDs) and risk factors of tobacco, alcohol, high salt and sugar intake (Tangcharoensathien, 2016).

Thailand's health system

Thailand has a national health system, described in Figure 2 whereby central bodies have responsibility for the health system, particularly in policy making, planning and financing, while delivery of services is at the province level substantially through district health service (DHSs) with an emphasis on primary health care (PHC). The organisational structure of the Thai health system sees a Ministry of Public Health (MoPH) as the national health authority. The MoPH is supported by other autonomous health authorities consisting of the Thai Health Promotion Foundation, the National Health Commission with a central role of invoking engagement and participation of all in the development of public policy. The Emergency Medical Institute role is self-evident, while the National Health Security Office (NHSO) has responsibility for universal health coverage (UHC), purchasing and payment mechanisms. The Health Systems Research Institute (HSRI) is responsible for building research capacity (Tangcharoensathien *et al.*, 2016; Tejativaddhana *et al.*, 2016).

Progressive health reform

The earlier mention of the plaudit from the World Bank about Thailand's development is also applicable and can equally be applied to the progress made in the Thai health system over the last few decades. That improvement confirms that Thailand is performing at a higher level than many of its counterpart nations and indeed has been innovative in adopting contemporary health policy into practice (Balabanova *et al.*, 2011; Strasser *et al.*, 2016). This progressive public policy approach and the achievements over time have been significant.

Thailand's health system is based on PHC, and the network of health services provides good overall coverage with solid evidence of its "pro-poor" effect (WHO, 2014). Thailand had become recognised for the creation and now the long-term use of "village health volunteers" (VHV) within local villages and health centres as the first point of contact with PHC and the wider health system. They are citizens trained as the first line of care with a focus on health promotion and prevention (Balabanova *et al.*, 2011).

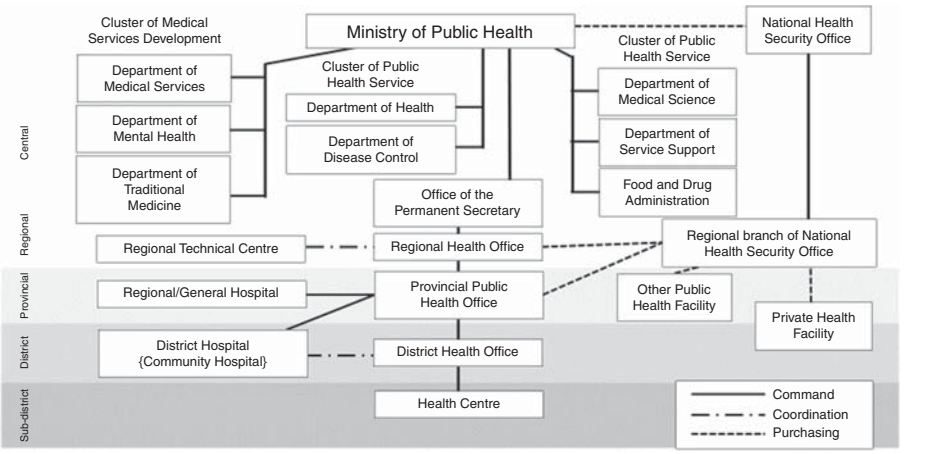


Figure 2.
Thailand's health system

Source: Tangcharoensathien (2015, p. 23)

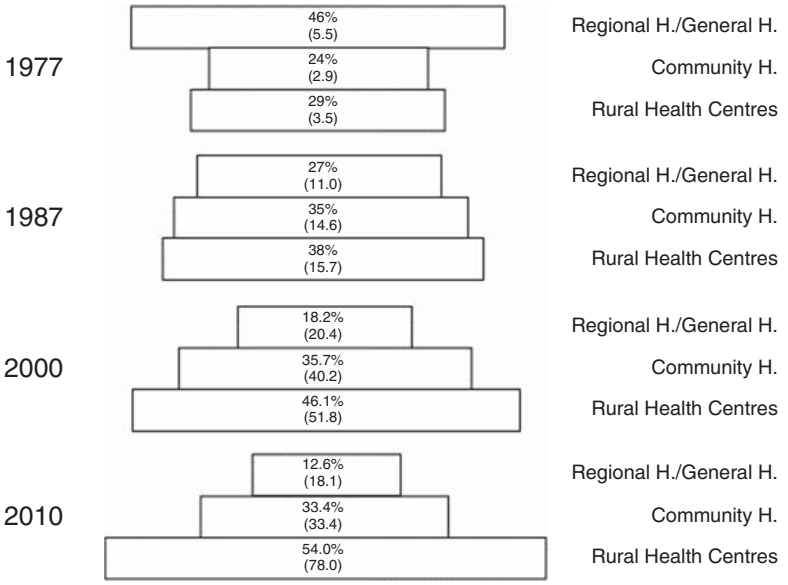
UHC was achieved in 2002 with comprehensive benefits package with free care at the point of service delivery and almost no co-payment. This policy aims to strengthen PHC with a dominant public-sector role in service provision with extensive geographical coverage of DHSs that have become the main contractor for out-patient, prevention and gatekeeping functions (Pongsupap, 2013; Tangcharoensathien, 2016).

Thailand was ranked first amongst the top ten achievers of millennium development goals (MDGs) for MDG 4 (Reduce Child Mortality) performers in the reduction of children under five years of age mortality rate (U5MR) with an 8.5 per cent yearly reduction in mortality during 1990–2006 (Rohde *et al.*, 2008, p. 953). In 2016, the Joint United Nations Programme on HIV/AIDS (UNAIDS) announced that Thailand was the first country in Asia to eliminate mother-to-child transmission of HIV and Syphilis (UNAIDS, 2016).

Perhaps what might be described as the greatest and most recent achievement has been that of convincing Thai society that PHC through the DHS structure is the first point of contact with the health system where previously community hospitals (CHs) and outpatient clinics were the dominant and preferred entry point for most Thais (Tangcharoensathien, 2016). The notable change from the dominant acute outpatient care utilisation to PHC is represented in Figure 3. This significant achievement has been further reinforced in 2017 with the adoption of a new national constitution that clearly states that Thai people will be able to access primary care provided by family doctors (Office of the Council of State, 2017).

Success factors in the development of the Thai health system

Thailand, in both the acute sector and in the PHC system has been an early adopter of health reform internationally as evidenced by the adoption of Australian Diagnostic Related Groups as a costing/funding model for acute care in 2001 was significantly ahead of any general adoption in the Australia's context (Tangcharoensathien, 2015). Second, Thailand is generally recognised as having stable institutional arrangements at the national level irrespective of the often-changeable nature of occupancy at the



Source: Prakongsai (2014)

Figure 3.
PHC utilisation and location service utilisation by level of care: 1970s-2010s

political level. This is strengthened at the policy level by the philosophy espoused by the Late King of Thailand's philosophy of sufficiency economy that proposes moderation, reasonableness and self-immunity set in the context of morality and knowledge. This is espoused as a relatively new philosophy that "aims at improving human well-being as a development goal". This philosophy describes a "middle path" that applies to all levels of society and requires attention to the economic, social and political aspects of society and is particularly relevant to the emergence of Sustainable Development Goals (SDGs) (Mongsawad, 2010, pp. 127-128). The imprimatur of the late King has been reinforced in his practical support of projects that have demonstrated the "way forward", and this approach continues to have consistent, visible Royal support and leadership, particularly in health and education achievement in Thai society.

The other beneficial public policy setting in Thailand that has been pervasive in Thailand's progress is referred to as that proposed by Prof. Prawase Wasi called the "Triangle that moves the mountain". This suggests that the challenge is best addressed in reform agendas by the triangulated use of research-based knowledge; social movement or social learning and political/regulatory approaches. There is a history in Thailand of investment in both research and capacity building before policy adoption (Wasi, 2000; Thammatach-aree, 2011). This is also evident in the Naresuan University College of Health Systems Management (NUCHSM) approach as described in this case study.

The third determinant of success in the progress of health care in Thailand has been the political adoption of PHC as the cornerstone of Thai health care delivery and, more recently the commitment of the Prime Minister that Thais will be able to access care from medical practitioners at the PHC level (Ministry of Public Health, 2016). Thailand, over the past three decades, has increased its medical workforce and "the proportion of rural physicians […] and has reallocated resources to support extensive primary health care systems and to increase access to services" (Strasser *et al.*, 2016, p. 406).

The fourth dimension of success for the Thai health system is the adoption of the concept of DHS as the delivery mechanism for acute and PHC delivery and as the contracting authority for determining the funding directions and allocations. This demonstrates a clear distinction between policy, planning and financing at the national level with an evolutionary delegation for service delivery at the district level (Tangcharoensathien, 2016). While the capacity and capability of the DHS to undertake this role continues to be developed, national policy has also set a higher challenge that planning, and service delivery must be at the "across sector level" that engages not only the DHS but communities, local government, education and other portfolios (Hfocus, 2017).

This approach, being implemented now, is truly innovative and obviously recognises the context and importance of socio-economic determinants in the improvement of individual health and the health of communities. It also recognises the challenges set by the United Nations (UN) adoption of SDGs and the desire of the Thai Government to address the challenges that present (CHSM, 2017a). The innovation discussed below is demonstrated by the establishment of pilot DHS "StartUPs" that embraced cross-sectorial approaches and the utilisation of SOECD determinant data in the NUCHSM research described below and currently underway and at the time of publication. The progress of this research and outcomes has recently been presented to the Minister of Public Health and Administration Board members of the HSRI.

The underlying and recent national policy initiatives will further focus the health systems strategic approach through the desire to achieve the UN SDGs. Of the 17 SDGs established in 2015 there are 169 targets with the specific SDG 3—"ensure healthy lives and promote well-being for all at all ages". In addition, Thailand has recently adopted a 20-year strategic plan and the 12th National Social and Economic Development Plan 2017–2021 (Setthasiroj, 2016). Importantly, the newly established Constitution for the Kingdom of Thailand prescribes that Thailand will "Set up a primary health care system equipped with family physicians in an appropriate ratio" (Office of the State Council, 2017).

The most potent demonstration of the Thai Government's commitment to this process has been the Prime Ministers Statement at the United Nations General Assembly (UNGA) side event on September 2015, where he stated amongst other things that "Thailand's health policies will focus more on prevention than treating patients after they become ill […] and Thailand will be the centre of learning in the region in health management and universal health coverage […]" (Ministry of Foreign Affairs of the Kingdom of Thailand, 2015).

District health services

There are approximately 878 DHSs across Thailand that might serve populations of between 2,000 and 500,000 (Wikipidea, 2017). They essentially include the CH nominally as it has reporting mechanisms through the Provincial Health Office (PHO) to the MoPH and the NHSO. At the same time, the PHC centres (or also called Sub-District Health Promoting Hospitals (SDHPH)) and programs report to the Contracting Unit for Primary Care (CUP) which is the CHs through the District Health Office (DHO). Under the UHC policy, all CHs are assigned to be CUPs. CH and DHO, as well as SDHPH through the order of the MoPH, form the CUP Board to be the organisation that manages comprehensive health care (including primary care, secondary care and referral care to tertiary care institutes) to their responsible population (Taytiwat, 2007). Most of CH directors chair the Board. However, in some districts, CH directors and chief of DHO take turn for their chair positions year by year or every two years. Besides CH directors and chief of DHO, the members of the CUP Board are those representatives from the CH, DHO and SDHPHs. In some districts, they invite representatives from the community such as presidents of local governments (sub-district level), community leaders and VHV.

The structure of CUP Board is very similar to the structure of the District Health Collaborating Committee (DHCC) which is the previous structure before the launch of the UHC policy (Taytiwat, 2007). The DHCC is a platform for those working at CH, DHO and health centres to coordinate their work but was claimed to be ineffective as there is no authority to order or control. The CUP Board seems to have more authority as the CH controls the health budget that supports the CH and the SDHPH. SDHPH reports to the DHO and the DHO reports to the Chief of the District (CD) who is under the management of the Ministry of Interior (MoI) and looks after all the range of public services at the district level. Also, the DHO and the SDHPH need to report to the Provincial Chief Medical Officer (PCMO) at the PHO. The CH does not directly report to the CD but reports directly to the PCMO at the PHO. However, for the general matter, the CH director needs to consult or ask advice from the CD. These co-ordinating mechanisms may appear to be tortuous to the uninformed bystander, but they do reflect current arrangements.

The case study context

In 2016, the MoPH and the MoI together with the NHSO and the Thai Health Promotion Foundation signed the Memorandum of Understanding to pilot 73 districts for setting up District Health Boards (DHB) in which their members come from all sectors in the district including public, private and people sectors (Bureau of Information, Ministry of Public Health, 2016). The major aim of the DHB is to be a platform for encouraging participatory and integrated networking of those in the district to help improve health and quality of life of their population by using people-centred and area-based approach. In 2017, the government expands the project to cover 200 districts. Recently, the Cabinet has approved the draft of the regulations of the Office of Prime Minister on District Committee on Improving Quality of Life on 6 October 2017 (Royal Thai Government, 2017). This regulation will apply to all districts before the end of 2017.

The NUCHSM has been instrumental in the establishment of three research projects demonstrating approaches to DHS innovation, working across sectorial boundaries and focusing on SOECD data and SDG achievement in three projects in six districts, across three provinces. The focus of the studies is the cross-sectorial collaboration through the identification and addressing of a specific health issue. The latter focus in one district

is the ageing population, the second district is focusing on childhood obesity while the third is focused on the DHS StartUp project. The specific outcomes of these projects will be the subject of future published research articles (CHSM, 2017b).

The DHS is a collaborating health system by every sector, not just the health sector in the district. Management style is specific to the context of each district enabling sharing of resources, collaboration through appreciation and affective knowledge management through learning together so that people and communities can be more self-reliant and so "no one will be left behind". The common goal is "for the health of all people" (WHO, 1987). A typical structure that reflects the DHS organisation and relationships is described in Figure 4.

In the Thai context, the DHS is the appropriate level to bridge between policy and implementation, ensuring that health services are close to communities and that proposed service delivery fits local needs. The approach is useful in effective cooperation and distribution of health resources that strengthen coverage and equity of access. Importantly, it is an effective focus for intersectoral collaboration and engagement of other relevant sectors (Saelee *et al.*, 2014; Tangcharoensathien, 2016). The DHS reform underway sees the DHS as the entity that provides access and delivers services in a local context with the aim of improving health and quality of life through a "good health orientated system which 'guarantees access to adequate quality health care for all' ". The reform is focused on developing strong collaborative health networks, improving quality, standards, patient satisfaction and that of health professionals and providing an underlying strengthening of primary care (Tangcharoensathien, 2016).

The challenges faced by the health system and the DHS includes the increased urbanisation of what was previously a majority rural population, the increasing ageing of Thai society that is already demonstrating higher utilisation rates than the general population, addressing risk factors of tobacco, alcohol, high salt and sugar intake. Like many countries, the health challenges have mostly become NCDs and emerging diseases (Tangcharoensathien, 2016).

Responding to the challenges in the District Health Construct

Responding to the challenges to the health system and to the policy initiatives of the government have been extensive and multi-dimensional and reflect extensive

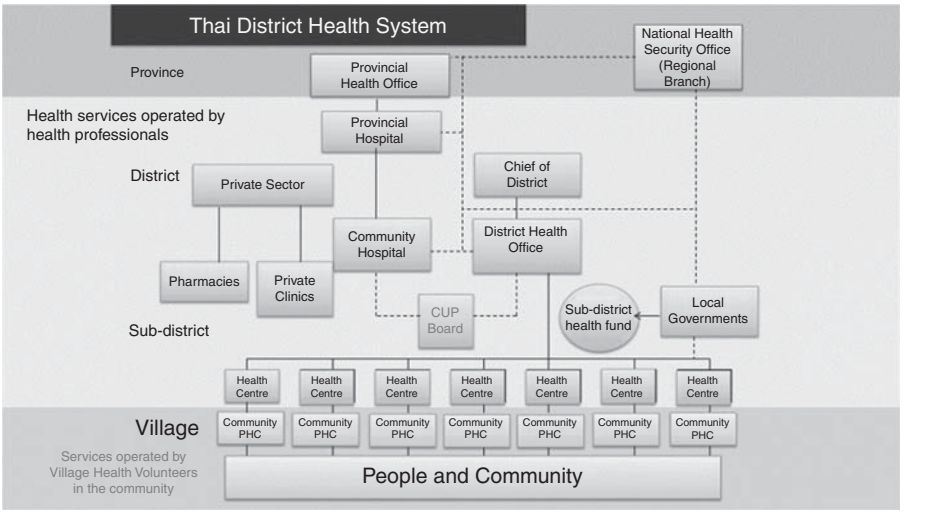


Figure 4.
Thai district health system

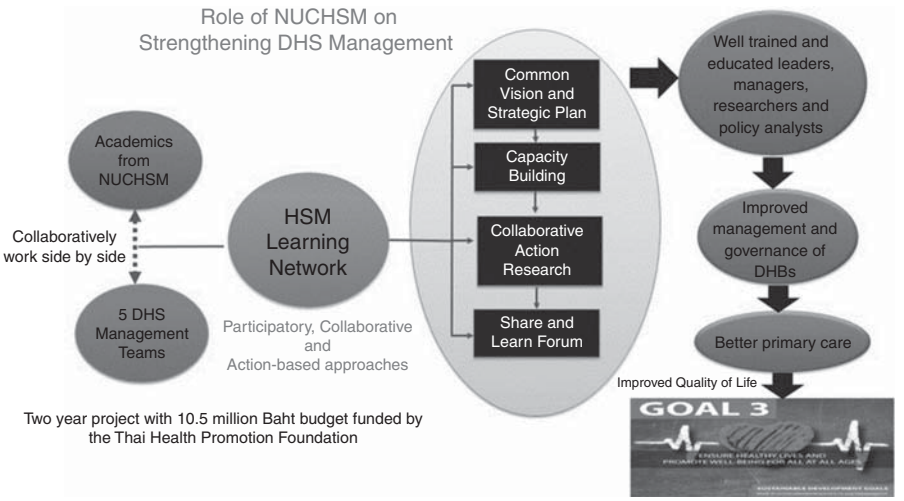
Source: Tejativaddhana *et al*. (2017)

commitments by individuals and organisations over the last few decades. The authors of this case study describe an international collaborative approach that has been developed and is responding to those challenges over the last two decades. The earlier history of this approach had been described as the "Thai-Australian Health alliance" and had an objective, the development of health management capacity and sustainability for PHC services. The extent of co-operation between Thailand and Australian health and education professionals and institutions was extensive and reported elsewhere. This period of the collaboration also saw the principal collaborators conducted the 1st International Conference on Health Service Delivery Management that had some 470 delegates from 17 countries that led to the creation of the Phitsanulok Declaration "which calls for more resources and new policies to promote leadership, good management and governance to strengthen health systems" (Briggs *et al.*, 2010, p. 7).

A further significant outcome of this collaboration has seen Naresuan University, Thailand take the initiative to establish the NUCHSM to provide a unique and positive response to the public health policy initiatives and health reform initiatives described herein. The College was established in 2016 with a vision to establish a "World–Class College of Health Systems Management". The purpose was to be innovative and build on the body of knowledge on health systems management which requires an integrated and multidisciplinary approach and aims to develop academic support activities and to exchange knowledge on leadership, management and governance of health systems, ensuring sustainability of health systems and SDG attainment across Thailand and other neighbouring countries in Southeast Asia and in ASEAN (Tejativaddhana *et al.*, 2016, p. 84). The role of NUCHSM is described in Figure 5.

The early initiatives and achievements of NUCHSM are impressive; A Master of Science (Health Management Systems) by research and a similarly entitled PhD have been established. The College is supported by an International Academic Advisory Committee, and further scholarships have been provided by the Thailand International Cooperation Agency and current students come from Bangladesh, Bhutan, Kenya, Malawi and Timor Leste (CHSM, 2017c).

NUCHSM has also implemented DHS research and consultancy projects that include a project to develop the way forward in Lao People's Democratic Republic (Lao PDR) to ensure the adequate access to needed quality health services without financial hardship,



Source: Tejativaddhana *et al*. (2016)

Figure 5.
Role of NUCHSM

funded by the WHO, a research project to develop a prototype effective DHS management system that is responsive to SDG attainment funded by the Thai Health Promotion Foundation and a project on policy options and guidelines for urban health system development, funded by the Health Sciences Research Institute (Tejativaddhana *et al.*, 2017). Further current projects include a consultancy funded by WHO to strengthen the institutional capacity of National Health Insurance Bureau staff in Lao PDR and a consultancy project funded by Japan International Cooperation Agency (JICA) to establish a sustainable Ageing Society philosophy for Phitsanulok City Municipality (CHSM, 2017c).

Taken as a case study NUCHSM and its antecedents have demonstrated a long-standing international collaboration, a significant international Conference and the Phitsanulok declaration. It has been identified by the national government to provide scholarships to citizens of the countries to undertake postgraduate studies in health management through a concept of learning from each other and together through action research projects funded to enhance the evolution of DHSs.

The way forward admiring the problem or addressing the SOED of health with the SDGs and DHS strategy

Thailand is using DHS as a platform to integrate health and social services and encourage participation of all sectors to work together to improve their local people's quality of life. This approach recognises that cross-sector collaboration, utilising DHS and PHC as the platform, is required to achieve this goal. It also acknowledges the importance of addressing socio-economic determinants of health (SOCEDH), requiring greater than just a health sector approach. The DHS concept can also encourage people-centred and area-based planning and service delivery. Coupled with the concept of Sufficiency Economy Philosophy (Mongsawad, 2010), it is believed that this is one of the ways to bring the achievement of SDGs in the Thai context.

Health is recognised as a precondition to outcomes to the dimensions of sustainable development. Following achievement of MDGs, attention is now turning towards the achievement of SDGs. Strong political commitment, universal health care, an effective, sustainable health workforce and financing system are prerequisites to addressing SDGs (Tangcharoensathien *et al.*, 2015), and Thailand is now well placed in these contexts.

The pre-conditions for Thai PHC had been set as being accessible, comprehensive delivery at home or in centres, coordinated, providing continuity of care and community orientated (Bureau of Primary Care Development Coordination, 2010). Kitreerawutiwong *et al.* (2017) indicate that their research and research of others in international contexts suggest positive outcomes and that, taken with factors of quality of service performance, can provide a useful measurement of PHC performance.

Addressing the specific SDG 3 to "ensure healthy lives and promote well-being for all at all ages" requires an understanding of social justice, the meaning and differences between equity and equality. Social determinants of health are attributable to "inequities to the circumstances in which people are born, grow, live, work, and age, in addition to the health care systems put in place to deal with illness" (Marmot *et al.*, 2012, p. 181). The authors emphasise that this is not just a context for developing countries but one that can be demonstrated in the social gradients in most countries, giving us sub-groups of populations that do not have equality of access and are deprived of equity. Therefore, the challenge before us is to identify those health inequalities that are deemed "avoidable by reasonable means" (Marmot *et al.*, 2012, p. 182).

Addressing the SDG challenges, for Thailand and many others, will require an inter or across sectorial commitment and the health system needs to ensure "UHC access to high-quality health care, an increased focus on prevention and health promotion, advocacy for action on social determinants and research and public policy that evaluates these approaches and increases the knowledge base" (Marmot *et al.*, 2012, p. 183).

Organisational challenges

While District Health Systems are traditionally described in bureaucratic organisational terms as set out in Figure 4, the reality is that the language supporting this approach suggests "networks of services" which in themselves can be considered complex. However, to extend the vision to one that addresses SOCEDH and the attainment of SDGs means, we are developing a complex but adaptive systems approach to the management and delivery of health services.

This offers the possibility to move from the traditional bureaucratic structure with interconnected but siloed services that reflect acute care, primary health care and rehabilitation services to a network that might more accurately deliver patient centred care and flexibly adapts to local community care needs.

Braithwaite suggests that the gaps in siloed service need to be better understood if we want to "bridge policy-practice disconnections, to better secure resources, remedy shortfalls between poor and idealized care, and for clinicians to provide services across the divides of organisation silos" (Braithwaite, 2010, p. 1). This approach and the language that it uses adds challenges, requiring new practices and the learning on the part of health managers. Braithwaite's research and that of others suggest that the new language of health managers is about boundary crossing and spanning, engagement and communication, interpretation and understanding (sensemaking), flexible thinking, managing competing interests, critical thinking, big picture visioning, understanding and managing self (Briggs *et al.*, 2012).

Working in complex systems means developing networks of people to work across organisational boundaries. This "requires critical relationships between people from different programs who need to cooperate and exchange information in complex systems" (Hofmeyer and Marck, 2008, p. 145). These authors take a social-ecological approach to the maintenance and development of social capital within the complexity of health systems that are continually under pressure to perform often without adequate resources and in addressing the demand from increased service utilisation. Social capital refers to human resources, assets, economic resources that provide the productive capacity to achieve goals that make a difference (Hofmeyer and Marck, 2008, p. 146).

The human social capital in complex networked systems requires that advanced leaders and managers might take note of this ecological approach. They need to further consider in their capabilities, the importance of trust and solidarity, collective action and cooperation, formation and communication together with social cohesion and inclusion. These authors also talk in terms of bonding, bridging and linking social capital both horizontally and vertically (Hofmeyer and Marck, 2008, p. 146).

Lasker and Wise report on an innovative approach to broadening community participation in problem solving in the US context. They describe a community health governance (GHC) model as a road map to broader collaborative participation, suggesting barriers along the way as politics of interest groups, the eroding sense of community, limited participation. In increasing a sense of community collaboration, they suggest proximal outcomes that might empower people, bridge social ties between individuals and creating synergy in thinking and action. The authors emphasise the importance of leadership and management in the successful development of this model. Leadership and management are said to be critical and different to organisation or service approaches. In fact, leadership and management might be more diffused and involve a variety of people in both formal and informal roles. Leadership and management are more participatory and need to "promote broad and active participation, ensure broad-based influence and control, facilitate productive group dynamics and extend the scope of the process" (Lasker and Weiss, 2003, p. 31).

Best *et al.* in their "realist review" of large system transformation in health care suggest "five simple rules" to enhance success. These initiatives are "blending designated leadership with distributed leadership, establish feedback loops, attend to history, engage physicians and include patients and families" (Best *et al.*, 2012, p. 421). The Commonwealth Fund in their

assessment of some communities' performance in health systems performance suggests that of those who are performing well the factors that stood out in that performance were that local government acted as catalysts for change, health care and other community organisations cooperated to achieve common goals, data often guided action. Their important conclusion was that "collaboration across sectors—not just within health care—appears to be central to advancing local health system performance in both large and small ways" (Klein *et al.*, 2014).

Conclusion

This paper describes the progress of the Thai health system over recent decades. It demonstrates a variety of progressive initiatives within a case study example that have been timely and innovative. The public policy development has been extensive, and the implementation of reform has received Royal Family support and interest, and the direction has been enshrined in constitutional doctrine and publicly endorsed by the Prime Minister. The current initiative is to progress an across sector approach to PHC at the DHS level. This innovative measure is well supported by the health system at both the policy and local levels. The case study describes the recently established Naresuan University, College of Health Systems Management that has responded to the Prime Ministers challenge for Thailand to become the centre of learning in the region in health management and universal coverage. It has become an international centre for health management research and learning and is attracting students from the sub-region. The College is focused on addressing challenges relevant to the SOCEDH with the SDG and DHS focus by imparting a strong understanding of relevant organisational theory and other theoretical constructs relative to health reform and PHC.

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