Linking households and communities to health systems

A Ugandan saying has it that 'Health is made at home and only repaired at health facilities when it breaks down.' In practice, how can this relationship work better? Francis Omaswa ponders

I have been prompted to share my thoughts – and hope to stimulate a discussion – by a number of recent events. There is an ongoing online conversation moderated by the Global Health Workforce Alliance (GHWA) on 'frontline health workers' that is a spin-off from the multiple meetings on community health workers that we discussed in June and July. In Uganda, parliament refused to pass the national budget until government increased the health budget for recruiting rural health workers. The government accepted this demand and increased the salaries of doctors in rural health centres by four times, surpassing senior consultants and professors! The African Women parliamentarians met in Pretoria in mid-October where the African Center for Global Health and Social Transformation (ACHEST) presented a paper on the tools needed by the parliamentarians to advocate for increasing financing for health especially Millennium Development Goals (MDG) 4 and 5. It is apparent from all these events that gaining more clarity and a shared vision on how complex health systems work for ordinary households could help us to focus our discussion and efforts for better and sustainable results. This is how I see it in the African context.

The statement that 'Health is made at home and only repaired in health facilities when it breaks down' is well known in Uganda. The report and recommendations of the WHO Commission on Social Determinants of Health, and the advocacy for embedding implications for population 'health in all policies', all reaffirm the centrality of linking the way in which people live out their daily lives with consequences for their health outcomes. It is, therefore, an imperative of all effective health systems to be permanently focused on where and how people live, namely: households, communities, and the workplace. Mechanisms for mediating these linkages will vary and are influenced by context. Here is one example.

Growing up in rural colonial Africa I saw an administrator – the local chief who knew the village and ensured that all households complied with the public health act: domestic hygiene with clean homesteads, pit latrines, nutrition, and granaries for food security; checked that girls were old enough to marry; settled disputes for law and order, etc. He was backed up by a professionally trained health assistant who covered a wider area. There was a health facility in the village where illnesses were treated by non-physician cadres.

At its best, the routine governance of society should be the foundation of the health system by ensuring that laws, regulations, and good practice are complied with by all: that homesteads are hygienic, mothers attend antenatal clinics, children are immunised, the nearest health facility has required personnel and supplies, the referral system is in place, the correct food crops are grown and stored properly, all children go to school, the rural road network is maintained, law and order is enforced, etc. This should be the job description of the village or community administrator as the very first frontline health worker. The roles of the general administrative cadres must include and prioritise health and such officials need management skills and authority and not health training. Embedding health goals and aspirations in routine governance of society will facilitate the achievement of health in all policy objectives and address social determinants of health at all levels. Where and how are health workers brought into play at this level?

Health workers at the village or community level should be 'needs based' and with health training sufficient to provide them with the competencies needed. The nearest health facilities should be as close to the communities as possible with linkage to the community-based health workers. These health workers perform in inseparable teams: clinical, laboratory, operating theatre, midwifery, nursing, and outreach. Packages of health services cannot be delivered to the required standard if the teams are incomplete or if some members are less motivated than others. Some of these health worker roles will be sophisticated, undertaking major surgical procedures such as Caesarian sections with highly trained cadres including nurses, laboratory workers, and physicians. These in turn will be linked to a referral system with other facilities providing more specialised care.

Coordination, supervision, and accountability are assured by health technical administrative cadres, general administrators, and political leaders at district, provincial, and national level. Given the above scenario, could we not achieve more sustainable progress by putting more emphasis on securing effective integrated societal governance with health at the centre, focus on tools such as the budget process for resource allocation and monitor for accountability and results? As for health workers, could we not achieve quicker and sustained results if we focus our efforts in establishing effective in-country partnerships.

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