

# Community Health Systems for Primary Health Care

Francis Omaswa looks at the background and justification for community health systems

Community Health Systems (CHS) are a subset of health systems, which are defined by the World Health Organisation (WHO) as 'The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health'.<sup>1</sup> In my own words, health systems are 'The arrangements that society makes to take care of the health of its people'. What is a community? It is defined for the purposes of this discussion as 'A group of people living together in a catchment area and geographic location within a larger region or country.'

The justification for effective arrangements that take care of the health of the population is founded on two premises, namely that health people is a precondition for wellbeing and for living productive lives. Secondly, it is based on the innate human tendency of belonging together and feeling for each other so that the pain and suffering of one or a section of the group is shared and addressed collectively in such a way that 'no one individual or group of individuals is left behind' to suffer alone. The core message in the definitions of Health by both WHO and the Universal Declaration of Human Rights is that it is more than the absence of disease or infirmity; it is about feeling well and being at peace physically and mentally, including having access to the basic human necessities such as food, security and clothing among others, and that these needs constitute human rights.<sup>1,2</sup> Accordingly, the right to life is also the right to health and a right to responsive health system that assures a decent quality of life with dignity, social justice and equity in society. We know that today's connected and globalised world has the knowledge and resources to make this possible but lacks the compassion and the will to make it happen.

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A community health worker providing family planning services

It is therefore our duty to advocate for this until a climate of opinion is created that makes it happen in the same ways that we mobilised and created movements that abolished slavery and conquered colonialism and apartheid.

On top of these powerful moral and humanistic arguments there is new evidence to show that health is no longer perceived as just a cost but that investment in population health has high economic returns and the

health economy contributes to economic growth, employment and Gross Domestic Product (GDP).<sup>3</sup> It is now argued with evidence that this is the best investment. Indeed the purpose of all Sustainable Development Goals (SDGs) is to contribute to wellbeing and health of people and our planet. Last but not least voters value their health and there

are political implications on investing in the health and wellbeing of the population politically.

## CHS strategies from Alma Ata to Astana

In 1978, leading thinkers and governments met in Alma Ata capital then of the Soviet Republic of Kazakhstan and proclaimed the Alma Ata Declaration of Health for All by the year 2000 through Primary Health Care with the following key elements.<sup>4</sup>

- The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.
- Primary health care is essential health care made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development.
- The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.

On the 40th Anniversary of the Alma Ata Declaration in 2018, the world health leaders convened again in Astana, the new capital of independent Kazakhstan, and reaffirmed the original Primary Health Care (PHC) principles. The Astana Declaration<sup>5</sup> acknowledged that Universal Health Coverage (UHC)<sup>6</sup> is the approach for achieving SDG 3 on health and wellbeing through the life course and that the foundation for UHC is PHC achieved through the following five enabling action points in:

- UHC is a political choice taken by governments to provide citizens with the health services that they need without financial embarrassment. Strong Government leadership is needed to bear the responsibility for ensuring that the conditions and systems exist that allows people to be as healthy as they can be. These conditions include enabling laws, regulations, access to the healthy food, clean water, decent housing and education by marshaling actors from across all sectors to work for health.
- Building sustainable primary health care based on informed, empowered and accountable citizens. Ownership and active participation by the people in co-designing their services based on locally generated solutions and making the best use of available resources for their level of economic development. Empowering individuals and communities is based on the premise that good health starts with, and is created by individuals, their families and the communities, and is supported, where necessary, by skills, knowledge and technology of the professionals. Individuals have the primary responsibility for maintaining their own health. Indeed health is inborn with inbuilt self-regulating physiological mechanisms that ensure that wellbeing is maintained within defined parameters. The slogan that 'Health is made at home, and only repaired in health facilities when it breaks down' applies here. The health system supplements individual responsibility by providing the services, information and facilitating behaviors that individuals need to achieve their best health. According to Miriam Were, 'if health development does not happen in African communities, it will not happen in African nations. And if health development happens in African communities, it will happen in the nations'.<sup>7</sup>
- Aligning stakeholder support to national policies, strategies and plans that contribute to UHC and PHC is critical to success of PHC and UHC. Health affects and is affected by everything and cannot be treated just as a separate department or enterprise. Health has to be part of all policies and integrated into the national development vision and plans. According to WHO 'social determinants of health are the conditions in which people are born, grow, live, work and age'<sup>8</sup> and need to be factored in when health and other plans are developed and implemented across sectors.

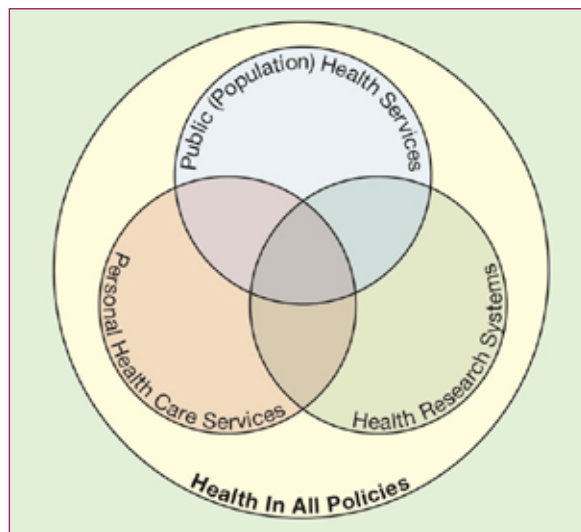


Figure 1: Health systems

- An Implementation plan for the Astana Declaration is necessary and has been developed and will be submitted to the next World Health Assembly for adoption next month. The failure of the Alma Ata Declaration to take root in countries has been attributed to the absence of an implementation plan that is agreed to by all stake holders. The availability of an implementation plan will fill a gap that impacted negatively in the case of the Alma Ata Declaration. It will make it possible for progress to be monitored during implementation.

### Design priorities for CHS

Figure 1, from a report entitled 'Strong Ministries for Strong Health systems'<sup>9</sup> presents overlapping priority areas in the design of effective health systems namely:

- Public or population health services protect the population from health risks by providing information and identifying and removing health risks from the population. This is also known as health promotion and disease prevention. It includes the passing of laws, bye laws, and regulations to guide health seeking behavior among the population.
- Personal health care services involve direct interaction with individuals and families who have specific health care needs. This included treating acute and chronic illnesses, providing family planning services, antenatal and maternity care and counseling as examples.
- Health information and research services are needed to generate data and information for planning and decision making. Such data should be disaggregated by geographical locality, gender, age and income levels among others. Research and data is also needed to evaluate the performance of the health system and enable adjustments on an ongoing basis.

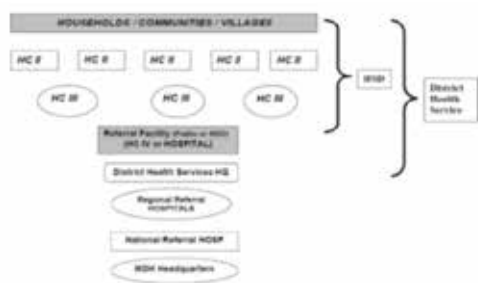


Figure 2: National health service delivery structure

The health workforce for CHS should be an integral part of the national health workforce policy and plans.<sup>8</sup> They should have well-defined roles, training and terms of service including remuneration that provides for supervision and support from more skilled members of the health workforce. CHWs are drawn from the community and may have different skill sets and all should have opportunities for career progression.

**Scope and structure of CHS**

SDG 3 states: ‘Ensure healthy lives and promote well-being for all at all ages’ and this implies that the community health system will design interventions that respond to the needs of neonates, infants, children, adolescents, youth, middle and end old age.<sup>10</sup>

The first step is the to undertake research and make a community diagnosis which refers to the identification and quantification of health problems in a community as a whole in terms of mortality and morbidity rates and ratios, and identification of their correlates for the purpose of defining those at risk or those in need of health care. Special attention will need to be accorded to each population age group in order to address their particular needs in their homes and in the community. The Community diagnosis should be made with the full participation of members of the community.

As illustrated in Figure 2, the CHS structure comprises households, communities and villages. It also includes physical health facilities that provide support, oversight for personal and public health services to households and families in a defined catchment geographical area and population. These are known as Health Sub-districts or District Health systems.<sup>11</sup>

Following the community diagnosis, a minimum health care service package to be provided should be defined for all age groups. Service Standards at all levels especially household and community level should be agreed, costed and implemented with affirmative action for vulnerable groups. Financing arrangements should ideally be from the tax base but can also be from appropriate community insurance schemes so that payment at the point service should be avoided for access to the minimum package of services.

**Governance of CHS**

Management should ensure that the quality of services provided is acceptable to the population. A management approach that entrenches continuous quality improvement of services delivery is ideal as it enhances

client participation and demand for quality of health services. The management of the health workers and facilities should involve the community to assure ownership and sustainability. The use of data for performance improvement should be institutionalised. Technology provides great opportunities for countries to leapfrog eHealth development to strengthen the CHS.

CHS easily lend themselves to inter-sectoral collaboration and integration. At its best, the routine governance of communities should be the foundation of the community 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 are going to school, the rural road network is maintained, and law and order is enforced. This should be the job description of the village or community administrator as the very first frontline health worker. This village administrator has capacity to collaborate with community based public servants, community-based civil society organisations and religious and cultural leaders to ensure that the health of the people is given the highest priority.

**Conclusion**

The international community has committed to UHC that leaves no one behind so that ‘All people obtain the good-quality essential health services they need without enduring financial hardship.’ The targets are that ‘By 2030, all populations, independent of household incomes, expenditure or wealth, place of residence of gender, have at least 80% essential health services coverage. By 2030, everyone has 100% financial protection from out-of-pocket payments for health services starting with those who are farthest behind.’

It is therefore incumbent on all of us to get engaged in advocacy and action for health and wellbeing, starting with ourselves and our families followed by our communities and countries and eventually globally. Our duty individually and collectively is to work to create a climate of opinion that will make it a political imperative for all communities and countries to build sustainable community and national health systems for the health and wellbeing of all people everywhere.

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