Reaching households

Africa's most effective route to UHC

In the April 2019 issue of this journal, we discussed Community Health Systems and how they can be organised to 'leave no one behind' through embracing multisectoral action and integrating health into the routine governance of communities. What we did not discuss is how this happens in practice.

We pointed out that the international community has committed to UHC 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 or 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.'

Further, during the Special Consultation on Governance for Health in Africa convened by ACHEST in July 2019, the proceedings of which are published in the July 2019 edition of this journal, concern was expressed that Africa may miss the opportunity offered by SDGs in a similar way in which we missed the aspirations at independence of ridding Africa of disease poverty and ignorance, unlike South Asian countries that had similar development indices but made better progress.

As a young doctor I recall my senior colleagues saying that the Alma Atta Health for All Declaration was 'a soft-headed unrealistic dream'. I know people who are saying the same about SDGs in Africa. However, I am not one of them. I am convinced that Africa can achieve the SDGs if the emphasis shifts to reaching households through community health systems and integrated primary health care applying the currently available resources in each country. Here is an example of how to reach households that we designed for the Uganda Health Policy and Strategy of the year 2000.

That Health Policy and Strategy in Uganda recognised the critical need to mobilise families and communities as the cornerstone of health promotion and disease prevention as 75% of the disease burden was due to preventable infectious diseases. The key guiding principle is that health promotion and disease prevention should be integrated into the routine governance of communities. Accordingly, a structure named the Village Health Team (VHT) was established alongside the elected village Local Council that is responsible for the overall governance of the village.

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The Local Council governs each sub parish of 5,000 residents and each has a VHT which has nine elected members from the village of whom at least 30% are women; including Local Council member in charge of Women and Child affairs. One of them is designated as the Community Health Worker and is the coordinator of the VHT and links the VHT to the nearest health facility.

The designated CHW of the VHT was to be equipped with a uniform, a bicycle, an essential medicines bag and a book that serves as the village health register (mobile phones were not widespread at that time).

Illustrative activities prescribed to be undertaken by the VHT include: Making a map of the village, maintaining the village register with a record of the health status of each family, observing the health practices, hygiene, and health condition of household members and sharing information and advice on healthy living. The clinical work includes follow up with patients at home, saving lives by recognising danger signs in individuals, referring people needing health care to health unit, ensuring that all children are immunised and counseling every pregnant woman about timely ANC visits, newborn care including timely post-partum checks.

The VHTs also report on suspected infectious diseases outbreaks and importantly the VHT serves as the link between the village and the nearest health facility

The VHT programme in Uganda that we launched in 2001 had some significant birth injuries. At that time Uganda was heavily donor dependent and the donors were not supportive of this program and refused to fund it, including the paying the allowances of the Community Health Worker. Nevertheless the VHTs were established in the whole country and have made positive contributions as volunteers. Allowances were occasionally paid for example during immunisation drives. For example, the programme was key to the control of the Ebola outbreak in Uganda during 2000/01. They were responsible for contact tracing reporting of suspected cases and follow up and integration of those individuals discharged from the Ebola treatment facilities into communities. There are many positive reviews of the performance of the VHT programme in Uganda, including one that was commissioned by the government.

I chose to present the case of the VHTs in Uganda to illustrate my conviction that reaching households using various country customised approaches is not only feasible but is also the cheapest and the quickest route to UHC and the achievement of not only SGD3 on health but other SDGs as well. Mobilised communities for health will be prepared to own and discuss all other issues and take charge of the quality of their lives and hold higher level duty bearers accountable.

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