Communities, universal health coverage and primary health care

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Abstract Universal health coverage (UHC) depends on a strong primary health-care system. To be successful, primary health care must be expanded at community and household levels as much of the world’s population still lacks access to health facilities for basic services. Abundant evidence shows that community-based interventions are effective for improving health-care utilization and outcomes when integrated with facility-based services. Community involvement is the cornerstone of local, equitable and integrated primary health care. Policies and actions to improve primary health care must regard community members as more than passive recipients of health care. Instead, they should be leaders with a substantive role in planning, decision-making, implementation and evaluation. Advancing the science of primary health care requires improved conceptual and analytical frameworks and research questions. Metrics used for evaluating primary health care and UHC largely focus on clinical health outcomes and the inputs and activities for achieving them. Little attention is paid to indicators of equitable coverage or measures of overall well-being, ownership, control or priority-setting, or to the extent to which communities have agency. In the future, communities must become more involved in evaluating the success of efforts to expand primary health care. Much of primary health care has taken place, and will continue to take place, outside health facilities. Involving community members in decisions about health priorities and in community-based service delivery is key to improving systems that promote access to care. Neither UHC nor the Health for All movement will be achieved without the substantial contribution of communities.

Introduction

The achievement of universal health coverage (UHC) depends on a strong primary health-care system that can provide essential health services for the entire population. Primary health care is especially important for people who have limited access to high-quality health care because they are socially or geographically disadvantaged. Although primary health care offers a feasible and equitable route to UHC, success depends on expanding primary health care at community and household levels because, for much of the world’s population, local health facilities are still too far away to ensure convenient access to basic health services. In a 2017 report on UHC, the World Health Organization (WHO) and the World Bank concluded that over half of the world’s population lacks access to basic health services and that over 100 million people are forced into poverty annually because of health expenses, including the cost of transportation. Although improving the quality of facility-based care is necessary and may itself lead to some increase in utilization, the reality is that the cost (in terms of time, effort and money) of reaching distant facilities means that, for the foreseeable future, UHC cannot be achieved through health facilities alone. There is abundant evidence that community-based services are effective in improving health care utilization and outcomes, especially for maternal, newborn and child health, when they are integrated with facility-based services.

Furthermore, primary health care needs to be comprehensive, of a high quality, people-centred, affordable and truly accessible to all. The Declaration of Alma-Ata asserts that primary health care can meet most of an individual’s health needs through the basic preventive, promotive, curative and rehabilitative care provided by low-level health workers (including community health workers, CHWs). These workers can function in teams close to people’s homes and often outside of health facilities. In a well-coordinated primary health-care system that truly operates across all health-care levels, patients with conditions that require specialist care can be referred to a higher care level, as needed. The Declaration advocates “community self-reliance and participation to organize, plan, operationalize and control health services and address the social determinants of health.” In 2018, in acknowledgement of the continued lack of universal primary health care, the Alma-Ata principles were reaffirmed at a global conference in Astana, Kazakhstan.

Communities are “groups of families, individuals and other types of networks and social circles that provide support and are often the unit on which health activities are organized and focused.” Data show that community members and community-based organizations can be effective at identifying health priorities, addressing health concerns, managing financial and personal processes at the local level, and evaluating health systems and holding them to account. Local organizations trusted by the community can also be essential for guiding interventions aimed at behavioural modification and for facilitating adaptation to changing environmental, demographic and epidemiological conditions.

Communities can consist of a wide and diverse set of actors, from geographically defined groups and local governance structures to users of health services. Communities are difficult to study, they are not monolithic or homogeneous and they can even be oppressive when conformity is demanded or local elites are in control. Nevertheless, they are entities with agency that must be engaged with by the formal health system. Acknowledging this lack of homogeneity entails recognizing the unique nature of participating community members and organizations, each with their own capabilities, resources, needs and interests.

Some communities are transient, mobile or even virtual. They may change over time, with shifting membership, scope...
and priorities. In addition, changes may occur within community organizations as skills are gained and new challenges are tackled. Thus, new research approaches may be required to assess the attributable impact of community involvement in primary health care and the changes it can bring about. Communities may also have longstanding traditional power structures that do not promote the inclusion of marginalized people, such as women, ethnic and linguistic minorities, oppressed tribes or castes and the most economically disadvantaged. Addressing inequity requires paying explicit attention to power, for example by recognizing previously unacknowledged barriers to community participation and seeking types of knowledge that have not historically been given primacy.

Individuals and communities – the most important stakeholders in the health system – must be enabled to demand a health-care system that is responsive to their needs and concerns and that works collaboratively to improve their health and well-being. Consequently, policies and actions for improving primary health care must regard community members as more than passive recipients of health care. Instead, they should be seen as leaders who have a substantive role from the beginning of planning to decision-making, implementation, evaluation and evidence-based iterative learning. This includes addressing power imbalances that limit the ability of communities to participate and restrict which community members can participate, while acknowledging differences in power and civic participation within communities. Powerful community members may monopolize the process of community engagement for their own gain, thereby reinforcing existing intracommunity power asymmetries. Addressing internal and external power imbalances is difficult; a conscious effort must be made to promote equitable involvement by the whole community. Moreover, some community members may be preoccupied with other concerns and have little time or resources to spare. Nevertheless, identifying the priorities of different community members, including those not typically consulted, through rigorous participatory research not only increases enthusiasm in the community but also respects local knowledge of urgent needs and capabilities.

Community involvement
Community involvement is the cornerstone for developing local, equitable and integrated primary health care. The pillars of primary health care include: (i) empowered people and communities; (ii) a focus on equity; and (iii) multisectoral policy and action. Successful primary health care requires evidence-based interventions at the community level (by outreach teams from health facilities as well as trained community members) coupled with deliberate efforts to provide care for marginalized people. Community members and organizations can have active roles in providing services, promoting healthy behaviour and linking people to care (Table 1).

One example of the stalemate that health interventions can encounter when they lack community support and trust was a polio eradication initiative in Uttar Pradesh, India, where pockets of persistently unvaccinated children impeded progress towards elimination of the disease. Intensive community engagement by the CORE Group Polio Project, which started in 1999, ultimately led to a broader range of maternal and child health services being provided for marginalized and predominantly Muslim families who had not participated in previous polio immunization campaigns. In effect, collaboration with the community and the actions taken in response to their specific needs resulted in greater participation.

Addressing the burden of maternal and neonatal conditions, infectious and chronic, noncommunicable diseases and the drivers of these disorders, such as pollution, migration, conflict and climate change, requires action at global, national, subnational and local levels. However, change must begin in households. In Ethiopia, a health extension programme trained and deployed 38,000 paid CHWs between 2003 and 2008. Soon after, the programme set up a women’s development army of 3 million volunteers who focused on community action and behavioural change to promote clean water, sanitation, good nutrition and healthy behaviours. Each volunteer worked with a group of five female neighbours to establish the conditions necessary for them to achieve “model household” status. However, even in a large, institutionalized programme like the one in Ethiopia, the needs of CHWs must be recognized and properly provided for. High levels of stress and distress were observed among volunteers, from whom, “much was asked but to whom little was given.”

High-quality health systems must include mechanisms for monitoring, evaluating and adapting. In particular, ensuring good primary health-care coverage requires robust documentation on service utilization and population health, especially for marginalized populations and places affected by disease outbreaks, conflicts or other disasters. Participatory, community-based, health information systems can complement facility-based records in providing better understanding of health among often-overlooked groups. In the slums of Freetown, Sierra Leone, community data review committees used data from a participatory, community-based, health information system to recommend changes and to hold health facilities and governments to account.

Although community groups may be involved in health planning or implementation in some capacity, unless they have authority and resources, they may have little power to set priorities, tailor interventions or effect change. In 1994, the government of Peru embarked on a health system reform programme that aimed to increase access to primary health care through decentralization and community participation by creating administrative entities called Comunidades Locales de Administración en Salud (CLASs; local health administration communities). These groups managed the local health budget, oversaw health service delivery and facilitated community development projects. Official contracts between community groups and the national government can help ensure resources are continuously available but frequent contract renewals, variations in the budget and weak oversight can threaten these partnerships. Further, the way individuals are selected for the local management committee will have implications for its representativeness and for the community’s willingness to accept group decisions.

Metrics and frameworks
The metrics used for evaluating primary health care and UHC largely focus on clinical health outcomes and the inputs and activities necessary for
achieving them. Frequently, less attention is paid to indicators of equitable coverage or other measures of overall well-being, ownership, control and priority-setting within the health-care system, or to the extent to which communities have agency. With some notable exceptions, efforts to engage communities in assessing and improving the quality and coverage of primary health-care programmes have not been well documented. In the future, more comprehensive metrics need to be used when evaluating the success of efforts to improve primary health care and UHC. Metrics for consideration include: (i) the degree to which communities contribute to formulating programme priorities; (ii) the degree to which community members are involved in supervising CHWs and the effect this supervision has on their performance; (iii) the presence and effectiveness of committees responsible for overseeing local health facilities; and (iv) the level of engagement of volunteers in community health activities.

Advancing the science of primary health care requires better conceptual and analytical frameworks and research questions. Many scholars, policymakers and programme implementers have noted that existing frameworks have a limited ability to address community health questions and that new approaches to obtaining evidence are needed. The conceptual framework proposed by WHO’s Commission on Social Determinants of Health provides a valuable way of monitoring and understanding feedback loops in the social determinants of health and emphasizes the context in which people and interventions are operating. However, it lacks an explicit focus on the role of the community in addressing inequities. Recently, a proposed expansion of WHO’s building blocks framework differentiated community-based service delivery from community mobilization and organization. The proposed expansion also called for greater recognition of nontraditional aspects of the health system, such as social capital, intersectoral partnerships, local governance, equitable financing, community information and data systems, and of the role of households in producing and maintaining health. Guiding frameworks, such as the Primary Health Care Performance Initiative’s conceptual framework, also expanded many of WHO’s building blocks (such as the service delivery portion of the logic model) to tease out nuances in the processes necessary for achieving the desired community outputs and for improving population health. Finally, in 2018 the Declaration of Astana’s operational framework expanded the vision of the 1978 Alma-Ata Declaration to include a set of “levers” for community engagement and primary health care-oriented research.

Much of primary health care has taken place, and will continue to take place, outside health facilities, often in homes (where mothers and families usually care for ill children) and at local community health posts. Involving community members in decisions about health priorities and strategies

Table 1. Selected programmes promoting community involvement in primary health care, worldwide, 1994–present

| Characteristic | Programme |
|---------------|-----------|
|               | CORE Group Polio Project)* | Ethiopia’s health extension programme)* | Sierra Leone’s participatory community-based health information system* | Local health administration by communities (CLAS)* |
| Timeframe     | 1999 to present | 2003 to present | 2015 to present | 1994 to 2008* |
| Context       | Rural and Muslim communities in Uttar Pradesh, India | Rural communities in Ethiopia | Slums in Freetown, Sierra Leone | Nationally in Peru |
| Challenge     | Low vaccination rates associated with communities’ lack of trust in a polio eradication campaign and in the government health system | Lack of healthy behaviour change by households despite the deployment of a national cadre of professional CHWs | Routine health records and information incomplete and underutilized | Health priorities and resource allocation had been established without local input |
| Main actors   | CORE Group Polio Project (a consortium of NGOs with national technical input) and community leaders | Government of Ethiopia and a large volunteer women’s development army | Government of Sierra Leone, NGOs and community development groups | Government of Peru and local entities created to oversee health budgets and activity (i.e. CLASs) |
| Community’s role | Sharing community concerns and collaborating with community leaders to identify solutions | Volunteers work with their neighbours to teach and provide a role model for basic health and sanitation behaviours | CHWs collect health information, which is reviewed by community data review committees at bimonthly meetings | Community control over budgeting and the distribution of funds |
| Outcome       | Increased participation in and understanding of polio eradication activities, expanded health services and greater government responsiveness to community health needs | “Model household” status achieved by many throughout the country | Increased community capacity to use data and take the appropriate actions | Transparent financial management and decentralized priority-setting |

CHW: community health worker; CLAS: comunidades locales de administración en salud; NGO: nongovernmental organization.
* The programme was modified from its original form in 2008.
for service delivery is key to improving systems that ensure access to care.20 Even in challenging circumstances, such as in the urban slums of Free-town, Sierra Leone, which were dealing with Ebola virus disease and cholera epidemics, local neighbourhood committees supported CHWs and primary health-care activities.21 More research is needed into: (i) the role community engagement plays in fostering trust in local health services; (ii) whether local epidemiological data gathered by CHWs and given to communities can improve healthy behaviours and the utilization of health services; (iii) how best to distribute the responsibility and burden of community engagement among community members; and (iv) which policies can increase community participation. The critical roles of health education and of social, behavioural and structural interventions should not be underestimated. More investment is needed in health policy and systems research to identify the larger societal and contextual determinants of health and health systems dynamics.

Building the evidence

Achieving UHC and Health for All, as proposed in the Alma-Ata Declaration, requires the entire population to have access to high-quality, basic and essential services and protection from financial harm.2 Patients who feel their needs are not being met, that they are being mistreated by the health system or that the quality of the service is not worth its cost may not seek further care and may discourage others from seeking care.23 As a patient’s experience of care quality depends on expectations, the views of community members and health service beneficiaries are paramount for setting the context within which the quality of a health system can be assessed and improved. Moreover, the provision of health care to everyone through primary health care entails reducing, if not entirely eliminating, health-related inequities. Access to health care must be evaluated in multiple domains, such as geographical accessibility, financial affordability, and patient and provider acceptability.24,25 Any examination of the effect of a programme on health equity must not only measure the equity of service utilization in terms of the users’ economic status but must also take into account social parameters, such as ethnicity, gender and educational level.26 Although community-based primary health care can be more equitable than facility-based care, equity must be monitored over time as programmes evolve, secular trends occur, and the circumstances and preferences of community groups and members change.27

In 2017, an expert global panel that reviewed a synthesis of the evidence on community-based primary health care recommended that it should be a priority in any primary health-care strategy.28 In addition, a modelling study based on evidence about the effectiveness of interventions for mothers and their children indicated that expanding coverage of evidence-based community services would save more lives than expanding coverage only of the services that must be provided at health centres and hospitals.29 The case for integrated, multilevel systems is further strengthened by reports that sustainable, effective, health-care programmes require collaboration between the formal health sector and communities.30 There is also strong evidence supporting programmes that integrate health services with organizations that promote health education and empowerment, such as women’s groups.31,32 Another example of the role communities can play is participation in management and oversight committees for health and district planning, where community members can make up the majority, or even the entirety, of governing boards that provide practical guidance and have decision-making authority.33 In the United States of America, such committees serve as the boards of directors of federally qualified health centres, of which there are now more than 6000 serving over 20 million people.34 In Peru, CLAS committees oversee the activities of primary health care centres and their outreach programmes in one third of the country.35

Improving primary health care requires a multisectoral approach that involves addressing the social, physical and structural determinants of health that the health system cannot address effectively itself, such as poverty, educational inequalities, gender inequities, access to water, sanitation and a hygienic environment, safe and reliable transport, and government policies that promote health. Consequently, the complexity of population health demands that we look beyond formal health facilities and beyond the health sector itself when seeking improvements.36 Programmes that take a holistic approach to health – for example, women-focused poverty alleviation programmes that include both government and civil society institutions – have produced clear improvements in child mortality and reduced inequity.37,38 In addition, CHWs (who are known by many names and acronyms) are a recognizable and often essential part of health systems. In many situations, they serve as the primary providers of community-based primary health care. The many elements of service delivery provided by health workers in the community must be planned, funded, regulated, monitored, evaluated and improved.39 Thus, as CHW programmes for improving primary health care increase in scale, more attention should be given to health workers’ competence, the sustainability of their roles and proper compensation. A recent review of national programmes for CHWs provided comprehensive details about 29 initiatives identified.40

Evidence linking community engagement with improvements in health outcomes still remains “situation-specific…unpredictable, and not generalizable.”41 Nevertheless, lessons can be learnt from research on smaller, community-focused projects: investigating how actions undertaken within primary health-care systems produce the desired activities and outputs can be instructive for designing and implementing larger-scale systems. Community meetings and local organizations are critical for reaching service delivery targets and for optimizing improvements in health, especially when they form part of a dynamic and iterative agenda that changes in response to ongoing dialogue and regularly reflects progress and revised goals.42 The extent to which communities are included, and play a leading role, in progress towards UHC is political. Community involvement is essential for maximizing coverage of primary health care and achieving Health for All.43 The most recent Disease Control Priorities report stated that, “Without initiatives to help community health platforms flourish around the world, the health gains promised by interventions will cost more and deliver less… With the availability of local data, local forums for sharing data, and local multisectoral stakeholder engagement, the solutions will work better and deliver more.”44 To deliver UHC for all efficiently, primary
health care must be advanced in partnership with communities.

**Conclusion**

Community involvement in primary health care is essential for achieving UHC and Health for All because, in practice, primary health care begins in the household and community. Similarly, research to guide, and demonstrate the value of, an orientation towards communities also requires meaningful community leadership and participation at all stages in the process of increasing access to, and improving the quality of, health services. Neither UHC nor Health for All will be achieved without the substantial contribution of communities.

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sanitaires et la fourniture de services communautaires est essentiel pour améliorer des systèmes qui permettront de promouvoir l’accès aux soins.

Resumen

Comunidades, cobertura sanitaria universal y atención primaria de salud

La cobertura sanitaria universal (CSU) depende de un sistema de atención primaria de salud sólido. Sin embargo, la atención primaria de salud se debe ampliar a nivel de la comunidad y de los hogares para que logre resultados efectivos, ya que gran parte de la población mundial sigue sin tener acceso a los centros de salud para recibir los servicios básicos. Existen muchas pruebas que demuestran que las intervenciones basadas en la comunidad son efectivas para mejorar el uso y los resultados de la atención de la salud cuando se integran con los servicios que se prestan en los centros de salud. La participación de la comunidad es el elemento fundamental de la atención primaria de salud local, equitativa e integrada. Las políticas y las medidas para mejorar la atención primaria de salud deben tener en cuenta que los miembros de la comunidad son más que receptores pasivos de la atención de salud. Por el contrario, deben ser líderes con una función importante en la planificación, la toma de decisiones, la implementación y la evaluación. El progreso de la ciencia en la atención primaria de salud requiere mejorar los marcos conceptuales y analíticos y los temas de investigación. Los parámetros que se usan para evaluar la atención primaria de salud y la CSU se centran en gran medida en los resultados clínicos de la salud y los recursos y las actividades que permiten alcanzarlos. Se presta poca atención a los indicadores de cobertura equitativa o a las medidas de bienestar general, propiedad, control o establecimiento de prioridades, o a la medida en que las comunidades participan activamente. Por consiguiente, las comunidades deben participar más en la evaluación del éxito de los esfuerzos por ampliar la atención primaria de salud en el futuro. Gran parte de la atención primaria de salud siempre ha tenido y seguirá teniendo lugar fuera de los centros de salud. La participación de los miembros de la comunidad en las decisiones sobre las prioridades sanitarias y en la prestación de servicios comunitarios es fundamental para mejorar los sistemas que promueven el acceso a la atención, ya que ni la CSU ni el movimiento Salud para Todos se lograrán si las comunidades no contribuyen de manera sustancial.

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