Achieving Improved Primary Health Care and Universal Health Coverage through community led responses and Community Empowerment: A Proposition for East Africa, Uganda.

The present-day focus in health systems around the world has embraced Universal Health Coverage (UHC) approach to improve accessibility to quality and affordable healthcare for all nations' citizenries regardless of their income stratas. But is the UHC global stratagem grounded adequately to address the crisis in access to crucial healthcare services chiefly in low and middle income nation-states? At least half of the world's population still doesn't have full coverage of essential health services[1] due to the exclusion factors molded in the high cost of treatment. Case-in-line is Uganda with a high out of pocket (OOP) payment rated at 40.5% in private health expenditures (OOP)[2]. On average the government of Uganda spends as little as three thousand Uganda shillings (UGX 3000) or 0.82 US Dollars per Ugandan monthly[3] way below the recommended 86 US Dollars per year. Considering an initial threshold of 10% of household income, about 23% of Ugandan households face financial ruin. Based on both US $1.25 per day recommended by the World Bank[4] and the Ugandan poverty lines are at 4% showing that people are further impoverished by such payments. This represents a relative increase in poverty head count of 17.1% and 18.1% respectively[5].

In order to deal with the malignant discrepancy of health outcomes as well as health care utilization across different socio-economic strata both across and within countries, public health experts coined the concept of Universal Health Coverage. By UHC we mean a health financing system which ensures that all people have access to required health services without suffering financial hardship while paying for it[6]. There is a need as recommended by WHO[7] that the model of service delivery and package of services offered through primary health care to achieve UHC should vary according to local needs and health priorities shaped in inclusive and non-discriminatory approaches that embrace diversity. One of the essential functions of primary health care is to coordinate service delivery across the whole spectrum of health and social care services, including sub-specialized medical care, long-term care and social care, through integrated, functional, and mutually supportive arrangements (including referral systems) for transitions and information sharing along evidence-based care pathways.

This correspondence seeks to ensure that the hard to reach communities and the furthest behind are considered. UHC is one such approach we need to interrogate considering market based

[1] Universal Health Coverage, January 24, 2019 World Health Organization
[2] WHO. (2019). Out-of-pocket expenditure as a percentage of current health expenditure (CHE). Geneva: WHO (Global Health Observatory (GHO) data).
[3] Emmanuel, A. (2018, April Tuesday). Out of Pocket Expenditure in Uganda. Daily Monitor, p. 23.
[4] Global Poverty Line Update, World Bank, September 30, 2015
[5] Assessing catastrophic and impoverishing effects of health care payments in Uganda, Brendan Kwesiga, Charlotte M Zikusooka, and John E Ataguba, BMCHealth Serv Res 2015
[6] WHO. (2010). Health Systems Financiing: The Path to Universal Health Coverage. Geneva: WHO.
[7] Report on UHC by WHO, EB144/12

provision of health care, and most significantly incorporating the people and community centered ethos of its earlier iteration from the Alma Ata.

Evidence in a Ugandan perspective shows that UHC is bound to face diverse challenges relating to how it will be effected due to the opposition by the formal sector service holders to pay anything on top of existing income tax; 'private interest' (strong lobbying by private health insurance providers in fear of dilution of their existing profit) [8]; 'institutional conflict of interest' (fear of the existing service providers to lose their authority); and 'technical barriers' (difficulty in collection of premium from a massive informal sector) and finally the high costs associated with establishing the mechanism (necessitating a referendum to okay the government to levy such fees on the population at hand). Much of the attention in relation to UHC has focused on financial risk protection: less has been said about coverage by effective services. Coverage can be achieved in many different ways, but will always include some community-based services as an essential link in the service delivery chain.

Achieving UHC in a country is a gradual process. Over time, provision can expand to include an evolving range of preventive, promotive and curative services, including palliative care and rehabilitation. Each country has a different starting point in terms of its disease profile, gaps in service coverage and level of health spending. However whatever the circumstances, community-based services are vital in achieving universal health.

Community-based health services will need to continue to adapt to a fast-changing world and the challenge of UHC. However one feature of community-based service delivery is that there is little systematic documentation about the whole range of services being provided by health workers in communities. This is an area of focus for People's Health Movement (PHM) in Uganda as a social movement motivated by the need for social justice in health care, to push political leaders to opt for UHC. As a civil society platform 'Community empowerment' as a key aspect of social movements emerges as one of the most important pre-requisites for establishing UHC. It is imperative that we build the evidence on community empowerment to support and create evidence for policy formulation on UHC.

PHM-UGANDA makes the case from its engagements in Western Region of Uganda (Kakoma)[9] that community empowerment (Community led initiatives) is a powerful instrument to achieving UHC. The approach deployed in Kakoma Isingiro District considered the introduction of communities to culturally sensitive and demand driven Primary Health Care (PHC) by emphasizing community empowerment. PHM-UGANDA established that reaching people left furthest behind requires the active engagement of community-led initiatives and constituency-based networks that are trusted and embedded in affected communities. Further thereto, is the need

[8] UN. (2013). United Nations General Assembly resolution 67/81. Geneva: WHO.

[9] Building Health through Community Health Workers and Communities: Challenges and Solutions, May 2019. PHM global website

for innovative focused engagement through participatory community led service delivery oriented approaches to ensure that resource allocation for social enabling activities, advocacy, community and political mobilization, community monitoring, public communication and outreach programmes are enhanced for rapid attainment of UHC.

Our PHM-UGANDA engagement quantified the commitment on investment in community-led responses as a ground breaking social enabler to attainment of UHC in Uganda. The foregoing demonstrates that as the international community strengthens global partnerships to fulfill the Sustainable Development Goals (SDGs), the global strategy on UHC needs to be community responsive in a bid to address the underlying determinants of health so as to mobilize energy and knowledge on communities at grassroots.

However there are critical notable barriers to financing community innovations from national governments, donors and civil society organizations which necessitates for exploring opportunities for overcoming them. Analytically the strategy deployed in Isingiro District bared for a strong presence of community centric grassroot strategies-- flooring a way for advocacy and provision of people centred PHC initiatives.

PHM-UGANDA under the hospice of Human Rights Research Documentation Centre (HURIC) can ably attest to the impact of women empowerment programmes, legal aid services programs, and local micro-credit program as a booster to health programs in the District. Notably is TWETAMBIRE, and AMAGARA health insurance schemes which have successfully incorporated the contributions from the NGOs, local commercial enterprises, and even community volunteers. This inclusive nature of scheme is indicative of people's involvement from different spheres and their eventual empowerment.

Assessing the impact of the community empowerment model designed for the Western region in Uganda, has explicitly showed the willingness of the people towards becoming empowered to engage UHC. The people have taken a step forward in suggesting innovative approaches for achieving this goal. Some of their many creative suggestions were to engage the local government in organizing regular health meetings; developing health promoting display materials around the issues of entitlements and not just health practices; utilizing the existing vast network of government health educators (known as the Village Health Teams) in informing people about their health rights besides the healthy practices they currently promote.

BIBLIOGRAPHY

[1] Universal Health Coverage, January 24, 2019 World Health Organization

[2] WHO. (2019). Out-of-pocket expenditure as a percentage of current health expenditure (CHE). Geneva: WHO (Global Health Observatory (GHO) data).

[3] Emmanuel, A. (2018, April Tuesday). Out of Pocket Expenditure in Uganda. Daily Monitor, p. 23.

[4] Global Poverty Line Update, World Bank, September 30, 2015

[5] Assessing catastrophic and impoverishing effects of health care payments in Uganda, Brendan Kwesiga, Charlotte M Zikusooka, and John E Ataguba, BMCHealth Serv Res 2015

[6] WHO. (2010). Health Systems Financiing: The Path to Universal Health Coverage. Geneva: WHO.

[7] Report on UHC by WHO, EB144/12

[8] UN. (2013). United Nations General Assembly resolution 67/81. Geneva: WHO.

[9] Building Health through Community Health Workers and Communities: Challenges and Solutions, May 2019. PHM global website