

**Ted Lankester** explains why community based health care is essential

## Empowering communities to **CARE**

**C**ommunity based health care (CBHC) is now a dominant theme in cutting edge literature on global health. Started by the earliest communities on earth, it was modelled by Jesus Christ and formulated in the Alma Ata Charter of 1978. Without CBHC, there will be no effective health services in the poorest communities, which will likely return to subsistence medicine. It is not just a good idea – a neglected part of the health care system in resource poor countries – but the imperative for improving the health of the neediest people on earth, a fifth of the world's population.

A pioneering example of CBHC is based in two remote Himalayan valleys. I was part of an early team working there. Nurse trainers, backed up by weekly doctor visits, trained community health volunteers to see and treat two thirds of all illness episodes through house-to-house visiting. Many more illnesses were prevented. In one village alone, child malnutrition plummeted within two years from over 30 percent to less than two percent.

### Supporting a depleted workforce

The developing world isn't training enough health care staff, many of whom are leaving for developed countries.<sup>1</sup> This is a serious issue: 'Money and drugs will fail unless poor countries have enough people to tend the sick...Africa needs a million more health workers'.<sup>2</sup> CBHC is often the only health care available, and with the right management, training and support, it offers an excellent return for investment.<sup>3</sup>

### Involving the community

CBHC can empower communities to deal with health problems themselves. The ASHA Christian project, working with half a million Delhi slum-residents, has seen spectacular health improvements through community worker empowerment: 'Thousands of disadvantaged and illiterate slum women are now acting as highly effective pressure groups, and this has resulted in proper housing and a vastly improved environment. As vibrant community groups these women are at the fore-front of resolving social issues and community conflicts'. This approach is especially valuable where HIV/AIDS is prevalent: 'HIV prevention programmes should be planned *with* and not just *for* whom they are meant...[to ensure] participation and ownership of communities'.<sup>4</sup>

But often CBHC programmes are too busy and stretched to document their achievements. Smaller programmes need to be strengthened and linked together for mutual learning. New initiatives such as Community Health Global Network, ICMDA Mission Mobilisation Network and Crossnetwork Journal, and ongoing CMF/HealthServe initiatives are trying to address this enormous need.

### The increasing role of faith

The need is never ending, and health workers need huge motivation to remain active, resident and competent. Often religious faith

inspires people and programmes to function and local Christian communities are central in this. Even organisations such as UNAIDS, WHO and UNICEF recognise that faith based groups can have a unique role 'not just in delivery of care but in leadership, to address the root causes that have fuelled this epidemic'.<sup>5</sup>

### Changing perceptions

We need to erase the idea that CBHC is an optional extra. It should be the central plank of any effective strategy aiming to have lasting impact on the 1.2 million people estimated to be without basic health care. 'The focus of all strategies should be to ensure access by every family to a motivated, skilled and supported health worker...family members, relatives and friends, an invisible workforce consisting mostly of women: they are backed up by diverse informal and traditional healers...by formal community workers; all strategies should seek to promote community engagement in recruiting, retaining and accounting of worker performance.'<sup>6</sup>

## faith based groups can have a unique role

Imagine how this could work in practice. A young child becomes sick in a remote community. The health centre, 30 miles away, has run out of medicine, but the trained community health worker correctly diagnoses malaria and treats the child with medicine from her medical bag. Even better, perhaps the child's mother has been similarly trained, and has been given a supply of malaria medicine to keep at home. The same system could work for acute respiratory infections. This would have a huge impact as these two conditions cause most of the deaths in many resource-poor areas.

Without CBHC, the world's poorest people, especially mothers and children, will continue to die needlessly.<sup>7</sup> Access to and affordability of health care in rural and isolated communities provided by well trained and motivated staff who are on hand to deliver it, must be considered immediately so that the diseases of poverty and the factors that strengthen its grip can be tackled at their roots.<sup>8</sup>

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### references

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