AFRICAN COLLABORATIVE FOR HEALTH FINANCING SOLUTIONS

STUDY SUMMARY

Perceptions of health and the pathways to safeguard or restore it

Why it is important to take into account community representations of health in accountability for UHC

Authors: Simon Kaboré – Regional Executif Director RAME, Hamidou Ouedraogo, National Executif Director RAME

Introduction

When countries around the world adopted the Sustainable Development Goals (SDGs) in 2015, one of the ambitions they set for themselves was to achieve Universal Health Coverage by 2030. According to the World Health Organization WHO, UHC refers to a situation in which all people and communities receive the health services they need without facing financial hardship. It encompasses the full range of quality essential health services, including health promotive, preventive, curative, rehabilitative, and palliative care.

The global SDG accountability system has selected two indicators to monitor progress towards UHC:

- the proportion of the population with access to quality essential health services (SDG 3.8.1);
- the proportion of the population spending a large share of family income on health (SDG 3.8.2).

To achieve these two indicators, WHO recommends that efforts be made to make quality people-centered integrated services available and accessible. Putting the individual at the center of the organization and delivery of health services is therefore an important element of universal health coverage. This is part of one of the pillars of primary health care, which is "the mobilization and empowerment of individuals, families and communities for increased social participation, self-care and self-reliance in health".

It is therefore important to ensure that the accountability system, through these two indicators, effectively takes into account the determinants of health within communities. People's perceptions of the causes of ill health and the possible pathways to get back to good health actually influence the two indicators mentioned above. Do the notions of "quality essential health services" have the same implications and connotations for both health experts and African communities? Furthermore, are all the expenses made by communities on services that are *not* considered "essential quality health services" taken into account in the evaluation of health expenditures?

Synthesis

The Réseau Accès aux Médicaments Essentiels RAME (Essential Medicines Access Network) conducted a study in Burkina Faso in 2021[1] to assess perceptions of health and the means to safeguard

[1] Study carried out by a research team of the Laboratory of Interdisciplinary Research in Social Sciences (LARISS), find the full report here.

it. According to the opinions gathered during the study, a variety of considerations emerge that influence a person's health status. For some, the state of health is linked to beliefs, to the sacred (offenses to sacred places, transgression of lineage/ prohibitions by a certain ethnic group), to divine principles, to mystical or metaphysical phenomena. This opinion sums up this perspective: "***we have been cursed. No hospital will provide you medicine for these kinds of diseases***." Therefore, "...***being healthy is also to live in peace with one's social environment, in other words, to be in harmony with others, to respect the customs of one's community and also the religious rules***". Health would hence depend on "***the physical and social environment, that is to say on hygiene and our relations with nature***", on "***respect of customs, sacred places and others…good communication between the visible and the invisible***".

These beliefs influence the attitudes of some community members when it comes to seeking health care. It's in this respect, the use of "quality essential health services", as perceived by the WHO, is not always the first choice. "***Based on their beliefs, some people consult diviners or the nearest traditional healers for care. They only turn to health centers if all that does not work***.". Sometimes it is the use of religious practices, including prayers in church for the healing of the patient, self-medication by pharmaceuticals or home- made concoctions that are preferred.

It should be noted that there is no actual chronology among the different types of recourse to care. They can be sought simultaneously or in any order, depending on the levels of conviction, the means of access to the recourse (geographical and/or financial), or the results of the first recourse.

Figure 1: Circuit of seeking in case of illness

In addition to disease-related considerations that drive the pathways of recourse, failures in the formal health system drive communities toward alternative remedies. Among the grievances identified by the study are "***poor quality and side effects of some pharmaceutical products, lack of trust in the health system and in some health workers, as well as in pharmaceutical products ".*** Comments made during a radio program organized with the support of RAME are evocative; "***In interactive programs, people always talk about it. How many times have people complained about the Sourou Sanon hospital in Bobo Dioulasso, compared to some health centers in Burkina Faso. Remember recently at CMA 22 in Bobo, you couldn't carry drinking water on a bike to get to the hospital. Just recently at the Sourou Sanon hospital there was a water shortage. But in this context, how can we ensure health coverage for the population? No, it's not possible***."

Seeking services outside the traditional health system is not free of charge, and entails significant expenses, very often related to travel (travel and lodging) to reach the traditional or the religious healer, as well as the costs of providing the service and writing the prescription (e.g., sacrifices to be made). Sometimes, these expenses can exceed those needed for "quality essential health services". Nevertheless, even in the absence of a formal solidarity mechanism (government subsidies, mutuals, insurance), communities manage to meet these expenses through endogenous alternative mechanisms. These mechanisms are based on feelings of compassion and moral duty and manifest themselves in several forms (money, food, physical presence, etc.) towards the sick or their families. The sick person often benefits from compassion, support from relatives and acquaintances both financially and

psychosocially. In a way, there is a form of risk pooling set up by social groups, obliging each member to take part in health maintenance and safeguarding.

Recommendations

WHO needs to recognize, thus, that health services, whether traditional or complementary, must be organized around the full range of needs and expectations of individuals and communities to empower them to play a more active role in their health and in the health system. They recognize the need for the mobilization and empowerment of individuals, families, and communities for increased social participation and strengthened self-care and self-sufficiency in health. Such an approach creates more community buy-in for health services and cultivate community accountability, which makes the health system more effective. It also takes a more holistic view of the evidence related to the health of communities thereby rendering the accountability system more inclusive and comprehensive. For example, estimates of health spending will be more complete relative to the actual financial commitments of communities. This is why the study recommends that the CSU approach in African countries should take into account multiple pathways of recourse to health in order to reduce exclusion from care and better incentivize people's adherence to the health system.

The move toward UHC should be seen as a process of negotiation between modern and community-based care (traditional and religious) to achieve true community ownership of the system. "***Sometimes endogenous strategies are contrasted with so-called modern systems without first understanding the concepts. Yet when we look closer, they are actually complementary mechanisms***" *(Informal discussions, young people, Ouagadougou).*"

Restricting the UHC approach to building infrastructure, training and deploying human resources and setting up health insurance mechanisms may achieve the indicators as articulated by the SDGs but are not sufficient to produce desired impact on people's well-being.

This summary is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this summary are the sole responsibility of Results for Development, Duke, Feed the Children, Amref, Synergos, RAME, RESADE, CERRHUD, and UHF and do not necessarily reflect the views of USAID or the United States Government.