Enhancing Harmonization to Ensure Alignment of Partners, Implementation and Priorities for Provision of Quality Primary Healthcare to Communities in Rural Zambia

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Abstract

This paper discusses the processes of harmonization of various approaches by partners that have been implemented in Zambia, in an attempt to overcome the fragmented implementation of community-based primary healthcare (CBPHC) systems strengthening, facilitated by multiple non-governmental organizations (NGOs) and donors, impeding country ownership and nationalization. To achieve equitable and sustained improvements in health, social and economic development outcomes for all, there is evidence that governments should consider building CBPHC systems based on three legs namely:

1. Front-line health workers trained, supervised and able to deliver services;
2. Community engagement through interactions to enhance community participation and Social Accountability for delivery of healthcare services.
3. Enabling environments through strengthening of community health systems

To realize a harmonized approach and alignments, the government and key stakeholders must uphold a common vision ensuring that all the three legs of CBPHC systems are implemented to scale. In evaluating the health system in Zambia and the related healthcare provision at community level, gaps were identified in the available mechanisms for the provision of quality CBPHC thus necessitating processes of harmonization, that include capacity building and orientations at all levels on importance of taking to scale the three legs of CBPHC systems, revision of the Community Health Strategy, and elaboration of Operational Guide for Neighbourhood Health Committees, clarifying the role of NHC as platform for community engagement and Community-Based Volunteers (CBVs). There is need for harmonization of health systems at national, provincial, district, zonal and communal levels to ensure the delivery of quality, cost-effective healthcare as close to the family as possible .

Background

Across the world, maternal and child mortality rates have fallen over the last two decades. The global under-five mortality rate has dropped by 53% between 1990 and 2014 (UN Interagency Group for Child Mortality Estimation 2015). The global maternal mortality has fallen by 44% over the same time period (Maternal Mortality Estimation Inter-AgencyGroup 2015), and stunting prevalence declined from 39.6% to 23.8% (UNICEF 2015). Despite these achievements, unacceptable inequities remain both among and within countries. For example, Zambia's many years of investment in primary healthcare systems seem to be yielding positive results; but even so women and children in some areas of Zambia are still dying. The recent Zambian Demographic Health Survey (ZDHS 2013–14) showed significant reduction in maternal, infant and under-five mortality with newborn mortality showing only a slight reduction. Despite these gains, child and maternal mortality indicators for Zambia remain among the highest in the world. Children and women continue to die from preventable and curable causes. Over 40% of children less than 5 years old are stunted (ZDHS 2013–14). Timely access to a package of proven and inexpensive interventions would avert these deaths.

The vision of the Zambian healthcare system is "Equity of access to cost-effective, quality healthcare as close to the family as possible." It is well understood that attaining this vision requires the invocation of the four principles of primary healthcare (PHC) namely equitable distribution of health services, participation of the community in healthcare delivery, inter-sectoral coordination through facilitating the interest of communities from all related sectors and factors that impact on health as health determinants, and the use of appropriate technology (WHO 2003). Quality delivery of this vision is largely dependent on an effective, equitably distributed and well trained health workforce. Indeed, a factor that has been recognized as a global priority for achieving the Sustainable Development Goals (SDGs), including the goal of Universal Health Care (UHC), especially in the hardest to reach communities and in countries experiencing a health workforce crisis, is the rapid scale-up of a Community-Based Health Workforce (Cometto et al. 2013). Therefore, in pursuit of the SDGs with the objective of the UHC goal in mind, extra effort must be mobilized by every government to reach the unreached, working in the most challenging contexts of both remote, rural villages and poor urban slums to build resilient and responsive community health systems (McIntyre et al. 2009; Mogedal et al. 2013).

The Alma Ata Declaration (WHO 1978) advocated for the delivery of PHC, "based on practical,scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families *in the community through their full participation* and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination," for there to be comprehensive, quality PHC (Chopra et al. 2012).This is an important phenomenon to appreciate and internalize as a government strives to attain the SDGs.

The foundations of community health within the context of PHC are increasingly recognized as crucial components of national policies and strategies to accelerate progress in health. Advancing community health is said to be pivotal to achieving sustainable development and universal PHC. There is need to further integrate community health approaches into national and local health policy and systems to achieve the SDGs (ICHC 2017a). Zambia has made this commitment and is implementing the community-based primary healthcare (CBPHC) system strengthening and the necessary healthworker strategies to facilitate the attainment of these goals.

It is well appreciated that without taking steps to synergize through partnerships offering harmonized support and holistic implementation, investments in community health systems, community engagements, and community health worker (CHW) programs will not bear the intended fruit in making optimal contributions to achieving UHC (Etienne et al. 2010). The optimal framework for harmonization provides a basis for moving from fragmented efforts of siloed partners to collaboration and alignment across partners and actors at local, national and global levels.

This paper is about harmonization, and discusses the processes of harmonization of various approaches by partners that have been successful in Zambia, and should be considered by other countries to develop, strengthen and implement quality PHC delivery to communities through community engagement.

However, the grass-roots approach to support CBPHC and community level health workers has led to overwhelming diversity and variation in community health systems. The fragmented implementation of CBPHC systems strengthening, facilitated by multiple non-governmental organizations (NGOs) and donors, impedes country ownership and nationalization (McIntyre et

al. 2009; Peters et al. 2013). This fragmentation undermines the goal of collective action that the Millennium Development Goals (MDGs) were intended to achieve. As a result, many countries have not been able to realize the potential of the CBPHC systems, including a fit-for-purpose community level workforce, including maximizing the potential contribution of volunteers or CHWs, in helping to end preventable maternal and child deaths, fight infectious disease pandemics and ensure global health security (Cometto et al. 2013; Peters et al. 2013).

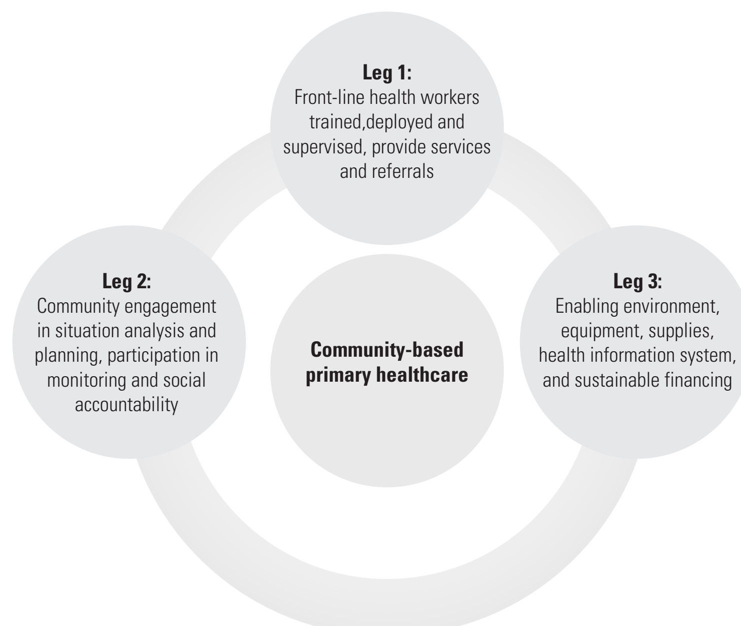
Community-Based Primary Healthcare System

Commitments to community health to ensure that women and children have the opportunity to survive, thrive and transform have been re-affirmed through various efforts since Alma Ata. NGO's, CSOs and Cooperating Partners have increasingly improved their willingness and capacity to align their efforts under the direction of national public health authorities. Overall strategies to facilitate harmonization and leverage synergies are reflected in the SDGs, the Global Strategy on Women's, Children's, and Adolescent's Health; Every Women Every Child (EWEC, 2015) and the Global Strategy on Human Resources for Health (WHO 2016a), to name a few. Through these frameworks, governments and key organizations have demonstrated their commitment to leverage synergies through a shared agenda. More specifically, there has been consensus built in many countries to build and to strengthen CBPHC systems.

To achieve equitable and sustained improvements in health, social and economic development outcomes for all, there is evidence that governments should consider building CBPHC systems based on three legs (ICHC 2017c) namely:

1. Front-line health workers trained, supervised and able to deliver services;
2. Community engagement through interactions to enhance community participation and social accountability for delivery of healthcare services and
3. Enabling environments through strengthening of community health systems (availability of needed services and supplies including drugs as appropriate, sustainable financing and community health information system).

Figure 1. The three legs of community-based primary healthcare systems



To realize a harmonized approach and alignments, the government and key stakeholders must uphold a common vision ensuring that all the three legs of CBPHC systems are implemented to scale. Strategies for the implementation are described below.

Leg 1: Front-line health workers

It is acknowledged that integrated and resilient community health systems are the result of having trained and recognized front-line health workers with the ability to deliver services to the community (SDSN 2014). For example, community health workers, employed by the MoH, well trained and supported, can provide essential health services to communities that otherwise would have limited access to these services (Cometto et al. 2013; Mogedal et al. 2013; McIntyre et al. 2009). Additionally, community-based volunteers working closely with community members and supported by clinical professionals in the facility, are key to engaging the community, advancing healthy behaviours and improving maternal and child health.

Leg 2: Community engagement

For effective and efficient delivery of PHC services, communities must be engaged and empowered to build a system that contributes to improved health outcomes. A growing body of evidence and country experience does support important diverse roles of communities in strengthening health systems (WHO 2016b). This leg emphasizes the role of communities to support service delivery, oversight, social and behaviour change, and social accountability for healthcare delivery. It is important to adopt a bolder vision for community health systems strengthening, by addressing context-specific opportunities and challenges.

There is growing interest globally regarding the potential of social accountability approaches in improving health outcomes (Chopra et al. 2012). An effective evaluation and ongoing monitoring system with information made available to communities (e.g.Community Score Cards) can contribute to significant change through citizen (right holder) empowerment, duty bearer effectiveness, accountability and responsiveness and spaces for joint monitoring between the right holders and duty bearers that are expanded, effective and inclusive (Chopra et.al., 2012; Mogedal, Wynd and Afzal, 2013).

Leg 3: Enabling environment

For CBPHC systems to deliver efficient and effective care based on quality and safety, there must be supportive systems in place. It is advised that these health systems provide for effective supportive supervision in the line of relations from central government to community-based agents which also provides for availability of healthcare requisite supplies such as drugs. It is critical that the health information systems be integrated at all levels and should include new technologies that promote timeliness, completeness and quality information for decision-making. These information systems will enhance the countries' ability to face challenges to bring effective promotive, preventive, diagnostic and treatment services to the communities.

Existing Gaps in the Implementation Processes

In evaluating the health system in Zambia and the related healthcare provision at community level, it is evident that gaps exist in the available mechanisms for the provision of quality CBPHC thus necessitating processes of harmonization.

Leg 1: Front-line health workers

Zambia has invested research, capacity building and systems supports to a front-line team that brings together clinically trained professionals with lesser trained cadres and volunteers that work with the community toward improved community health.

Physicians, nurses, nurse-midwives and environmental health technicians depend on the volunteer community health workforce that has been recognized as a vital part of their front-line team to deliver services that are available, accessible, acceptable and quality.

Zambia's efforts at addressing this first leg are apparent as it has trained and deployed a network of community-based agents to support and enrich the work of clinical facility staff. These include Community Health Assistants (CHAs), a new cadre of paid community health workers, a number of different Community-Based Volunteers (CBVs), all who are tasked with provision of segments of healthcare programs (Table 1). Indeed, a CBV, well trained and supported, can provide essential health services to communities that otherwise would have limited access to these services (Cometto et al. 2013; Mogedal et al. 2013; McIntyre et al. 2009).

Table 1. Types of community-based volunteers

No.	Community-based volunteers	Main area of focus
1	Safe motherhood action groups	Maternal and new-born health
2	Infant and Young Child Feeding	Nutrition
3	Out-patient Therapeutic Feeding	Treatment of acute malnutrition
4	Integrated Community Case Management	Treatment of pneumonia, malaria and diarrhea
5	Community-Based Distributors	Family planning
6	Peer Educators, and Adolescent Counsellors	Adolescent health
7	Growth Monitoring Supporters	Nutrition
8	TB Treatment Supporters	TB
9	Care for Newborn	Newborn health
10	Child Supporters	Early child hood development
11	Malaria Agents	Prevention of malaria

The CBVs are described as key agents of health promotion and disease prevention in the rural communities (Wakerman et al. 2009). However, their effectiveness lies in the quality and harmonization of their training and subsequent supervision in their different communities, as well as the availability of the needed supplies especially for iCCM.

The existing Zambian healthcare system consists of district health managers who are supposed to report to health centres and health posts that are staffed with health workers (Nurses, Clinical Officers, EHTs). However, there has been no formal reporting relationship between the CHA (MoH, 2015) and the community members, or between the CHAs and the facility heads and between CBVs and the facility heads. Further, there has been no clear mechanism for coordinating responsibilities or shifting tasks between CHAs and facilities staff or among CHAs and volunteers. Furthermore, there is no legal framework for galvanizing community-based health systems that comprise Health Centre Committees (HCC), Neighbourhood Health Committees (NHCs) and CBVs. Zambia is committed to strengthening its regulatory, legal, and accountability frameworks and recognizes that legal mechanisms need the alignment of engaged and harmonized internal and external partners to address the gaps successfully.

A 2016 assessment carried out by the Clinton Health Access Initiative found that district health managers needed an orientation regarding the purpose and roles of the CHAs and CBVs to better evaluate the performance of CHAs and CBVs and to better support and engage the front-line teams of staff, volunteers and community members to meet community needs (Shelley et al, 2016). Furthermore, rural health facility managers required some training in supportive supervision to provide effective guidance and comprehensive oversight to the CHAs so that they could perform the duties in the communities for which they were trained.

A broader assessment, carried out by the University of Zambia and partners in the Primary Health Care to Communities collaboration (PHC2C) found that there was need for re-orientation of the entire district health management and front-line provider teams so that the individual workforce components, which are strengthened individually, that is, CBVs, CHAs, NHCs and facilities clinical staff, are oriented as a whole with clear roles and responsibilities, information flows, and lines of accountability and supervision (Foster et al. 2017). It is advised that the government, as well as most development partners, focus on re-reinforcing capacities of front-line health workers, paying particular attention to building CBPHC systems.

Furthermore, the coordination of the zonal activities of the CBVs is said to be weak, because the role of the health facility "in-charges" or facilities heads in relation to their interaction with the community has not been clearly defined thus not prescribed. The District Health Office and CBV-supporting Cooperating Partners (CPs) often plan development activities independently one from another, without much effort for coordination with other CBV development groups, facilities heads or community committees at community level. There is a particular gap in the coordination and dissemination of funding. This leaves the District Health Office (DHO) and health facilities without oversight functions at the community level. Incentives and related schemes for the volunteers are not harmonized, causing the programs with more attractive remuneration packages to have more volunteers participating. This inequitable distribution of CBVs and their incentive packages presents considerable challenge to the DHOs to implement effective community health interventions or plan and manage a sustainable, fit-for-purpose front-line team.

Leg 2: Community engagement

In Zambia the 2012 National Health Policy recognizes the community as a critical component of the health system and structure. However, as observed in the midterm review of the National Health Strategic Plan 2011–2016(Zambia MoH 2014), there has been weakened community and civil society participation in health governance since abolishing the Central Board of Health (CBoH) in 2006. However, Neighbourhood Health Committees (NHC) (Masange et al 1997) survived although without the necessary legal Acts of Parliament. While the National Health Strategic Plan (NHSP) 2011–2015, NHSP 2017–2021 and the revised National Health Policy 2012 have identified the significance of enhanced participation, transparency and accountability at all levels, there are still no legally binding provisions of diagonal accountability in the health sector. Mechanisms to provide for community engagement in planning and budgeting, review of performance reports at health facility level or provision of a platform for community members to question the care of service providers are not catered for in the law at present (GRZ/UNICEF/EU 2016). This lack of legal backing and limited functionality of community oversight structures recognized by the sector is considered a significant factor that impedes progressive and interactive improvement to health service delivery in Zambia (GRZ/UNICEF/EU 2016). The deficit demonstrates a lack of harmonization and coordination across the health system, where initiatives are not supported by complimentary and coordinating transparency, accountability and enforcement mechanisms.

Despite the absence of this legal framework, NHCs still exist in most districts of Zambia(JICA, 2017). Their functionality is widely variable, depending largely on the

managerial skills of the District Medical Officer. The link between communities and NHCs in relation to expected standards of operation in health facilities is very weak (JICA, 2017). There are hardly any meetings held to determine community priorities, which are needed to transfer community preferences and concerns to facilities, as well as to engage communities to support facilities' responses.

The system is thus not designed as an accountability mechanism; there are no means through which health facility staff members are accountable to community members as there are no guidelines linking NHCs to expected performance at health facilities (JICA 2017). However, weaknesses in the organization, coordination and general management of NHCs seem to have been addressed in areas supported by development partners finding new ways to harmonize their efforts and catalyze change. For example, the European Union (EU), and other agencies of the United Nations (UN 2017) coordinate with the Swedish International Development Agency (SIDA), the United States Agency for International Development and the United Kingdom's Department for International Development among others (GRZ/UNICEF/EU 2016).

Efforts Being Made in Zambia to Harmonize

The capacity at Provincial and District levels to provide appropriate support to community level structures and management remain weak largely because of limited appreciation of the degree to which the three legs of the CBPHC system ought to be expressed and integrated for quality healthcare provision. There have been achievements in capacity building for sustainable community health systems especially with reference to communities participating in planning, implementation, monitoring and evaluating of the interventions. Participating in this way helps to influence the motivation of volunteers to sustainable contribution in activities such as offering supportive supervision, mentorship and enhancement of CBV efficacy self-assessments (JICA 2017). It is critical that partners engaging in CBPHC work in concert to build and sustain a functional platform for community engagement in planning, monitoring and social accountability (Table 2).

Table 2. On-going efforts in Zambia to harmonize at every level to re-enforce community engagement, participation and social accountability

Action	Initiative	Improvements in harmonization leading to engagement, participation and social engagement
Action 1	Revision of the Community Health Strategy	Updated strategic orientation document to guide harmonization
Action 2	Elaboration of an operational guide for the NHC ensuring there are no conflicts of interest between the NHC responsible for community engagement, participation and social accountability and the Community-Based Volunteers.	Operational guide at community level avoiding gaps and overlaps in functions
Action 3	Revitalization of NHC in 11 districts of Lusaka and the Copperbelt province under the European Union (EU) funded Millennium Development Goal initiative (MDGi) Programme managed by UNICEF.	Example of existing interventions for learning
Action 4	Follow-up for legally binding provisions of diagonal accountability in the health sector.	Legal framework defining relationships between the community and institution for participation and social accountability.

Leg 3. Enabling environment

The glaring omission in system is an effective and "harmonized" health information system. Zambia does not have a functional Community Health Management Information System (C-HMIS). Systems are numerous and not all connected. Further, many of the systems that exist, particularly at community level, are not able to capture the needed data or take it where it is needed. For example, the health management information system for the CHAs does not fully capture data from community-based volunteers. With support from the European Union(EU) under the MDGi, the MoH and UNICEF are currently designing a community-level HMIS system that will be linked to the DHIS2 platform (personal communication). On this platform the community actors (CBVs and CHAs) will submit monthly reports using pre-defined forms which will be compiled and transmitted onto the DHIS2 platform at health centre level. Furthermore, efforts are on the way to improve the procurement and supply chain management system (PSCMS). Through a bottle neck analysis of the PSCMS, the government with support from UNICEF and partners will implement key resolutions to ensure supplies are delivered to the last mile.

The Need for Harmonization

Harmonization must transcend donor aid alignment and advance the integration of efforts among global partners, national stakeholders and implementation schemes. Sustainable efforts will align with national priorities, led by the public authorities and will leverage existing health worker's ability to coordinate tasks across cadres and levels. To advance UHC and progress toward the SDGs, all these efforts need to be harmonized in alignment to the national priorities and leverage existing country mechanisms (CHRD 2008). Real harmonization is not just across partners. Harmonization must happen across the elements of the three legs of CBPHC system. Health workers must be coordinated to work as a fit-for-purpose front-line team, linking NHC members with volunteers and MoH staff. That linkage must have strong supervision at the local zone level, through cooperation and accountability between community leaders in the NHC and facilities level to successfully coordinate tasks across various CBVs and staff available, and to facilitate the exchange of accurate information from the communities to the decision-makers and from decision-makers to the systems users. Harmonization is needed across the various zones within the district so that community engagement is consistent and equally resourced. A portion of funds for districts in Zambia are earmarked for community-based interventions. There is need for follow up to ensure this is effective in all districts. Finally, harmonization is important in coordinating systems infrastructure that supports health workers to do their job. Information systems, commodities delivery systems and legal frameworks that support policy priorities for example, need to be interoperable and directed holistically.

The global community is learning to navigate the complex business of sharing information, data, best practices and evidence so that healthcare can be integrated, front-line teams can be coordinated, and systems can be holistic, consistent and responsive through the spectrum of care. There is therefore need for harmonization of health systems at national, provincial, district, zonal and communal levels to ensure the delivery of "*quality, cost-effective healthcare as close to the family as possible in a clean, caring and competent environment.*"

Universal Health Coverage as a Strategy

Zambia has taken UHC as a strategy to improve health and reduce inequalities in health (Zambia MoH 2017). Indeed, UHC allows stakeholders to universally focus on

the equitable distribution of access to health services within and across countries (Chopra et al. 2012). The intent is that having universal health coverage as an overarching goal translates into unified services that are delivered in a comprehensive and integrated way through a strengthened PHC system (WHO 2016c). Without PHC, UHC cannot be achieved.

A. Harmonization at the global level

At the global level, all actors need to contribute together to a comprehensive systems approach in advocacy, programming, funding, implementing, monitoring and in building the knowledge base for community health programs (Mogedal et al. 2013). Establishing partnerships that cultivate ingenuity and resourcefulness also requires the harmonization of the global health strategies with partners' agendas and resources. The Global Health Workforce Alliance's Framework for Partners' Harmonized Support emphasizes the need to: 1. Harmonize donor support, 2. Build greater synergies across Community Health Worker programs with communities, districts and countries, guided by national leadership, national strategies and nationally agreed systems and 3. Improve focus on effective linkages between community-based and facility based health workers at the front line of service delivery. This necessitates actors in all settings to contribute to a comprehensive systems approach in advocacy, programming, funding, implementing, monitoring and in building knowledge base for community health worker programs.

Progress of global efforts towards harmonization has been evidenced by a multitude of partnerships and frameworks. Partnerships such as that of Zambia's Thematic Working Group on Supporting and Strengthening the role of CHWs in Health System Development; and The International Health Partnership (IHP+) have been working to promote effective development cooperation and optimize synergies to overcome fragmentation. Global accountability efforts by IHP+ and the Global Fund Community Systems Strengthening have been developed to harmonize efforts toward strengthening systems and communities toward key national goals.

B. Harmonization at the national level

Harmonization at the national level has been a recurring conversation of necessity in the realm of public health. Initiatives such as The Council on Health Research for Development's Alignment and Harmonization of Research for Health (COHRED); and the Global Health Workforce Alliance's Harmonization for Health in Africa (HHA) study explores global aid and alignment of donor programs with country needs (CHRD 2008; WHO 2016c). It is essential that donors and governments alike be cohesive in formulating, implementing and evaluating solutions. Principles for alignment and harmonization across public and non-state programs and initiatives need to be compatible with broader national health system development frameworks (Mogedal et al. 2013).

Furthermore, the government and key partners in Zambia have focused on equity and Health System Strengthening (HSS) especially at the community level as platforms for delivery of reproductive, maternal, new-born, child and adolescent health and Nutrition (RMNCAH-N) services (UNICEF 2016–2020). To achieve this requires harmonization of effort by policy-makers, NGOs, donors, activists and communities to realize effective collective action in line with the *Joint Commitment to Harmonized Partner Action for Community Health Workers and Frontline Health Workers* formalized in Recife, Brazil in 2013 (Cometto et al. 2013).

Community-based programs are often implemented under district level authority at the Health Facility and community level,

or operated independently through NGOs. With the growing focus on scaling up CHW programs to support the formal health system, there is an urgent need for attention from the national and district levels to address the fragmentation and inefficiencies that result and to build synergies at the level of implementation(Mogedal et al.2013).

The Zambian PHC system had a missing link between the Health Facility and the community (and therefore the CBVs). To a large extent, the introduction of the CHA is promising to resolve this problem. The CHA is on a government salary, and the addition of this community-based cadre is intended to improve the provision of PHC services to communities. The CHA is supposed to spend 80% of their time in the community where they interact with the CBVs and the NHCs. The NHC is supposed to interact with a smaller subset group, the HCC, where the meaning of data and performance indicators are discussed, accountabilities identified and correcting actions proposed. The HCC then gives feedback to the DHO where overall planning of the district health services takes place. This process is designed to improve communication and harmonization between the communities and the DHO. However, despite the intention, there is still fragmentation between the partners. For example, different partners are still building capacity in different cadres or levels of the community without consulting each other (Natuzzi and Novotny 2014).

C. Harmonization at the community level

Effective PHC is community-based and requires governance, management and leadership, funding, linkages, infrastructure and workforce supply. To provide effective PHC also requires significant changes in the way health systems currently operate. UHC reforms must ensure that health systems move toward universal coverage and social health protection by reorganizing health services as PHC, around people's needs and expectations (McIntyre et al 2009; WHO 2008).A strong focus on PHC is said to be the driving force for the strengthening and development of health systems and health workforces. World leaders at The Third Global Forum on Human Resources for Health (HRH) supported the framework for UHC by agreeing that patient-centred care advances with the presence of community involvement in governance of PHC interventions (Cometto et al. 2013). New evidence and norms on HRH planning, education, management, retention, and migration continue to emerge and are providing dynamic innovative approaches to achieve UHC (Cometto et al. 2013). The interest for focusing on HRH for UHC is vast and continues to be a priority for global sustainable development (Shamian et al, 2015).

Nurses stand in an innovative position and are able to direct the community needs toward solutions. Benton (2012) states that nurse leaders are "*transforming agents, effective in bringing about change.*" By engaging in leadership through training and policy discussions, nurses are able to assess, plan for, and evaluate the health system's resources. Their position as leaders of front-line health workers can merge the needs of the community, region, and globe.

The assessment of Foster et al. (2017) has demonstrated that nurse leadership of the "front-line team" within the community facilitates collaboration and harmonization among various provider efforts, and thus brings about greater gain. When the Nurse-in-Charge was seen as a good manager and a "team builder", the CHAs and CBVs were motivated into clearly assigned roles and the community members had confidence in the health facility and in the services provided by the MoH staff.

The NHCs are said to be in the process of being reformed to perform their duties as well. The main impediment currently lies in the fact that most NHCs are manned by CBVs, thus conflicting in their interests.

The NHCs ought to consist of independent members of the community who can effectively play the role of claim holders to the health system.

Conclusion

To ensure CBPHC systems deliver results in line with overall strategies embodied in the SDGs; Global Strategy on Women's, Children's, and Adolescent's Health; Every Woman Every Child (EWEC) and Global Strategy on Human Resources for Health, it is key to have a harmonized approach to the provision of PHC to communities, ensuring that all the three legs of CBPHC systems are considered across sectors at the national level. Donors and all cooperating partners must tailor their support in line with national needs and designed strategies prescribed by the government. Experiences need to be documented and shared, and recommendations from Global meetings such as the Institutionalizing of Community Health Conference March 2017 in Johannesburg, South Africa (ICHC 2017b), applied in countries in line with their local contexts.

Harmonization of all systems and processes for CBPHC is necessary for the provision of quality PHC to communities. This harmonization must occur at national, district and community levels to be effective and must involve government and the related development partners. Central to the success of the delivery of this scheme is the role of the Health Facility in-charge who must be the competent leader of the front-line team comprising the Health Facility Staff, the CHAs and the other CBVs. This will contribute greatly to the improvement of all health indicators within the given community.

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