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Access to formal healthcare services in rural Uganda: why non-medical social resources matter

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English Summary

The Uganda government, and her development partners, have implemented a number of interventions at community level to improve access to formal healthcare services. Some of these interventions such as the government policy of construction of health centers in every parish, increasing medical supplies and building a strong health infrastructure take on a biomedical perspective. Other interventions such as the training of lay persons as village health teams, the formation of HIV and AIDS post-test clubs, supporting the establishment of community health insurance schemes, and community health outreaches for immunization or safe male circumcision entail an infusion of biomedical and socially-oriented approach. Initiatives, such as community-based microfinance, have also come up, but these have often been considered to have no immediate and direct impact on access to formal healthcare services. Adoption of community-based interventions for promoting health is based on the knowledge that illness is a social phenomenon, whose management requires collective community action. It is also based on the recognition that community-based interventions tap into existing systems of cooperation and norms of interpersonal trust and reciprocal relations that inhere in community structures. As a result of this knowledge, there has been a growing consensus that solutions to healthcare access in the majority of low-income countries are as social as they are medical.

However, there is limited consensus on how to turn this knowledge into locally relevant solutions that enable vulnerable populations to access formal healthcare. In particular there is limited information on how structures and processes in the community perceived to have no direct impact on healthcare access could in effect provide the much needed solutions to problems of healthcare access. This lacunae raises an important question, do non-medical resources matter in enabling vulnerable community members access formal healthcare.? The aim of my study therefore was twofold; first, I sought to examine why interventions initiated from outside the community with a significant biomedical bias fail to link vulnerable communities to formal healthcare services; and secondly, to underscore why non-medical community resources matter in enabling community members access formal healthcare services.

To study these processes, I conducted ethnographic fieldwork between 2012 and 2014 in a rural community in Luwero district, central Uganda. I used participant observation in the naturally

occurring activities. I conducted a total of 91 in-depth interviews with community members, 42 focus group discussions, seven pile-sorting exercises and several informal everyday interactions with community members. The process of data collection was highly iterative and so was the analysis. Data were processed and analyzed using a qualitative data analysis software Nvivo10.

Drawing on village health teams (VHTs) as an example of a *biomedical-oriented* intervention conceived and implemented by actors external to the community, we found that VHTs in Luwero have not been effective in linking communities to formal healthcare. At the initiation of the VHT program, community members took the advice of VHTs seriously, and the VHTs themselves were enthusiastic about their work because of the incentive-led motivations. The referrals by the VHTs to the formal healthcare facilities worked well. However, interest in their work waned and the VHTs lost the trust of community members. Their biomedical orientation created a sense of *a policing* healthcare system and an extension of a formal healthcare structure than a supportive resource in the community. Yet, even with the biomedical orientation, their inability to address the wider social determinants of health and a lack of support from the formal healthcare providers affected their work.

People's longstanding friendships, membership in savings and credit associations, connections with informal transport providers and tendency to mobilize each other to help disadvantaged community members were found to be key resources in overcoming problems of poverty and accessing distant health facilities. These are what I have called non-medical social resources whose effectiveness for healthcare access lies in their ability to trigger activation of localism/grassroots initiatives to meet the costs of healthcare. Terms such as "twekolamu omulimu", translated as "we mobilize ourselves", were used to refer to the sense of collective mobilization of resources for meeting the costs of healthcare access especially for those members considered unable to meet their own health related costs (papers II and III). The idea of "twekolamu omulimu" unfolds a novel perspective on the embeddedness of formal health care seeking practices in rural Uganda. Community members in village savings and loan associations got support from their membership in the groups and mentioned that such savings groups are taking over the obligations that would otherwise belong to the domain of the extended family. We found that to understand and appreciate the role of non-medical resources in enabling

community members' access to formal healthcare, it is critical to understand how the everyday networks of embeddedness influence the appropriation of the benefits of interventions and emerging social processes (paper IV and V).

Although these processes lie outside the traditional boundaries of the formal healthcare system, they nonetheless present opportunities for a people-centered approach towards improving access to formal healthcare. Unlike the seemingly conventionally held view that community-based interventions draw from existing norms of trust and mutual support at community level, the experiences of VHTs in the community we studied in Luwero district show that community-based medical interventions initiated externally from the community draw little from existing social resources of mutual cooperation. Moreover, it was found that in some instances, programs such as village health teams (VHTs) are ineffective tools for linking communities to formal healthcare and they potentially undermine, instead of harnessing, effective utilization of social relations as a vehicle for healthcare access.

The leitmotif of a collection of papers in this dissertation is that communities are already doing enough to access formal healthcare services and that access to formal healthcare can be improved through simple, locally crafted solutions spontaneously initiated by community members as part of the daily practices and long-standing traditions of mutual support. While some resources, such as informal transport providers, have tended to attract negative publicity, and others such as VSLAs are fraught with endemic cheating perpetuated by attempts to preserve community norms of general goodness (buntu bulamu) they constitute a critical resource for overcoming some barriers to healthcare access. As obligations for support to healthcare access begin to shift from the traditional extended family system to institutions such as VSLAs or burial groups, it is critical to begin a process of rethinking community-based strategies for promoting access to formal healthcare in rural areas. The findings of this study suggest that the existence of such social resources in the community is in direct contradiction to the labels often given to such communities as resource-limited, or resource-constrained.