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Re-thinking Community Health Work in Rural Areas: Lessons from Existing Informal helping Frameworks in Uganda

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Abstract

Uganda's health indicators show that the health of the population has improved over the last two and a half decades owing to relative political stability which has allowed investment in health by private for profit, public, and private not for profit actors. The Government of Uganda, supported by international development partners, has implemented policies and programs aimed at improving the health of its citizens. One major change in healthcare delivery in Uganda over the last two decades has been the implementation of the decentralized healthcare delivery policy which placed community health volunteers, known as village health teams (VHTs), at community level, in an effort to increase the link between communities and health facilities. VHTs were organized a bid to increase community involvement in health interventions in the spirit of community participation, which was strongly advocated at the Alma Ata conference of 1978. At the Alma Ata conference, participants argued that community health workers (CHWs) would be a socially acceptable resource in the effort to achieve universal accessible to healthcare for majority of families and communities that were hitherto underserved. However, in what was seen as a tendency for healthcare professionals to resist innovations that undermine pre-existing power structures, many of the interventions that came through CHWs became overly top-down and ended up doing no more than creating just another cadre of para-professionals representing the health centres, not the communities as was intended.

Drawing from the natural helper model, I show that community resources can be approached through existing informal networks of helping relationships which may be re-enacted to improve health in the communities concerned. These relationships grow through experience of everyday helping activities, using local resources to solve problems of day-to-day living, including health issues. Ethnographic fieldwork conducted between July 2012 and March

2014 in the rural district of Luwero, Uganda, illustrates how utilizing pre-existing networks of helping relationships has the potential to produce community participation that reflects the richness of the social and cultural resources that are already embedded within these communities.

The findings show that community-based programs such as the VHTs in Uganda have not harnessed informal helping networks effectively, especially due to the top-down methods employed in recruiting community representatives, which ended up alienating many in the community and maintaining pre-existing power asymmetries between powerful leaders and the general populace (chapter 2 and 3). The results also show that despite the expansion of formal healthcare, community members continue to rely heavily on their informal helping networks for both medical and non-medical issues, sometimes resisting government policy pronouncements (Chapter 4). Finally, the results also show that once these community health volunteers are seen to be helpful in the community, their weaknesses notwithstanding, there will be an increased likelihood of increased mutual support and helping relationships, thus creating a conducive environment where those specific VHT members can benefit from motivational rewards both material and symbolic from those they help to access healthcare (chapter 5).

The embeddedness of informal helping networks which rely on an ethos of social support, solidarity mechanisms and reciprocity makes them an important resource that can be harnessed when implementing community-based health interventions. Modes of tapping this resource in ways that maximize the advantages of this embeddedness are not yet agreed upon by social scientists. Paying attention to these embedded, informal social resources is paramount for understanding how communities negotiate and navigate the different terrains of problem solving, chief of which is access to healthcare.

Although a lot of research has been done that advocates the involvement of existing traditional structures, both cultural and social, in the provisioning of formal/professional healthcare, this study specifically concentrates on how key individuals can be identified and recruited from those existing informal networks of helping relationships. Lessons are drawn from the natural helper model (NHM) to call for a re-imagining of community health interventions through key resource persons both medical and non-medical including their interlocking networks that may be endogenous in various communities. This is especially true in Uganda and other parts of the developing world where access to professional healthcare is dismal.