

# Building Health Through Community Health Workers And Communities: Challenges and Solutions

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Kakoma-Birere, Isingiro  
Western-Uganda



Our Core Outreach Team

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Community based interventions, the sustainable path to UHC

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## Executive Summary

In efforts to achieve our goal of health for all through promoting health care accessibility in the hard to reach and high priority communities, People's Health Movement-Uganda through its grass root organization, Human Rights Research Documentation Centre organized a training workshop in Kakoma-Birere, Isingiro District of western Uganda aimed at improving the skills of the Community health workers (CHWs), Identify barriers faced by patients to access health care, share experiences and knowledge on how a bond between CHWs, frontline health workers and community can be strengthened. We additionally provided medicine supplies and health related products, dentistry and legal aid services. Challenges affecting the health facility's, health workers' and CHWs' performance were identified such as inadequate space to accommodate many patients admitted, insufficient human resource (they don't have a dentist and an ophthalmologist), poor remuneration for frontline health workers, no compensation or motivation stipend for CHWs, electricity disconnection at the facility, no safe and piped water, inadequate consistent training for both health practitioners and CHWs and so many more challenges were identified. We engaged the Local Council leaders and sensitized them on how to promote the right to health, solidarity and support to health through a proper follow up on service delivery with those we entrust with the health mandate as we move towards Universal Health Coverage. Since the CHWs were the epicentrum of our study and outreach, we recommended the following, proper integration of the WHO guidelines on CHWs into our national CHW policy, support a distinct occupational identity for CHWs by the relevant stakeholders, integrate CHW language into local and national healthcare reform legislation, engage CHWs in creation of conjoint definitions and generally recognized standards of core competencies for CHW practice, encourage employers of CHWs and academic institutions to support strong initial and continuing CHW education and capacity building, and strong support of research and funding to create common standards for research studies concerning CHWs.

## Introduction

Community health workers (CHW) are health worker aides in Uganda bridging the gap of health provision in so many remote communities. The umbrella term "community health worker" (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come. They are trusted as members of the community and, have a close and remarkable understanding of the community served. This trusting relationship enhances the community health worker to serve as an intermediary between health services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Community health workers also build individual and community capacity especially in remote settings by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. World Health Organization (WHO) justifies the use of community health workers through its CHW resolution that it passed at the seventy-second World Health Assembly as one strategy to address the growing shortage of health workers, particularly in low

-income countries. Using community members to render certain basic health services to the communities they come from is a concept that has been around for at least 50 years.

Kakooma-Birere in Isingiro district being one of the areas with a widespread inequality in access to qualified health practitioners in Uganda as a result of their inadequate and maldistribution, Human Rights Research Documentation Centre (HURIC) together with its umbrella global network, People's Health Movement (PHM), Makerere University- School of Medicine carried out an impact oriented outreach at Kakoma Health Centre III. This encompassed three significant programs, explicitly; provision of medicine supplies and health related products, dentistry services to the patients in the area, an engagement with the CHWs and the mainstream health workers through a participatory centric model and provision of legal aid to people in the context of social justice in health through the support of Nakuya & Co. Advocates.

## Background

### About the Isingiro district area's health indicators

The district has a population of 486,360 populace, Safe water coverage of 35 percent, Number of Health Centers -53, Staffing levels of health workers- 42percent. Malaria remains the major killer responsible for 44.5percent of the deaths, HIV/AIDS prevalence is 5.9percent generally and 7.2percent among those who tested in 2008, IMR is 83/100 and MMR is 506 deaths per 100,000 mothers giving birth.

### Status of health provision

In Kakoma, the health centre serves a population of 8,800 people, with the health facility staff population of seven health workers (One clinical officer, two laboratory technicians, and four nurses who also act as midwives) and two support staff, however the health facility service provision is auxiliary enhanced by the community health aides who are the Community Health Workers.



### Rational for the Outreach

This was a community based outreach molded in our major objective of promoting health care accessibility for all in the high priority communities which is in line with the goal of Uganda's Health Sector Development Plan (HSDP) 2015/16 - 2019/20 of "accelerating movement towards Universal Health Coverage (UHC) with essential health and related services needed for promotion of a healthy and productive life" as a path to achieve Uganda Vision 2040 of a healthy and productive population that contributes to socioeconomic growth and national development. In the outreach, HURIC/PHM team fundamentally focused on; improving the skills of the Community health workers CHWs, identifying barriers faced by patients to access health care, share experiences and knowledge on how a rapport between CHWs and community can be strengthened. Further, the team with the assistance of a dental practitioner from



Makerere University School of Medicine provided a one-day check-up and treatment in dentistry services.

A one-day capacity enhancing training and experience sharing session was held for the CHWs as mechanism to equip them with the necessary skills in meeting their responsibilities as first-level health care duty-bearers and educating their communities on the important pre-paid health services like community based insurance schemes to reduce the risk exposure to unprepared for out-of-pocket catastrophic health expenditures.

### **Justification for CHWs In The Area and The Outreach**

During our morning engagement on May 6<sup>th</sup>, 2019 with the facility administration, health workers informed us about how CHWs have been an epicentrum in the extension of essential health interventions and linking the health facility with the communities through delivery of outreach services such as; creating a link between vulnerable populations and healthcare systems; community health service system navigation; managing care and care transitions for underserved communities; reducing social isolation among patients; determining eligibility and enrolling individuals into the ongoing public health programmes ie malaria campaigns through mosquito net distribution; informing health facility about community health needs; and basic health education,

As a remote low-resource setting, strengthening CHWs' linking position to enhance sustainable extension of health system through improved working atmosphere is integral in expanding health accessibility for people in Kakoma to essentially contribute to the Sustainable Development Goal #3 of good health and wellbeing and Universal Health Coverage in broader picture.

### **In The Context of WHO Contemporary Guiding Instruments**

The HURIC/PHM outreach and workshop also worked in-line with the SDG #3 and WHO global strategy on Human Resources For Health: Workforce 2030 which focuses on diverse

approaches and mechanisms including CHWs to enhance partnerships to support technical cooperation in health to achieve its objective of strengthening evidence-informed policies to optimize the workforce.



### **The Session with the Health Workers**

Opened by the clinical officer in charge of the health centre, Ms Judith Natuhwera who introduced her health workforce team and our team. She further mentioned the health care projects ongoing such as circumcision, funded by the NGOs like USAID. The centrality of this engagement aimed at

exploring the significant challenges and root cause of the qualified health worker inaccessibility by the patients due to poor staffing levels of health practitioners in this community which are far below the recommended standards of the WHO. It's upon this time that our HURIC/PHM team got to know that the facility has not had a single dentist and ophthalmologist for so many years. In her words the in-charge of the facility says “.....we don't have dental services, we have not had a dentist for so many years, and patients for dental issues are just referred to Mbarara town”. What a dispiriting statement to hear from a facility serving a population close to nine-thousand people! Can the right to health and UHC that our policy enablers have supported on good papers and great statements through global bidding health agreements, be achieved in isolation without the health workers in our health system? The health workforce must remain central in the interplay of all components in the public health system functioning.

**Major challenges that were discussed included;** the inadequate space at the facility, most of the clinics in this area refer most of the patient complicated cases to this health centre. Inadequate personnel mentioned also as one of the most hampering challenges to the facility efficacy, and inadequate funding which makes the facility administration unable to meet the decent pay scale (we were told 84% of staff who migrate to other areas or outside Uganda, quit because of low pay) and poor accommodation services for the staff. We were told, as a faith based health facility situated in a community without any government health centre, the government contribute little to support the facility which is one million Uganda shillings or two hundred sixty four US dollars per quarter, to assist in immunization (four immunization outreaches per month), administration costs and also pay a motivation allowance of fifty thousand Uganda shillings or thirteen US dollars to each health worker per quarter. Which has detrimentally resulted into a substantial migration of their personnel to other areas, and reliance of the facility on patient user fees for its operations. Unfortunately some of the user fees especially the laboratory services are not affordable to some patients which indisputably creates an inequality in accessing certain health services.

**On the maternal health services,** the facility handles up to a maximum of two deliveries per day due to the inadequate space, the clinical officer goes ahead to inform us “....usually we advise people to go elsewhere for delivery, because we have one suit for delivery”. For postnatal care the facility mixes the mothers with other patients, which is a peril to the dignity of a mother and exposure of the newborns to external patient transmissions. No mama kits too at the moment.

**On trainings,** the facility has partners from the district who invite them for the refresher trainings but for a few members in the staff. Unfortunately, the midwives are usually left out for these trainings yet they have to transfer these skills to the community based maternal para-health assistants like Traditional Birth Attendants.

The reporting of the health facility to the Ministry of health is done every month. They also report to the diocese, district and the Uganda Catholic Medical Bureau.

**On the facility's amenities,**

No safe and clean piped running water at the facility, we were told by the facility staff that their tank is leaking, they have to get a person to fetch the water for the health centre and worse of all patients are over burdened with the duty of carrying themselves the water from home especially those that are admitted. The facility largely depend on the rainy water through its now leaking reservoirs or buying water from those hired to fetch it at the cost of five-hundred Uganda Shillings per jerry can. The electricity at the health centre was disconnected and affecting delivery of key health services due to the outstanding accumulated bills that have not been cleared for a very long while.

In our observance as anchors of health rights, electricity is always considered as the last priority in many parts of Uganda. When it comes to its supply in public health facilities however, it can mean life or death. Uganda transferred its ownership of the parastatals to private actors through the divestiture process as a result of the external forces encouraging neoliberalism globalization, now the electricity supplier shuts off power to hospitals, the results are catastrophic, how does one prioritize profitization and better production economic rent at the cost of life!

### **Their work with the community health workers**

The CHWs assist them in the outreach works and campaigns such immunizations since they are well vast with their communities. Also known as the Village Health Teams are given medicines like Mabendazo, Panado and Vitamin C for simple ailments.



### **Community health workers' session**

In this area there are twenty-nine community health workers, ranging from the age of twenty-four years to fifty-five years. They work mainly on the simple treatment ailments (give medicines like mabendazo, panados, Vitamin C etc, which are in first aid treatment), health education through sensitization, proper hygiene and sanitation, and immunization campaigns which are run by the health facility. They also register patients in communities attended to and refer those with

serious illnesses to the health centre.

They mainly get training from the health facility and the sub-county. The training also depends on the programs running and when the need arises.

### **Their selection from the communities**

We were informed, the process goes as follows. The Local Council one confines a meeting through which residents choose one or more members to become Village Health Teams (VHTs)

or CHWs. However, challenge with this, there is no any complaint mechanism on the process in case there dissatisfactions among some members of the community.

**We engaged the Local Council leaders**, and sensitized them on how to promote the right to health, solidarity and support to health through a proper follow up on service delivery with those we entrust with the health mandate as we move towards UHC. Unfortunately, we were informed that, so many programs are introduced in their communities without their proper inclusion from start and education on how they will be executed.

### **How each area is constituted?**

Each community has VHTs constituted of both male and female VHTs. The two can cover over one-hundred and fifty households. They receive a stipend of thirty-thousand Uganda Shillings from the Health Centre for three months. They also get in-kind payments/gifts like food from the members of community for appreciation.

### **Challenges faced**

Poor sensitization from the government, some communities in which CHWs work are not aware of certain government programmes running which becomes tricky for the CHWs to convince their communities.

Long distances trekked.

Some community members don't want to engage in government programmes like immunization due to the cultural beliefs.

Our team also discovered that the CHWs here are not aware of the new government Community Health Workers Extension Policy which had been designed by the Ministry of Health.

### **Their pleas**

Have payments or a compensation mechanism at least.

Get T-shirts and budes for easy identification and recognition in their village cells.

Proper certification at least to show that they are trained.

### **How CHWs here advance Universal Health Coverage**

The community based health insurance schemes have been largely promoted by the CHWs in Kakoma, Akatete, Rutsya and other areas in the Isingiro district. A social protection programme like Twetambire community health insurance scheme which HURIC/PHM team was informed about by CHWs, is fundamental in reducing financial risks and hardships that maybe associated with high out-of-pocket health expenditures during the hospitalization period. Such health expenditures take a big fraction of the households' incomes, the expenditures become



catastrophic and impoverishing in nature. Many individuals who cannot afford the required treatment quite often resort to self-medication using traditional herbs and alternative medicines or a resignation to the natural hypothetical amazing ability of the human body to heal itself. In many instances this leaves patients with severe and chronic complications as a result of a failure to treat the medical conditions early.

This community based voluntary semi-legal insurance system works like other forms of mainstream insurance systems and is based on a prepayment and risk pooling plans through which people pay a nominal fee of twenty-thousand Uganda shillings quarterly for four members of the family in exchange for a compensation of financial cover for medical treatment in the partner health centres. Every policy holder has a book and card which bears their passport picture. Only registered people or the members of this scheme get medical cost cover in the event of sickness.



### The Dentistry services

Part of our outreach programme involved provision of the dentistry services through the assistance of the Dr Jane Francis Namatovu from School of Medicine - Makerere University. Since our long term aim is to achieve health for all in all through impact oriented and human rights based approaches, we helped as many people as possible with dentistry issues since the health centre didn't have any single dentist, we

observed that our assistance to this area would be counterproductive to dental services inaccessibility and we basically would be just like all the other charity services that we incorporated in this outreach program. We helped people of diverse ages including the children that needed pediatric dentistry services and adults that needed dental treatment.

However, we also engaged some of the local council leaders this area for proper provision of health services more on critical positions at this health centre which have not yet been filled by vital medics like dentists and ophthalmologists. Political leaders are key in lobbying strategems for more resources essentially for health services, their political will and action is vital in closing the resource gap and linking institutions and citizenry to secure funding for the fragile parts of the health systems. Proper funding for health therefore is a sustainable path to achieve UHC, as this increases access to proper timely treatment and availability of the necessary human resources.

### Legal Aid

Through the assistance of our legal team led by Ms Maria Gorrete Kaluhanga, we provided legal advice, education, and mechanisms for addressing health related injustices that were presented to our team and alternative dispute resolutions to the



community members that approached our legal aid clinic. Our inventive strategies coupled legal aid with health care and health rights which we sensitized the community and health practitioners at this health centre on to continue their work in providing accessible and culturally relevant health care services.

### **Recommendations from HURIC/PHM**

In spite of the recent progresses in workforce development and a growing acknowledgement of CHWs' abilities to affect health disparities, access to care, quality of care, and health care cost containment, much work remains to be done. Full integration of CHWs into the health and human services systems requires further vigorous effort to support CHW workforce development; through pre service training, competency based certification, supportive supervision, data collection, community engagement, target population size, resources and availability of supplies, sustainable funding; and to strengthen community-based organizations employing CHWs in outreach and education efforts as enshrined in the WHO guidelines on CHWs.

We recommend that all public health and human service professional organizations support and promote a distinct occupational identity for CHWs as acknowledged in the WHO guidelines on health policy and system support to optimize the community health workers' programs -2018, including support for the growth and development of the established CHWs' groups/circles and recognizing the term CHWs as an umbrella occupational category embracing multiple titles such as "outreach worker".

Request that public health institutions and healthcare advocates and policy enhancers to integrate CHWs and CHW language into local and national healthcare reform legislation such as the recently proposed Community Health Extension Workers' (CHEW) policy related dialogues and initiatives.

We urge the public health and health care industry officials to engage in a campaign to raise awareness of CHWs and their potential to improve access to care, eliminate health disparities, improve quality of care, and control the cost of care as a leeway to strengthen the right to health.

We call on public policymakers and other relevant stakeholders to engage CHWs in creation of conjoint definitions and generally recognized standards of core competencies for CHW practice, based on an updated understanding of core CHW roles as recognized by the World Health Organization and the CHWs' resolution passed in the Seventy second World Health Assembly.

Encourages employers of CHWs and academic institutions to support strong initial and continuing CHW education and capacity building for CHWs, implemented in a manner allowing multiple points of entry into practice so as to establish standards and qualifications for certain job titles such as "patient navigator" in communities explicitly to acknowledge the capacity of well-qualified CHWs to serve in such positions.

HURIC/PHM did a simple study on CHWs Kakoma Isingiro- district, western Uganda, but the challenges facing CHWs are diverse which need strong support of research and funding to create common standards for research studies concerning CHWs and make these studies more comparable and replicable and to create an evidence based CHW field which is comprehensive, coherent and useful to inform public policy.

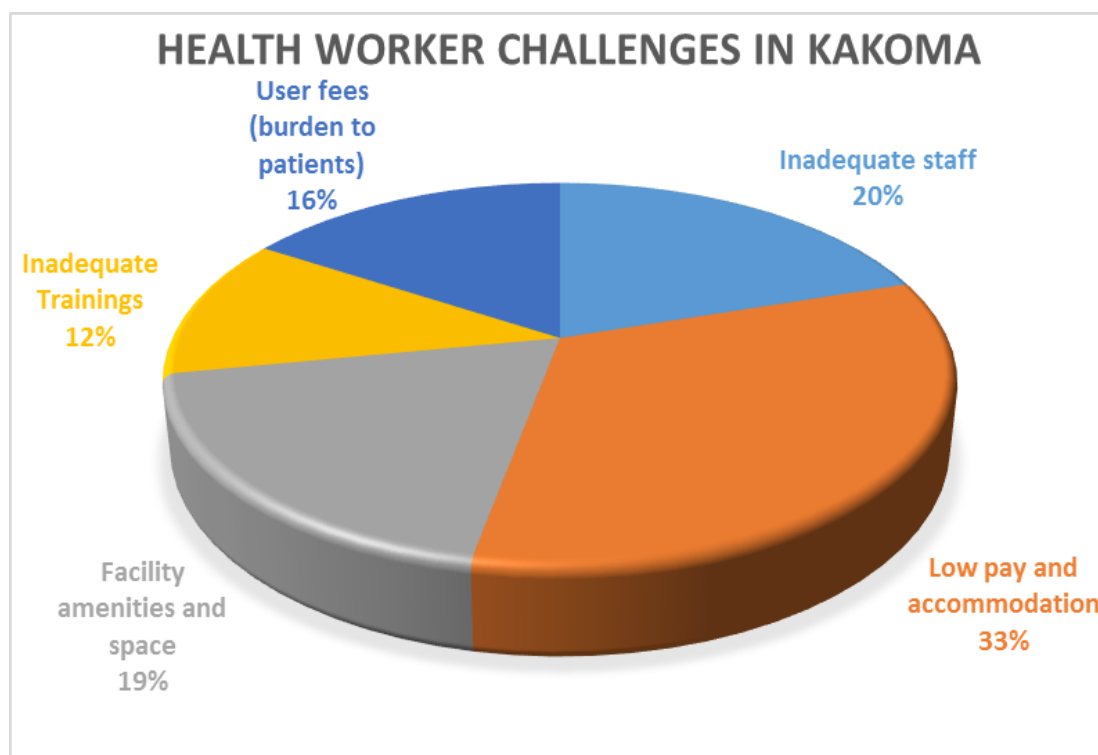
To motivate CHWs employers and funders should recognize CHWs' contribution to the public health and healthcare infrastructure by compensating CHWs (equal pay for work of equal value) at competitive wage levels at or above a locally determined living wage and providing employee benefits comparable to those received by other health professionals.

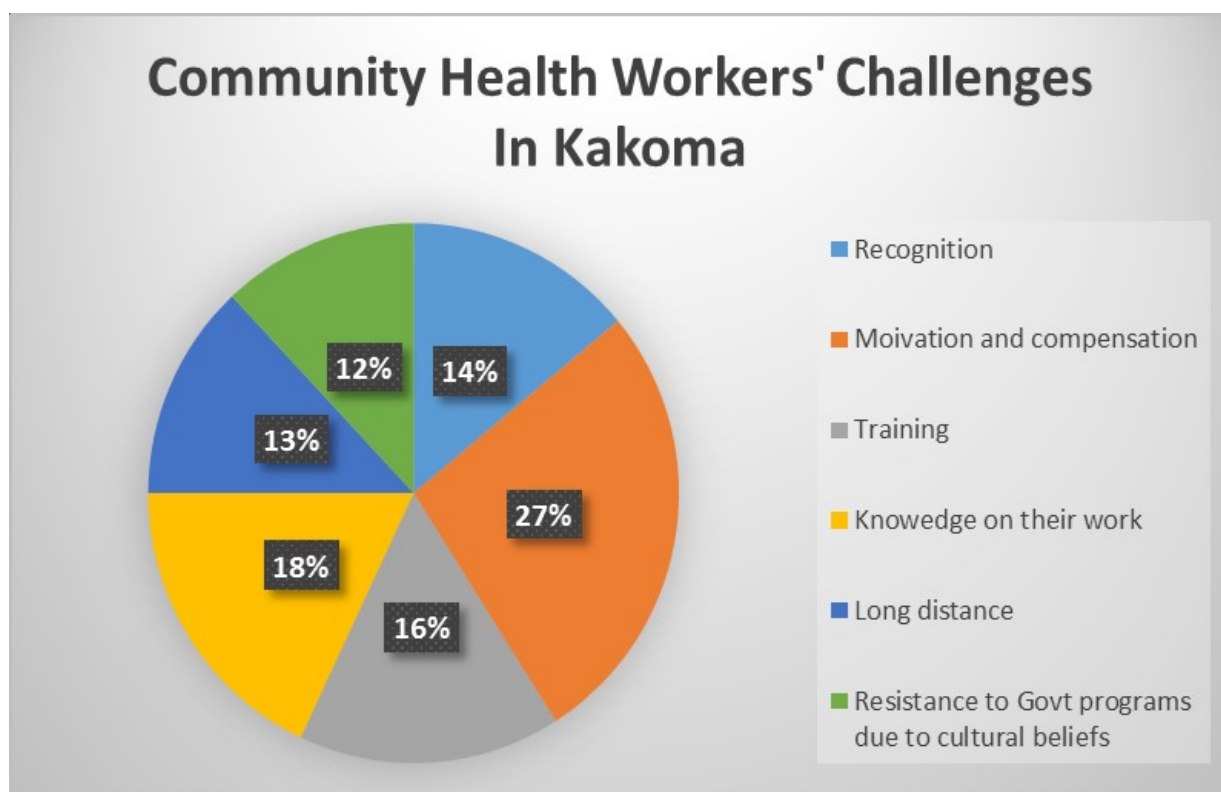
## Annexes

*Pie Charts ranking challenges facing HW and CHWs in Kakoma.*

### Methods to compile the data

*The challenges were based on the study that was done by our HURIC/PHM team during the outreach. This was based on **Purposive sampling** through use of sample questionnaires and the engagement that we had with both the frontline health workers and the community health workers through which these challenges were sighted out, and ranked*





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