Understanding Community Health Workers' Motivation, Function and Role in Uganda

Literature review on Village Health Teams in Uganda

Introduction

Uganda has a large-scale Community Health Worker (CHW) programme known as Village Health Teams (VHTs) which has been operational since 2001. The programme is primarily voluntary with small financial incentive introduced over the years, mainly for reimbursement of transport costs or social mobilization events. A range of non-financial material incentives have been introduced by different programmes in specific areas. With heavy reliance on external funding, there has been very little standardization in the VHT programme for the past 20 years.

From 2018, a new cadre of Community Health Extension Workers (CHEWs) were to be introduced to augment the existing VHTs and provide a stronger link between the community and health facility. CHEWs were to be paid a monthly consolidated allowance. Despite this policy development, the support for the CHEW approach has faltered and the policy has not been approved by the Government.

The commitment to a fully institutionalised and remunerated CHW programme remains evident, and it has been the response to the COVID-19 pandemic and the development of National Communication Engagement Strategy for COVID-19 response that has created an opportunity to establish a monthly allowance to a formerly volunteer cadre of VHT. A COVID-19 focused package of tools has been outlined and considered as necessary enablers to perform their tasks. Beyond the initial commitment of three months, it is not yet known how long this package of incentives is planned for.

It is within this shifting context that research into the motivated structure for community frontline workers is now much needed. Understanding the complexities of factors that affect CHW motivation and designing the right combination of incentives and support structures is essential for the MoH in Uganda to institutionalize the CHW programme at scale and allocate sustainable financing beyond immediate needs of the resilient health systems in Uganda.

This paper examines understanding the motivation of existing community health cadres focusing on CHWs' roles, functions and motivations to attain one of the key objectives of the Ugandan Community Health Acceleration Roadmap.

Methodology

A global and local literature review was conducted, and 32 global studies and 15 local Ugandan studies were included. The aim of this literature review is to summarize key findings from global approaches and Ugandan studies that analyze motivation for CHWs along with the role and function this plays in health service delivery. This study was supported by UNICEF's commitment to community health systems strengthening under the intelligent Community Health Systems (iCoHS) initiative, a partnership with The Rockefeller Foundation.

Results and Discussion

This section applies the findings of the literature review to the Uganda context and considers options for increasing motivation and retention in the national VHT programme. The Uganda specific literature review has been centred around the existing VHT programme (in all its various forms) but must take into account the development and recent stalling of the CHEW policy.

This policy could still have far reaching implications for the future of VHT programme. Very little policy attention has been given to developing the incentive package for VHTs for the last few years despite much energy focused on garnering financial support for the CHEWs implementation

By 2021 the situation had changed significantly, the CHEW policy was not passed by parliament, the country was rapidly mobilizing to respond to COVID-19 and the country advanced the decentralization agenda with the Parish Development Model that promotes greater local government and community engagement in the provision and monitoring of services including health.

It is in this context that UNICEF is supporting a re-examination of global and local literature related to motivation and retention of CHW programmes in order to develop recommendations in the form of a policy brief for MoH and Government of Uganda stakeholders in community health.

Literature shows that motivation is complex and attention must be given to hardware and software factors. The consensus is that some form of commensurate financial remuneration is required. This must be consistent and fair or it runs the risk of demotivating and creating tension. However, relying on financial incentives is insufficient as it cannot compensate for motivation generated by community acceptance, trust and valuing of positive contribution. Investments in programme enablers and support could have a significant effect on motivation and can even off set demands for financial packages. This is an important option for countries where a long-term financial commitment to the CHW programme cannot yet be materialized. Material but non- financial incentives such as T-shirts, bags and gumboots are important but unlikely to be sufficient to sustain motivation over time. Supportive supervision, retraining and community acknowledgement are increasingly being understood to hold much weight in long term motivation.

Health sector enabling environment has not been conducive to motivating and standardizing the VHT programme. Findings on how CHW expectations affect motivation are particularly relevant for Uganda. Themes of broken promises, delayed payment and inconsistencies are very much in evidence in the Uganda specific studies. A fragmented programme environment has developed where different incentive and support packages are available to different cadres of CHWs. Whilst NGOs may have been trying to fill gaps in government investment in the VHTs programme, there is considerable evidence of the damage that short lived project-based support can do to VHT motivation. Studies have shown that a lack of standardized support has led to demotivation, loss of trust and high attrition rates.

However, one positive result from the lack of standardization is that Uganda has a diverse experience with CHW incentives based on different modes of engagement across different focus areas and supported by different development partners. If well consolidated, these can offer important insights into motivational factors and can guide a more harmonized policy environment.
Motivation of CHW programmes reflects the values of the society around volunteerism and the broader issue of how governments and its citizens should interact in promoting health and well- being. Ugandan studies generally valued the VHT model and whilst many national researchers concluded that the volunteering spirit has been eroded over time, this was due to the basic needs of the programme not being met. Very few researchers critiqued the fundamental basis of the VHT programme. It is likely that the failure of the CHEW policy was in part related to resistance to change the nature of the VHT programme. The Political Economy Analysis (PEA) indicates that while the introduction of a new slimline and more efficient cadre makes sense from a health systems point of view to drive forward primary health care and UHC agenda, the Ministry of Health and partners may have misjudged the support for the VHT programme from local government and communities. The PEA also makes reference to the VHTs as being part of the local political process as they are considered to be significant influencers and mobilizers within their communities.

Overall, there was positive appreciation for the scale and the reach of the VHT programme, in that it provided 4-5 VHTs per village. Most of the studies framed this within the context of the chronic shortage of health workers to reach dispersed rural communities. However, authors concurred that the VHTs' role was to bridge the gap between the service providers and the community. For instance, studies in Uganda described the success of the VHTs as mobilizers around behaviour change for protective health behaviours, rather than providers of curative services. The CHEW policy only made provision for 2 CHEWs at the parish level and would have fundamentally changed the landscape for community based primary health care.
This finding is very much in line with the idea that incentive hardware has to be considered with an appreciation of the software, i.e. the relationships, trust and expectations between VHTs and the communities that they serve. Health system supply side solutions which tend to prioritise monetary incentives should not be developed at the expense of ignoring the underlying nature of the Uganda CHW program.

Community Health Worker motivation is increasingly seen from a multi-sectoral lens and under the purview of local government. The 2018 Astana declaration on Primary Health Care promotes multisectoral action, engaging relevant stakeholders and empowering local communities to strengthen health and well-being. At the local level, countries on the path towards universal health coverage are striving for better integration between actors for community health, social care/social protection, environmental health and elimination of harmful gender norms including child marriage and Gender Based Violence. The literature clearly demonstrates that funding of CHWs has a bearing on how communities see the CHWs. This is particularly important in the Ugandan situation where there is evidence of conflict between how much VHTs are seen as part of the community or part of the health system. Studies describe high levels of distrust between communities and the health system in Uganda. Incentive packages provided by local governments that align with other community workers is an important way of defusing this issue. Local governments and communities can also bring other resources to bear to support community health workers based on flexible local needs. Both financial and non-financial incentives from the parish level structures could include material/branding support, peer supervision, cross learning, training on communications skills, social rewards and career opportunities.

Indeed, the response to COVID-19, has also moved beyond health sector actors and whilst acknowledging the primacy of the health system, the 2021 Community Engagement Strategy is implementing a multi-sectoral model of COVID Task Committees. There has also been a willingness for local government funds to be used to support and motivate VHTs to manage the covid response at the village level. Further exploration of this model on motivation levels and relationships between the 4-5 VHTs themselves is an important next step.

There is a lack of discussion in the literature on expected retention rates and what might be reasonable for a large-scale volunteer programme. A number of studies in Uganda have demonstrated fairly high levels of retention, with VHTs staying in service on average between 5-10 years. Some researchers have concluded this is a very positive situation given the key challenges faced by lack of investment in the programme and the increasing workload which has had important opportunity costs for other income generating activities.
With only a few studies attempting to understand the reasons for attrition, there is little information for policy makers to go on to design incentives that actually respond to VHT realities. In the Uganda context, income generation opportunities to offset the impact of volunteering are not well explored in the literature and few models have emerged. In particular, gender differences in reasons for leaving have been noted in the literature such as divorce or lack of husband/family approval, but very little attention is paid to gender sensitive incentives that promote women to stay as volunteers longer.

Exploring gender sensitive incentives and motivational support in Community Health Worker Programmes has the potential to improve programme outcomes and raise the bar on empowerment for female health workers. There is significant debate about whether female-only CHW programmes such as in India, Pakistan and Ethiopia are empowering women or reinforcing traditional gender roles and women's limited status and position. Jackson (2019) describes how Ethiopia has chosen a culturally acceptable approach for its community health workforce. Given women's limited power at the bottom of the hierarchy, they are forced to operate within existing gender norms but lack a meaningful voice in community health policy and discussions on remuneration and institutionalization.
For Uganda, where a mix of both genders is generally acceptable, and in the context of the shift from a voluntary to a financially remunerated CHW programme, there are now important opportunities for identifying and addressing gender barriers that affect motivation and retention

Conclusion

In summary, as shown by the recent costing analysis of the CHW programme, investing in a financial incentive package for the community health workforce requires significant cost over the medium to long-term. Without taking the time to consider the evidence, the position of stakeholders, the gender implications, and the long-term financing sustainability, there is a high risk of getting it wrong. Undoubtedly some planners and decision makers are looking for quick wins, a package of financial and non-financial material incentives that can be doled out through the health sector as a magic bullet to remedy years of underinvestment and disharmonious practice. However gathering of evidence and opinions should increasingly include VHTs and their communities as part of the dialogue, if the gains for VHTs are to be sustained.

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