Potential challenges of implementing the Community Health Extension Worker programme in Uganda

James O'Donovan,1,2 Christina Elise Stiles,2 Deogratias Sekimpi,3 Isaac Ddumba,4,5 Niall Winters,1 Edward O’Neil Jr2

Uganda faces a significant shortage of trained healthcare professionals, especially in the public sector and rural areas. As a result, the Ministry of Health (MoH) has supported delivery of the Village Health Team (VHT) model since 2001. VHTs are lay people, working in a voluntary capacity, acting as a link between the formal health sector and their communities. They are given basic training on major health issues, including childhood diarrhoea, malaria and pneumonia, and play a role in disease surveillance through activities such as data collection and reporting.

Although the exact selection process for those wishing to become a VHT member varies depending on location, individuals commonly undergo selection starting in their own communities. After a period of sensitisation and consensus building among local stakeholders, a popular vote is held. To be selected as a VHT member, an individual must meet several criteria. He or she must be ‘above 18 years of age, a village resident, able to read and write in the local language, a good community mobiliser and communicator, a dependable and trustworthy person, someone interested in health and development and someone willing to work for the community’. Unlike formally trained healthcare professionals, such as doctors and nurses who are based at health facilities, VHT members are based in the communities in which they live and serve. This means the roles they play and the expectations that community members have of them are likely to be different.

Yet, despite reported successes of VHTs in improving and promoting health at a community level, challenges remain regarding their motivation, remuneration, training and retention. To try and address these issues, the Ugandan MoH has announced the planned roll out of a Community Health Extension Worker (CHEW) programme.

The proposed roll out of the Community Health Extension Worker (CHEW) programme is due to take place in Uganda in 2018 at an estimated cost of US$102 million over a 5-year period.

Although this is a welcome move towards supporting the existing Village Health Team (VHTs) cadre of community health workers, several challenges and potential solutions are raised in this article.

Uncertainties remain around potential tensions that may arise between current VHTs and the new CHEWs, the logistical implementation of the programme and financial sustainability.

To try roll out of the CHEW programme, greater attention must be given to the practical, logistical and financial challenges of the proposed strategy, taking a health systems strengthening approach towards implementation.
the introduction of a paid cadre of community-based health workers, questions have been raised regarding whether VHTs will continue to be willing to volunteer their time. A study by Mbugua and colleagues, found that discrepancies in pay between volunteer and salaried community health workers in Kenya resulted in poor levels of motivation and higher levels of attrition in the unpaid cadre. These responsible for implementing the CHEW policy should therefore consider strategies that have been shown to increase community health worker performance and motivation, in order to ensure existing VHTs do not feel undervalued. This might include the provision of tangible incentives, such as equipment and supplies, but also ensuring VHTs ideas, interests and relationships are duly considered so that tensions between the two cadres are minimised. Whichever incentives are chosen, they must be responsive to the needs of VHTs.

Additionally, there is potential for tensions to arise between CHEWs and community members. In a study by Musinguzi and colleagues, it was noted that community members in rural Uganda were distrusting of paid health workers, since they were concerned they might be profiting from referrals to health centres. Working closely with community members so that they understand the role of CHEWs will therefore be important.

The second challenge lies in the practical and logistical implementation of the programme. In the Mukono District where we work, there are nine parishes in the Ntenjeru subcounty alone, with a total population of approximately 550,000 people. Given the MoH have proposed allocating two CHEWs per parish, covering this number of households between 18 CHEWs will be extremely difficult, especially since they will spend just 60% of their time in the community and the remaining 40% in health facilities. Despite initially proposing to dissolve the VHT programme entirely and replace it with the CHEW model, the Ugandan MoH have now stated that CHEWs will supervise VHTs who will remain active in the community. Utilising both care of health workers would make sense, given the logistical challenges of covering such a large population over a vast area, however, as previously mentioned, consideration must be given to the power dynamics and resulting conflicts that might arise.

It is also important to note the different, but complimentary roles that CHEWs and VHTs might play. Compared with the selection criteria for CHEWs, which largely focuses on the pre-service level of education, the selection criteria for VHTs places greater emphasis on community engagement, communication, trust and respect. Additionally, unlike CHEWs, VHTs are specifically selected by their own communities, meaning they could continue to play important roles in community mobilisation and advocacy.

The third challenge lies in the financial costs and sustainability of the programme. Implementing the CHEW strategy will cost an estimated US$102 million over a 5-year period, representing approximately 10% of the MoHs budget at present. Since the Ugandan public health system is already underfunded, introducing this paid cadre of CHEWs may not be possible without the support of external donors or a restructuring of the budget. Furthermore, although this proposed investment into community health must be welcomed, appropriate long-term funding into the health system at every level should also be encouraged so that this intervention is not approached in a vertical manner, but rather contributes to a wider health systems strengthening approach.

Finally, CHEWs and VHTs cannot be regarded as a panacea to address the dire shortage of health professionals seen across all cadres. Continued investment into the recruitment and training of other cadres of health workers must occur simultaneously. Second, it is important to note that the complex and multifaceted challenges facing community level healthcare in Uganda extend beyond the recruitment, training and deployment of CHEWs. As such CHEWs should not be seen as a ‘silver-bullet’ solution, but rather as one piece of a complex, multifaceted puzzle, which requires concurrent strengthening of other key areas known to influence community health. Taking this holistic approach will help to ensure that strong foundations are in place to maximise the potential benefits of the CHEW strategy.

In conclusion, prior to roll out of the CHEW programme, greater attention must be given to the practical, logistical and financial challenges of the proposed strategy. If these issues can be addressed and the relationship between CHEWs and VHTs harmonised, this initiative could represent an exciting opportunity to improve the attention and support given to community-based healthcare in Uganda.

Contributors J O conceived the initial idea for the manuscript and wrote the first draft with assistance from CS, DS, ID, NW and EO then significantly contributed to a revision of the final manuscript for intellectual content and structure. All authors approved the final version prior to final submission.

Funding This study was funded by Economic and Social Research Council (ESRC).

Competing interests None declared.

Patient consent Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

Data sharing statement This is not an original research article and thus no data is available.

Open access This is an open access article distributed in accordance with the Creative Commons Attribution 4.0 Unported (CC BY 4.0) license, which permits others to copy, redistribute, remix, transform and build upon this work for any purpose, provided the original work is properly cited, a link to the licence is given, and indication of whether changes were made. See: https://creativecommons.org/licenses/by/4.0/.

REFERENCES
1. Baine SO, Kasangaki A. A scoping study on task shifting; the case of Uganda. BMC Health Serv Res 2014;14:184.

BMJ Global Health
BMJ Global Health: first published as 10.1136/bmjgh-2018-000960 on 10 August 2018. Downloaded from http://gh.bmj.com/ on March 5, 2024 by guest. Protected by copyright.


