

“They have been neglected for a long time”: a qualitative study on the role and recognition of Rural Health Motivators in the Shiselweni region, Eswatini

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Abstract

Background: Community health workers (CHWs) are increasingly engaged to address human resource shortages and fill primary healthcare gaps. In Eswatini, a cadre of CHWs called Rural Health Motivators (RHM) was introduced in 1976 to respond to key public health challenges. However, the emergence of health needs, particularly HIV/TB, has been met with inadequate programme amendments; and the role of RHMs has become marginalised following the addition of other CHWs supported by non-governmental organisations. This study was implemented to understand the role of RHMs in decentralised HIV/TB activities. In this paper, we explore the findings in relation to the recognition of RHMs and the programme.

Methods : This exploratory qualitative study utilised individual in-depth interviews, group and focus group discussions, participatory methods (utilising a game format) and observations. Participants were purposively selected and comprised RHM programme implementers, community stakeholders, and local and non-governmental personnel. Data collection took place between August and September 2019. Interviews were conducted in English or siSwati and transcribed. SiSwati interviews were translated directly into English. All interviews were audio recorded, manually coded and thematically analysed. Data was validated through methodical triangulation.

Results: Suboptimal organisational structure and support, primarily insufficient training and supervision for activities were factors identified through interviews and observation activities. Significant confusion of the RHM role was observed, with community expectations beyond formally endorsed tasks. Community participants expressed dissatisfaction with receiving health information only, preferring physical assistance in the form of goods. Additionally, gender emerged as a significant influencing factor on the acceptability of health messages and the engagement of RHMs with community members. Expectations and structurally limiting factors shape the extent to which RHMs are recognised as integral to the health system, at all social and organisational levels.

Conclusions: Findings highlight the lack of recognition of RHMs and the programme at both community and national level. This, along with historical neglect, has hindered the capacity of RHMs to successfully contribute to positive health outcomes for rural communities. Renewed attention and support mechanisms for this cadre are needed. Clarification of the RHM role in line with current health challenges and clearer role parameters is essential.

Introduction

Community health workers (CHW) are increasingly recognised as an integral part of the health system (1–7) and are used to address human resource shortages and improve access to basic healthcare (3–5,7–11). Overall, the scope of CHW work includes the provision of social services and the “promotion of preventive or curative primary health services” (3) often in hard-to-reach areas and lower/middle income countries (3,4,12–14). In the HIV response, CHWs have provided health education, mobilisation of HIV testing, client follow-up, adherence support and condom distribution (15). Although CHW programmes enhanced the reach and uptake of HIV services in sub-Saharan Africa (15), challenges persist including fragmented services(6), poor integration with the health system (6,16–18), insufficient support (19) and lack of training (6,20) as well as insufficient remuneration (15,20).

Eswatini faces a myriad of health challenges (7,11,21). The Ministry of Health (MoH) recognised the role community volunteers play to increase the uptake of health services, and established the Rural Health Motivator (RHM) programme in 1976. This responded to the main primary health needs of the time (e.g. hygiene, nutrition, infant mortality). More recently, the programme has focused on health promotion messages, household assessments and general community health referrals (22). With the declaration of a national HIV emergency in 1999 (23), the programme also incorporated some HIV and (tuberculosis) TB related responsibilities (22).

Certain elements of the programme have been highlighted for further development. RHM leads were introduced to improve supervision (6) and given reporting responsibilities in addition to regular tasks (14), yet elaboration on support mechanisms is still needed (5,7). The existence of parallel donor funded CHWs (7) performing HIV/TB specific tasks has resulted in ambiguity around the RHM role. Low remuneration (7) highlights tensions in the role of volunteer versus compensated CHW (6). Lastly, community trust of the group could be improved, partly influenced by the predominantly female RHM workforce (5), RHMs working in home communities (5) and training (7).

Table 1
Main characteristics of RHM programme

- Over 5,000 RHMs in the country (majority female)
- The programme aims to reach every household in the country
- RHMs are chosen by community leaders and work in their home communities
- MoH gives a monthly stipend of 350 Swazi Emalangeni (approximately 24 USD)
- The programme stipulates working hours of 2.5 days per week
- Main RHM responsibilities:
 - Visiting homesteads/households
 - Referrals to health facilities
 - Health education on hygiene, nutrition, antenatal care, immunisation and HIV/TB
 - Community based growth monitoring
 - First aid

The study aimed to understand the role of RHMs in decentralised HIV/TB activities. Due to the above shortfalls, we will focus on the RHM experience of programme recognition, and the understanding of their role by key stakeholders, including community and leadership and government structures. This study intends to inform the MoH on future iterations of the RHM programme and health policy, assist NGOs (including MSF) in how best to support RHMs, as well as inform CHW programmes in comparable settings.

Methods

Study design

This study used a qualitative research design with an exploratory approach (24). Data was gathered between August and September 2019, using individual in-depth interviews (IDIs), participant observation,

focus group discussions (FGD), and group discussions including participatory methods to understand the different perspectives of participants.

Setting

The predominantly rural Shiselweni region has approximately 210,000 inhabitants with an estimated HIV prevalence of 25.9% - 36,000 people living with HIV (25). Shiselweni comprises three health zones with each served by one secondary care facility and approximately eight primary care clinics. An estimated 1,200 RHMs operate in the region under the supervision of three RHM trainers.

Two areas were selected as study sites, both remote with substantial distance to main roads and poor transport availability, allowing the comparison and contrast of RHM experience. Disparity of access to health services distinguished the areas; one had a primary healthcare clinic while the other had significant distance to any health services.

Study population

The study population comprised RHMs, RHM trainers, community leaders and members, MoH nurses, Key Informants (KI) from MoH and Ministry of Tinkhundla Administration and Development[1], Médecins Sans Frontières (MSF) staff and people living with HIV.

[1] The country is subdivided into rural councils known as Tinkhundla

Table 2: Characteristics of the study participants per methodology

| Methodology of data collection | Participants | Number of interviews |
|---|---|--------------------------------------|
| IDI | RHM MoH nurse Community leader RHM trainer KI MoH KI MTAD MSF staff | 8 2 2 2 2 1 2 3 |
| FGD | Women Men People living with HIV (women) | 2 1 1 |
| | | <i>Total of 29 participants</i> |
| Group discussions (using participatory methods) | RHMs | 1* |
| | | <i>Total of 5 participants</i> |
| Groups discussion | Men | 1 |
| | | <i>Total of 3 participants</i> |
| Observation | RHMs | 4* |
| *Observation and participatory methods were done with RHMs already interviewed, in order to further develop a trusting relationship and to add depth to understanding of IDI discussions. | | |

Sampling and recruitment

Purposive sampling was used to identify potential research participants with stakeholder sampling based on those most involved in the RHM programme (26). Community leaders were approached to explain the study before participant recruitment and assisted in mobilisation for FGD. Those identified were invited to participate in interviews organised in relevant community settings by research assistants and MSF staff working in Shiselweni communities. RHMs engaged in observation and group discussion were selected

based on willingness after IDI. RHM trainers were interviewed and gave permission for individual RHM involvement. KI interviews were arranged by the RHM programme manager.

Data collection

IDIs were used with all participants to gain a broad perspective of the RHM role and to understand the social and organisational context in which they work. FGD were used to gather views of the community (both men and women) and people living with HIV, to allow in-depth understanding of RHM work and community reception. Observation was used to gain a stronger understanding of RHM activity and community engagement. As understanding the RHM experience was paramount, a group discussion using participatory methods was conducted with RHMs (27). Mixed data collection methods were applied for RHMs for a better understanding of their work, challenges, and recommendations.

Interviews were conducted in English and siSwati, depending on participants' preference. Two female research assistants, fluent in siSwati and trained in qualitative research, conducted the siSwati interviews. Interview guides were developed and discussed in depth with the research team and additional themes were added if needed from interview experience. After each siSwati interview, the Principal Investigator (PI) debriefed with research assistants to discuss main themes, translation issues or difficult questions.

An observation template was used in order to incorporate additional aspects of the RHM perspective. The participatory methods discussion was conducted in a comfortable and open environment. A game format was utilised, designed by the PI and pre-tested with the MSF community team.

Data analysis

All interviews were transcribed verbatim by the research assistants (interviews in siSwati translated directly into English) and PI (interviews in English). Notes from observations, participatory exercises and additional notes taken during research were typed. Research assistants validated each other's siSwati interview transcripts, and overall quality control and assurance of all transcripts was done by a co-investigator experienced in qualitative research and the context.

Data was coded manually by the PI, developing codes, categories and themes from the data. This approach allowed for comparisons and contrasts to be made among transcripts (28,29) and for key issues to be identified (29). To ensure consistency of data analysis, continuous discussions were held between the PI and co-investigators to explore emerging themes and develop coding schemes. For supporting analysis, the PI discussed findings with members of the MSF community team.

Data validation was ensured through methodological triangulation (24) and continuous reflection and discussion within data validation workshops. Workshops were held with RHMs to assess the extent to which research findings were representative of their perspectives. Contributions on suggested amendments were included in the analysis and recommendations.

Ethics and informed consent

The study protocol was approved by the MSF Ethics Review Board and Eswatini's National Health Research Review Board. All participants provided written informed consent before study enrolment.

Results

This study identified misunderstandings of the RHM role and the structural limitations that reduce their effectiveness. These two components underpin and influence the extent to which the programme is recognised and accepted at the health system, community and individual level. Gender further influences how the community experiences and recognises the work of RHMs.

1. Understanding of the role

1.1 The RHM role: "their visibility is not clear"

Confusion over the exact role of RHMs was widespread among all study participants, including MoH representatives. Some common understandings of the focus on sanitation and hygiene emerged, yet numerous additional responsibilities were identified ranging from looking after sick people to "giving pills". The historical development of the RHM programme was noted as a reason for this confusion at community level, with many comparisons made between the original and current role. Regarding HIV/TB work, little was mentioned without probing. Historical inclusion of home-based care for HIV was occasionally stated, with challenges on disclosure and promoting condom use often cited. Older community members were more likely to know RHMs personally. Observation showed RHMs focus on older community members in household visits, with the exception of babies.

1.2 Expectations: "when you are going to check on a sick person, bring a hoe"

There is an expectation for RHMs to work past their MoH endorsed role. Additional tasks included distribution of food parcels, collection of money, and washing dead bodies. Such tasks affect RHM relationships with community members, the latter perceiving RHM bias in choosing 'favourite' households for distribution of food. Expecatations were identified at community, clinic and governmental level, with some RHMs being asked to clean clinics.

Community members expressed an understanding and expectations for RHMs to provide more than health education and clinic referrals:

"When my wife was sick, [the RHM] used to come to my home, even when she was weeding she could come and assist her, the role of the RHM stayed in my heart as a big thing." (Male community member)

Various reasons for poor recognition emerged, including that RHMs no longer provide first aid material (historically distributed). One RHM emphasised that community members complain:

“A person will come when you are teaching and tell you they have a headache, you do not have paracetamol, so when you are teaching, they will not listen because there is nothing that you have helped them with.” (Female RHM)

During IDIs, RHMs were positive about reception from community members, only discussing these challenges more openly in the group discussion. Community expectations and confusion over what health education entails, leads to assumptions of RHMs doing work for community members, e.g. building a latrine after sanitation education. One RHM explained this, including the influence community leaders have on community expectations:

“The way [community leaders] say it, it sounds like we are supposed to do it for the people. The people will also think that a RHM is someone that has nothing to do.” (Female RHM)

2. Organisational structure of the RHM programme

Several aspects related to the organisation of the RHM programme, emerged from the data. It was identified that RHMs could absorb new activities and deliver health programmes more effectively with appropriate training and materials provided. The MoH and NGOs do not consistently provide RHMs with sufficient training, materials and support needed to perform required tasks.

Comparing RHMs with Active Case Finders (ACF) of the TB programme, a KI explained the success:

“Ask anything to an ACF right now they give you... the knowledge the ACF has it is more than what the RHM has. Because we trained them.” (KI, MoH)

Following initial training, RHMs reported that they felt neglected. Accessing formal programme support structures was a common challenge. In particular, a lack of supervision was mentioned, with several RHMs explaining that they needed more supervision to have their work validated or corrected.

The large number of RHMs and the ratio to supervisors was highlighted by MoH KIs as a limitation in the programme structure.

“... For the RHM programme manager to manage 5,000 people, that's a very big group of people.” (KI, MoH)

The RHM programme falls under the MoH. An MoH KI admitted to not knowing what the RHM job currently is.

“I'm not sure, honestly I just have to be honest, I'm not sure” (KI, MoH)

Participants reported a lack of collaboration between national and regional levels, with current MoH structures hindering RHM performance and programming.

"They are so many that their data should have an impact in the country. But from what I've seen, it seems the national level has to come up with a system..." (KI, MoH)

Lack of organisational structure was also seen in the absence of clarity on HIV/TB activities. KIs and MSF staff explain how other CHW groups like the ACFs were given TB specific tasks and relevant training, leaving the RHM role unclear in terms of HIV/TB. The position of the RHM programme within the broader MoH system was clearer at the peak of the HIV crisis, compared to the current low prioritisation of the programme:

"We were working together but it was then, when HIV was a problem, we had good relationship because we wanted to see them taking care of the sick..." (KI, MoH)

Insufficient stipends, termed "soap money", was commonly cited as a challenge and often affected the RHMs' ability to present themselves as professionals in the community. Irony in terming it a 'salary' was acknowledged. MoH informants discussed how this could affect motivation, with the need to cover transport costs leaving some at a loss each month. RHMs considered insufficient stipends as a lack of 'consideration' for them and their work:

"We are wondering if the [government] may consider us and give us a bit of something so that even as I go along the mountains, it may feel easy to walk if there is money making me happy" (RHM)

"Unfortunately my sneakers are worn out. You wouldn't want to arrive to people dressed like that, you need to dress better" (Female RHM)

3. Recognition

3.1 Self-recognition: "It's something in the heart, you just get happy that you have done the visit" (RHM)

Many RHMs portrayed their work as significant, explaining it as an 'act of service'. Numerous RHMs invoked religious language when describing their work, often involving elements of benevolence. Responding to socio-economic challenges, the majority of RHMs discussed sharing their own food with community members under their care, and paying for transport to clinics.

Contrasting with this however, RHMs saw limitations in their efficacy. For HIV, they emphasised that 'nothing' can be done but to motivate people to go to the clinic where doctors could provide substantial help.

"The stories [health promotion], they already know, we have already told them, only we have nothing helpful ..." (Female RHM)

3.2 Visibility and respect for RHMs: "We have them, but we do not see them"

There is consensus that no 'one' type of RHM exists, with commitment to work schedule, skill and knowledge varying among the group. For RHMs to be successful, community members felt RHMs needed to work every day. On average, RHMs are tasked with 15-20 households to visit each month. However, some households were never visited by their RHM.

Support from community leadership was seen as vital for the success and ease of RHM work. Many RHMs felt unsupported by community leaders, with some leaders seeing RHMs as "earning for free." There are not always opportunities to conduct health education at community meetings. A community leader said he was unable to remark on how well RHMs are working, and that he did not have their phone numbers. Challenges including the old age of RHMs and low education levels, especially regarding updated MoH criteria, were common.

"These days we are living in times where people are educated, it seems even the RHMs could be people who are at a level of the people ... Today I feel like the RHMs should be upgraded, able to look at things that are written down." (Community leader)

4. The experience and influence of gender

Gender emerged as a fundamental component in both the content of RHM health education, and the acceptability of interacting with the group. Poor male health seeking behaviour compared to women was often identified as problematic. The programme was regularly perceived by community members as dealing with "women issues."

Engaging men was explained as a big challenge, with several examples of men rarely prioritising interactions with RHMs, as they are too busy with other tasks - "men do not like to sit and listen." Instead they instruct their wives to meet with RHMs. Gender was seen to potentially influence the ease and acceptability of discussing certain topics, both for RHMs sensitising members of the community on specific health issues, and for members of the community to raise their individual health needs with RHMs. Community leaders echoed this widespread opinion, explaining that female RHMs are appropriate to speak to women, and that men would accept information better from male RHMs.

"...obviously the man will think that the female RHM could go and tell his wife that your husband has had this, whereas if it is a man he could easily understand." (Community leader)

"It is difficult to take my issue and share it with somebody's wife [RHM]." (Male community member)

In contrast, higher level MoH participants did not consider gender as a limiting factor on the acceptability of health messaging in the community.

"I do not think there is difficulty in talking to each other for whichever gender when it comes to seeking health related information." (MoH nurse)

"I think any gender of RHMs can work." (KI, MoH)

In addition to gender influencing whether RHMs can discuss certain topics, one RHM highlighted the difficulty of changing behaviour in topics related to gender (e.g. condom use) by comparing to her personal life.

"With HIV, I think not using condoms [is the biggest problem] ... I usually talk about that to people as an RHM, but I am failing to do that inside my own house. Even with my own husband, it is difficult for us [women] to use a condom ... (Female RHM)

Discussion

Overall recognition of RHMs appeared as the main emerging theme in this study exploring the role of RHMs in Eswatini. We identified that the lack of structural recognition and understanding of RHM realities influences RHM work, hindering positive health outcomes of communities. In relation to recognition, we discuss the ambiguity of the role, gendered dynamics in community interactions, and organisational structure and support.

Ambiguity of the role: We identified several ways in which RHMs occupy an ambiguous position in the Eswatini health system, with confusion around the role recorded among all study participants. Since the introduction of the RHM programme, the country's health landscape has changed significantly; inextricably linked to the emergence of HIV/TB. Lack of RHM recognition is exemplified specifically by their indistinct role on HIV/TB. Responding to priority health issues was the original aim of the RHM programme at its inception. However, the introduction of other donor funded CHW groups, e.g. the ACFs focused on TB, illustrates the marginalisation of RHMs on pertinent public health issues.

Although MoH informants detailed the role of RHMs as prevention and health information-focused, this study identified considerable scepticism on their effectiveness. Previous distribution of items, including first aid, as well as the willingness of RHMs to perform tasks outside their remit, may have created unrealistic community expectations and confusion over the position[1]. A previous study in Eswatini highlighted the lack of clarity on the role of volunteer health workers detrimentally impacted their work (30). This supports our findings that clearer parameters of work are needed for effective implementation of community health interventions:

"The hasty nature in which expert clients were engaged, in the midst of an AIDS emergency, resulted in a lack of consensus on the scope of work and definition of the position of expert clients within the government structure" (30)

Gender dynamics and community interactions: The social and cultural influence of gender on how the RHM programme is viewed by community members, as well as the ease for RHMs to fulfil their tasks,

were clearly identified in this study. Globally, insufficient attention has been paid to gender in CHW programmes (5,31–33), and in this context, gender has been recognised as a specific challenge (34,35). The introduction of male RHMs has been recommended to increase the reach and acceptance of health messaging for male community members (5,8). The impact of gender in how community members view health and its impact on health choices (e.g. the RHM having difficulty to negotiate condom use with her husband) cannot be understated. Gender needs to be considered when designing public health interventions, e.g. the presence of more men in the programme might address widespread notions that community health work is for women and deals with “women’s issues” only. However, careful attention must be paid to not further compound gender inequality (36,37).

Organisational structure and support: Insufficient recognition of the RHM role in public health structures was illustrated in this study through numerous examples, including low remuneration, limited opportunities for regular quality supervision, suboptimal training, and other forms of formal support such as uniforms. The low stipend and suboptimal structural support may be understood at an institutional level as a symbolic lack of RHM recognition. RHMs reported that in addition to a sufficient stipend, they needed their work to be *considered* – for higher levels to understand their work and challenges and provide relevant support. This is further understood as RHMs not being consulted in programme design, or programme design not reflecting RHM realities. Studies have identified the impact of poor structural support; links between insufficient compensation and negative outcomes, including psychological distress (38) or financial compensation as a key motivator for CHW performance (39,40). However, monetary recognition is not consistently seen as a singular motivator for work (31–34). Supportive supervision has shown to address challenges of recognition and improve work output (3,8,40,43) and regular training is positively associated with CHW confidence in their role (3,44). In order to enhance institutional recognition of the programme, and make further positive health contributions at community level, increased structural support is needed, designed in consultation with RHMs.

Recommendations

Globally, the lack of recognition of CHWs in MoH programmes has been cited as a challenge (20,40,41,45,46). Increased recognition is seen as potentially improving lay health worker performance (43). In this context, lack of recognition and historical neglect has hindered the capacity of RHMs to successfully contribute to positive health outcomes for rural communities. Improved recognition might be achieved through the clarification of the RHM role in alignment with current public health challenges. In light of the country’s cultural landscape, increasing the number of male RHMs may contribute to improved uptake of refined health messaging (5). Adjusted ratios between community-based and supervisory positions, with strengthened supervision and stipends, would possibly address inefficiencies of current structural support mechanisms and improve overall efficiency of this key group. Community participation is essential to address community health problems, and in this context would be complimented by the involvement of RHMs in the planning of activities for future iterations of the programme. Finally, a reintroduction of the RHM programme by government ministries at national to

regional level, including community level implementers (e.g. RHMs, nurses, community leaders), would allow for increased recognition of RHMs, clarification of the role and potentially improve health outcomes in rural areas. Addressing these matters represents an important opportunity to recognise and harness the full potential of community-based approaches to public health challenges.

Limitations

Several limitations of this study have been identified. MSF has a history of training and engaging RHMs, and recruitment of participation was done by MSF staff. Despite efforts otherwise, most RHMs interviewed had already been trained by MSF on HIV. This may have influenced participants during interviews due to existing relationships with the organisation. Attempts to mitigate this were made - the objective of the research was emphasised when introducing it, in efforts to de-link MSF and their historical involvement with RHMs. Additionally, only active RHMs were interviewed meaning a fuller perspective of RHMs and their challenges is not possible. Due to the small number of male RHMs none were interviewed, thus only the female RHM perspective is recorded. Finally, in the broader scope, direct implementation for research focuses on the country of Eswatini and may not be generalisable to all contexts. However, similarities among health challenges and CHW experiences in southern Africa have been recognised, meaning this research may serve as a point of reflection for other contexts considering CHW recognition, specifically in rural communities.

Conclusion

In order to provide recognition for RHMs promoting positive health outcomes in communities, adequate support mechanisms and role clarification is needed. Understanding of community realities is essential to plan successful public health interventions and to recognise community level implementers.

Abbreviations

ACF: Active Case Finder; CHW: Community Health Worker; FGD: focus group discussion; IDI: in-depth interview; KI: Key Informant; MOH: Ministry of Health; MSF: Médecins Sans Frontières; PI: Principal Investigator; RHM: Rural Health Motivator; TB: Tuberculosis

Declarations

Ethics approval and consent to participate

The study protocol was approved by the MSF Ethics Review Board and Eswatini's National Health Research Review Board. All participants provided written informed consent before study enrolment.

Consent for publication:

Not applicable

Availability of data and materials

Due to confidentiality, access to data is restricted to MSF

Competing interests

The authors declare that they have no competing interests.

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Union) and Médecins Sans Frontières (MSF/Doctors Without Borders). The specific SORT IT programme that resulted in this publication was managed by MSF.

Authors' contributions

CW, DB and BK conceived the study. CW and DB wrote the protocol and developed the interview guides, with JK, BM, BS, BR providing input. CW led on data collection and analysis under the supervision of DB, who also supported data validation. DB and KW provided additional input on data analysis. CW, DB and KW drafted the manuscript. All authors provided feedback and approved the manuscript

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