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Rwanda: Adding Re-supply of Hormonal Contraceptive Methods to Community Health Worker Tasks Does Not Increase Their Workload

Key Findings

- **Workload impact:** Community health workers (CHWs) provided services to approximately 40 clients per week in about 20 hours in intervention and control groups, with no significant difference found in overall time spent providing individual services to clients or other service-provision activities.
- **CHW satisfaction and motivation:** Virtually all (98%) of CHWs in both control and intervention groups reported they are satisfied with and motivated to do their jobs, and that their workload is manageable (92%).
- **CHW perceptions on FP service:** Of CHWs trained to resupply FP clients (intervention group), 69% believed that with additional training they could also initiate clients on pills and injectable contraception.
- **Client satisfaction:** Nearly all (97%) of CHW clients reported they are very satisfied with the services provided by CHWs, and more than 75% said they preferred to receive services from CHWs rather than other health care providers.

Background

Many governments and development partners see community health workers (CHWs) as a solution to some of the human resource challenges in the health care system. CHWs—whether paid or volunteer—provide many services in an existing package of services that include antenatal, maternal and child health, infectious diseases, immunizations, sanitation and hygiene, and HIV/AIDS services. The addition of family planning (FP) to a package of services potentially contributes to an already substantial workload to be managed by CHWs. The quality of any of these services could suffer and CHWs become dissatisfied if they perceive their workload to be excessive or unsustainable.

In Rwanda, FP services are a recent addition to the many tasks of a select group of CHWs, or binomes. Binomes are a male and female pair of CHWs in each village—the first level of entry into the health care system. All binomes provide condoms, contraceptive counseling,

and referral. They are attached to health centers from where they receive supportive supervision, training, commodities, and supplies. Binomes are also organized in cooperatives to ensure income generation and accountability of results. Payments are made to cooperatives by the Government of Rwanda upon receipt of proof of performance, in a system called community-based performance-based financing (PBF). As such, there is a built-in system of incentives.

In March and April 2010, 3,061 CHWs in three districts (Gatsibo, Rusizi, and Kicukiro) were trained in community-based provision (CBP) of FP and in December of that year commenced offering the additional service of re-supply of short-acting hormonal methods (enhanced FP provision). The Rwandan Ministry of Health (MOH) plans to scale-up CBP of FP throughout the country and to train one member of the binome pair per village. This would likely result in a larger number of FP clients for those binomes.

Study Objectives and Methods

Between May and August 2012, the Rwandan MOH, with technical assistance from FHI 360 through PROGRESS conducted an assessment of CHW workload in four districts in Rwanda—two where binomes in each village were trained to provide enhanced FP services (intervention districts: Kicukiro, Rusizi) and two control districts (Gasabo, Kayonza) where these male and female pairs of CHWs had not yet been trained in CBP of FP. In each treatment group, one site was rural and the other urban. The sole distinction between the control and intervention districts was MOH support for re-supplying oral contraceptive pills and depot medroxyprogesterone acetate (DMPA) in the latter.

The goal of the assessment was to document CHW activities and to collect evidence regarding CHW workload when re-supply of short-acting hormonal methods were added to the services they were already providing. The primary objectives were:

1. To ascertain monthly measures on CHW client contacts in both treatment groups
2. To describe CHW perceptions of workload and its association with performance in both treatment groups
3. To obtain client reports of satisfaction with services provided by CHWs in both treatment groups

The secondary objectives were:

4. To compare FP uptake statistics from health centers in the four study

districts before and during the time CHWs provided enhanced FP services

5. To document FP uptake statistics from CHW reports in intervention districts during the provision of enhanced FP services

Quantitative data collection methods were employed in both intervention and control districts and included CHW activity sampling, structured interviews, and analysis of service statistics. A random sample of approximately 200 CHWs trained to provide enhanced FP services in the two intervention districts, along with 200 CHWs from the control districts were selected to participate in the assessment. Of the 400 CHWs selected, 383 completed the diaries and about 100 (50 from each treatment group) also participated in structured interviews. Two hundred CHW clients (50 per district) completed structured in-person interviews as well.

CHWs logged their daily activities over a one-month period and were interviewed before and after that one-month activity;¹ CHW clients were interviewed to assess their satisfaction with services; the four study districts provided service statistics to examine FP uptake for clinics and for CHW contributions separately. Data from district health centers were obtained for a one-year period before and after the initiation of CHW provision of FP services in December 2010. Because CHW uptake data exist only for intervention sites, those data describe trends since the introduction of CBP of FP.

¹ Results are based on pre-diary-keeping interviews, as there was little difference between pre and post responses.

Table 1: Weekly time in hours spent on CHW activities by study group for all services

Activity	Control (N=195)			Intervention (N=188)			Test Statistic p-value
	Mean	Median	Range	Mean	Median	Range	
Providing individual services to clients	6.1	5.8	0.5–21.2	6.5	5.9	0.5–25.0	0.3195
Book-keeping/ administrative tasks	2.2	1.8	0–24.5	1.7	1.4	0–7.8	0.0116*
Meetings, training, and supervision	4.1	2.9	0–29.6	5.8	3.4	0–36.2	0.0045*
Community sensitization	0.9	0.5	0–8.2	1.2	0.6	0–7.0	0.0490*
Travel to/from clinic and home visits	5.6	5.3	0–20.4	5.6	4.9	0–16.3	0.8484
Other work-related activities	1.7	0.6	0–18.7	2.7	0.5	0–39.7	0.0585
Total time spent overall each week per CHW	21.3	20.5	2.0–67.8	19.4	19.4	2.1–50.8	0.0536

* Indicates a significant difference in time spent on that activity between the control group and the intervention group.

Results

CHW Activity Diaries. CHW caseloads did not appear to differ between the intervention and control groups (see Table 1). There were no significant differences between the treatment groups with regard to overall time spent providing individual services to clients, travel, or other direct service-provision activities. CHWs in the intervention districts spent less time on bookkeeping and administrative tasks than CHWs in control districts, but significantly more time on meetings, training, supervision, and community sensitization events. CHWs in the intervention group reported that their additional FP responsibilities had no effect on their ability to provide other services.

CHW Workload and Motivation. Structured in-person interviews indicated that there were no differences between the CHWs in intervention and control groups regarding perceptions of workload manageability, satisfaction with, and motivation to perform their jobs (see Figure 1).

One of the main forms of motivation designed for CHWs is the use of community PBF payments to support CHW cooperatives. The results indicate that cooperatives are not serving as the motivation that they were meant to be for the CHWs. In the control and intervention districts 0% and 12.5%, respectively, reported earning income from their cooperative. In addition, 4% and 21% in the control and intervention districts, respectively, reported being part of a cooperative as a positive aspect of being a CHW.

Client Interviews. Structured in-person interviews with clients who recently received any service from a participating CHW revealed that clients were highly satisfied with the service regardless of whether the CHW was from the intervention (98%) or the control group (97%). The overwhelming majority of clients also indicated that the quality

Figure 1: Percentage of CHWs reporting their workload is manageable, that they are satisfied with and motivated to perform their job

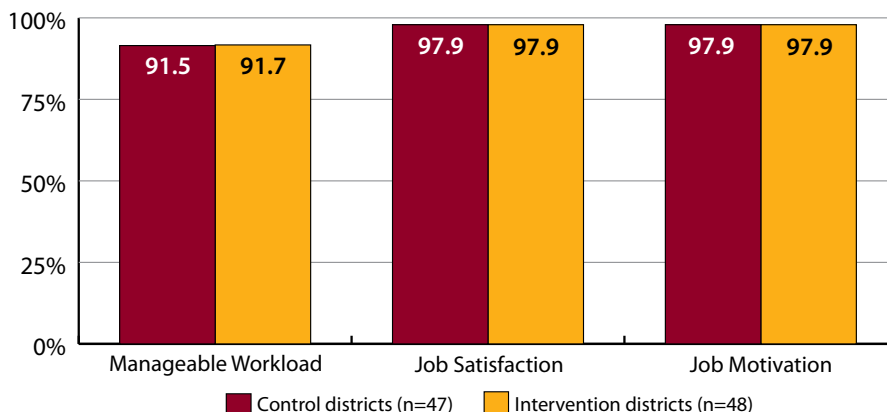


Figure 2: Number of clients who received DMPA in the intervention sites, December 2010–July 2012

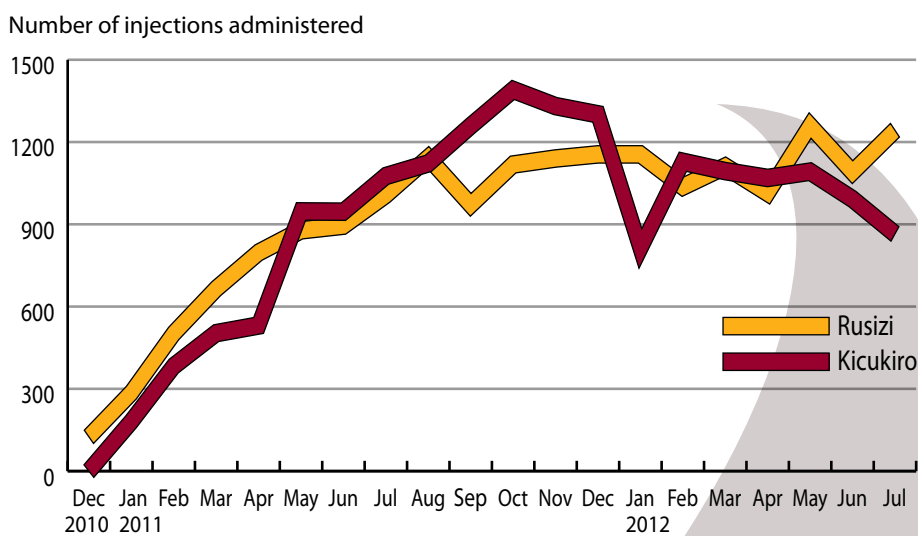
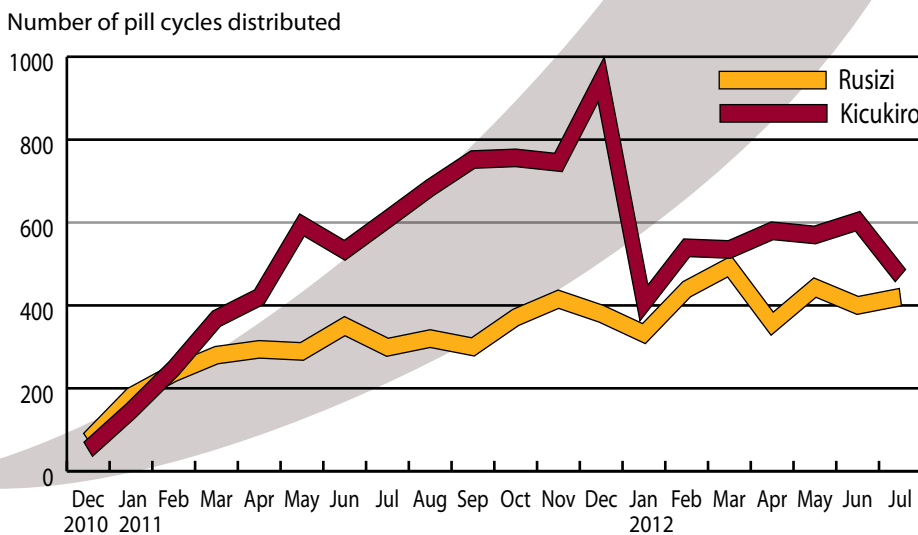


Figure 3: Number of clients who received contraceptive pills in the intervention sites, December 2010–July 2012



of services provided by CHWs in both groups increased over time. This finding suggests that the addition of pill and DMPA resupply had no negative effect on service delivery. Indeed, about 83% of intervention clients and 77% of control group clients reported that they would prefer to get future health services from their CHWs rather than the health center. Lastly, 98% of clients in the intervention group and 99% in the control group said that FP services would be a good addition to the services that CHWs can provide. CHWs and clients both feel that the CHWs are capable of doing the initial screening for FP methods they provide through enhanced FP services.

Service Statistics, Health Centers. HMIS data on DMPA and pill uptake include intervention and control group districts but *do not* include CHW data. The HMIS data revealed no discernible pattern among the study districts before or after CBP of FP was implemented in December 2010. However, for DMPA, uptake was greater in control than intervention districts. For pills, uptake was also greater for control districts and in the rural intervention site, Rusizi. Since CHW data were not included in HMIS data, it was difficult to assess the contribution of CHWs to FP uptake in the study districts. Assuming fidelity of HMIS data, the initiation of enhanced FP services by CHWs in December 2010 did not result in a notable decrease in health center provision of FP services.

CHW Service Statistics, MOH Registers. CHW data on FP uptake were obtained from dedicated registers maintained by the Ministry of Health. These data are separate from the HMIS so findings from the two sources are independent. The MOH register data for DMPA uptake indicated a sharp increase from the introduction of CHW re-supply in December 2010 to the latter part of 2011 (see Figure 2). Oral contraceptive pill uptake also steadily increased over time after CHWs were trained to resupply that method (see Figure 3). For both pills and

DMPA, there were large dips in uptake between December 2011 and January 2012 in Kicukiro, which could be a result of poor record keeping or an actual decrease in FP uptake over that time period during the Christmas holidays.

Conclusion and Recommendations

CHWs who resupply pills and injectable contraception do not report a heavier, unmanageable workload than their counterparts, suggesting that enhanced provision of FP services would not add undue burden on CHWs. Moreover, client preference for CHW services and the belief that family planning would be a good addition to the responsibilities of CHWs further support the scale up of CBFP.

To facilitate integration of CHW data into the HMIS, the MOH should develop one uniform data collection form for CHWs, eliminating separate registers for NGOs and the public sector. Also this data system should incorporate regular site visits to collect CHW reports.

In addition, the study indicated that in order to maintain motivation and provide incentives to CHWs, the MOH could monitor and modify the distribution of earnings in the performance-based financing program.

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