Motivating Volunteer Community Health Workers in Family Planning Programs in Uganda

This study was conducted among volunteer community health workers (CHWs) in Uganda to identify the key factors that affect their level of activity and motivation.

Key Findings

- ***Activity Level:*** Service records showed a mean of 56 client visits per CHW during a three-month period. Less active CHWs were significantly more likely than active CHWs to have had problems with resupply of commodities and to have not collaborated with other CHWs.
- ***Facilitators:*** According to survey results, the most common benefits of family planning volunteer work for CHWs were acquisition of new skills and knowledge, perceived impact, and enhancement of social status. Data from in-depth interviews reinforced and supplemented these findings.
- ***Challenges:*** The survey and in-depth interviews showed that the most common challenges CHWs faced were transportation difficulties, insufficient transport refunds, and stock-outs.

Background

Amid widespread shortages of health care workers, the role of community health workers (CHWs) has gathered more attention as a way to make primary health care services more available at the community level. In Uganda, as in many countries, volunteer CHWs could be especially important for extending family planning services to underserved populations in rural areas. In Uganda, the latest Demographic and Health Survey reported only 26% of married women of reproductive age using modern contraception.

Retention and performance of CHWs are important concerns, particularly in volunteer programs. A range of factors can affect the motivation of CHWs, which drives job performance and continuation rates. However, rigorous studies of these factors, how they affect motivation, and their relative importance are limited.

Study Objectives and Methods

FHI 360 conducted a cross-sectional, mixed-methods study among CHWs providing family planning services in three family planning programs covering seven districts in Uganda. The objectives of the study were to identify the key factors that affect the level of activity and motivation of CHWs and to quantify the relative importance of some pre-selected factors from the perspective of the CHWs.

The study included a public-sector family planning program, a family planning program supported by a nongovernmental organization (NGO), and a public-sector family planning program previously supported by an NGO. All three offered the same contraceptive method mix, including condoms, oral contraceptive pills, and injectable contraceptives.

The program managers helped identify eligible CHWs for the study. Eligibility criteria included one year of experience providing contraceptives and attendance at the last supervisory meeting. CHWs from a subset of health centers were invited to join the study in the NGO program; all eligible CHWs were included from the other two programs.

CHW service records were used to calculate the number of visits the CHWs had with family planning clients who received any method between April and June 2011. Health centers were grouped

by geographical area defined according to their terrain and population profile. CHWs were classified as highly active if their number fell above the median or at the median for CHWs associated with health centers in each group. All other CHWs were classified as less active.

In July and August 2011, a structured survey was conducted with 183 active CHWs, and in-depth interviews were conducted with 43 active CHWs and with 5 former CHWs who had dropped out. The survey included a discrete choice experiment (DCE) to determine the relative importance CHWs placed on selected program inputs. A DCE is a method in which participants are asked to choose their preference between two hypothetical scenarios characterized by a set of attributes of varying levels corresponding to feasible programmatic options.

These inputs were identified in consultation with stakeholders working with CHWs in Uganda. They included training (initial training, or initial training and yearly 3-day refresher), supervision (monthly meetings at health center, or monthly meetings and quarterly community visits by staff), incentives (a kit with gumboots, raincoat, job aids, and stationary; the kit, a T-shirt, and a badge; or the kit, the T-shirt, a badge, and a bicycle), a transport refund (5,000 Uganda shillings per meeting or 10,000 Uganda shillings), and communication (no mobile phone or a mobile phone with no airtime).

All study participants received a small compensation (approximately US $4). The study was approved by the Uganda National Council for Science and Technology and FHI 360's Protection of Human Subject Committee.

Survey Results, with Service Statistics

Survey respondents had a mean age of 41.3 years and a mean of 5.5 children. Half were women, and 83% percent were currently married or cohabitating. All had attended at least primary school, with 73% having attended secondary school or higher. The CHWs had been providing family planning for a mean of 5.6 years. Just over half of the CHWs in the NGO-based family planning program and nearly all of the CHWs in the other two programs offered injectable contraceptives in addition to condoms and oral contraceptive pills.

Service statistics showed a mean of 56 client visits per CHW between April and June 2011. The mean number of visits was the highest in the former NGO program (68 visits). Next came the current NGO program (52 visits) and finally the public-sector program (42 visits). Highly active CHWs were more likely than less active CHWs to have had no prior volunteer experience. Also, these highly active CHWs were more likely to have problems with resupply from their health centers and not to collaborate with other CHWs. In multivariate analysis, problems with resupply and lack of collaboration with peers remained significantly associated with level of activity.

Overall, the study showed that CHWs had high motivation levels. About nine of every ten surveyed CHWs said they had never thought about leaving the program. Among those who had thought about leaving, dissatisfaction related to compensation was the most common main reason. An obligation to serve the community was the most common main reason for staying.

The most commonly reported positive aspects of community health work were that it allowed CHWs to acquire new skills and knowledge (74%), to have a perceived impact (67%), to enhance their status (66%), to help others in the community (54%), to work with health care professionals (38%), and to feel competent (21%).

The most commonly reported challenges were transport or difficulty reaching

clients (74%) and insufficient transport refunds for supervisory meetings (60%). Stock-outs were also frequently mentioned by CHWs from the former NGO program (50%), and lack of compensation was mentioned often among public-sector CHWs (50%).

The DCE showed that the provision of a T-shirt, badge, and bicycle was the program input CHWs valued the most on average (Table 1). On average, CHWs preferred this input four times more than their second choice — provision of a mobile phone (with no airtime). The third and fourth ranked inputs were an increased transport refund and the addition of a yearly refresher training, respectively. The last two inputs were not significant in the analysis (see Table 1).

Table 1: Weighted ranking of incentives based on significance and magnitude of mean coefficient estimates (n=182)

Program Input	Mean estimate
T-shirt, badge, and bicycle	3.90**
Mobile phone, no airtime	0.99*
10,000 Ugandan shilling transport refund	0.77*
Yearly refresher training	0.73*
T-shirt and badge	1.97
Quarterly supervisory visits in community	0.70

* $p < 0.05$ ** $p < 0.01$; number of observations = 1092

Results of In-Depth Interviews

In-depth interviews (IDIs) further explored challenges to, and facilitators of, the CHW level of activity and motivation. The data reported by active CHWs are described below. Findings from IDIs with former CHWs highlighted similar themes. The three major challenges highlighted involved transport, payment and refunds, and stock-outs. The major facilitators involved: social responsibility and prestige, new skills and knowledge gained, and aspirations. Another important theme was staff relationships.

Social responsibility and prestige. Nearly all active CHWs who were interviewed reported that volunteering had given them an enhanced status not only among clients but also in the larger community. Many described feeling proud in being called musawo, a generic term for health professionals. Related motivators included greater access to help or information and being consulted by others on a range of problems. Commitment to serving the community was also important, particularly among women. Almost half of the female CHWs and one third of the male CHWs expressed satisfaction in helping others.

New skills and knowledge. Several CHWs indicated that they did not know that the volunteer work was related to family planning when they agreed to be trained. However, more than half of the CHWs said that family planning had improved their personal lives or those of their families.

Aspirations. Most CHWs saw their work as an opportunity for other work. This provided an incentive for CHWs to perform well and stay on the job.

Transport. Nearly three-quarters of the active CHWs who participated in an IDI said they experienced challenges that related to transport. The challenges mentioned pertained to trips to the health centers and to travel from the CHWs' homes to the homes of clients. They reported that travel time took them away from other domestic and work responsibilities, and complained of the costs of seeking a faster alternative to walking, like a bicycle taxi.

Payment and refunds. CHWs received a small transport refund when they attended supervisory meetings (typically between 5,000 and 10,000 Ugandan shillings, or about US $2 to $4 at the time of the study). Even so, many indicated that this was not enough financial support. Even though CHWs knew their position was voluntary, about two of every three felt they deserved some form of payment. About one of every five CHWs said that a lack of money – either

If there was transport and the drug is there, things become easy. Because if I have transport, I can go wherever it is necessary and on time. And if I have the drug, whoever comes at any time can be served.

— 46-year old male CHW

the transport refund or no salary – had caused them to think about leaving the program. When CHWs used their personal resources for this volunteer work, dissatisfaction was most pronounced.

Stock-outs. Stock-outs of commodities was another critical and demoralizing issue, according to more than half of the CHWs. Without commodities, CHWs could not provide full services with their clients, which affected this relationship. Also, CHWs sometimes made trips to health centers to get commodities but in vain, which exacerbated the issue of transport.

Staff relationships. CHWs interacted with supervisors at the health center and with district-level or NGO staff. Generally, CHWs felt that the health center staff treated them well, but some identified challenges. These typically related to feeling unappreciated or paid staff being busy or away when CHWs needed to see them. CHWs valued their interactions with higher-level district or NGO staff. In cases where a supporting NGO had or was going to leave the program, this was cause for discouragement and concerns related to transport refunds and morale. In one program, the loss of support from NGO extension workers who provided a bridge between the CHWs and the health centers and who facilitated the resupply of commodities was also an issue.

Recommendations

Based on the study findings and on discussions with implementing partners in Uganda, the following recommendations are suggested. Specific measures can be taken to tailor the recommendations to local contexts and programmatic structures.

- Standard provision of a bicycle would help with the major challenge: transport.
- CHWs should receive an allowance separate from normal meeting transport refunds in order to attend supervisory meetings and to make additional visits to the health center for supplies.
- Community leaders and supervisors need to emphasize accountability to the community and to the health structure, as opposed to NGOs.
- Supply forecasts should integrate supplies needed by CHWs.
- The contributions of CHWs to service statistics should be prominently displayed as a motivational tool.

Conclusions

In Uganda, the Ministry of Health has begun implementing a nationwide village health team strategy in which teams of volunteers provide a government-endorsed set of services and are the recommended platform for all community-based health programming. Although the study results may not be directly applicable to the entire country, they will be helpful in informing the current rollout of the village health team strategy. Since the study included three different models of community-based family planning programs, the results may also be useful to program managers in other parts of sub-Saharan Africa who are integrating multiple CHW programs into a coordinated system.

Although this study identified several factors that motivate CHWs, such as relationships with the community and new skills and knowledge, it also identified several important challenges. For instance, transportation was one of the main problems CHWs faced. Although CHW programs eliminate transportation barriers for clients, they can shift those problems onto CHWs who have to travel long distances.

Stock-outs were another major challenge. Although CHWs are supposed to pick commodities up during supervision meetings at the health center, chronic health system shortages can prevent this from happening.

CHWs receive a transport refund only for attending supervisory meetings, and thus must spend their own time and resources to support additional trips to the health center for supplies. Results of the DCE suggest that providing CHWs with a bicycle could help decrease these challenges, and that this option would be preferable over a small increase in the amount of the transport refunds.

Although IDIs with former CHWs revealed challenges similar to those experienced by active CHWs, further research is needed to identify what causes CHWs to go from feeling discouraged to actually dropping out of a program.

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