

# The influence of incentives on community health worker motivation in the provision of family planning. A case of Msalala and Shinyanga Districts, Tanzania

Maryse Kok,<sup>1</sup> Scholastica Lucas,<sup>2</sup>  
Josiah Otege,<sup>2</sup> Zando Mkwazu,<sup>2</sup>  
Ingrid Zuleta,<sup>1</sup> Eefje Smet,<sup>3</sup>  
Frida Ngalesoni<sup>2</sup>

<sup>1</sup>KIT Royal Tropical Institute, Amsterdam, the Netherlands; <sup>2</sup>Amref Health Africa Tanzania, Dar es Salaam, Tanzania; <sup>3</sup>Amref Health Africa, the Netherlands, Leiden, the Netherlands

## Abstract

Community health workers (CHWs) are essential in the provision of a wide range of services, including family planning. In Tanzania, deployment of CHWs has largely been supported by non-governmental organizations (NGOs) who often determine their incentives. A mix of incentives is required to increase CHW motivation and, ultimately, performance. This qualitative study aimed to explore how incentives influence CHW motivation in the provision of family planning services in Msalala and Shinyanga districts. The study included focus group discussions and in-depth interviews with 21 CHWs, 12 supervisors and eight policy makers and NGO representatives. Transcripts were coded and narratives were written on types of incentives, motivating and demotivating factors. The study revealed that although CHW motivation was related to feelings of accomplishment and respect from the community, financial incentives were found equally important for motivation. While most CHWs received non-financial incentives, CHWs had unequal access to financial incentives. Key informants confirmed that there was no coordination on incentives at district level. Some CHWs reported demotivation because of misconceptions and unacceptance of family planning in the community and irregular supply of contraceptives. Results from this study show that motivation of voluntary CHWs in Msalala and Shinyanga districts is currently sub-optimal, because of inequity in access to (financial) incentives. There is a need for better coordination and standardization of CHW incentives. Advocacy is needed to increase funding for CHWs' deployment and remuneration. This would increase CHW moti-

vation and ultimately performance, also in the field of family planning.

## Introduction

Family planning services are essential for the health and wellbeing of women and children. Meeting the global need for both family planning and maternal and newborn health services would avert 70% of maternal and 44% of newborn deaths. It would also result in a 60% reduction of healthy years of life lost due to disability and premature deaths among women and newborns, and enhance status of women and economic growth.<sup>1</sup>

The contribution of community health workers (CHWs) to maternal and child health has been widely documented.<sup>2</sup> A systematic review on CHWs' provision of family planning services in low- and middle-income countries revealed that involving CHWs in the provision of these services has proven to result in increased use of modern contraceptives and improved knowledge about and attitudes towards family planning.<sup>3</sup> In 2010, the government of Tanzania set a target of 60% contraceptive prevalence rate (CPR) by 2015. Despite not achieving the goal, the modern contraceptive prevalence rate (mCPR) among married women has increased from 27% in 2010 to 32% in 2015. The unmet need for family planning among married women has remained between 22% and 24% since 1999.<sup>4</sup>

In 1983, primary health care was adopted as a main strategy for improving access to equitable health services in Tanzania. Since then, most of the CHWs worked on voluntary basis and were employed by various non-governmental organizations (NGOs).<sup>5</sup> CHWs have various tasks and roles in maternal, newborn, child and adolescent health. With regard to family planning, they conduct family planning promotion, distribute non-invasive contraceptives (pills and condoms) and refer clients to primary health facilities.

Previously, under the national community-based health programme, the government of Tanzania developed a scheme of service to harmonize community health programmes through formal recognition, deployment, and absorption of one-year trained CHWs in the health system. However, the implementation of this scheme of service has been put on hold, as the government currently focuses on voluntary CHWs based on the Uturo approach.<sup>6</sup>

Motivation is an individual's degree of willingness to exert and maintain an effort towards an organization's goals.<sup>7</sup> CHW motivation is an instrumental component of

Correspondence: Maryse C. Kok, KIT Royal Tropical Institute, P.O. Box 95001, 1090 HA Amsterdam, The Netherlands.  
Tel.: +31.20.5688388 - Fax: +31.20.5688444.  
E-mail: Maryse.kok@kit.nl

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CHW performance and it can be influenced by intrinsic and extrinsic factors,<sup>8</sup> of which the latter are related to CHW programme design.<sup>9</sup> As concluded by several studies, including studies from Tanzania, a combination of financial and non-financial incentives is required to increase CHW motivation.<sup>5,8,10,11</sup> Financial incentives include salary, performance payment or other financial support. Non-financial incentives can

include training, supervision, career perspectives, respect from the community and more intrinsic rewards, such as altruism and having a desire to serve the community.<sup>5,11-14</sup> In Tanzania, CHWs receive different incentives depending on the place and organization that they are working for. This can potentially lead to differences in motivation of CHWs working under different programmes.

This study sought to understand how external incentives that CHWs receive influence their motivation to perform well in the provision of family planning services in selected districts of Tanzania. The study was undertaken as part of Amref Health Africa's advocacy campaign on support and remuneration of CHWs and their role in increasing contraceptive access in Tanzania.

## Materials and methods

A qualitative study was conducted in Msalala, a rural district, and Shinyanga DC, a semi-urban district, in Shinyanga region. The mCPR among married women aged 15-49 is 21% in this region, lower than the national average.<sup>4</sup>

Msalala has about 418 active CHWs serving a population of 523,803, while Shinyanga DC has 126 active CHWs serving a population of 272,990. In both districts, CHWs are incentivized by NGOs and through a World Bank results-based financing (RBF) scheme. This scheme is implemented by the government through health facility in-charges. Under the RBF mechanism, CHWs are paid TZS 5,800 (USD 2.50) for every new user of modern contraceptives who they have referred to the health facility.<sup>15</sup>

Focus group discussions (FGDs) were used to collect information from CHWs

about their current incentives related to their work in family planning and in general. The FGDs also explored how these incentives motivated or demotivated CHWs in conducting their job, and potential recommendations on incentives. In-depth interviews (IDIs) were administered to CHW supervisors: facility in-charges for technical supervision and village executive officers (VEOs), who are secretaries of village councils, for administrative supervision. These interviews also focused on the influence of different types of incentives on CHW motivation. Furthermore, key informant interviews (KIIs) were conducted with district and regional health coordinators, representatives from NGOs, and policy makers at national level. We asked these study participants about their perceptions on CHW motivation and performance in family planning, and about the mechanisms that are in place for the provision of CHW incentives (Table 1).

Study participants were purposely selected at the level of the ward (health centre) and village (dispensary). In each district, we selected five villages (two with high volume health centres and three with high volume dispensaries), which had CHWs working for different NGOs. Supervisors and VEOs were selected from the same villages. District-level health staff assisted the research team in selection of the study areas and recruitment of participants. Key informants were selected based on their knowledge about CHWs' incentives and roles in family planning.

Data were collected for a period of two weeks in February 2019. The data collection team, consisting of three Amref staff and four research assistants, made use of various pre-tested topic guides for conducting the interviews and FGDs. At community level, the interviews and FGDs were conducted in Swahili. Interviews with key

informants took place in English. The data collection team held daily debriefings to discuss progress and preliminary findings, to adjust sampling strategies where needed and to discuss data saturation.

Interviews and FGDs were digitally recorded with consent from study participants and then transcribed into English. A deductive approach, using pre-existing themes based on the topic guides (which were informed by existing literature on CHW incentives and motivation), formed the basis for the development of a coding framework. Emerging themes were added to the coding framework. Transcripts were coded in Nvivo 11, and data were further analysed, 'charted' in themes and sub-themes and summarized in narratives. While the coding was done by one researcher, the full data analysis was conducted by the whole research team. In April 2019, validation meetings were held with the council health management teams of Msalala and Shinyanga DC, with 24 CHWs who did not participate in the study and with 14 NGOs working in the study areas.

## Results

### Characteristics of study participants

Twenty-one CHWs participated in this study. All CHWs were over 30 years and a third of them were over 50 years. More than half (12) of the CHWs were males and the majority of the CHWs were married. They also had other jobs – mostly in agriculture – and household activities. The majority of the CHWs had attained primary and few (four) of them secondary education. The majority of the CHWs had been on service for over 10 years and all were voluntary CHWs.

**Table 1. Overview of methods and study participants in Msalala and Shinyanga districts, February 2019.**

Method	Study participants	Sample size and characteristics
FGDs	CHWs	21; 4 FGDs of 5 to 6 CHWs, 2 FGDs per district, each FGD with 3 CHWs from a dispensary and 2 from a health centre
IDIs	CHW supervisors VEOs	8; 4 per district 4; 2 per district
KIIs	DCHWCo DRCHCo RRCHWCo RRCHCo Head of FP unit at MoHCDGEC Deputy director of health promotion MoHCDGEC NGO CHW coordinators (national level)	2; 1 per district 2; 1 per district 1 1 1 1 4
Total	45	

VEO = Village Executive Officer; DCHWCo = District Community Health Workers Coordinator; DRCHCo = District Reproductive and Child Health Coordinator; RCHWCo = Regional Community Health Workers Coordinator; RRCHCo = Regional Reproductive and Child Health Coordinator; MoHCDGEC = Ministry of Health, Community Development, Gender, Elderly and Children.

## General features of the CHW programmes

Most CHWs were selected for their job by the community, after which recruitment took place by NGOs. Some were selected and recruited by NGOs in cooperation with the District Health Office from an existing CHW pool. Selection criteria were not clearly reported, but one facility in-charge mentioned that education level and being capable of doing the job, as perceived by the community, were important. One CHW underwent the selection and recruitment process via the new one-year training provided by various health-training institutions accredited by the government. This CHW had not been formally employed by the government and was, like all others, working voluntarily. All other CHWs had received short-term tailor-made trainings provided by the Ministry of Health, Community Development, Gender, Elderly and Children in collaboration with various NGOs. These trainings covered a broad range of health areas, including family planning, and varied from three days to two months.

Most CHWs reported that their tasks in family planning were not difficult and brought them satisfaction. However, one CHW supervisor mentioned that he recently received a report from a male CHW on his difficulty to talk openly about family planning to women. He also mentioned that sensitization on family planning becomes challenging when the audience is male or has a strong religious background. These community members were said to have misconceptions about contraceptives or were generally not supportive of contraceptive use. With regard to the provision of pills and condoms, the majority of the interviewed CHWs said that community members trust them to keep the provision of these services confidential. When referring women to the health facility for long-term contraceptives, a few CHWs found it challenging to deal with their clients' complaints about a lack of commodities at the health facility, mistreatment from health workers, and side effects of contraceptives received at the facility.

Health centre in-charges reported that their supervision activities mainly involved checking the quality of reports submitted by CHWs. They sometimes oversaw sensitization activities and they coordinated referrals with CHWs. VEOs were said to support CHWs when they need village data for their reports. Sometimes, they also supported CHWs while conducting activities in the community. Two VEOs reported that they monitored the work of the CHWs, including the implementation of their weekly plans, and provided them with feedback on per-

formance. The district community health workers coordinator had direct contact with CHWs, making sure that CHWs are available and evenly distributed between the villages, and that they have the required knowledge, skills and resources to perform (family planning) duties.

## Existing incentives

The study revealed a number of incentives that CHWs currently receive. Most CHWs mentioned that they receive financial incentives. The major sources of financial incentives were from NGOs and in some extent from the government through specific (outreach) programmes or the RBF programme. Financial incentives from NGOs included per diems and transport allowances for implementing special interventions such as immunizations and other outreach activities, with a reported maximum monthly compensation of Tsh. 60,000 (26 USD). The RBF programme was reported to have a maximum monthly payment of Tsh. 25,000 (10.80 USD). In most cases, financial incentives were delivered on a quarterly basis by government facilities, and on a monthly basis by NGOs. The incentives were mostly delivered through bank accounts, mobile transfer and in a few cases via cash on hand.

Many CHWs also mentioned non-financial incentives such as trainings and working tools (bicycles, carrier bags, cell phones and work guidelines). Besides that, CHWs considered community recognition and appreciation as a moral support to keep them working. One facility in-charge mentioned that the professional health workers pay special attention when a CHW or his/her family members visit the facility for treatment: they do not queue.

The study found contradicting responses on the current incentives received when performing family planning duties. Many CHWs said that there are no specific financial incentives for performing family planning duties.

*“No, there are no payments for family planning, rather for other health initiatives. Currently there is no one who incentivizes us on family planning. When we perform family planning activities in the community we just volunteer.”* (FGD, CHW from Shinyanga DC)

However, supervisors and key informants did point towards incentives related to family planning. These incentives were related to the RBF scheme and to specific community interventions that included family planning (among other services), supported by certain NGOs.

## How incentives (de)motivate CHWs

The CHWs reported that, although they are volunteers, their workload requires them to be compensated. They said that currently, financial incentives were not enough, unequally distributed, sometimes delayed or completely stopped altogether. This led to demotivation. Regular monetary incentives would be used to meet basic needs for their families. Regardless of the preference to receive financial incentives, CHWs reported that they were motivated to volunteer, because they received recognition of health professionals and respect from the community. They were less happy with the limited provision of working tools and things that identify them as CHWs, such as T-shirts or uniforms. Transport was mentioned as a major obstacle and demotivating factor for many of the CHWs. Having a bicycle to conduct their household visits and report to the health facilities was reported as a necessity, while none of them had one.

*“Incentives would make me fully committed in fulfilling my activities. If I would receive a bicycle, my family becomes happy. When I would receive money, I use it to provide for my family, my wife also feels comfortable with the community work that I am doing. It [being paid] will also result in respect within the community, because other people may think that we are jobless, we are only moving around in different households, but when there is payment the community also values our work.”* (FGD, CHW from Msalala)

## Supporting mechanisms for the provision of incentives

Our findings show that in future, dedicated financial resources for CHWs from the national government may not be available. Instead, key informants recommended district-based financial resource mechanisms. While at the time of data collection, the CHW scheme of service was reported as the most recent (2018) CHW-related policy document, not all key informants were familiar with it. According to a policy maker, the scheme covered issues such as roles and responsibilities of CHWs, financial and non-financial incentives, career progression, disciplinary measures and criteria for joining government employment, after which CHWs would be named health assistants.

*“The name used by the government is health assistant... Those who are volunteering, we still call them CHWs, even those trained for one year but are yet to be employed and (thus) volunteering, we also*

call them CHWs, but once they join in the government system, that is when we call them health assistants.” (KII, national level policy maker)

While the scheme of service is currently on hold, one key informant reported that the government seeks to develop other guidelines to standardize CHW operations across the health sector regardless of whether or not CHWs work with the government, private health facilities or NGOs. The current lack of coordination regarding incentives was mentioned by many study participants – CHWs, supervisors as well as key informants – and was said to lead to demotivation and unsustainable programmes.

*“Each organization pays CHWs according to their budgets. This gives me some worries in terms of sustainability of CHWs, because if an NGO is paying higher for instance, when another organization comes and pays low them [CHWs] will just quit.”* (KII, NGO)

NGOs mentioned that they would be willing to adhere to a governmental policy on how to incentivize CHWs. They would adjust project budgets, which can be justified to donors if there is an existing and implemented policy.

### Study participants' recommendations on incentives

Proposed incentives were similar to the existing incentives, but in an improved or expanded way, across all types of study participants. The recommendations mainly focussed on financial incentives, working tools, and trainings. They included higher and more regular financial incentives to be able to support CHWs' families. They further included transport and communication means, identity cards and garments that help communities to identify CHWs, and gumboots and umbrellas for the rainy season. Another proposed incentive was training, not only for the work carried out by CHWs, but also for their personal development. CHW supervisors suggested trainings on income generation activities and one CHW recommended CHWs to receive a health insurance.

A few CHWs mentioned the need for specific trainings that they regarded as important for smooth execution of their tasks. For example, they suggested training on male involvement in family planning, as some men prevent their wives to access family planning services and may even quarrel with CHWs during home visits.

## Discussion

This study explored the influence of incentives on CHW motivation, particularly in provision of family planning services, in Msalala and Shinyanga districts. Motivation of CHWs is a critical determinant of performance,<sup>7</sup> and is therefore instrumental for increasing family planning uptake in Tanzania.

Most CHWs mentioned that they receive financial incentives, trainings and working tools. However, they indicated that the incentives they receive are related to their full job, and not only to family planning. A few CHWs received incentives specifically for their tasks in family planning: this concerned the RBF scheme, where CHWs are incentivized for every new user of family planning, or it concerned allowances or goods for being part of specific programmes run by NGOs. The amount of financial incentives greatly varied and payment was often irregular. Although CHW motivation was related to feelings of accomplishment, respect from the community and gained knowledge, it was also indicated that financial incentives are needed for CHW motivation and performance – even though they are volunteers.

These findings correspond with other studies conducted in Tanzania.<sup>5,11,16</sup> Some scholars argue that volunteerism makes CHWs more responsive and accountable to their communities instead of (only) to the health sector.<sup>17,18</sup> However, other studies show that the provision of financial incentives improves the sustainability of CHW programmes, through reduced attrition,<sup>19,20</sup> and potential increased community respect, as suggested in this study. In addition, being able to meet basic needs for the family is very important for CHWs, who often live in poor areas.<sup>18</sup> Other studies have indicated that remuneration should be provided when CHWs have multiple tasks that require substantial time investment. Furthermore, financial incentives need to be distributed in an equitable and reliable way to avoid demotivation.<sup>8,21</sup> These recommendations are reflected in the 2018 World Health Organization (WHO) guideline on health policy and system support to optimize community health worker programmes. The WHO strongly recommends remuneration of CHWs for their work “with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake” (p. 47).<sup>22</sup> However, we found that differences in types and number of incentives for CHWs led to demotivation and were a result of uncoordinated programmes among

all the stakeholders working with CHWs: mostly NGOs and the government. Findings were similar across both Msalala and Shinyanga districts. This lack of coordination has been found problematic in other countries as well.<sup>23</sup>

Besides the irregular and unequal provision of incentives being demotivating, some CHWs who participated in this study reported demotivation because of misconceptions or unacceptance of family planning in the community,<sup>24</sup> irregular supply of contraceptives and unequal training opportunities. While training, working materials and (contraceptive) supplies can be seen as non-financial incentives, they can also be regarded as job enablers: minimal resources required to be able to conduct the job.<sup>8</sup>

A review of Bellows *et al.* (2014) on performance-based incentives in community-based family planning programmes suggests that easy-to-understand incentives can be effective in increasing the use of family planning.<sup>25</sup> The design of performance-based incentives requires careful attention to ensure incentives are ethical, non-coercive and choice-enhancing. While the RBF incentives related to family planning for CHWs in Tanzania indeed seems simple, non-coercive and choice-enhancing, because it concerned new family planning users of any kind, the main problem was that some CHWs received those RBF incentives, and others not. This variation in access to incentives is unethical and, as stated above, can lead to demotivation and ultimately underperformance of CHWs – also in the field of family planning (26). A recent study from Tanzania found that CHWs who provided family planning services preferred a flat rate payment over performance-based incentives. It was suggested that this could be explained by weak performance appraisal systems, making CHW insecure of what they would earn.<sup>16</sup>

This study confirms that there is currently a lack of funding to realize implementation of the scheme of service. Donors and partners could pool their funds to harmonize CHWs programmes and integrate a paid CHW cadre into the health system. However, it is unclear whether this will take place, especially now that a new national guide is to be published that focuses on volunteerism.<sup>26</sup> Based on the responses of study participants, as well as the recent ‘sudden’ change in policy direction (from establishing a one-year trained and paid cadre of CHWs to keeping an (improved) model of voluntary CHWs based on the Uturo approach), we observe that processes to formalize CHWs in the health system in Tanzania have been confusing.

## Limitations

This study explored how incentives influence CHW motivation, and while motivation is a proxy of performance, the study did not look into CHW performance on provision of family planning services. Other studies found that RBF could lead to CHWs neglecting non-incentivized tasks,<sup>22</sup> but this study did not look into this. CHWs involved in this study did not refer to supervision or being part of a team with health professionals as main motivating factors, while other studies have pointed these out.<sup>14,27</sup> The study focused on incentives for CHWs, which justifies a focus on health system study participants only. However, perspectives of the side of the community on CHW incentives could have added value to the findings. A strength of this study is that discussion of findings took place in a multi-disciplinary group of researchers, NGO staff, government personnel as well as CHWs.

## Conclusions

Incentives are meant to motivate CHWs, so that performance – also in relation to family planning tasks – increases. This study found that motivation of voluntary CHWs in Msalala and Shinyanga districts is currently sub-optimal, because of inequity in access to incentives. While non-financial incentives were found to be important, CHWs indicated that there is a need for financial incentives as well.

A paid, one-year trained cadre of CHWs was about to be introduced in Tanzania. However, this is put on hold and the government intends that CHWs will stay volunteers, (financially) supported by NGOs or, occasionally through government-led health events. Based on the findings of this study, Amref Health Africa advocates for government, NGOs and donors to join efforts and pool funding to (still) implement the new scheme of service and deploy the new one-year trained and paid cadre of CHWs. At the same time, harmonization of incentives of voluntary CHWs should be a priority, to increase CHW motivation and performance, including in the field of family planning.

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