ROLE OF NON-MONETARY INCENTIVES ON COMMUNITY HEALTH WORKERS PERFORMANCE IN MAKUENI COUNTY, KENYA

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ABSTRACT

Introduction: Community Health Workers (CHWs) were recognized as the cornerstone of comprehensive during the Alma Ata conference in 1978. CHWs were defined as being able to serve communities in the remote areas and to assist in meeting the unmet demand for health care services across countries. The CHWs would improve access to health care services among the poor and in the geographically medically underserved regions. Since the implementation of CHW programs across countries there has been an experience of high attrition rates ranging from 3.2% to 77 % which could be attributed to several factors and low morale among the CHWs.

Methods: A community based Cross-sectional comparative design was used which employed both qualitative and quantitative methods of data collection.

Findings: Receiving of subsequent training, frequency of supervision and number of households served by the CHWs was significantly associated with performance. Majority of CHWs for both groups were satisfied with their job with 40.4% of CHWs not receiving incentives compared to 46.6% among CHWs receiving monetary incentives. Majority of CHWs had ever contemplated dropping off their CHW roles with the major constraints faced by CHWs cited being lack of support of the supervisors and lack of transport.

Conclusions and recommendations: The CHWs performance can be enhanced through subsequent training, harmonization of the training curriculum, setting up of proper supervision mechanisms, harmonization of workload, and provision of transport and community support.

Key words: Community Health Workers, Community Units, Performance, Non-Monetary incentives.

Introduction

The Alma-Ata international declaration of 1978 initiated the global policy of Primary Health Care whose main goal was provision of health for all by the year 2000 (WHO, 2007). The signatories of the Alma Atta Declaration include Kenya though the goals outlined in the declaration and that of the Bamako initiative of 1988 are yet to be met. The Primary Health Care approach that was adopted was too expensive while the health budgets were decreasing coupled by global recession which led to the approach being abandoned. This approach was replaced by the less expensive "selective PHC" in form of vertical disease-specific interventions (Opiyo et.al., 2009).

The second National Health Sector Strategic Plan (NHSSP II) defined a new approach to the delivery of Health Care Services to Kenyans, the Kenya Essential Package of Health (KEPH). The main innovations of the KEPH is the emphasis on the introduction of services at the community level (Level 1 services) whose main aim is to empowering the community and the household to spear head their own health. The main goal to be achieved by the community strategy was to improve access to health care which would contribute to the general health across all the stages of lifecycle in the community. This would be achieved through the decentralization of health services in the entire country and at the community level. The workforce involved in implementation of the Community Strategy includes Community Health Workers, Community Health Extension Workers and Community Health Committees (MOH, 2005).

Community Health Worker programs have experienced challenges across countries which include remuneration, inadequate training, lack of well-structured supervision and inadequate support and appreciation by the communities they serve. High drop-out rates of CHWs has been one of the most frustrating elements of CHW programs across countries. High drop-out rates have been experienced in many programmes across countries with the drop-out rates of CHWs ranging between 3.2% and 77% (Bhattacharyya *et al*., 2001). High drop-out rates results in the loss of resources as the CHWs are already trained and some households may remain unattended before the replacement of the CHWs who remain inactive for a long period of time. The experiences regarding the remuneration of CHWs across countries vary with some recommending CHWs to be employees of the central government, others being part time employees receiving a stipend or receiving non-monetary incentives and some recommending a combination of monetary and non- monetary incentives while others recommend volunteers to be the ideal (WHO, 2007).

Community Health Workers support is very vital for the success of a CHW program. CHWs can be motivated through the use of monetary incentives and non- monetary incentives. CHW programs implemented across countries have different experiences with majority supporting the use of volunteers and the use of non-monetary incentives. CHWs require adequate training and refresher training coupled by adequate supportive supervision and feedback to enhance their performance. This would enhance their ability to achieve and exceed their performance indicators targets and increase their retention.

Small things can enhance the motivation of CHWs and assist them to gain a sense of pride in their work and improve their status in the community; this can include the issuing of badges for identification, certificates and recognizing their presence during community meetings. Provision of the CHW with kits and regular replenishment of supplies can help ensure that CHWs feel competent to do their jobs. Community support can also come in many forms, which include appreciating of their work by giving of tokens by community members after a good service is rendered to them. (WHO, 2007)

In Kenya CHWs programme has been found to be effective across counties throughout the nation some being done at pilot level and some on small scale. However the main problem has been sustaining the morale of the CHWs over a long period of time which is mainly attributed to the lack of incentives. This has greatly contributed to them falling prey to organizations whose agenda is not in tandem with that of the Ministry of Health and the community which may interfere with meeting the main objectives of the community strategy.

The CUs establishment and training of CHWs in Kenya is mainly done by the Ministry of Health however other partners that's is the Non- Governmental Organizations are also involved which include AMREF, USAID-APHIA II, APHIA Plus and Kenya Red Cross Society among others. The CHWs trained by the MOH are mainly volunteers who work on part time basis receiving mainly non-monetary incentives while their counterparts trained by other partners may receive both monetary and non-monetary incentives. (MOH, 2006)

Methods

The study design was a community based cross-sectional comparative study. Quantitative data was collected through a structured questionnaire while qualitative data was collected through Focus Group Discussions and Key Informant Interviews. The study was conducted at Kibwezi Sub-county which is a geographically underserved region in Kenya. The Community Units (CU) selected for those receiving monetary incentives were: Mukaange, Nthongoni, Ngulu and Ivingoni and those from CUs not receiving incentives were: Mtito- Andei, Athi-Kamunyuni, Nzambani and Athi-Kiaoni.

A total of 282 CHWs were included in the study. A total of 6 Focus Group Discussions (FGDs) were held comprising of CHC members and Key Informant Interviews with the Public Health Nurse, Public Health Officer and Community Strategy Focal Point Person. Quantitative data collected was coded and analysed using the Stata Version 11. Logistic regression was used to establish the relationship between the research variables and Chi – square was used to test the hypothesis. Significance level was $P < 0.05$ at 95% CI. Ethical clearance was sought for Kenyatta University Institutional Research and Ethics Committee and permission to carry out the research from National Council of Science, Technology and Innovations.

Findings and Discussion

The study consisted of 242 CHWs with 140 representing CHWs receiving monetary incentives and 142 being CHWs not receiving monetary incentives. Majority of the CHWs were females for CHWs receiving monetary incentives and the comparative group. Majority of the CHWs were aged between 20-49 Years with majority being married and having secondary education level. On the criteria of selection of Community Health Workers, All (100%) of CHWs receiving monetary incentives were selected by the Community whereas for the group not receiving incentives majority (98.6%) were selected by the community and 1.4% had Volunteered themselves to serve as CHWs.

The overall performance of CHWs was below average with CHWs receiving monetary incentives performing better (47.8%) than CHWs who were not receiving monetary incentives (38%). Poor performance was recorded for the two groups in the sessions of health education conducted where the group receiving monetary incentives scored 28% in comparison to 21% for the group not receiving monetary incentives. The major role of CHWs is promoting health in the community through provision of health education which would assist the community to engage in behaviors which promote health. Refresher training of the CHWs should be conducted to enhance their relevance in provision of health education to households.

Non-monetary incentives provided to Community Health Workers.

Non- monetary incentives play a vital role in the motivation of CHWs. The study findings indicate that there was a significant difference in the provision of non-monetary incentives for CHWs receiving monetary incentives and those not receiving monetary incentives. (P=0.019).All CHW receiving monetary incentives reported getting Community recognition (100%) followed by training (80%), Supervision (74%), provision of bicycles (49%) and Tokens; chicken, foodstuff (3.5%) compared to CHWs not receiving monetary incentives who reported receiving Community recognition (97%),Subsequent training (58.4%), Supervision (79%), Tokens; chicken, foodstuff (5.7%) and provision of a bicycle (3.6%). Majority of CHWs did not have bicycles which would enhance their movement in the community and enhance their workload coverage.

Table 1: Socio demographic characteristics of CHWs

Variable	Incentives	No Incentives	χ^2 P-value
Gender			$\chi 2$=12.1 p= 0.001*
Female	80(43.01%)	106(56.99%)	
Male	62(64.6%)	34(35.4%)	
Age (Years)			X ^{2} =6.56 P=0.363
<20	0(0.0%)	2(100%)	
20-29	22(61.11%)	14(38.89%)	
30-39	41(43.62%)	53(56.4%)	
40-49	49(51.1%)	48(48.9%)	
50-59	21(52.3%)	19(47.5%)	
>60	6(50%)	6(50%)	
Marital status			$\chi 2$ =8.1027 P=0.017*
Married	138(53)	124(47)	
Single	4(21)	15(79)	
Widowed	0(0)	1(100)	
Education level			$\chi 2$=0.0132 P=0.993
Primary	63(51%)	61(49%)	
Secondary	72(49.32%)	74(50.68%)	
Post-secondary	5(50%)	(50%)	
Occupation			$\chi 2$=12.8 P=0.025*
Business	6(25%)	18(75%)	
Farmer	128(51.6%)	120(48.4%)	
Formal employment	3(100%)	0(0.0%)	
Others	1(100%)	0(0.0%)	
None	4(66.67%)	2(33.33%)	

Table 2: Performance of Community Health Workers

	% of CHWs who met the targets for performance indicators.	
Performance indicator	**Receiving monetary incentives.**	**Not receiving monetary incentives**
House hold visits conducted	56 %	43 %
Addressed expected no. of community meetings	36%	35%
Conducted expected number of health education sessions	28%	21%
Referred expected number of patients	49%	36%
Attendance of targeted CHWs meeting	70%	55%
Overall performance	**47.8%**	**38%**

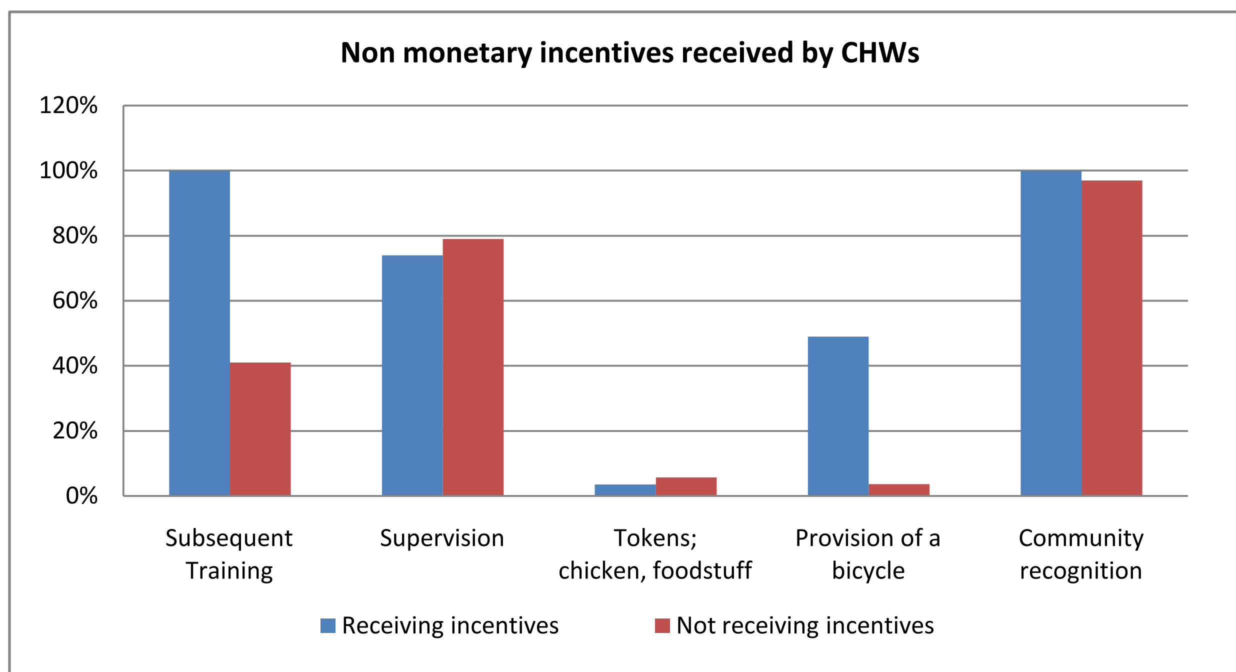

Figure 1: Non-monetary incentives received by CHWs

Training of CHWs

Community Health Workers (CHWs) who do not receive monetary incentives were trained by the Ministry of Health (62%) and AMREF (38%) whereas CHWs receiving incentives were all trained by Non- Governmental Organizations with majority being trained by AMREF (64%) and USAID, APHIA II and APHIA plus (36%). There were discrepancies on the duration of the initial training with majority of CHWs receiving monetary incentives being trained for a period of 3weeks (42.8%) whereas majority (56.3%) of CHWs not receiving monetary incentives had been trained for a period of 2weeks. There was a significant difference in the duration of the training for those receiving incentives and those not receiving incentives. (P=0.0001).

On subsequent training after the initial training of the CHWs, there was a significant difference between those receiving incentives and those not receiving incentives. 58.4% of CHWs from CUs not receiving monetary incentives had received subsequent training compared to 80% for CHWs from CUs receiving monetary incentives. (P =<0.0001).On average the respondents from CUs receiving monetary incentives had received 2 trainings compared to 1 training for the respondents from CUs not receiving monetary incentives. Receiving of subsequent training was significantly associated with performance of CHWs. CHWs who had received subsequent training after the initial training performed better than those who had not received subsequent training. [OR =2.7469, P = 0.008 (CI 95% 1.303001 5.791126)].

Majority (67.7%) of respondents from CUs not receiving monetary incentives felt that the training was not adequate for the role they played as CHWs compared to 43.5% of respondents from CUs receiving monetary

incentives. Areas which the respondents from CUs not receiving monetary incentives felt that they needed to be improved included, Duration of training (18.2%), Content of training (6.1%), Inclusion of Curative services(24.2%) and introduction of refresher courses(51.5%) compared to 10.7%, 10.7%, 32% and 46.6% respectively for respondents from CUs receiving incentives. Majority of the respondents from both groups felt that introduction of refresher courses would help improve their performance. Introduction of refresher courses and subsequent training of CHWs can increase the motivation of CHWs and hence improve their morale to perform better. Similar findings were reported by Kok et al., 2015 who found that introduction of refresher training enhanced the performance of CHWs. A study done in Ethiopia found that future training was the most common non-financial incentive mentioned by CHWs as a motivator (Haile et al., 2014).

Key informant reported that;

"*The discrepancies in training are a major problem as CHWs trained by other partners (AMREF) have undergone subsequent training like Home Based Care and Data collection where as others have not and this definitely affects their performance and also refresher courses and curative courses on minor ailments should be introduced to enhance their performance*"

Support Supervision

Regarding support supervision in the last one month preceding the study, Majority (66.2%) of CHWs not receiving monetary incentives had been supervised once compared to 71% for CHWs receiving incentives. There was a significant difference on frequency of supervision for the two groups. (P =0.019). Majority of CHWs receiving monetary incentives were supervised by the CHEWs (88.6%) followed by the CHC members (11.4%) compared to 97.2% and 2.8% respectively for CHWs not receiving incentives. There was a significant difference in the main supervisor of the CHWs. (P =0.006).Majority of the CHWs receiving monetary incentives felt that the frequency of supervision they got was adequate (77.1%) compared with (49%) for the group not receiving monetary incentives.

Adequacy of supervision was significantly associated with performance of CHWs. The odds of performance were five times higher for those CHWs who reported that they received adequate supervision compared to those who reported it was inadequate. [OR =5.955224, P = 0.0001 (CI 95% 2.271631 - 15.61199)]. A systematic review in low- and middle-income countries has similar findings where the studies showed a variety in frequency of supervision and good performance was associated with frequent supervision (Kok, et al., 2015). Similar findings were reported in a study done in India which found that providing performance feedback significantly affected the performance of CHWs (Kaphle, et al., 2016). Another study in Kenya found that the frequency of supervision on had no effect on the adherence of CHWs to the guidelines (Rowe et al., 2007).

This was also reported in the Focus Group Discussion where majority of the CHWs said;

"*CHEWs should visit us at the household level so that they can understand our problems*

instead of just meeting us at the link health facility to pick our reports. This makes us feel like they are not part of what we are doing and sometimes when you need them in between you cannot get them we look at them as people who collect reports from us."

Households Served

Regarding the number of households they serve, Majority (58.9%) of CHWs not receiving monetary incentives were serving 11-20 households whereas for CHWs receiving monetary incentives majority (53.6%) were serving 21-30 households. There was a significant difference in the number of households served by the CHWs. (P=0.0001). The number of households served by a CHW was significantly associated with performance; CHWs with fewer households were better performers than those serving 21-30 households. [OR =3.091168, P value= 0.001 (CI 95% 0. 15033, 0. 63562] .Majority of the CHWs (98.2%) suggested time as a motivating factor to perform their roles as they have other duties to fulfill which may be affected if they use so much time carrying out their roles as CHWs. The average working hours suggested in a day by CHWs not receiving monetary incentives was 1.2 hours compared to 2.6 hours for CHWs receiving monetary incentives. Similar findings were reported by Haile, et al., (2014) who found that time was a motivating factor for CHWs.

Community and Family Support

All CHWs receiving monetary incentives reported having family support while 3% of CHWs not receiving monetary incentives reported being discouraged by their families from continuing with their roles. Majority of the CHWs felt that the community appreciated their work, all (100%) of CHWs receiving monetary incentives reported the community appreciating their work compared to 93% for those not receiving incentives. However the CHWs felt that the community sometimes did not appreciate them because they did not have basic drugs like pain killers and materials to dress wounds and transport to carry the sick individuals to hospital. This was expressed by majority of CHWs during Focus Group Discussion as illustrated below;

"*When we go to the household to attend to a sick member they ask us what kind of doctors we are since we do not have any thing for first aid or even pain killers and transport to carry the sick person to the hospital".*

Level of Job Satisfaction

On job satisfaction rating, majority of CHWs for both groups were satisfied with their job.40.4% of CHWs not receiving incentives were satisfied with their job, followed by fairly satisfied(26.2%), very satisfied(23.4%), Not satisfied(8.5%) and Totally unsatisfied(1.4%). For the CHWs receiving monetary incentives Majority (46.6%) reported that they were satisfied with their job, followed by fairly satisfied (30%), very satisfied 10.7 %, totally unsatisfied (8.6%) and not satisfied (P =0.002). Majority of CHWs (80%) not receiving monetary incentives and 66% CHWs receiving monetary incentives reported that they had ever contemplated dropping off from their CHW role. The reasons cited to contribute to dropping out of CHWs included; Financial constraints, inadequate compensation for their work, inadequate support by CHEWs ,

uncooperative CHC members, in-adequate training and lack of family support.

Constraints Encountered

Regarding the major constraints faced by the community Health Workers during their work, majority of CHWs not receiving monetary incentives cited Lack of supervisors support(45%) followed by Lack of transport (35%) this was also reported by CHWs receiving monetary incentives with a majority(54%) citing lack of support for the supervisors followed by lack of transport(29%). Other constraints faced by CHWs cited included Lack of supplies, lack of community support and financial constraints. The study findings indicate that there was no significant difference in the major constraints faced by the CHWS receiving monetary incentives and those not receiving monetary incentives. (P-value=0.622). Similar findings were reported in a study done in Uganda which found that the most common challenges faced by CHWs were related to transport (Brunie, et al., 2014). CHWs require moving around the households that they serve therefore lack of a means of transport can tremendously affect their performance.

Conclusion and Recommendations

CHWs had sub-optimal performance which could be attributed to various challenges they face which vary depending on the training partners. Based on the research findings, support supervision can enhance the performance of CHWs and hence monitoring and supervision systems should be strengthened to maintain the quality services provided by CHWs and regular feedback on their performance given by CHEWs to motivate the high performers and assist the low performers to improve.

Adequate training and provision of refresher courses can motivate CHWs and enhance their performance. The government and other training partners should harmonize the training of CHWs to ensure that all CHWs undergo through the same training and subsequent training which will motivate the CHWs and enhance their performance. There should be harmonization of CHWs workload regardless of the training partner to ensure that the households are served adequately by the CHWs.

Non- monetary incentives can enhance performance of CHWs. There is a need for government and other training partners to explore sustainable non- monetary incentives which should be harmonized to avoid discrepancies. They should explore non-monetary incentives like badges, certificates and provision of bicycles for CHWs coupled with refresher training, supportive supervision and feedback to CHWs to enhance their motivation.

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