

Preferred Incentives for Improving Community Health Worker Satisfaction and Retention in Bangladesh

BACKGROUND

Community health workers (CHWs) are critical actors within community health systems, providing a range of reproductive, maternal, child, and primary health information, counseling, and services. CHWs facilitate access to healthcare services and serve as trusted intermediaries between communities and other skilled health workers in countries such as Bangladesh, which is credited with the development of one of the first CHW programs globally (1).

In addition to CHW programs supported by non-governmental organizations (NGOs, e.g. BRAC), three governmental cadres of CHWs operate in Bangladesh: Family Welfare Assistants (FWAs), Health Assistants (HAs), and Community Health Care Providers (CHCPs) (2). These cadres are responsible for health promotion and education in their communities, encouraging health service utilization, and delivering health services, including family planning (FP), and maternal and newborn care. FWAs provide FP services under the Directorate General of Family Planning (DGFP) while HAs support the Expanded Programme on Immunization (EPI) under the Directorate General of Health Services (DGHS) (3–5). CHCPs are responsible for managing Community Clinics (CCs) and providing preventative and primary care services.

Despite successes in facilitating access to and usage of health services, CHWs face challenges with recruitment, performance, and retention. Unwieldy workloads coupled with insufficient recruitment are among the many factors that contribute to CHW work dissatisfaction and program attrition (6-9).

To better understand factors that influence CHWs' work motivation and satisfaction in Bangladesh, the Frontline Health project, implemented with collaborators from Johns Hopkins Bloomberg School of Public Health, and supported by the government of Bangladesh's Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP), conducted a discrete choice experiment (DCE) study. This brief presents key qualitative findings from the DCE study in Bangladesh and implications for program and policy stakeholders.



Photo: Pooja Sripad, Population Council

KEY FINDINGS

1. Changes to technical ranks and wages for the healthcare sector need to take a sector-wide lens so that wages for all healthcare workers can be systematically calibrated.
2. It may be important to consider possible alternatives such as renting a community members' home, or another existing community-owned location.
3. As revisions to CHW and healthcare compensation structures are considered, provisions need to be in place to account for adequate training and risk allowance.

The information presented in this brief is based on focus group discussions (FGDs) with a total of 121 participants including CHWs (n=62) [FWAs and HAs] and their supervisors (n=59) [including Family Planning Inspectors (FPIs), Assistant Health Inspectors (AHIs), and Health Inspectors (HIs)], as well as in-depth interviews (IDIs) with a total of 30 district and national stakeholders [including Civil Surgeons (CSs), Deputy Directors of Family Planning (DDFPs), Medical Officers (MOs), and Upazila Family Planning Officers (UFPOs)]. This study took place in four districts of Bangladesh: Bangladesh's Cox's Bazar, Rajshahi, Khulna, and Sylhet between December 2019 and January 2020.


RESULTS

CHWs are motivated by a range of monetary and non-monetary factors, which include compensation, relationships with communities, transportation, workloads, and work recognition.

The results of the FGDs and IDIs highlight a range of motivating and demotivating factors, as well as potential incentives.

MONETARY MOTIVATING FACTORS

Salary Compensation




CHWs felt their salaries were insufficient. Compensation differences further fueled tensions between CHWs cadres receiving different levels of monetary compensation, as FWAs felt they deserve the same compensation as HAs for conducting overlapping activities. HAs also shared that salary level did not increase with promotion, which was demoralizing.

Unequal compensation and pay scale grading affects CHW work motivation; some CHWs shared that they were often disheartened when comparing themselves to other occupations of similar starting salary grades.

“If an HA gets the same basic [salary] of 20,180 BDT (\$238) that an AHI or HI gets...then why would he address an HI as sir?” —AHI/HI, FGD

Transportation Allowance




Currently, CHWs receive around 600 BDT (\$7) to offset travel-related costs, though many CHWs reported having to pay for travel costs out-of-pocket, as the amount provided was negligible given actual travel costs. Notably, FWAs do not all report receiving their allowances on time

“We have to spend a lot of money on transportation. But we don’t get any transportation allowance for it. In this upazila the FWAs aren’t provided transport allowances.” —FWA, FGD

An increase in the amount of transportation allowance would play an important role in increasing CHW productivity.

Other Allowances




CHWs shared the need for an array of other allowances, including compensation for increased workloads, risks/emergencies, meals, and referral fees. The need for increased workload allowances—

similar to overtime pay—were especially emphasized by CHWs working with the Rohingya refugees in Cox’s Bazar. In terms of exposure risks to illness/injury (e.g. providing communities’ vaccinations) or for emergency response work, CHWs felt they deserved compensation to account for exposure to potential dangers. FWAs also discussed increasing referral fees earned after referring community members to receive family planning care to offset incurred client costs. Both cadres of CHWs expressed the desire for a tourism or meal allowance to subsidize the high cost of living in areas with increased tourism. Additionally, CHWs expressed frustration with being unable to take meal breaks due to high workloads.

NON-MONETARY MOTIVATING FACTORS


Means of Transport



Providing means of transport can help CHWs reach remote locations and reduce the amount of time it takes to reach communities by foot. Transportation was also essential as tools and supplies can be difficult to carry. CHWs specifically discussed a need for the provision of bicycles or motorcycles.

“So to work in eight sub-block, to visit the ward, visit the house, one motorcycle can be provided either by [the] government or by the donor. If it [the motorcycle] is provided, the service will be faster, sounder, and more successfully done by us.” —HA, FGD


Official Identification



Identification in the form of official cards (ID cards), branded uniforms, and branded working tools can help bolster CHW credibility and acceptability. ID cards can help CHWs claim ownership over their work by building trust and recognition with community members and healthcare facilities.

“Wherever they roam without their uniform, people get scared of them. It’s a city. It’s full of danger. People of this upazila often assume that they are frauds and do not want to believe them. [...] How can they do their job without a basic [uniform]?” —FPI, FGD

Provision of Working Tools



CHWs requested distributable medicine supplies to strengthen community relationships and better meet community needs. CHWs also discussed the need for blood pressure machines, weight machines, and thermometers when check-ups are performed on pregnant mothers and other community members.

“It would be better if we get some medicines for the field. [...] It will increase [community] belief towards [CHWs]. But we don’t get any medicines.”
—FWA, FGD

HAs desired support to better run health education and EPI sessions (e.g. posters and leaflets). Both CHW cadres discussed the need for mobile phones or tablets to reduce paper-based job-aids (e.g. bulky notebooks), as digitizing aspects of their work would increase work efficiency.

Training

CHWs requested increased and thorough basic and refresher trainings for existing job-specific skills such as counseling or vaccinations. CHWs also expressed the desire to gain new content-specific skills such as community-based skilled birth attendant (CSBA) training as well as training on digital devices.

“We need training in a regular basis. There are lots of things that we forget [...] and if there are regular training session, it will be easier for us to remember all the directions, and our work will be smooth.”
—FPI, FGD

Recognition

Opportunities for promotions and technical recognition of CHWs were preferred forms of recognition for their work. Increased technical recognition would improve class ranking and make CHWs eligible for higher salaries. Currently, promotions to supervisory positions do not exist for FWAs.

“Thirty years have passed. This work feels boring now. I feel that if there was promotion for us, we would be happy with our work. I have worked all my life being in the same rank.” —FPI, FGD

HAs have the opportunity for promotion, but they are not provided often. When promotions do occur, they often do after HAs spend many decades on the job:

“They join the department as Health Assistant [and] also retire from the department as Health Assistant. They do not get the opportunity to become AHI or HI. How cruel is this!” —AHI/HI, FGD

Relationship with Communities

The CHW-community relationship is critical for CHW performance and motivation. CHWs reported that community members often refer to them as ‘doctors’, indicating high trust levels in CHWs. One MO shared:

“They [CHWs] can even solve the issues like the health, education, marriage, and familial problems of the people.” —MO, IDI

Positive community perceptions of CHWs also support CHW motivation and performance. However, these relationships can be strained by constraints on CHWs (e.g. high workloads, inability to provide medicines, lack of transportation). CHWs also discussed the importance of growing their skill sets through trainings to better match their community’s needs and foster stronger relationships.

Relationship with Health Facilities

CHWs’ relationships with healthcare facilities is detrimentally affected by a lack of adequate workspace and supplies, as well as by poor collaboration with facility staff.

Additionally, existing inter-cadre challenges with collaboration exacerbates tensions; for example, FWAs may assist HAs with EPI and not receive reciprocal assistance for their own work. To strengthen inter-cadre relationships, CHWs recommend improving supportive supervision and addressing manpower and working tool shortages.

“...Overall, the relationship is quite good, otherwise we wouldn’t be able to work properly. We must work together. But they [HA] show a quite superior vibe although they are not of our supervisor.” —FPI, FGD

Workplace Environment

CHWs emphasized the need for a CHW-dedicated workplace to strengthen relationships with communities and healthcare facilities. When spaces are provided at CCs, Upazila Health Complexes, or Family Welfare Centers they are often underequipped and feed into tensions between CHW cadres.

Additionally, HAs often conduct EPI sessions within community member homes, but may face logistical challenges. HAs suggest renting spaces for immunization (potentially from community members) to help better facilitate their work:

“Government doesn’t have to make a new facility for us as well. We could keep all of our logistics there and prepare ourselves better.” —AHI/HI, FGD

Workload

High CHW workloads and work pressures were demotivating factors for many CHWs, contributing to overall dissatisfaction with their work. With

inadequate appointments to fill long-standing vacancies, CHWs often are responsible for more community members than originally intended:

“Now that person has to work for 6 wards where it supposed to be two people per ward. [...] Last appointment was in April 2010. Some people retired or got promoted in the meantime. But no appointment was conducted for these vacant posts.” —HA, FGD

For FWAs, the pressure to fulfill hard to reach government-set targets for family planning methods can be demoralizing.

“One left in my area for the pressure [...] she couldn't fulfill the targets. They used to hold her salary.” —FWA, FGD

CONCLUSION

This study identifies several challenges that are unique to and have direct implications for Bangladesh's healthcare sector. Tensions between HAs and FWAs, given the differences in their technical ranks and salary grades despite comparable responsibilities and workloads, further undermines CHWs' motivation. Such changes to technical rank and salaries must take a sector-wide lens so that all wages for healthcare workers can be systematically calibrated.

The study also highlighted importance of workplace environment in fostering motivation and ability to work effectively. FWAs noted a lack of a physical workspace in community clinics, where they spend a few days out of the week, and HAs do not always have access to a community member's home to conduct EPI sessions. Given this, it is important to consider alternatives that help support and facilitate CHW performance and improve CHW-community relationships such as renting a community member's home (instead of it being volunteered) or identifying another community-owned location.

CHWs also continue to be seen as quick fix solutions to emergent health challenges, such as for chronic diseases, refugee health crises, and a global pandemic. As changes to CHW compensation structures are considered, provisions need to be in place to account for adequate training and risk allowance. This is of particular importance as CHWs are often deployed

to respond to emergent situations without adequate investment in preparing or supporting them.

Lastly, it is important to note that while institutionalizing CHWs is valuable, it is also insufficient towards improving the quality of CHW programs. Governments must continue to plan for adequate and sustained investments not just for the direct salaries and benefits for CHWs, but also in ensuring a supportive ecosystem that can adapt to changing community needs, assess performance, and align support with expected output. Greater coordination is needed at the global level to pool and align donor investments towards building a supportive ecosystem that facilitates the success of CHW programs.

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REFERENCES

1. Exemplars in Global Health. Community Health Workers in Bangladesh. 2020. Available from: <https://www.exemplars.health/topics/community-health-workers/bangladesh>
2. Egan KF, Devlin K, and Pandit-Rajani T. 2017. Community Health Systems Catalog Country Profile: Bangladesh. Arlington, VA: Advancing Partners & Communities. Available from: https://www.advancingpartners.org/sites/default/files/sites/default/files/resources/bangladesh_chs_catalog_profile.pdf
3. World Health Organization. Regional Office for the Western Pacific. Bangladesh Health System Review. Vol. 5, Health systems in transition. Manila; 2015. Available from: <https://apps.who.int/iris/handle/10665/208214>
4. Government of the People's Republic of Bangladesh. Ministry of Health and Family Welfare. Bangladesh National Strategy for Community Health Workers. 2019. Available from: http://www.communityclinic.gov.bd/admin/content_uploads/CHW_strategy.pdf
5. Riaz BK et al. Community clinics in Bangladesh: A unique example of public-private partnership. *Heliyon*. 2020 May 1;6(5):e03950.
6. Rahman SM et al. Factors affecting recruitment and retention of community health workers in a newborn care intervention in Bangladesh. *Hum Resour Health*. 2010 May 3 ;8(1):12. Available from: <http://human-resources-health.biomedcentral.com/articles/10.1186/1478-4491-8-12>
7. Alam K, Tasneem S, Oliveras E. Retention of female volunteer community health workers in Dhaka urban slums: A case-control study. *Health Policy Plan*. 2012 Sep 1;27(6):477-86. Available from: <https://academic.oup.com/heapol/article/27/6/477/566892>
8. Ormel H et al. Salaried and voluntary community health workers: Exploring how incentives and expectation gaps influence motivation. *Hum Resour Health*. 2019 Jul 19;17(1):59. Available from: <https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-019-0387-z>
9. El-Saharty S et al. The Path to Universal Health Coverage in Bangladesh: Bridging the Gap of Human Resources for Health. *The Path to Universal Health Coverage in Bangladesh: Bridging the Gap of Human Resources for Health*. 2015.

The Frontline Health: Harmonizing Metrics, Advancing Evidence, Accelerating Policy project seeks to advance community health systems metrics, monitoring and learning to improve the efficiency and performance of community health worker programs. www.popcouncil.org/research/frontline-health-harmonizing-metrics-advancing-evidence