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Original Research

Why do community health workers volunteer? A qualitative study in Kenya

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SUMMARY

Objectives: Globally, there is a dire shortage of healthcare workers, but the situation is particularly bad in low- and middle-income countries. To address this, task shifting of clinical work to lower-level staff, including volunteer health workers, has been used. Whilst there are examples worldwide of such an approach working, the sustainability of programmes based on a volunteer workforce is less certain. In addition, little is known about the factors that motivate such volunteers. This study sought to ascertain these motivational drivers.

Study design: Qualitative study using focus group discussions.

Methods: Qualitative study of volunteer community health workers (CHWs) in a rural district of Western Kenya. Twenty-three CHWs were sampled purposively, and took part in six focus group discussions. Thematic analysis was performed on the transcribed discussions.

Results: A variety of factors were identified as important drivers of motivation. These included financial as well as non-financial drivers, such as personal recognition, personal development and working conditions.

Conclusions: There are serious unanswered questions regarding the viability of healthcare programmes founded on a workforce reliant on volunteer CHWs. This study revealed the importance of some form of reward, be it financial or otherwise, in order to retain and maintain the engagement and motivation of volunteer CHWs in these settings.

Introduction

Globally, there is a dire shortage of healthcare workers. In 2006, the World Health Organization estimated that there was a shortfall of nearly 4.3 million doctors, nurses and midwives worldwide.[1] This will have a significant effect on the ability of low- and middle-income countries (LMICs) to achieve better population health and the Millennium Development Goals (MDG).[1–4] For example, in order for a country such as Mozambique to achieve the MDGs, it would need to increase its health workforce seven-fold.[4] Africa accounts for 25% of the global disease burden but only has 1.3% of the global workforce.[2] In addition to the problem of staff shortages, many countries are also beleaguered by skill mix imbalances, distributional problems, inadequate knowledge base and poor working conditions.[5] Countries in Sub-Saharan Africa, where

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the needs are greatest, are most affected by the shortage of health workers, especially doctors.[6]

One of the strategies tried by many countries to address this problem includes task shifting to lower-level health workers.[7–9] One example is community health workers (CHWs), who are often volunteers working in their local communities who have received some health training. Evidence from around the world has demonstrated that CHWs can be effective in delivering health programmes.[10,11] Notable examples include the Lady Health Workers Initiative in Pakistan,[12] and community-based breastfeeding peer counsellors in Bangladesh.[13] CHWs can facilitate community development and improve access and coverage to basic health services.[14–17]

However, CHW-based programmes are beset with problems such as high attrition rates.[9] Furthermore, it is difficult for part-time workers to cover a wide range of duties, including maternal and child care, and prevention and control of diseases. There are limited data on the effects of CHWs' motivation on their performance.[18,19] It is also unclear whether the motivational drivers for salaried health workers differ from those of non-salaried volunteers. Indeed, the sustainability of non-salaried volunteer CHW programmes is questionable.[19] Some studies have shown that when incentives and support for health workers are removed, many will stop carrying out their health functions.[13,20] An understanding of the underlying factors that motivate local people to volunteer as CHWs is therefore crucial. Although a number of studies have been performed on health worker motivation, there is little empirical research examining CHWs in developing countries. In order to address this, a qualitative study of CHWs in Kenya was undertaken to examine the determinants of their work motivation.

Methods

Study design

This qualitative study used focus group discussions to explore the determinants of CHW's work motivation. This approach was selected as it is best suited to uncovering the participating health workers' ideas, experiences and opinions through dialogue. It was felt that in a group setting, participants would be more forthcoming with their views and opinions than in individual interviews. The authors expected the group to challenge or find consensus on views expressed in their discussions. As such, this approach allows for observation of the participants in a more natural group setting that could also provide a rich vein of enquiry.

Study setting

This study was undertaken in Kisumu West District, one of 37 districts in Nyanza Province in western Kenya. This is a rural province with an economy based around subsistence agriculture and fishery. The province is among those with the worst health indicators in Kenya (Table 1), and one in seven children will die before their fifth birthday. Both infant and under-five mortality rates are twice the national averages. Similarly, the prevalence of human immunodeficiency virus (13.9%) is more than twice the national average (6.3%).[21]

Table 1 – Selected demographic and health indicators for Nyanza Province.[17]

	Nyanza	Kenya average
Population	5.4 million	39.4 million
Educational attainment (completed)		
Primary school	17.4%	17.0%
Secondary school	6.4%	8.7%
Employment status		
Male employed	83.2%	87.1%
Female employed	65.6%	56.6%
Maternal health		
Fertility rate	5.4	4.6
Delivery at home	54.9%	56.2%
Delivery attended by skilled health worker	45.5%	43.8%
Child health		
Infant mortality per 1000 livebirths	95	52
Under-five mortality per 1000 livebirths	149	74

The district has 15 community units, each with approximately 50 trained CHWs. Each CHW covers between 20 and 40 households. The CHWs are mainly trained in home-based care, such as first aid and the prevention and management of minor ailments. They make visits to households to find people with illnesses, provide health education on issues such as hygiene and sanitation, and promote measures to control diseases such as malaria. They encourage the uptake of routine childhood immunizations and give antenatal advice to pregnant women. Occasionally, they assist in patient referrals to health facilities. As this is an unpaid role, many have other employment (mainly farming-related).

Sampling

The participants were drawn from CHWs working in four of the 15 community units in Kisumu West District: Lower Kombewa, South Ratta, West Kadinga and Kuoyo Kaila. Each community unit consisted of approximately 50 CHWs, six of whom were selected at random to participate in the study. In total, 23 CHWs accepted the invitation and were recruited to the study. Purposive sampling was used to select the participants in order to ensure that the participants from all four community units were broadly similar. Each focus group included respondents drawn from the same community unit, of both genders and of all ages (Table 2). They tended to be drawn from the same tribe by virtue of their place of residence. Of note, as they were all

Table 2 – Characteristics of the participants.[17]

	Group 1	Group 2	Group 3	Group 4
Number of participants	6	6	5	6
Gender (female:male)	3:3	4:2	3:2	5:1
Mean age (years; range 26–78)	52	45	43	44
Education level:				
Up to primary school	5	3	2	3
Up to secondary school	1	3	2	3
Beyond secondary school	0	0	1	0