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Behavior of health workers

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Health Behavior Change at the Individual, Household and Community Levels
224.689
Rest of this course

- **Today**
  - Lecture
  - Discussion groups

- **Thursday**
  - 1 hour lecture/discussion: “Career paths related to community and behavioral interventions”

- Wed Dec 21: Final assignment due, complete course evaluations
Health workers

- Broadly defined:
  - Licensed and unlicensed
  - Public and private sectors
  - Health facilities or communities
Common concerns about health workers

- Poor performance
- Attrition
- Migration to other countries
Health worker performance

- “Adherence to accepted standards or guidelines”
- Demonstrated to be poor in multiple studies
- Consequences:
  - Decreased careseeking from health workers, low use of health facilities and health services
  - Harm from inappropriate injection practices, non-sterile surgical procedures etc.
Health worker performance

- References:
Factors Influencing Performance

- Job expectations
- Performance feedback
- Environment and tools
- Motivation
- Organizational support
- Skills & knowledge
Health worker performance

- Frequent focus of programmatic initiatives
- However: Performance and quality of care are at the end of a cascade of choices that health care workers make
- Need to address ‘upstream’ choices as well as health worker performance
Cascade of choices for health workers

- Undergo professional training Y/N
- Type of training/profession/specialization
- Practice in the country vs. migrate to another country
- Public sector vs. private sector employment
- Site/clinic/health facility to practice
- Live at site of practice vs. commute to site
- Performance/Quality of care/Style of practice
  - Assessment/diagnosis
  - Treatments/procedures
  - Communication/counseling
  - Outreach/Engagement with community
Paradigms for thinking about health worker performance

- Administrative/supervisory
- Behavior change
- Quality assurance/performance improvement
- Political economy
Administrative/supervisory paradigm

- Health workers are part of an organization
- The organization should define:
  - Roles and responsibilities
  - Guidelines for carrying out the work
- Supervision, based on the guidelines, is key to maintaining performance
- Considerable evidence that supervision can have an effect, but full implementation limited by operational constraints
- HUGE interest currently in mobile technologies as tools to overcome these constraints
Constraints to supervision

**Supervisor**
- Insufficient numbers of supervisors
- No training in supervision
- Inappropriate styles of supervision e.g. punitive
- No funds for transport to or accommodation at peripheral sites
- Identifying problems creates difficulties for supervisor

**Health worker**
- Irregular salary payments “Why should I listen to you?”
- Increased mobility + Mixed public-private styles of practice
- Cell phones: Can anticipate and prepare for supervisory visits, coordinate work in public and private practice
Behavior change paradigm

- ‘Performance’ of health workers is the same as their behavior
- Identify discrete behaviors we want health workers to be practicing
- Using behavior change models (TRA, SCT, Transtheoretical etc.) and intervention modalities (social marketing), implement behavior change interventions targeted at health workers
Behavior change paradigm

**Strengths**
- Body of literature to support behavior change approaches
- Voluntary behavior change perspective
- Focus on motivations of health workers rather than their knowledge

**Weaknesses**
- Often difficult to reduce performance to discrete behaviors
- May be unacceptable to organization
- Many organizations lack necessary skills
- Focus on individual level often inappropriate
Performance Improvement/Quality Assurance Paradigm
Performance Improvement/Quality Assurance Paradigm

- Sources of information:
  - www.hciproject.org/improvement_tools
Performance Improvement/Quality Assurance Paradigm

- Typically has people work as teams to analyze the problem (the gap) and identify solutions

- Advantages of teams
  - Focus on overall quality, rather than individual performance, may be less threatening and more acceptable
  - Teams may come up with innovative solutions
  - Peer support and pressure to make changes, establish new norms
Questions teams are to address:
- What performance do we want?
- What performance have we got now?
- What are the causes of the performance gap? (Gap between what we want and what we actually have)
- Which solution gives us the greatest return on our investment?
The Performance Improvement Process

- Reference:
  - http://www.reproline.jhu.edu/english/6read/6pi/pi_what.htm
The Performance Improvement Process

GET and MAINTAIN STAKEHOLDER AGREEMENT

CONSIDER INSTITUTIONAL CONTEXT
- MISSION
- GOALS
- STRATEGIES
- CULTURE
- CLIENT and COMMUNITY PERSPECTIVES

DEFINE DESIRED PERFORMANCE

FIND ROOT CAUSES
Why does the performance gap exist?

SELECT INTERVENTIONS
What can be done to close the performance gap?

IMPLEMENT INTERVENTIONS

MONITOR AND EVALUATE PERFORMANCE

DESCRIBE ACTUAL PERFORMANCE

GAP
Use the Performance Improvement Process to Guide Program Development

Work with stakeholders to:

- Define desired performance
- Conduct a performance gap analysis
- Conduct a root cause analysis
- Identify the most cost-effective interventions to close the performance gap
- Implement interventions as appropriate
- Evaluate the impact of interventions on performance
Limitations of the Performance Improvement Paradigm

- In practice, tends to focus on the health care facility as the unit of analysis (although the model includes the institutional context)
- Less room for consideration of life situation, needs and motivation of individual health workers
Paradigms for thinking about health worker performance

- Administrative/supervisory paradigm
- Behavior change paradigm
- Quality assurance/performance improvement
- Political economy perspective
  - Found in a range of social science critiques of development e.g. anthropology, development studies etc.
**Political economy perspective**

- Does it make sense to focus on the performance of individual health workers?
  - They have little control over the situation
  - Poor working conditions
  - Low salaries
- Isn’t this blaming the victim?
Political economy perspective

- ‘Real’ underlying causes of poor health worker performance include:
  - Chronic underfunding of the health system and health workers in many countries, low salaries for health workers
  - Focus on commodities, not people
  - Influence of drug companies and other commercial interests on health policy and health care spending decisions
  - Gender roles and constraints imposed on female health workers
Political economy perspective

- Health workers as distribution channels for commodities
  - Concern about health worker performance often arises when it is found that commodities are not distributed or used correctly
  - Problems with commodities provoke more concerns that poor counseling and communication, deficient or lacking surgical care, little community outreach
Political economy perspective

- Solutions should include:
  - Adequate funding of the health system, increased salaries
  - Balanced attention to commodities and human resources
  - Capacity building and training
  - Limit influence of commercial interests
  - Address gender-related constraints
Final issue: Attrition/retention of voluntary workers
Attrition/retention of voluntary workers

- For salaried health workers, attention tends to be on performance and motivation
- For voluntary workers e.g. community health workers (CHWs), much attention currently on attrition/retention
- Voluntary workers have expanding range of tasks, e.g.
  - Mass treatment for trachoma, onchocerciasis, malaria (IPT, IPTI)
  - Voluntary counseling and testing
  - Ensuring compliance with AIDS and TB treatment
  - Management of sick newborns
- Program cost-effectiveness threatened by high attrition, need to recruit & train replacements
Multilevel perspective on attrition/retention

- Factors affecting attrition/retention act at different levels
  - Individual education, motivation etc.
  - Family
  - Community
  - District or Program
  - National
Bhattacharyya K, Winch P, LeBan K, Tien M.
Community health workers incentives and disincentives: How they affect motivation, retention and sustainability.
Multilevel perspective on CHW Incentives and Disincentives

- Individual
  - Monetary factors
  - Non-monetary factors

- Community
  - Factors that Motivate the Individual CHW
  - Factors that Motivate Communities to Support and Sustain CHWs

- District/Health facility
  - Factors that Motivate MOH Staff to Support and Sustain CHWs
Individual level: Monetary Factors that Motivate voluntary workers

**Incentives**
- Satisfactory remuneration / Material Incentives / Financial Incentives
- Possibility of Future Paid Employment

**Disincentives**
- Inconsistent Remuneration
- Change in Tangible Incentives
- Inequitable Distribution of Incentives Among Different Types of Community Workers
Individual level: Non-Monetary Factors that motivate voluntary workers

Incentives
- Community Recognition and Respect of CHW work
- Acquisition of Valued Skills
- Personal Growth and Development
- Accomplishment
- Peer Support
- CHW Associations
- Identification (badge, shirt) and Job Aids
- Status within Community
- Preferential Treatment
- Flexible and Minimal Hours
- Clear Role

Disincentives
- Person Not from Community
- Inadequate Refresher Training
- Inadequate Supervision
- Excessive Demands / Time Constraints
- Lack of Respect from Health Facility Staff
Community Level Factors that Motivate the Individual CHW

**Incentives**
- Community Involvement in CHW Selection
- Community Organizations that Support CHW Work
- Community Involvement in CHW training
- Community Information Systems

**Disincentives**
- Inappropriate Selection of CHW
- Lack of community involvement in CHW selection, training, and support
Factors that Motivate Communities to Support and Sustain CHWs

<table>
<thead>
<tr>
<th>Incentives</th>
<th>Disincentives</th>
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<tr>
<td>• Witnessing Visible Changes</td>
<td>• Unclear Role and Expectations (preventive versus curative care)</td>
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<tr>
<td>• Contribution to Community Empowerment</td>
<td>• Inappropriate CHW behavior</td>
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<td>• CHW Associations</td>
<td>• Needs of the Community Not Taken into Account</td>
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<td>• Successful Referrals to Health Facilities</td>
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Factors that Motivate MOH Staff to Support and Sustain CHWs

**Incentives**
- Policies / Legislation that Support CHWs
- Witnessing Visible Changes
- Funding for Supervisory Activities from Government and / or Community

**Disincentives**
- Inadequate Staff and Supplies
Interaction of different dimensions

- Performance
- Motivation
- Relationship with community
- Retention/Attrition
- Environment