

# SUPPORTING COMMUNITY MOBILIZERS TO PROVIDE QUALITY SEXUAL AND REPRODUCTIVE HEALTH CARE IN URBAN TANZANIA

Gaps in human resources for health are among the most influential factors underlying poor health systems performance. Community health workers have positively impacted health outcomes by providing health services and linking the community to the health system. While there is evidence to support capacity development and successful deployment of community health workers, evidence of effective quality assurance mechanisms is lacking. Chaguo la Maisha—a three-year, anonymously-funded project implemented by Pathfinder International in Dar es Salaam, Tanzania—aimed to create an enabling environment for women to choose whether and when to bear children. Community health workers are integral to achieving this goal. This technical brief explores the project components designed to support quality in community health worker services and to support community health workers to build service-seeking behaviors as well as mutual accountability and shared responsibility for health between the community and the facility.



## Context

Today, the global health community rallies around a vision—set forth by the Sustainable Development Goals—of a world with equitable and universal access to health care and social protection, where physical, mental, and social well-being are assured.<sup>1</sup> Crucial to achieving this vision is primary health care—defined as essential care inclusive of: preventive, curative, and rehabilitative services in nutrition, maternal and child health, water, sanitation and hygiene, and infectious disease.<sup>2,3</sup> Necessary to primary health care is a skilled health workforce.<sup>3</sup> Research suggests that a shortage of health workers contributes to weaker health systems, which, in turn, negatively impact health outcomes and poses a barrier to achieving the Sustainable Development Goals.<sup>3</sup> Community health workers<sup>a</sup>, often a volunteer work cadre, have been relied upon to promote healthy behaviors, provide basic health services, refer for clinical services, and mobilize communities for disease prevention. They have served as a critical link between communities and health systems for decades.<sup>4</sup> Further, studies show that, under certain circumstances, community health workers can positively impact health outcomes.<sup>4,5</sup>

International agencies, aid organizations, and researchers have developed training resource packages, guidelines, and recommendations for community health workers and their contributions to specific sexual and reproductive health (SRH) interventions. What is lacking, however, are guidelines to support supervision and quality assurance of community health workers in general.<sup>6</sup>

### Tanzania

Though the World Health Organization estimates 4.45 skilled health workers per 1,000 people are needed to achieve Sustainable Development Goal 3 (“Ensure healthy lives and promote well-being for all, at all ages”),<sup>7</sup>

estimates from Tanzania report that the sub-Saharan African nation falls short, with 1.4 skilled health workers per 1,000 people.<sup>8</sup> This shortage of human resources for health contributes to Tanzania’s poor—when compared to the rest of East Africa and the world—sexual and reproductive health outcomes (see Table 1).

It is in this context that Pathfinder International implemented Chaguo la Maisha<sup>b</sup>—a three-year, anonymously funded project that aimed to create an enabling environment for women to choose whether and when to bear children by strengthening quality, needs-responsive service delivery. Integral to creating this enabling environment is an effective, community-based workforce for contraception and comprehensive postabortion care services. The community-based health worker cadre in Chaguo la Maisha—composed of volunteers called community mobilizers<sup>c</sup>—is a trained workforce that provided women with counseling and referrals for health facility-based services. This technical brief first provides an overview of the project, then examines the implementation and performance of four elements put into place to support quality assurance of Chaguo la

Maisha’s community mobilizers: supportive supervision, a digital job aide, incentive payments for performance, and routine coordination and learning meetings with project stakeholders. Finally, the brief offers lessons learned from implementation experience, with the hope of contributing to future efforts to develop guidelines for quality assurance of community health worker activities and services.

## Project strategy and implementation plan

Project implementation began in 2015. The project planned an integrated, systems strengthening approach—a Pathfinder strategy that involves working with the local health system to build capacity of providers and facility staff to deliver quality services to women; with community members to increase service-seeking behaviors and generate demand; and with both health facilities and community-based health workers to encourage dialogue, mutual accountability, and a shared responsibility for health. At the facility level, the project implemented provider trainings and a mentorship program to ensure provision of

**TABLE 1: EPIDEMIOLOGICAL CONTEXT**

*When compared to the rest of the region and the world, Tanzania has a higher maternal death to live birth ratio, lower modern contraceptive prevalence, higher unmet need for contraception, and higher total fertility rates.*

	TANZANIA	EASTERN AFRICA <sup>d</sup>	GLOBAL
MATERNAL MORTALITY RATIO (AMONG ALL WOMEN AGES 15 TO 49)	556 PER 100,000 <sup>9</sup>	417 PER 100,000 <sup>e,10</sup>	216 PER 100,000 <sup>10</sup>
MODERN CONTRACEPTIVE PREVALENCE RATE (AMONG MARRIED WOMEN AGES 15 TO 49)	32% <sup>9</sup>	38% <sup>11</sup>	55% <sup>11</sup>
UNMET NEED FOR CONTRACEPTION (AMONG MARRIED WOMEN AGES 15 TO 49)	22.1% <sup>9</sup>	22% <sup>12</sup>	12% <sup>12</sup>
TOTAL FERTILITY RATE (AMONG ALL WOMEN AGES 15 TO 49)	5.2% <sup>9</sup>	4.7% <sup>11</sup>	2.5% <sup>11</sup>

(a) The World Health Organization defines community health workers “as any health worker who performs functions related to health-care delivery; was trained in some way in the context of the intervention; but has received no formal professional or paraprofessional or tertiary education, should be members of the communities where they work, be selected by the communities, be answerable to the communities for their activities and should be supported by the health system” (Lewin SA et al. Lay health workers in primary and community health care. *Cochrane Database Syst Rev*, 2005;(1):CD004015; and Strengthening the performance of community health workers in primary health care. Report of a WHO Study Group. WHO Technical Report Series, No. 780. Geneva: World Health Organization; 1989) (b) Chaguo la Maisha translates from Swahili to “Lifetime Choice.” (c) The community health worker cadre in Chaguo la Maisha was referred to as “community mobilizers” to differentiate them from the community health workers that are recruited and trained by the government. To avoid creating parallel systems, community mobilizers were trained using national curricula and were engaged in places where there are no active community health workers.

quality and comprehensive contraception and postabortion care services for youth and women. At the community level, the project worked with local nongovernmental organizations (NGOs), supervisors, and community health workers to generate demand for clinical services, to collect post-referral data from clients, and to follow up with clients to continue counseling and to support satisfaction with contraceptive methods. While both components—facility and community—are necessary for an integrated systems-strengthening approach, this brief will focus on the community component.

## Site selection

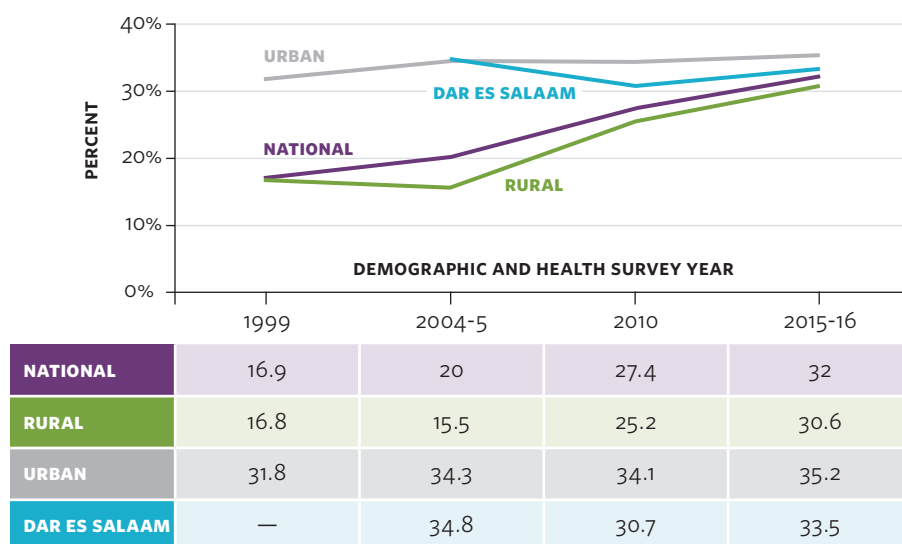
Nearly 5 million of Tanzania's 57.5 million people live in Dar es Salaam and the rapid growth of the city has strained its infrastructure.<sup>11,14</sup> Despite increases in the modern contraceptive prevalence rate (mCPR) over time both nationally and among rural regions of Tanzania, urban mCPR has stagnated and the mCPR in Dar es Salaam has decreased (see Figure 1)—making the city a good candidate for an intervention. The project planned to support 100 percent of public health facilities in Dar es Salaam's Temeke and Ilala districts in two phases: first in Temeke in January 2015 (both clinical and community components), and then in Ilala in January 2016 (clinical) and July 2017 (community).

## Community mobilizers

The project set a target of 215 recruited community mobilizers to provide quality counseling and referrals for contraceptive services and, when needed, for comprehensive postabortion care services. In collaboration with community members from project sites, the project adapted already existing national criteria to recruit community mobilizers: they must be women, they must have completed secondary school, and they must be from the community they intended to serve. Once recruited, community mobilizer candidates participated in a two-week training course.

**FIGURE 1: TRENDS IN MCPR AMONG CURRENTLY MARRIED WOMEN IN TANZANIA**

This chart shows, with data from Tanzania Demographic and Health Surveys, the slow growth of mCPR in urban areas of Tanzania and specifically Dar es Salaam, compared to increases nationwide and in rural populations. These data\* encourage implementers to focus on rapidly growing urban populations as well as the hard-to-reach rural areas.



\* Data gathered from Tanzania Demographic and Health Surveys, years 1999, 2004-5, 2010, 2015-16.

The first week consisted of didactic training using a curriculum that drew from the Government of Tanzania's National Community Health Worker Strategy, which was developed with Pathfinder support. By using national criteria and curricula for recruitment and training, the project facilitated future integration of mobilizers with government community health workers, thus enabling the possibility of sustainability of these interventions. The second week of training focused on practical skills. Finally, community mobilizer candidates participated in five days of field practice, supported and supervised by representatives from the local government—including the district community-based health care coordinator, family planning coordinator, and national family planning trainers.

Using a systematic door-to-door approach<sup>f</sup> to identify and counsel clients, community mobilizers equipped women of reproductive age with knowledge on contraceptive methods,

supported informed choice of contraceptive methods through counseling based on client needs and preferences, and referred clients for facility-based counseling and method provision. Community mobilizers were initially responsible for providing counseling to eleven women per day and follow-up visits at 7 days and 30 days after a client completed a referral. These follow-up visits were intended to support method continuation among contraceptive users through continued counseling.

Finally, the project planned for the community mobilization component to benefit not just the community, but also the facilities. Because of their knowledge of client perspectives and experiences at facilities (through follow-up visits and tools like the Citizen Report Card—see Digital health on page 6), community mobilizers shared information with facility staff at various project-sponsored performance review meetings to support quality improvement at the facility as well. In this way, community

(d) Data for Eastern Africa as defined by Population Reference Bureau: Burundi, Comoros, Djibouti, Eritrea, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mayotte, Mozambique, Reunion, Rwanda, Seychelles, Somalia, South Sudan, Tanzania, Uganda, Zambia, Zimbabwe. (e) Data for Eastern and Southern Africa, as defined by UNICEF: Angola, Botswana, Burundi, Comoros, Eritrea, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Rwanda, Seychelles, Somalia, South Africa, Republic of South Sudan, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe. (f) Previous Pathfinder implementation experience demonstrates that individual home visits are an effective way to engage hard-to-reach populations, such as adolescents and youth or first-time parents, who may face barriers to accessing facility-based health services. For more information, visit [www.pathfinder.org/projects/prachar](http://www.pathfinder.org/projects/prachar) and [www.pathfinder.org/projects/west-africa-adolescent-sexual-reproductive-health](http://www.pathfinder.org/projects/west-africa-adolescent-sexual-reproductive-health).



mobilizers were active participants in quality improvement by collecting and making data available, and by participating in review meetings, where they could share their observations as additional and complementary data. In addition, community mobilizers provided health talks about contraception and family planning for women waiting to be seen at health facilities.

Overall, community mobilizers made important contributions to Chaguo La Maisha's service results. From July 2015 to June 2018, community mobilizers counseled 283,127 women, made 208,691 referrals for service, and provided 160,544 and 112,686 7-day and 30-day follow-up home visits respectively. Of the referrals created, 96,702 were completed at the facility and resulted in a method adopted (see Figure 2).

Health service data also demonstrate that community mobilizers contributed quality counseling and referrals throughout the project. Results for the percent of clients who received the method for which they were referred by community mobilizers show high achievement (Figure 3). The achievement rate for implants, injectables, and intrauterine devices (IUDs) were 98.8 percent, 97.9 percent, and 96.7 percent respectively. While this metric is representative of a confluence of several quality assurance components of the program, it serves as a proxy indicator for the level of quality counseling and appropriate referral community mobilizers offered during the project.

## Monitoring and management of community mobilization

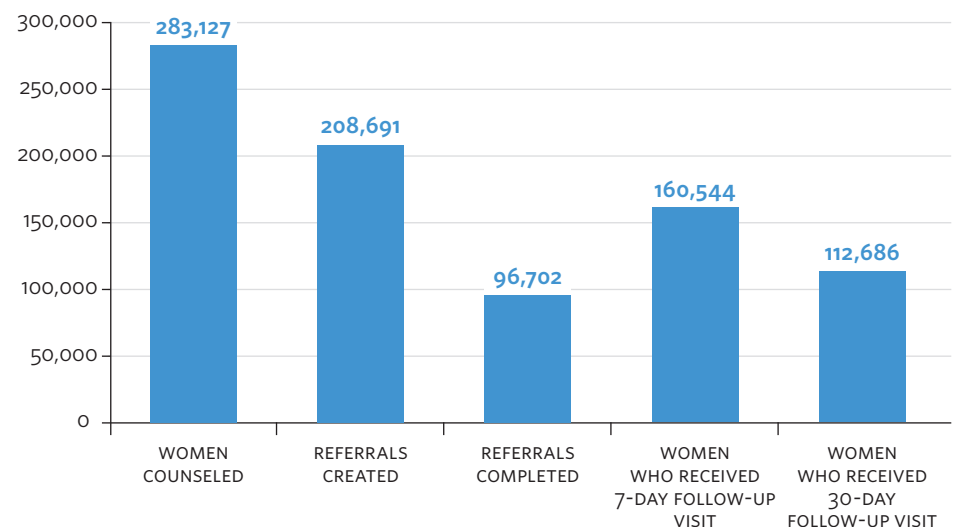
The project's community mobilization component was managed by two local NGOs, with technical assistance support from the project. Nongovernmental organizations were selected based on their technical and field experience, advocacy experience, and capacity to adopt new strategies. In addition to their relevant experience, both NGOs selected had strong financial management systems, but needed additional capacity building support in providing women and youth sexual and reproductive health and rights services, programmatic and financial management

(particularly, performance-based payments), community mobilizer management, and digital health use. The project collaborated with the NGOs to build these capacities and to ensure the possibility of successful management of future community health worker programs. Each NGO employed two field officers to manage Chaguo la Maisha supervisors and community mobilizers. This management included regular reviews of data collected via mobile applications (see Digital health on page 6); supporting regular meetings with project stakeholders to review performance, discuss

challenges, and identify adaptations and solutions; and providing community mobilizers with additional supportive supervision. The number of supervisors and community mobilizers per facility depended on both facility client volume and location—the project was designed so that both supervisors and community mobilizers would have easy access to the facilities and communities they served. Project staff and NGO partners assessed facility location and client volumes to determine how many (typically one or two) supervisors to assign to each facility.

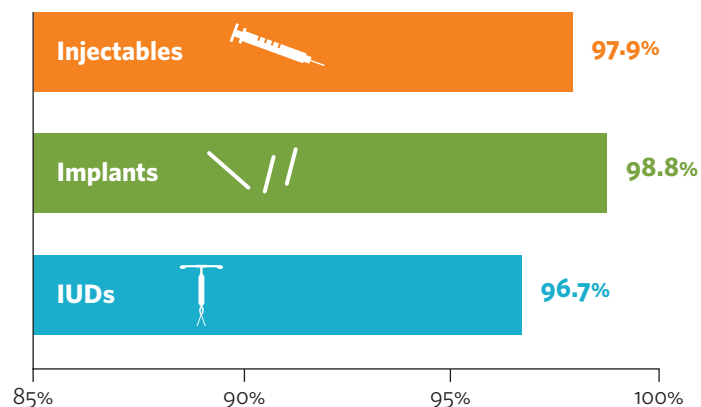
**FIGURE 2: COMMUNITY MOBILIZER SERVICE PERFORMANCE, JULY 2015 TO JUNE 2018**

*Number of service contributions (women counseled, referrals created, referrals completed, and follow up visits) by community mobilizers throughout the project.*



**FIGURE 3: PERCENT OF CLIENTS WHO RECEIVED THE METHOD FOR WHICH THEY WERE REFERRED BY COMMUNITY MOBILIZERS, JULY 2015 TO JUNE 2018**

*Percent of community mobilizer referrals that yielded a same-method uptake, by method.*



# Supporting quality assurance in Chaguo la Maisha

While global health and development implementing organizations agree that community health workers can and often do have a positive impact on health outcomes, the field generally lacks an understanding and consensus on what elements are necessary to support quality assurance in this health worker cadre.<sup>4,5,6</sup> Chaguo la Maisha implemented four components to support quality assurance of its community mobilizer cadre: supportive supervision, a digital job aide, incentive payments for performance, and routine coordination and learning meetings with project stakeholders.

## Data collection

To monitor and understand the contributions of these components to community mobilizer performance, the project relied on quantitative data collected through the project's digital health tools and a series of semi-structured focus group discussions and interviews with community mobilizers (two focus group discussions with ten to twelve participants each), supervisors (one focus group discussion with eight participants), providers (one focus group discussion with six participants), NGO field officers (one focus group discussion with four participants), and community-based health care coordinators (two individual in-depth interviews)—government health workers tasked with managing community-based health care initiatives in their districts.

## Supportive supervision

### PLAN

While human resources for health are necessary to the performance of the health system as a whole, supervision from higher to lower levels of staff has been recognized as a necessary element for ensuring quality of care and thus for reaching the highest standard of physical, mental, and social health and wellbeing.<sup>4,6,14,15</sup>

Chaguo la Maisha designed a supportive supervision component to improve community mobilizers' quality of care through performance monitoring, two-way communication, and joint problem-solving.

During community mobilizer training, trainers identified individuals with prior supervision experience, or who demonstrated a superior ability to transfer their knowledge and skills to other colleagues and recommended them as supervisors. Selected individuals received additional training, primarily focused on developing leadership skills, data monitoring and analysis practices, and use of a mobile-based job aide to support supervision. Each supervisor was responsible for eight to eleven community mobilizers. Supervisors provided, at minimum, twice-monthly one-on-one supervision during a community mobilizer home visit. At these visits, supervisors observed community mobilizers and the mobilizers' adherence to counseling guidelines and provided feedback on what went well and what could be improved. At the end of each visit, supervisors completed a survey on community mobilizer performance and provided mobilizers with an overall quality classification rating of "proficient," "competent," or "needs improvement." Through their mobile applications, supervisors could track community mobilizer performance over time. In addition, supervisors held weekly meetings with community mobilizers and a facility-based provider to provide a forum through which community mobilizers, supervisors, and service providers could share experiences, discuss challenges and successes, and solve problems together. Through such forums, project implementers identified approaches for quality assurance and improvement.

### PERFORMANCE

Project staff used data from the supervisor app to compare supervisors' assessments of community mobilizer performance using the quality classification data for their first and last supervised home visits as one proxy

measurement of community mobilizer quality performance. Quality classification data show that, between March 2017 and June 2018<sup>g</sup>, approximately 75 percent of supervised community mobilizers had a change in quality classification: the majority (140/189) of community mobilizers improved (see Figure 5). While 160 of 189 community mobilizers were scored as "needs improvement" in the first visit, a majority (127 of 189) were scored as "proficient" by their last home visit, demonstrating that most community mobilizers improved their quality performance in the eyes of their supervisors.

Quantitative data show us that the supervisor-community mobilizer relationship positively affected community mobilizers' performance, but does not tell us what about the relationship positively impacts performance. The qualitative data collected suggest that supervisors contributed to improved performance and quality assurance by providing targeted, individualized feedback and increased linkages between community mobilizers and the formal health system:

***"I think the [supervisors'] visits have positive impacts and have helped to improve the level of performance because supervisors are more knowledgeable and can identify weaknesses and tell community mobilizers how to improve. Eventually, the community mobilizer becomes competent. We have noted a mobilizer becoming competent after being trained and mentored by supervisors."*** —FIELD OFFICER

Community mobilizers shared the field officer's perception, seeing growth in themselves and crediting the supervisor for this growth. One respondent articulated this point:

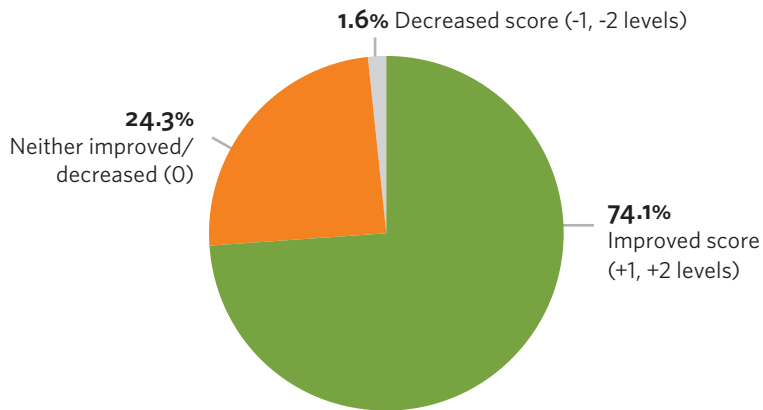
***"It [supervision] helps us improve. The supervisor will say, here are your shortfalls and your strengths, and maybe you should improve on these weak points. So, it builds us, as we work on improvements suggested by supervisors."***

—COMMUNITY MOBILIZER

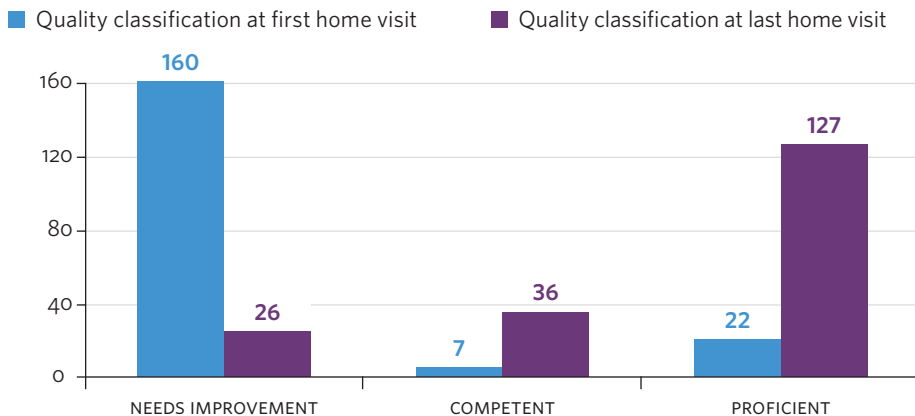
(g) Data analyzed and presented for community mobilizer performance classification come from March 2017 to June 2018 rather than the duration of the project because of adaptations to the data collection tool made in March 2017. To be included in this analysis, community mobilizers had to have had a minimum of two supervised home visits.

**FIGURE 4: CHANGE IN COMMUNITY MOBILIZER PERFORMANCE OVER TIME, MARCH 2017 TO JUNE 2018**

The percent of community mobilizers whose quality assurance classification (“proficient,” “competent,” “needs improvement”) changed over time according to supervisors’ assessments. Most community mobilizers improved over time, with 74.1 percent receiving an improved score by one or two classification levels.

**FIGURE 5: CHANGE IN COMMUNITY MOBILIZER PERFORMANCE CLASSIFICATION FOR HOME VISITS BETWEEN FIRST AND LAST VISIT, MARCH 2017 TO JUNE 2018**

How community mobilizers’ quality classification scores changed between first and last supervised home visit. Most moved from “needs improvement” to “proficient” during this period.



Finally, several community mobilizers indicated that, with the support of supervisors, they had access to facility and community representatives, which facilitated their work by enabling community mobilizers to connect with key stakeholders and establish credibility:

***“It’s the supervisor that plays the role to make sure that we are known by the government.***

***So, everyone in your catchment area knows you. We like this because it also makes it easier to attend the facilities, do awareness creation at facilities, and also attend meetings.”***

—COMMUNITY MOBILIZER

Qualitative findings also illuminated ways in which supportive supervision could be improved to further support the quality of community mobilizer services. For example, some community mobilizers felt that supervisors did not adequately communicate mobilizers’ challenges to those (such as the NGOs) with the power to address them:

***“Sometimes they might overlook what you tell them. I have these challenges, will you take them to [NGO]? As the supervisor, sometimes she forgets or doesn’t tell them on time and then my issues are not solved.”***

—COMMUNITY MOBILIZER

While some community mobilizers identified the supervisor relationship as beneficial to connecting them to key stakeholders, others expressed feeling frustrated that this relationship did not yield stronger connections and reported that they would have liked more support from the supervisors to access community groups to do family planning awareness activities and increase registration:

***“Sometimes you might tell your supervisor, ‘you can back me up or add some strength if you come with me to this women’s group.’ I cannot go alone if I don’t have any support.”***

—COMMUNITY MOBILIZER

## Digital health

### PLAN

The project worked with Dimagi, Inc. to develop digital health tools to support quality assurance of its community mobilization component. With Dimagi, the project designed an app for supervisors and an app for community mobilizers. Both were hosted on CommCare, a platform for mobile-based data collection. The community mobilizer app was designed to support community mobilizers to build service-seeking behaviors by ensuring counseling and follow-up visits that met evidence-based quality standards<sup>h</sup>. The app guided community mobilizers through counseling and referrals by prompting a series of questions. Based on clients’ answers, the app would recommend a method of contraception. For referrals, community mobilizers provided clients with referral slips with individual bar codes. These bar codes were scanned by the community mobilizers, then stored at the facility upon referral completion, and afterward scanned by the supervisor to confirm referral completion. Further, through GPS and automated follow-up reminders, the application made it easier to re-locate clients for follow-up visits—during which community mobilizers discussed potential side effects and helped with method continuation.

After facility visits, community mobilizers offered clients the Citizen Report Card (CRC)—a survey that was digitized and embedded into

the community mobilizer app to document client experience at the facility. The project used data from the CRC to understand how best to focus technical assistance and mentorship efforts at the facility for quality assurance and improvement. The project also shared CRC data with district-level decision makers to support them in evidence-based decision-making. In other words, the CRC was a tool to support shared responsibility and mutual accountability for health between communities and facilities. In this way, the app supported Pathfinder's integrated system strengthening strategy.

The supervisor app supported quality assurance by enabling supervisors' use of a digitized checklist with which to assess community mobilizer performance. The checklist tracked whether community mobilizer performance met certain quality indicators. For example, did the community mobilizer treat the client with dignity and respect? Did the community mobilizer adequately explain potential side effects? In addition, at the end of each supervised home visit, the app prompted the supervisor to rate the community mobilizer's overall performance. As a result, through the apps, the project collected both objective data points—whether community mobilizers followed quality standards—and more subjective data points, such as how a supervisor rated community mobilizer performance. Finally, the supervisor app allowed supervisors to scan and confirm all referral slips at facilities to track confirmed referrals. Data from both apps were stored on a secure, cloud-based server from which project stakeholders could download and view data on project-specific dashboards to monitor progress.

## PERFORMANCE

To understand the contributions of the digital job aide towards community mobilizer quality performance, project staff looked at data from the supervisor application, which tracked how well community mobilizers adhered to the

digitized counseling protocol embedded in the app. Specifically, project staff looked at the percent of community mobilizers that achieved select quality indicators while using the community mobilizer digital job aide during home visits. The average achievement for select quality indicators, as shown in Figure 6, ranged from 91.1 percent to 98.2 percent, suggesting that digital tools can be used to ensure that performance aligns with quality standards.

Qualitative findings supported the quantitative findings and suggested additional benefits the digital job aide contributes to community mobilizers' performance quality. Community mobilizers agreed that the application, with its embedded counseling guide, helped ensure they provided complete counseling. One community mobilizer stated,

***"Yes, it is easy because [the app] guides the community mobilizer step by step until she finishes her counseling. And, it also reminds her to follow up after 7 days and 30 days."***

—COMMUNITY MOBILIZER

Further, community mobilizers perceived that the application improved data management and self-evaluation—both of which contribute to performance quality:

***"[D]ata management is better in the app. You don't have to carry around a lot of papers and get them lost. You're sure your data is secure because of the app."***

—COMMUNITY MOBILIZER

***"The app also helps you evaluate yourself at the end of the day. You can sit down, come back home, and see how many people you reached each day. But, with papers, it would be tiresome and take so much longer."***

—COMMUNITY MOBILIZER

Finally, participants reported that using a phone boosts the confidence of community mobilizers themselves and community mobilizers

hypothesized it also changes how they are perceived in the community, such that clients may be more receptive to interaction with and counseling from community mobilizers:

***"It gives us confidence to work with people. The client will understand that this person knows what she is doing, knows how to use the phone."***

—COMMUNITY MOBILIZER

Data from interviews and focus group discussions also yielded weaknesses and challenges of using a mobile-based job aide. Community mobilizers explained that they frequently faced problems out of their control—such as poor service or insufficient phone storage capacity that put their eligibility for incentives at risk:

***"If you're using CommCare and it's not as fast as you expected, and it is roaming, and it takes ten minutes. You'll lose the customer."***

—COMMUNITY MOBILIZER

Further, relying on such a digital system means community mobilizers' work tools are dependent upon service and battery charges:

***"We normally have frequent power cuts. You want to work, but you can't because your phone is dead and you cannot do anything. The kinds of phones we have, have battery issues. They may work for half an hour and then the battery dies. It makes our work very hard."***

—COMMUNITY MOBILIZER

## Pay-for-performance

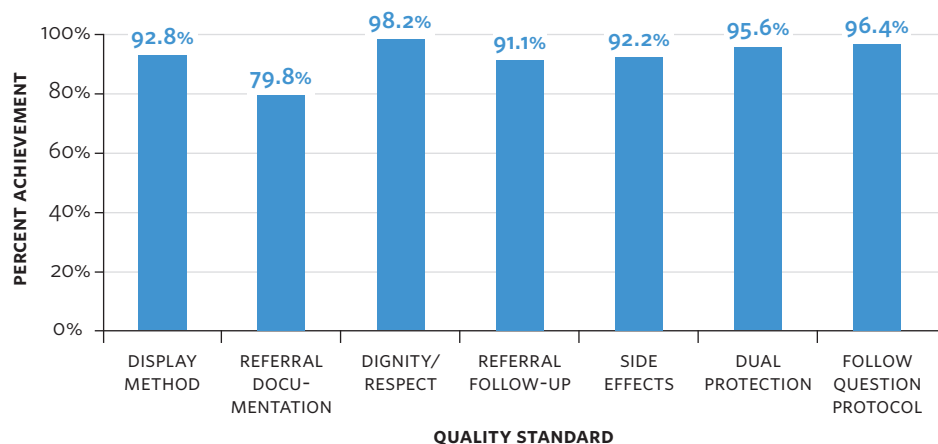
### PLAN

While the digital health tool supported quality assurance by guiding community mobilizers on how to provide counseling, a pay-for-performance mechanism incentivized increased community mobilizer activity. Though community mobilizers were volunteers, the project originally provided financial incentives in amounts below the minimum wage in Tanzania. Underlying the pay-for-performance mechanism was the hypothesis that if

(h) The project designed a mobile counseling application—based on the Balanced Counseling Plus strategy—which prompts community mobilizers to counsel clients in order of method-effectiveness, taking into account client medical eligibility, lifestyle needs, and fertility preferences, and addresses non-contraceptive benefits of different methods of contraception and contraception myths and misconceptions, particularly with regard to long-acting and permanent methods. The BCS+ is a strategy and toolkit developed by Population Council to provide information and materials to health care providers to support complete, quality family planning counseling. For more information, please visit [www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service](http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service).

**FIGURE 6: AVERAGE ACHIEVEMENT SCORES OF COMMUNITY MOBILIZERS FOR SELECT QUALITY INDICATORS<sup>i</sup>, MARCH 2017 TO JUNE 2018**

On average, community mobilizers adhered to the prompts and guidelines in the digital job aide. They were weakest in documentation of referrals, and strongest in treating clients with dignity and respect.



high-quality counseling is provided, clients will complete referrals at the facility. Originally, community mobilizers and supervisors received a monthly base pay of 100,000 Tanzanian shillings (Tsh, approximately 44 USD) and 140,000 Tsh (approximately 61 USD), respectively. Community mobilizers also received financial rewards based on the number of women they counseled and the number of home visits they conducted.

### ADAPTATIONS

During implementation, the project made changes to the pay-for-performance mechanism based on data and feedback from supervisors, field officers, and community mobilizers. As a result, there were, effectively, three phases of the pay-for-performance mechanism. In phase one, described above, community mobilizers and supervisors received a small monthly payment and community mobilizers were eligible for additional rewards based on performance in number of clients registered and homes visited. Between September 2015 and December 2015, the project received feedback through supervisors, field officers, and in regular coordination and learning

meetings that community mobilizers did not like this method of payment because they felt that it was unfair; some women worked hard and received a base payment, and others didn't work at all and received a base payment. They felt the method of reward didn't align with the effort put forth. In addition, the project recognized that there was no incentive tied to confirmed referrals despite the project's goal of increasing service uptake at facilities. The project modified the pay-for-performance mechanism so that the base pay for community mobilizers was removed and targets for incentives were modified to include confirmed referrals.

Between December 2015 and April 2016, achieving the following targets made community mobilizers eligible for incentive payments: registration of 100 clients a month (one month equals 20 working days), 80 clients counseled a month, and 48 referrals confirmed at the facility (phase two). While this adaptation ensured confirmed referrals were incentivized—and thus incentivized higher quality counseling—community mobilizers complained that targets were too high and did not take into account that for every client registered,

there are also follow-up visits. So, there was a high target for recruitment, which resulted in even more work in the form of follow-up visits. Community mobilizers began to drop out of the program due to the high targets.

In April 2016, the project revised the pay-for-performance mechanism again (phase three). This time, the targets were revised: 60 women counseled each month, 40 clients visited for follow-up, and 20 completed referrals. While the changes in targets made incentives more attainable, these revisions also made critical changes to the number of service contacts clients received with the health system. In phase one and two, only one service contact was incentivized (first home visit), while in the third phase, three service contacts were incentivized (first home visit, completed referral to the facility, and a follow-up home visit). In addition, supervisors became eligible for an incentive payment based on the number of meetings held with the community mobilizers for whom they were responsible, the number of one-on-one visits with community mobilizers, the number of weekly meetings conducted, and for the number of referrals made by their community mobilizer supervisees that were confirmed at the facility—meaning that a portion of the supervisors' incentive payment depended on community mobilizer performance. This helped reinforce the partnership between community mobilizers and supervisors.

### PERFORMANCE

Data show that as the project adapted the community mobilizer pay-for-performance scheme to elongate the continuum of care by incentivizing more service contacts with clients, the number of confirmed referrals and follow-up visits increased. Figure 7 presents the performance changes over the three periods during which the incentive structure changed. When the pay-for-performance scheme incentivized only the first home visit (phase one and two), the percent of completed referrals and follow-up visits showed

(i) List of Chaguo la Maisha quality indicators: Did the community mobilizer display the methods during counseling; Did the community mobilizer refer the client to services at the health facility and use the referral form and phone to document the referral; Did the community mobilizer treat the client with dignity and respect related to the client's choices and rights; Did the community mobilizer explain that she will return for a follow-up visit seven days after the client visits the health facility; Did the community mobilizer provide appropriate counseling on the benefits, side effects, and instructions for use for each method to help the client make an informed choice; Did the community mobilizer emphasize the importance of using a condom for dual protection against HIV, STIs, and preventing pregnancy; Did the community mobilizer accurately follow the protocol to respond to client questions.



little positive movement (from 22.8 percent to 31.6 percent for the former, and 40.6 percent to 39.4 percent for the latter). However, when the scheme adaptations incentivized three service contacts with the client, the percent of completed referrals and follow-up visits increased, sometimes dramatically (from 31.6 percent to 52 percent and from 39.4 percent to 95.6 percent respectively).

Qualitative data collected from interviews and discussions suggest that pay-for-performance contributed to the quality of community mobilizer activities by creating opportunities for competition and public recognition for a job well done. These findings are in line with the feedback community mobilizers provided on base pay and their preference for incentives more directly linked to level of effort and performance. For example, one community mobilizer explains:

***“This is very good because it gives you a reason to put effort in and reach the target and get the full amount of money. If community mobilizer A sees that community mobilizer B gets the full money, the community mobilizer A will put in more effort to reach the target and get the money like community mobilizer B.”***

—COMMUNITY MOBILIZER

Participants had several recommendations for how to improve the pay-for-performance mechanism—most had to do with increasing the range of incentives. Some community mobilizers felt that the existing incentives and pay-for-performance structure didn’t reflect their level of effort, and that by recognizing a range of effort—for example by recognizing achievement of a percentage of a target—the project could increase the motivation of community mobilizers:

***“For example, if you are given a target of 60 [women] and you reach 59, just deduct your money. But couldn’t they see that this person put in such an effort to reach 59 out of 60 [...] So, they don’t see your efforts.”***

—COMMUNITY MOBILIZER

Other focus group discussion participants indicated that the range of incentives could also be expanded to include non-financial rewards:

***“For us, we say ‘a gift is always a gift.’ It doesn’t matter if a person gives a pencil. It’s a gift [...] something to give her the chance to go back and look at it and say, ‘I got this, and I am proud of this. I worked hard, and I got this thing.’”***

—COMMUNITY MOBILIZER

***“Motivation is very important, and motivation isn’t like money. The person who performs well, who performs good should be known. Even providers should be motivated even for just a piece of paper. I received a certificate from Pathfinder, and I felt very good.”*** —PROVIDER

## Coordination and learning meetings

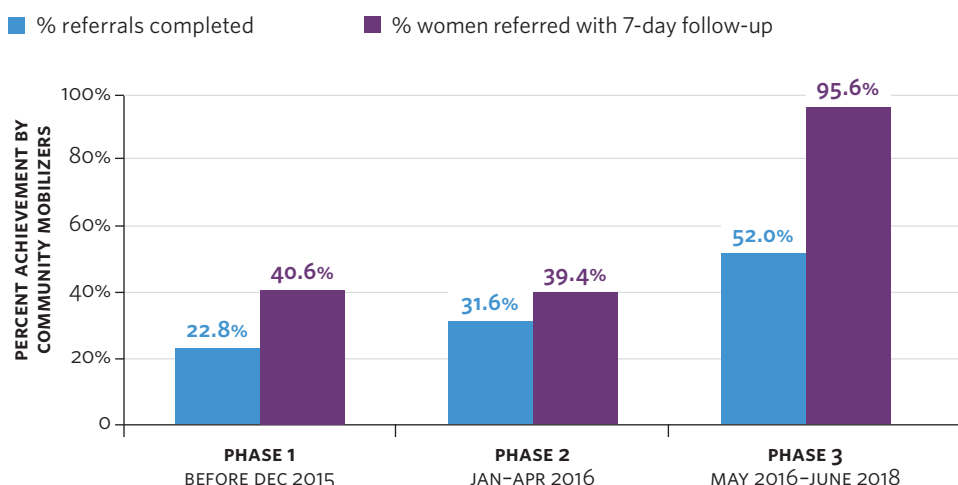
### PLAN

Through participation in monthly, quarterly, and health facility board meetings, community mobilizers provided facility staff with feedback from their visits with clients, and client feedback from the CRC. With this information, facility staff could focus their quality improvement and

assurance efforts within the facilities. In this way, community mobilizers supported a shared responsibility for health between the community and facilities. Monthly meetings engaged community mobilizers, supervisors, and NGO field officers in role-playing games to inform improved counseling practices, reviewed monthly data from the mobile apps, and identified areas for improvement or promising practices to be replicated and scaled-up. Quarterly meetings involved health providers, district managers, and supervisors in reviewing performance data to ensure that information about service delivery challenges and successes flowed between community and facility stakeholders. Health facility board meetings were existing meetings (i.e., not established by the project) with representatives from private for-profit health service facilities, community leaders, representatives from private not-for-profit facilities, as well as government representatives from the dispensary and Ward Development committees that community mobilizers joined at least once a quarter to present performance data, to represent the community voice to the health system, and to gather information to bring back to the community.

**FIGURE 7: PERCENT OF REFERRALS COMPLETED AND SEVEN-DAY FOLLOW-UP VISITS COMPLETED BY PAY-FOR-PERFORMANCE PHASE, OVER THE LIFE OF THE PROJECT**

*In phase three, community mobilizers received incentives for performing follow-up visits. When there were more contacts between clients and community mobilizers, referral completion rates increased.*



## ADAPTATIONS

Though facility staff and district managers received feedback on client experience and client perspectives of service quality through community mobilizers, they did not receive it in the way the project had intended. The project planned to draw upon CRC data, collected by community mobilizers, to inform recommendations for quality improvement at the facilities. However, at monthly and quarterly meetings, project implementers found that community mobilizers felt confident in bolstering data provided by the CRC with their own feedback based on their relationships with clients. Rather than just present data from the application, community mobilizers provided anecdotal data based on their first-hand experiences. Such feedback included identification of frequent stock outs, staff demanding payment for contraceptive methods that were supposed to be free, and long waiting times at facilities.

## PERFORMANCE

Focus group and interview participants agreed on the value of regular meetings to improve project implementation and community mobilizer work quality. Community mobilizers felt these meetings held the health system accountable to community members and improved their ability to provide quality services:

***“The chance to attend community meetings, health board meetings—this is where we can address the challenges we are facing in the community.” —COMMUNITY MOBILIZER***

***“Also, get to learn from those who do better each month, and get to know what strategies they are using, so when they go back to the community, they’ll improve using the strategies that others have shared.” —COMMUNITY MOBILIZER***

Participants consistently emphasized the importance of these meetings and the importance of having these meetings regularly. The only areas for improvement that were expressed were to consider holding more meetings with a wider net of project stakeholders. One NGO field officer explains:

***“We should have platforms that can make us meet with implementing partners, stakeholders, and donors frequently to share program progress [...] It would be easier to identify problems, tease out how to address them earlier, and discuss about improvement. We could also celebrate success.” —FIELD OFFICER***

## Community mobilizers’ capacity to provide quality service delivery

Finally, observations gathered from focus group discussions also offered valuable

commentary on quality assurance components working in tandem. These observations referred specifically to community mobilizers’ contributions to an improved community- and facility-based service delivery experience for women. Participants suggested community mobilizer strengths included: ability to form close and supportive relationships with clients, ability to successfully counter myths and misconceptions about contraceptive methods, ability to increase client knowledge through counseling, and their contribution to a decrease in the amount of time providers spend counseling clients.

***“What I can take from [community mobilizers] and what they are doing, they have a closeness with clients. She knows the person. They are even at her home. It’s different from us because they just come to the facility. The closeness they have with her helps them to increase the number [of clients reached].” —PROVIDER***

***“Community mobilizers are helping to demystify rumors people get in the community regarding family planning methods. For example, women are scared of using implant, they say ‘it disappears or will sink in your womb.’ So, community mobilizers help to clarify and explain about the side effects.” —PROVIDER***

***“I also noted clients’ knowledge has increased; now women come and ask for [IUD] and when you try to see whether they understand the method, they tell you exactly what it means.” —PROVIDER***

***“It takes a short time to attend to a client who has been referred by a community mobilizer, while it consumes a lot of time to counsel a client who has not [...] A client who comes with a referral slip has an idea, and she has already selected a method. As a provider, I will just confirm eligibility criteria.” —PROVIDER***

In addition, community mobilizers themselves identified ways in which their perceived capabilities translated into more opportunity for them. One community mobilizer explains:



Community mobilizers and supervisors learn how to use their mobile applications.

***“I started seeing more opportunity in my community because I’ve been identified as a community mobilizer in the community. There are people who have seen my good work and think maybe I can do more... Just because I’m known, the community trusts me, they give me opportunities.” —COMMUNITY MOBILIZER***

Focus group discussion data suggest that recognition by the community increases community mobilizers’ motivation for the work they do and could, in turn, contribute positively to the quality of service provided:

***“The community has accepted me, because, now, the whole community knows me as the community mobilizer. Sometimes, the community comes to me, asks different questions about family planning, and I answer. To be accepted in the community has helped me love my work.” —COMMUNITY MOBILIZER***

## Lessons learned

Components of this project sought to support community mobilizers and ensure the quality of their activities. Implementation experience and quantitative and qualitative data yield lessons for future implementers with regard to how these project components—supportive supervision and pay-for-performance in particular—can be leveraged to support improved quality of community- and facility-based service delivery.

### Community mobilizers perceive supervisors as links to hard-to-access populations

The project intended for supervisors to support quality improvement and assurance of community mobilizers’ activities primarily by supervising home visits, tracking community mobilizer performance, providing feedback on this performance, and hosting weekly meetings with all community mobilizers to discuss challenges, identify solutions, and learn from successes. In other words, supervisors were primarily intended to serve as educators, coordinators, and motivators. Qualitative data

suggest that Chaguo la Maisha supervisors achieved this goal as community mobilizers reported feeling like they learned from and were supported by supervisors. Further, quantitative data show an increase in community mobilizer performance assessments between the first and last supervisor visits.

Community mobilizers also viewed supervisors as gatekeepers or links to settings and populations which a community mobilizer might not feel comfortable or capable of accessing. Because of the authority supervisors held, community mobilizers perceived supervisors as having the ability to grant access to others with influence and authority—such as facility providers and district government representatives. As a result, community mobilizers were recognized by facilities and communities and it became easier for them to increase family planning awareness across facilities and communities, and to be received as counselors on contraceptive methods.

The opposite was also true. Community mobilizers perceived that supervisors could—intentionally or unintentionally—block community mobilizer access to community members or facility staff, thus preventing community mobilizers from achieving recruitment and counseling objectives, and from receiving incentive payments in a timely manner—both of which decreased community mobilizer motivation. Thus, project experience suggests that supportive supervision can foster quality assurance of community-based health work. But, future programs implementing supportive supervision may consider revising supervisor trainings to more intentionally explore the various roles supervisors can play, including their spheres of influence and external factors—such as relationships—that support community mobilizer success.

### Recognition increases motivation for community mobilizer work

Implementation experience—which saw several adaptations to the pay-for-performance mechanism to ensure an incentive mechanism that was acceptable to community

mobilizers—and findings from the focus group discussions with community mobilizers and providers suggest that financial incentives provided an expected extrinsic motivation as well as a less obvious intrinsic motivation. By reporting progress towards incentives publicly in monthly meetings, the project incited competition between community mobilizers who wanted to outperform each other. Further, community mobilizers reflected that this public recognition for a job well done resulted in an elevated status in their communities, which helped them love their work. Future projects may consider approaches to increase intrinsic motivation for work by expanding public recognition of community mobilizer efforts.

### Diversified incentives can increase motivation

Similarly, community mobilizers reported feeling demotivated when they came close to their targets, but missed, making them ineligible for an incentive payment. There are several factors outside of a community mobilizer’s control that could put receiving incentives at risk, despite a community mobilizer having provided quality counseling that contributed to a client’s decision to seek services (e.g., client loses referral slip, client goes to a different facility than the one to which she was referred, provider loses referral slips). Given the importance of recognition to a community mobilizer’s motivation, future pay-for-performance efforts might consider diversifying incentives to mitigate demotivation. Community mobilizers and providers suggest this can be achieved by offering incentives of lesser financial amounts for those who achieve varying degrees of the target, or by offering non-financial incentives, such as certificates or rain boots.

### Supporting quality assurance can contribute to integrated systems strengthening

As expressed by providers in focus group discussions, community mobilizers increased client knowledge of sexual and reproductive health services and preparedness for visits such that when clients presented at facilities

they were better able to engage with providers to ensure their needs were met. Not only did providers perceive increased client knowledge of contraceptive methods and confidence in clients' own method selection, but providers also perceived that their visits with clients took less time, thus slightly easing burdens at the facility. In addition, due to their close relationship with clients and their regular participation in meetings, community mobilizers were able to bring the concerns of the community to the facility and to hold the facility staff accountable. For example, while not an intentional adaptation to implementation, community mobilizers took a more proactive role in monthly and quarterly meetings than was originally intended. Rather than just sharing Citizen Report Card data in these meetings, community mobilizers complemented this data with targeted information that would not have otherwise been captured. This information was important because the Citizen Report Card did not allow for open-ended questions and responses. Community mobilizers, and the interventions that supported them, facilitated integrated systems strengthening by supporting the community to access the health system and to identify its own needs and concerns, and by communicating with the facilities to better meet the community's needs.

## Conclusion

The Chaguo la Maisha experience suggests that supportive supervision, digital health, pay-for-performance mechanisms, and coordination and learning meetings can work in tandem to have a positive impact on the quality of community mobilizer service delivery. An enabling environment for women to choose whether and when to bear children includes not only a strong health system capable of delivering high-quality and unbiased services, but also a strong community that is knowledgeable about its own health and needs and is able to advocate with the health system for those needs. Community health workers are crucial to developing this enabling environment, not only because they can improve health outcomes under the right circumstances, but, mostly, because of the unique role they play in strengthening linkages between the community and facility. Continued questioning and critical reflection upon our implementation efforts is necessary to ensure we develop programs that support and capitalize on the health worker cadres that bring communities and health systems together.

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**ABOUT THE PROJECT:** Funded by an anonymous donor, the **Chaguo la Maisha project** (the Tanzania component of the multicountry Strengthening Contraceptive and Abortion Service Delivery Project) was designed to create an environment that enabled women of reproductive age to choose whether and when to bear children. Working with facilities in the public sector, communities, and the spaces in which the two interact, the project aimed to increase access to quality-contraception and abortion services (including postabortion care), as well as increase effective contraceptive uptake specifically among postpartum women, postabortion women, and adolescents and youth.

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