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Where a Bar of Soap Can Make a Difference: Family Planning Volunteers in Uganda Express Their Needs

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Abstract

The purpose of this study was to assess the experiences and daily challenges of family planning volunteers in Uganda. Focus group discussions were conducted with active volunteers and former volunteers. Four study sites were selected from 24 program sites. Volunteers rated lack of remuneration and rewards as a major factor for a low working morale. Lack of recognition by the family planning program undermined their credibility in the community. In-spite of these frustrations most volunteers expressed their willingness to continue with their work. The Kabarole family planning program needs to seriously address the deficiencies in supporting their volunteers. As the volunteers have made very modest requests, an innovative incentive system could be quickly put in place without major increase in program spending.

Key Words:
family planning, volunteers, Uganda

Introduction

Trained community-based distribution (CBD) volunteers provide contraceptives and family planning information to their fellow neighbors in numerous villages, towns and cities of the developing world. By taking safe and simple contraceptives to people within their community rather than requiring people to visit clinics for these services, CBD volunteers meet the family planning needs of those who regard clinic-based services to be too far away, too time consuming or socially and culturally inappropriate. A 1999 review of community-based family planning initiatives in sub-Saharan Africa concluded that CBD is administratively feasible in Africa and that it does indeed generate contraceptive use that would not otherwise occur (Phillips et al., 1999). This study also emphasized that CBD volunteers are ideally placed to reduce fear and misconceptions about contraceptive use, to encourage male participation, to address religious and cultural barriers to family planning and to mobilize overall community support for family planning (Simmons et al., 1988).

Acknowledging the crucial role played by volunteers in the effectiveness and overall sustainability of a CBD program, we embarked on a study to assess CBD volunteers' experiences with their CBD program in Kabarole district, western Uganda. The perceptions of active and former CBD volunteers were ascertained with the intention of incorporating these grassroots ideas and suggestions into organizational efforts to improve and

expand the CBD program. As outlined above, the literature shows that volunteer motivation was the greatest challenge to sustaining CBD programs and their impact (Phillips et al., 1999; Evans et al., 1997; Population Council, 1987).

In this article, we share CBD volunteers' perceptions of factors affecting their motivation and program output, as well as their suggestions on how their efforts can be more satisfactorily facilitated. Focus group discussions with active and former CBD volunteers uncovered a preoccupation with the poverty and socioeconomic hardships and subsequent "empty bellies" of CBD volunteers. Like the clients they serve, most CBD volunteers live in poverty, are overburdened with multiple commitments and the daily struggle for survival, and are often unable to meet the basic needs of their families. Given that CBD volunteers' poverty, ensuing low motivation, directly impact program success and sustainability, we conclude that the socioeconomic context in which family planning services are received and provided must be acknowledged and be addressed by programs aiming to improve family planning and reproductive health.

Community-based Distribution in Kabarole District

In Uganda's Kabarole district, geographical access barriers mesh with a complex web of community challenges (such as male and/or religious opposition and misconceptions and/or fears about family planning) to keep reproductive health indicators low. The average annual population growth rate is 3.3% and the Total Fertility Rate (TFR) is eight both poorer than national figures (District Health Department Kabarole, 2000). Although awareness of family planning is high, contraceptive use remains low with only about five percent of Kabarole women using modern contraceptives (Ferguson, 1998).

Recognizing that family planning services in the district were not satisfactory, the Kabarole Health Department first initiated the Kabarole CBD program in 1991. To date, there are CBD sites operating in 24 sub-counties within Kabarole district. The number of CBD volunteers operating in each sub-county ranges from six to 30, with an average of 22 CBD volunteers per site. Officially, this involves over 500 CBD volunteers. However, a worrisome number of these volunteers is either partially active, completely inactive or not reporting consistently. Additionally, only a few CBD sites have volunteers reporting more than 10 client contacts per month, though the average number of households covered by a CBD volunteer is estimated to be between 40 and 80. The majority of clients are female, although the number of male clients continues to rise. The number of male CBD volunteers has also increased in recent years. At present about 40% of the active CBD volunteers are male (Baryomunsi, 2000). Both male and female CBD volunteers provide services to both male and female clients.

Family planning staff work together with local community leaders to recruit and select CBD volunteers, generally one to two per village, who then attend a two-week, non-residential, training course. Selection criteria include residence in the area to be covered, literacy (at least in the local language), ability to keep simple records, and a willingness to work as a volunteer. CBD volunteers' main duties are to provide family planning education to communities, to recruit and counsel clients, distribute contraceptives, to refer clients for other health services, and to compile and submit monthly activity reports. CBD volunteers do not receive any monetary incentives for their efforts. While they are required to attend monthly reporting meetings at the sub-

county health unit, they are not regularly provided with lunch or travel allowances to do so. A few CBD groups have attempted to initiate small-scale income-generating projects, such as brick making or weaving, and some groups operate small (often sporadic) revolving loan funds.

Methods

Four sites were selected from the 24 existing CBD program sites for this study. Based on documented information from the Kabarole Health Department, all 24 program sites were ranked according to their program performance. The sites with the highest and lowest program performance were chosen, as well as two sites that had average program performance. Selected study sites were geographically dispersed throughout the district and included semi-rural and rural areas ranging from 40 to 140 return kilometers from the town of Fort Portal, the district capital.

Four focus group discussions (FGDs), ranging from 55 to 75 minutes, took place with active CBD volunteers (n=l5, 11 females) and former CBD volunteers (n=8, 5 females). The FGDs were carried out in the local Rutooro language and were facilitated by a qualified local research assistant. Pilot-tested interview guides consisting of probe questions were available for all FGDs. FGDs were audio recorded with permission of the participants and recordings were translated from Rutooro into English by the facilitator immediately following the FGD. These initial translations were checked for accuracy and augmented by a second translator. A trained and experienced local note-taker also kept written accounts of the discussions. The audiotapes were transcribed and entered into Microsoft Word®. A thematic approach to the qualitative analysis of focus groups was used, the general goal being to locate and group together patterns and themes of program constraints and challenges faced by CBD volunteers (Rothe, 1998).

Approval for the study was received from the Health Ethics Research Board at theUniversity of Alberta and the Ugandan Ministry of Health via the Kabarole District Director of Health Services. All study participants were assured of confidentiality, privacy and anonymity before participating and were requested to sign consent forms before participating in data collection activities.

Results

When asked about the challenges faced by CBD volunteers, the overwhelming response from all participants was that they "are not properly facilitated" or they "lack facilitation." In Ugandan English, the word "facilitation" was discovered to be an all-encompassing one. When used in reference to the CBD program, facilitation was literally anything needed to ensure that CBD activities are carried out as well as anything that would make the work of the CBD volunteers easier. A common theme was discovered to run through all discussions on facilitation and motivation - a preoccupation with the poverty or socioeconomic hardships and subsequent "empty bellies" of CBD volunteers.

Not Even a Bar of Soap

Though participants cited lack of remuneration or rewards for CBD volunteers as the major program related problem, it must be noted that very few participants referred to the need for CBD volunteers to receive actual salaries. More often, "remuneration" implied modest cash allowances for lunch or travel and non-monetary rewards or token incentives such as soap, lunch or other food items.

"You go to mobilize people, you spend the whole day and you have not eaten,

you have gone hungry and you have not been given an allowance." (Former CBD volunteer, male)

"It is not that we wanted to be paid primarily but we needed some help because we are poor people, we expected some little help and we deserved some. Help because of the good work we were doing." (Former CBD volunteer, female)

"The main problem is that they are not properly facilitated, we have seen that it is necessary for them to have even a piece of soap for their motivation. " (Local Council Leader)

In the majority of cases, the underlying basis for complaints of lack of "remuneration" appeared to be a genuine concern for the livelihoods of CBD volunteers and a keen recognition of the fact that they are poor. Like the clients they serve, most CBD volunteers live in poverty, are overburdened with multiple commitments and the daily struggle for survival, and are often unable to meet the basic needs of their families.

"To work for nothing is too much especially if you have hungry children at home. " (CBD volunteer, female)

"You cannot continue working for nothing when you do not have what you need to live, you need to be facilitated " (Former CBD volunteer, female)

"You walk a lot, you walk through the village and you do not even have money to buy soaps. You are walking and you don't even have a piece of bread to eat." (CBD volunteer, female)

This lack of remuneration or compensation was also thought to contribute to the community ridicule experienced by some CBD volunteers. In villages characterized by poverty and desperation, there is often an understandable suspicion that if one is doing community work, she or he is either being "idle" and unproductive or accruing benefits, financial or otherwise. Some CBD volunteers sensed a lack of support from their husbands or other community members, and at times experienced blatant ridicule from other poor women, for their involvement in CBD volunteer work.

"Other women ridiculing the CBD volunteers, women who are busy in the fields and when she is passing by she is just laughing at you, saying what are you getting from that work: she thinks you have time to waste. " (CBD volunteer, female)

"The other thing is *that when people see you coming with the chairman (the local government leader), they think that you are 'eating money' with the chairman and yet you are not getting anything."* (CBD volunteer, female)

"Spouses say to us 'you have been away all day (at the CBD monthly meeting) and you come home without even a *bit of salt.* " (CBD volunteer, female)

It's Like Chasing the Sun

Low morale was evident amongst some volunteers, particularly those who had already dropped out of the program. CBD volunteers often expressed that despite their substantial efforts and time commitment, they were "disappointed" or felt they were "wasting their time". This frustration, often accompanied by a sense of failure, is suggested in the following comments:

"Distance, for example. The CBD volunteers who are supposed to be *going to*

seminars, they walk a *long distance, she stays all day, it* is a *waste of time, she gets no food, no money, she* has *no transport."* (CBD volunteer, female)

"You come to the training seminar for three weeks and in *that time you cannot work. And you have no time to do anything else. And this discourages you. And you say to yourself. You have wasted your time.* '" (CBD volunteer, female)

"It's like chasing the sun, we *are not getting anything,* we *are engaged* in a *venture where* we *are not going to get anything from it."* (CBD volunteer, female)

CBD volunteers complained of being asked by management to express their ideas and suggestions and then never receiving any response or reaction. Although many participants acknowledged that lack of funds was a probable reason for the lack of response, a substantial number of CBD volunteers appeared to assume that this lack of interest stemmed from the fact that the CBD program relies on volunteers, not paid staff, and is therefore somehow less worthy of support and attention. Lack of feedback was taken as an indication that CBD problems and issues were not being listened to or taken seriously by program supervisors. Some pointed out that since they were "not looking for handouts", but instead were expressing their commitment to working even harder, for example, in income-generating projects, they expected feedback and were even more disappointed when it was not forthcoming. Disinterest from supervisors and management was also perceived to be the reason for the lack of follow-up after training, the lack of supervision and the lack of refresher courses to reinforce or supplement training curriculum content.

The cry for increased support for CBD volunteers and the CBD program was loud and constant, and participants offered a variety of ideas for improving the knowledge and activity of CBD volunteers (e.g. increasing training activities and refresher courses and providing more and better information, education and communication materials). However, more frequently cited were requests for increased recognition, respect and legitimacy for CBD volunteer work. CBD volunteers expressed a desire to have their perspectives considered, their issues listened to, and their ideas and suggestions entertained. They stated that honest communication, immediate feedback and better coordination between them and program managers would greatly ease their concerns and improve their sense of purpose.

"If you put those problems we *have told you about under consideration then* we *know that the program will take* off" (CBD volunteer, female)

"There should always be *feedback whenever such problems are presented to people like you, like today during this research.* " (Former CBD volunteer, male)

Frustrated But Committed

Most CBDs agreed that their work as a CBD volunteer was 'making a positive change to the health of families in their communities and the majority agreed that being a CBD volunteer had increased their popularity, prestige, recognition or respect. CBD volunteers, both former and active, spontaneously offered expressions of CBD volunteer commitment and recognition that their efforts have made a difference:

"*We know women's problems - you produce lots of children and then you die*

and you produce lots of children and you cannot even have money to let them go to school. We really love to help women, we have that commitment, and the problem is, that we are becoming frustrated." (CBD volunteer, female)

"What really makes me happy that I was a part of this is that I can see the benefits. Some people express their gratitude now for the wok we did back then, they are better off because of fewer children. Our work was appreciated by the community. " (Former CBD volunteer, male)

Incentive Schemes

When asked for suggestions on how to combat the low morale of CBD volunteers and ensure their continued participation in the program, participants requested that monthly motivation and incentives be provided to CBD volunteers. Some participants also mentioned the need to develop a system of competitions and contests so that CBD volunteers working the hardest, e.g. obtaining the most new clients in a year, would be recognized and rewarded for their efforts. Again, it was made clear that only meager, humble requests for financial support were being made. '

Facilitator: *"How much do you think you would like to be paid every month if it was possible?"*

Participant 1: *"You should just be able to earn enough to get some salt, some soap, we really are not asking for so much money but just the ability, to get some things we need"* (Former CBD volunteer, female)

Participant 2: *"Personally I would like to have made enough money to get my lunch."* (Former CBD volunteer, female)

Participant 3: *"Remuneration, like being given lunch when you are on the job, when you are doing your work."* (*Former* CBD volunteer, male)

Providing encouragement and financial support to CBD programs interested in improving their drama and drumming initiatives and income-generating activities was another solution offered by many participants. Drama and drumming was thought of as potentially serving the dual role of educating communities about family planning and generating some income for CBD volunteers. Support for income-generating activities was not limited to financial input or set-up funds but included issues of capacity building and training. This type of support was viewed as a key to increase CBD volunteer morale and ensure the sustainability of the program.

Discussion

There is scarce published literature providing examples of community-based program volunteers and how their motivation can be sustained. A literature review of the databases Medline, Cinahl and Embase with keywords "community-based," "volunteer(s)," "motivation" revealed three citations from developing countries (South Africa, Indonesia and Sri Lanka) and 12 citations from developed countries. In South Africa, it was reported that the supervision for direct observed treatment (DOT) of tuberculosis was as effective when done by volunteers as when done by health staff (Dick et al., 1996). In another study the same authors found that volunteers provided a more personalized service, and concluded that volunteers can bridge the gap between TB patients and the health care system. It was also concluded that support for the volunteers was absolutely vital to the sustainability of this volunteer program (Dick et al., 1996). Research findings from

Indonesia indicate that volunteers performed considerable duties and faced numerous difficulties in the course of their volunteer activities. It was also reported that incentives played an important role in determining the motivation and the performance of volunteer cadres. The authors concluded that the first step of a better understanding of volunteer work is to know what it is like to be a volunteer (Lysack et al., 1993). Studies from North America also indicate that volunteers can be very useful and provide supportive, pragmatic and personalized services (Hiatt et al., 2000). In another study from an AIDS Hospice, continued volunteer involvement depended on the support and sense of value they received from staff and on the intensity of their experiences (Murrant et al., 1995). Other studies also found that a functional incentive and recognition schemes for volunteers are essential for their sustained involvement (Danoff et al., 1994; Christensen et al., 1999).

Our study findings agree with the literature cited above in the following ways: 1) CBD volunteers in Kabarole district feel that they make a contribution towards their communities. This has been acknowledged in informal discussions between the research team and key informants held during the implementation of the study. However, as we did not collect data on specific contributions of CBDs to the overall distribution or use of contraceptives in Kabarole, we cannot draw any definite conclusions in this regard. 2) CBD volunteers want to be recognized for their volunteer work by the health care system. As they asked for only modest incentives or remuneration (mostly in kind), this request could be granted without a lot of additional program spending, but with innovative programmatic approaches and engagement of the CBD supervisors towards the volunteers.

Some of the constraints for CBDs which we found in our study can be directly addressed by the managers of the CBD family planning program in Kabarole District: e.g. the unresponsiveness of the district health system to questions and complaints of CBDs about their work in a timely manner. A better organized supervision system with supportive (vs. authoritarian) supervision being one of the corner stones for the support of CBDs in the district could be designed and implemented in a short time. In addition, regular refresher courses for upgrading CBDs knowledge and skills can be easily organized and used for more effective interactions between supervisors and CBD volunteers.

The efforts in Kabarole to formally recognize CBDs are grossly inadequate. Lack of visible program support for the CBDs and lack of visible recognition of their activities undermines their credibility with their communities and exposes them to the ridicule of community members. Incentives can work, as shown by an example from western Kenya where in a large CBD program some 10,000 volunteers have been sustained based on recognition of their work without any regular payment (Deutsche Gesellschah fuer Technische Zusammenarbeit, 1998). The severe resource constraints of western Uganda implies that only non-monetary incentives can and should be considered at this time. The disbursement of cash allowances, even if cash were available, would set an unsustainable precedent. Similarly, the introduction of user fees to generate cash for volunteers does not appear to be a viable option - expecting cost recovery from the economically desperate rural population would likely exclude the poorest (Price, 2000).

Conclusions

The quotes from the volunteers, their delicacy in describing the lack of program

"facilitation," their perceived reactions of some members of the community (e.g. ridiculing their work), and some professional commitment to their roles - at least in helping women to avoid unwanted pregnancies provide a clear and valuable description of the realities in a rural district in Uganda. The quotes they use paint a vibrant and believable picture of CBD workers "negotiating via the researchers" for some remuneration and recognition of their work. We were impressed by the volunteers participating in our study. They deserve the full attention of family planning program managers and researchers alike to create a conducive working environment for them without further delay. This study gave voice to a group of volunteers in Kabarole district, who are saying that they cannot effectively fulfill their roles as community-based distributors of contraceptives largely because they have "empty bellies." Their urgency to meet their own basic needs (i.e. food or even a bar of soap) and the lack remuneration, rewards or recognition makes it difficult to sustain their CBD volunteer activities, despite their desire to do so.

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