MOTIVATION AND RETENTION OF COMMUNITY HEALTHWORKERS IN WEST AND CENTRAL AFRICA

A multi-country research
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EXECUTIVE SUMMARY

Background
This research focuses on what motivates Community Health Workers (CHWs) in Save the Children projects in Côte d’Ivoire, the Democratic Republic of Congo (DRC), Mali and Senegal. Although much literature on CHW motivation exists, there is insufficient qualitative evidence that takes a comprehensive approach to understanding CHW motivation in a range of contexts, including fragile settings, in West and Central Africa (WCA). Therefore, this research seeks to establish how CHW motivation is affected by activities and context in, by comparing qualitative evidence across four countries in WCA, so that Save the Children, Ministries of Health and other development actors can implement high quality and effective approaches to motivating CHWs in WCA.

Research design
We developed a Research Theory, proposing how CHW activities are expected to improve CHW motivation, drawing on our literature review, and the experience of technical and programmatic experts. We conducted a contribution analysis against this research theory to compare and contrast the extent to which CHWs’ experience mirrored that of the theory in each of the four countries. We conducted purposive sampling of communities within project areas to ensure inclusion of communities with different geographic and cultural contexts. Qualitative data was collected from approximately 195 CHWs (93 men, 100 women; for 2, sex was not recorded) through participatory methods, 339 community members through group discussions, 15 health facility staff and 16 chiefs through interviews, and numerous project staff members through discussions and written contributions. Qualitative data was managed in Nvivo software and was coded and analysed by the Principal Investigator, using an analytical framework derived from the Research Theory.

Findings
Section 1: Achieving a shift towards autonomous types of motivation
Section 1 focuses on the aspects of being a Community Health Worker that the research team found to be essential to achieving motivated Community Health Workers.

1.1. Our analysis found that an appropriate and regular financial compensation package is necessary to keep CHWs motivated in their role. Despite CHWs having varied motivations for taking on the voluntary role, the challenge of being able to provide for themselves and their families whilst fulfilling their duties is demotivating for many CHWs and is the key reason that CHWs drop out in Côte d’Ivoire, DRC and Senegal. Quality of accommodation provided varied for CHWs in Mali, affecting CHW motivation. Further, injustice in the small amounts of remuneration provided to CHWs for specific activities in Côte d’Ivoire, DRC and Senegal caused demotivation: in Côte d’Ivoire, it was implied that nurses were keeping CHWs’ financial incentives; in DRC, this also happened and nurses would bring in their own family members for paid activities; in Senegal, some CHW cadres received more benefits from the Ministry of Health than others.

1.2. The study found that CHWs who had a sense that their work was achieving positive results for their community felt motivated to continue in their work as a result of this sense of achievement. In order to be able to attain this feeling of achievement, CHWs had to experience a combination of outcomes: they had to have a ‘Licence to Operate’ (through community acceptance and physical access to the community); they had to be enabled to fulfil their duties (technically); and they had to have pride and confidence in their work. Activities that support a sense of self-efficacy and thereby motivation are: provision of identification materials, job aids that facilitate travel, necessary supplies and equipment, making the community aware of CHW responsibilities and compensation package, appropriate CHW training on technical and interpersonal skills, and ongoing supportive supervision. This was relevant to CHWs across all four country contexts.

1.3. Our analysis found that it was possible for CHWs, who had not initially been driven by the “integrated or identified regulation” type of motivation, to develop this type of motivation, through having achieved a sense of self-efficacy in the role. This is significant because it is well evidenced that autonomous types of motivation (such as this) are associated with higher levels of performance, better attendance and greater retention1, and because the analysis clarified how Ministries of Health (with the support of other development actors, where necessary) can create a sense of achievement and self-efficacy amongst CHWs by delivering the interventions listed in 1.2. Therefore, CHWs in each of the four countries can be supported to shift along the continuum of

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Save the Children
types of motivation towards the autonomous motivation of integrated or identified regulation where they feel that their work is of utmost importance, leading to improved ongoing motivation, performance and retention.

Section 2: Attaining motivating outcomes that are significant to many, but not essential to all CHWs
In Section 2, we outline the activities and outcomes that were significant in motivating many CHWs, but that were not essential to motivation for all CHWs.

2.1. The research found that being a female CHW can lead to improvements in social status for those women, resulting in them making more decisions; however, there is a need to work with other community members to ensure that others are supportive of change to avoid posing risks to women. We also found that increased motivation of female and male CHWs can result from: improved community respect, CHWs’ broadened networks which include people in positions of power, increased respect from CHWs’ families; and also how positive social changes can be undermined by negative perceptions of voluntary work in Côte d’Ivoire, DRC and Senegal.

2.2. CHWs, health facility staff members and chiefs felt that the professional development opportunities of the role contributed to some CHWs feeling more motivated. It is noteworthy that professional development opportunities increased motivation amongst CHWs who reported different primary motivation types. Although a number of CHWs felt that their current role would open up future job opportunities to them, the extent to which they are on a viable career path is questionable as only a few examples exist of CHWs taking on more senior roles.

Section 3: Recruiting, motivating and retaining female CHWs in each of the sampled projects
Through our analysis, we found that there are barriers and facilitators to recruiting, motivating and retaining CHWs that are specific to female CHWs and to each of the country contexts.

3.1. In Côte d’Ivoire, there were very few female CHWs. Despite there being no official minimum level of education for CHWs, there is a working assumption that a CHW must be able to read and write well in order to meet the requirements of the job, resulting in few women who are eligible for the role. Some respondents also reported gendered social expectations as limiting women’s opportunities to become CHWs as the time required to fulfil women’s household responsibilities and cultural limitations in women making decisions reportedly undermined women’s opportunity to take on the CHW role.

3.2. In DRC, there are more male than female CHWs; however, we found that a number of different respondent groups (including chiefs and men) reported a preference for female CHWs and women were frequently selected by communities as their CHW. Many women initially accepted the role and then dropped out before or during training because the training setting and style made female CHWs, who had typically left school at an early age, feel uncomfortable. The training was designed to be delivered to participants of all levels of education, but the education setting made many women feel intimidated as it is resembled formal schooling.

3.3. We found that the CHW workforce is mostly female in Kadiolo, Mali, but that working away from their own communities reportedly affects female CHWs more than male CHWs. Some female CHWs face marital issues as a result of being deployed anywhere in the district and therefore living apart from their spouses and families. The conflict between a woman’s marital or familial obligations and living away from home puts pressure on the retention of women as CHWs in Kadiolo.

3.4. In Fatick, Senegal, some CHW cadres are considered to be women’s work and other cadres are fulfilled mostly by men. CHWs and chiefs highlighted the social expectations of women to spend their time undertaking housework as a limitation on women’s availability to be a CHW. This poses a challenge in retaining female CHWs as they feel that they are required to choose between their household duties and their professional responsibilities.

Recommendations
It is recommended that development actors working with CHWs in West and Central Africa:
• Provide a regular compensation package for CHWs which allows them to meet the needs of their families;
• Ensure systematic sharing of information with community members on CHW responsibilities and full compensation package to increase social acceptance of CHWs and accountability;
• Ensure CHWs have access to the necessary medicines, supplies and equipment and receive sufficient training and supportive supervision;
• Ensure inclusion of all social groups within the intended community by working with community members to design activities;
• Undertake context-specific analysis to develop interventions to address access barriers for CHWs, especially considering the need for identification badges in areas of recent or current conflict.
• Conduct gender analysis into gendered social norms within the project area to avoid causing harm and to develop a fully-costed strategy to working with the community to shift gender norms, if appropriate.
• Determine possible career paths for CHWs and communicate these to CHWs during recruitment or selection and throughout their time in the role.
• In Côte d’Ivoire, develop training and methods to support women who have low levels of education to access and fulfil the responsibilities of the CHW role.
• In DRC, ensure that training takes place in a setting that is familiar and accessible for all community members and that the training format and style is appropriate for all participants.
• In Kadiolo, include distance from home community as a key criterion during the deployment of CHWs to support ongoing motivation and retention of recruited and trained female CHWs.
• In Senegal, consider a gender transformative project to address the cultural barriers to women’s available time, and therefore to their ability to remain in the CHW role.

INTRODUCTION

Background

This research focuses on what motivates Community Health Workers in projects in West and Central Africa. The study aims to identify the specific interventions that support or undermine Community Health Worker (CHW) motivation, and how this is affected by the context in which the projects are delivered. The research was conducted in Côte d’Ivoire, the Democratic Republic of Congo (DRC), Mali and Senegal, in areas where Save the Children had delivered activities with CHWs within the year prior to data collection. The findings and recommendations will support Ministries of Health and NGOs to implement programmes that motivate and retain Community Health Workers by determining which interventions seem to work in which contexts and why.

Focus on Community Health Workers

Community Health Workers are fundamental to the delivery of integrated Community Case Management. Integrated Community Case Management (iCCM) is the agreed best practice to providing postneonatal treatment to children, who are often marginalised and in poorer communities, and who are unlikely to access fixed health facilities. CHWs are the cornerstone to delivering iCCM in remote and poor settings and to providing a continuum of care for children under 5 between the home, the community and the facility. Therefore, there is significant emphasis on delivering health programmes with CHWs sector-wide, intensifying the need to collate and generate robust evidence on effective approaches to working with CHWs.

Save the Children has identified iCCM as a Common Approach, committing to prioritising this approach to delivering health care services across all relevant programmes and projects; thereby working with CHWs whenever possible and appropriate.

There is insufficient evidence at a global level on how to motivate and retain CHWs, despite their critical role in development programming and in spite of the challenges in motivation and retention of CHWs being widely recognised. Although there have been several relevant studies conducted at a local or national level, there is a lack of qualitative studies linking programming inputs to CHW motivation and retention.

As a result of the confluence of the importance of CHWs to Save the Children projects and of the limited available evidence on how project activities influence CHW motivation, this research was designed to inform and influence the design and implementation of Save the Children interventions that target CHWs.

The term “Community Health Worker” is defined by the WHO as:

“…members of the communities where they work, [they] should be
selected by the communities, should be answerable to the communities for their activities, should
be supported by the health system but not necessarily a part of its organization, and have shorter
Although Community Health Workers globally are a widely diverse group with varied titles, duties and levels of formal integration into health systems, we have used the above definition as a guide for this research, focusing on Community Health Workers as frontline workers who deliver their work within the community. Typically, Community Health Workers in Save the Children projects are supervised by (government-employed) staff in health facilities.

**Literature Review**

In order to help formulate and refine the research framework and theory of change for this study, a desk-based review of recently published literature was carried out, whereby 29 publications focusing on Community Health Workers (CHWs) motivation, retention and performance were analysed. Based on this review, key influencing factors and gaps were identified relating to CHW motivation, retention and performance. Key findings from the literature review are summarised below, with references footnoted where appropriate, and a full list of literature reviewed is included in the Bibliography (Annex C).

Most studies concur that CHWs play a critical role in improving access to maternal, newborn and child health (MNCH) services by providing low-cost high-impact services at the community level, contributing to saving lives in underserved and vulnerable communities. It is also established that CHWs are not a homogenous group and their characteristics, roles and responsibilities can vary considerably, depending on the local context. It is evident from the majority of publications reviewed that CHWs provide a variety of preventative and curative services and promote healthy behaviours and appropriate family practices at the household level. However, their utility as a critical pillar of health systems and their effectiveness as the frontline healthcare provider is variable, and is affected by multiple factors, spanning personal, societal and systems levels.

In addition, most studies confirm that several factors play a role in CHWs’ motivation and retention; however, their correlation with personal and societal factors and their contribution to CHW performance, effectiveness and impact are not quite clear. Understanding these factors and causal linkages, and taking appropriate measures to address these can help improve CHW effectiveness, quality, impact and sustainability.

Most studies confirm that CHWs need satisfaction, identity and context, CHW incentives promote motivation, and CHW motivation and performance are integrally dependent on their community. However factors influencing their satisfaction and motivation are not well known, and evidence from fragile settings, in particular from the West and Central Africa regions is insufficient. In many countries, community health workers and volunteers only provide preventative and promotive services, whereas global evidence suggests curative service provision may help increase CHW motivation in low and middle income country (LMIC) settings.

There is some evidence to suggest adequate and frequent trainings and appropriate use of participatory learning methods and job-aids corresponding to CHW education, promotes effective and independent service delivery, contributing to increase CHW motivation and retention. A key factor influencing CHW satisfaction and retention is the training received, as it helps increase workers’ knowledge and skills, leading to an increase in community confidence and utilisation, which in turn increases the CHWs’ confidence in their own capacity and ability to effectively provide valuable service to their communities.

There is insufficient evidence to suggest that different training approaches affect CHW motivation and performance variably, however it is clear that brief and insufficient training erodes CHW confidence and reduces community trust and uptake of their services.

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Most studies found that supportive supervision systems, affiliation with health facilities and health systems, personal identification materials (such as ID, jackets, uniform) promote a sense of belonging and improves job satisfaction and retention. Some evidence suggests that clear career pathways and mechanisms for career advancement also act as a motivational factor for CHWs.

Majority of literature reviewed confirms that supervision is critical to maintaining quality of service provision and motivation of CHWs, however community health programmes often inadequately roll-out and resource quality supervision systems, resulting in negative implications for CHW motivation and performance. Low recognition of CHWs from the health system and inadequate supervision and engagement by professional health workers undermine CHW integration, motivation and performance.6

Systemic factors such as lack of sufficient human resource, high rates of attrition, low resource allocation and use, and lack of integration of CHWs within primary health systems (lack of recognition, appreciation, supervision and technical support) are cited as other key factors contributing to lower CHW effectiveness and quality of care, however their correlation with CHW self-efficacy and motivation is not well understood in low-income settings.

Most studies confirm that recognition and incentives, both monetary and non-monetary, help improve CHW satisfaction, retention and motivation. Access to additional benefits, such as reimbursement of transportation costs and enrolment in micro-finance /livelihoods schemes etc further improves CHW satisfaction and motivation.

Literature reviewed suggests financial remuneration is closely linked with CHW motivation and performance, and can help reduce attrition in low-income settings. Kok MC, Dieleman M. et. al. found that monetary incentives increased CHW motivation and that CHWs receiving these performed better than CHWs receiving in-kind incentives.

Evidence from some settings suggest that CHWs have an intrinsic desire to volunteer and deliver services despite not receiving a salary or other incentives, and their motivation often derives from support received from their families and local communities when other sources of motivation are insufficient. However, reviewed literature suggests that CHWs’ intrinsic desire to volunteer does not preclude a desire for external rewards. This is particularly relevant for low-income and fragile settings, however there is an evidence gap in this area. Some studies suggest that financial or in-kind incentives augment already-motivated CHWs to increase their commitment to their work.

Low literacy contributes to difficulties with case management, referrals and recordkeeping. Lack of clear roles and responsibilities, and poor working and enabling environment (unclear working hours per week) and higher workload can lead to CHW demotivation.7

Local traditions, religious beliefs and cultural practices influence motivation for CHWs, gender bias for their selection and utilisation of services provided by CHWs. Community preference for traditional healers for example may affect CHW motivation and performance.

Community engagement and ownership in recognizing the work of CHWs and volunteers promotes their acceptance and use. Ensuring the CHW services provided are contextualised and locally relevant, owned by local communities and promoting CHWs as key village health assets through participatory activities, can help improve CHW motivation, retention, performance and accountability, improving community acceptability and uptake of services.8

Use of setting-appropriate technology (information communication technology, mHealth etc) and innovative approaches enabling promote CHW learning and enables them to effectively perform their roles, which in turn improves CHW motivation and retention.

In summary, many studies have been conducted to link groups of programmatic interventions to CHW motivation; however, there is insufficient evidence that takes a comprehensive approach to understanding CHW motivation as a whole, how programmatic interventions can affect different types of motivation and how this is affected by

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specific contextual factors, in particular in fragile settings such as within the West and Central Africa region. Therefore, clear causal linkages between how personal types of motivation and contextual factors affect CHWs’ motivation to stay in the role remain unestablished.

METHODS

Research theory

The research team considered it necessary to bring together the disparate findings from the existing literature on CHW motivation to develop a comprehensive theory on how CHWs are motivated based on literature to date. We could not find any theory that already existed that brought together the full set of CHW interventions and how they led to motivation, so we developed one for the purpose of this research, drawing on the literature review and the experiences and expertise of staff who support or deliver CHW programmes at Save the Children.

The research theory demonstrates how CHW inputs and activities are expected to lead to short-term and medium-term outcomes, and how these contribute to CHW motivation. The theory also outlines contextual conditions which should be analysed and taken into account during design and delivery of the CHW interventions in order for CHW motivation to follow the described theoretical pathways. The theory assumes that improvements in CHW motivation contribute to increased retention of CHWs. The full Research Theory is included in Annex A.

Defining “motivation”

In recognition that motivation is not a singular concept, the research team thought it would be useful to understand the types of motivation that were experienced by Community Health Workers. Therefore, this research is also informed by a framework on different types of professional motivation, which is developed from Self-Determination Theory. The framework used has been adapted by Lohmann et al.\(^9\) in the context of health professionals in West Africa. The framework outlines types of motivation along a spectrum, from motivation that is controlled by external factors towards motivation that is autonomous coming from within the individual, with five different types of motivation identified along this spectrum. The framework is represented in Diagram 1.

![Diagram 1: Modified Social Determination Theory taxonomy of motivation, as measured by the scale](image)

This framework was used to analyse and interpret the qualitative data and the results from a questionnaire, specifically designed to assess these types of motivation. The use of this framework supported a more nuanced understanding of which types of motivation are affected by which interventions.

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Research design

The research team, with the oversight of a Research Advisory Group, developed the research objectives, theory and research questions based on the literature review and to ensure that the research would generate findings that were relevant to improving the effectiveness of our health programmes, most of which are community-based.

The research questions for this study are:

1. In which ways do interventions intended to improve CHW legitimacy and governance contribute to the motivation and retention of Community Health Workers?
2. In which ways do interventions intended to improve the personal and societal aspects of being a CHW contribute to the motivation and retention of Community Health Workers?
3. What are the key successes and challenges in designing and implementing Community Health Worker interventions in order to improve CHW motivation and retention?

Due to the complexity of the linkages between project activities, outcomes and CHW motivation in the Research Theory, it was clear that a theory-based approach would be appropriate to understanding how CHWs are motivated and in which ways. Due to the focus of the research being on understanding individuals’ lived experiences and perceptions, we used a contribution analysis with a nested Most Significant Change technique as the qualitative research design, allowing for discussion to bring out the nuances around individuals’ motivation.

The limitation of the contribution analysis approach is that it does not quantify motivation levels of CHWs or the extent to which observed outcomes are attributed to project activities; instead, it seeks to understand whether CHWs feel that their motivation has changed and will focus on how and why there have been any changes (both positive and negative). For more information on the research questions, sub-questions and associated research methods and data sources, please refer to Annex A.

The research team acknowledged that the experiences of male and female CHWs vary greatly, as do the experiences of male and female patients, and so a gender lens was applied throughout the research to understand these varied experiences as much as possible. For more information on how this was taken into account, please refer to Annex B.

Data collection and analysis

Purposive sampling was undertaken to select four projects using specific programming criteria from the full portfolio of Health Worker projects. Purposive sampling was selected as the sampling approach as we wanted to ensure that we were generating findings and learning from projects that had the greatest application to future programming priorities. The sampling criteria included a ranking of the total number of inputs provided to CHWs, the strategic importance of the project to Save the Children and to GSK, and ensured inclusion of at least one fragile and conflict affected states, based on DFID definition in 2015\(^9\). This resulted in the selection of the projects in Côte d’Ivoire, the Democratic Republic of Congo, Mali and Senegal.

Within each project, communities were sampled purposively to ensure inclusion of different contexts, for example including both rural and peri-urban communities, if appropriate, and including different communities with varied cultural heritage. Qualitative data was collected from approximately 195 Community Health Workers (comprised of 93 men and 100 women; sex was not captured for 2 respondents) through Most Significant Change technique, group participatory methods and group discussions; 339 community members (approximately equal numbers of men and women) through group discussions, 15 health facility staff members and 16 community leaders through interviews, and numerous project staff members through formal and informal discussions and written contributions.

All qualitative data was audio recorded, transcribed and translated to English. The data was coded according to the coding framework which was based on each component of the research theory. Analysis took place in two phases: interrogating each country’s data against the expected research theory and comparing the data between countries.

\(^{9}\) DFID, “Proportion of DFID Official Development Assistance (ODA) budget spent in fragile states and regions”, 2015
More information on sampling, data collection and analysis methods and ethical considerations can be found in Annex B: Research Design and Methods.

COUNTRY CONTEXT

Côte d’Ivoire

Kouibly, the project area in Côte d’Ivoire, was particularly affected by the post-election crisis of 2011. The project was implemented there between January 2015 and December 2016. Within the project, Save the Children trained CHWs, supported CHW supervisors, provided some job aids and basic equipment to CHWs, conducted demand generation activities and advocated for CHW support nationally and at district level.

DRC

In DRC, we implemented the selected project in Lomami from June 2013 to November 2016. From August 2016, the project area experienced active conflict and large-scale displacement, with many communities fleeing their villages, as a result of the Kamwina Nsapu rebellion. In DRC, there are two cadres of CHWs: one focuses on health promotion and messaging and are known as “relais communautaires promotionnels”, the other are “relais communautaires prestataires” and are responsible for iCCM including treatment and referral of children with common childhood illnesses. This specific project worked with “relais communautaires promotionnels” only and therefore, they formed the respondent group for this study. Project support to these CHWs included: training, financial incentives for specific activities, demand generation activities including communication materials, jackets and basic equipment, training and support to CHW supervisors and national and district level advocacy.

Mali

The project was implemented in Kadiolo in Mali from June 2015 to May 2018. The security context of the area is relatively stable, with some security incidents as a result of terrorist groups crossing the border with Burkina Faso. In Kadiolo, CHWs are paid a monthly stipend by the municipality and are integrated into the formal health system. This means that CHWs are deployed based to a village based on need; therefore, CHWs come from the district in which they work, but are unlikely to support their own home community. The project provided training for CHWs and for their supervisors, delivered demand generation activities amongst communities, and conducted district and national level advocacy.

Senegal

In Senegal, the project was implemented in the Fatik region from September 2015 to August 2018. There are 4 distinct cadres of CHWs in Senegal Agents de Santé Communautaires (ASC, who are responsible for treating and referring children and pregnant women), Relais Communautaires (who are responsible for health promotion and messaging), Matrones (who are responsible for supporting women during pregnancy and visiting newborns) and Bajenou Gox (who are responsible for accompanying women to the health facility when they are in labour). The research involved CHWs from all of these cadres as respondents. The project activities included CHW training, provision of communications materials, supplies and job aids to CHWs, community demand generation, national and district level advocacy.

FINDINGS

Through our analysis, we found that there were three different clusters within the ways in which Community Health Workers (CHWs) feel motivated: one cluster was relevant to all CHWs and was considered to be essential to CHW motivation; the second cluster included ways in which many CHWs were motivated, which were significant, but not essential to all CHWs; and the third cluster exposed that there are specific challenges and barriers to motivating female CHWs which were specific to the context and needed to be directly addressed.

Therefore, the findings in this report are split into these three respective clusters: the first section focuses on the essential interventions and outcomes required for CHWs to feel motivated; the second highlights aspects
motivating factors that are significant to many CHWs (but not essential to all), the third section centres on how Ministries and NGOs can recruit, motivate and retain female Community Health Workers. Specific successes, challenges and lessons learned from the sampled projects are included throughout the Findings part of the report. Recommendations are included in these sections with the finding to which they relate to provide the necessary context for the recommendation; however, they are also included in a section of their own at the end of the report for easy reference.

**Section 1: Achieving a shift towards autonomous types of motivation**

Section 1 focuses on the aspects of being a Community Health Worker that the research team found to be essential to achieving motivated Community Health Workers.

These are depicted in the image above, which reads from the bottom upwards, with the foundational intervention on financial compensation at the bottom, upon which other interventions are required in order to achieve the essential outcomes (of ‘Licence to Operate’, enabled to fulfil duties, and pride in work achievements) that are required in order for CHWs to achieve a sense of self-efficacy, leading to a critical shift in the type of CHW motivation towards an autonomous type of motivation (which is associated with high performance and retention) which is depicted in green at the top. It is noteworthy that we found that these interventions and outcomes were essential to CHW motivation across all four projects studied.

This section explains that regular financial compensation is necessary (Section 1.1.), how these essential interventions lead to the outcomes (Section 1.2.), and how these lead to the shift in motivation type (Section 1.3.), working from the bottom of the image to the top.
1.1. Foundational intervention for all motivation types: appropriate, regular financial compensation package

It is essential to ensure that CHWs and their families are not financially disadvantaged as a result of taking on the CHW role, as this leads to a decrease in motivation and CHWs feeling that they cannot continue in the role.

1.1.1. Need for timely payments and appropriate living conditions for CHWs

It is essential for CHWs to be able to look after themselves and their families financially, in order for CHWs to remain motivated and to continue in the role. This could either be achieved through financially compensating CHWs for the work that they do or by reducing the expectations of the role, in terms of geographical coverage and scope of responsibilities, to increase time available for CHWs to conduct their own income generating activities.

In Côte d’Ivoire, DRC and Senegal, CHWs received small amounts of remuneration for specific activities, rather than a regular stipend. These financial remunerations would be provided by Save the Children or by the Ministry of Health as small payments for specific activities, such as for their support to a vaccination drive. They would be linked to the delivery of specific activities (rather than paid at regular intervals) and were formalised payments for work done (rather than being optional contributions from health facilities). CHWs in some areas benefit from reduced cost of health care in exchange for their services, in addition to the small sums that they are given for specific activities.

Only a few CHWs reported that the financial benefits associated with the role were the motivating factor for them to become a CHW in Côte d’Ivoire, DRC and Senegal. Most, although not all, CHWs were aware that it was voluntary work at the time of accepting the position. The most common motivating factors for becoming a CHW were to serve their community, because of a long-held desire to work in the health sector, to develop skills and knowledge that could provide CHWs with access to future job opportunities, or to gain social recognition. However, the financial realities of not having regular pay despite conducting full-time work meant that many CHWs found the lack of remuneration to be the key de-motivating factor once they are already in post, as reported by chiefs and health facility staff members, as well as CHWs themselves. Some community members also reported that they felt it was unreasonable for CHWs to work without pay given the service that they provide and the difference that they were making to the community’s health.

CHWs in these three project areas were reportedly at a disadvantage financially as a result of their work and this financial disadvantage reportedly affected their families. CHWs reported that their work requires long hours, resulting in insufficient time for farming or other income generating activities. It was noted that in the remote and marginalised areas in which the projects operated and which CHWs are designed to serve, not having time to farm makes it particularly difficult for individuals to feed their families. As a result, many CHWs in Côte d’Ivoire, DRC and Senegal highlighted the strain that the role puts on them as providers for their families. Furthermore, chiefs and health facility staff members reported that the inability to provide food and education for family members was the leading cause of CHWs dropping out of the role in their area. This was the same across the three countries where CHWs were not regularly remunerated.

“Volunteering is hard and very damaging to our motivation. We have families to support and this volunteer work does not allow us to assume our duty as head of family – I am a widow.” (Female CHW, Senegal)

“The first is the financial problem, the only [CHW] that left was because their field was no longer producing.” (Health Facility Staff member, Côte d’Ivoire)

The significance of being able to provide for the family on CHW motivation is further reinforced by the positive examples from Mali, where CHW are paid a monthly stipend by the municipality. Where regular remuneration is
paid, many CHWs are motivated to continue in the job because of the financial contribution that they can make to their family.

“One day my mother needed 1000 francs. She went everywhere without being able to have that money. She was very sad and she came to talk to me about it. She told me that there is no stupid job, any work pays back, even if it is small. It really made me think. I had tears in my eyes and I heard that they were looking for CHWs. That’s why I filed my application and by the grace of God, I was able to be selected. I’m very happy because today if my mum needs anything I can help her.” (Female CHW, Mali)

The introduction of stipends has improved motivation amongst CHWs a great deal in Kadio, Mali. However, there were still issues experienced with the financial sustainability of the role as there had been delays in the payment of the stipends, meaning that CHWs could not rely on their stipend each month.

Further to this, as CHWs in Mali are deployed to communities based on need, they are required to live away from their home village. Community chiefs arrange for the community to provide accommodation for their CHW. This has led to a wide-ranging quality of accommodation for CHWs. Although some disenchantment with accommodation that is provided could be as a result of CHWs having higher expectations of living standards because their housing forms part of a remuneration package, there are some important issues that were reported as some CHWs felt that they had insufficient privacy due to shared accommodation, and others reported feeling unsafe due to the location and amenities in their homes. Some CHWs, however, felt very well looked after by the chief and their host community, enjoying high quality living quarters.

“CHWs are adults having the will [to do the job] but also families, the fact that they have financial motivation makes everything easy.” (Health Facility staff member, Mali)

“Community support affected me a lot because they built a house for me, including a toilet. Even if I am in need if I go to the village chief, he manages without any problem. One day my door was broken I told that to the village chief, he changed the door the same day.” (Female CHW, Mali)

“I’m not safe enough I live in the bush and I have no light.” (Female CHW, Mali)

Through our analysis, we have identified regular, timely payments as a foundational intervention, which is essential to CHW motivation, as the lack of financial compensation is the leading reason that CHWs in these project areas leave the role and because CHWs are clear that providing for their families is the most important responsibility that they have; therefore, all other interventions as explored throughout the rest of the report are insufficient in motivating and retaining CHWs if they cannot fulfil the basic needs of their families.

1.1.2. Injustice in remuneration leads to demotivation

Many CHWs reported feeling demotivated by various injustices that they had experienced in the small financial remunerations that were intended to be made available to CHWs. This was experienced across all three of the countries in which CHWs were voluntary: Côte d’Ivoire, DRC and Senegal; but the lack of fairness manifested itself differently in each location.

In DRC, CHWs and community members reported that the nurses (who are responsible for managing the CHWs) would often overlook CHWs when it came to tasks for which they would be paid a small fee, such as vaccination campaigns, selecting their own family members to conduct these activities instead. In one location, community members reported that the nurse would take 50% of what each CHW was due to be paid for these activities, so that the CHWs only received half of what they were owed. This led to CHWs reporting “social injustice when there are rewards” as one of the leading factors affecting how they feel about their work (CHW, DRC).

In Côte d’Ivoire, injustice in remuneration was reported, but it was raised less frequently as an issue in comparison with DRC. Although the perpetrator of the financial unfairness was masked, the implication was that the nurse
from the local health facility (who was also responsible for managing the CHWs in Côte d’Ivoire) had kept money that was owed to the CHWs. Nurses were very highly respected in Côte d’Ivoire, more so than in any other country included in the research, which could lead to under-reporting of such an issue.

In Senegal, the Bajenou Gox have received more support from the Ministry of Health than the other CHW cadres, which has resulted in Bajenou Gox being given mobile phones, whilst other CHWs have not received any similar desirable job aids from the Ministry. This sense of unfairness has caused disengagement amongst other types of CHWs. Furthermore, variations in reward packages and schedules between NGOs in the same geographical area has also caused a sense of injustice and therefore demotivation amongst some Community Health Workers.

In Section 1.1. we have demonstrated that it is essential to ensure that Community Health Workers are provided with regular remuneration and appropriate living conditions – and that they have fair access to these compensation packages – as a minimum requirement to motivate them in their role and to make the work sustainable for them to meet their own and their families’ basic needs.

**RECOMMENDATION:** Provide a regular compensation package for CHWs which allows them to meet the needs of their families, including safe and appropriate accommodation where necessary; and ensure that the compensation package is distributed to CHWs directly and regularly so that it can be relied upon.

### Learning from Mali

Achieving stipends for Community Health Workers from government bodies is not easy! However, the team in Mali put the success that they experienced down to:

- Working with an open-minded political leader, in their case, this was the Prefect of the district.
- Knowing from the start that it might take a long time, but remaining committed to the objective despite changes in funding partners and grants.
- Demonstrating how monthly stipends could be implemented and then scaling back the project’s financial contribution to the stipends as the government scaled up their proportional contribution until the government took over entirely.
- Agreeing with communities on how they would support CHWs, so that the government did not have to take responsibility for all aspects of CHW support.
- Their involvement of the community throughout.
1.2. Creating a sense of self-efficacy as a means to improve motivation

The study found that Community Health Workers who had a sense that their work was achieving positive results for their community felt motivated to continue in their work as a result of this sense of achievement. In order to be able to attain this feeling of achievement, Community Health Workers had to experience a combination of outcomes: they had to have a ‘Licence to Operate’ (through community acceptance and physical access to the community); they had to be enabled to fulfil their duties (technically); and they had to have pride and confidence in their work. We found that there were some interventions designed to support CHWs that were critical in enabling Community Health Workers to achieve these outcomes and therefore to developing a sense of self-efficacy.

“Feeling like they are achieving positive things for their community affects how CHWs feel about their job in the sense that, by doing good things, they are relieved to have done their job and it encourages them when they see the impact.” (Health Facility staff member, Mali)

1.2.1. ‘Licence to Operate’

We found that there are two critical outcomes that need to be realised in order for Community Health Workers to achieve explicit or implicit permission to conduct their activities: community acceptance of CHWs and physical access to homes and communities. We are referring to the explicit or implicit permission to conduct their activities as a ‘Licence to Operate’.

Community Acceptance of CHWs and their role

Community Health Workers across all four countries reported that their community’s acceptance of their work was critical for them to meet the responsibilities and requirements of the job, thereby affecting their sense of achievement.

As such, across all four countries, the community’s rejection of CHW services was one of the leading factors that discourage CHWs in their work:

“When I see some women run away with their children so that we do not vaccinate them” (Male CHW, Côte d’Ivoire)

“When the community reacts badly” and “When the community does not respect [the CHW] or when awareness is raised for children’s vaccination and parents do not bring their children to the centres” (Women from the community, DRC)

On the contrary, community acceptance of the CHW and of the work that they do was very important for CHWs to feel motivated in their job.

“When the community embraces change, the [CHW] feels very good about its work, otherwise he gets discouraged.” (Health facility staff member, DRC)

“This story proves that I do my job well and knowing that the villagers apply the advice is an encouragement in my work.” (Female CHW, Mali)
Without the acceptance of the community, Community Health Workers could not conduct their activities as community members would not seek their services and may not allow them access to their homes, and therefore CHWs could not attain a sense of achievement. Therefore, when delivering a CHW programme, it is essential to include activities that are reportedly the most effective in influencing community acceptance.

From the research team’s findings, the activities that played the greatest role in affecting the initial acceptance of the community were: the inclusion of community members in the selection and ongoing support of CHWs (as found in Côte d’Ivoire, DRC and Senegal), being visibly associated with the high-status nurses (as found in Côte d’Ivoire, DRC and Senegal), and the systematic information sharing with community members on CHW responsibilities and compensation package (as found in all four countries).

We found that community involvement in selection of CHWs facilitated initial community acceptance of CHWs in Côte d’Ivoire, DRC and Senegal. Chiefs and community members reported feeling that they were already proud of their CHW from the start because of their involvement in the selection process. In Mali, as aforementioned, CHWs were not selected by the community but recruited by the municipality. This led to a slower community acceptance of the individuals; however, once the community had accepted their CHW, the level of active community support to the CHW was higher than experienced in the other countries. In Mali, there were many examples of communities demonstrating their support of the CHW by building homes for the CHWs, personal latrines, giving them crops and food, and farming land on their behalf. Some of these demonstrations of support also took place in the other countries, but there were far fewer.

“There is a good collaboration with them, because I took part in their selection.” (Chief, Cote d’Ivoire)

“The fact that the whole village chooses you, it gives you more confidence, it’s different from someone else dropped on us just like that” and “It is very different between the one we choose ourselves and the one who came because of his qualifications.” (Male community members, Senegal)

In Côte d’Ivoire, DRC and Senegal, communities were inclined to accept their CHW more readily due to the endorsement that the CHW was given by the nurse. In these communities, the nurses of health facilities were of high status, particularly in Côte d’Ivoire where their status was described as second only to the chief.

“This relationship [between nurses and CHWs] builds trust and easy access to the community” (Health Facility staff member, Cote d’Ivoire)

“I am considered as a nurse, and if I take a decision, it is carried out because they know that I am in contact with the nurses all the time, so it is a means by which they value me.” (Male CHW, DRC)

Community acceptance of CHWs was undermined in some communities by community members not having the full information on what CHW responsibilities were and what their compensation package was. Because of the lack of information, some community members had made assumptions about what the CHWs were able to do and felt disappointed that CHWs were not fulfilling these duties, such as in Mali, where many community members were frustrated that CHWs were not providing them with injections, even though this is not within the duties of the CHW.

Similarly, in DRC and Senegal, many Community Health Workers and community members reported that the community members believed that the CHWs were being paid for their activities. This reduced trust between the two parties as community members believed that CHWs were not telling the truth about their compensation package. It also meant that community members were less likely to pay for their medicines or facility consultation and were less inclined to support their CHWs with food or help with their farms as they felt that kind of support was unnecessary.
These misunderstandings about CHW duties and compensation packages resulted in community members distrusting or openly criticising Community Health Workers, leading to CHWs feeling disenchanted about their role.

**RECOMMENDATION:** Integrate, into programmatic interventions, the systematic sharing of information with community members on CHW responsibilities and full compensation package in order to increase social acceptance of CHWs, and to improve the accountability of the project to children and families in the community.

### Learning on interventions to improve community acceptance of CHWs

**Increasing community sense of responsibility for CHWs in Mali**

The Mali team had great success in involving the communities in supporting CHWs, despite not having selected the CHWs themselves. They attributed their achievement to the use of a range of tactics to keep the community interested and engaged. These included community radio, leveraging national networks, and demonstrating how communities could use their own resources to support CHWs. The team recommend making the most of the positive competition that exists between CHWs by using the community radio shows to showcase communities that have done particularly well in supporting their CHW.

Following initial social acceptance, ongoing improvements to levels of acceptance are achieved by CHWs demonstrating effectiveness in the role, which is reliant on other interventions which are described throughout this finding on self-efficacy, but include having the equipment, jobs aids, skills and experience to do the job well.

We found that social acceptance and self-efficacy were in a virtuous cycle of supporting and compounding one another. The more accepted a Community Health Worker is by the community, the greater the CHW’s ability to do the job; the greater the CHW’s ability to do the job, then the more positively the community perceives the CHW.

> “After six months of training, a health outpost was opened for me in my village. The community accepted me professionally and my popularity generally increased, thanks to the experience that I demonstrated and since then I use this asset to advise my patients.” (Female CHW, Senegal)

It was notable, however, that in Côte d’Ivoire, there were some ethnic groups which the Community Health Workers felt that they could not deliver health services to as they were rejected by the community. In particular, CHWs struggled to conduct their activities amongst the Burkinabé and the Mauré communities. The programme in Côte d’Ivoire was intended to serve communities from all ethnic groups; however, it’s possible that more could be done in the future to ensure that the CHWs are better able to serve these populations, for example, it may be advisable to select CHWs from these ethnic groups to influence their own communities.

> “Everything is going well except with the Burkinabe community, which very often refuses to participate in vaccination campaigns.” (Male CHW, Côte d’Ivoire)

> “The refusal of our Mauré brothers to vaccinate their children, they are not open to vaccination” (CHW in group discussion, Côte d’Ivoire)

**RECOMMENDATION:** Invest time in understanding from community members about how best to engage all social groups within the intended communities, regardless of ethnicity, disability, gender or other potential marginalisation factors, during the design and inception stages of a project.
Access to communities

In order for Community Health Workers to be able to do their job, they need to have physical access to the communities which they are responsible for supporting. In all of the sampled projects, access was difficult as a result of the distances to travel between communities, which we found had not been recently facilitated by the Ministry of Health or by Save the Children in any of the sampled projects with job aids such as bicycles, umbrellas or appropriate footwear. Access was particularly challenging where communities had experienced conflict (in recent years in Côte d’Ivoire, and during the project lifetime and months preceding data collection in DRC). As the violence had resulted in roadblocks and armed forces’ checkpoints. In these countries, CHWs were frequently turned back from these checkpoints as they did not have identification badges which demonstrated their link to the health system or to community work.

“The police annoy us at the roadblocks [because of] a lack of identification documents” . . . “The disadvantages in this profession are lack of visibility and badges, harassment with the police ...” (CHWs in group discussion, Côte d’Ivoire)

Many respondents also indicated that CHWs required ID badges in order to gain the trust of potential patients and to access people’s homes.

“Yes, [the lack of ID badges] has an impact, it is very important that they have all these things, so that they are not tired by the FRCI (police forces) and also the population.” (Male community members, Côte d’Ivoire)

The need for CHWs to have identification materials to be able to conduct their work activities is a crucial addition to our initial Research Theory, which had proposed that identification materials were primarily useful in supporting improved status within the community. Although, our research did find that CHWs and other respondents did also feel that identification materials, such as T-shirts, vests, caps and badges, were important in ensuring that the community knew who the individuals were and to create a sense of pride and belonging amongst CHWs.

**RECOMMENDATION:** Undertake context-specific analysis during project design or inception phase to understand barriers for CHWs accessing communities and homes; and agree with Ministry of Health on what interventions should be integrated to address these in CHW programming, especially considering the needs for identification badges in areas of recent or current conflict.

1.2.2. Enabled to fulfil duties

For Community Health Workers to be able to feel that they are making positive changes in their own community, they need to be enabled to fulfil their duties. We have found that this requires them being fully equipped with the supplies and equipment that they need and that it is necessary for them to have the skills and knowledge to be able to meet the requirements of the job.

**Fully equipped**

Across all countries, respondents pointed to the lack of sufficient supplies, medicines and equipment as something that demotivates CHWs, as well as undermining their ability to meet their role requirements successfully and achieve a sense of accomplishment. CHWs did report challenges with insufficient supplies, medicines and equipment; however, they did not report this issue as much as chiefs, health facility staff members and men from the community (female community members did not remark on this as an issue). It is clear that if CHWs do not have the supplies, medicines and equipment that they need to fulfil their responsibilities, then they will not be able to promote health messaging, treat or refer children as intended, limiting their opportunity to feed as though they are making a difference in their community.
Skills and knowledge to fulfil duties

Community Health Workers highlighted the importance of training as they felt that their increased skills and knowledge allowed them to do their jobs better. They referred to the training as developing their skills and knowledge, which motivated some CHWs in itself, alongside supportive supervision from the health facility staff to continue to develop these skills. As well as being motivating in itself, development of skills, knowledge and experience were found to be essential, across all countries, in order for Community Health Workers to be able to conduct their job to a high standard.

“Training has helped me a lot in my work. Thanks to this training, I was able to treat diseases I didn’t know about.” (Male CHW, Mali)

“The nurse often helps us and that allows us to do our job better.” (Male CHW, Côte d’Ivoire)

However, some CHW respondents in DRC became CHWs to support their communities during the mass displacement as a result of the Kamuina Nsapu rebellion. As they started the role at the end of the project and whilst their communities were in hiding, they did not receive formal CHW training from Save the Children, but had been coached by trained CHWs. These CHWs explained that the lack of training was demotivating to them and also meant that it was more difficult for them to be effective in their activities. There is also a potential risk involved in having untrained CHWs working within communities; although, it is worth noting that all the CHWs in this specific DRC project were responsible for health promotion only, not for treatment or referral.

“For what dissuades us we do not have a thorough knowledge to carry out our activities in the field… When you have knowledge, it is easy to undertake activities.” (Male CHW, DRC)

The links between training and having the skills and knowledge to do the job, and between having those skills and the sense of achievement in the role are made clear by the extensive validation of these links by CHWs and other respondents in Côte d’Ivoire, Mali and Senegal; and by the explanation of CHWs in DRC who report feeling less able to do the job as they haven’t received training. Therefore, we can see that receiving training and support from clinical professionals is essential to CHWs being able to conduct their tasks properly and as such, to their sense of achievement in their work.

**RECOMMENDATION:** CHW programmes should ensure that CHWs have access to the medicines, supplies and equipment that they need to do the job and that they receive sufficient training and supportive supervision. It is recommended that these discussions take place with the Ministry of Health during design or inception phase to support the sustainability of the interventions beyond project end dates.

1.2.3. Pride and confidence in work and achievements

The research team found that it is essential for CHWs to feel pride and confidence in their own work and achievements in order to be able to feel that they are effective in their work and that they are contributing to positive change for the community. We found that there are two components which are crucial to a CHW’s pride in their work; these are being impressed by one’s own achievements and community gratitude for CHW work.
Impressed by own achievements

Various respondent groups across all four countries referred to the sense of pride that CHWs feel as a result of reflecting on their own achievements amongst the community. This is also in a virtuous cycle with a sense of self-efficacy in that the greater a CHW’s feelings of pride and confidence, the better they work, achieving more, and the more they achieve, the greater pride and confidence they experience.

“What influenced me most was the concern, to see my population in good health, to put into practice what I give as advice.” (Male CHW, DRC)

CHWs reported a visible change in the health of their community members since they started work, leading to a sense of pride in their work and their work achievements.

Community gratitude

Community Health Workers reported that the gratitude of community members led to them feeling proud and confident about their work, and resulted in increased motivation. Other respondents, including chiefs, community members and health facility staff members, also noticed that the gratitude that the community showed the CHWs affected how proud they were of their work.

It was notable that there were very few formal recognition events that were organised by communities to thank CHWs. Although the idea of these activities was well received by many groups, CHWs felt that the thanks that they received whilst doing their work was sufficient to make them feel proud of themselves.

“I have a story that has always amazed me. A woman once came to see me and told me that every time she brings her child for consultation she always comes home with satisfaction and every time she used to praise my modest person. Because of these praises I had more self-confidence and more respect from the community and patients. This had a positive impact on my professional work…” (Female CHW, Senegal)

Therefore, it is clear that the visible positive results of CHW work and the community’s positive response and thanks for the CHW’s work lead to CHWs feeling proud of their achievements.

Further, we have found in Section 1.2. that it is essential to support CHWs to be granted a Licence to Operate, through community acceptance and physical access to communities and homes; to be enabled to fulfil their duties, through training supervision and provision of equipment and supplies; and to feel pride and confidence in their work, through their own recognition of their achievements and through community gratitude. These outcomes allow CHWs to achieve a sense of self-efficacy in their role as they feel that they are making a positive change in their community; and the next section will demonstrate how the sense of self-efficacy is critical to CHW motivation.

The outcomes that lead to self-efficacy are supported by the following activities:

• Identification materials, including badges where appropriate
• Job aids to facilitate travel, such as bicycles, motorbikes, boots or umbrellas
• Necessary supplies and equipment, including medicines
• Engagement with the community on CHW responsibilities and compensation package
• Appropriate CHW training on both technical skills and interpersonal skills
• Ongoing supportive supervision from a health professional
1.3. How essential interventions can lead to a shift in type of motivation, improving the retention and performance of CHWs

Some Community Health Workers reported having been initially motivated to become a Community Health Worker because the role was aligned with their values, because they had always wanted to work in the health sector or because they felt that the role of CHW was critically important to the health of their community. These are motivating factors that are associated with the type of motivation known as “Integrated or Identified Regulation” and it is a type of autonomous motivation which means that it is not dependent on external factors, with reference to Diagram 1 on page 6.

“I am a son of the village, for a very long time I wanted to help my parents and the community, as I saw people suffering, ASC’s work is important to me.” (Male CHW, Cote d’Ivoire)

However, it is significant that the research team found that it was possible for CHWs, who had not initially been driven by the “integrated or identified regulation” type of motivation, to develop the feeling that the role was in line with their values, was part of who they were and that the role was of extreme importance to their community through having achieved a sense of self-efficacy in the role. This is significant because it is well evidenced that autonomous types of motivation are associated with higher levels of performance, better attendance and greater retention11, and because we have already outlined how Ministries of Health (with the support of other development actors, where necessary) can create a sense of achievement and self-efficacy amongst CHWs, by delivering the above interventions.

Many Community Health Workers reported that their own sense of accomplishment in the job had supported their feeling that the role was critical to the community and to them as individuals.

“I chose this story [about referring a patient with severe malaria] because it is an event that I will never forget and it is special because thanks to this experience I am more motivated every time I think about it; I tell myself that I must continue this work to prevent loss of human life.” (Female CHW, Senegal)

“The reasons that encouraged me to remain a CHW are: the trust the people have in me. Also, through this work, I have more and more experience. What affected more the way I work was the fact that I was able to get malnourished children to the centre for care and as a result they came back in good health and mortality rates were decreasing.” (Female CHW, DRC)

As such, we can see that CHWs can be supported to shift along the continuum of types of motivation towards the autonomous motivation of integrated or identified regulation where they feel that their work is of utmost importance, leading to improved ongoing motivation, performance and retention. In Section 1, we have outlined that a shift in type of motivation towards autonomous motivation can be driven by a sense of self-efficacy, which in itself is enabled by ensuring that CHWs are: well positioned to access communities physically and to be accepted by their communities, well equipped, trained in technical and interpersonal skills and supported through supervision.

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Section 2: Improved social status and professional development opportunities are significant to many CHWs, but not essential to all

In Section 2, we outline the activities and outcomes that were significant in motivating many CHWs, but that were not essential to motivation for all CHWs. We found that many CHWs, across all four countries, felt that the improvements that they experienced in their social status was important to their own levels of motivation. Additionally, many CHWs pointed to the professional development opportunities that they felt were associated with being a CHW as being a key motivating factor for them. In this section, we explore what affected their social status and their professional development opportunities, and how these influenced CHWs’ motivation.

2.1. Improvements in social status were significant to many

There were several factors that influenced CHWs’ social status, which are explained in Section 2.1, and in doing so are significant to increasing the motivation of many CHWs. At the start of this section, we focus on how women experienced improvements in social status, and the limitations of this, in recognition that the research theory (and many CHW programme theories) expected women to gain additional reputational outcomes from their work. We also explore the key factors affecting social status: increased respect from the community, being well networked with powerful figures, improved respect from family members; and then outline how these positive outcomes can be undermined by the limited value for voluntary work amongst some members of CHWs’ communities. The positive and negative influences on social status are directly linked to the CHW motivation.

“When you know that it is because of your work that everyone respects you, you want to continue and do it even better” (Women from the community, Côte d’Ivoire)

“There is much lack of respect and consideration for our position. That could discourage me.” (Male CHW, Senegal)

2.1.1. For women

We found that some female CHWs did experience improved social standing because of their work; however, this positive outcome was limited and could pose a risk to women if these changes are not supported by activities with other community members.

The research theory proposed that female CHWs would have increased agency in their own homes, due to improved community respect for them because of their role and because some female CHWs may be able to contribute financially towards their household as a result of their work. We found that some respondents did feel that women could make more decisions in the home and they considered this to be as a result of their improved reputation amongst the community and because of their financial contributions to the home, in line with what was expected in the research theory. However, it was notable that this increased decision-making was mostly, but not exclusively, limited to decisions that were directly related to their new health skills and knowledge. This was found across all four project areas, despite their cultural differences.

“Well, for the moment, I can say that I am a bit confident; because of my work my family has more respect for me; it has strengthened my ability to make decisions in my family because everything I tell them about health, they respect it.” (Female CHW, Mali)

“A woman who works and earns her own money, has more self-confidence, is respected and her husband often take advice from her.” (Women from community, Côte d’Ivoire)

However, it is important to note that some men raised concerns about the idea of women making decisions or gaining confidence. Empowering women to have a voice without working with other members of the community to accept this change can be potentially harmful for women.
“Respect and trust lead her to have confidence in herself...It can go to her head until she makes mistakes in her job.” (Chief, Mali)

“In her family, everything she says about health is taken into account, even in the village, but she must not go beyond this context.” (Men from the community, Mali)

“This is inevitable; because a woman who wears health clothing and is able to support herself can become too confident, can challenge her co-wives, her relatives, even her husband in some decisions, woman is naturally like that.” (Men from the community, Senegal)

Therefore, it is clear that including women as Community Health Workers presents opportunities to improve women’s standing in the community and in her own home and that these opportunities are present across a range of cultural contexts. However, recruiting female CHWs is not sufficient in itself to shift gender norms, this intervention should be accompanied by a more comprehensive strategy to work with a range of community members to challenge discriminatory social norms, rather than being delivered in isolation.

**RECOMMENDATION:** Gender analysis should be conducted at programme design or inception stage to understand the gendered social norms within the project area, whether these can be challenged without posing harm to women and the best strategy to working with the community to shift gender norms. If it is decided that the project will seek to address gendered social norms, then it is recommended that the desired change is captured and fully integrated into the project design with a specific project outcome, appropriate budget, indicators and monitoring and evaluation design.

### 2.1.2. Increased respect from community

Many CHWs, women and men from the community, chiefs and health facility staff reported that CHWs had an increased respect from others in the community as a result of their CHW position. Although this was true to some extent across all four sampled projects, in Mali CHWs did not live in their supported communities prior to the role and many described initial challenges in being respected in their community; however, after a slower start, some did report an improvement in the respect that they experienced.

“When I returned to the village I was not considered in the village. I couldn’t even speak during meetings. My word was not taken into account. I did not have money and I was always despised. But since I am CHW, I am constantly seen with the nurse, my sensitizations within the community is effective and I am now respected and considered in the community, I’m happy and I feel comfortable” (Male CHW, Côte d’Ivoire)

“The training I receive and the respect of the community have allowed me to have a doctor’s status” (Female CHW, Senegal)

Respondents attributed the improved status amongst the community to the following key activities to support CHWs:

- community members’ awareness of CHWs’ training
- uniforms that CHWs wear such as T-shirts, vests, caps etc which make it clear to everyone that the CHW has a formal role within the community
- community’s involvement in the selection of the CHW in Côte d’Ivoire, DRC and Senegal
- formalised recognition activities (where these had taken place, although these were limited in number).

It is widely understood that increased respect from community members is critical to improved social status. Increased respect amongst the community was identified as one of the factors that most influenced motivation for many CHWs.
2.1.3. Feeling well networked

Many CHWs noted that they are motivated to stay in the role because of the extended network which they feel that they have as a result of their position. CHWs referred to their improved networks as comprising at least one of the following:

- Nurses – this was particularly prevalent in Côte d’Ivoire and DRC where nurses were of particularly high social status
- Chiefs
- NGO staff
- Providing the link between communities and government officials
- Providing the link between communities and health centres

“The advantages in this job are the training, the relationships we have with health workers and with some community leaders.” (CHWs in group discussion, Côte d’Ivoire)

“[Advantages of the job include that] you have a lot of relationships with the nurses, it allows you to be in touch with a lot of NGOs…[and] the recognition of your nurse” (CHWs in group discussion, Côte d’Ivoire)

“I am considered as a nurse, and if I take a decision, it is carried out because they know that I am in contact with the nurses all the time, so it is a means by which they value me.” (Male CHW, DRC)

It is noticeable that improved networks were more pertinent to CHWs in Côte d’Ivoire, DRC and Senegal than they were to colleagues in Mali, where CHWs were not originally from the area in which they were working and where it seemed that health facility staff were not of the same high status as they were in the other countries, perhaps as the involvement of the health facility in daily life was less in general due to the greater distances between communities and facilities.

CHWs reported that feeling well networked motivated them as they were brushing shoulders with decision-makers and powerful people in their community, which motivated some CHWs in itself and motivated others due to their perception that this visible association with decision-makers was improving their own social status.

2.1.4. Improved respect from family

Some CHWs also noted that they had increased respect from their own family members since taking on the role, which contributed to their improved social status and therefore motivated them in their CHW job. Some CHWs noted that their increased respect from their family was due to the improved community respect for them since becoming a CHW; other CHWs reported that their family’s improved regard for them was due to their success in the role, in creating positive change for families and the community.

“…the respect between my family and I has a positive impact, and yes it allowed me to make decisions.” (Female CHW, Mali)

Although improved respect from the family was not a key motivating factor for CHWs, it was found to support increased CHW motivation by contributing to CHWs’ perception of having an increased social status as a result of their CHW work.

2.1.5. Community mockery of voluntary work undermined improvements in social status

The gains made in social status from being a CHW as outlined above are only from some parts of the community or in some communities, as these improvements are frequently undermined by some community members’ low esteem for voluntary work. Many CHWs and other respondents noted that voluntary work is often associated with people who don’t want to work or with older people who have more time on their hands, and therefore some
don’t consider it to be a valid professional choice. This was more prevalent in Côte d’Ivoire, DRC and Senegal where CHWs aren’t remunerated.

“Some people sometimes laugh at us because we don’t get paid.” (Female CHW, Côte d’Ivoire)

Frequently, it is within the same communities that there are some who have increased respect for CHWs as a result of their work and those who have a negative perception of voluntary work. This results in mixed social outcomes for CHWs with benefits of increased respect from some being undermined by mockery from others in the community. CHWs in Côte d’Ivoire, DRC and Senegal associated the negative perception of voluntary work with their own decreased motivation.

Section 2.1. has outlined how changes in CHWs’ social status affect women specifically and how changes for women and for men can result from: improved community respect, CHWs’ broadened networks which include people in positions of power, increased respect from CHWs’ families; and also how positive changes can be undermined by negative perceptions of voluntary work. The section has also outlined how changes in social status affect CHWs’ motivation, with improvements supporting motivation levels and with negative changes in social reputation having a direct effect on CHW motivation.

2.2. How professional development opportunities engage CHWs, regardless of their initial type of motivation

CHWs, health facility staff members and chiefs felt that the professional development opportunities of the role contributed to some CHWs feeling more motivated in their jobs. It is noteworthy that professional development opportunities increased motivation amongst CHWs who reported different primary motivation types.

Some CHWs who were primarily driven by the potential for improved social status as a result of their work, ie external regulation – social, felt motivated by the possibility of growing their own skills, knowledge and experience as it meant that they might be able to access a more senior role in the future, with a better reputation within the community.

“I became a CHW to become someone tomorrow” (CHW [gender not recorded], Côte d’Ivoire)

Similarly, some CHWs were primarily motivated by the importance of their role to the community, ie integrated / identified regulation, or their desire to be seen to create positive change in the health of their community, ie introjected regulation, and some of these CHWs felt that professional opportunities were key to them as these could result in the CHW having, or to be recognised for having, even more impact on the health of their neighbours.

“I have the ambition to someday become a nurse, that’s why I remain a CHW and take care of my patients.” (Female CHW, Mali)

For those that were intrinsically motivated by the daily tasks of the role, opportunities to learn more and to access new roles were motivating because they wanted to learn new skills and how to do things, like administer injections, that they weren’t already doing as a CHW.

Therefore, we can see how professional opportunities appeal to some CHWs, regardless of their primary motivation type.

Although a number of CHWs felt that their current role would open up future job opportunities to them, the extent to which they are on a viable career path is questionable. There are few examples of CHWs having taken on more senior roles within the health system; although some examples do exist. In order to ensure that we are being transparent with CHWs, we should be clear on potential career path opportunities that CHW work can
support and ensure that this is clearly communicated to potential CHWs before they take the role and whilst they are in position.

**RECOMMENDATION:** Determine with the Ministry of Health what the possible career paths that CHW work could lead into and support the Ministry of Health, where necessary, to communicate these to CHWs during recruitment or selection and throughout their time in the role.

In Section 2, we have outlined ways in which female and male CHWs can be motivated, through activities intended to improve their social status and through providing genuine professional development opportunities, but that there are some social results which can damage motivation or even pose a risk to CHWs, which should be identified within specific contexts and mitigated. We found that outcomes of increased social standing and of professional development were significant in affecting the motivation of many CHWs, who specifically articulated these outcomes as affecting their motivation; however, they were not necessary to all CHWs to ensure motivation.

**Section 3: Recruiting, motivating and retaining female CHWs in each of the sampled projects**

We found that there are barriers and facilitators to recruiting, motivating and retaining CHWs that are specific to female CHWs and to each of the country contexts. Section 3 explores these influencing factors for female CHWs’ motivation by project area, in order to emphasise the importance of context and to support the use of the findings and recommendations by project teams in each country.

3.1. In Côte d’Ivoire

In Kouibly, there are very few female CHWs which we understood to be as a result of very few women having the education levels that are expected to be necessary to conduct the role. Despite our intended sampling of equal numbers of female CHWs and male CHWs in each sampled project, in Côte d’Ivoire, we only managed to speak to two female CHWs compared with 44 male CHWs. This was not found to be an issue with data collection scheduling (such as holding discussions at a time of day that is inconvenient for women) but is an accurate reflection of the very limited number of women in the role.

Through interviewing project staff, we found that it was perceived that this was a result of the low level of education attained by women in the project area and, in fact, nationwide. Although there is no official minimum level of education that is required for a CHW by the decentralised District Health Management Team, there is a working assumption that a CHW must be able to read and write well in order to meet the requirements of the job, resulting in few women who are eligible for the role.

In addition to the view of the project staff, some respondents reported gendered social expectations as limiting women’s opportunities to become CHWs. It was reported that women’s household responsibilities mean that they cannot make themselves as available to conduct the role as men can, causing a barrier to them accessing or staying in the role. Furthermore, cultural limitations in women making decisions reportedly undermined women’s opportunity to take on the CHW role.

> “Women work better than men. They’re at every appointment. They work well but they cannot make decisions. It’s the custom.” (Female community members, Côte d’Ivoire)

In contrast to these social barriers, some women in the community specified that they would prefer to be visited by female CHWs than men. In order to overcome the barriers to women becoming CHWs and staying in the role in Kouibly, it would be necessary to think creatively about how to involve women with low levels of literacy and how to encourage the community to support women to conduct the role.

**RECOMMENDATION:** Work with the Ministry of Health to review the expected level of literacy that is required to fulfil CHW duties in Côte d’Ivoire; and, if necessary, develop training and methods to support women who have low levels of education to access the role and fulfil the responsibilities of the CHW role; for example, by working in pairs where one colleague has a higher literacy level, by using pictorial aids, etc.

3.2. In the Democratic Republic of Congo
In Lomami, there are more male than female CHWs, with women reporting that the training seemed intimidating due to their limited experience of formal schooling. CHW respondents included 21 women and 24 men; but this was a result of the research team’s active attempt to include equal numbers of female and male CHWs, rather than being representative of the ratio of female CHWs to male CHWs. In practice, the role is mostly filled by men.

Contrary to there being more male CHWs than female, we found that a number of different respondent groups (including chiefs and men) reported a preference for female CHWs. In this area, community members were involved in the selection of their CHWs and frequently selected female CHWs. However, many women initially accepted the role and then dropped out before or during training. The reason that was given for women dropping out was that the training setting and style made female CHWs, who had typically left school at an early age, feel uncomfortable. The training was designed to be delivered to participants of all levels of education, but the education setting made many women feel intimidated as it is resembled formal schooling.

“The women were selected but to our great surprise we found that they do not work like their male colleagues, in my opinion together with the IT we need to create a mechanism to encourage the women to be CHWs in our village.” (Chief, DRC)

In order to support women to become CHWs in Lomami, it will be necessary to re-think the training setting and style to ensure that women and men both feel comfortable and confident learning the skills and information required to be a CHW.

**RECOMMENDATION:** Work with the District Health Management Team in DRC to ensure that training takes place in a setting that is familiar, comfortable and accessible for all community members and that the training format and style is appropriate for all participants. For example, on-the-job style training through peer coaching by pairing up one trained CHW and one trainee may be more appropriate to the learning styles of those who have not been through the education system.

### 3.3. In Mali

We found that the CHW workforce is mostly female in Kadio, Mali, but that CHWs working away from their own communities reportedly affects female CHWs more than male CHWs. The vast majority of the CHWs that we spoke to as part of the research were women: there were 40 female CHWs and only 8 male CHWs; again, we had aimed for equal numbers of women and men in the sampling. Despite most of the CHWs being women, there are some retention issues that are specific to women. The research team heard from project staff and Research Assistants that some women face marital issues as a result of being deployed anywhere in the district, which can result in CHWs having to live a long way away from their spouses and families. The research team heard that this can lead to women leaving the role as their husbands become dissatisfied with their wives living some distance away. This has led to some female CHWs being divorced or threatened with divorce, or becoming concerned that co-wives may have more children or become favoured by the CHW’s husband. In some cases, if the husband is comfortable with his wife undertaking the role and living away from home, there can be other influential figures who oppose the idea, such as mothers-in-law. Furthermore, it is challenging for CHWs to leave their families behind for the role.

“My husband understands and he does not complain, but it’s my mother-in-law who is a little difficult”

(Female CHW, Mali)

The conflict between marital or familial obligations (which are specific to being a wife or mother) and living away from home puts pressure on the retention of women as CHWs in Kadio.

**RECOMMENDATION:** Work with the District Health Team in Kadio, Mali to ensure that distance from home community is one of the key criteria that is taken into account during the deployment of CHWs to support ongoing motivation and retention of recruited and trained female CHWs.

### 3.4. In Senegal
In Fatick, some cadres of CHW are considered to be women’s work and other cadres are fulfilled mostly by men, with women’s retention as CHWs undermined by the gendered expectations of household responsibilities. There were more female CHWs included in the research as respondents than male CHWs, at 37 women to 17 men (with the sex of 2 CHWs not recorded). The roles of Matrone and Bajenou Gox were entirely fulfilled by women within our sample; whereas, the more technical role, with higher social status, of ASC was conducted by 10 men compared to 8 women within our sample.

CHWs and chiefs highlighted the social expectations of women to undertake housework as being a limitation on women’s available time to dedicate to CHW activities.

“Well, the difficulties of combining housework and work. Sometimes, our husbands are very reluctant”
(Female CHW, Senegal)

“Women CHW are very busy and it is difficult for them to combine housework and work-related activities, and women tend to neglect one of the two activities.” (Chief, Senegal)

Therefore, in order to support women to become CHWs or to stay in the role in Fatick, Senegal, it would be necessary to address the social norms related to household chores and responsibilities, so that women have more time available in which they could choose to work as a CHW.

RECOMMENDATION: In order to overcome these social barriers in retaining female CHWs in Senegal, it would be necessary to consider a gender transformative project, looking at the ecological model in which the community live. An analysis of this nature would support a broad understanding of people’s experiences within the community and how this might be influenced through a social and behaviour change communication strategy. If it was decided that it was safe and appropriate to address the barriers to women’s available time, then it is advisable to develop a project objective related to the intended changes in attitudes and behaviour and to ensure that it is fully resourced, monitored and evaluated within the project.

In this section, we have identified the specific barriers to women becoming CHWs, feeling motivated to be a CHW, and staying in the role within each of the project areas. These centre around expectations of how educated a CHW should be, the ways in which CHWs are trained, and the challenge of balancing familial expectations of a woman and the commitments required by the role. We have outlined recommendations to address these specific barriers.

RECOMMENDATIONS

As integrated throughout the Findings section above, below is the full list of Recommendations included as a standalone section and organised according to its relevant section within the Findings. Please note that “Achieving a shift towards autonomous types of motivation” identifies the interventions which are essential and necessary to CHWs being motivated to do their work.

The recommendations are intended to be useful to those who are working to support CHWs in their daily activities and assume that CHWs are a part of the national health system and therefore are governed by the Ministry of Health; but with an acknowledgement that Save the Children, and other development actors, are conducting activities with CHWs in collaboration with the respective Ministries of Health.

Achieving a shift towards autonomous types of motivation

RECOMMENDATION: Provide a regular compensation package for CHWs which allows them to meet the needs of their families, including safe and appropriate accommodation where necessary; and ensure that the compensation package is distributed to CHWs directly and regularly so that it can be relied upon.

RECOMMENDATION: Integrate, into programmatic interventions, the systematic sharing of information with community members on CHW responsibilities and full compensation package in order to increase social acceptance of CHWs, and to improve the accountability of the project to children and families in the community.
RECOMMENDATION: Invest time in understanding from community members about how best to engage all social groups within the intended communities, regardless of ethnicity, disability, gender or other potential marginalisation factors, during the design and inception stages of a project.

RECOMMENDATION: Undertake context-specific analysis during project design or inception phase to understand barriers for CHWs accessing communities and homes; and agree with Ministry of Health on what interventions should be integrated to address these in CHW programming, especially considering the needs for identification badges in areas of recent or current conflict.

RECOMMENDATION: CHW programmes should ensure that CHWs have access to the medicines, supplies and equipment that they need to do the job and that they receive sufficient training and supportive supervision. It is recommended that these discussions take place with the Ministry of Health during design or inception phase to support the sustainability of the interventions beyond project end dates.

Improved social status and professional development opportunities are significant to many CHWs, but not essential to all

RECOMMENDATION: Gender analysis should be conducted at programme design or inception stage to understand the gendered social norms within the project area, whether these can be challenged without posing harm to women and the best strategy to working with the community to shift gender norms. If it is decided that the project will seek to address gendered social norms, then it is recommended that the desired change is captured and fully integrated into the project design with a specific project outcome, appropriate budget, indicators and monitoring and evaluation design.

RECOMMENDATION: Determine with the Ministry of Health what the possible career paths that CHW work could lead into and support the Ministry of Health, where necessary, to communicate these to CHWs during recruitment or selection and throughout their time in the role.

Recruiting, motivating and retaining female CHWs in each of the sampled projects

RECOMMENDATION: Work with the Ministry of Health to review the expected level of literacy that is required to fulfil CHW duties in Côte d’Ivoire; and, if necessary, develop training and methods to support women who have low levels of education to access the role and fulfil the responsibilities of the CHW role; for example, by working in pairs where one colleague has a higher literacy level, by using pictorial aids, etc.

RECOMMENDATION: Work with the District Health Management Team in DRC to ensure that training takes place in a setting that is familiar, comfortable and accessible for all community members and that the training format and style is appropriate for all participants. For example, on-the-job style training through peer coaching by pairing up one trained CHW and one trainee may be more appropriate to the learning styles of those who have not been through the education system.

RECOMMENDATION: Work with the District Health Team in Kadiolo, Mali to ensure that distance from home community is one of the key criteria that is taken into account during the deployment of CHWs to support ongoing motivation and retention of recruited and trained female CHWs.

RECOMMENDATION: In order to overcome these social barriers in retaining female CHWs in Senegal, it would be necessary to consider a gender transformative project, looking at the ecological model in which the community live. An analysis of this nature would support a broad understanding of people’s experiences within the community and how this might be influenced through a social and behaviour change communication strategy. If it was decided that it was safe and appropriate to address the barriers to women’s available time, then it is advisable to develop a project objective related to the intended changes in attitudes and behaviour and to ensure that it is fully resourced, monitored and evaluated within the project.

CONCLUSION

Our analysis has shown that there are some interventions that are essential in motivating CHWs; that many CHWs are motivated by other interventions, but that these are not essential to all CHWs; and that there are some barriers to CHW motivation that are specific to female CHWs.

CHW motivation is dependent upon CHWs receiving a regular compensation package that allows them to provide for their own basic needs and those of their family. As this is an absolute necessity for many CHWs, other
activities to support their motivation will be insufficient in achieving motivation if a regular compensation package is not provided. It is essential for CHWs to attain a sense of self-efficacy and achievement in their work to feel motivated and this can lead to CHWs being driven by autonomous types of motivation. The sense of self-efficacy can be achieved by supporting CHWs to have a ‘licence to operate’ (through community acceptance and physical access to the community); be enabled to fulfil their duties (technically); and have pride and confidence in their work. There is an identified set of activities that can be delivered to support these outcomes amongst CHWs.

Some female CHWs experienced improved social status as a result of their work; however, there is a need to work with other community members to ensure that others are supportive of change to avoid posing risks to women. Increased motivation for some female and male CHWs can result from: improved community respect, CHWs’ broadened networks which include people in positions of power, and increased respect from CHWs’ families; but that positive social changes can be undermined by negative perceptions of voluntary work in Côte d’Ivoire, DRC and Senegal. CHWs, health facility staff members and chiefs felt that the professional development opportunities of the role contributed to some CHWs feeling more motivated, but the extent to which they are on a viable career path is questionable as only a few examples exist of CHWs taking on more senior roles.

Female CHWs faced different barriers to accessing or remaining in the role based on the context in which they were working. In Côte d’Ivoire, there is no minimum level of education to be a CHW, but there is a working assumption that a CHW must be able to read and write well, resulting in few women who are eligible for the role. Also gendered social expectations limit women’s opportunities to become CHWs as the time required to fulfil women’s household responsibilities and cultural limitations in women making decisions reportedly undermined women’s opportunity to take on the CHW role. In DRC, the training setting and style made female CHWs, who had typically left school at an early age, feel uncomfortable and therefore drop out; despite community members preferring women as CHWs. Working away from their own communities reportedly affects female CHWs more than male CHWs in Kadiolo, Mali as some female CHWs face marital issues. The conflict between a woman’s marital or familial obligations and living away from home puts pressure on the retention of women as CHWs. In Fatick, Senegal, CHWs and chiefs highlighted the social expectations of women to spend their time undertaking housework as a limitation on women’s availability to be a CHW. This poses a challenge in retaining female CHWs as they feel that they are required to choose between their household duties and their professional responsibilities.

Our analysis has found that there are a number of activities that Ministries of Health, with the support of other development actors if necessary, can deliver in CHW programmes to improve motivation, and therefore retention, in West and Central Africa.
MOTIVATION AND RETENTION OF COMMUNITY HEALTHWORKERS IN WEST AND CENTRAL AFRICA; ANNEXES

ANNEX A: RESEARCH THEORY AND FRAMEWORK

The research theory outlines the typical types of activities (implemented by Ministries of Health or by NGOs) that are put in place to support CHW on the left of the diagram, and proposes how these activities link to outcomes for CHWs (in the middle of the diagram), and how these lead to CHW motivation, and thereby retention (at the right of the diagram).

**Personal**
- Capacity development
- Career development
- Peer support
- Linked to other trainings

**Societal**
- Community engagement in ID and selection of CHWs
- Raising awareness among community of CHW R&R
- Family and community support to CHWs to be able to conduct their activities

**Legitimacy**
- Recognition
- Reward
- Identification materials
- MoH ownership

**Governance**
- Linked to primary health system
- Clear R&R
- Supportive supervision
- Compensation, including monetary and non-monetary incentives
  - Commodities
  - Supplies
  - Job aids

CHWs have the necessary skills to meet job requirements
CHWs are on a career path that supports development and promotion
CHWs feel part of health system
Community aware of CHW role and work
CHWs feel valued by healthcare professionals

Job satisfaction
Community respect and trust for CHWs
Increased agency for female CHWs at household level
Increased social recognition
Increased sense of achievement and contribution to positive change

CHWs are well equipped to conduct their activities
CHWs are enabled to meet their job requirements with sufficient autonomy
CHWs are not financially disadvantaged as a result of taking on CHW role
Improved financial sustainability of CHW work

Contextual factors are assessed and accounted for in the design of activities

Increased CHW motivation, supporting improvements in retention
The activities are grouped into four types: legitimacy, governance, social and personal. The grouping was done based on types of intervention that have already been articulated by others in the literature reviewed and was done in order to simplify the proposed causal linkages in the theory. The diagram also includes a representation of contextual conditions to the furthest left of the image. The theory proposes that these contextual conditions must be analysed and taken into account during design and delivery of the CHW interventions in order for CHW motivation to follow the described theoretical pathways. The lists below detail what the proposed relevant contextual conditions are.

**Contextual factors that affect motivation of CHW**

- Policy environment
- Extent to which CHW responsibilities remain stable
- Fragility of context in terms of conflict and disasters
- Level of functionality & sustainability of health system (including HRH)
- Policies & legislation that support CHWs
- Existence of complementary community demand generation activities
- Effectiveness of CHW training
- Community perception of health system

**Other potential influencing factors**

- Demographics of CHW (age, gender, literacy)
- Perception of gender roles and capabilities
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<tr>
<th>Research Question</th>
<th>Sub-questions</th>
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<th>Sources</th>
<th>Indicators</th>
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<tbody>
<tr>
<td>1. In which ways do interventions intended to improve CHW legitimacy and governance contribute to the motivation and retention of Community Health Workers?</td>
<td>1.1 How have project activities intended to improve the legitimacy and governance of CHWs contributed to their motivation?</td>
<td>Interviews, Questionnaires, Focus group discussions, Most Significant Change</td>
<td>CHWs, Community members (Male and Female), Community leaders, Health facility staff, District MoH Officials</td>
<td>Evidence of the extent to which activities related to legitimacy (recognition, reward, identification materials, Ministry of Health (MoH) ownership) are perceived to have affected CHWs' sense of being part of the health system Evidence of the extent to which activities related to legitimacy (recognition, reward, identification materials, MoH ownership) are perceived to have affected whether the community are aware of the CHW role and CHW work Evidence of the extent to which activities related to legitimacy (recognition, reward, identification materials, MoH ownership) are perceived to have affected whether CHWs feel valued by healthcare professionals Evidence of the extent to which community awareness of CHW role and work is perceived to have affected social recognition of CHWs Evidence of the extent to which CHWs feeling valued by healthcare professionals is perceived to have affected CHW sense of achievement and contribution to positive change Evidence of the extent to which CHWs feeling part of the health system is perceived to have affected CHW sense of achievement and contribution to positive change Evidence of the extent to which a sense of achievement and of contributing to positive change has contributed to CHW motivation Evidence of the extent to which activities related to governance (linkages between CHWs and primary health system, clear R&amp;Rs, supportive supervision, compensation including monetary and non-monetary incentives, commodities, supplies, job aids) are perceived to have affected how well equipped CHWs are to conduct their activities Evidence of the extent to which activities related to governance (linkages between CHWs and primary health system, clear R&amp;Rs, supportive supervision, compensation including monetary and non-monetary incentives, commodities, supplies, job aids) are perceived to have affected whether CHWs are not financially disadvantaged as a result of taking on the CHW role</td>
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<td>Evidence of the extent to which the equipment of CHWs is perceived to have affected whether CHWs are enabled to meet the job requirements with sufficient autonomy</td>
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<td>Evidence of the extent to which CHWs having the necessary skills is perceived to have affected whether CHWs are enabled to meet the job requirements with sufficient autonomy</td>
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<td>Evidence of the extent to which the formal link and support from other healthcare professionals to CHWs is perceived to have affected whether CHWs are enabled to meet the job requirements with sufficient autonomy</td>
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<td>Evidence of the extent to which a sense of achievement and of contributing to positive change is perceived to have affected whether CHWs are enabled to meet the job requirements with sufficient autonomy</td>
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<td>Evidence of the extent to which the financial implications of the CHW role is perceived to have affected the financial sustainability of CHW work</td>
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<td>Evidence of the extent to which CHWs being able to meet their job requirements with sufficient autonomy has contributed to CHW motivation</td>
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<td>Evidence of the extent to which the financial sustainability of CHW work has contributed to CHW motivation</td>
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<td>1.2 Have project activities intended to improve the legitimacy and governance of CHWs resulted in any unintended outcomes for CHWs?</td>
<td>Interviews</td>
<td>CHWs Community members (Male and Female) Community leaders Health facility staff District MoH Officials</td>
<td>Evidence that activities related to legitimacy (recognition, reward, identification materials, MoH ownership) are perceived to have led to additional positive or negative outcomes which are not included in the research theory</td>
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<td>Focus group discussions Most Significant Change</td>
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<td>Evidence that activities related to governance (linkages between CHWs and primary health system, clear R&amp;Rs, supportive supervision, compensation including monetary and non-monetary incentives, commodities, supplies, job aids) are perceived to have led to additional positive or negative outcomes which are not included in the research theory</td>
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<td>1.3 How have contextual factors affected the design and/or implementation of project activities intended to improve</td>
<td>Interviews Focus group discussions Document review</td>
<td>Project staff District MoH officials Health facility staff Existing project documentation</td>
<td>Evidence that an analysis of the political climate for CHWs was accounted for in the design and implementation of legitimacy and governance activities</td>
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<td>Evidence that an analysis of the current state and structure of the health system was accounted for in these design and implementation of legitimacy and governance activities</td>
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<td>Evidence that an analysis of the cultural expectations and perceptions of CHWs and community work was accounted for in the design and implementation of legitimacy and governance activities</td>
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<td>CHW legitimacy and governance?</td>
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<td>Evidence that an analysis of previous and existing community health worker and other development projects in the implementation sites was accounted for in the design and implementation of legitimacy and governance activities</td>
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<td>1.4 How have contextual factors affected the linkages between activities intended to improve CHW legitimacy and governance and CHW motivation?</td>
<td>Interviews Focus group discussions Most Significant Change</td>
<td>CHWs Community members (Male and Female) Community leaders Health facility staff District MoH Officials</td>
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<td>Evidence that the political climate for CHWs is perceived to have affected the extent to which activities related to legitimacy (recognition, reward, identification materials, MoH ownership) contribute to CHW motivation Evidence that the current state and structure of the health system is perceived to have affected the extent to which activities related to legitimacy (recognition, reward, identification materials, MoH ownership) contribute to CHW motivation Evidence that the cultural expectations and perceptions of CHWs and community work is perceived to have affected the extent to which activities related to legitimacy (recognition, reward, identification materials, MoH ownership) contribute to CHW motivation Evidence that previous and/or existing community health worker and/or other development project are perceived to have affected the extent to which activities related to legitimacy (recognition, reward, identification materials, MoH ownership) contribute to CHW motivation Evidence that the current state and structure of the health system is perceived to have affected the extent to which activities related to governance (linkages between CHWs and primary health system, clear R&amp;Rs, supportive supervision, compensation including monetary and non-monetary incentives, commodities, supplies, job aids) contribute to CHW motivation Evidence that the cultural expectations and perceptions of CHWs and community work is perceived to have affected the extent to which activities related to governance (linkages between CHWs and primary health system, clear R&amp;Rs, supportive supervision, compensation including monetary and non-monetary incentives, commodities, supplies, job aids) contribute to CHW motivation Evidence that previous and/or existing community health worker and/or other development project are perceived to have affected the extent to which activities related to governance (linkages between CHWs and primary health system, clear R&amp;Rs, supportive supervision, compensation including monetary and non-monetary incentives, commodities, supplies, job aids) contribute to CHW motivation</td>
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<td>2. In which ways do interventions intended to improve the personal and societal aspects of being a CHW contribute to the motivation and retention of Community Health Workers?</td>
<td>2.1 How have project activities intended to support the personal and societal aspects of being a CHW contributed to CHWs' motivation?</td>
<td></td>
<td>Interviews, Questionnaires, Focus group discussions, Most Significant Change</td>
<td>Evidence of the extent to which activities related to personal aspects of being a CHW (capacity development, career development, peer support, being linked to other trainings) are perceived to have affected whether CHWs have the necessary skills to meet the job requirements</td>
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<td>CHWs, Community members (Male and Female), Community leaders, Health facility staff, District MoH Officials</td>
<td>Evidence of the extent to which CHWs having necessary skills to meet job requirements is perceived to have affected CHW job satisfaction Evidence of the extent to which CHWs having necessary skills to meet job requirements is perceived to have affected whether CHWs have access to professional development Evidence of the extent to which CHWs being on a career path that support development and promotion is perceived to have affected CHW job satisfaction Evidence of the extent to which CHWs being on a career path that support development and promotion is perceived to have affected whether CHWs have access to professional development Evidence of the extent to which job satisfaction has contributed to CHW motivation Evidence of the extent to which having access to professional development has contributed to CHW motivation Evidence of the extent to which activities related to societal aspects of being a CHW (community engagement in ID and selection of CHWs, raising awareness among community of CHW R&amp;R, family and community support to CHWs to be able to conduct their activities) are perceived to have affected whether communities have respect and trust for CHWs Evidence of the extent to which community respect and trust for CHWs is perceived to have affected the agency of female CHWs at the household level Evidence of the extent to which community respect and trust for CHWs is perceived to have affected social recognition of CHWs Evidence of the extent to which female CHWs not being financially disadvantaged as result of the CHW role is perceived to have affected the</td>
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<td>2.2 Have project activities intended to support the personal and societal aspects of being a CHW resulted in any unintended outcomes for CHWs?</td>
<td>Interviews Focus group discussions Most Significant Change</td>
<td>CHWs Community members (Male and Female) Community leaders Health facility staff District MoH Officials</td>
<td>Evidence that activities related to personal aspects of being a CHW (capacity development, career development, peer support, being linked to other trainings) are perceived to have led to additional positive or negative outcomes which are not included in the research theory Evidence that activities related to societal aspects of being a CHW (community engagement in ID and selection of CHWs, raising awareness among community of CHW R&amp;R, family and community support to CHWs to be able to conduct their activities) are perceived to have led to additional positive or negative outcomes which are not included in the research theory</td>
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<td>2.3 How have contextual factors affected the design and/or implementation of project activities intended to improve the personal and societal outcomes of being a CHW?</td>
<td>Interviews Focus group discussions Document review</td>
<td>Project staff District MoH officials Health facility staff Existing project documentation</td>
<td>Evidence that an analysis of the political climate for CHWs was accounted for in the design and implementation of personal and societal activities Evidence that an analysis of the current state and structure of the health system was accounted for in the design and implementation of personal and societal activities Evidence that an analysis of the cultural expectations and perceptions of CHWs and community work was accounted for in the design and implementation of personal and societal activities Evidence that an analysis of previous and existing community health worker and other development projects in the implementation sites was accounted for in the design and implementation of personal and societal activities</td>
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<td>of being a CHW and CHW motivation?</td>
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<td>3. What are the key successes and motivations in CHW retention and motivation have</td>
<td>3.1 What notable successes in CHW retention and motivation have</td>
<td>Focus group discussions</td>
<td>Project staff</td>
<td>Examples of successes in CHW motivation and/or retention within sampled projects including project staff perspective on what led to the successes</td>
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<td>challenges in designing and implementing Community Health Worker interventions in order to improve CHW motivation and retention?</td>
<td>3.2 What notable challenges in CHW retention and motivation have project staff experienced, what caused them and how were they addressed?</td>
<td>Focus group discussions</td>
<td>Project staff</td>
<td>Examples of challenges in CHW motivation and/or retention within sampled projects including project staff perspective on what led to the challenges and insight into how they were addressed</td>
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ANNEX B: RESEARCH DESIGN AND METHODS

Research Approach

The focus on CHW motivation and retention puts an understanding of CHW perspective, interpretation of, and response to, project inputs at the centre of the study. As such, the study seeks to understand how CHWs respond to the various project inputs that are intended to improve motivation and how these affect them on a personal, professional and social level.

The study will include analysis of the effect of contextual factors on the achievement of outcomes related to CHW motivation. Within this study, the principal relevant contextual factors will be grouped into the following categories: political climate (including policy environment, policies and legislation that support CHWs, fragility of context in terms of conflict and disasters), state and structure of health system (including extent to which CHW responsibilities remain stable, level of functionality and sustainability of health system and HRH, and community perception of health system), cultural expectations and perceptions of CHWs and community work (including the role of volunteering within local and religious expectations, the effect of age, gender and literacy on CHW acceptance and the perceptions of gender roles and gendered capabilities) and previous and/or existing CHW and/or other development projects (including existence of complementary community demand generation activities, and effectiveness of CHW training).

As the study is theory-based and puts individual experiences at the centre of its focus, it is appropriate to conduct a qualitative study which values and analyses individuals’ experiences of how and why project activities influence motivation levels. Upon consideration of qualitative approaches to research, contribution analysis was selected as the appropriate approach due to its focus on understanding how causal linkages within a project theory work and the extent to which the project activities contribute to the observed outcomes. It was also selected due to its analysis of the complex and changing environment within which projects are delivered and of how this influences the achievements (or non-achievement) of outcomes. The recognition of external factors allows a contribution analysis approach to provide evidence on how and why outcomes have been achieved within the full context of the operational area.

The theory-based approach will be supplemented by documentation of specific successes and challenges encountered within the sampled projects. These lessons learnt will be documented and presented as illustrative examples of successes and challenges, acknowledging the variety of activities involved in a project including those that are not specific to CHW programming. These lessons will provide an insight into the effectiveness of project activities that focus on working with CHWs within the wider project, as opposed to the specificity of the theory-based approach which will hone in on causal linkages within the theory.

The shortcomings of the contribution analysis approach is that it will not measure changes in levels of motivations of CHWs quantitatively. Instead it will seek to understand whether CHWs feel that their motivation has changed and will focus on how and why there have been any changes (both positive and negative). Further the contribution analysis will not quantify the level at which the project activities contributed to the observed outcomes. Additionally, the contribution analysis will not identify whether observed outcomes are attributable to the project, nor will it comprehensively assess the systemic context in which the CHWs operate, such as how the economic systems or the full historic context or power relations affect the achievement of results.

The refined and tested theory, resulting from the research findings, can be used to inform the design and implementation of projects that work with CHWs, and also to structure future monitoring, evaluation and research into Community Health Worker programming. The lessons learnt that are integrated throughout the Findings section of this report demonstrate achievements and challenges within the wider context of the projects and are intended to provide further ideas and suggestions for those designing and implementing Community Health Worker projects.

Research purpose, objectives and questions

As such, the purpose of the research is to:

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• Support national health advocacy priorities, by generating evidence on how CHWs can be motivated which could be presented to Ministries of Health;

• Inform the design and implementation of GSK Health Worker projects and other Save the Children Health and Nutrition projects, by generating evidence on CHW motivation and by documenting learning and good practice from CHW projects within the GSK Health Worker portfolio to date;

• Provide useful evidence on how CHWs can be motivated and retained to other development actors who engage with Community Health Workers in their projects and programmes, by sharing research findings widely.

The ‘purpose’ of the research elucidates how the research is intended to be useful and used, ensuring that a focus on research utility and uptake is maintained throughout the research process.

The objectives of the research are to:

Inform future programmatic decision-making for health projects working with Community Health Workers across Save the Children and sector-wide;

Support advocacy priorities and actions related to human resourcing for health (HRH) in countries of operation and globally.

Gender sensitive data collection and analysis

The research team acknowledged that the experiences of male and female CHWs may vary greatly, as might the experiences of male and female patients, and so a gender lens was applied throughout the research to understand these varied experiences as much as possible. This was taken into account during the sampling of respondents to ensure a gender balance to the extent possible, by matching the sex of Research Assistants with the sex of respondents during interviews, individual data collection and group discussions to the extent possible, and by separating male and female community members for group discussions. The sex of respondents and possible patterns of experience based on gender were considered throughout data coding, analysis and interpretation of findings.

Sampling Approach

The sampling of projects to be included in the research study was done by means of analysis based on an exercise of mapping project interventions related to Community Health Workers. It is pertinent to note in the sampling that there is one relevant GSK-funded Health Worker project per country.

The initial step to the sampling of projects was to map the GSK Health Worker projects in which working with CHWs was a significant component. The mapping tool used to conduct the overview of the GSK Health Worker portfolio reviewed each project’s set of activities (related to CHWs) against the following criteria, using available project documentation as the key sources, including proposals, budgets, reports and Detailed Implementation Plans.

Binary criteria of presence versus absence were used to map projects against the following categories of activities:

• Provision of pre-service training by Save the Children
• Provision of in-service training provided by Save the Children
• Financial incentives provided by Save the Children
• Non-financial incentives provided by Save the Children
• Training of CHW supervisors provided by Save the Children
• Joint supervision of CHWs by Save the Children (alongside Ministry of Health)
• Save the Children quality assurance activities
• Save the Children support to CHW reporting
• Provision of commodities and/or supplies by Save the Children
• Provision of communications materials by Save the Children
• Provision of job aids by Save the Children
• Community demand generation in project
• Nutrition interventions in project
• Support to community referrals to health facility
• National policy engagement/advocacy activities
• District level health systems strengthening activities
20 countries were included in the mapping survey. Ten of these were eliminated from the sample for the following reasons: it is not currently possible to conduct primary data collection due to security risks, they did not include CHWs, they had CHWs who were focused on only one disease or the CHWs had not yet been trained. The projects that had the highest number of interventions that were relevant to CHW programming were included in the research sample. This resulted in the following list of GSK Health Worker projects being sampled:

• Cote d’Ivoire
• DRC
• Mali
• Myanmar
• Senegal

The list of Cote d’Ivoire, DRC, Mali, Myanmar and Senegal was then reviewed against some additional criteria, identified to ensure that findings would be relevant to a range of Save the Children maternal and newborn child health programming. These criteria were: the Fragile and Conflict Affected State rating,14 Save the Children UK’s priority country list for Health, Save the Children UK’s priority country list. The list of sampled projects provides a good range across all these criteria, with a focus on West and Central Africa (due to the regional focus of the 20% Reinvestment Initiative between Save the Children and GSK) but with the inclusion of a South East Asian country.

Sampling of communities within each project will be undertaken on a project-by-project basis and will be informed by the local context in which the project is operating with the support of project staff. The sampling will be done to ensure coverage of the range of variables within key criteria which are developed based on the local operating environment. For example, if a project is delivered in urban and rural settings, then the criteria of “rurality of project site” will be included in the criteria with the variables “urban” and “rural”. This would ensure that both urban and rural communities were included in the sample.

At an individual level, sampling of community members to be included in the research will take into account the following categories: age, sex and minority groups to ensure coverage of variables within these. The definition of minority groups will be set locally to each sampled project with the support of project staff. Community Health Workers will be sampled based on the sampling of communities as all Community Health Workers who operate in the sampled communities will be invited to participate in the study. This approach may introduce bias as it’s likely that the more motivated CHWs will self-select for participation in the study. To mitigate this bias, a snowball sampling approach will be introduced for CHWs, requesting that some of those that are willing to participate identify another CHW or former CHW that they know who is not very motivated in their role or who used to be a CHW but no longer is.

An additional criterion will likely have to be added to the sampling at community level for logistical reasons and will be applicable to all sampled projects: accessibility of community by road.

Within each selected project, four health facilities will be visited, and a number of research participants will be selected in each facility visited:

- All relevant CHWs attached to that facility (this varies from project to project, ranging from 1 to 20. Facilities that have between 8 – 12 CHWs will be sampled.)
- 1 FGD of male community members (8 – 12 members)
- 1 FGD of female community members (8 – 12 members)
- 1 community leader
- 1 health facility staff member who supervises the CHWs

For each project sampled, data will also be collected from:

- Up to 3 district Ministry of Health officials
- At least one project staff member

Secondary data will also be collected from the Ministry of Health and from project records which are related to CHW recruitment, selection, training, incentives, motivation, retention and performance.

14 Department for International Development. 2016. International Development Inquiry: Allocation of Resources Memorandum
Data collection

Primary data collection will be qualitative in nature and will be collected via interviews, focus group discussions and participatory methods including Most Significant Change. Interviews will be conducted with project staff, community leaders, health facility staff members and district level Ministry of Health officials. Focus Group Discussions will be held with male and female community members. The focus group discussions will be conducted with men and women separately to mitigate any concerns about discussing health issues that are specific to being male or female, such as sexual and reproductive health or maternal health issues.

There is a risk of positive bias in asking CHWs about their own motivation levels and this risk is increased when project staff are collecting the data. In order to mitigate this bias, a combination of methods to collect the data from CHWs will be used. Initially, CHWs will form one group and the data collectors will facilitate a force field analysis of CHW motivation, identifying the contributing factors and the limiting factors and discussing the strength of these factors on influencing motivation. This discussion will be audio recorded and its translated transcript, as well as the force field itself, will form part of the qualitative data set. Following this, the facilitator will group the contributing factors into three groups: those related to social aspects of CHWs’ lives, personal, and professional. The facilitator will ask for one of the CHWs to volunteer for a role play in which the CHW should explain to someone considering becoming a CHW what the pros and cons of the role are, focusing on the social aspect of being a CHW. The same role play will be done for person and for professional aspects too. After the three role plays, CHWs will be asked to tell a story to a data collector, individually, which represents the most significant change in their motivation levels since being a CHW. The domains of changes for the Most Significant Change will be: social, personal and professional. Once each CHW has told their Most Significant Change story, the group will select one story for each domain of change which best represents their collective experience. The stories themselves and the discussion during the selection of the most representative stories will be audio recorded, transcribed and translated and will form part of the qualitative data set.

In addition to the above qualitative data collection, a questionnaire will be administered to Community Health Workers which assesses the types of motivation which they have in relation to their CHW work. This questionnaire will only be administered to the qualitative sample of CHWs and therefore will not generate statistically significant data. However, the use of a questionnaire will support the analysis and interpretation of qualitative data by providing an assessment of motivation using an existing validated tool15.

Relevant quantitative data will be identified from existing data sets held by Save the Children project staff or by the Ministry of Health. Quantitative data will be considered to be relevant if it relates to CHW recruitment, selection, training, incentives, motivation, retention or performance.

Data collection will be carried out by Save the Children following the approval of the Ministry of Health and/or other appropriate authorities. It is expected that primary data collection will take four days in each sampled project; however, this is dependent on the distances of the sampled communities from the nearest Save the Children base and on the distances of sampled communities from one another. The number of days of data collection may also be affected by curfew times and the number of Save the Children staff members available to support data collection, and assumes that three Save the Children staff members from the Country Office will be actively participating in the data collection. Six Research Assistants are required in total; therefore additional human resourcing will be brought in specifically for the task.

Save the Children staff members and recruited Research Assistants collecting data will have experience in facilitating interviews and focus group discussions. The principal investigator will spend two days (per sampled project) with those who will conduct the interviews, focus group discussions and participatory sessions, conducting an intensive refresher training on good qualitative data collection technique, participatory methods, reviewing the data collection tools and the information that the research aims to collect, discussing specific terms and vocabulary choices within the tools and practising administering the tools. The refresher training will include reviewing the Informed Consent Form closely and ensuring that each person who will be responsible for collecting data fully understands the process of obtaining informed consent in an ethical fashion.

Ethical considerations

Research ethics, in particular confidentiality and safety will be taken very seriously throughout this study. As such, it will be ensured that all data will be kept confidential during data collection and analysis and when reported upon, all data will be anonymised. Some information, such as location, respondent group and sex will be included in the report as relevant to provide context, but respondents’ names and other identifying factors will not be listed.

Qualitative data collection will be conducted by Save the Children staff members with in-depth knowledge of the sampled project as well as evaluation or research. All data collection tools are annexed to this document in French and English. They can be found in Annex E.

All participants will be briefed on the purpose of the research, of their role, how their information will be used and that if they choose not to participate, this will not affect the services that they or their community receive from Save the Children. Informed consent will be collected from all respondents prior to their interview or participation in focus group discussions, and forms will be used (See Annex E). Consent for participation in the respective projects was established during project set-up; therefore, research participants are expected to be familiar with Save the Children and its health project(s) already, but will be provided with refresher information as part of the Informed Consent process. The form presents options for the respondent to sign or to make their mark, dependent on personal preference, disability or literacy levels.

Respondents will have the opportunity to participate in discussions or interviews in a language in which they feel comfortable and confident speaking. Audio recording of interviews and group discussions will be made where contextually appropriate and safe and with the informed consent of participants. Audio recordings will be transcribed and translated into English by professionals who will be fully briefed on their responsibilities with regard to confidentiality and safekeeping of data.

Additional information on Ethical Considerations is included in the above section of Data Collection, particularly in terms of training those collecting data on obtaining informed consent.

Data analysis

All qualitative data collection will be audio recorded. The recordings will be transcribed by external professional transcribers and translated by external professional translators. The translation process will also include a proofreading and feedback by a third party translation specialist and further edits made by the translator responsible.

All qualitative data collected will be coded and managed using Nvivo software by the research team. De-briefing and reviewing of codes will take place amongst the relevant Research Team members to provide quality assurance and consistency across the data coding process.

Due to the theory-based approach, the analysis will take a deductive approach, using a framework analysis. The framework method for analysis will support the summary of individual and group experiences and provide a useful structure to facilitate sub-group comparison as a means to test the theory. After the initial coding phase, a framework matrix will be developed and shared with Co-Investigators and those actively involved in the research from the sampled projects for discussion and interpretation of emerging findings against the analytical framework of the theory. This will take place shortly after the completion of data coding and will provide the opportunity for revisions to the theory to be proposed and thoroughly discussed.

Following this, more extensive and detailed analysis and interpretation will take place. This will be verified across the Research Team of Principal Investigator, Co-Investigators and those actively involved in the research from the sampled projects. The agreed findings, associated recommendations and revised theory will be included in a final research report.

Study limitations and risks

The study design will focus on causal pathways and implementation processes and does not seek to assess the quantitative impact of the interventions. The limitation of this focus is that the study assumes that measurement of project outcomes and impact is being completed through project monitoring activities; as such the study will rely on perceptions of effectiveness of project interventions, rather than independently verifying their effectiveness.

The research is also limited by its resources, as all research studies are to some extent. To mitigate any effect that this might have on the quality or usefulness of the research, the scope of the research has been revised to ensure
that the research objectives and questions can feasibly be thoroughly addressed through the selected research methods with the given resources.

The research may be limited by data collection logistics, for instance there may be issues with mobilising Community Health Workers, community leaders and community members, particularly in locations where project delivery has been completed, such as Cote d’Ivoire and DRC. Attempts will be made to mitigate this risk by ensuring that mobilisation is done in advance. Other logistical risks include the challenge of accessing project sites, which may be limited as a result of a number of issues, including security risks and effect of weather conditions on usability of access roads.

The research may pose a risk to the Save the Children operations in raising expectations of CHW remuneration. This has been mitigated to the extent possible by clarifying that changes to working conditions are outside the scope of this research. This has been formalised through the Informed Consent Process.
ANNEX C: BIBLIOGRAPHY


Department for International Development. 2016. International Development Inquiry: Allocation of Resources Memorandum


ANNEX D: FURTHER EVIDENCE FROM QUALITATIVE DATA

Section 1: Achieving a shift towards autonomous types of motivation

1.1. Foundational intervention for all motivation types: appropriate, regular financial compensation package
1.1.1. Need for timely payments and appropriate living conditions for CHWs

“Sometimes it is difficult to volunteer as a responsible family member in order to meet the needs of the children” (Male CHW, DRC)

“It’s hard to work properly knowing that he has no money to earn. The health worker has a family to support and needs to provide for.” (Chief, Senegal)

“When health activities disturb their family, they are compelled to stop (Health Facility staff member, Senegal)

1.1.2. Injustice in remuneration leads to demotivation

“NGOs through their activities plan to motivate financially every three months; if we take [our] zone, we have 5 PRN sites and on each PRN site not all Relais are paid.” (Health Facility staff member, Senegal)

1.2. Creating a sense of self-efficacy as a means to improve motivation
1.2.1. ‘Licence to Operate’

“It is true that [CHWs] are good and have the confidence of the community as a result of their work” (Chief, DRC)

ID badges would “make it easier for [CHWs] to pass through the police roadblocks and facilitate their access to families.” (Health facility staff member, Côte d’Ivoire)

“[Badges] allow him to be identified and facilitate his work within the community. If that is lacking, he has trouble doing his job with ease.” (Chief, DRC)

“The [CHW] is mistaken and is not considered or even respected because he must introduce himself at every turn. Sometimes he is driven out by jealous men in their households, this issue needs to be solved with his identification by a uniform.” (Health Facility staff member, DRC)

1.2.2. Enabled to fulfil duties

“Trainings allowed me to do the job well.” (Male CHW, Côte d’Ivoire)

“Training is very important for any job. Our CHW work requires a little knowledge and patience.” (Male CHW, Senegal)
“[The nurses’] collaboration strengthens my technical skills and human relations.” (Female CHW, Senegal)

1.2.3. Pride and confidence in work and achievements

“It is not from our culture that we organize activities to thank them, but nevertheless we sometimes visit them at home to thank them one by one.” (Male Community members, Senegal)

“The community is very happy with me. I am appreciated and proud of myself.” (Male CHW, Cote d’Ivoire)

“After the consultation sessions and treatments, once cured, patients always return to the health worker to thank him. Expressions of appreciation and gratitude will always encourage the health worker.” (Chief, Senegal)

1.3. How essential interventions can lead to a shift in type of motivation, improving the retention and performance of CHWs

“The experience we acquire will allow us to protect the people from diseases and make them abandon the old practices that could harm their health. It is these aspects that motivate me more to remain a CHW.” (Male CHW, Mali)

“When I came to my village, people did not accept family planning. I started the different awareness raising by explaining the pros and cons so that they can accept family planning. Now the community has accepted contraceptive methods…What I do matters a lot for villagers.” (Male CHW, Mali)

Section 2: Improved social status and professional development opportunities are significant to many CHWs, but not essential to all

2.1. Improvements in social status were significant to many

2.1.1. For women

“The financial advantage plus the CHW status has well strengthened confidence and respect in women’s decision-making” (Women from the community, Mali)

“Once I had a problem with my husband about my work as a relay agent. But out of love for the job, I stood up to him and let him know that during my studies, my goal was to work one day, and that my parents did a lot for me. Besides, this job has always been a passion. Then he knew he couldn’t stop me from doing this job. I continued to do my tasks as at the beginning. Today I’m moving region after region to follow trainings and others.” (Female CHW, Senegal)

“Much more confident, and Bajenou Gox, our CHW is the typical example. Since we chose her, she is more active and the community gives her more consideration. Also, she is the only one to decide about health issues in her household. She coordinates everything…She is in charge of almost all the needs of her household and for this reason, she is respected more and more.” (Chief, Senegal)
“Courage, because even if I have not studied before, I could not say or do anything in my home but through the training received, I feel considered in the community and can take decisions” (Female CHW, DRC)

“Thanks to this job, my situation is better, I am respected, listened to, I manage to provide for my family.” (Female CHW, Côte d’Ivoire)

“For me to see ASC women is very interesting, but she cannot have more than this, she must be wise in her work but not make decisions.” (Chief, Côte d’Ivoire)

“Here, if the woman makes greatness it is at this moment that she will have problems; but when she plays modesty it is better.” (Men from the community, Senegal)

2.1.2. Increased respect from community

“The CHWs are more confident and better seen by their community.” (Health facility staff member, Côte d’Ivoire)

“A CHW can have a better position by doing his job well” (Male CHW, Côte d’Ivoire)

“I have found out that I am listened to by my community and then I also have a great responsibility to fulfill in my community.” (CHW, DRC)

“My being chosen allowed me to gain more competence and respect from my community” (Male CHW, Senegal)

“Yes I now know that I have nothing to fear, because old and the young people respect me.” (Male CHW, Mali)

“I’m given a high regard in my community because when they see me they think directly of the training and teaching I give them.” (Female CHW, DRC)

“[The successful treatment of a child that I referred] has given a sense of community and increased trust and respect among us.” (Female CHW, Mali)

2.1.3. Feeling well networked

“It is the fact of being the intermediary between my population and the health centre. I have connections.” (Male CHW, Côte d’Ivoire)

“As a Bajenou Gox, what really pleased me was that I was an intermediary between the community and the government. We are advisors and confidants.” (CHW in group discussion, Senegal)

2.1.4. Improved respect from family
“Our family members always respect us because every decision we take is followed by good results. That is what push them to respect us even more.” (Female CHW, DRC)

“Because I have support mostly from my family and almost everyone else, everyone respects me as a family and although in the community, my word counts a lot.” (Male CHW, Côte d’Ivoire)

2.1.5. Community mockery of voluntary work undermined improvements in social status

“I often receive mockery and criticism because in our custom you have to work to be considered, not volunteering.” (Male CHW, Côte d’Ivoire)

“Opinions are divided, CHWs are doing a good job and changes are palpable in the community but other people make fun of CHWs who do volunteer work and are exhausted instead of looking for a paid job.” (Chief, DRC)

2.2. How professional development opportunities engage CHWs, regardless of their initial type of motivation

“The training I have received is a great service to me. I hope to become an nursing auxiliary or an orderly.” (Male CHW, Côte d’Ivoire)

“Here, we learn the job in order to share the acquired knowledge with other members who wish to work like us, but especially this knowledge can help us work elsewhere one day...” (CHWs in group discussion, DRC)

“Of course, we have an example: a CHW who has become a state inspector, the fact of reaching higher levels also motivates them and they can achieve this through regular training.” (Health Facility staff member, Senegal)

Section 3: Recruiting, motivating and retaining female CHWs in each of the sampled projects

3.1. In Côte d’Ivoire

“It’s complicated. [There’s an] availability problem, their availability is not the same as a man.” (Chief, Côte d’Ivoire)

3.2. In the Democratic Republic of Congo

“Women make it easier for messages to reach the community... CHW women are very committed to awareness raising because they interact better with each other.” (Men from community in group discussion, DRC)

“The participation of the woman is highly desired because she is the one who is at home all the time with the children and the practice of measures of change through her serves as a model for others she is the hub of
3.3. In Mali

“My husband understands and he does not complain, but it’s my mother-in-law who is a little difficult…my husband did not say anything, since the first day I told him, he allowed me to go. On some weekends, I go to visit my husband. My single concern is the education of the children because I have a 15-year-old daughter who is in high school. So she’s with her grandma and the grandchildren don’t listen to their grandma, if no one is there to correct them, there is a problem.” (Female CHW, Mali)

3.4. In Senegal

“Currently I have stopped practicing the profession and remained at home.” (Female CHW, Senegal)

“If you leave home very early you are criticized by people in your household; if you have to take care of your household, you don’t come to the hospital very early, they say you don’t respect your work... it’s very difficult.” (Female CHW, Senegal)
ANNEX E: OVERVIEW OF GSK-FUNDED PROGRAMME

Background to the GSK-funded Healthworker Programme

Save the Children and GSK launched an ambitious, global partnership in 2013, intended to share expertise and resources in order to deliver results for children in developing countries around the world. GSK have committed to a 20% Reinvestment Initiative, in which GSK reinvests 20% of its profits in the Least Developed Countries back into the healthcare infrastructure, contributing to its wider goal across all GSK community investment programmes to improve access to healthcare for 20 million under-served people between 2012 and 2020.

Since 2011, Save the Children has been delivering 20% Reinvestment Initiative (RI) projects in partnership with GSK, as the 20% RI partner for West and Central Africa (WCA). At the time of writing, Save the Children is implementing 20% RI projects in 13 countries and has helped train over 5,000 Health Workers in the past five years. As the partner for WCA, Save the Children are currently implementing, overseeing implementation of, or has recently finished implementing, projects in nine countries across the region (Benin, Burkina Faso, DRC, Liberia, Mali, Niger, Senegal, Sierra Leone, Togo). In addition, Save the Children delivers 20% RI projects in Yemen, Myanmar, Sudan and Haiti. GSK’s other partners, AMREF and Care International, deliver similar health worker projects globally.

In addition to the GSK 20% RI, there are a number of other projects that have been funded by GSK outside of the 20% RI contract, which also have a focus on Health Workers and are explicitly considered by GSK to be ‘Health Worker projects’. As such, the current GSK Health Worker programme covers 16 countries. Save the Children’s portfolio of 13 GSK-funded 20% RI projects and three Health Worker projects. However, for the purposes of this study, projects which have been recently closed are also being included in the portfolio from which the sample has been drawn. Therefore, the full portfolio of GSK Health Worker projects for the purposes of this study includes 16 20% RI projects and four other Health Worker projects. The full list can be found in Annex B of this document.

The GSK Health Worker programme is comprised of projects which have a significant focus on training of and support to various cadres of Health Workers; however, there is a substantial focus within the portfolio on working with Community Health Workers.

Recently, a new GSK Health Worker Programme Strategy was finalised, setting the strategic direction for GSK-Save the Children Health Worker projects in the future. The strategy confirmed the central role of Health Workers, and more specifically Community Health Workers, in Save the Children and GSK’s shared plan for future projects. The completion of one strategy phase of the GSK Health Worker programme and transition to a new strategy phase creating an opportunity for reflection on what has been learnt from the Health Worker projects to date and to use that learning for future project design and implementation. Documenting and sharing the lessons from Health Workers projects to date will allow Save the Children to use learning to inform future programming within the GSK Health Worker programme and across Save the Children’s projects with Community Health Workers.

The following is a list of projects within the GSK-funded Health Worker programme at the time of project sampling:

1. Benin
2. Burkina Faso
3. Cambodia
4. CAR
5. Cote d'Ivoire
6. DRC
7. Guinea
8. Haiti
9. Liberia
10. Mali
11. Mauritania
12. Myanmar
13. Niger
14. Nigeria
15. Senegal
16. Sierra Leone
17. South Africa
18. Sudan
19. Togo
20. Yemen