

FACTORS INFLUENCING MOTIVATION OF VOLUNTARY COMMUNITY HEALTH WORKERS IMPLEMENTING THE COMMUNITY HEALTH STRATEGY: A CASE OF MBEERE SOUTH DISTRICT, KENYA.

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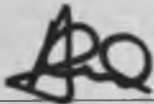
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DECLARATION

This research project report is my original work and has not been submitted for award of any degree in any other university or institution of learning.

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DEDICATION

This work is dedicated to women of reproductive age who endure the challenges of childbearing in Kenya.

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TABLE OF CONTENTS

DECLARATION.....	ii
DEDICATION.....	iii
ACKNOWLEDGEMENTS.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES.....	xiii
LIST OF FIGURES.....	ix
ABBREVIATIONS AND ACRONYMS.....	x
ABSTRACT.....	xii
CHAPTER ONE: INTRODUCTION.....	1
1.1 Background to the study.....	1
1.2 Statement of the problem.....	2
1.3 Purpose of the study.....	3
1.3 Objectives of the study.....	3
1.5 Research questions.....	3
1.6 Significance of the study.....	3
1.7 Delimitations of the study.....	4
1.8 Limitations of the study.....	4
1.9 Assumptions of the study.....	4
1.10 Definitions of significant terms.....	4
1.11 Summary.....	5
CHAPTER TWO: LITERATURE REVIEW.....	6
2.1 Introduction.....	6
2.2 Motivation of community health workers implementing the community health strategy in Kenya.....	6
2.3 Physical incentives.....	6
2.4 Training.....	8
2.5 Support supervision and recognition.....	11
2.6 Community support and expectation.....	13

2.7	Critical review of major issues.....	16
2.8	Theoretical framework.....	17
2.9	Conceptual framework.....	17
CHAPTER THREE: RESEARCH METHODOLOGY.....		18
3.1	Introduction.....	18
3.2	Research design.....	18
3.3	Target population.....	18
3.4	Sampling procedure.....	19
3.5	Methods of data collection.....	19
3.6	Validity and reliability.....	19
3.6.1	Validity.....	20
3.6.2	Reliability.....	20
3.7	Operational definition of variables.....	21
3.8	Methods of data analysis.....	22
3.9	Summary.....	22
CHAPTER FOUR: DATA ANALYSIS, PRESENTATION AND INTERPRETATION.....		23
4.1	Introduction.....	23
4.2	Response Rate.....	23
4.3	Characteristics of Respondents.....	23
4.3.1	Sex distribution of the respondents.....	23
4.3.2	Educational status of the respondents.....	24
4.4	Motivation of Community Health Workers.....	24
4.4.1	The length of service.....	25
4.4.2	Number of hours worked by the CHWs.....	25
4.4.3	Number of duties performed.....	26
4.4.4	Willingness to continue in service.....	26
4.5	Influence of Physical Incentives on the Motivation of CHWs.....	26
4.6	Influence of Training on the Motivation of CHWs.....	27
4.6.1	Type of training.....	27

- 4.6.2 Trainings the CHWs will receive after initial training.....28
- 4.6.3 Frequency of training the community health workers.....28
- 4.6.4 The rating of trainers.....29
- 4.7 Influence of Support Supervision on the Motivation of CHWs.....30
- 4.8 Influence of Community Support and Expectation on the Motivation of CHWs.....31
 - 4.8.1 Relationship with the community.....31
 - 4.8.2 Kind of support received from the community.....31
 - 4.8.3 Community actions that would improve the work of a CHW.....32

CHAPTER FIVE: SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS.....33

- 5.1 Introduction.....33
- 5.2 Summary of the findings.....33
- 5.3 Discussions.....34
- 5.4 Conclusions.....37
- 5.5 Recommendations.....37
- 5.6 Areas for further study.....38

REFERENCES.....39

APPENDICES.....44

- APPENDIX 1 - Introduction letter to the community units.....44
- APPENDIX 2 - Questionnaire for the Community health workers.....45

LIST OF TABLES

	Page
Table 3.1: Community units in Mbeere South district.....	18
Table 3.2: Sample size	19
Table 3.3: Operationalization of variables	21
Table 4.1: Sex distribution of the respondents	23
Table 4.2: Age distribution of the respondents	24
Table 4.3: Community health workers education level.....	24
Table 4.4: Length of service by the CHWs.....	25
Table 4.5: Number of hours worked by a CHW per month	25
Table 4.6: CHWs willing to continue in service	26
Table 4.7: Comparison of the type of incentive and hours worked	27
Table 4.8: CHW training needs.....	28
Table 4.9: Frequency of training to the CHWs	29
Table 4.10: Rating of the training provided to the CHWs.....	29
Table 4.11: Hours that would constitute adequate supervision as per the CHWs	30
Table 4.12: Relationship between the CHWs and the community	31
Table 4.13: Type of support given to the CHWs by the community	32
Table 4.14: community actions which would enhance the work of a CHW.....	32
Table 5.1: Summary of the findings	33

LIST OF FIGURES

Figure 1: The conceptual framework.....	17
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ABBREVIATIONS AND ACRONYMS

AMREF	American Medical Research Foundation
ANC	Ante natal care
APDK	Association of Physically Disabled Association of Kenya
APHIA	Aids Population Health Integrated Assistance
ARI	Acute Respiratory Infection
CARE	Cooperative for Assistance and Relief Everywhere
CBO	Community Based Organization
CHC	Community Health Committee
CHEW	Community Health Extension Worker
CHW	Community Health Worker
CHS	Community Health Strategy
CHU	Community health Unit
CHV	Community health Volunteers
CU	Community Unit
CS	Community strategy
CSO	Civil Society organizations
CRS	Catholic Relief services
DHMT	District Health Management Team
DHO	District Health Office
DPHO	District Public Health Officer
GAVI	Global Alliance for Vaccines Initiative
HENNET	Health Non Governmental Organizations Network

KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package of Health
MOH	Ministry of health
MNCH	Mother and New Child Health
NGO	Non Governmental organization
NHSSP	National Health Sector Strategic Plan
PMCTC	Prevention of Mother To Child Transmission
PSI	Population Services International
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VCHW	Voluntary Community Health Worker
VHC	Village Health Committee
VHW	Village Health worker

ABSTRACT

The Kenya demographic and health survey of 2003 and 2008 revealed declining trends in the main health indicators of Maternal and child health. It is in this backdrop that the ministry of public health and sanitation developed the Kenya Essential Package for Health (KEPH), a life cycle based approach aimed at reversing these trends. The community health strategy is the mechanism through which KEPH is implemented at level 1, the community.

This study was aimed at investigating the factors influencing the motivation of Voluntary community health workers implementing the community health strategy in Mbeere South district, Kenya. The objectives of the study were to determine the influence of physical incentives on motivation of CHWs, to establish how training influences motivation of CHWs, to explore how supportive supervision influences motivation of CHWs, and to determine the influence of community support and expectation on the motivation of CHWs implementing the CHS.

To achieve this, a descriptive survey was carried out in the thirteen community units in Mbeere South district. The target population was 650 CHWs. A 10% sample was drawn from this sampling frame giving a sample size of 65 respondents. Data was collected using questionnaires. Analysis was done using SPSS and findings presented using frequency tables.

The main findings of the study were that initial and continuous training, support supervision and community support have the greatest influence on the motivation of CHWs. Paying CHWs and providing them the information, skills and environment they require greatly influences their motivation. It also established that physical incentives do not have great influence on the motivation of CHWs.

It is recommended that the government should allocate more resources towards Community health strategy to cater for the initial and lifelong trainings for CHWs. The community health extension workers should regularly spend quality time with the CHWs and they should be provided with logistics for this activity. The community should be sensitized on their role in supporting this voluntary workforce.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

The international conference on PHC (Primary Health Care) in Alma Ata, 1978, built consensus on the definition of PHC and outlined the five pillars of PHC (CHAK Times, 2008). PHC implementation in Kenya commenced in early 1980s and contributed to notable gains in the late 80s. However these gains had reversed from the 90s to-date due to: deepening poverty, emergence of new and resurgence of old communicable diseases, HIV/AIDS pandemic, development of drug resistance and so on (MOH, 2006; CHAK times, 2008)

The Kenya demographic and health survey of 2003 revealed the following worsening health indicators; Rising infant mortality , rising under-five mortality , 30.7% of children under five years are stunted, Only 2.6% children are still exclusively breastfeeding at six months, while 56.8% are still breastfeeding by the end of 23 months, 61.5% of under-fives had child health cards. Only 59.2% of children in the second year of life are fully immunized, only 4.3% of under-fives and 4.5% of pregnant mothers sleep under ITNs, Only 40.8% of deliveries are assisted by a health professional and only 39.4% occur in health facilities. Kenya Demographic health survey (KDHS, 2003)

The situation is further complicated by the emergence of new and resurgence of old communicable diseases. The community is then left to cope with growing demand for care. In addition, the cost of health services has escalated well beyond the financing capacity of the Ministry of Health. The result has been deteriorating trends in health status throughout the country. MOH (2006), MOH (2007). This is in part the premise for the evidence based, life-cycle approach to health care introduced in the second national health sector strategic plan (NHSSP II.), MOH (2006).

Kenya's Vision for health is to provide equitable and affordable health care at the highest affordable standard to her citizen (Vision 2030, 2007). Under vision 2030, Kenya will restructure the health delivery system and also shift the emphasis to promotive care in order to lower the national disease burden. This will be achieved through the community health strategy among

others. This strategy entails establishing a level I care unit also known as a community unit to serve about 5000 people, Institute a cadre of well trained voluntary community health workers (CHW) who will each provide level 1 services to 20 households. Every 25 CHWs will be supported by a community health extension worker (CHEW.)

The ministry of public health and sanitation has worked closely with partners to mobilize resources for initiation and maintenance of the community units. By 2009, Kenya had established 1214 units (414 by the government and over 800 by NGOs and CSOs.) (Mwitari, 2009). In eastern province, there were 141 CUs established by the ministry in partnership with AMREF, Aphia II Eastern, APDK, world vision, PSI, GAVI, plan international among others. Thirteen of these are in Mbeere south district.

1.2 Statement of the problem

The Community Health Strategy was launched in 2006 and is viewed as one of the flagship health projects (Vision 2030, 2007; Luoma et al., 2010)). Its coverage is limited and has been hampered by delayed training implementation and funding. Currently only 23.5% of the targeted community units have been established in 83 out of an existing 269 districts(Luoma et al., 2010) The majority of this initiative is not being funded by the government; however, its sustainability depends on Ministry support. Many of the existing community units have been experiencing retention challenges due to uncompensated community health workers (HENNET, 2011).

An evaluation of CHS in April 2010 identified motivation of community health workers as one of the challenges facing the implementation of the community health strategy (Mwitari, 2010). The ministry of public health and sanitation then recommended a performance based incentive of Kshs. 2000 per month per CHW. Although this is a policy directive, no funds have been committed by the government to this end. It is therefore important for the actors involved in implementation of the community strategy to find suitable ways to motivate the CHWs who are a major workforce in the implementation. This study therefore seeks to establish the factors influencing the motivation of voluntary community health workers implementing the community health strategy.

1.3 Purpose of the study

The purpose of this study was to investigate the factors influencing the motivation of community health workers implementing the community health strategy.

1.4 Objectives of the study

The objectives of this study were as follows;

1. To determine the influence of physical incentives on motivation of CHWs implementing the CHS
2. To establish how training influences motivation of CHWs implementing the CHS
3. To explore how supportive supervision influences motivation of CHWs implementing the CHS
4. To determine the influence of the community support and expectation on the motivation of CHWs implementing the CHS

1.5 Research questions

The specific research objectives listed above were converted into the following research questions:

1. Does the preference for physical incentives have an influence on CHWs implementing the CHS?
2. How does training influence the motivation of CHWs implementing the CHS?
3. Does support supervision have an influence on the motivation of CHWs implementing the CHS?
4. How does the community support and expectation influence the motivation of CHWs implementing the CHS?

1.6 Significance of the study

The findings of this study will benefit the CHWs because it will give them a chance to state the factors that affect their motivation causing them to stop rendering their services. Once such factors are known there is a high possibility of the health sector addressing their plight.

The findings of this study are useful to MNCH and child survival programs that use the concept of community volunteers in their work. The results of the research may help the government on

policy formulation, especially the ministry of Public Health and sanitation that intends to roll out the community health strategy in all the sub locations using CHEWs and CHWs as the main workforce. Future researchers will use the findings of this research as part of their reference.

1.7 Delimitation of the study

The study was limited to voluntary community health workers implementing the community health strategy in Mbeere south district, Kenya. Mbeere south district has thirteen community units. They are served by a total of 650 community health workers and 25 Community health extension workers. The study involved data collection from the CHWs who are main workforce in implementation of the community health strategy.

1.8 Limitations of the study

Due to time constraint, the study was conducted in Mbeere south district only. It was also expensive to use a variety of data collection tools. The researcher therefore used questionnaires solely for data collection since their administration was faster and less costly.

During data collection, some of the respondents had a challenge with language. They were assisted with translations of the questionnaires and data collected on the spot. Most Community Health Workers are in farming and small scale business. They were therefore unavailable at home during the day where they had been targeted. This necessitated for organizing to collect data during their scheduled monthly feedback meetings.

1.9 Assumptions of the study

The main assumptions in this study were that the respondents answered the questions correctly and truthfully, that the data collection instruments had validity and measured the desired constructs and that the selected sample size was representative of the population to help in generalization of the results.

1.10 Definition of significant terms

Community health worker/s (CHW/s) workers who live in the community they serve, are selected by the community, are accountable to the community they work with, receive a short defined training and are not necessarily attached to any formal institution (Community Action Network, 2009).

Kenya Essential Package for Health (KEPH) – this is a package of promotive, preventive and curative services designed to specific needs of each cohort in the life cycle given at different levels of health service delivery.

Community Health Strategy/Community strategy (CHS/CS) - An approach by the ministry of public health and sanitation to support the achievement of the goals of second national health sector strategic plan, 2005-2010(NHSSP II) at level 1 which aims to reverse the declining trends in key health sector indicators.

Level I services – It is the basic level of health service delivery. It is designed to provide basic community health services (preventive and simple curative) to households in a formal structure is known as a community unit

National Health Sector Strategic Plan II (NHSSP II) - This is the second and current five year national health strategic plan which aims at revitalizing the health sector strategic one its objective is to bringing KEPH to level 1 through Community Health Strategy is one of its key goals.

Community health unit/ Community Unit (CHU/CU) - A community unit is a local level coordination structure through which people who live in the same geographical area, sharing resources and challenges take an active role in health and health related development issues.

Motivation - Desire to serve and perform effectively as a CHW.

Physical Incentives - Provision of physical things such as money, t-shirts and food.

Support supervision - Supervision given with the honest intention of capacity building and mentoring.

Training - Training refers to the process of developing skills, attributes, knowledge, behavior and experience aimed at improving performance in a specific area or job.

1.11 SUMMARY

In this chapter, we have given an introduction of the research area, giving the background of the study, the problem statement, the purpose of the study, the objectives and research questions, significance, assumptions, limitations and delimitations of the study and finally defining the significant terms to be used in the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviewed literature on motivation of community health workers from global, African and local perspectives. A literature search was conducted using the Internet databases. The key words *motivation, incentives; sustainability, training, challenges, CHWs, and volunteers* were used in different combinations during the search. Grey literature was also considered for review. The review dealt specifically with the influence of Physical incentives, training, support supervision and community support and expectation influence the motivation of community health workers implementing the community health strategy. Finally, the chapter presents a theoretical perspective and a Conceptual Framework of the study.

2.2 Motivation of community health workers implementing the community health strategy in Kenya

The MOH Kenya describes the following as strategies of motivating the Community Health Workers; continuous lifelong training based on the needs expressed by CHWs, religious commitment, giving meaning to service to others, having responsibility over households to which they belong, cultural, religious or economic ties permitting permanent loyalty and reciprocal giving and receiving from members, organizing their work into fixed number of days in a quarter/year, beyond which they must be financially compensated, supportive supervision and coaching as individuals or groups based on need, giving them regular feedback on performance and improvement being made, giving them priority when there are paid jobs for health campaigns and mass treatments, for example, or distribution of communities, encouraging them to take up paid jobs when such opportunities are available and accepting them back when such assignments end and logistical support, regularly providing working materials (Ministry of Health, 2007).

2.3 Physical incentives

By definition a CHW is not usually a full-time salaried employee of the ministry of health (MOH) or other organization. The primary reason is the belief that the MOH cannot afford to pay

CHWs over the long term. Compensation of CHWs for their services, however, is a recurrent issue in many programs. CHWs often work long hours, even full time, alongside salaried employee, which inevitably leads to demands by CHWs for regular compensation for services provided. While full-time salaried CHWs are relatively rare, many CHWs receive some type of cash incentive (UNICEF, 2004).

The main programmatic advantage to cash incentives is the apparently lower attrition rate among paid CHWs. From the CHW perspective, appropriate, respectful, and regular compensation is a sign of acknowledgment and approval that allows them to earn a living or supplement other income. Cash incentives may come in several forms. CHWs may be part of the civil service and be paid a salary. They may also be given a small stipend. Monetary incentives can increase retention. CHWs are poor people trying to support their families. But monetary incentives often bring a host of problems: the money may not be enough, may not be paid regularly, or may stop altogether. Monetary incentives may also cause problems among different cadres of development workers, some of whom are not paid. Nevertheless, some programs have paid CHWs successfully, and many have used in-kind incentives effectively (Bhattacharyya, Winch, LeBan and Tien, 2001)

Some studies from the United States (Ballester, 2005; Scott & Wilson, 2006) have shown a significant drop out of CHWs due to lack of career prospects. Thus career prospects along with salaries are strong incentives in both retaining CHWs, and enhancing their performance. Prasad (2007) alludes that stable, continuous and flexible funding was ensure that CHW efforts can be sustained, be responsive to community needs, and be maximized across an ever-changing health care environment.

Another type of in-kind payment is material items provided by NGOs. Such items are often, though not always, related to the CHW job functions. Successful in-kind payments provided by NGOs have included bags to carry supplies, agriculture tools, raincoats, backpacks, supplies for home improvement, educational materials, herbal plants, fruit trees, identification card with a photo, and free care in MOH inpatient health facilities, certificates presented at public

ceremonies, tee-shirts and training opportunities (Martin L., Hosain M., Casanovas C., and Guyon A. 2008).

Relatively small tokens, such as identification badges, can give CHWs a sense of pride in their work and increased status in their communities. Appropriate job aids, such as counseling cards and regular replenishment of supplies, can ensure that CHWs feel competent to do their jobs. Some programs provide bicycles or motorcycles for CHWs to use but usually not own. Other form of support especially logistics and infrastructure support, drug supplies and equipment have been identified as another weak link in CHW effectiveness. People who completed the Ghana Red Cross training program were allowed to purchase and wear the Red Cross smock or t-shirt. The Red Cross symbol identified them as Red Cross volunteers and provided recognition and respect from their communities and from the MOH (Bhattacharyya et al., 2001).

Even though it may be possible to access Medicaid funds to support financially the work of certified Promotores (as)/CHWs, if funding to sustain the TCAC is not forthcoming, or the training and certification program's infrastructure is removed in some way, there was be no certified Promotores(as)/CHWs to receive Medicaid funding (May, Kash and Contreras, 2005) . Studies in Ethiopia, Malawi and Uganda have shown that without adequate remuneration, community health workers cannot be maintained in the long run (Hermann *et al.*, 2009). Other studies have found that incentives given too often or in too many forms are unsuccessful and demotivating in the long term. Selectively giving payment or food to some communities and not to others can generate animosity among communities and jealousy among families (Bhattacharyya et al., 2001).

2.4 Training

Training is essential if CHWs are to carry out their work effectively. After The Massachusetts Department of Public Health (MDPH) undertook an investigation of CHWs in Massachusetts to inform effective strategies for their support, development, recruitment and retention, it was realized that CHWs require formal training on a continuous basis and continuous supportive supervision to ensure that they can meet the community challenging healthcare needs in times of calm and crisis (Ballester, 2005). A number of studies have found that if regular refresher training

is not available, acquired skills and knowledge are quickly lost and that, on the other hand, good continuing training may be more important than who is selected (Lehmann and Sanders, 2007)

Training covers not only providing preventive, curative, or other relevant services to the community, but also teaching and communicating with community residents. In Nepal more training allowed the community health volunteers (CHVs) to identify causes and treatment of night blindness and to recognize fast breathing as a major sign of ARI (Curtale, 1995). Their ability to deliver treatment increased their motivation. To be effective, training has to be done regularly and continuously, with the needs of the community in mind (Gilson et al., 1989)

On training, Creigler and Hill note that there should be initial CHW training to prepare them for their role and an ongoing training for update on new skills, reinforce initial training and ensure that they are practicing the skills learned. (Creigler and Hill, 2009). Training should be practically oriented and not consist of transferring disease-specific knowledge alone, but also communication and counseling skills. Guidelines and standardized protocols are beneficial tools for initial training (Hermann et al., 2009).

Without the ability to provide treatment or prevention, a CHW can lose standing in the community. The volunteers in the Sri Lanka study stated that they often had to go to the public health nurse midwife to get an answer, and then tell the householder. When that happened, the community lost faith in them and refused to accept any advice given by the volunteer (Walt et al., 1989). Advocacy and development of policies and programs for training and certification programs within states should include attention to a breadth and/or range of substantive and practice skills specializations sufficient to meet the primary expectations and obligations that they are expected to fulfill. The same consideration is essential in the creation of training curricula (May et al., 2005).

The algorithm developed by WHO on managing multiple childhood illness was found to be ineffective as CHWs reported serious difficulties in understanding training manuals (Kelly, Osamba, & Grag, 2001). Similar findings were reported in India by an Oxfam study about CHWs having difficulty in understanding training manuals (Ramprasad, 1988). The findings from the national survey on CHWs in the US suggest on the job-training to overcome these difficulties in understanding training manual (Kash, May, & Tai-Seale, 2007). The review of the CHW

literature revealed a strong need for the training in interpersonal communication and counseling skills, including methods of adult participatory learning. It also noted that continuous training is found to be an essential prerequisite for an effective CHW program and an important factor in retaining their motivation level (UNICEF, 2004).

Those designing training should consider the way material is taught, the place where training is carried out, and relevant skills that strengthen CHWs' ability to educate community members (Ofosu-Amaah 1983; Gilson et al., 1989; Kaseje 1987; Robinson and Larsen 1990). Problem-solving skills are a critical part of the training needed to promote behavior change rather than knowledge accumulation.

Robinson reports that most training should take place in the community. Time spent in hands-on activities increases visibility and reinforces the relationship with the community (Robinson and Larsen 1990). Using other CHWs to assist with the training can help ensure that it is relevant to the local situation. In an adaptation of the training-of-trainers approach in Mozambique, lead activists (the strongest CHWs) were excellent auxiliary trainers, and their assistance reduced the time and costs of Continuous training has been cited as "an essential prerequisite for an effective CHW program" (Frankel 1992) and an important factor in retaining the motivation of workers, in light of the short training periods available and the low levels of education of most CHWs (Ofosu-Amaah, 1983).

Evidence from Bangladesh suggests that the level of institutional support in training and retraining, program management and supportive supervision by health workers greatly determine the sustainability of the CHW scheme (UNICEF, 2004). Refresher training allows the CHWs to learn new skills, take on new challenges, and interact with peers, keeping the job interesting and promoting personal development. In their manual :improving child health through nutrition, Tina and Murray, recommend that health workers should receive adequate training and tools to provide appropriate nutritional counseling, give micro nutrient supplements , access ,classify and treat sick children (Tina and Murray, 1997).

In Kenya, continuous training provided enough motivation for the village health helpers to continue working even without financial support (Kaseje,1987). Training is clearly a critical and ongoing part of any CHW program.

Many VCHWs expressed that receiving ongoing mentoring and support, as well as certification for what they have done, would motivate them to work even harder. One worker explained the satisfaction and recognition she obtained from receiving a certificate. As she explains, this has “facilitated my work because it was given to me in the presence of the community. It is therefore very pleasing. The community is very receptive to us when we make house visits.” Similarly, workers believe that evaluations or performance reviews serve as good incentives for them to work harder. CHW perspective: certification and standardized training validates the value of the work of CHWs, provides greater opportunities for reimbursement of CHW services, equips them with greater community building capacity, and offers opportunity for personal growth(May et al., 2005)

2.5 Support supervision and recognition

SOVEREIGNTY OF NATIONS
"KUNYU I IRROAD"

Typically, after the initial training a CHW's relationship with the rest of the health system is limited to what is usually called supervision. CHWs need to feel through supportive supervision and appropriate training that they are part of the health system (Bhattacharyya et al., 2001). Supervisors can give CHWs opportunities to discuss problems, exchange information, and take advantage of continuing education. Supervisory visits help reduce the feelings of isolation that often accompany a CHW's occupation. To be effective, supervisory visits should be regular and based on a common understanding of the purpose of the visit. CHWs appreciate good supervision given with the honest intention of capacity building and mentoring. In Guatemala supervised CHWs had attrition rates two to three times lower than those of unsupervised CHWs because their link with outside experts gave them higher status (Parlato and Favin, 1982).

While often beneficial, close contact with health staff can create problems when CHWs compare themselves with professional health workers. For example, CHWs in Colombia affiliated with health institutions such as hospitals felt that their work was undervalued and that they were treated differently from the other health workers and assistants, even though they performed the same tasks. This perception was seen as a major demotivater and reason for attrition (Quinones, 1999). People also questioned whether community health workers actually empowered or oppressed as a result of the existing, socioeconomic political structures, bureaucracies, and lack of support from health professionals, Rosato, et al., 2008). For example, a study in South Africa

describes the relationships between professional nurses and CHWs, and how one viewed the other as a “threat” in their career. In such unhealthy competitive situations, it is not possible to have an effective “referral system” in place (May & Contreras, 2006). However, the Namibian experience shows that through mutual understanding on agreed roles and responsibilities, it would be possible to have positive inter-personal relationships (Low & Ithindi, 2003).

The evidence from the field shows that regularity of supportive supervision and appropriate refresher training helps to sustain the interest and motivation of CHWs to do their assigned tasks (UNICEF, 2004). In an attempt to unify a model of practice for CHWs and care givers in South Africa, Fieldman recommends that Technical support, mentoring and monitoring of CHWs should be provided by CHF, accountable to the DHM. Skilled health professionals such as palliative care nurses could provide technical support and supervision to improve the quality of home based care programmes. To achieve functional integration within complex settings within homes of vulnerable individuals, generic CHWs should supervise and coordinate the work of single purpose CHWs (Fieldman, 2004). Ongoing professional backup that is comprehensive and aimed at gradual improvements in quality is far preferable to sporadic high profile activity. (Friedman et al., 2007).

Curtale et al. (1995) study of the impact of a nutrition intervention on a CHW programme found that “continuous supervision diminishes the sense of isolation that CHWs usually experience in the field and helps to sustain their interest and motivation to do their assigned tasks”. Lack of supervision, mentoring, and encouragement is a common theme and a reason why CHWs become discouraged (Martin et al., 2008).

When supervision is inconsistent, CHWs may not feel supported by the health system. Ensuring that supervisors are trained to supervise and soliciting the community’s involvement in supervision can increase retention of CHWs and help ensure their long term sustainability in the community. CHWs should be employed by CHCs or some other representative CBO, who would also provide a governance function. Funding for the CHCs should be made by a provincial DoH grant channeled through an accredited Training and Supervision Service Provider, probably itself a provincial scale NGO (Fieldman, 2004).

Crigler and Hill summarize twelve programmatic components for an effective community health worker program. On incentives they note that there should be a balanced incentive package that includes financial incentives, such as salary and bonuses and non financial incentives such as training, recognition, certification, uniforms medicines etc. that is appropriate to the work expectations (Crigler and Hill, 2009).

2.6 Community support and expectation

Prevention is extremely hard to sell in all public health programs. When curative care is offered, it is generally more welcomed and appreciated by the residents (Frankel 1992; Heggenhougen et al., 1987; Curtale et al., 1995). A report from Tanzania noted that “CHWs have expressed frustration at not being able to provide the quality of services demanded by the community and therefore want further training in curative medicine” (Heggenhougen et al., 1987). With disappointment on the part of the villagers and feelings of inadequacy among the CHWs, the relationship has been “characterized by a lack of support from the community....” The Tanzania report states that “unless the community’s expectations change, the lack of support for the CHWs will be aggravated if the preventive role predominates over their curative activities....”

“Credibility of CHWs is highly dependent on the workers’ curative role,” found Parlato and Favin (1982). A lack of curative skills may be a disincentive for CHWs, compromising their standing in the community. (Gilson et. al.,1989). Given a choice between preventive and curative care, community members demand more curative care (Walt et al., 1989), and problems often arise when CHWs cannot meet community demands.

The respect and status of CHWs in their communities unquestionably increases when they have drugs at their disposal., In their review of 52 projects, Parlato and Favin (1982) found that “CHWs’ credibility suffers when drug supplies are irregular.” Recent experience with recruiting CHWs from practicing drug sellers and pharmacists has shown that this strategy makes drugs available, gives the drug sellers greater prestige, and greatly reduces attrition (Ishan, 2001). A study in Colombia (Robinson and Larsen 1990) found that the community had more influence on the CHWs than the health system, contrary to widely held assumptions. If the community and not the health system is the primary reference group for CHWs, then feedback from the community

has a significant influence on motivation and performance. This study suggests that the supervisor should ask, "How can my contact with the CHW contribute to further development of the relationship with the community?" These findings indicate that a health facility or NGO supervisor should foster more positive interactions and dialogue with community members on pertinent issues.

Communities understanding of their own role in changing their health status can help sustain the CHWs' activities. Community members should be informed of the job description, capabilities, and commitment of CHWs (Frankel 1992; Ofosu-Amaah 1983; Heggenhougen 1987; Walt et al., 1989). If the communities understand what the CHWs are trained to do, there is less chance that residents' expectations of a CHW was go unmet Community understanding was also reduce inappropriate demands and frustrations (Heggenhougen, 1987). Although they are often regarded as neighborhood resources for health and nutrition information, some feel that they do not receive enough respect from their community. A number of CHWs interviewed in Madagascar encountered opposition during home visits from those who questioned what made them "experts" and why someone from their own social class and community should tell them how to care for their children (Martin et al., 2008).

Ideally, a CHW should be chosen with the input of the community so that residents' health needs are considered and they respect and feel comfortable interacting with the CHW for their health services. Several programs have mentioned the support of the community as an incentive for CHWs. Trust, prestige, mobility, and social interaction are other factors that are favorably mentioned (Walt et al.1989; Kaseje 1987; Lysack and Krefting 1993; Ruebush 1994). Many CHWs volunteer because they enjoy serving. The community's interest in sustaining a CHW program is based in large part on evidence of positive changes in health status because of the CHW or on benefits such as effective referrals to health facilities. Visible change is limited by the predominance of preventive health in a CHW's work. One way CHWs and communities can create visible change is to monitor simple health indicators over time. In Eastern Province, Zambia, communities use risk maps to monitor indicators such as immunization status and availability of latrines. Households using color codes to mark indicators, such as green for fully immunized children and red for those not fully immunized (Bhattacharyya and Murray, 1997). The collection and analysis of health information to chart changes in behavior (for example, more

use of health services) or health status (for example, fewer cases of dehydration) allows CHWs to show the communities the results of their work.

Praise and respect from community residents and peers can motivate CHWs positively and increase their length of service. The appreciation of the people they serve is a strong incentive that is often cited as important to CHWs' job satisfaction. Increased community recognition and acceptance of the work of VCHWs was found to further motivate them. Minnesota International Health Volunteers has trained about 2,000 community volunteers in Uganda for a variety of tasks. Community recognition has proved to be a valuable tool in motivating and retaining community volunteers by increasing their status in the community. About 70 percent of them have been elected to various positions on their local councils since becoming volunteers (Mullins, 2000).

From evaluating various studies Prasad, concludes that what is eventually important in sustaining the motivation of CHWs to function with commitment and effectiveness is the degree of trust and confidence that CHWs have gained from community members over a period of time. (Prasad, 2007). The western Kenya project to promote vaccinations has made steady progress towards achieving its goal for immunization, but many say that its real success has been the way it has helped to build a new level of intersectional and interfaith collaboration in many communities of the region. This collaboration has *paid off* by stimulating the construction of latrines and helping create better access to clean water (One county, 1996).

However, only a few studies have demonstrated the importance of building healthy "inter-relationships" and "trust" among health professionals for developing an effective feedback and referral system (Bhattacharyya et al., 2001). But studies from Colombia have also shown that "feedback and rewards from the community" are more significant in the overall motivation and performance of CHWs (Robinson & Larsen, 1990; Prasad 2007).

Overall, community health workers are most successful when they have the respect and support of governments, public service workers, and the communities they serve (Rosato et al., 2008)

2.7 Critical review of major issues

From the issues raised above by various writers, it is obvious that there is no tidy package of incentives that would ensure motivated CHWs who will continue to work for years. Rather a complex set of factors affect CHW motivation and attrition. While CHWs' success rate is often lauded in the early stages of a new and exciting project, their motivation diminishes over time unless frequent steps are taken to maintain their enthusiasm for their essential but voluntary role. Despite all what has been written, it is important to note that none has been on a large scale CHW program in Kenya especially the community health strategy.

This research was therefore interested in finding out the factors that influence motivation of CHWs implementing the community health strategy. It was localized to Mbeere south district in Eastern province to find out how the factors play out in this area.

2.8 Theoretical framework

Within the area of motivational theories, there are two groups. The first is content theories and the second is process theories. Content theories, also known as needs theories (Lundberg et al, 2009), are static and have the emphasis on what motivates people for example, what specific things that motivates employees. The leading theories within content theories are Maslow's hierarchy of needs, Herzberg's two-factor theory and Alderfer's ERG model. Process theories were developed to explain human behaviour on the basis of different human characteristics. The aim is to investigate how personal characteristics interact and form our behaviour. Some of the most well known process theories are; equity theory by Adams, goal theory by Locke, and expectancy theories.). In their study to see if traditional motivational theories can be applied to volunteers, Jesen and Kristiansen (2010) found good evidence to support the Herzberg's two factor theory. Therefore the variables used in the study relate to hygiene factors and motivators. Training, community support and expectation fall under the motivator factors while support supervision and physical incentives fall under the hygiene factors.

2.9 Conceptual framework

The following section presents the conceptual framework on which the study was based.

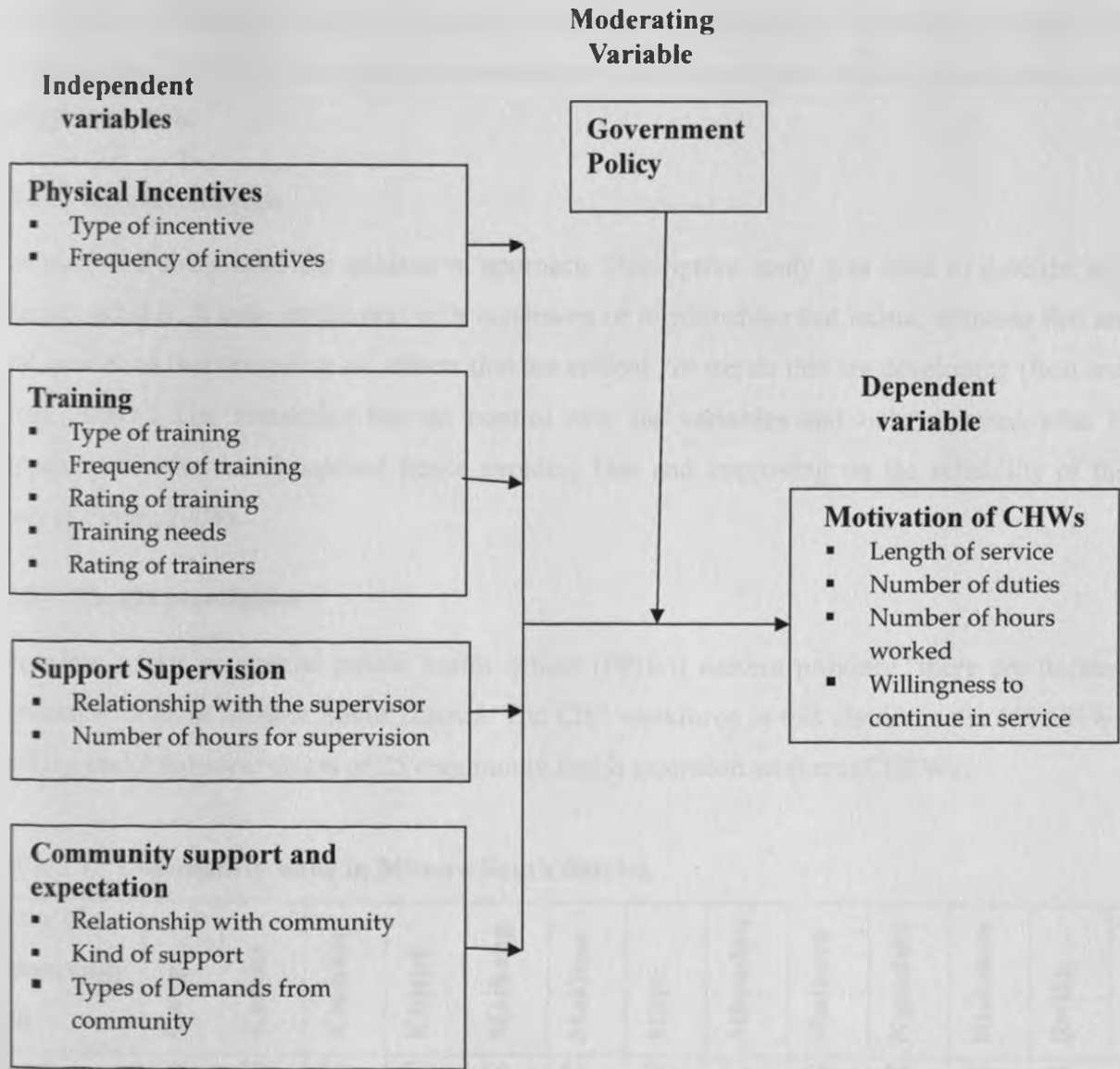


Figure 1: Conceptual framework

Motivation of community health workers is dependent on various independent variables. Consideration was given to four independent variables that have an effect on the motivation of community health workers. The variables are; preference for physical incentives, training, support supervision and community expectation and support.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains the design of the study, the target population and the sample design. The chapter also explains the data collection methods and instruments used. It also explains how data analysis was done.

3.2 Research design

The proposed study used the qualitative approach. Descriptive study was used to describe and interpret what is. It was concerned with conditions or relationships that exists, opinions that are held, processes that are going on, effects that are evident, or trends that are developing (Best and Khan, 2009). The researcher has no control over the variables and only reported what is happening or what has happened hence avoiding bias and improving on the reliability of the study (Kothari, 2004).

3.3 Target population

According to the provincial public health officer (PPHO) eastern province, there are thirteen community units in Mbeere South District. The CHS workforce in this district is the 650 CHWs working under the supervision of 25 community health extension workers (CHEWs)

Table 3.1: Community units in Mbeere South district.

Name of Community unit	Gategi	Karaba	Kiamber	Kiritiri	Machang	Makima	Mbita	Mbondon	Mutuova	Nganduri	Riakanau	Rwika	Wachoro	Total
No of CHWs	50	50	50	50	50	50	50	50	50	50	50	50	50	650
No of CHEWs	2	2	2	2	2	2	1	2	2	2	2	2	2	25

Source: Mbeere South DPHO's office, January 2011

3.4 Sampling procedure

The sampling frame was divided into homogenous group hence stratified random sampling was used. The sub groups consisted of the community health extension workers and the community health workers. Mugenda and Mugenda (2003) citing Gay (1981) observes that for correlational research, 30 cases or more are required: for descriptive studies, ten percent of the accessible population is enough and for experimental studies, at least 30 cases are required per group. Since this was a descriptive study, a 10% sample was drawn from the target population. This gave a sample size of 65 respondents as shown in the Table 3.2 below;

Table 3.2: Sample size

	Population	Percentage	Sample size
Community health workers	650	10	65

3.5 Methods of data collection

The data for the study was collected by the use of questionnaires. These questionnaires had open ended and closed questions. The closed questions included an array of choices/answers from which the respondents choose. Such questions were easier and quicker to answer and the responses were more comparable among respondents. The questionnaires were distributed using drop and pick method. This method enabled the researcher to agree with the respondents on the duration of time to be taken to fill the questionnaires and when to collect them. Telephone contact was established to ease follow up.

3.6 Validity and reliability

Patton (2001) argues that reliability and validity are two factors which any qualitative researcher should be concerned about while designing a study. White (2002) emphasizes the need to build into the research design the concept of validity and reliability. Validity is concerned with the idea that the research design fully addresses the research questions and objectives. Reliability on the other hand is about consistency in research, and whether another researcher could use the same design and obtain similar findings.

3.6.1 Validity

The questionnaires were validated through a pilot with a sample of respondents taken from Kithimu community unit in Embu West district. This was confirmed the reliability of the structure, question sequence and meaning of questions. An analysis was done on the pilot study. This helped identify items which need amendments before the actual data collection. Instrument validity was also ensured through expert advice of the supervisor and other members of the department.

3.6.2 Reliability

Instrument reliability refers to the level of internal consistency, on the stability of the measuring device (Thorndike and Hagen, 1961). It is the degree to which the test score are free from measurement errors (Best 1981). The test-retest method was used where a part of the sample was used to test reliability.

3.7 Operational definition of variables

Table 3.3: Operationalization of variables

Objectives	Variables	Indicator	Measurement	Scale measurements	Level of analysis
To measure the level of motivation of CHWs implementing CHS	<ul style="list-style-type: none"> Motivation of CHWs 	<ul style="list-style-type: none"> Level of motivation 	<ul style="list-style-type: none"> Length of service Number of duties Number of hours worked Willingness to continue in service 	<ul style="list-style-type: none"> Ratio Ratio Ratio nominal 	<ul style="list-style-type: none"> frequency tables, percentages and graphs
To determine the influence of physical incentives on motivation of CHWs implementing the CHS	<ul style="list-style-type: none"> Physical incentives 	<ul style="list-style-type: none"> Value of the incentive 	<ul style="list-style-type: none"> Type of incentive Frequency of incentives 	<ul style="list-style-type: none"> Nominal Ordinal 	<ul style="list-style-type: none"> frequency tables, percentages and graphs
To explore how supportive supervision influences motivation of CHWs implementing the CHS	<ul style="list-style-type: none"> Support supervision 	<ul style="list-style-type: none"> Adequacy of supervision time 	<ul style="list-style-type: none"> Relationship with the supervisor Number of hours for supervision 	<ul style="list-style-type: none"> Nominal Ratio 	<ul style="list-style-type: none"> frequency tables, percentages and graphs
To establish how training influences motivation of CHWs implementing the CHS	<ul style="list-style-type: none"> Training 	<ul style="list-style-type: none"> Quality of training 	<ul style="list-style-type: none"> Type of training Frequency of training Rating of training Training needs Rating of the trainers 	<ul style="list-style-type: none"> Nominal ordinal Nominal 	<ul style="list-style-type: none"> frequency tables, percentages and graphs
To determine the influence of the community support and	<ul style="list-style-type: none"> Community support and expectatio 	<ul style="list-style-type: none"> Kind of support 	<ul style="list-style-type: none"> Relationship with community Kind of 	<ul style="list-style-type: none"> Nominal Nominal 	<ul style="list-style-type: none"> frequency tables, percentages and graphs

expectation on the motivation of CHWs implementing the CHS	n		support ▪ Types of Demands from community	♦ Nominal	
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3.8 Methods of data analysis

At the end of the data collection exercise all component instruments were assembled. A code sheet was developed for each instrument and then the coded information was entered into a matrix and analyzed using the SPSS (Statistical package for social sciences) software.

The result of analysis was presented in form of frequency tables, percentages and graphs depending on the appropriateness. The research findings were presented in tabular forms alongside background information and the discussion and conclusions drawn from the results.

3.9 Summary

In summary, the chapter presented the research design that was used in the study. The study was carried out in the thirteen community units in Mbeere South district. The target population was 650 CHWs implementing the community health strategy in the Mbeere south district. A 10% sample was drawn from the sampling frame giving a sample size of 65 respondents. Data was collected using questionnaires. Analysis was done with the help of SPSS and findings presented using frequency tables and graphs.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.1 Introduction

This chapter presents the findings of the study. The data collected was analyzed and presented by use of percentages, frequencies and graphs generated through the SPSS computer software. The data is then interpreted to give meaning and address the questions of the study.

4.2 Response rate

A 100% response rate was achieved in this study. This was made possible by the deliberate self administration of the questionnaires. This was done during the CHWs monthly feedback meeting.

4.3 Characteristics of the respondents

4.3.1 Sex distribution of the respondents

This section covers the bio data of respondents under the following headings: Sex distribution of the respondents, age distribution and education status of the respondents.

Table 4.1: Sex distribution of the respondents

	Frequency	Percentage
Male	22	33.8
Female	43	66.2
Total	65	100

Table 4.1 above shows that from the total sample of 65 participants 33.8% were Male and 66.2% were female. The results show that more males than females participated in this study. Most of the community health workers in the study were aged between 41-50 years (66.2%), followed by 41-50 years (16.9%) and the least are over 50 years at 6.2%. as shown in Table 4.2 below.

Table 4.2: Age distribution of the respondents

<i>Age group</i>	<i>Frequency</i>	<i>Percentage</i>
21-30 years	7	10.8
31-40 years	43	66.2
41-50 years	11	16.9
Over 50 years	4	6.2
Total	65	100

4.3.2 Educational status of the respondents

As shown in table 4.3 below, majority of the CHWs have attained at least the secondary level of education. Only 16.9 % of the CHWs had primary level of education. This shows that all the CHWs have the ability to read and write as stipulated in MOH guidelines.

Table 4.3: Community health workers educational level

Educational level	Frequency	Percentage
Primary level	11	16.9
Secondary level	44	67.7
Polytechnic	1	1.5
Collage	9	13.8
Total	65	100

4.4 Motivation of community health workers

The parameters that were used to measure the motivation of the community health workers were the length of service, the number of duties performed, number of hours worked and the willingness to continue in service.

4.4.1 The length of service

As indicated in Table 4.4 below, the study found out that less than half (47.7%) of the respondents have worked for more than four years with the majority (49.2%) having worked for between one and three years. The MOH guidelines stipulate that a CHW should be able to volunteer for a period of at least five years.

Table 4.4: Length of service by the CHWs

	Frequency	Percentage
Less than 1 year	2	3.1
1-3 Years	32	49.2
More than 4 years	31	47.7
Total	65	100

4.4.2 Number of hours worked by the CHW per month.

Asked about the number of hours they work in a month, 49.2% indicated that they work for over five hours a month. The rest work between 1-5 hours with only one respondent indicating working for less than an hour in a the month. Given that a CHW is expected to work with 20 households and to conduct household visits every month, working for less than five hours a month would amount to under working and could be an indicator of low motivation of the CHWs. See Table 4.5 below.

Table 4.5: Number of Hours worked by a CHW per month.

No. of hours worked	Frequency	Percentage
Less than 1 hour	1	1.5
1-2 Hours	13	20
3-5 Hours	19	29.2
Over 5 Hours	32	49.2
Total	65	100

4.4.3 Number of duties performed

Majority of the CHWs are conducting their duties. Health education was the highest scored with 95.4% score. This was closely followed by home visits and feedback meetings with 90.77% and 87.69% respectively. Making referrals was also another of the leading duties of the CHWs at 87.69%. Asked whether they perform any duties not in their official roles, Charity work and fund raising were identified as the major unofficial duties performed by the CHWs.

4.4.4 Willingness to continue in service

Almost all the CHWs are willing to continue offering their services as CHWs. Only one out of the 65 CHWs interviewed was not willing to continue with the CHW work as shown in Table 4.6 below. The reasons given for willingness to continue were cited as good work environment, regular work schedules, supervisor support and allowances.

Table 4.6: CHWs willing to continue in service

	<i>Frequency</i>	<i>Percentage</i>
Yes	64	98.5
No	1	1.5
	65	100

4.5 The Influence of Physical Incentives on Motivation of CHWs

As indicated before, the more the numbers of hours in service the higher the motivation. Table 4.7 below compares the types of incentives and hours worked. On average, those who received more incentives have correspondingly given more voluntary time in their service as CHWs.

Table 4.7: Comparison of the types of incentives and hours worked

	<i>Incentives</i>							
		None	Monthly allowance	Bags	Tee-shirts	Lessos	Free treatment at the health facility	Other,
Average, hours worked each month as a CHW	Less than 1 hour	0	1	1	1	0	0	1
	1-2 Hours	0	9	6	7	3	3	7
	3-5 Hours	2	8	3	12	3	3	8
	Over 5 Hours	3	14	7	15	9	6	17
Total		5	32	17	35	15	12	33

4.6 The Influence of Training on the Motivation of CHWs

Under this section, the study sought the influence of training on the motivation of community health workers. Key parameters used were; the type of training, the frequency of the training, the training the CHWs will receive after the initial training, the availability of an initial training and the CHW ratings of trainings.

4.6.1 Type of training

All the CHWs indicated having been given some training when they started working as CHWs. A training on stigma reduction, making referrals, report writing, HIV AIDS, tuberculosis Malaria and FP were fronted as the initial trainings received. Other kind of training included the PMTCT and reproductive health training. Comparing the trainings received with the duties performed indicate a good level of preparation of the CHWs before embarking on their official duty. But comparing the training types with the additional roles they have to provide, there is still a gap as they have to do resource mobilization without formal training on methods.

4.6.2 Trainings the CHWs will receive after the initial trainings

Asked about the type of trainings they will receive after their initial trainings, most of the CHWs repeated the same trainings that they had received during the initial training. This may mean a lack of understanding of the question or it could be an indicator of poor trainings received by the CHWS. Table 4.8 below shows that all the respondents still want more training on HIV&AID/TB/malaria/cancer/typhoid/MCH/ANC/PMTCT/ and stigma management despite being the main training topics at the CHW initiation stage.

Table 4.8: CHW training needs

	frequency	Percentage N=165
Dealing with PWA/defaulters tracing	10	6%
Disease management/first aid/drugs- dosages and administration	14	8%
Fundraising/resource mobilization/facilitation skills	11	7%
Community strategy/leadership/computer/gender based violence & guidance and counselling	9	5%
Health & development/mentoring techniques/ making referrals	16	10%
Management/ organisation skills/social life education	11	7%
Proposal/report writing, records keeping & resource mobilization	8	5%
HIV & AID/TB/malaria/cancer/typhoid/MCH/ANC/PMTCT/ and stigma management	63	38%
Signs/symptoms of minor illness & treatment, midwife	23	14%
Total Responses	165	100%

4.6.3 Frequency of training the community health workers

According to the MOH, there is a basic CHW training followed by lifelong training as a motivator and as the need arises. When the CHWs were asked about the frequency of training they have received in the last one year, 71% did not have any training, 20% had been trained once while only 9% had been trained more than once as shown in Table 4.9 below. This was said to

have been occasioned by lack of funds and pull out of a major partner (APHIA II Eastern) who had provided trainings.

Table 4.9: Frequency of training to the CHWs

Number of trainings	Frequency	Percentage
None	46	71%
Once	13	20%
More than once	6	9%
Total	65	100%

4.6.4 The rating of trainers

The Ministry of public health and sanitation and the APHIA Plus were cited as the main bodies providing training to the CHWs. When asked to rate the kind of training received, a majority of the CHWs rated it as good. Only 24 % thought the training was fair with 10% feeling that the trainings were excellent .Table 4.10 captures these findings.

Table 4.10: Rating of trainings provided to the CHWs.

	Frequency	Percentage
Fair	15	24%
Good	42	67%
Excellent	6	10%
Total	63	100%

4.7 The influence of support supervision on the motivation of CHWs

The MOH guidelines stipulate that the CHEW has a duty to provide support supervision, technical advice and train the Community health workers. 63 out of 65 respondents correctly identified the CHEW as their supervisor. When asked about their relationship with their supervisor, only 11% rated this as fair with the rest calling their relationship good or excellent. 50% of the respondents reported that they receive over 5 hours of guidance and technical support every month. A cross tabulation of the number of hours for the supervision and whether it was adequate supervision, revealed that 38 out of the 64 persons who responded to this question considered the time to be adequate supervision. The other 28 respondents who felt that they are not receiving adequate supervision gave Varying lengths of what would constitute adequate supervision with the majority (75%) saying that over 6 hours would be adequate supervision. These findings are captured in Table 4.11 below.

Table 4.11: Hours that would constitute adequate supervision as per the CHWs.

	Frequency	Percentage n=28
1-2 Hours	1	4%
3-5 Hours	6	21%
6-10 Hours	11	39%
Over 10 Hours	10	36%
Total	28	100%

The study findings were that the main challenges with support supervision include; poor transport means, inadequate resources, poor time management and control and lack of commitment. Lack of adequate meeting time was the biggest challenge scoring 41%.

4.8 The influence of community support and expectation on the motivation of CHWs

The parameters used to gauge the influence of community support and expectation on the motivation of CHWs were: the relationship with the community, Kind of support and the types of demands from the community.

4.8.1 Relationship with the community.

The respondents felt that they had a good relationship with the community. Only 8 per cent rated their relationship with the community as fair as shown in table 4.12 below. Because of the good relationship with the community, they had opportunities like village meetings, church gatherings, provincial administrative meetings, community dialogue days and special events to give feedback or receive feedback from the community members.

Table 4.12: Relationship between the CHWs and the community

	Frequency	Percent
Fair	8	13%
Good	46	72%
Very Good	10	16%
Total	64	100%

4.8.2 Kind of support received from the community

The respondents enumerated that they receive support from the community e.g encouragement, praise, appreciation, logistical support and participation as shown in Table 4.13 below. However they had frustrations that although the community comes to them with their demands, they are not able to meet these demands all the time. This makes them feel sorry and inadequate. 1% of the respondents felt like resigning and another 1% was indifferent.

Table 4.13: Type of support given to the CHWs by the community.

Type of support	Frequency	Percentage; N= 65
None	2	3%
Encouragement/praise/appreciation	44	68%
Material gifts	2	3%
Transport and other logistics	2	3%
Participation	52	80%
Other.	8	12%
Total	110	

4.8.3 Community actions that would improve the work of a CHW

Table 4.14: Community actions which would enhance the work of a CHW

	Frequency N=180	Percentage
Appreciate, encourage and act on what has been taught	23	13%
Training and provision of minor illness drug kits	17	9%
Motivation of the CHWs and the community	13	7%
Community action plan and programs be owned by the community	28	16%
Cooperation (Punctuality, united, supportive, active, help without pay, follow instructions etc)	99	55%
Total Responses	180	100%

Asked about what can be done by the community to enhance their work, the CHWs had diverse suggestions as shown in Table 4.14 above. Cooperation was the mode action occurring 55 % of the time.

CHAPTER FIVE
SUMMARY OF FINDINGS, DISCUSSIONS, CONCLUSIONS AND
RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the findings, discussions, conclusions and recommendations as well as suggested areas for further investigations.

5.2 Summary of the findings

The study sought to assess the factors influencing the motivation of community health workers implementing the community health strategy. The summary of findings generated from this study, will be based on the four objectives set for this study. Table 5.1 below provides the summary of findings.

Table 5.1: Summary of findings.

Objective	Tools for data collection	Type of analysis	Main findings
To determine the influence of physical incentives on motivation of CHWs implementing the CHS	Questionnaire	Descriptive statistics	The findings of the study were that CHWs who received more incentives have correspondingly given more voluntary time in their service as CHWs. It also found out that where incentives are given, the CHWs are more willing to continue rendering their service.
To establish	Questionnaire	Descriptive	On the influence of training on the motivation of

how training influences motivation of CHWs implementing the CHS		statistics	CHWs, Training itself has been cited as a motivating factor. Also lifelong training helps to keep the CHWs relevant to the dynamic health period that they are working in. The CHWs still felt that they needed more training and that they should be consulted on what to be trained on.
To explore how supportive supervision influences motivation of CHWs implementing the CHS	Questionnaire	Descriptive statistics	For this objective, the main findings are that the CHWs felt inadequate when left on their own. They in fact wished that the CHEWs could increase the number of contact hours. They were not happy with the many challenges that face supportive supervision.
To determine the influence of the community support and expectation on the motivation of CHWs implementing the CHS	Questionnaire	Descriptive statistics	The study found out that the CHWs were motivated by any form of community support. Most even cited that praise and cooperation are the key actions by the community that would increase their motivation. However, unmet community expectations were strong de-motivators leaving most CHWs feeling sorry or inadequate.

5.3 DISCUSSION

Previous studies have established that a health system cannot function effectively without

sufficient number of skilled, motivated and supported workers (Prasad & Muraleedharan, 2007).

An earlier study by IDS health and development Information Team (2008), suggested that CHWs need financial and nonfinancial incentives if they are to carry out their work effectively. The findings of the current study were that CHWs who received more incentives have correspondingly given more voluntary time in their service as CHWs. It also found out that where incentives are given, the CHWs are willing to continue rendering their service as CHWs. This is contrary to previous studies that had found out that incentives given too often or in too many forms are unsuccessful and de-motivating in the long term (Bhattacharyya et al, 2001).

A number of studies have found out that if regular refresher training is not available acquired skills and knowledge are quickly lost and that on the other hand, good continuing training may be more important than who is selected (Lehmann and Sanders, 2007). The current study found out that few CHWs had received training in the period of a year. It also established that although the CHWs had received trainings on various topics, they still needed more training on the same areas meaning a loss of knowledge and skills in that area. This is in agreement with the study by Lehman and Sanders cited above. Another study by UNICEF noted that continuous training is found to be an essential prerequisite for an effective CHW program and an important factor in retaining their motivation level (UNICEF, 2004). On the influence of training on the motivation of CHWs the current study found out that training itself is a motivating factor. Also lifelong training helps to keep the CHWs relevant to the dynamic health period that they are working in. The CHWs still felt that they needed more training and that they should be consulted on what to be trained on.

Contrary to a study in south Africa that described the relationship between professional nurses and CHWs and how one viewed each other as a "threat" in their career (May and Contreras,

2006). the current study found out that the CHWs describe their relationship with their supervisors as good or very good. This is in agreement with the Namibian experience which shows that with mutual understanding on agreed roles and responsibilities, it would be possible to have positive interpersonal relationships (Low & Ithindi, 2003). The current study findings are that the CHWs felt inadequate when left on their own. They wished that the CHEWs could increase the number of contact hours. They were not happy with the many challenges that face supportive supervision and recommended that addressing these challenges would enhance their work.

A report from Tanzania noted that CHWs have expressed frustration at not being able to provide the quality of services being demanded by the community and therefore want further training in curative medicine (Heggenhougen et al., 1987). A study in Colombia (Robinson and Larsen, 1990), found out that feedback from the community has a significant influence on motivation and performance. The current study found out that the CHWs were motivated by any form of community support. Most CHWSs cited that praise and cooperation are the key actions by the community that would increase their motivation. This is in agreement with a study by Mullins and that by Prasad. Mullins found out that community recognition has proven to be a valuable tool in motivating and retaining community volunteers by increasing their status in the community (Mullins, 2000). After evaluating various studies, Prasad concludes that what is eventually important in sustaining the motivation of CHWs to function with commitment and effectiveness is the degree of trust and confidence that CHWs have gained from community members over a period of time (Prasad, 2007). The current study also found out that providing avenues for feedback from and to the community are strong motivating factors for the CHWs. However, unmet community expectations were strong de-motivators leaving most CHWs feeling sorry or inadequate.

5.4 Conclusion

Based on the findings of this study, it can be concluded that Motivation of voluntary CHWs implementing the community health strategy in Mbeere south district is influenced to a great extent by the independent variables in the study. Further training would motivate the CHWs as well as being consulted on what to be trained on. Motivation can also come from the community support in terms of cooperation and recognition. Supportive supervision is a form of motivation and should be improved by increasing the number of contact hours and addressing the challenges that face support supervision. Finally, physical incentives is not a strong factor in motivation of community health workers as the study found out that the incentives to the CHWs were minimal and that they continued with their work as CHWs even after the major partner who was providing these incentives had pulled out.

5.5 Recommendations

From the study, the following recommendations are made to motivate Community health workers implementing the community health strategy.

1. The researcher recommends that the government should allocate more resources towards Community health strategy. The need to have community units set up in every sub location compounded by the need for initial and lifelong training requires setting aside a significant amount of resources that cannot be left at the hands of donors.
2. The community health extension workers should regularly supervise the CHWs. Logistics for supervision should be available. This can be through provision of motor cycles and Fuel. The CHEWs should purpose to spend quality time with the CHWs during such activities.
3. The community should be sensitized on the role of CHWs and their role in supporting this voluntary workforce.
4. Physical incentives should also be maintained for CHW programs.

5.6 Areas for further study

Based on the findings of this research study, the following are suggestions for further study.

- Current attrition rates in CHW programs and how they can be reduced.
- How to sustain long-term CHW programs and to retain Volunteer health workers.
- What combination of incentives yields best motivation?

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Appendix 1: Introduction letter to the community units

Dear Sir/Madam

Factors influencing the motivation of community health workers implementing the community strategy, the case Mbeere South district.

I am currently carrying out a masters' research on the above topic in order to determine and share insights in the area of motivation of CHW implementing the community health strategy. I am attached to the University of Nairobi, school of continuing and distance education.

You have experience that will be of value to this research and very much wish to know your views on the motivation of community health workers. I hope you will take out a few minutes and fill out the questionnaire I have attached.

I am aware of the need to treat the responses with utmost confidentiality. No source, individual or organization will be identified. The output will be in form of summarized ratings from all participants.

Yours faithfully,



Agrivina Muthoni.

Appendix 2: Questionnaire for the CHWs (community health workers)

Thank you for taking the time to complete this survey. Your answers will provide a voice for the community health workers in Kenya and help to support and promote the CHW work. The information you provide is anonymous and confidential.

Please circle the letter next to your answer or fill the blank space when provided.

SECTION I – GENERAL INFORMATION

1. What is your Sex?

A Male B Female

2. What is your age bracket?

A under 20 B 21-30 C 31 -40 D 41- 50 E over 50

3. What is the highest level of school you attended?

A Primary level

D College

B Secondary level

E University

C Polytechnic

F None

SECTION 2: PHYSICAL INCENTIVES

4. How long have you worked as community health worker?

A Less than 1 year B 1-3 years C More than 4 years

5. On average, how many hours do you work each month as a community health worker?

A Less than 1 day B 1-2 days C 3-5 days D over 5 days

6. What benefits if any do you get as a result of being a community health worker?

- a. None
- b. Monthly allowance
- c. Bags
- d. Tee-shirts
- e. Bags

- f. Lessos
- g. Free treatment at the health facility
- h. Other, specify-----

7. What activities do you currently do as a community health worker?

- a. Health education/information
- b. Make referrals
- c. Home visits
- d. Support groups
- e. Health actions
- f. Case management
- g. Feedback meetings
- h. Case management
- i. Data entry/capture
- j. Community organizing
- k. Follow up to referrals
- l. Fundraising/proposal writing.
- m. Charity work eg. Building toilets for less the aged.
- n. Other Specify:-----
- o. Other , specify: -----

8. Which of the answers you checked above (in question 3) are not included in your official roles and responsibilities or what extra activities do you do beyond what you volunteered to do? (Circle all that apply)

- a. Health education/information
- b. Make referrals
- c. Home visits
- d. Support groups
- e. Health actions
- f. Case management
- g. Feedback meetings
- h. Case management
- i. Data entry/capture
- j. Community organizing
- k. Follow up to referrals
- l. Fundraising/proposal writing.
- m. Charity work eg. Building toilets for less the aged.
- n. Other Specify:-----
- o. Other , specify: -----

9. Would you like to continue offering services as a community health worker?

- A Yes
- B No

10. Why do you or why don't you feel like continuing with offering CHW services? Circle all that apply

If "Yes" why

- A. Good work environment
- B. Regular work
- C. Supervisor support
- D. Stable funding
- E. Allowances
- F. Other, specify -----

If "No" Why

- G. Poor work relations
- H. Irregular hours
- I. Lack of support
- J. changes in funding sources
- K. Irregular/Poor pay allowances
- L. Other specify-----

11. How many households are under your care?-----

12. What are up to three biggest barriers you face doing your work? (for example : not enough support, not enough training, lack of services/ supplies for clients, many households under your care, lack of transport facilities etc.)

i-----

ii-----

iii-----

13. What are up to three things that would make your job easier or more effective?\

i-----

ii-----

iii-----

SECTION THREE: SUPERVISION

14. Who is your supervisor-----

15. How would you rate your relationship with your supervisor?

- A poor B Fair C Good D excellent

16. Does your supervisor have experience working as a community health worker?

- A No B Yes C I don't know

17. On average, how many hours of supervision (guidance, technical support etc) do you get each month?

- A Less than 1 hour B 1-2 hours C 3-5 hours D over 5 hours

18. Do you consider this enough time for you to be effective in your work?

- A Yes B No

19. If "No" what would be enough time?

- A 1-2 hours B 3-5 hours C 6-10 hours D over 10 hours

20. Please write up to three problems you face, if any, with supervision. Please remember that this survey is completely anonymous. (If none, write "None")

i-----
ii-----
iii-----

SECTION FOUR –TRAINING

21. What kind of training did you receive when you began working as a CHW? (Circle all that apply.)

- a) I received no training when I began working as CHW
- b) HIV/Aids, Tuberculosis, Malaria, Family planning
- c) Health and development
- d) Treatment of minor ailments
- e) Counseling/mentoring techniques
- f) Making referrals
- g) Report writing
- h) First Aid
- i) Safety
- j) Leadership training
- k) Management /organizing skills
- l) Fundraising/resource mobilization
- m) TB DOTs
- n) Integrated management of childhood illnesses
- o) Stigma reduction

p) Other , specify -----

22. **What sorts of training have you or will you receive after your initial training? (circle all that apply)**

- a. I received no training when I begun my job
- b. HIV/Aids, Tuberculosis, Malaria, Family planning
- c. Health and development
- d. Treatment of minor ailments
- e. Counseling/mentoring techniques
- f. Making referrals
- g. Report writing
- h. First Aid
- i. Safety
- j. Leadership training
- k. Management /organizing skills
- l. Fundraising/resource mobilization
- m. TB DOTs
- n. Integrated management of childhood illnesses
- o. Stigma reduction

p. Other , specify -----

23. **Who provides your training? (Tick all that apply)**

- A Ministry of public health and sanitation
- B Aphia plus
- C Other, specify-----

24. **In general., How would you rate the training?**

- A Poor B Fair C Good D Excellent

25. **Are you paid during the training?**

- A Yes B No

26. **Do you receive any form of recognition for training such as certificate, ceremony e.t.c.?**

- A Yes B No.

27. **Are you consulted on the kind of training you need?**

- A Yes B No.

28. Please list up to three training topics you feel important for you as a community health worker.

i) -----

ii) -----

iii) -----

SECTION 5: COMMUNITY EXPECTATION AND SUPPORT

29. In your opinion, what is the relationship between you and your community

A Poor B Fair C Good Very good

30. What are the available opportunities for you to give or receive feedback from the community members? (Circle all that apply)

- a. None
- b. Village meetings
- c. Church gatherings
- d. Provincial administrative meetings
- e. Community dialogue days
- f. Special events
- g. Other, specify-----

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31. What support do you receive from the community to help in your work? (Circle all that apply)

- a. None
- b. Encouragement/praise/appreciation
- c. Material gifts
- d. Transport and other logistics
- e. Participation
- f. Other, please specify-----

32. Does the community come to you with their demands?

A Yes B No

33. Are you always able to meet their demands?

A Yes B No

34. If "No" what does it makes you feel?

- A Sorry B Inadequate C like resigning D Indifferent

35. Suggest what can be done by the community to enhance your work as community health worker? (Up to three suggestions)

- i. -----
- ii. -----
- iii. -----

THE END

THANK YOU FOR RESPONDING TO THE QUESTIONNAIRE