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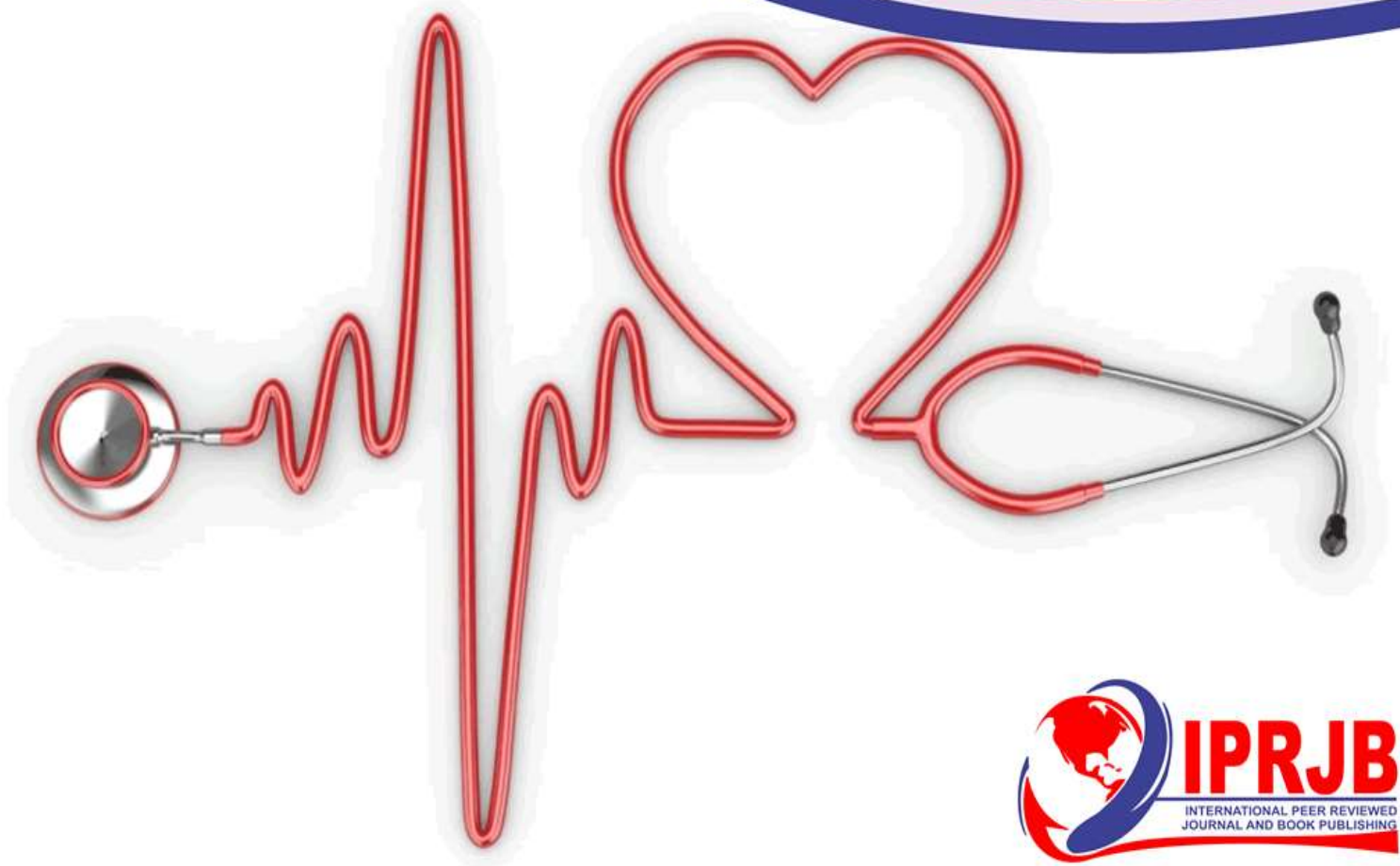
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Influence of the Health Provider Non-Financial Incentives on Motivation of CHPs for Provision of Community Health Services in Voi Sub-County, Taita Taveta County

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Influence of the Health Provider Non-Financial Incentives on Motivation of CHPs for Provision of Community Health Services in Voi Sub-County, Taita Taveta County



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Abstract

Purpose: The study aimed to assess the influence of the health provider non-financial incentives on motivation of chps for provision of community health services in Voi Sub-County, Taita Taveta County

Methodology: A cross-sectional research design was used, employing various data collection methods such as questionnaires and key informant interviews. The primary population included 1,394 CHPs, with a sample of 310 selected via cluster sampling. Additionally, 40 members from the Sub-County Health Management Team (SCHMT) and 12 from the County Health Management Team (CHMT) were purposively sampled. Pre-testing of the tools ensured their validity and reliability, followed by a baseline survey before any interventions. Quantitative data were analyzed using SPSS version 26, while qualitative data underwent thematic analysis.

Findings: The findings indicated that CHPs exhibited high levels of motivation, which correlated with several non-financial incentives. CHPs acknowledged certain health provider non-financial incentives, these did not significantly affect their motivation, thereby upholding the null hypothesis.

Unique Contribution to Theory, Practice and Policy: This suggests a critical need for enhanced support in this area. To enhance CHP motivation, the study recommends developing structured career pathways, improving recognition systems, strengthening supply chains, and tailoring non-financial incentives. Future research should focus on longitudinal studies, regional comparisons, financial incentive impacts, qualitative insights, and the correlation between CHP motivation and community health outcomes.

Keywords: *Health Provider, Non-Financial Incentives, Motivation, CHPs, Community Health Services*

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INTRODUCTION

Non-financial incentives are those positive rewards that can inspire and engage employees in a manner that money cannot. They are not part of an employee's compensation and often cost an organization little or no money, but have a substantial impact on healthcare worker motivation (Zulfiqar et al., 2010). Non-financial incentives include possibilities for professional advancement, ability to work in an appealing and stimulating work atmosphere, significant and demanding work, interesting job designs, recognition and success, which are considered as part of the formal health-care system. CHPs are being engaged by both the county and national governments and are utilized mostly in out-patient departments when there is a surge of clients and patients or when professional health personnel are in low supply (Bhutta et al., 2010). Motivation improves recruitment, retention, and performance of CHPs, which is impacted by non-monetary incentives such as community praise and uniforms, among others (Ormel et al., 2019).

Community Health Promoters (CHPs) refer to a group of community health assistants recruited, trained, and working in the communities from which they were appointed from (Ministry of Health [MOH], Kenya, 2020). A definition of CHPs that is more universally accepted is that they are individuals within a community who volunteer in their own neighborhoods, and are chosen to work for them willingly, and are directly accountable to them. They act as a critical point of connection between their neighborhoods and the official health systems, and are supported by them, but they are not necessary required to be members of any association nor possess formal academic qualification (Oliver et al., 2015). CHPs have also been recognized as community members who have undergone some form of training on healthcare delivery in order to offer basic healthcare services to their communities but are non-members of the formal healthcare workforce. They are considered as health workers whose basic responsibility is to improve access to healthcare services and serve as change agents by facilitating community involvement and participation in order to improve health outcomes (Singh et al., 2015). Another most popular terminology for CHPs include frontline workers, lay health workers, health volunteers, community health workers (CHWs), non-specialist healthcare practitioners, and village health agents (van Ginneken et al., 2013). Their work spans a variety of areas, including administration of vaccines, bed net distribution, prenatal care, and treatment of chronic illnesses including Acquired Immune Deficiency Syndrome (AIDS) and Tuberculosis (Koon et al., 2013; Saeterdal et al., 2014; Scott et al., 2015; Tripathi et al., 2016). Studies have shown that CHPs have a number of benefits over their professional counterparts. They can improve the cultural relevance of health materials and information, and they can also influence how the healthcare system is run. They can also find it simpler to interact with the community and win patients' trust.

CHPs collaborate with a health facility in their region of operation which is known as a link health facility. This is the health institution which could be a dispensary, health center or a hospital to which they refer patients whom they are not able to manage and whom they feel require specialized medical care (MOH, Kenya, 2020). A study conducted by Tripathy et al. (2016) on motivation of CHPs, revealed that training, career development opportunities and regular support supervision as factors motivating CHPs. It further showed that community support and recognition are environmental motivating factors to the CHPs. It also determined that non-financial motivators such as interpersonal connections, family support, and career

chances deserve more attention, and that frequent need-based training is required to sustain high levels of motivation among the CHPs.

In another study by Ankomah et al. (2016), whose main objective was to establish the role of non-financial incentives on CHPs (n=150) at Komfo Anokye Teaching Hospital in Ghana, non-financial incentives such as a pleasant work atmosphere, training and career growth, mere acknowledgment, and appreciation were shown to be the most important motivators for CHPs. The study also revealed that age, gender, and professional history all have significant impact on how much people are driven by non-financial motivators. In comparison to adult CHPs, young CHPs (18-29 years) were largely (84%) motivated by training.

Another study by Kok et al. (2019) in Tanzania whose main objective was to establish incentive preferences of voluntary community-based health mobilisers (n=69), found out that a variety of factors motivated voluntary community-based health mobilisers. The majority of health mobilizers were driven to do their job by a strong aspiration to help their community. The most often reported extrinsic motivators were community and supervisor recognition, the availability of supporting resources, trainings, identification, supervision, and feedback. It further stated that, while becoming a community-based mobilizer is optional, incentives, particularly those of a non-financial character, are key motivators among the CHPs.

Training of CHPs

According to Creigler and Hill, (2009), training is one of the most important requirement for the CHPs to carry out their work effectively and efficiently. This study further indicated that there should be an initial training to prepare the CHPs for their future roles, and an on-going update on skills to re-inforce the initial training and ensure they practice their skills they learnt. Another study conducted by Ballester, (2005) on motivation of CHPs, showed that continuous training and support supervision empower CHPs to execute their duties effectively and meet the growing health needs of their respective communities which they serve. In another study by Lehmann & Sanders, (2007), also revealed that irregular refresher trainings contribute to loss of acquired skills, knowledge and the right attitude among the CHPs, and therefore continuous training is more important than who is actually selected to serve as a CHP

Training of CHPs in Kenya is being guided by a national curriculum which has got two modules namely; basic and technical. The training is conducted by the Community Health Assistants in collaboration with other health officials who are drawn from the sub-county or their nearest health facility which the CHPs will be expected to serve (Kenya Community Health Strategy [KCHS], 2020-2025). On completion of the prescribed training, the CHPs get motivated when they are awarded certificates in a public ceremony within their respective communities (Martin et al., 2008). A balanced incentive package which include both financial and non-financial incentives such as; bonuses, trainings, certification, recognition, uniforms and medical kits for the CHPs to be able to realize their expectations in the course of executing their services are needed (Creigler et al., 2009).

Table 1: CHPs Training Modules

Basic Modules	Technical Modules
1. Community health & development	1. Community IMCI
2. Community governance and leadership	2. Hygiene, sanitation & water
3. Communication, advocacy & social mobilization	3. Maternal and newborn care,
4. Promotion & prevention of diseases	4. Reproductive health
5. First aid skills	5. HIV-AIDS, Tuberculosis, Malaria, & Covid-19
6. Community health information management and use	6. Community nutrition
7. Community disease surveillance.	7. Non-communicable diseases

Source: MOH (2020-2025)

Support Supervision of CHPs

According to Oxford Dictionary, (2023), support supervision is defined as an art of guiding, mentoring, instructing and encouraging staff so that they can improve their competencies and ultimately their performance. It is a teaching and learning process to ensure workers execute their work well and use the available resources efficiently and effectively.

After their initial training, the CHPs need to be followed up through regular support supervision for them to feel that they are part and parcel of the health systems (MOH, Kenya, 2020). Support supervision provides an opportunity for the CHPs to discuss challenges, exchange information, and learn from one another as well as from their immediate supervisors. Effective support supervision should be objective and regular (Bhattacharyya et al., 2001). A study conducted by Parlato and Favin, (1982) in Guatemala, whose results indicated that regularly supervised CHPs had an attrition rate two to three times lower than those not being supervised. This is because regular support supervision helps to sustain the interest as well as the motivation of the CHPs (UNICEF, 2010). Again results of another study conducted by Lehmann et al., (2018), showed that appropriate training, supervision, and logistics support greatly motivate CHPs and thus enhanced performance in services delivery

Preferential Treatment for CHPs

According to Kithuka et al. (2016), preferential treatment basically means that CHPs are served without having to queue with other community members for social services either by the community members or by the healthcare providers. CHPs, for example when visiting a health facility seeking for medical care, they should be able to be attended to first so that they can go back to their respective communities to continue serving them, this significantly motivate them. A study conducted by Robinson and Larson, (2007), indicated that some healthcare programs have demonstrated some appreciations to the CHPs for their work through preferential treatment such as first-in-line medical care at the health facilities, and availing credit facilities to them.

Statement of the Problem

Despite adequate available evidence from studies showing a significant link between use of CHPs and improved healthcare access (Datiko et al., 2017), CHPs still face myriad of challenges notably; inadequate, irregular and delayed incentive practices, inadequate supervision and supplies, which have contributed to insufficient motivation among the CHPs

(ROK, 2010). Insufficient motivation prevents CHPs full contribution towards the realization of national development agenda such as PHC, UHC and Vision 2030 (Tulenko et al., 2013).

Consequently, CHPs drop out of service, in Kenya drop-out rate is estimated at 33% (Olang'o et al., 2010), in Taita Taveta County at 29% (Kenya Red Cross & British Red Cross, 2021). CHPs have been receiving unpredictable financial incentives, thus conflicting with their personal economic activities, and affect the quality of their work (Kenya Community Health Policy, 2020-2030).

Non-financial incentives are favorable in low- and middle-income countries, because use of financial incentives on motivation of CHPs has largely proven to be unsustainable (Lusambili et al., 2021; Mbugua & Mwitari, 2017).

Despite the available evidence on the importance of engaging CHPs for the improvement of healthcare access, there has been scanty studies and attention on non-financial incentives on motivation of CHPs in low- and middle-income countries (Kithuka et al. 2016). Therefore, this study will be looking at those incentives that are feasible, acceptable and sustainable for the motivation of CHPs.

Theoretical Framework

Intrinsic Motivation Theory; it states that someone does something without clear external incentives, he or she does it because it is delightful, entertaining, intriguing, and gratifying rather than because of an expectation of an external incentive or pressure to do it, such as a gift. Autonomy, purpose, and mastery are the three fundamental components of intrinsic motivation. When individuals can act on their own initiative, believe that their efforts count, and experience fulfillment from mastering new skills, they are intrinsically motivated (Ryan & Deci, 2000).

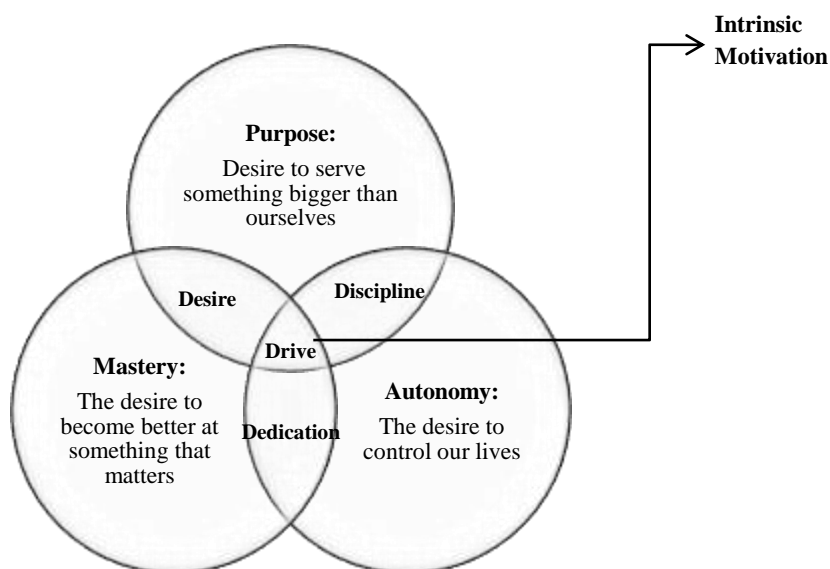


Figure 1: Intrinsic Motivation Theory

Source: Pink, (2009)

Non-financial Incentives Model Implementation Phases

According to Bobby Milstein and Tom Chapell, (2020), during the planning phase, the researcher identifies appropriate stakeholders, and sets specific outcome targets, and avoids

overpromising the esteemed beneficiaries. He or she coordinates his or her efforts with those of other stakeholders and continuously assess the potential efficacy of the intervention, and establishes priorities for allocating resources, and program timelines. During the implementation phase, the researcher establishes the partnerships required, agree on roles and duties, take inventory of what has been achieved, and eliminates unwanted impacts. He or she further explains how the overall initiative operates, how different stakeholders can cooperate, what each stakeholder is expected to perform, how to determine whether the program is effective, why it will be effective, and how resource investments will be employed

METHODOLOGY

The research design that was adopted in this study was a cross-sectional design. The research was carried out in Voi Sub County. The primary target population were Community Health Promoters, who were 344 in total, working within their respective Community Health Units, and who are active, and conduct monthly meetings at their link health facilities. Additionally, 10 Sub-County Health Management Team members, and 12 County Health Management Team members, directly involved in the coordination and support supervision of basic community health services within their areas of jurisdiction, were targeted for this research as secondary target population. 310 CHPs participated in the study, who were chosen using cluster sampling from the sampled sub-county of Voi. The 4 SCHMT members and 4 CHMT members were chosen using purposive sampling. Data from CHPs were collected using a semi-structured questionnaire. The motivation of CHPs was measured using a modified Community Health Promoter Motivation Indicator Scale borrowed from Close-to-Community (CTC) Provider Motivational Indicator Scale developed by Vallières et al. (2020). Key Informant Interviews (KIIs) were used to collect qualitative data from the SCHMT members, as well as the CHMT members. The Key Informant Interviews were conducted by the researcher using an interview guide (Appendix 5) to collect qualitative data. Content analysis was used to analyze qualitative data from the key informant interviews and the open-ended questions in the questionnaire. The SPSS analytical tool, version 26, was used to examine the quantitative data and coded categories. The findings were presented using tables, figures and prose.

RESULTS AND DISCUSSIONS

Non-Financial Incentives and CHPs Motivation

This section presents a descriptive analysis of CHPs perceptions regarding the availability of non-financial incentives in their work environment, importance of the non-financial incentives, and their level of CHPs motivation. Non-financial incentives are integral to motivating and sustaining CHPs' commitment to health promotion and community engagement. The specific non-financial incentives examined in this study encompass a range of factors, including CHPs' expectations of future opportunities, non-financial incentives provided by health providers, and access to health commodities. Understanding CHPs' perceptions of these incentives is essential for optimizing their effectiveness and retention in community health programs. By analyzing these perceptions, this study aims to illuminate the factors that influence CHPs' motivation, thereby informing strategies to enhance support systems and maximize the impact of CHPs in improving health outcomes within their communities.

The study employed multiple sets of 5-point Likert scales to gauge respondents' opinions on various constructs. The scale ranged from 1 to 5, with 1 indicating "strongly disagree," 2 representing "disagree," 3 indicating "indifferent," 4 signifying "agree," and 5 denoting "strongly agree." Each point on the Likert scale was standardized with a width of 0.8, calculated

as $[(5-1) \div 4]$. As a result, the scale delineated mean ranges as follows: 4.21 to 5 for "strongly agree," 3.41 to 4.2 for "agree," 2.61 to 3.4 for "indifferent," 1.81 to 2.6 for "disagree," and 1 to 1.8 for "strongly disagree." This approach facilitated a systematic evaluation of respondents' perceptions regarding the constructs examined in the study.

Perceived Availability of Health Provider Non-Financial Incentives

The survey assessed the perceived adequacy of non-financial incentives provided to Community Health Promoters (CHPs) by health providers. Results indicate high satisfaction among CHPs in several key areas including training, mentorship, supervision, peer engagement, and opportunities for additional responsibilities, with mean scores ranging from 4.24 to 4.47 on a scale of 1 to 5. These findings suggest that CHPs generally feel well-supported in these aspects of their roles. The corresponding frequencies further supports these findings, revealing that 93.5% of CHPs feel they have received adequate training, 90.5% report having assigned mentors, and 93.9% express satisfaction with the support supervision sessions they receive. Additionally, 92.5% of respondents feel they have opportunities to connect and engage with peers, while 92.5% also agree that they can assume additional responsibilities beyond their primary tasks. These findings suggest that CHPs generally feel well-supported in these aspects of their roles. The standard deviations, varying between 0.737 and 0.927, suggest moderate to somewhat high variability in perceptions, implying differing levels of perceptions on the adequacy of these incentives provided to CHPs. Negative skewness values (-1.613 to -2.455) indicate that the responses are concentrated towards the higher end of the scale, indicating strong agreement and positive sentiment towards these incentives.

However, there are areas for potential improvement, particularly in CHPs' perceptions regarding receiving certificates for training and accessing medical services without waiting. The mean score for receiving certificates is 2.61, with 59.7% of respondents indicating disagreement, suggesting a significant concern regarding the lack of certification. Similarly, access to medical services without waiting has a mean of 2.86, with 50.5% of CHPs expressing dissatisfaction. The standard deviations, varying between 1.350 and 1.525, suggest high variability in perceptions, implying responses are more spread out, suggesting a more varied opinion among CHPs regarding the adequacy of these incentives. Positive skewness values (0.180 to 0.540) indicate that the responses are concentrated towards the lower end of the scale, suggesting that the majority of CHPs do not find the incentives adequate, highlighting areas that need improvement or reconsideration in the support provided to CHPs. Table 2 presents the results.

Table 2: Availability of Health Provider Non-Financial Incentives

Statements	1		2		3		4		5		Mean	Std Dev.	Skewness Statistic	Std. Error	
	N	F	%	F	%	F	%	F	%	F					%
I have been trained as a CHP.	293	12	4.1	5	1.7	2	0.7	87	29.7	187	63.8	4.47	.927	-2.455	.142
I get refresher/update trainings after the initial training.	293	6	2.0	18	6.1	4	1.4	147	50.2	118	40.3	4.20	.898	-1.613	.142
I get certificates for every training I receive.	293	65	22.2	110	37.5	34	11.6	43	14.7	41	14.0	2.61	1.350	.540	.142
I have been assigned a mentor to help me grow and develop as a CHP.	293	3	1.0	8	2.7	14	4.8	118	40.3	150	51.2	4.38	.787	-1.630	.142
I consistently receive regular and constructive support supervision sessions from my supervisors	293	6	2.0	3	1.0	9	3.1	121	41.3	154	52.6	4.41	.783	-2.036	.142
I get the opportunity to connect and engage with my peers.	293	4	1.4	4	1.4	10	3.4	143	48.8	132	45.1	4.35	.737	-1.689	.142
I get the opportunity to assume additional responsibilities beyond my primary tasks which allows me to broaden my skill set.	293	8	2.7	8	2.7	6	2.0	154	52.6	117	39.9	4.24	.848	-1.844	.142
I can access medical services at the health facility without having to wait in line.	293	75	25.6	73	24.9	28	9.6	52	17.7	65	22.2	2.86	1.525	.180	.142

These results highlight the importance of continuing to enhance these non-financial incentives to further strengthen CHP motivation and effectiveness in community health initiatives. By focusing on enhancing effective incentives like training, mentorship, and support supervision, while reevaluating less impactful incentives such as certificates, organizations can better support and motivate CHPs. Tailoring these incentives to align with CHPs' needs and preferences will not only improve motivation but also enhance their overall effectiveness in delivering community healthcare services. Regular evaluation and adaptation of incentive programs are crucial to maintaining high levels of CHP engagement and satisfaction over time.

Thematic analysis of the KIIs reveals significant insights into the quality and impact of training, as well as the broader issues of certification and career progression for CHPs. The SCPHN highlighted the variability in training opportunities for CHPs, stating:

"Training programs are sporadic and depend on funding availability. While some CHPs receive basic primary health knowledge, not all have equal access to training opportunities." KII 1

This statement underscores the challenges associated with inconsistent funding and resource allocation, which can affect the quality and frequency of training received by CHPs. Disparities in training can lead to uneven skill development among CHPs, potentially impacting their confidence and effectiveness in community health roles.

Conversely, the County Coordinator described more structured training initiatives, stating:

"We conduct 5-day class-based trainings using the national curriculum, funded by partners. This training helps CHPs feel more confident in their roles." KII 2

This approach suggests efforts to standardize training content and delivery, aiming to equip CHPs with essential knowledge and skills necessary for effective service delivery. Such structured training programs are essential in enhancing CHP capacity and fostering their sense of professional competence.

Despite the positive impact of training on CHP motivation and skills development, concerns remain regarding the lack of standardized certification and clear career progression frameworks. As one respondent articulated:

"There are no clear career development paths or mentorship programs in place, which affects CHPs' motivation to continue." KII 2

This observation highlights a critical gap in the support structure for CHPs, as formal recognition and opportunities for career advancement are essential factors in sustaining volunteer commitment over time. The absence of standardized certification can undermine the credibility of CHPs' skills and competencies, potentially limiting their opportunities for career growth within the health sector. Moreover, the lack of mentorship programs deprives CHPs of guidance and professional development support that could enhance their effectiveness and job satisfaction.

To address these challenges, there is a need for concerted efforts from health authorities and stakeholders. Developing clear career pathways and certification mechanisms would provide CHPs with tangible goals and recognition for their contributions. Implementing structured mentorship programs could also support ongoing skill development and enhance CHPs' professional growth. Moreover, ensuring consistent funding and resources for training programs would help standardize and improve the quality of education provided to CHPs across different regions within the county.

Time of Initial Training

The survey results offer valuable insights into the timing of initial training among CHPs, highlighting potential implications for their motivation through non-financial incentives. Approximately 7.8% of respondents received their training within the past 1-2 years, while 15.7% were trained 3-5 years ago. A significant majority, 62.5%, were trained over 5 years ago, indicating a substantial cohort of experienced CHPs. Conversely, a notable proportion

(6.5%) did not receive initial training, while 7.5% reported not remembering their initial training. Table 3 presents the results.

Table 3: Time of Initial Training

	Frequency	Percent
1-2 years ago	23	7.8
3-5 years	46	15.7
>5 years	183	62.5
I do not remember	22	7.5
I did not receive	19	6.5
Total	293	100.0

These findings suggest that a considerable number of CHPs possess extensive experience, which could enhance their effectiveness in community health roles. Additionally, the distribution of training periods suggests varying levels of experience and possibly differing motivations among CHPs. Those trained more recently might be more responsive to current non-financial incentives, such as recognition programs, training opportunities, or community support initiatives. On the other hand, CHPs with longer-term experience might require incentives that acknowledge their dedication and contributions over time, potentially focusing on career advancement opportunities or enhanced roles within the community health system. To effectively enhance CHP motivation through non-financial incentives, it's crucial to tailor strategies based on the varying needs and experiences of CHPs across different training periods. This could involve periodic assessments of motivational factors, targeted incentive programs aligned with career progression and recognition, and efforts to ensure all CHPs receive initial training to promote continuity and sustained motivation among CHPs. Further research and dialogue with CHPs themselves could provide deeper insights into their motivations and preferences for non-financial incentives, thus optimizing their effectiveness in supporting community health initiatives.

Frequency of Refresher/Update Training

The survey results provide insights into the frequency of refresher or update trainings received by CHPs, which is crucial for understanding the potential impact of non-financial incentives on their motivation. A notable 34.1% of CHPs receive monthly refresher trainings, indicating a proactive approach to maintaining their skills and motivation through frequent updates. Quarterly (16.0%) and semi-annual (15.0%) trainings also show consistent efforts to sustain CHP competencies over longer intervals. Annual trainings, received by 21.2% of CHPs, while less frequent than more regular intervals, still play a significant role in ensuring CHPs remain informed and motivated throughout the year. A smaller proportion (4.8%) of CHPs reported receiving refresher trainings irregularly, while a notable proportion (8.9%) do not receive refresher trainings at all. This variability could potentially affect their motivation if the trainings are not offered, or predictable or consistent. Table 4 presents the results.

Table 4: Frequency of Refresher/Update Training

	Frequency	Percent
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Monthly	100	34.1
Quarterly	47	16.0
Semi-annually	44	15.0
Annually	62	21.2
Irregularly	14	4.8
I do not receive	26	8.9
Total	293	100.0

The distribution of training frequencies suggests opportunities to leverage refresher trainings as non-financial incentives to enhance CHP motivation. Monthly and quarterly trainings may be particularly effective in maintaining engagement and enthusiasm among CHPs, providing them with ongoing support and skill development opportunities. Conversely, irregular trainings might benefit from greater structure to ensure consistent motivation and knowledge retention. To optimize the influence of refresher trainings on CHP motivation, it is essential to tailor the frequency and content of these sessions to the specific needs and preferences of CHPs. This could involve regular assessments of training effectiveness, feedback mechanisms from CHPs, and adjustments to training schedules to ensure they remain impactful and supportive of CHP roles in community health. Additionally, exploring innovative approaches such as blended learning methods or peer-to-peer training could further enhance the effectiveness of refresher trainings as motivational tools for CHPs.

Perceived Motivation of CHPs

The survey results provide insightful data on the motivation levels of CHPs, categorized into satisfaction, organizational commitment, community commitment, and work conscientiousness dimensions. The survey results reveal that CHPs exhibit high levels of satisfaction across various dimensions of their roles. For items measuring satisfaction (1-4), CHPs show strong agreement with means ranging from 4.42 to 4.58. This indicates robust satisfaction with the meaningfulness of their work, its positive impact, support from colleagues, and community recognition, with 95.2% to 99.7% of CHPs expressing agreement. The moderate standard deviations (0.559 to 0.879) suggest some variability but overall consistent high satisfaction levels. Negative skewness values (-1.935 to -1.307) indicate a distribution where more CHPs agree strongly with these statements.

Regarding organizational commitment (items 5-6), CHPs consistently express pride in working for the county government, reflected in 91.1% of CHPs agreeing, with a mean score of 4.42 and a moderate standard deviation of 0.879. However, there is more variability in their perception of the county government's ability to inspire them to perform at their best, where 72.0% of respondents express agreement, with a mean score of 3.95 and a higher standard deviation of 1.161. Negative skewness values (-0.833 to -2.193) indicate that most CHPs feel positively about affiliations with the county government.

For community commitment (items 7-8), CHPs express strong pride and inspiration, where 98.3% to 99.3% of CHPs indicate agreement on related items, with means ranging from 4.55 to 4.67. Low standard deviations (0.544 to 0.564) suggest high agreement and less variability, supported by negative skewness values (-0.775 to -2.193), indicating widespread agreement among CHPs. In terms of work conscientiousness, CHPs consistently agree that they are reliable, efficient, proactive, and hardworking, where 97.3% to 99.7% indicate agreement or strong agreement across these dimensions, with means ranging from 4.56 to 4.80. Low standard deviations (0.427 to 0.588) suggest strong consensus and minimal variability, with negative

skewness values (-2.156 to -1.030) indicating strong agreement across these dimensions. Table 5 presents the results.

Table 5: Motivation of CHPs

Statements	1		2		3		4		5		Mean	Std. Dev.	Skewness Statistic	Std. Error
	N	F %	F %	F %	F %	F %	F %	F %						
I am satisfied that I accomplish something worthwhile with my work as a CHP	293	7 2.4	5 1.7	2 0.7	105 35.8	174 59.4	4.48	.809	-2.380	.142				
I am satisfied with the positive impact of my work.	293	1 0.3	1 0.3	1 0.3	114 38.9	176 60.1	4.58	.559	-1.502	.142				
I am satisfied with the support I receive from my colleagues.	293	0 0.0	4 1.4	4 1.4	115 39.2	170 58.0	4.54	.599	-1.307	.142				
I am satisfied with the community thanks and recognition I receive for my work.	293	1 0.3	2 0.7	2 0.7	125 42.7	163 55.6	4.53	.588	-1.421	.142				
I am proud to be working for the county government as a CHP.	293	5 1.7	13 4.4	8 2.7	95 32.4	172 58.7	4.42	.879	-1.935	.142				
The county government really inspires me to do the very best on the job.	293	6 2.0	46 15.7	30 10.2	85 29.0	126 43.0	3.95	1.161	-.833	.142				
I am proud to be working for my community.	293	1 0.3	2 0.7	2 0.7	83 28.3	205 70.0	4.67	.564	-2.193	.142				
My community inspires me to do the very best I can for them.	293	0 0.0	1 0.3	4 1.4	121 41.3	167 57.0	4.55	.544	-.775	.142				
I can be relied upon at work.	293	1 0.3	1 0.3	3 1.0	100 34.1	188 64.2	4.61	.566	-1.717	.142				
I always complete my tasks efficiently and correctly.	293	0 0.0	1 0.3	10 3.4	106 36.2	176 60.1	4.56	.580	-1.030	.142				
I take initiatives to do things without being asked or told.	293	1 0.3	3 1.0	1 0.3	96 32.8	192 65.5	4.62	.588	-2.007	.142				
I am a hard worker.	293	0 0.0	1 0.3	0 0.0	56 19.1	236 80.5	4.80	.427	-2.156	.142				

In general, these results highlight that CHPs are highly motivated and satisfied with their roles, find pride in their organizational and community affiliations, and demonstrate strong work conscientiousness. The data suggest areas where additional support or recognition could further enhance CHP motivation, particularly in fostering stronger organizational inspiration.

SUMMARY, CONCLUSION AND RECOMMENDATIONS

Summary

The survey revealed that CHPs held a generally optimistic outlook on future opportunities related to their roles, anticipating significant gains in career experience, networking, and personal fulfillment. However, there was some uncertainty about the clarity of pathways to permanent employment, with some CHPs feeling hopeful while others expressed doubt about the long-term benefits of their service. To enhance motivation and retention, it's suggested that programs offer non-financial incentives such as structured career paths, mentorship opportunities, and job placement assistance, which could strengthen the connection between volunteer work and formal employment prospects.

The survey assessed the perceived adequacy of non-financial incentives for CHPs provided by health providers. CHPs expressed high satisfaction with aspects such as training, mentorship, supervision, and peer engagement, indicating they felt well-supported in these areas. However, concerns emerged regarding the lack of certificates for training and access to medical services without waiting, with many CHPs dissatisfied. The findings suggest a need for improvement in these areas, as well as a call to enhance effective incentives while reevaluating less impactful ones. Thematic analysis highlighted challenges in training consistency and certification, emphasizing the importance of clear career pathways and structured mentorship programs to sustain CHP motivation. Additionally, the timing and frequency of training were examined, revealing that many CHPs had extensive experience but varied access to refresher training, which could impact their motivation. Tailoring incentives to meet CHPs' diverse needs and preferences is crucial for maintaining engagement and effectiveness in community health initiatives.

Conclusions

The study yields several important conclusions regarding the motivations of CHPs based on the research hypotheses;

Secondly, concerning health provider non-financial incentives, while CHPs recognized the support they received, these incentives did not significantly impact their motivation levels. Thus, the null hypothesis (H02) is upheld. This suggests that while some non-financial incentives are valued, there is a critical need for improvement in this area to better support and motivate CHPs, perhaps through the introduction of formal recognition programs or additional training opportunities. By implementing robust recognition programs and offering ongoing professional development, the county government can cultivate a more supportive environment. This can lead to greater job satisfaction, reducing turnover rates, and ensuring continuity of care for the communities served.

Recommendations

Based on the findings of the baseline study regarding the motivations of CHPs and the various influences on their engagement, several key recommendations can be made to enhance their effectiveness and job satisfaction. Firstly, developing structured career pathways is essential. Establishing clear advancement opportunities through formal mentorship programs, job

placement assistance, and continuous professional development initiatives will significantly boost CHP motivation and retention by providing them with well-defined paths to permanent employment and career growth.

Additionally, enhancing recognition and support programs is crucial. Implementing robust recognition systems that celebrate CHP contributions, such as performance-based awards and public acknowledgments, can foster a sense of appreciation. Expanding ongoing training opportunities will ensure that CHPs feel supported in their professional development, thus improving their engagement and satisfaction levels. Strengthening supply chain management is also vital, as ensuring consistent access to necessary health commodities directly affects CHPs' effectiveness. Improving logistics and timely replenishment of essential supplies will bolster their confidence and capability to deliver quality care.

REFERENCES

- Ankomah, S. E., Kumah, E., & Kusiwaa-Karikari, A. (2016). Health Worker Motivation in Ghana: The Role of Non-Financial Incentives. A Case Study of Accident and Emergency Department of Komfo Anokye Teaching Hospital. *International Journal of Biosciences, Healthcare Technology and Management*, 6(4), 34–49. <https://doi.org/10.5281/zenodo.1421931>
- Bhattacharyya, K., Winch, P., LeBan, K., Tien, M. (2001). *Community health worker incentives and disincentives: how they affect motivation, retention and sustainability*. Arlington, Virginia: BASICS/USAID.
- Crigler, L., Gergen, J., Perry, H. (2014). Supervision of Community Health Workers. In H. Perry, & L. Crigler (Eds.), *Developing and Strengthening Community Health Worker Programs at Scale: A Reference Guide and Case Studies for Program Managers and Policy Makers*. Washington, DC: USAID/MCHIP. <https://coregroup.org/wp-content/uploads/2017/08/CHW-Reference-Guide-Chapter-10-Supervision-of-Community-Health-Workers.pdf>
- Cuevas, L. E. (2017). Health extension workers improve tuberculosis case finding and treatment outcome in Ethiopia: a large-scale implementation study. *BMJ global health*, 2(4), e000390. <https://doi.org/10.1136/bmjgh-2017-000390>
- Kenya Red Cross Society and British Red Cross. (2021). *An Evaluation Report of the Taita Taveta Cash for Health in Emergencies Project*. Kenya Red Cross Society. <https://cash-hub.org/wp-content/uploads/sites/3/2021/07/Evaluation-Report-Cash-for-Health-in-Emergencies-Taita-Taveta-Kenya-FINAL.pdf>
- Kithuka, P. M. (2016). *Predictors of community health volunteers' retention in service in Makeni county, Kenya* [Unpublished doctoral dissertation]. Kenyatta University. <https://ir-library.ku.ac.ke/bitstream/handle/123456789/10617/Predictors%20of%20community%20%20health.....pdf?isAllowed=y&sequence=4>
- Kok, M., Abdella, D., Mwangi, R., Ntinginya, M., Rood, E., Gassner, J., Church, K., & Wheatley, N. (2019). Getting more than "claps": incentive preferences of voluntary community-based mobilizers in Tanzania. *Human Resources for Health*, 17(1), 101. <https://doi.org/10.1186/s12960-019-0438-5>
- Lehmann, U., Sanders, D. (2007). *Community Health Workers; what do we know about them? The state of the evidence on programs, activities, costs and impact on health outcomes of using community health workers*. Geneva. World Health Organization
- Lusambili, A.M., Nyanja, N., Chabeda, S.V., Temmerman, M., Nyaga, L., Obure, J., & Ngugi, A.K. (2021). Community health volunteers challenges and preferred income generating activities for sustainability: a qualitative case study of rural Kilifi, Kenya. *BMC Health Serv Res*, 21, 642. <https://doi.org/10.1186/s12913-021-06693-w>
- Mbugua, R., Oyore, J.P., & Mwitari, J. (2017). Role of Monetary Incentives on Motivation and Retention of Community Health Workers: An Experience in a Kenyan Community. *Kenyan Journal of Nursing & Midwifery*, 2(2), 170-181. <http://article.sapub.org/10.5923.j.phr.20180801.01.html>

- Ministry of Health, Kenya. (2020). *Kenya Community Health Policy 2020-2030*. Ministry of Health. <https://www.health.go.ke/wp-content/uploads/2020/07/Kenya-Community-Health-Policy-Signed.pdf>
- Ministry of Health, Kenya. (2020). *Kenya Community Health Strategy 2020-2025*. Ministry of Health. https://www.health.go.ke/wp-content/uploads/2021/01/Kenya-Community-Health-Strategy-Final-Signed-off_2020-25.pdf
- Olang'o, C. O., Nyamongo, I. K., & Aagaard-Hansen, J. (2010). Staff attrition among community health workers in home-based care programmes for people living with HIV and AIDS in western Kenya. *Health Policy*, 97(2-3), 232-237.
- Oliver, M., Geniets, A., Winters, N., Rega, I., & Mbae, S. M. (2015). What do community health workers have to say about their work, and how can this inform improved programme design? A case study with CHWs within Kenya. *Global health action*, 8(1), 1-17. 27168. <https://doi.org/10.3402/gha.v8.27168>
- Parlato, M. B., & Favin, M. N. (1982). *Primary health care--progress and problems*. American Public Health Association.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68–78. <https://doi.org/10.1037/0003-066X.55.1.68>
- Sarma, H., Jabeen, I., Luies, S. K., Uddin, M. F., Ahmed, T., Bossert, T. J., & Banwell, C. (2020). Performance of volunteer community health workers in implementing home-fortification interventions in Bangladesh: A qualitative investigation. *PloS one*, 15(4), e0230709. <https://doi.org/10.1371/journal.pone.0230709>
- Singh, D., Negin, J., Otim, M., Garimoi, O., Cumming, R. (2015). The effect of payment and incentives on motivation and focus of community health workers: five case studies from low-and middle-income countries. *Human Resources for Health*, 13(1), 58. <https://doi.org/10.1186/s12960-015-0051-1>
- Tripathy, J. P., Goel, S., & Kumar, A. M. (2016). Measuring and understanding motivation among community health workers in rural health facilities in India-a mixed method study. *BioMed Central Health Services Research*, 16(a), 366. <https://doi.org/10.1186/s12913-016-1614-0>
- Tulenko, K., Møgedal, S., Afzal, M. M., Frymus, D., Oshin, A., Pate, M., Quain, E., Pinel, A., Wynd, S., & Zodpey, S. (2013). Community health workers for universal health-care coverage: from fragmentation to synergy. *Bulletin of the World Health Organization*, 91(11), 847–852. <https://doi.org/10.2471/BLT.13.118745>
- UNICEF. (2010). *Implementing Community Health Strategy in Kenya; an evaluation report*. Division of Community Health Services, UNICEF. http://guidelines.health.go.ke:8000/media/Evaluation_Report_of_the_Community_Health_Strategy_Implementation_in_Kenya.pdf