# Community Health Volunteer Incentives

*MAHEFA's multi-faceted approach for sustaining motivation*

## Background

Global initiatives, research, and investment reflect renewed interest in the role of community health volunteers (CHVs) in strengthening health systems and extending access to health services[1]. Since CHVs are not salaried members of the health system and since much of the strength of community health activities depends on their effectiveness, it is important to understand what motivates them and to integrate motivation activities into community health programs to strengthen quality of services and ensure high retention rates. CHVs are a part of, and simultaneously are influenced by the larger cultural and political environment in which they work. In addition, their motivation and retention as active volunteers is influenced by the role they play within their community context. Inherent CHV characteristics such as age, gender, ethnicity and economic status affect how they are perceived by community members and their ability to work effectively. MAHEFA built the capacity of this important cadre of workers to address the comprehensive needs of vulnerable women, children and families in six regions in Madagascar. In order to optimize quality and long term sustainability of their work MAHEFA used a multi-faceted approach to address motivation among 6,052 CHVs.

## MAHEFA Context

For 83 percent of Madagascar's 22.9 million people living in rural areas, access to quality health services is limited. Following the contested 2009 elections and subsequent political and economic crisis, the Government of Madagascar (GOM) closed down 339 primary healthcare centers (*Centres de Santé de Base* or CSB) resulting in a 20 percent decrease in CSB utilization rates. Additionally, the health system experienced frequent stock outs of essential medicines and interrupted delivery of health services[2]. In this context, the role of CHVs became even more important in parts of the country where access to CSBs and other existing health service delivery facilities was affected by geographic and seasonal barriers (e.g., long distances, poor-quality roads and flooding). Approximately 34,000 CHVs throughout Madagascar have been trained to provide services[3]. CHVs have been a recognized cadre of the GOM's health system. The National Policy on Community Health (*Politique Nationale de la Santé Communautaire,* PNSC) addresses the role of CHVs, recommending that each *fokontany* (a collection of villages) appoint multiple CHVs to provide basic home and community based health services.

The USAID/African Strategy for Health project conducted a study on CHV incentives in Madagascar. The study found that CHVs should be supported through a combination of financial and non-financial incentives. Additionally, it concluded that factors such as the CHVs' workload, opportunity costs, the physical environment, and the socio-cultural context should be taken into consideration when identifying the advantages and disadvantages of each incentive scheme[4]. Similarly, in a recent USAID/PMI study on CHV performance in Madagascar[5], CHV incentives were identified as both financial and non-financial in nature, with per diems for attending trainings viewed as a financial incentive originating from their supporting organizations. CHVs in the cross sectional study also reported that recognition by the community in which they work was an important benefit of being a CHV.

## MAHEFA Approach

The MAHEFA program used a combination of four main activities to maintain and increase CHV motivation. The program 1) strengthened links between CHVs and the public health system, 2) supported extension of the CHVs' relationships into many parts of the community, 3) used multiple motivational activities for CHVs, and 4) examined monitoring and understanding the factors behind CHV turnover.

## Key Activities

***1. Strengthened links between CHVs and the public health system.*** Informal interviews with CHVs in the MAHEFA program

1. *Singh P, Sachs JD. 1 million community health workers in sub-Saharan Africa by 2015. Lancet. 2013;382(9889): 363–365.*
2. *Plan de développement du Secteur Santé 2015-2019, Minister of Public Health, Madagascar. July 2015.*
3. *Idem.*

regions showed that the highest source of motivation was being a part of the formal public health system. In the first three and a half years of implementation, MAHEFA could not work officially with Madagascar's public health system due to US government (USG) restrictions against use of USG funds to support GOM activities. Despite, this restriction, MAHEFA ensured that CHV activities under the program were aligned with GOM policies to respect CHVs' role within the PNSC and facilitate their collaboration with CSBs and GOM entities. By mid 2014, MAHEFA could work with the GOM and quickly put into place the following activities to enable CHVs to work closely with GOM's PNSC structures.

- Conducted training of trainers (ToT) for the government's health training teams at the regional and district levels (EMAR, EMAD) and CSBs so they conducted all pre-service and refresher training for CHVs.
- Assisted CSB heads to conduct monthly meetings and technical supervisions of CHVs to further reinforce relationships and allow CSB staff to better understand CHVs' work contexts.
- Carried out health campaigns together such as polio and long lasting-insecticide-treated net (LLITN) campaigns.
- Organized joint program review and dissemination sessions that included the Regional Management Team (Équipe de Management de la Region or EMAR), and the District Level Management Team (*Équipe de Management du* District or EMAD), CSB and CHVs.

***2. Supported CHVs to assume their role as service providers at the community level.*** While the CHVs were selected by members of their own communities, it took time for the community to accept them in their new role. The MAHEFA program carried out the following activities to promote the CHV role in the community:

- Provided the necessary training and launch kit (which included more than 100 items) for CHVs to do their work. Also held official presentations to formally introduce CHVs to their community after the completion of their training.
- Used two approaches namely the Champion Commune approach and Community Score Card (CSC) to strengthen the relationship between CHVs and community members. More information on both these approaches is available in other MAHEFA technical briefs.
- Encouraged the community to build health huts and equip them with basic furniture, e.g., chairs, table, board, shelf and waiting bench and sanitation facilities, namely latrines, disposal pits and tippy taps to allow CHVs to perform their services (as stipulated in the PNSC).

***3. Used multiple motivational activities for CHVs.*** MAHEFA used several types of incentives to ensure CHVs' remained motivated. The incentives for increasing CHV motivation are described below. Note the first two incentives were program-wide and the remaining were supplemental activities that were made available for limited CHVs.

- Organized exchange visits for high performing CHVs to visit and mentor other or low performing CHVs in other districts.
- Invited high-performing CHVs to attend and share their testimony at regional- and national-level workshops organized by GOM and development partners.
- Showcased CHV work during the health days organized by local government at the commune (or the smallest territorial division as defined for administrative purposes), district and regional levels.
- Provided bicycles to 1,020 CHVs (17 percent of the total CHVs in MAHEFA program areas).
- Administered CHV launch kits, which included medicines, health supplies, and health products to all 6,052 CHVs after their pre-service training. This allowed them to have their own revolving drug fund.
- Provided income generation opportunities for 30 CHVs through the provision of the WASH products.
- Provided e-box activity to 97 CHVs.

***4. Monitored and identified factors affecting CHV turnover.*** While the above-mentioned approaches contributed to increased CHV motivation, MAHEFA also attempted to monitor and identify the factors which seemed to contribute to a high CHV turnover rate. The factors affecting high CHV turnover included: moving to a different community, starting a family (e.g., having a baby and therefore being unable to travel frequently), and aging. When possible, MAHEFA tried to investigate the reasons why CHVs had left by asking NGO field staff or the affected community leaders the reasons for leaving as to improve retention.

*4. Community Health Worker incentives: Lessons Learned and Best Practices, Madagascar Country Report, USAID/African Strategy for Health Project, 2015.*
*5. Community CHV Program. Functionality and Performance in Madagascar: A Synthesis of Qualitative and Quantitative Assessments, Research and Evaluation Report. USAID/PMI. April 2013.*

## Results

There were a total of 6,052 CHVs (60 percent male and 40 percent female) in MAHEFA's six regions. Throughout the five years of the MAHEFA program, the CHV turnover rate was at 8.7 percent. A higher percentage of male CHVs left the program than women (63 percent for men compared with 37 percent for women). The turnover rate is considered a middle range for CHVs programs which typically report between 5 percent and 77 percent [6]. A study by the USAID/African Strategy for Health Program in 2015 reported CHV attrition in the MAHEFA program area in one year as 5.08 percent compared to the USAID/Mikolo program at 9 percent [7]. The same study reported that there was no other CHV program in Madagascar that collected data on CHV attrition. Among CHVs who received bicycles, the WASH income generation start kit or those who were part of the eBox micro enterprise, there was zero CHV attrition.

1,717 CHVs (28 percent ) participated in the exchange visits and the workshops outside of their home place. The visits and the participation in the workshop were generally viewed as a prestigious opportunities since only high-performing CHVs were selected to attend these events. All CHVs in the MAHEFA program areas received a pre-service training and refresher trainings throughout their careers. They received trainings in a wide array of technical areas including: short-acting family planning methods including injectable contraception, child integrated community case management (c-iCCM), WASH, nutrition and behavior change empowerment techniques. After each pre-service training, the CHVs received a start-up kit comprised of medicines, health products and job aids. More information on the training received by CHVs in the MAHEFA areas is presented in Table 1.

Many CHVs explained that their link with the CSBs served as a major source of motivation. The rate of CHV attendance at the monthly CSB meetings was very high, from 82 percent to 90 percent. The other area that showed effective links between the CHVs and CSBs was through the number of cases referred and countered-referred between CHVs and CSBs. In total, 540,456 pregnant women were referred for antenatal care (ANC) and delivery at the CSB. Out of this, 89,226 women were referred back to CHVs for follow up in the community. For children under 5 (CU5), the referral and counter-referral rate was extremely high at 2,688,855 for referral and 715,691 for counter-referral.

## Challenges

**CHVs are motivated by different types of motivation activities.** All CHVs were exposed to MAHEFA motivation activities including training, launch health kits, and links with the public health system. A smaller number of CHVs participated in supplemental motivation activities such as exchange visits or additional income generation schemes. The varying levels of participation in each motivation activity and the diversity of supplemental motivation activities make it difficult to assess impact on CHV motivation.

**CHV motivation activities were added to the program at different times based on MAHEFA's evolving context and priorities.** While this adaptive approach may help to respond to immediate needs, the fact that there was no deliberate plan prior to each motivation activity rollout reduced opportunities for advanced planning to maximize opportunities to address CHV motivation. For example, the locations for eBox cooperative activities were decided based on the results of a feasibility study, but did not take into account the existing motivation activities in that area. Thus, CHVs in sites with eBox cooperatives may receive more

**Table 1. CHV Trainings in MAHEFA Program Regions (2011-2016)**

| Topics of Training | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | Total |
|---|---|---|---|---|---|---|---|
| c-ICCM | 418 | 4,381 | 151 | 1,519 | 577 | 2 | 7,370 |
| Reproductive health and Family Planning (4 methods) | | 1,752 | 4,005 | 627 | 56 | 42 | 6,482 |
| DEPOCOM and WASH 1 | | | 2,584 | 3,290 | 317 | 42 | 6,233 |
| Nutrition and WASH 2 | | | 2,271 | 3,780 | 231 | | 6,282 |
| Behavior Change Empowerment | | | 2,888 | 3,075 | 79 | 152 | 6,194 |
| Refresher training on integrated themes | | | | | 6,028 | 4 | 6,032 |
| CHX - Misoprostol - SAYANA Press | | | | 541 | 22 | 5,944 | 6,507 |

*6. Lay health worker attrition: important but often ignored, Lungiswa Nkonki a, Julie Cliff b & David Sanders. Bulletin of the World Health Organization, Volume 89, Number 12, December 2011, 919-923*

*7. Idem 4. The annual CHW attrition rate for USAID Mikolo is based on a six-month period (June – December 2014) during which 207 of 4,726 CHWs stopped working. The annual CHW attrition rate for USAID|MAHEFA is based on a two-year period (September 2012-September 2014) during which 683 CHWs of 6,728 stopped working.*

benefit from the motivation activities than in other sites.

**Some CHVs who were not part of the supplement motivation activities felt less motivated to do their work.** In the qualitative survey of CHV bicycle activities, some CHVs who did not receive the bicycles may have felt less motivated to do their work upon hearing about the CHV motivation activities that they did not have access to.

**Sustainability of certain motivation activities is not always feasible.** Motivation activities that have start-up or ongoing associated costs, such as providing bicycles or WASH supply kits, are harder to sustain outside of a donor-supported program.

## Lessons Learned and Recommendations

**Design CHV motivation activities as part of the overall community health program from the beginning.** In order to better understand effectiveness of each motivational activity, it is important to integrate the motivation activities in the overall program. Consequently, the data on the motivation activity will be integrated into the overall program's monitoring and evaluation system. This will facilitate the study of impact of the motivation activity on service delivery.

**Communicate transparent motivation plans.** Plan most or all motivation activities at the beginning of any program and clearly explain the plan to all stakeholders including the CHVs themselves. Advanced planning and transparency will contribute to effective integration of motivation efforts into program activities and reduce confusion and jealousy among CHVs or other community members.

**Develop a solid foundation of low-cost, sustainable motivational activities while also pursuing impactful higher-cost options.** As described above, MAHEFA recognized that one of the most essential motivating factors for CHVs was feeling included in and recognized by the larger public health system as well as the community. Promoting this inclusion and recognition should be a mainstay of programs working with CHVs. Even in contexts where higher-cost motivation activities can be pursued, the appreciation from and links with the public health system and community represent a reliable form of motivation.

**Monitor and report the impact of the motivation activities as part of the broader program monitoring activities.** Evaluation, including comparison of low-cost and high-cost motivation activities, was not conducted in MAHEFA but may have yielded important information on the impact of such activities on CHV performance and retention. As needed, develop new and low-cost methods to track CHV retention, and gather information on CHV reasons for leaving to identify common challenges faced by CHVs. Challenges should be presented to all stakeholders, with discussion and implementation of alternative solutions.

Madagascar Community-Based Integrated Health Program (CBIHP), locally known as MAHEFA, was a five-year (2011-2016), USAID-funded community health program that took place across six remote regions in north and north-west Madagascar (Menabe, SAVA, DIANA, Sofia, Melaky, and Boeny). The program was implemented by JSI Research & Training Institute, Inc. (JSI), with sub-recipients Transaid and The Manoff Group, and was carried out in close collaboration with the Ministry of Public Health, the Ministry of Water, Sanitation and Hygiene, and the Ministry of Youth and Sport. Over the course of the program, a total of 6,052 community health volunteers (CHVs) were trained, equipped, and supervised to provide basic health services in the areas of maternal, newborn, and child health; family planning and reproductive health, including sexually transmitted infections; water, sanitation, and hygiene; nutrition; and malaria treatment and prevention at the community level. The CHVs were selected by their own communities, supervised by heads of basic health centers, and provided services based on their scope of work as outlined in the National Community Health Policy. Their work and the work of other community actors involved with the MAHEFA program was entirely on a voluntary basis.

This brief is included in a series of fifteen MAHEFA technical briefs that share and highlight selected strategic approaches, innovations, results, and lessons learned from the program. Technical brief topics include *Behavior Change Empowerment*, *Community Radio Listening Groups*, *Community Score Card Approach*, *Chlorhexidine 7.1%/Misoprostol*, *Champion Communes Approach*, *Community Health Volunteer Mobility*, *Emergency Transport Systems, Malaria, Community Health Volunteer Motivation, Family Planning & Youth, WASH, eBox, Community Health Financing Scheme, Information Systems for Community Health and NGO Capacity Building.*

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