Chapter 11

What Motivates Community Health Workers? Designing Programs that Incentivize Community Health Worker Performance and Retention

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Key Points

- Financial compensation is one – but only one – of many influences on the motivations of community health workers (CHWs) to perform their responsibilities.
- Non-material incentives need to be given careful consideration along with financial incentives.
- Indirect non-material incentives, such as the degree to which the environment is supportive of CHWs and the degree to which the health system functions effectively are also motivating influences for CHWs.
- Lack of appropriate incentives, with resulting high rates of turnover, are common in large-scale CHW program and costly in terms of actual cost to replace CHWs and also in terms of the performance of the CHW program.

INTRODUCTION

A perennial challenge in CHW programs is the question of how to motivate community members to engage in community health work as CHWs, to remain in these positions once trained, and to perform their work effectively over time. Motivation is a complex phenomenon that is the product of a range of psychological, interpersonal, and contextual factors. Thus, there is no one right or best way to motivate CHWs in their work, but there are some lessons that can be gleaned from the experiences of other CHW programs. This chapter reviews the question of CHW motivation and identifies a range of issues that policymakers and program managers would need to grapple with as they consider how best to motivate CHWs in their own context.

The most common approach to developing and sustaining motivation in CHW programs revolves around the use of discrete "incentives." These incentives are often understood in a fairly narrow fashion, as specific forms of reward—like payments, promotions, or awards—to motivate CHWs to perform specific tasks or achieve a certain level of performance. It is in this sense that many policymakers, program managers, and CHWs themselves understand the term "incentive."

However, one can also define CHW incentives as any factor that increases motivation to engage and perform well in CHW work. In Bhattacharyya's (2001) seminal review on this issue, the authors used the concept of "incentives" (and "disincentives") in just such a broad fashion.[1] The value of this more expansive idea of incentives is the insight that the factors that serve as incentives for CHWs to perform well are far more numerous and complex than just the explicit financial or non-financial incentives (in the narrow sense) offered by programs to reward particular behaviors. Decent salaries and opportunities for advancement may motivate CHWs, but so too can supportive colleagues, a safe working environment, and the recognition of the community.

This chapter shares this broad view of incentives and discusses a wide range of factors that can support or inhibit a CHW's motivations to engage in CHW programs and perform well in their tasks. It examines how CHW programs can produce and sustain CHW motivation by paying attention to the many different factors that act as incentives for their work.

KEY QUESTIONS

- What forms of incentives are there?
- What are decisions related to incentives that must be made?

WHAT FORMS OF INCENTIVES ARE THERE?

Although there are many ways to define and categorize incentives, some common and useful distinctions can be made. Table 1 presents some illustrative examples of these common categories of incentives.

Table 1. Common categories and examples of CHW incentives

	FINANCIAL INCENTIVES	NON-FINANCIAL INCENTIVES
DIRECT INCENTIVES	*Terms and conditions of employment*: salary/stipend, pension, insurance, allowances, leave	*Job satisfaction/work environment*: autonomy, role clarity, supportive/facilitative supervision, manageable workload
	Performance payments: performance-linked bonuses or incentives	*Preferential access to services*: health care, housing, education

	Other financial support: reimbursement of costs (travel, airtime), fellowships, loans, ad hoc	*Professional development*: continuing training, effective supervision, study leave, career path that enables promotion and moving into new roles
		Formal recognition: by colleagues, health system, community, wider society
		Informal recognition: T-shirts, name tags, access to supplies/equipment, bicycles, etc.
INDIRECT INCENTIVES	**HEALTH SYSTEM**	**COMMUNITY-LEVEL**
	Well-functioning health systems: effective management, consistent M&E, prompt monthly payments, safe environment, adequate supplies, and working equipment	Community involvement in CHW selection and training
	Sustainable health systems: sustainable financing, job security	Community organizations that support CHWs
	Responsive health systems: trust, transparency, fairness, consistency	CHWs witnessing visible improvements in health of community members
COMPLEMENTARY/ DEMAND-SIDE INCENTIVES	**HEALTH SYSTEM**	**COMMUNITY-LEVEL**
	Health care workers witnessing and grateful for visible improvements in health of community members	Community members witnessing and grateful for visible improvements in health of its members
	Policies and legislation that support CHWs	Successful referrals to health facilities
	Funding for CHW activities from state or communities	CHW associations

CHW incentives are most commonly divided into financial and non-financial incentives. Both of these kinds of incentives might be referred to as "direct" since they are specific incentives offered directly to individual CHWs as part of a CHW program. Most programs offer some form of financial incentive. In larger government-run programs, these might be modest but full-time salaries. In non-governmental organization (NGO)-run or community-supported programs, these incentives might be small stipends and reimbursements for travel or airtime. Rwanda and India, for example, have developed performance-based incentive programs that reward CHWs for better job performance. India also offers a life insurance program to some of its government CHWs, and some NGO programs in South Africa offer scholarships for further training. Common non-financial incentives found globally include formal uniforms, T-shirts, and name tags; access to bicycles and medical supplies; and preferential access to health or housing resources. See the first set of rows in Table 1 above for common categories and examples of direct incentives.

The second set of rows in Table 1 lists what can be called "indirect incentives." Dambisya et al.[2] define indirect incentives as incentives "not specific to individuals or groups, but to the system as a whole." Dambisya focuses on health systems-related indirect incentives, such as good management, sustainable financing, fairness, and transparency. In many settings, indirect incentives have been identified by CHWs and program managers alike as critical success factors for effective CHW programs.

Bhattacharyya et al.[1] also describe "community-level factors that motivate individual CHWs." These include community involvement in CHW training and selection, and community support for the work of CHWs. These forms of community involvement are not intended to directly incentivize CHWs, but promoting a positive and effective working relationship with the communities they serve can be a powerful motivating force for CHWs. Therefore, these kinds of incentives can be considered as community-based forms of indirect incentives and are placed

alongside the health system-related ones in the second set of rows in Table 1. (Also see Chapter 13 on community relations for more detail.)

Finally, incentives, whether direct or indirect, are generally defined by their impact on the motivation of individual CHWs. Bhattacharyya et al.[1], however, make an useful distinction between factors that motivate individual CHWs and factors that motivate others to support and sustain CHWs in general. Here, we have called these "complementary incentives" because they complement efforts to incentivize CHWs themselves. One example might be the greater support for CHWs and their work that can emerge when health care workers or community members witness tangible changes in health outcomes that are the result of CHW initiatives. As with the indirect incentives, we have divided complementary incentives into health systems and community-specific ones (see the third set of rows in Table 1).

Because we have taken a broad view of incentives, as all those factors that affect the motivation of CHWs, many of the incentives we discuss below will overlap with issues raised in the other chapters in this book (for example, supervision, financing, training, and governance). To try to reduce duplication, we will consider them here only with respect to their impact on CHW motivation and performance.

Case study: incentivizing CHW cadres in India

CHW program designers and managers often do not fully understand the complex set of motivations that lead CHWs to engage in the difficult work that they do. Many programs rely on a vague notion of altruism to explain why CHWs take on this work and offer small "stipends" and ad hoc incentives, such as T-shirts, to keep CHWs engaged. Altruism is indeed, for most CHWs, paid or not, an important source of intrinsic motivation.

Creating and sustaining CHW motivation over time, however, is much more complicated than relying on altruistic motives or the occasional symbolic or material incentive. To illustrate how challenging it can be to produce and maintain CHW motivation over time, we present here a brief case study of three linked CHW cadres in India and the various, and contrasting, ways in which they have been incentivized in their work.

Auxiliary nurse midwives (ANMs) were established in the 1960s as part of the Indian government's effort to offer maternal and child health (MCH) services at a lower level than its primary health care (PHC) centers. ANMs are paraprofessional, village-level midwives with several years of MCH and midwifery training, but are not considered fully-qualified health professionals. Over time, their scope of tasks has expanded considerably beyond midwifery to a range of preventive and curative services, including family planning and immunizations. They are not selected by the community and are transferred regularly to different communities. They are full-time salaried employees and also receive some housing benefits.

The anganwadi worker (AWW) cadre was created in 1975 as the centerpiece of the government's Integrated Child Development Service program. The initial focus on children from birth to six years of age has expanded to include nutritional support and health education for adolescent girls and lactating women, and in some states, even curative services. They receive 2 to 3 months of training, and are responsible for a wide range of preventive and promotive services. They are supposed to be selected and managed by the community, and as 'honorary workers,' are paid a monthly stipend, which functions as a salary for most AWWs. They work closely with ANMs and accredited social health activist (ASHA) Workers (see below).

The ASHA initiative began in 2005 as part of the Indian government's restructuring of its rural primary healthcare system. ASHA Workers (often called simply ASHAs) live in the communities where they work and are supposed to raise community awareness around health and the social

determinants of health. They should also work to enable communities to plan, access, and hold accountable their local health services. They are selected and managed by the community and receive one month of training. They are considered unpaid volunteers, but receive outcome-based payments from some of the activities that fall within their scope of work, including promoting immunizations, facility deliveries, family planning, and latrine construction. They are also compensated for time spent in trainings and meetings.

There are some common health system-related challenges shared by all three of these cadres that affect CHW motivation and performance. Poor training and supervision are frequent complaints. Also, their overall workloads and their scopes of work seem to increase continuously. Finally, poor quality health services affect their relationships to the communities they are supposed to serve and represent.

There are also motivational challenges specific to each type of worker. ANMs struggle with frequent transfers within the health system that can separate them from their families and weaken ties to the communities where they work. AWWs also suffer weak links to many communities in practice, even though they are supposed to be selected and managed by communities. In reality, the AWW program has been too top-down and inflexible in its approach, and this has affected program responsiveness and AWW morale. AWWs' monthly stipend, and their long-standing presence in communities, however, does bolster their status and provides many a sense of superiority over the ASHAs with whom they work.

The issues of motivation and incentive are probably most complicated for the ASHAs. Though classed as volunteers, the outcomes-based payment scheme incentivizes work that produces income. Therefore, ASHAs often neglect tasks that do not generate funding. ASHAs also receive their funding from ANMs at the PHC centers, and this funding has led them to be perceived by many as part of the health system rather than as community-level activists. Nonetheless, ASHAs are increasingly dissatisfied with the funding they do receive and have lobbied for more remuneration. States have begun to introduce a range of additional financial and non-financial incentives, such as cash awards for the best performing ASHAs, newsletter and radio programs, bicycles, and nursing scholarships.

Although ANMs, AWWs, and ASHAs represent different points on the spectrum between paid and unpaid CHWs, they are impacted by many of the same health system-wide challenges that affect motivation. The specific ways in which they are incentivized also have their own unique impacts, both positive and negative, on their motivation. Well-intentioned attempts to incentivize the work of the ostensibly volunteer ASHAs toward priority health outcomes, such as immunizations and facility births, have resulted in several unintended consequences. These consequences present ongoing challenges to ASHA program managers as they try to strike a balance between promoting a wide-ranging social health activist role for ASHAs and financially incentivizing priority health activities.

WHAT ARE DECISIONS RELATED TO INCENTIVES THAT MUST BE MADE?

Designing effective incentives to increase motivation and performance is clearly a complex task and requires careful attention to a range of interconnected factors. Like any other aspect of the health system, incentives need to be 1) properly designed through review of the evidence and consultation with stakeholders, 2) implemented, managed, and monitored on an ongoing basis, and finally, 3) evaluated to assess their effectiveness and plan for changes. These three steps outline the stages of a generic program "planning cycle" that is commonly used to manage programs over time.

The decision questions discussed below are designed to help policymakers, program managers and implementing staff at all levels to think through how various elements of a CHW program work (or do not work) together to increase CHW motivation and improve recruitment, retention, and performance. The first decision question explores the issue of how to design direct incentives, the second examines the design of indirect and complementary incentives, and the third reviews issues related to sustaining, managing, and evaluating incentives over time.

DECISION 1: WHAT KIND OF DIRECT FINANCIAL AND/OR NON-FINANCIAL INCENTIVES SHOULD CHWS RECEIVE?

Background

Policymakers and CHW program managers wrestle with this question most directly. It is often framed as a choice between "paid" and "volunteer" models, but the options and the challenges involved are actually much more complicated. In fact, there is a spectrum of possible approaches, from volunteers who cover their own costs and determine their own hours of work on one end, to salaried CHWs on the other end who have contracts, supervisors, and benefits similar to the other health care professionals with whom they work. Every program, however, that we have reviewed provides some kind of direct incentive for participation.

In practice, most CHW programs fall somewhere in the middle and incentivize their CHWs with some combination of salary or stipends (depending on whether they are considered to be employed by the government or acting as volunteers from the community) and a range of non-financial incentives such as uniforms, T-shirts, training opportunities, or community recognition. CHW salaries are typically less than those of nurses, but are still a substantial means of support for most CHWs. Stipends for volunteers, by contrast, are often framed as mere "honoraria" or "token" payments to volunteers, meant to reimburse them for the cost of their travel or their food during the day.

In most of the economically marginalized communities where one finds CHWs, however, these stipends and other non-financial incentives can still represent a significant financial or material benefit. Non-financial incentives, such as training opportunities, preferred access to healthcare services, or access to uniforms and bicycles can also have substantial material benefit. Even stipends that are well below the minimum or average wage in a community are often meaningful enough to keep CHWs, who might otherwise be completely unemployed, engaged in this work.

Whether or not these stipends can be justified ethically or whether they are legal with respect to local labor law is a separate but important concern. When CHWs are employed full-time as members of the formal health system, they typically enjoy many of the same legal protections and financial benefits as other employees. When framed as volunteers, however, they can sometimes be paid very little, despite the fact that the services they perform can require considerable time and energy and look very similar to the work of other paid healthcare staff.

Many of the non-financial incentives can also be quite powerful motivators of CHWs. These motivations include not only altruism rooted in religious or cultural norms of self-sacrifice for others, but also the desire for social recognition and status. Being identified as a valued member of the community and/or a trained member of the health system can be an important source of social standing and affirmation for CHWs. Successful CHW programs typically offer a mix of financial and non-financial incentives. There is no general rule for how many of these incentives should be offered or at what level, but successful incentive strategies do reflect the local contexts and concerns of the CHWs. This includes not only the country's cultural or religious context but also its economic, political, and social contexts.

Key Issues to Consider

Programs need to consider local precedents and expectations with respect to CHW incentives (see 1.1 in Table 2 below). Past or present CHW programs, operated either by the state or by NGOs, may have offered incentive packages that then become the basis for the expectations around new CHW programs. Local cultural and religious norms also shape the expectations of CHWs (see 1.2 in the Table 2 below). Religious norms can support the altruistic impulse behind CHW work, and, in some cases, financial incentives may be perceived as a direct threat to religious norms of service. Some have argued that this is the case, for example, among the Female Community Health Volunteers (FCHVs) in Nepal, whose participation in CHW work is often framed explicitly as part of a religious duty to serve. In other cases, however, social values may instead highlight the importance for fair and equitable levels of financial incentive.

Program designers and managers should also try to understand the personal motives and triggers of CHW involvement (see 1.3 in Table 2 below). Some CHWs are motivated to do this work because of personal experience with a specific health problem. Many of the CHWs in Southern Africa who work on HIV/AIDS programs, for example, have direct experience themselves or in the families with the disease. For others, the involvement of people in their social network can trigger their engagement. No matter how personal these motivations and triggers for involvement might be, however, they can and should be reinforced through social recognition of the value of CHWs (see 1.4 in Table 2 below). Programs can support the intrinsic motivations of CHWs by recognizing them for their contributions and encouraging community affirmation of their importance and impact. For example, Afghanistan holds an annual "CHW Day." Nepal too has a national day of recognition for its FCHVs and also provides them with ID cards to identify them as representatives of the health system.

Often, CHWs judge the value of incentives in terms of how equitably they are distributed, how consistently they are provided, and how they relate to the local labor market and economic contexts. The fairness of incentives matters because incentives are generally perceived to signal something about how the health system or community values CHWs (see 1.5 in Table 2 below). Incentives do not have to be *equal* across all sub-categories of CHWs, but when they are seen to be inconsistently or *inequitably* distributed, CHWs express frustration and resentment at both the implied message this sends, as well as the domino effect it can have on a family's welfare and access to resources.

Similarly, the sustainability of incentives is critical, and incentives that are distributed at inconsistent intervals, or run out at unexpected times can communicate lack of regard for CHWs as well (see 1.6 in Table 2 below). FCHVs in Nepal, for example, had their small stipends discontinued when the financing proved unsustainable. CHWs in Pakistan and South Africa often suffer demotivating delays in their monthly payments.

The messages that these delays and inequities can send about the value of a CHW's time and effort are also interpreted against the backdrop of the local labor market and economic contexts (see 1.7 in Table 2 below). If alternative employment opportunities are relatively plentiful, CHWs may have higher expectations of how their time is recognized and compensated. On the other hand, if work is scarce, CHWs may accept lower levels of incentive, both because there are few alternatives and because CHW training experience can provide a "stepping stone" to hard-to-reach employment opportunities.

To help policymakers and program managers think about the impact of local context on the particular mix of incentives that might be most effective, Table 2 reviews each of these issues and offers some questions to consider when designing incentives for CHWs.

Table 2. Questions to consider regarding direct incentives

1.1 Local precedents and expectations	Are there (or have there been) other CHW programs in the area? What have they offered as incentives? Do CHWs in your program expect the same? How will they interpret something less or something different? Are you in "competition" with these other programs? If so, how will you motivate CHWs to join and remain in your program, even if your incentives are different?
1.2 Local cultural and religious norms	What are the cultural or religious values that sustain altruism among CHWs? Does the work they do speak to those values? Is there a potential conflict between the material benefits offered (such as stipends) and these values about the virtue of self-sacrifice? Are there ways to manage this tension? How widely shared are values in actual practice or is there diversity in the value systems that motivate CHWs?
1.3 Personal motives and triggers of CHW involvement	How many of the CHWs in your program have some personal connection to the health problems addressed? What was their trigger for getting involved? How do the incentives offered relate to (promote or hinder) these personal motives and triggers for CHW involvement?
1.4 Social recognition of the value of CHWs	How are CHWs made visible in the health system and the community? How is their identity, their status and the value communicated? In what ways are CHWs formally recognized by the health system and the community?
1.5 Fairness of incentives	Are the incentives in your setting distributed fairly among different types of CHWs? If some CHWs are offered more or different incentives, is there a good justification for this and do the CHWs involved understand this justification? Are there inequities with respect to gender, age, type of work, length of service, religious or ethnic affiliation, or geographic region?
1.6 Sustainability of financing	How sustainable is the incentive package you are offering? Does it rely on overseas or special project funding from the MOH? Are alternative funding sources available? What do the CHWs understand about the longer-term sustainability of this financing?
1.7 Local labor market and economic context	How bad is poverty or unemployment in the area and how does this shape the meaning of the incentives offered? What are the other job opportunities available to CHWs, if any? Do CHWs see their training and experience as a CHW as a "stepping stone" to other job opportunities?

The seven key issues raised in Table 2 are not exhaustive, but they cover some of the most frequent kinds of questions that arise when trying to design and implement effective CHW incentives. Every local context will answer these questions differently, but if they can be answered well, there is a good chance that the particular mix of incentives offered to CHWs will be effective and sustainable.

DECISION 2: HOW CAN THE HEALTH SYSTEM AND THE COMMUNITY CONTRIBUTE TO INDIRECT AND COMPLEMENTARY INCENTIVES FOR CHWS?

Background

Although most of the attention paid to CHW incentives revolves around direct financial and non-financial incentives, it is also important to consider indirect and complementary incentives. Indirect and complementary incentives are those features of the health system and community context that either support or inhibit CHW motivation for their work (see Table 1 above). We have outlined a series of questions regarding these kinds of incentives in both the health system and the community in Table 3 below.

It should not be surprising that a well-functioning health system is motivating for CHWs and health care professionals alike. A well-functioning health system that also promotes recruitment, retention, and performance of CHWs includes: good training and supervision, clear roles and responsibilities, adequate supplies and equipment, up-to-date health information, effective referral relationships, and fair and transparent forms of accountability.

Key Issues to Consider

CHW programs operate in contexts where health systems are struggling. Although strengthening these health systems is a necessary long-term endeavor, there are some small improvements that can be made in the short-term that have a big impact on CHW motivation. CHWs can be motivated, for example, by having clear roles and responsibilities and the opportunity for feedback to and from both their peers and managers (see 2.1 in Table 3 below). The supervision chapter in this volume (Chapter 10) highlights some practical ideas for how managers can help CHWs, and those with whom they work, be clear about what CHWs can be expected to do and, as importantly, what CHWs should not be expected to do. Strong nurse supervision of community health agents (CHAs) in Brazil has been identified, for example, as a critical factor in that program's success.[3]

CHWs also express a desire for the opportunity for personal growth and professional development (see 2.2 in Table 3 below), which involves not only the development of personal and professional skills required to do one's work, but also opportunities for developing new skills and promotion. The lack of longer-term planning for a career path is often identified as a critical reason CHW programs struggle with high turnover and dissatisfaction. Providing CHWs opportunities to take leadership roles among their peers, as is done in Rwanda and Pakistan, can have important benefits for motivation.

The day-to-day working relationships among CHWs and between CHWs and other health care professionals can also have a powerful effect on motivation (see 2.3 in Table 3 below). When CHWs feel valued by nurses, doctors, and other healthcare staff, their motivation can be greatly increased. On the other hand, indifference and hostility from these staff can put a serious drain on the job satisfaction CHWs may be getting from other parts of their work.

The community context also plays an important part in producing and sustaining CHW motivation. Clear lines of accountability and recognition across the health system and the community are important, especially if CHWs are seen to represent and work for both the health system and the community (see 2.4 in Table 3 below). It is important for CHWs to know whom they are "reporting" to, both for recognition of a job well done and also to manage poor performance or work conflict. The relationship between CHW, community, and health system can be complicated, however, as we saw in the India case study presented above, and what happens in practice is often not what is intended in policy.

In smaller CHW programs, supporting CHW "champions" in the community can also help to sustain CHW recruitment, retention, and performance (see 2.5 in Table 3 below). Many programs are started by dedicated local founders and/or sustained by the devotion of the time and resources of a few or key community champions of CHWs. Many of the NGOs that run CHW programs in South Africa are sustained by these kinds of champions. Even as programs scale up, making a place for the involvement of local champions in the community or the health system can be useful.

Similarly, working effectively with civil society partners is a critical element of a strong CHW program (see 2.6 in Table 3 below). In some contexts, civil society partners such as NGOs take direct responsibility for managing and delivering CHW services. In settings where CHW

services are state run, however, the participation and buy-in of civil society organization can still provide a valuable source of community energy and legitimacy for CHW programs.

Finally, the relationship between the community and the health system is an important part of the context as well (see 2.7 in Table 3 below). How CHWs see their work and are valued by their community and depends on the history of this relationship. In some places, where state-run health services and/or the state more generally, are perceived with suspicion and even antagonism, CHWs may need to downplay their relationship to the health system. In others, where the state is trusted or biomedicine is seen as a source of prestige, CHWs may value opportunities to be seen as representatives of the health system.

Table 3 below reviews each of these issues and offers some questions to consider when designing incentives for CHWs.

Table 3: Questions to consider regarding indirect and complementary incentives

2.1 Clear roles, responsibilities, and feedback	▪ Do CHWs have clear job descriptions and distinct roles? ▪ Are the other health care workers aware of these roles? Are there areas of ambiguity or overlap? ▪ Do CHWs have the chance to get and give feedback from other staff or managers on a regular basis?
2.2 Personal growth and professional development	▪ What elements of the CHW role promote personal growth (e.g., social, emotional, psychological, intellectual skills, and development)? ▪ How can these elements be strengthened in the program? ▪ What elements of the CHW role promote basic professional development (e.g., computer, administrative, financial, or logistical skills)? How can these elements be strengthened in the program?
2.3 Day-to-day working relationships	▪ Do CHWs ever get the chance to work with each other in their daily work? ▪ Are there CHW associations or networks? ▪ How do CHWs and healthcare professionals relate to each other? How does the work environment affect these relationships? ▪ How are conflicts between CHWs and other health care workers addressed?
2.4 Accountability in the health system and community	▪ Are there multiple or confusing lines of accountability for CHWs (e.g., do they report to both the health system and the community or civil society managers)? ▪ How are conflicts or issues of poor performance among CHWs handled and by whom? ▪ How can overlapping or confusing lines of accountability be clarified or reconciled?
2.5 CHW "champions"	▪ Are there "champions" behind the CHW programs in your context, whether from the community, the health system, or civil society? ▪ How do they contribute to the program and what risks does their participation involve? ▪ Is the policy environment flexible enough to allow champions to emerge and contribute to CHW programs in a positive way?
2.6 Role of civil society partners	▪ What is the character of civil society (e.g., NGOs, community-based organizations, faith-based organizations and other forms of community organization) and how does civil society engage with CHWs? ▪ Who runs these organizations and do they represent broader community interests and perspectives? ▪ How does the relationship between civil society and the health system affect CHW motivation? To what extent does the CHW program's success rely on civil society?

2.7 Community's relationship to the health system and government	▪ What is the historical relationship between the local community and the health system/government? ▪ If one of antagonism and mistrust, how does this impair CHW motivation? ▪ If one of solidarity and confidence, how does this promote CHW motivation?

Again, many of the issues raised in Table 3 above involve broader issues in the health system (and are dealt with in other chapters), the community, and civil society. They are often not easily modifiable by CHW policymakers and program managers. However, these issues can often be understood and their effects anticipated and mitigated by CHW programs. Thinking about the troubled history of the relationship between a community and its health system might lead a policymaker, for example, to offer non-financial incentives that highlight the CHW's community identity (through NGO-led community appreciation days) rather than their relationship to the health system (through uniforms or name tags). Knowing that difficult relationships in a clinic between CHWs and nurses impact CHW motivation might lead a program manager, for example, to find ways of promoting better working relationships through shared training opportunities or joint staff meetings.

DECISION 3: HOW WILL CHW INCENTIVES BE DESIGNED, NEGOTIATED, MONITORED, EVALUATED, AND RE-ADJUSTED OVER TIME?

Background

Once programs have addressed some of the issues raised in Decisions 1 and 2 above, and once they have developed an effective mix of direct, indirect, and complementary incentives, the next challenge for both program designers and managers is maintaining the impact of these incentives over time. As one of our key informants put it:

> The number two issue [leading to the failure of CHW programs] is related *to lack of long-term perspectives* with regard to CHW careers [career trajectory] and long-term issues that CHW programs face.

As part of the preparation for this volume, we have reviewed the available evidence on incentive programs and asked individual program managers about their experiences of running CHW programs. We found that there is much more attention paid and evidence available with respect to the initial design of incentive packages, and much less is known about how to effectively manage and adjust these packages over time. In many cases, it appears that, once instituted, incentive packages either do not change or they change due to external circumstance (e.g., loss of funding) rather than a planned process.

Maintaining the motivation of CHWs through the appropriate incentives is critical for program effectiveness, regardless of where they fall on the spectrum between volunteers and paid employees. Therefore, it is important to see incentives not as a static problem with a straightforward answer, but as a dynamic process over time that requires attention.

Key Issues to Consider

The first step in thinking about how to use and manage incentives over time is to ensure an inclusive design process from the beginning that meaningfully incorporates the perspectives, needs, and expectations of the CHWs themselves (see 3.1 in Table 4 below). Proper consultation early on can be vital in ensuring that incentives are seen as legitimate and appropriate on an ongoing basis, even if the incentive package does not meet many of the expectations of CHWs. Early consultation also lays the foundation for an easier process at a later stage of reviewing and adjusting incentives. Just as with the initial design process, the process of evaluating and

reflecting on incentives and making changes to incentives packages should be similarly inclusive.

Once an incentive package has been designed and implemented, ongoing management is required for a number of reasons. For example, workloads for CHWs can change over time. The case study from India highlighted the fact that the tasks allocated to CHWs also often change and can present new technical challenges for individual CHWs who may have less capacity or experience. Feeling that the workload and technical requirements of the job are "do-able" is an important incentive for CHWs, especially given that their scope of work is often poorly defined and supervision weak (see 3.2 in Table 4 below).

CHW incentives can also lose their effect and can interact in unexpected ways over time (see 3.3 in Table 4 below). The case study of the ASHAs in India above illustrated several unintended consequences of the outcomes-based incentive scheme in that program. These included an over-emphasis on those health tasks that could generate income and an association of ASHAs with the health system, even though they were supposed to function as community-based activists. Similarly, FCHVs in Nepal are increasingly dissatisfied with the small stipends they have received. Rather than seeing payments as contrary to religious imperatives, they are starting to lobby for full salaries. Managing these kinds of issues that emerge over time requires ongoing attention.

Finally, CHWs themselves change over time as do the social, economic, and political contexts in which they work (see 3.4 and 3.5 in Table 4 below). The longer a CHW remains in a program, the more likely they are to have (more) children or pursue further training and education. Their interests may shift over time, and their motivation for engaging in CHW work may wax or wane. Although programs cannot attend to the changing circumstances of every CHW, ongoing supervision would provide an opportunity to identify and respond to some of these changes as they emerge. Similarly, changes in the social and community contexts, in the economic situation, or in the political circumstances of the country can also impact, positively or negatively, on the ongoing effectiveness of CHW incentives.

Table 4 below reviews each of these issues and offers some questions to consider when designing and managing incentives for CHWs.

Table 4: Questions to consider regarding the ongoing management and evaluation of CHW incentives

3.1 The importance of feedback and participation in the policy/program cycles	▪ What kind of planning and consultation went into the design of incentives at the beginning of your CHW program? Were CHWs consulted? If so, how? If not, why not? ▪ What do CHWs feel about the current, formal incentive package? ▪ Are there opportunities for soliciting their feedback and feeding it into ongoing policy and program design cycles? ▪ Do CHWs perceive this consultation process to be fair and responsive?
3.2 Ensuring the "do-ability" of CHW work	▪ How is the CHW's set of responsibilities decided on and how do managers ensure CHWs have the capacity to fulfill these responsibilities? ▪ Will managers know if the workload or the job requirements are exceeding the capacities of individual CHWs? ▪ Do CHWs have the opportunity to speak out about issues of workload or technical capacity? ▪ Are CHWs or program managers able to re-organize tasks to improve the "do-ability" of the role?

3.3 Sustaining the effect of CHW incentives and managing their unintended consequences	▪ How do CHWs understand and prioritize the various incentives (of all kinds) offered by the program? ▪ What increased or alternative incentives do they say would help sustain their motivation? ▪ Are incentives sustainably and equitably distributed? ▪ Have there been unintended consequences of a particular mix of incentives in a program? ▪ Does policy afford program managers flexibility in adjusting the mix of incentives?
3.4 Change over time as motivations, needs, and capacities of individual CHWs change	▪ Have the incentives offered to CHWs remained the same over a long period of time? ▪ If so, do they still motivate CHWs? ▪ If not, should the incentive be increased or complemented with another kind of incentive? ▪ As CHWs get older and have families, do they report that previous incentives are less relevant and alternative incentives potentially more effective?
3.5 Changes in social, cultural, political, economic, health systems, and demographic contexts	▪ Since the initial design of a CHW program and its incentives, what has changed in the broader context that might impact on these incentives? ▪ Have there been changes in the priority diseases, disease-related stigma, demographics of the local setting, political or social conflicts, economic opportunities, or structure of the health system? ▪ If so, do any of these changes affect the incentives offered to CHWs?

As with the indirect and complementary incentives outlined in Decision 2 above, the challenges of managing CHW incentives over time are often outside the control of program designers and managers. Some of these challenges can be anticipated and planned for, but many cannot. The key question, therefore, to ask in these circumstances is not what kinds of incentives will last the longest over time, but what kind of local process for designing, managing, and re-evaluating incentives will be most effective at responding to these changes over time.

CONCLUSION

This chapter has highlighted the fact that there is no easy, one-to-one relationship between incentives, motivation, and practice. Local relationships, contexts, histories, beliefs, and expectations can each have a dramatic effect on how and why a particular mix of program features may or may not work to incentivize CHWs in a particular place and time.

Many of the factors described above are features of the broader health system or social and economic context (see especially Decisions 2 and 3). We have argued above that although programs cannot change or predict many of these factors, they can anticipate and manage them, which is especially important because the "stick" factors – the factors that keep one in a job –are generally much weaker for CHWs than they are for health care professionals. [4] Thus, it is critical to pay careful attention to all the factors that motivate CHWs to engage, remain in, and perform their best in this important work.

Key Resources

A good in-depth case study related to CHW incentives: Glenton C et al. 2010. The female community health volunteer programme in Nepal: decision makers' perceptions of volunteerism, payment and other incentives. *Soc Sci Med* 70(12): 1920-7.

A good overview on incentives: Strachan D et al. 2012. Interventions to improve motivation and retention of community health workers delivering integrated community case management (iCCM): stakeholder perceptions and priorities. *Am J Trop Med Hyg* 87(5 Suppl): 111.

A useful empirical study that also incorporates a helpful conceptual framework for sources of CHW motivation at individual, family, community, and organizations levels: Greenspan JA, McMahon SA, Chebet JJ, Mpunga M, Urassa DP, Winch PJ. Sources of community health worker motivation: a qualitative study in Morogoro Region, Tanzania. *Hum Resour Health* 2013; **11**: 52.

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