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Programmatic factors influencing motivation and retention of community health workers
(CHWs) in humanitarian emergencies context

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List of abbreviations

| | |
|-------|--|
| AIDS | Acquired Immunodeficiency Syndrome |
| CBHFA | Community Based Health and First Aid |
| CHVs | Community Health Volunteers |
| CHWs | Community Health Workers |
| HIV | Human Immunodeficiency Virus |
| ICRC | International Committee of the Red Cross |
| IDPs | Internally Displaced Persons |
| IFRC | International Federation of Red Cross and Red Crescent |
| LMICs | Low and Middle Income Countries |
| MSF | Medicins Sans Frontieres |
| MDGs | Millenium Development Goals |
| NCDs | Non-communicable Diseases |
| NGOs | Non-governmental Organizations |
| PHC | Primary Health Care |
| RCRC | Red Cross Red Crescent |
| TB | Tuberculosis |
| WHO | World Health Organization |

Abstract

Introduction: CHWs are essential component of health workforce that play pivotal role in the delivery of- and expanding access to- primary health care of the affected population. In humanitarian emergencies context, they are working under restrictive and unsafe conditions that may in-turn cause demotivation and failure of community health programmes to retain trained CHWs. However, sustaining CHW motivation and retention has been identified as attributes to the observed successes of CHW programmes. This study explores the people management factors embedded into the design and implementation of CHW programmes that influence motivation and retention of CHWs in the humanitarian emergencies

Methods: Review of literature relevant to CHW motivation and retention, comparative analysis of policy documents and reports from humanitarian organizations implementing CHWs programmes i.e IFRC and MSF, and key informant interviews with relevant personnel at MSF.

Key findings: Six key people management factors embedded into the design of CHWs programmes were identified, and its interaction in humanitarian emergencies context demonstrated using the theories of workers motivation and retention. Factors identified community-driven selection and recruitment of CHWs, duty of care, training and personal development process, fairly compensated workload, provision of adequate financial and non-financial incentives, and supportive supervision.

Conclusion: CHWs remained one of the most reliable vehicle for delivery of key community-based interventions and backbone for successes of community health programmes for saving lives and improve health and wellbeing of affected populations. The six key people management factors are crucial from programmes designing stage to execution to retain trained CHW and keep them motivated to perform.

Key words: community health workers, volunteerism, motivation, retention, people management factors, humanitarian emergencies

1. Introduction

1.1. Background

Globally, health workers are regarded as a backbone of strong and resilient health system towards achieving the Sustainable Development Goals commitments particularly to improve human wellbeing and addressing inequities in access to health services⁰. In the framework of Universal Health Coverage, having adequate health workforce is identified as not only a necessary component of a functional and equitable health system, but also a major determinant of service delivery and improved health outcomes^{2,3}.

However, many countries of varying socioeconomic development levels fail to have adequate health workforce to cope with the population growth and migration, and with resulted increasing demand for access to quality health care. This became prominent towards the end of the Millennium Development Goals (MDGs) era when the global health workforce shortage was identified as rate-limiting for achieving individual country health outcomes, notably MDGs 4 (child mortality reduction), 5 (maternal mortality reduction) and 6 (combating malaria, tuberculosis and HIV/AIDS) in Low and Middle Income Countries (LMICs)².

The degree and effects of inadequate skilled health workforce is worst felt in the response to humanitarian emergencies, especially in conflict settings where humanitarian agencies are struggling to find and retain skilled staff to work in difficult unsafe conditions. In the World Health Report 2006, the World Health Organization (WHO) identified 57 countries as having an acute health workforce crisis, and almost all countries affected by conflicts are among in this group³. Majority of these countries are also facing greatest burden of diseases. As the frequency, magnitude and protracted nature of conflicts are on the rise in the recent decade, it calls for the urgent strategies to respond to the health workforce challenge.

One of the key strategies proposed in the Human Resources in Humanitarian Health Working Group Report during the 2009 Humanitarian Action Summit to address health worker shortage in humanitarian settings is task shifting – *“a review and subsequent delegation of tasks to the lowest category who can perform them successfully”*, including trained Community Health Workers (CHWs)⁴.

In recent years, the world has observed almost a two fold increase in number of people displaced by violence and conflicts from 16.3 million in 2009 to 27.9 million in 2014⁵. About ninety-five percent of the world’s displaced population, both refugees and internally displaced persons (IDPs), are hosted in LMICs where the shortage of health workforce is prominent (Global Humanitarian Assistance Report, 2015; WGR HR in Humanitarian Health, 2009)^{2, 6}.

In such context where the impact of health problems associated with mass displacements and overcrowding is likely to be overwhelming, Community-based interventions are becoming more vital for lifesaving and improve wellbeing of affected populations, and CHWs are increasingly recognized as an integral component of health workforce needed to achieve that goal^{7,8}.

1.2. Problem Statement

It is well established through extensive literature that CHWs can make a positive impact on health and wellbeing of the communities they serve, supporting their effectiveness in the delivery of health care services especially in maternal, newborn and child health^{8,9}. CHWs are conducting home visits to deliver health education and preventive services; identification of common childhood illnesses and address early care seeking; identification of pregnant women and referral; facilitate the access to- and promote the use of- health services in their communities. These actions have shown to contribute to improved maternal and child health outcomes⁴.

Sustaining CHW motivation and retention, as well as optimizing their performance has been identified as attributes to the observed successes of CHW programmes across all health conditions, age groups and contexts^{9,10}. Although little is known on how the three concepts interact to influence one another, research studies to examine factors that influence CHWs motivation and retention in LMICs suggested that, the two concepts are linked and determined by a number of inter-related factors which can be personal-driven or embedded in the programme. The literature focusing on people management factors embedded into programmes suggested that the following play a major role – recruitment process; adequate training; workload assigned; remuneration or incentives; supportive systems for supervision and link to health facilities; and community participation^{7,8,9,11}.

While the influence of key people management factors mentioned above are widely explored in development context, there is still a literature gap on how they interact to influence motivation and retention of CHWs working in humanitarian emergencies especially in conflict settings. CHWs in conflict settings are often under restrictive and unsafe environment, likely to have short and inadequate training, relatively heavier workload, inadequately compensated for the workload, and weaker supportive supervision systems. However, despite these challenges, CHWs remained an essential health workforce that play pivotal role in the delivery of- and expanding access to- primary health care in humanitarian emergencies^{9,13,14}.

This study explores the factors embedded into the design and implementation of CHW programmes, and their interaction to influence motivation and retention of CHWs in the humanitarian emergencies. Adequate understanding of how these factors interact is critical to humanitarian actors in designing more effective and sustainable community-based health programmes that not only will contribute to saving lives and improve wellbeing of affected populations, but also reflecting the needs for CHWs job satisfaction.

1.3. Research Question

- How do people management factors embedded in community health programmes influence the motivation and retention of the CHWs in humanitarian emergencies?
- Sub-research questions:
 - What are the key people management factors embedded into designs of community health programmes to influence motivation and retention of CHWs?
 - How do the key people management factors reflected in humanitarian organizations policies and guideline for programme design, implementation, and management?
 - How do key people management factors interact in humanitarian emergencies context to influence motivation and retention of CHWs?

1.4. Methodology

Two methods were employed to answer the research question. First, internet search was conducted to identify literature relevant to research question. This was followed by desk review and secondary data analysis of identified literature from peer-reviewed journals, reports, and grey literature. Various databases and search engines were explored including Google Scholar, Rero-explorer of Graduate Institute library, PubMed NCBI, and Cochrane database. The search key words used were – community health workers, health workforce, task shifting, Alma Ata declaration, volunteerism, motivation, retention, performance, programmatic factors, humanitarian emergencies, low and middle income countries. Reference was also made to relevant book chapters from internet search as well as Graduate Institute and University of Geneva Uni-Mail libraries.

Secondly, comparative analysis of key policy documents, guidelines and reports from two key humanitarian organizations implementing community health programmes. The two organizations are International Federation of Red Cross and Red Crescent (IFRC) and Medecins Sans Frontieres (MSF), and were purposeful selected based on (i) organizations are currently implementing or have recently implemented community health programmes in humanitarian emergency settings (ii) NGOs head offices are in Geneva and consented for the

sharing of key documents and key informant interviews.

Thirdly, primary data were collected through two key informant interviews with the MSF – Operational Centre Geneva with reference to the subject in question. Semi-structured questionnaires with open question were used to probe the discussion during the interviews. IFRC could not participate due to unavailability of key informants to the subject in question.

The primary and secondary data collected and analyzed were triangulated to explore the interaction between people management factors that influence the motivation and retention of CHW in humanitarian emergency settings.

1.5. Limitations

The main approach of this research was review of the secondary data from peer-reviewed journals and books. The major limitation of this approach was the fact that majority of the peer-reviewed literatures exploring factors that influence motivation and retention of CHWs are conducted in development setting. Most of the available literatures in humanitarian emergencies, particularly in conflict settings, were disseminated reports from various organizations and unpublished researches i.e “grey literature”. Although the secondary data analysis was complemented by primary key informant interviews, for convenience purposes and availability of key informant, the interview were limited organizations head quarters level in Geneva. Due to time and logistic constraints, interviews were neither conducted to personnel in the field nor CHWs despite of the big contribution it would have to answer the research question.

The paper is structured into four main parts i.e introduction, literature review of the main concepts, discussion and conclusion. Introductory chapter has provided background information on relevance of community health approaches and CHWs in humanitarian emergencies context challenged by growing burden of health needs with inadequate health workforce. The second chapter is focusing on review of literature to describe evolution of volunteerism and its adoption into CHW concept; exploration of key concepts of motivation and retention, their theories and set of people management factors interacting to influence the two concepts; and comparative analysis on the reflection of mentioned factors in the policies, guidelines and programme reports of IFRC and MSF. This first part forms the basis of discussion in answering the research question and sub question.

2. Literature Review

2.1. CHWs and volunteerism

2.1.1. Volunteerism and its challenges

Volunteerism is an old concept traced back to 1600s as derived from the noun ‘volunteer’ referring to “one who offers himself for military service”, and also as an adjective from Latin word ‘voluntarius’ meaning “one’s free will”¹⁵. Out of the military context but keeping the original meaning of the concept, volunteers’ management specialists Susan J. Ellis and Katherine H. Campbell defined a volunteer as an individual who “*choose to act in recognition of a need, with an attitude of social responsibility and without concern for monetary profit, going beyond one’s basic obligations*” – the choice to act emphasizing free will, social responsibility indicating action that benefit society at large, and without monetary profit meaning not for personal economic gain¹⁶.

While volunteering can be formal or informal, the history of what is considered to be formal volunteering started in humanitarian settings in 1859 during the battle of Solferino, when Henry Dunant, a Swiss businessman and social activist, took the initiative to organize the civilian population to provide assistance to the injured and sick soldiers. This prompted the creation of International Committee of the Red Cross (ICRC) in 1863, and later marked the beginning of the largest ever-documented volunteering movement in the world, the Red Cross and Red Crescent (RCRC) movement. It is partly because of this long history and the associated feeling of altruism, that volunteerism has been closely linked with humanitarianism, to provide assistance and protection based on the needs of people directly affected by the crisis event.

At the present time, volunteerism is in the core of humanitarian action with multitudes of humanitarian organizations implementing community-based programmes for protection and assistance through mobilization of community volunteers. Investing on their local knowledge and capacities as members of the affected communities, especially in terms of culture, social norms and values, trained and supported community volunteers can take charge to address issues and challenges affecting their lives and their communities to positively cope with the upheaval.

One of the prominent successes of community-based programmes is in the health sector where evidence from the literature has shown that, community health workers and volunteers expanded the access of health services to the poorest, marginalized and hard-to-reach areas; facilitated strengthening of local capacities for sustainable delivery of social services;

mobilized communities to take actions on matters that are relevant to their lives and wellbeing; and influenced inclusion and participation of marginalized groups like women and youths to voice their opinion on matters concerning them and the community at large^{17, 18}.

However, number of challenges are already facing and threatening the performance and sustainability of community programmes based on volunteerism, merely by embracing the sole definition of a volunteers. Community volunteers in humanitarian emergencies settings are likely to be exposed to effects of the same contextual difficulties that employees of the governments, NGOs and humanitarian organizations are experiencing, such as of security risks, unfavorable working conditions, exposure to physical and mental health risks, and inadequate resources. Yet, human resource management policies for many international organizations especially in terms of duty of care to staff, recognition, rewards and benefits have been towards the employees and international volunteers, ignoring wellbeing of the community volunteers. In many occasions, this has resulted into job dissatisfaction, demotivation and high attrition among the community volunteers, and ultimately collapse or poor performance of community-based programmes^{19, 20}.

United Nations General Assembly through resolution number A/RES/56/38 of 2001 proposing ‘Recommendations on Support for Volunteering’, recognized the valuable contribution of volunteering and its importance as a component of any strategy aimed at poverty reduction, sustainable development, health and social services delivery, disaster prevention and management, and social integration²¹. The resolution underlined the largely overlooked economic contribution of volunteering and monetary value of life-saving voluntary actions that volunteers are conducted, and argued that volunteerism is ‘cost-effective’ but not ‘cost-free’. In response to the challenges facing volunteerism, the resolution proposed in support for volunteering, the following recommendations to the United Nations agencies, governments, NGOs and humanitarian organizations:

1. Promote volunteerism through formal recognition of volunteers, measuring and highlighting economic and social impacts they make to the communities
2. Improve infrastructure and friendly work conditions for volunteers including legal and-or contracture status, duty of care, rewards and benefits, and access to relevant information
3. Training of volunteers to develop a standard set of skills and knowledge necessary for the tasks assigned to them
4. Develop non-partisan financial support and approaches to cover costs associated with volunteering including mobilization, training, monitoring and supervision, reward and

recognition of volunteers

2.1.2. Evolution of CHWs as volunteers

The idea of using CHWs, the front-line health workers who are members of- and are selected by- the communities to deliver basic health services has existed for more than five decades⁴. In the 1960s, China implemented in rural areas one of the most successful and inspiring CHW programme famously known as ‘Barefoot Doctors programme’ in which peasants were trained to provide basic health services at community level, including proper hygiene, diagnosing and treating simple infectious diseases, family planning, and maternal and child healthcare services²².

The approach became more prominent after the Alma Ata Declaration on Primary Health Care (PHC) in 1978, which identified CHWs as a part of legitimate health workforce necessary to ensure that health services are equally accessible to all individuals, households and communities⁴. The WHO proposed a definition that: *“Community Health Workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers”*⁴.

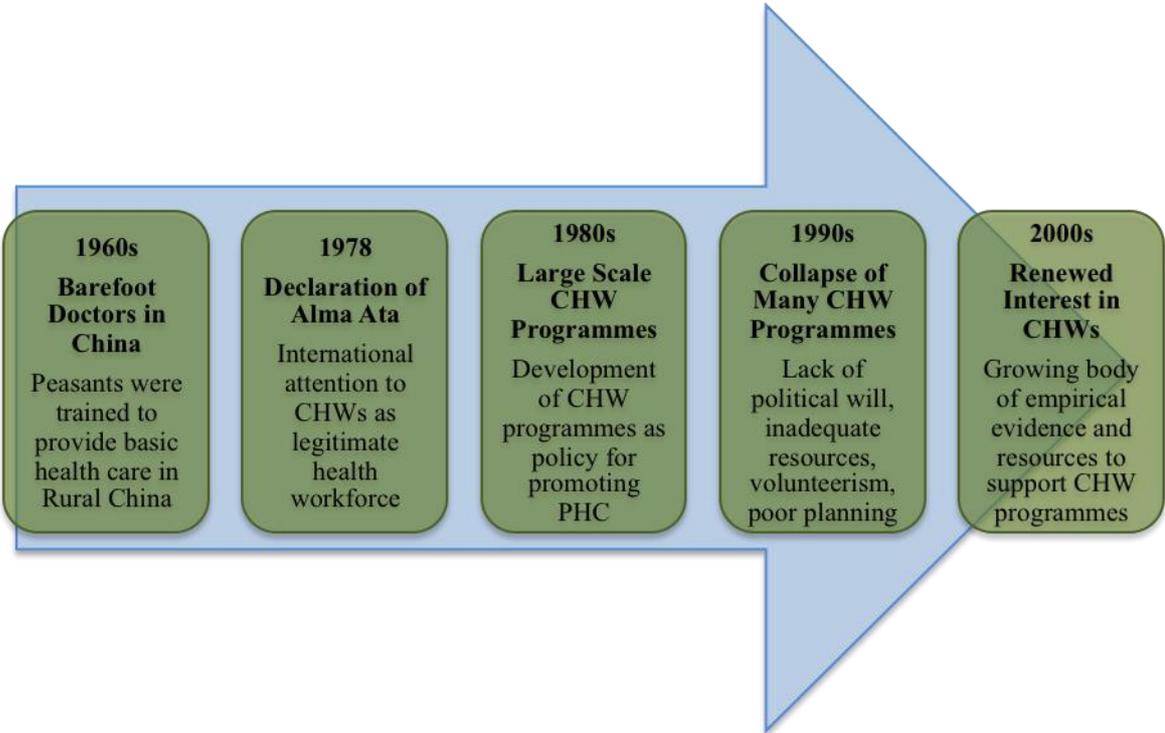
In the 1980s, many countries of low and middle income embraced the WHO model of CHW and adapted to their resource-limited context as community volunteers. Many countries signatory to Alma Ata declaration, especially developing countries, considered the establishment of CHW program and mass training of CHWs as the principal approach for implementation of the PHC policy²³. In most of these countries, trained CHWs were employed by the governments on voluntary and full time basis, covering wide population in difficult rural areas, with no or inadequate incentives and career prospects²³. Despite that, the era was marked with proliferation of the government CHW programmes at national scale and some successes were documented in countries such as Tanzania, Zimbabwe, Malawi, and Mozambique in Africa; Indonesia, India, and Nepal in Asia; Nicaragua, Honduras and other countries in Latin America¹⁸.

However, the approach of using community volunteers for CHW programmes posed challenges to the effectiveness and sustainability of community health programmes in most of the LMICs. Lack of political commitment and financial supports from the governments and donor organizations failed the programmes to scale up while maintaining the original levels of altruism, commitment and effectiveness¹⁹. In between 1980s and 1990s, a number of national

scale CHW programmes suffered serious difficulties and many of them collapsed due to, among other reasons, the insufficient remuneration and incentives that de-motivated the trained CHWs and affected their retention and performance¹⁸. Evidence from a number of studies show that many CHW programmes suffered frequent turnovers and recorded high attrition rates of up to 77 percent, especially among programmes solely associated with volunteerism¹⁹.

Nevertheless, the undisputed successes of the CHW programmes as the most reliable vehicle for delivery of crucial and culturally sensitive key health messages to empower individuals, households, and communities to make informed decisions pertaining their health, as well as increase local access to lifesaving health care services maintained the CHWs as a vital health workforce in LMICs^{4, 18, 20}. As the reason, the 2000s era observed the renewed interest in the contribution of CHW programmes and the associated health sector reforms including decentralization of health systems and services in developing countries as the means to achieve the United Nations’ health-related MDGs. This led to the formation of a number of global alliances, initiatives and campaigns to revitalize the CHW programmes including the WHO community Integrated Management of Childhood Illnesses in 2004, Global Health Workforce Alliance in 2006, and One Million CHWs Campaign in 2013.

Figure 1 : Evolution of large scale CHWs programmes



Source: The author Thomas Victor Lyimo, 2017

2.2. Workers motivation and retention – concepts and definitions

2.2.1. Motivation

Despite of the richness of literature from various scholars in psychology and social sciences who studied the concept of motivation with regards to workers, including employees and volunteers, there is no single self-explanatory definition of workers motivation. However, it is appreciated that originated from the root word ‘motive’ that Webster’s Dictionary define as “*reason or something that causes a person to act*”²⁴. In addition, there is also consensus from the available literature that motivation can be intrinsic when the motive is driven by the individual internal rewards, or extrinsic when the motive is to earn external reward or avoid punishment²⁵.

Psychologist Ray Williams as quoted by Burton, K et al 2012, defined motivation as “*predisposition to behave in a purposeful manner to achieve specific unmet needs, and the will to achieve, and the inner force that drives individuals to accomplish personal and organizational goals*”. This definition proposed that workers are motivated to perform assigned tasks at their workplaces in order to achieve not only organizational goals, but also their personal goals. Therefore, the more motivated the workers are, the more likely they will identify themselves with the organization and achieve the organizational goals²⁶. The author of this paper find the definition above as relevant to support answering the proposed research question, because it employs both organizational and personal attributes that can be influenced by the way programmes are designed and implemented to sustain workers motivation.

Theories have been proposed to aid an understanding of how different factors interact to influence workers motivation, and have been applied in various organizations when developing their human resource policies. For the purpose of this paper, the two most famous motivation theories widely examined by different scholars to describe factors that influence motivation will be discussed.

i. Maslow’s Hierarchy of Needs

In 1943, psychologist Abraham Maslow proposed one of the oldest theories of motivation with an idea that people are driven with keen to satisfy their unmet needs depending on what they already have. He therefore developed a hierarchical pyramid with five levels of needs that people will seek to meet, starting from the bottom level that once achieved an individual will strive for the next higher level of satisfaction towards the top. The hierarchical needs levels are as follows:

- Lowest level is *physiological needs* – these are basic survival need such as food, water,

shelter, clothing, and sleep/rest.

- Second lowest level is *security needs* – the sense that individual and family surrounding is safe, protected from violence, and household has financial and/or job security.
- Third level is *affiliation need* – expresses the need to belonging to a group or team, friendship, being appreciated, receive and give love.
- Fourth level is *esteem need* – expresses the need for feeling self-worthy and need for respect from others based on your achievements
- Top most level is *need of self-actualization* – based on the satisfaction of all four levels and refers to the need of self-fulfillment and tendency to become actualized in one's potentials.

CHWs often are living and working in rural and impoverished areas in LMICs and humanitarian emergencies settings, where tend to have the lowest status because of their low levels of education and poor economic status¹⁹. In such settings, community members including CHWs are often struggling to meet their daily basic and security needs. Therefore, they are more likely to spend their time engaging in activities that rewards gained can fully or partially satisfy their pressing needs before seeking to address other higher need. CHWs working full time as volunteers, despite of their altruistic motive, have found it difficult to be motivated and continue working without rewards either in form of monetary or material incentives to address their individual and family needs.

ii. Herzberg Two-factor Theory

In the late 1950s, another psychologist namely Frederick Herzberg whose work focused on management, including people management, conducted a study to describe satisfying events at workplace, and factors that are connected to the work itself while influencing satisfaction²⁷. Based on the study findings, Herzberg theorized that workers' motivation is influenced by two sets of factors that act independently to cause job satisfaction or dissatisfaction.

The first set is called 'motivation or growth factors' which influence the workers into higher performance. They tend to increase job satisfaction and hence sometimes referred to as 'The Satisfiers'. They include nature of the work, responsibility, recognition, personal growth and achievement. The second set is called 'hygiene or maintenance factors'. The absence of this set of factors is likely to cause dis-satisfaction among the workers, and hence sometimes referred to as 'The Dissatisfiers'. They include working conditions, compensation (remuneration, incentives, rewards), job security, organization policies and administration.

However, most of the CHW programmes based on volunteerism have only invested on

one set of few altruistic motivation factors such as perceived importance of nature of the work, sense of social responsibility, and recognition as the main rewards for engaging in the programme. Other motivation factors that are equally important such as personal growth and development, as well as hygiene factors such as remuneration and incentives, better working conditions and relationships are frequently not underscored. Evidence from the literature suggested that high attrition rates observed in volunteerism-based CHW programme is attributed to disregard of some motivational and hygiene factors when designing the programme.

The two discussed theories support the definition of motivation proposed by Ray Williams that it takes a person who have desire to prosper his personal and social unmet needs as proposed by Maslow, as well as programmatic/organizational wellbeing and enabling factors as proposed by Herzberg, to achieve goals that are desired by both parties respectively.

2.2.2. Retention

Various scholars have defined the concept of workers retention differently by referring it to a ‘process’, a ‘technique’, a ‘strategy’, ‘systematic efforts’ or ‘policies and practices’, but all agree that the ultimate aim is to maintain the workforce in the organization. Das Bidisha and Mukulesh Baruah conducted a review of literature in 2013 involving books and peer reviewed journal articles to study employee retention initiatives, and described employee retention as “*a process in which employees are encouraged to remain with the organization for a maximum period of time or until the completion of the project*”²⁸. Bidisha and Mukulesh defined retention in the aspect of workers’ needs that have to be satisfied as an encouragement to remain in the organization. But other scholars defined workers retention as “*the ability of an organization to retain its workforce*”, emphasizing organizations’ responsibility to foster environment with policies and practices that address workers’ needs and encourage them to stay²⁹.

The concept of workers retention is closely linked with motivation as they are both influenced by either the urge to satisfy intrinsic unmet needs as proposed by Maslow’s theory, or in addition extrinsic rewards from the working environment that elude dis-satisfaction as proposed by Herzberg theory. In 2014, Mohammad Ramdianee published a research paper and proposed a Join-Stay-Leave model that used elements in the two theories to summarize why employees and volunteers join, why they stay and why they leave an organization.

- *Why workers join* – attractiveness of the job position in terms of unmet needs and nature of the work that is perceived as important, is what entice individuals to join organizations

in the first place. However, that does not guarantee workers to stay especially when there is discord with their expectations for the particular position or the organization as whole³⁰.

- *Why workers stay* – after joining the organization, through participation in work and social life, workers develop a web of connections and relationships that make them embedded into the organization. The more embedded workers are into the organization, the more they likely to stay long, because leaving will sever the social networks and deprive them the sense of affiliation and belonging³⁰.
- *Why workers leave* – oftentimes, low satisfaction is indicated as initiator of the job withdraw process. Although the most common stated reasons for why workers leave the organization are better pay, better workload, or better opportunity, careful conducted exit interviews show that workers often leave due to relationships with managers, supervisors or treatment by other workers³⁰.

Although Ramdianee research was conducted in Australia, and the widespread application of his model to different contexts is questionable, the factors that he identified as influencing retention are in-line with factors that Maslow and Herzberg described as influencing motivation of employees and volunteers including CHWs. The factors that Maslow and Herzberg described as influencing the intrinsic motive of individuals such as need for achievement, recognition, personal development and the altruistic nature of the work itself, are the same factors that Ramdianee identified as encouraging employees and volunteers to join an organization. Furthermore, extrinsic factors like good interpersonal relations, social networking, sense of belonging, fair rewards and incentives that satisfy basic needs, job security, and better work conditions were found to encourage employees and volunteers to stay in an organization and contribute to the achievement of goals.

2.3. Motivation and retention of CHWs in humanitarian emergencies context

Application of the motivation and retention factors hypothesized in the theories above to workers and volunteers in humanitarian emergencies context has always posed a challenge to the responding local and international organizations. This is merely because such contexts are characterized with crisis events that pose critical threat to the health, safety, security and wellbeing to both affected population and aid workers. Owing to the crisis events and enormous needs of the people directly affected, as well as the urgency to satisfying them in impoverished conditions, humanitarian emergencies present unique contextual challenges for programme management.

Health is one of the sectors that are usually overwhelmed with increased needs in the

event of humanitarian crisis due to mass displacement and overcrowding, food insecurity and inadequate nutrition, poor access to safe water and sanitation facilities, physical and psychological effects, and disruption to the provision of basic and life-saving health care services. The impact of humanitarian emergencies on health systems and service provision is likely to be extensive including destruction of health facilities, loss of health workers, frequent and prolonged shortages of drug, equipment and supplies, infrastructural and security challenges restricting affected population to access health care⁹.

Responding to the needs and contextual challenges above, shifting of focus has been observed in emergency health programming towards community-based approaches. Most humanitarian organizations are implementing community health programmes through CHWs and volunteers, to provide essential PHC services at household and community levels, increasing access to health care for the affected and marginalized communities⁹. This approach has already been documented to improve health and nutrition outcomes both in development and humanitarian emergencies contexts.

However, despite of the rich documented successes, community health approaches are not immune to the contextual challenges of humanitarian emergencies. Various studies in such settings reported implementation of CHW programmes being confronted by dysfunctional health systems, insecurity, and unstable under-resourced working conditions⁹. Those pose challenges not only to the responding humanitarian organizations and programmes, but also to individual aid workers and community volunteers especially in terms of job satisfaction, motivation and retention.

Literature from various researches conducted to study motivation and retention of the CHWs and volunteers, have found that factors that are positively or negatively influencing the two concepts embedded into the programme design^{7, 8}. Using the experience of two purposefully selected international humanitarian organizations with high expertise in responding to health risks and consequences of humanitarian emergencies, this paper explores how are these factors reflected in the policies and guidelines that guide the design of their community health programmes, implemented, and facilitated management of CHWs.

2.3.1. IFRC – Community Health Volunteers model CHV model content and guiding tools

The International Federation of Red Cross and Red Crescent (IFRC) and national societies presents the world's largest volunteers network, with estimated tens of millions of RCRC movement volunteers scattered in 186 countries worldwide responding to

humanitarian emergencies³¹. For over a century, the movement relied on community volunteers not only to expand access to social services, but also to strengthen community resilience by supporting communities to develop and use its own resources and capacities to respond and positively cope to the impacts of crises^{32, 33}.

The community health volunteers (CHVs), a RCRC movement version of CHWs, are among the most prominent community volunteers responding to public health impacts of crises. They are recruited among the affected population and thus phenomenal in promoting community participation and dialogue to identify priority needs, exploiting local resources and capacities in designing solutions and programmes for the response³². CHVs work as change agents to empower individuals, households and communities in general to take charge of their own health, including reducing risks and strengthening resilience to health threats following humanitarian crises³².

The IFRC identified volunteers as the strength of the organization and at the heart of their operations in effectively responding to humanitarian emergencies worldwide³⁴. The capacity to attract millions of volunteers made the RCRC movement a ‘unique humanitarian force’ to cope with the increasing magnitudes of humanitarian emergencies with their associated public health threats and consequences. However, the legal, sociocultural and economic environments that are made worse by the humanitarian emergencies context have always challenged the movement and threaten the IFRC as well as national societies’ capacity to recruit, motivate and retain community volunteers³⁴. Increasingly, the ability of National Societies to mobilize community volunteers while competing with other organizations for the same workforce has in recent years been called into question³².

Recognizing both social and economic values of community volunteers to the organization, communities and volunteers themselves, IFRC developed volunteer management policies, guidelines and toolkits to address the potential challenges. These tools are adapted by national societies worldwide as framework that ensure coherence not only on technical aspect of community health programmes, but also in protection and management of CHVs. These includes:

- Federation Volunteer Policy (FVP): The FVP 1999 and its implementation guide 2002 define the rights and responsibilities of both the national society and its volunteers to each other and the affected population. It sets out a clear framework for national societies seeking to develop their own volunteering policies and provide guidance for well functioning management systems and practices to supervise, support and encourage volunteers

- Community Based Health and First Aid (CBHFA) – Toolkit: The 2009 technical guideline providing framework for the design, implementation, monitoring and evaluation of community health programmes. It is centered on CHVs defining their roles and responsibilities, and the integrated package of health interventions to be delivered at community level
- Legal Issues Related to Volunteers – Toolkit: The 2011 toolkit provides technical support to national societies to ensure better protection and management of their volunteers including duty of care and safety obligations based on legal definition of a volunteer. It provides a framework to national societies in analyzing the contextual legal issues that may impact on volunteers and volunteering, and suggests practical steps to reduce and mitigate the risks

Application of people management factors into the CHV model

The three above-mentioned documents are implemented or at least adapted by almost all 186 national societies, and serve as guide for both programming and CHVs management. Collectively, they emphasized on inclusion into the design, a set of factors previously described that are positively influencing motivation and retention of CHWs as an integral part of programme management. The following crucial people management factors are emphasized in the IFRC policies and guidelines, and strongly reflected in community health programmes implemented through national societies:

- CHV selection – The selection and recruitment of CHVs is community driven based on the specific and explicitly described roles and tasks. The recruitment is mainly based on individual intrinsic motive for volunteerism and wanting to do good for the community. CHV are recruited irrespective of their race, age, ethnicity, sex, religion, beliefs, disability or age ensuring inclusion of marginalized groups as well as equal participation of men and women. National societies are providing potential CHVs the opportunity to learn about what they are volunteering and how beneficial activities are for them and their communities.
- Duty of care – National societies bears the ‘duty to take reasonable care’ for both international and community volunteers as the humanitarian emergencies context often associated with unsafe and-or insecure working environment that increases their vulnerability to diseases, physical and mental trauma, or even fatalities. National societies are required to ensure same safety standards for CHVs as for employees, share relevant security information, provide appropriate protective equipment and safety training for the

tasks volunteers are asked to perform. In terms of services, national societies are encouraged to ensure adequate insurance coverage for CHVs as well as provision of health services and psychosocial support when required.

- Training and development - The IFRC and national societies has legal and moral duty to both volunteers and beneficiaries to identify required skills, and provide appropriate training and tools to enable CHVs to carry out the specific task or role they were recruited to perform. All recruited CHVs receive mandatory induction training into RCRC movement, and technical training on specific tasks in health, nutrition, and water, sanitation and hygiene promotion. National societies are encouraged to conduct peer-to-peer education with experienced volunteers training and supervise new ones. Furthermore, national societies are required to provide regular refresher trainings using various approaches including supportive supervision, on-job mentoring and coaching, and pool of local trainers.
- Financial and non-financial incentives – According to the IFRC legal definition, volunteering is not a paid activity. However, CHVs should neither gain nor lose out financially as a result of their assigned roles and tasks. Therefore, national societies are required to reimburse volunteers’ reasonable expenses or provide adequate allowances to cover costs related to carrying out approved tasks. However, the federation policy require national societies to recognize and reward the contribution of volunteers whenever possible and appropriate. Various formal and informal practices of recognition and reward to CHVs are conducted including letters of thanks, certificates of service, personal development opportunities including employment, life membership, nomination to the governing board, representation at regional or international events. National societies are also encouraging ‘sense of belonging’ to the organization by providing CHVs with identity badges and uniforms as well as engaging in programmes management and decision-making.
- Supportive supervision – National societies can be held legally responsible in an event that ‘third parties’ (beneficiaries) are adversely affected or injured by the approved actions of the volunteers, including CHVs. With the intent to ‘do no or less harm’, the federation policies and legal guides require national societies to have established mechanisms for supportive supervision to the volunteers. These may range from informal mechanisms such as peer assessments and feedback to more formal supervision by experienced CHVs or staff members. Many national societies are implementing peer-to-peer support for young or inexperienced volunteers as well as for high-risk activities to avoid harm for

both volunteers and beneficiaries.

- Inclusion and participation – IFRC policies require national societies to ensure participation of the communities and volunteers, and that their views and ideas are actively sought and acted upon at all stages of design, development, implementation and evaluation of community programmes. Most national societies involve community volunteers in programme management and decision-making process at community level though participation is particularly low at national level

2.3.2. MSF – Community Health Workers model

CHW model content and guiding tools

Médecins Sans Frontières (MSF) is a world-renowned humanitarian organization with proven expertise and reputation in responding to health risks and consequences attributed to natural disasters, armed conflicts, disease outbreaks, and to the situations of social violence and healthcare exclusio. It presents a field-based movement that engage employed staff and volunteers sharing a commitment and code of ethics to provide medical humanitarian action to populations affected by crises³⁵. The movement is coordinated by MSF International, the umbrella under which are five operational centres and twenty-four associations responsible for implementation and management MSF humanitarian assistance programmes worldwide.

As of current, MSF through its operational centres and associations is operating in 67 countries worldwide, with more than three-quarters (86%) of the programmes implemented in LMICs in Africa, Middle East and Asia³⁶. In collaboration with local governments and authorities, MSF teams are working to provide primary health care services; specialty services for surgery, reproductive health, non-communicable diseases (NCDs) and mental health; communicable disease outbreak control; and nutrition services³⁶.

However, in addition to provision of basic and specialized hospital-based health services, MSF operational centres are also implementing community-based health programmes that prominently complement to health outcomes of the affected populations. Subject to the actual needs of the affected population, the scope of MSF community health programmes ranges from health promotion to service delivery focusing on expanding the coverage of basic health services to remote, hard-to-reach and marginalized communities. Based on the two scopes, MSF CHWs who are also referred to as ‘outreach workers’, are organized into two broad typologies:

- ‘Specialist CHWs’ – recruited and trained on a narrow set of skills to perform specific activities or tasks determined by a certain disease or condition. They commonly provide

of HIV counseling and referral for treatment, home based care and treatment for chronic illnesses such as HIV, TB, and NCDs, and tracing treatment defaulters³⁷.

- ‘Generalist CHWs’ – recruited and trained to serve a broader range of primary health services at community level including provision of health education, address proper care seeking behaviors, promotion of key household practices for infectious diseases and outbreak control, social mobilization for mass vaccination campaigns, and treatment of common illnesses such as malaria, diarrhoea and pneumonia³⁷.

MSF has no formal guideline providing generic framework to all operational centres in the development and management of community health programmes. However, based on experience and lessons learned from various missions, some operational centres developed guidelines that are adopted among the rest to facilitate a satisfactory degree of coherence. The most commonly used is the ‘Manual for Organization and Supervision of Outreach Programmes’ developed by MSF Amsterdam in 2009. The guideline proposes different scopes of community outreach programmes, recommended the necessary skills for recruitment, define the package of interventions to be delivered to affected population, and provide recommendations for operational aspects of implementation, monitoring and evaluation³⁸.

Application of people management factors into the CHW model

Despite the absence of formal policies and guidelines with regards to development of community health programmes and management of CHWs between the operational centres, various factors influencing retention and motivation of CHWs are reflected in their designs and implementation³⁸. This is evident in the MSF community health programmes in seven countries (Ethiopia, Sudan, Malawi, Uganda, Bangladesh, Thailand and Papua New Guinea) that informed development of above-mentioned manual, reflecting the following programmatic factors:

- CHWs selection – Selection and recruitment follow a strict set of criteria based on basic education level, skills and experience related to community health and communication. Although the process encourages the participation of community leaders, it is not community-driven and is limited within the predefined programme based selection criteria. The process involve advertisement of minimal qualification requirements to the community and application by interested candidates, followed by a competitive process that include oral and-or written interviews to identify potential candidates. The recruitment also takes into consideration age, gender, religion, political affiliations, and economic status to avoid discrimination and inequities among different community groups.

- Duty of care – The MSF movement charter require employees, volunteers, and members to understand the risks and dangers involved in the missions they are carrying out, and make no claim for themselves or their assigns for any form of compensation other than that which the association might be able to afford them. Therefore, a limited ‘duty of care’ benefit package is afforded to employee and salaried non-employees like CHWs. These include quality health services with regard to physical, mental and psychosocial wellbeing while working in unsafe humanitarian emergencies contexts.
- Training – It is obligatory for all outreach workers including CHWs to receive trainings relevant to the tasks they are recruited to perform. However, the type and duration of initial training differ between operations. For specialist CHWs duration of training tend to be shorter to quickly equip participants with relevant skills necessary to carry out their assigned tasks, whereas for generalist CHWs training can be longer up to six months. The initial training has to be followed up with at least three monthly refresher training and on-job mentoring. Training curriculums and resource materials tend to differ between operational centres based on the desired skills as well as locally adapted training materials for community health. MSF training usually involve evaluation of participants and provide with certificates of completion.
- Financial and non-financial incentives – CHWs are currently not scaled in the generic MSF function grid for national staff based on the traditional ‘voluntary nature’ of the position especially in humanitarian settings. However, it is a practice of many MSF operational centres to pay salaries to CHWs with terms and conditions such as completion assigned tasks or allowances for attending trainings and meetings. The form or amount of payment may be based on local guidelines if available, salary scale of other humanitarian organization especially local NGOs, or community norms on systems of remuneration. Additionally, many operational centres has been customarily providing non-financial incentives such as certificates of completion of trainings, certificates of service, letters of thanks, and identification badges and uniforms.
- Supportive supervision – Regular supervision is mandatory for all MSF operations especially in activities that involve CHWs providing sensitive or basic curative services to avoid doing harm to the third parties. All operational centres managing community health programmes are required to have a systematic setup of supportive supervision to trained CHWs for quality check of their work. Supervision provide the opportunity for discussion on challenges encountered, identifying topics for the refresher trainings, and replenishing medicines and supplies for specialists CHWs conducting curative services. Supportive

supervision is often conducted by health facility workers, usually nurses, but also through peer-to-peer support by experienced CHWs to newly recruited ones.

3. Discussion

The factors that are identified from the key informant interviews and review of policies and guidelines of the two key humanitarian organizations form the core of the design of their community health programmes. Majority of the identified factors are the same as the set of factors described in the motivation and retention theories that are positively or negatively influencing the two concepts. Supported by the literature from studies conducted in LMICs, and comparative analysis of humanitarian organizations' policies and guidelines, the discussion of this paper is focused on the application of the motivation and retention theories to explore the interaction of the following key six people management actors in influencing the motivation and retention of CHWs and volunteers.

3.1. CHWs selection and recruitment

The selection and recruitment process for the CHWs has always been influenced by the WHO definition that they should be members of the community they are recruited from, and work within the same communities. A lot of expectations, or rather assumptions have been derived from the same definition that CHWs are motivated to improve the health outcomes and wellbeing of their own communities. However, studies that have been conducted to understand the motives behind CHWs joining the community health programmes, whether paid or on voluntary basis, have found that both altruistic motive to do good for their communities as well as desire to profit from external rewards played a role^{9, 10, 20, 39, 40, 41}.

The two motives for CHWs to join community health programmes are more prominent in the humanitarian emergencies contexts. Despite that in such contexts the amounts of health risks and consequences among affected population are enormous, and the will of members to improve the wellbeing of their communities may be high, the opportunities to earn income to satisfy family needs and obligation are extremely limited. It is therefore very important for humanitarian organization implementing community programmes by recruiting workforce from the same community to put the above facts into consideration from the designing stage.

The IFRC and the RCRC movement are investing on non-paid voluntary motive among affected population in the recruitment of CHVs. To achieve that, national societies are empowering communities to participate in the identification of their priority needs as well as soliciting their views and ideas in designing solutions and programmes³². The community-driven process facilitates ownership, perception of importance of the tasks assigned, and the

sense of social responsibility to contribute to the desired improvements attracted CHVs to join.

On the contrary, MSF movement follows the programme-driven process by setting the recruitment criteria based on the skills needed for the programme implementation, with limited involvement of the communities within already defined frame. In this approach, the external rewards are the drivers to attract potential candidates with desired skills.

Research show that, in addition to altruistic motive, many CHWs in LMICs are attracted to join organizations and programmes to profit from external rewards such as financial incentives, expanded social capital, improved skills and competencies, gain valuable experiences and career development opportunities^{10, 20}. Furthermore, in the study conducted in Uganda and Mozambique, CHWs who were willingly recruited on voluntary basis, indicated that the prospective reason would make them leave their work is if they will get a paying job to meet their family needs and obligations⁴⁰.

Herzberg motivation theory and Ramdianee join-stay-leave model partly explained reasons for engagement of CHW and volunteers in community health programmes as the desire to do good for the communities. However, Maslow motivation theory emphasized on the individuals' desire to satisfy their basic survival needs, particularly in rural areas of LMICs or areas affected by humanitarian emergencies where meeting such needs is often a challenge. Referring to the fact that CHWs are likely to be living in such contexts¹⁹, the failure to satisfy their basic needs in a long run can outweighs the altruistic and personal aspirations. This is supported by the evidence of high attrition levels observed in many community health programmes based volunteering limiting CHWs to earn income necessary to meet their families' obligations.

3.2. Duty of care

Humanitarian emergencies settings are often associated with unsafe and-or insecure working environment that increases CHWs and volunteers vulnerable to diseases, physical and mental trauma, or even fatalities. While most of the humanitarian organizations have policies and procedures that protect employed staff and international volunteers working in such environment, protection of non-employed staff and community volunteers is not certain. Statistics are showing that, local staff and volunteers including those working at community level, represents more than three-quarters (79%) of the victims of such incidents^{42, 43}.

MSF for example, in accordance to MSF movement charter, all employees and volunteers whether international or local, are required to understand risk and dangers that are involved

and they may encounter during their missions. And although a limited package of duty of care which include health services for physical, mental and psychosocial trauma is afforded to them, they cannot make a claim for compensation other than what can be provided by the organization³⁵.

Contrariwise, IFRC and the RCRC movement presents a clear policies and procedures pertaining duty of reasonable care to both international and community volunteers working and exposed to vulnerable situations in humanitarian settings. All national societies are required to afford CHVs with insurance cover for accidents and physical injuries, as well as relevant health services when needed.

In addition, both organizations are to the possible extent providing safe working conditions and environment including provision of safety training, protective gears and equipment, sharing of relevant security and safety information^{32, 38}.

Need for secure and safe working environment is one of the factors that both Maslow and Herzberg theories emphasized that influence CHWs and volunteers to continue engagement with the organization and motivated to perform their duties effectively. Furthermore, having policies and procedure that are indiscriminately protecting both employed and non-employed staffs exposed to the same vulnerable conditions enhance CHWs and volunteers sense of belonging to the organization and thus retention and motivation.

3.3. Adequate training and personal development

CHWs and volunteers consider their engagement to community health programmes as a prospect for personal career growth and hope for employment in the future, especially in contexts with high unemployment rates like LMICs and humanitarian emergencies. Therefore, they value acquiring new skills and knowledge through trainings as enhancing their competencies and become more competitive in the job market^{20, 41, 44}. Furthermore, they tend to value trainings impacting skills that are respected in the communities like identification and treatment of common illnesses, because such skills raise the credibility and status of CHWs in their communities¹⁹.

Providing relevant and adequate training has emerged as one of the strong factors that boost motivation, and if on continual basis facilitates retention of CHWs in the programmes^{7, 10, 12, 20, 39, 40, 41}. Although the urgency nature of responding to humanitarian emergencies pushed most organizations to focus on providing shorter trainings that quickly equip CHWs and volunteers with basic skills to perform their assigned tasks, CHWs valued relatively longer and technically strong trainings. CHW perceived such trainings as empowering in

terms of knowledge and skills, as well as enhancing their confidence and sense of self-efficacy to perform the assigned tasks^{39, 44}.

Both IFRC and MSF recognize and embrace the need to impart relevant skills to CHWs and volunteers to effectively be able to perform their tasks. That is clearly reflected in their policies and-or guidelines. The two organizations are similarly providing mandatory induction training to all newly recruited CHWs and volunteers as the way of introducing them to the organizations' culture, principles, ethics and code of conduct^{32, 38}. But they exhibit vast differences on the approach that each organization conducted technical trainings for CHWs.

While IFRC developed a CBHFA approach and tools as a framework that national societies are adapting for the training of CHWs, MSF have a relatively flexible approach in which the operational centres can adapt local resource materials for the training if available tailored to specific skills than needed by CHWs to perform their duties. This approach allowed MSF to have generalist CHWs with relatively longer training and wide scope of primary health services tasks, and specialist CHWs undergoing relatively shorter training but for specific skills such as basic curative services or TB and HIV 'lay counselors'^{32, 38, 46}. This approach is implemented with a great success by MSF in Ethiopia, Malawi, Bangladesh and Thailand where CHWs are trained to provide basic curative services for common illnesses such as malaria, diarrhea, pneumonia and malnutrition at community level³⁸.

In addition to trainings with longer duration and stronger specific skills-based trainings, CHWs also emphasized on the need for continual skills development through regular refresher trainings as a way of addressing daily challenges. Various approaches are applied including peer-to-peer support between older and newly recruited CHWs, on-job mentorship and coaching, and even innovative online or distance learning methods. Refresher trainings have been shown to reinforce CHWs' perception of importance of the assigned CHW tasks as well as keeping alive the excitement to work^{39, 44}.

In-line with Maslow's and Herzberg's theories on need for personal growth and achievement, CHWs joining the programme or organization with such ambitions are likely to be retained if they are continually acquiring skills deemed important for their prospect. As described earlier by Ramdianee's Join-Stay-Leave model, a mismatch between CHWs and volunteers' expectations for personal development when they joined is one of the strong reasons to leave the programme and-or organization. Lack of- or inadequate opportunities for personal development, particularly in terms of skills development, promotion to peer supervisor role or employment, have frequently been cited as reasons for job dissatisfaction

and attrition¹⁹.

3.4. Workload assigned

The fact that CHW is often a volunteer work with no formal remuneration particularly in humanitarian emergencies setting, pose a challenge for them to fulfill other family obligations if the workload is heavier necessitating them to spend long hours at work. Evidence from various studies suggested that CHWs' workload is usually heavier owing to high demand, geographical challenges, and addition activities they have to do or participate on top of their routine responsibilities^{7, 8, 10, 39, 41}. CHWs are in addition commonly involved in organizing and participating in rallies, campaigns, surveys and research works that take their spare time and sometimes not fairly compensated for³⁹.

The Sphere Project minimum standards in humanitarian response recommended ratio of at least one CHW to serve 1,000 population⁴⁵. However, owing to budgetary constraints, many humanitarian organizations implementing community health programmes are not meeting that standard. Although MSF do not have a generic guideline for CHW-to-population ratio across its operational centres, their community health programmes implemented in Bangladesh and Ethiopia recruited one CHW per 2,000 population³⁸, which is two-fold the Sphere recommended workload.

Similarly, the IFRC volunteering policy recommended to national societies a maximum of three hours of volunteering per week for volunteers recruited in long-term programmes³³. But it has been a trend for many national societies to give priority to recruit community volunteers who give more time. Many national societies responding to humanitarian emergencies or working in LMICs recruit volunteers for more than 20 hours of volunteering per week, which is seven times more than recommended duty time³³. That is almost equivalent to full-time employee but not compensated fairly as such.

Although not so many studies in-depth explored the effect of assigned workload alone to CHW motivation and retention, many have related it with inadequate compensation for the amount of time-spent undertaking the CHW tasks. In a study to document the challenges to keeping CHWs and volunteers motivated, Brunie et al 2014 described that being away from daily domestic and livelihood income generation activities is the biggest challenge that prompts them to leave the programme⁴¹. Furthermore, findings from studies conducted in Uganda and India both identified job burnout due to heavier workload as one of the main causes of job dissatisfaction especially when CHWs perceived that their efforts are not fairly compensated^{39, 41}.

However, findings from studies conducted in Bangladesh by Rahman et al 2010 challenged that, CHWs concerns about heavier workload including working in late hours and during holidays and weekends, was counterbalanced by the ability to meet their household financial obligations when their efforts are compensated through remuneration¹⁰. This is clearly suggesting that, fair rewards whether financial and-or non-financial are crucial to motivate CHWs and volunteers even when they perceived workload assigned is heavy.

3.5. Remuneration and incentives

Although CHWs work for long hours and even equivalent of full-time like other employees, by definition they are not usually salaried and-or afforded benefits like other formal employees. While full-time salaried CHWs are relatively rare, the demand for regular financial compensation with regard to services provided by CHWs is becoming inevitable¹⁹. However, if one defines CHW incentives as any factor that increases their motivation to engage and perform well in community work, then in almost all community health programmes, CHW and volunteers are receiving some form of financial or non-financial incentives¹⁸.

Financial incentives

Most studies exploring factors that influence motivation and retention has commonly identified these financial incentives as the biggest motivator especially for retention of CHWs, while debating if can influence performance of CHWs^{7, 8, 10, 12, 20, 39, 40, 41}. Singh et al 2015, in her review of five case studies of CHW programmes from LMICs, identified different models of financial incentives such as paid salaries, performance-based stipends, allowances for meetings or trainings, selling drugs and-or other health commodities, incurred costs refunds and access to low interest loans for income-generating activities¹².

Almost all humanitarian organizations are paying financial incentives to CHWs and volunteers using above-mentioned models based on their policies and guidelines, but the question remains whether is fair compensation relative to the workload they are assigned. IFRC for instance, although the federation policy regards CHVs as unpaid task, it allows national societies to provide adequate allowances to CHVs cover all the costs related to carrying out approved tasks. In addition, are required to reimburse all reasonable expenses that CHVs incur while performing those tasks³³.

Contrariwise, although MSF salary scale for national staff is not explicit on entitlements of outreach workers, the organization considers that adequate and sustained remuneration is essential to maintain the interest and motivation of outreach workers including CHWs³⁸.

Therefore, all MSF operational centres are recruiting CHWs as salaried staff based on the minimum wage according to the available local guidelines, local NGOs, or relative to other humanitarian organization working in the same setting³⁸.

Non-financial incentives

Overwhelming body of literature described non-financial incentives as intangible but critical factors in influencing CHWs motivation and retention, especially in terms of job satisfaction and sense of fulfillment¹⁹. Although they may not have a direct link with people management scope in the organization, but to a greater extent they influence CHWs sense of belonging to the programme and organization in general.

Both literature review as well as comparative analysis of policy documents and guidelines from IFRC and MSF reveal that humanitarian organization are to a greater extent investing in providing non-financial incentives as a way of motivating and retain recruited CHWs and volunteers. Not limited to, but the key non-financial incentives identified includes opportunities for personal development including regular trainings, promotion of peer supervisor role or formal employment; recognition and enhanced status in the community; sense of doing good and appreciation from the community; visible improvement in their communities; social and peer networking; involvement in planning and decision making about the programme; token of recognition and reward from the organization by letters of thanks and-or certificates of service; and sense of affiliation to the organization by providing them with identity badges and uniforms^{7, 8, 10, 20, 39, 40, 41, 47}.

Herzberg two-factor theory emphasized on the fact that the two sets of factors i.e. the ‘growth factors’ that are mainly non-financial and ‘maintenance factors’ which are mainly financial, exert their influence independently of one another. While the presence of non-financial incentives is likely to cause CHWs and volunteers job satisfaction and motivation to perform, the absence of financial incentives have shown to critically causing dissatisfaction and failure to retain them in the programme or organization. Both successes and failures have been documented in community health programmes that relied on one incentives approach over the other. However, theoretical and empirical evidences suggested that one set of factors acting alone is not sufficient to ensure CHWs and volunteers are retained in the programme and motivated to achieve both personal and organization goals.

3.6. Supportive supervision

CHWs in the context of deprived health workforce like LMICS and humanitarian emergencies tend to be assigned basic but sensitive tasks shifted from health facility workers

i.e 'task shifting'. In that contexts, it is common for CHWs to be tasked to carry out basic curative services for common illnesses, and counseling, testing and follow up with home-based treatment for persons with HIV/AIDS^{38, 46}. CHWs assigned such sensitive tasks need regular and sufficient supportive supervision to avoid doing harm to the affected populations.

However, research shown that supportive supervision remained inadequate in most of the community health programmes in LMICs and humanitarian emergencies. Studies conducted in Uganda and Mozambique have shown that although many programmes included structured supervision systems and approaches in their designs, supportive supervision to CHWs is often conducted irregularly and infrequently^{20, 47}. Many reasons has been cited for inadequate supervision of CHWs including difficult access to communities due to long distances, lack of reliable transportation, security concerns, and supervisors being busy with other responsibilities⁴⁷.

Both IFRC and MSF policies and guidelines remain explicit on the importance of supportive supervision to CHWs and volunteers not only for quality assurance, but also as an opportunity to identify and address challenges, provide clarity on assigned tasks and expected deliverables, and identify topics for refresher training and mentorship^{32, 34, 38}. However, it is common for the humanitarian organizations to designate health facility workers, whether clinicians or nurses, to be supervisors and-or mentors for CHWs in their catchment areas. Noting that LMICs context is likely to have high burden of diseases and inadequate health workforce, health facility workers are often overwhelmed with service provision responsibilities at the expense of other roles like supervising CHWs⁴⁷.

In the systematic review of 83 studies conducted in LMICs to identify intervention design factors that impacted on CHW motivation, Kok et al 2014 found that insufficient supportive supervision were often sources of under-performance and demotivation. Whereas, sufficient supportive supervision conducted by skilled supervisor enhances CHWs' performance, derive sense of affiliation with the organization, and thus increase CHWs credibility and recognition in the community^{7, 8}.

Maslow's hierarchy of needs theory ranked the need for self-esteem and credibility, as well as the sense of affiliation with the health system among high needs in the hierarchical pyramid for CHWs and volunteers within their communities. The two needs are among the powerful non-financial incentives that can enhance motivation and retention of CHWs and volunteers as described earlier section. Supportive supervision is also an opportunity to enhance good relationship between CHWs, their peers and supervisors or managers when are focused to provide positive feedback and constructive criticism that Herzberg model has

attributed to improved motivation.

4. Conclusion and recommendations

CHWs are undeniable a vital health workforce forming the backbone for successes of community health programmes, which are making huge impact in the reduction of mortality especially among children and women in humanitarian emergencies context. Over the years, CHWs form the most reliable vehicle for delivery of key health messages to empower individuals, households, and communities to make informed decisions pertaining their health, as well as increase local access to lifesaving health interventions and services.

In order to sustain or even to further the observed successes of community health programmes, people management conditions have to be conducive to retain CHWs and keep motivated to perform their tasks effectively. This study was set out to explore various people management factors that when embedded into the programmes from designing stage to execution, can favorably influence the motivation and retention of CHWs.

Through a thorough desk review of relevant literature, this study was able to show the link between the theories of workers motivation and retention with the people management factors that influence the two concepts. Additionally, the study conducted key informant interviews and comparative analysis of actual community health programmes implemented by IFRC and MSF to demonstrate the interaction between motivation and retention, the theories and the identified people management factors in the humanitarian emergencies context.

Based on the observed interactions, the following key factors are identified and recommendations are proposed:

- Community-driven selection and recruitment process – community participation in the selection of potential candidates enhances ownership of the community programmes, which in-turn reinforces the altruistic motive of CHWs to improve health and wellbeing of their own communities. Programmes should set skill-based criteria to guide the available local platforms to identify candidates with required competencies but yet acceptable in the community by empowering participation.
- Duty of care – indiscriminative policies and treatment between international and local, employed and non-employed staff like CHWs with regard to safety and secure working environment, health and other benefits afforded in case of adverse events enhance CHWs sense of belonging to the organization and improve retention. Humanitarian organization should afford equal duty of reasonable care package to employed and non-employed staff subjected to the same work conditions in humanitarian emergencies.

- Opportunities for training and personal development – opportunities for knowledge and new skills-building trainings, as well as regular refresher trainings to reinforce acquired skills does not only improve performance of CHWs and programme outcomes, but also optimize their prospect for personal development. CHWs are likely to be retained and motivated to perform if organizations and programmes provide adequate technical trainings and opportunities for promotion and-or employment.
- Fairly compensated workload – CHWs in humanitarian context, whether salaried or on voluntary basis, tend to work for longer hours almost equivalent to full time employed staff, but not compensated as such. Failure to earn income and meet family obligations has been one of the job dissatisfaction factors leading to high attrition. Programmes and organizations should provide fair remuneration to CHWs working for longer hours or on full time basis.
- Adequate financial and non-financial incentives – financial incentives appeared as major motivation factor for both CHWs with altruistic motive or desire for external rewards, and non-financial incentives as a set of significant retention factors. Most of the community health programmes described as successful included both elements of incentives to influence motivation and retention of CHWs.
- Supportive supervision – Although most of community health programmes included supportive supervision as a critical component, supervision visits are often inadequate when health facility workers overwhelmed with clinical task are designated as supervisors. Programmes and organization should identify and train separate supervisors, preferably experienced CHWs, to conduct regular supervision of their peers, especially if interventions doesn't include very skilled tasks like basic curative services.

Although this study attempted to explore the interaction of several factors, but the main on-going debate is centered on the actual definition of CHWs and the traditional assumption that it is a volunteering assignment. This led to CHWs being regarded as often non-employed and sometimes non-salaries position. Despite the rich evidence ascertaining 'social value' of CHWs through the impact they have made to reduce mortality as well as improving health outcomes in the communities, little had done on the 'economic value' to ascertain the financial and-or economic burden that is saved based on the work of CHWs. I think it is critical for future research to fill that knowledge gap which may help in estimating the worth of CHWs worldwide.

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