

Non-financial Incentives on Motivation of Community Health Promoters for Provision of Community Health Services in Taita Taveta County, Kenya



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Abstract

Aim: The aim of the study was to develop a non-financial incentives model which is culturally acceptable, feasible and sustainable on motivation of community health promoters for the provision of community health services in Taita Taveta County.

Methods: The study adopted a cross-sectional design conducted in Voi sub-county, Taita Taveta County. The primary target population were community health promoters, while secondary target population were county and sub-county health management team members. Data collection tools used were researcher-administered questionnaires and key informant interviews. Qualitative and quantitative data was collected for this study. Quantitative data was analyzed using SPSS version 26, results then summarized, and presented in frequency tables, figures and charts. Qualitative data was first analyzed thematically using content analysis by categorizing it into various themes, and the responses coded and classified into the various categories.

Results: The study found significant improvements in provision of work identification materials such as protective gear, medications, monitoring health tools, health educational materials, and growth monitoring tools (z-score =5.567, $p \leq 0.000$). Significant improvements were also observed in community appreciation, advocacy, safety guarantees, gratitude expressions, family support, and recognition (z-score=3.526, $p \leq 0.000$). Significant improvements were also observed in self-help group membership, reduced cost of trading licenses, access to government procurement opportunities, participation in expos/trade fairs, and access to markets (z-score= -4.669, $p \leq 0.001$).

Conclusion: The study concludes that CHPs' have got high expectations of gaining career experience and belief in career growth opportunities with high satisfaction levels in key areas such as training, mentorship, supervision, peer engagement and opportunities for additional responsibilities.

Recommendations: The study recommends that the department of health to enhance non-financial incentives that support professional growth and have clear and transparent pathways to permanent employment.

Keywords: Community health promoters, community health, non-financial incentives, motivation.

1.0 BACKGROUND INFORMATION

Community Health Promoters (CHPs) are community members, chosen and trained to provide basic healthcare services voluntarily to their communities (MOH, Kenya, 2020). Even though being a CHP is voluntary, non- financial incentives act as very important motivators for CHPs (Kok *et al.*, 2019). CHPs form an important linkage between communities and the formal health systems (Oliver *et al.*, 2015), and a critical workforce in the improvement of healthcare access particularly in LMIC (United Nations Environmental Program, 2016). Use of CHPs gained prominence following the Alma Ata Declaration in 1978 of ‘health for all by the year 2000’ which advocated for a major shift of health care delivery efforts towards disease prevention (Kithuka *et al.*, 2016). Non-financial incentives are simple positive rewards which inspire and engage employees in ways that money is incapable of doing and typically cost an organization little or no money, yet carry significant influence on the motivation of workers (Zulfiqar *et al.*, 2010). Non-financial incentives include; recognition, awards, honors, preferential treatment and appreciation (Bhutta *et al.*, 2010). Different countries have had varying experiences with both financial and non-financial incentives, with most of them favoring the adoption of non-financial incentives, because the use of financial incentives has largely proven to be unsustainable (Lusambili *et al.*, 2021; Mbugua & Mwitari, 2017).

1.1 OBJECTIVES OF THE STUDY

1.1.1 Broad Objective

To determine the influence of non-financial incentives on motivation of CHPs for provision of community health services in Taita Taveta County

1.1.2 Specific objectives

- i. To assess the influence of individual motivators on motivation of CHPs for provision of community health services
- ii. To establish the influence of organizational and system-level factors on motivation of CHPs for provision of community health services
- iii. To evaluate the influence of health commodities on motivation of CHPs for provision of community health services
- iv. To determine the influence of community-based motivators on motivation of CHPs for provision of community health services
- v. To determine the influence of livelihood support and economic empowerment on motivation of CHPs for provision of community health services
- vi. To develop feasible, sustainable and culturally acceptable non-financial model on motivation of CHPs for provision of community health services

2.0 LITERATURE REVIEW

2.1 Individual Motivators

CHPs are usually recruited at a community gathering organized, arranged and supervised by their local leaders, and to qualify for recruitment as a CHP, individuals are required to meet some conditions which include; they should be adults, literate, command great respect from community members, self-supporting, demonstrated leadership abilities, and must be residents of their respective communities (MOH, Kenya, 2020).

Amare, (2009) emphasized that aspects of recruitment and training were conducive on motivation of CHPs but could be strengthened even further, additionally recruitment of CHPs on the basis of nomination and election is likely going to enhance their recognition and acceptability in the community, and that their training and motivation can be strengthened by ongoing instruction and mentorship. He also indicated that potential community anchors such as churches and mosques have had some role in supporting and motivating the CHPs.

Jigssa *et al.* (2018) emphasised that non-financial incentives such as developing and implementing a career development program is necessary for the motivation and retention of CHPs in countries where they are not receiving any form of stipends. This is supported by Ajisegiri *et al.* (2022) who indicated that having opportunity for progression into a more skilled healthcare worker was a factor that motivates CHPs, and further appreciated that CHPs choose jobs that provide opportunities for career development.

2.2 Organizational and System-level Factors

CHPs collaborate with a health facility in their region of operation which is known as a link health facility. This is the health institution which could be a dispensary, health center or a hospital to which they refer patients whom they are not able to manage and whom they feel require specialized medical care (MOH, Kenya, 2020).

Tripathy *et al.* (2016) acknowledged that training, career development opportunities and regular support supervision as factors motivating CHPs and that community support and recognition are environmental motivating factors to the CHPs, and that non-financial motivators such as interpersonal connections, family support, and career chances deserve more attention and that frequent need-based training is required to sustain high levels of motivation among the CHPs.

Ankomah *et al.* (2016), also noted that non-financial incentives such as a pleasant work atmosphere, training and career growth, mere acknowledgment, and appreciation were shown to be the most important motivators for CHPs, and that age, gender, and professional history all have significant impact on how much people are driven by non-financial motivators.

Kok *et al.* (2019) however, found out that a variety of factors motivated voluntary community-based health mobilisers and that majority of health mobilizers were driven to do their job by a strong aspiration to help their community. Further indicated that the most often reported extrinsic motivators were community and supervisor recognition, the availability of supporting resources, trainings, identification, supervision, and feedback, and that while becoming a community-based mobilizer is optional, incentives, particularly those of a non-financial character, are key motivators among the CHPs.

2.3 Training of CHPs

Training of CHPs in Kenya is guided by a national curriculum which has got two modules namely; basic and technical. The training is conducted by the Community Health Assistants in collaboration with other health officials who are drawn from the sub-county or their nearest health facility which the CHPs will be expected to serve (Kenya Community Health Strategy [KCHS], 2020-2025).

Table 1

CHPs Training Modules

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

Source: MOH, 2020-2025

Creigler *et al.* (2009) emphasized that training is one of the most important requirements for the CHPs to carry out their work effectively and efficiently, this is supported by Martin *et al.* (2008), who indicated that on completion of the prescribed training, CHPs get motivated when they are awarded certificates in a public ceremony within their respective communities

2.3.1 Support supervision of CHPs

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

After their initial training, CHPs need to be followed up through regular support supervision for them to feel that they are part and parcel of the health systems (MOH, Kenya, 2020). Support supervision provides an opportunity for the CHPs to discuss challenges, exchange information, and learn from one another as well as from their immediate supervisors. Regular support supervision helps to sustain the interest as well as the motivation of the CHPs (UNICEF, 2010), Lehmann *et al.* (2018) further showed that appropriate training, supervision, and logistics support greatly motivate CHPs and thus enhanced performance in services delivery

2.3.2 Preferential treatment for CHPs

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

2.4 Health Commodities and Motivation of CHPs for Delivery of Community Health Services

Health commodities are any health goods, medical supplies, or any other materials required for the delivery of healthcare services. Medicines, vaccines, contraceptives, dressing materials,

needles and syringes, radiological items, and laboratory or diagnostic consumables are among these things (Agarwal *et al.*, 2018).

Abuya *et al.* (2021) emphasized that a packaged incentive comprising both financial and non-financial bundles was required to offer a favorable operational atmosphere for CHPs, and further indicated that the most essential motivator for CHPs was transportation, followed by instruments of trade and a monthly remuneration. However, there were substantial differences in preferences based on the age and gender of the CHPs, with older CHPs preferring incentives with a smaller money component than the younger CHPs.

2.4.1 Reporting tools

Reporting tools are those documents required by the CHPs to use in generation, consumption, and submission of the relevant healthcare reports to their respective link health facilities on monthly basis. These tools include; registers, referral forms, and work schedules logbooks (Kenya Community Health Strategy, 2020).

Kithuka *et al.* (2016) emphasized that non-financial incentives such as provision of adequate working tools, update trainings and follow up are necessary for motivation and retention of CHPs, this is supported by Munyoki, (2021) who demonstrated that CHPs feel ill equipped and demotivated when they lack basic reporting tools such as referral forms in the course of discharging their duties.

2.4.2 Medical supplies

Ogutu *et al.* (2021) indicated that availing adequate medical supplies and resources to CHPs greatly enhance their motivation.

2.4.3 Identification items

Identification items include; badges, caps, T-shirts, bags, aprons, umbrellas and rain coats. These items enable the community members to clearly identify their CHPs, this makes the CHPs feel recognized, appreciated and motivated (MOH, Kenya, 2020).

Tulenko *et al.* (2013), indicated that when CHPs have been trained well, and then facilitated with the necessary working items that include identification badges, they become motivated and can perform various tasks within their scope, this is further emphasized by Sarma *et al.* (2020) who indicated that providing CHPs with aprons, enhances their motivation since the community members can easily identify the CHPs.

2.5 Community-based Motivators

CHPs are members of the community who have volunteered to work for their specific communities and are directly accountable to them (MOH, 2020). Sarma *et al.* (2020), acknowledged that motivation and performance of the CHPs were linked to a variety of challenges at the program, organizational, community, and individual levels. Individually, perception of working as a CHP, age, education, self-efficacy (individual's conviction in his or her own capacity to do a job), work-related knowledge, and career prospects were all relevant indicators, albeit not necessarily. At the community level, social and religious standards, as well as community understanding of CHPs programs, affected their performance. At the organizational level, appropriate recruitment, training, regular monitoring and support supervision, and realistic workloads were cited as important factors of motivating CHPs. This is supported by Jigssa *et al.* (2018), who appreciated that health system, community, and individual dynamics all contribute to the motivation of CHPs. Brunie *et al.* (2014) also indicated that CHPs were of the feeling that non-financial incentives such as community

recognition and the acquisition of new skills and knowledge overcame the drawbacks of a lack of money, and further revealed that recognition, defined as any technique that assists CHPs in being acknowledged at the community or facility level, motivates them.

2.5.1 Recognition

According to Mullins, (2000), recognition, appreciation and respect accorded to the CHPs by the community members greatly motivate them, and increase their length of service, and that non-financial incentives are necessary for the CHPs job satisfaction. Community recognition is a valuable tool in motivating and retaining the CHPs by increasing their status in their respective communities. Schurer *et al.* (2020), indicated that CHPs not only value the trainings on health which they undergo, but are highly encouraged by the gratitude, respect and appreciation from the communities they serve, and further showed that CHPs satisfaction is enhanced when they receive recognition and appreciation from both their communities as well as the health systems.

2.5.2 Awards

In the context of community health, awards refer to public recognition mechanisms such as certificates, public mentions, and tokens of appreciation. Brunie *et al.* (2014), indicated that while CHPs desired financial compensation, they believed that problems such as community non-recognition and inadequate acquisition of knowledge, skills and the right attitude exceeded the drawbacks of a lack of financing, and further revealed that recognition, which is defined as any type of method that aids in the identification of CHPs at the facility or community level, should be given priority in various community meetings. Recognition at facility motivates them by giving them precedence for service provision for themselves and their families, giving them the option to serve as volunteers at the facility, and acknowledging their referrals and feedbacks. Further, emphasised that methods for rewarding top performing CHPs, such as, certification, gift distribution, a wall of fame, and chances for exchange visits, and bicycles or motorbikes, or any other type of assistance that will enable their mobility from one location to another have significant influence on CHPs. This is also emphasised by Mbuba, (2012), who showed that awarding and honouring CHPs in public gatherings make them feel appreciated subsequently their motivation is enhanced.

2.6 Livelihood Support and Economic Empowerment

Owing to the budgetary restrictions, CHPs program in Kenya is not fully funded, and hence Income Generating Activities (IGAs) are strongly encouraged to ensure the program's sustainability (Nyongesa *et al.* 2020).

2.6.1 Self-help groups and income generating activities

You *et al.* (2010) appreciate the fact that when CHPs form self-help groups, their retention rate in the services improves greatly, and further indicate that self-help groups that enable CHPs participate in income-generating activities contribute to increased CHPs camaraderie and togetherness, and that CHPs who mobilize themselves into groups and engage in income generating activities become economically stable and independent as further demonstrated by Syeid *et al.*, (2010). Lusambili *et al.* (2021) also noted that it is necessary to train CHPs on entrepreneurship skills and then provide them with initial capital to initiate income generating activities of their choice.

2.7 Theoretical Framework

This research employed three theories including; Intrinsic Motivation Theory, Systems Theory, and Maslow's Motivation Theory. Intrinsic Motivation Theory; it states that someone does something without clear external incentives, he or she does it because it is delightful, entertaining, intriguing, and gratifying rather than because of an expectation of an external incentive or pressure to do it, such as a gift. Autonomy, purpose, and mastery are the three fundamental components of intrinsic motivation. When individuals can act on their own initiative, believe that their efforts count, and experience fulfillment from mastering new skills, they are intrinsically motivated (Ryan & Deci, 2000). This theory is related to this study because CHPs take personal initiatives and derive satisfaction from helping the community without expecting external incentives

Figure 1 illustrates the three pillars of intrinsic motivation—autonomy, mastery, and purpose—which align closely with non-financial incentives such as skills training and community appreciation in the study context.

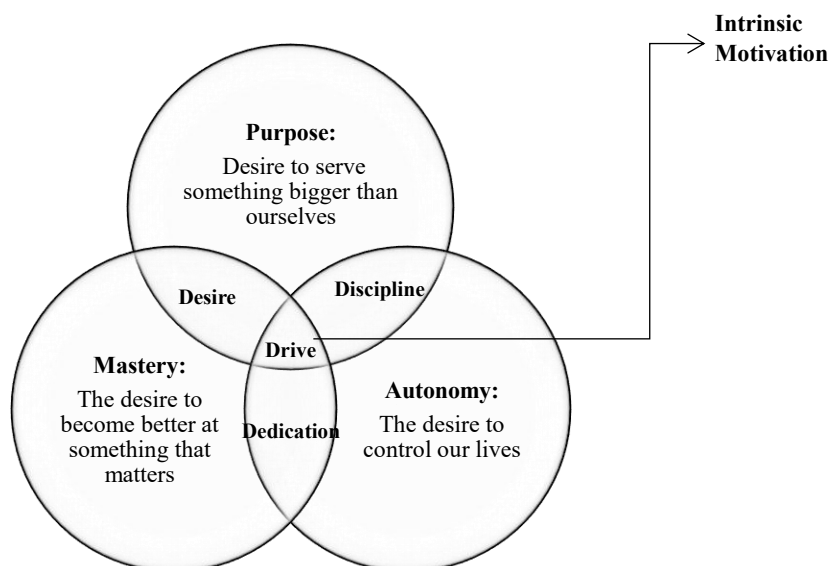


Figure 1
The Three Pillars of Intrinsic Motivation

Source: Pink, 2009.

The second theory is Systems Theory; according to Ludwig von Bertalanffy (1946), a system is defined as a collection of connected components that work together to accomplish a common goal. The fundamental idea of this theory is that the whole is more than the sum of its parts and that altering one system component may have an impact on other system components or the entire system. It is the interdisciplinary study of systems, which are cohesive collections of connected, dependent parts that may be created by humans or by natural processes. Every system has causal boundaries, is influenced by its environment, is characterized by its structure, function, and role, and communicates with other systems through these relationships. This theory is related to this study because CHPs form a critical component among the health workforce. They have a significant contribution towards service delivery to the community members.

The third theory is Maslow's Motivation Theory; which, according to McLeod (2022), is "a psychological motivational theory consisting of a five-tier model of human needs, often shown as hierarchical levels within a pyramid, enumerated in ascending order including physiological, safety, love and belongingness, esteem, and self-actualization needs. Needs at the lower-level must be met before persons can attend to needs at the higher-level". Again, this theory is related to this study because CHPs need to achieve their physiological needs such as food and shelter before attempting to achieve the needs of the higher level such as safety and belongingness.

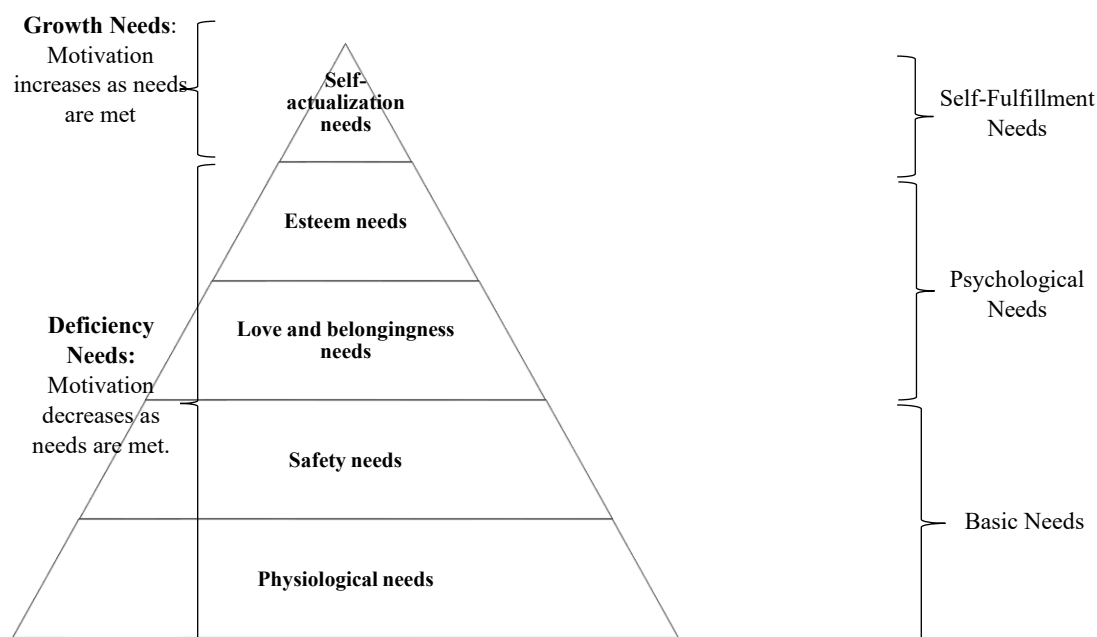


Figure 2
Maslow's Theory of Motivation

Source: McLeod, 2022

2.8 Non-financial Incentives Model Implementation Phases

According to Bobby Milstein and Tom Chapell, (2020), during the planning phase, the researcher identifies appropriate stakeholders, and sets specific outcome targets, and avoids overpromising the esteemed beneficiaries. He or she coordinates his or her efforts with those of other stakeholders and continuously assess the potential efficacy of the intervention, and establishes priorities for allocating resources, and program timelines. During the implementation phase, the researcher establishes the partnerships required, agree on roles and duties, take inventory of what has been achieved, and eliminates unwanted impacts. He or she further explains how the overall initiative operates, how different stakeholders can cooperate, what each stakeholder is expected to perform, how to determine whether the program is effective, why it will be effective, and how resource investments will be employed.

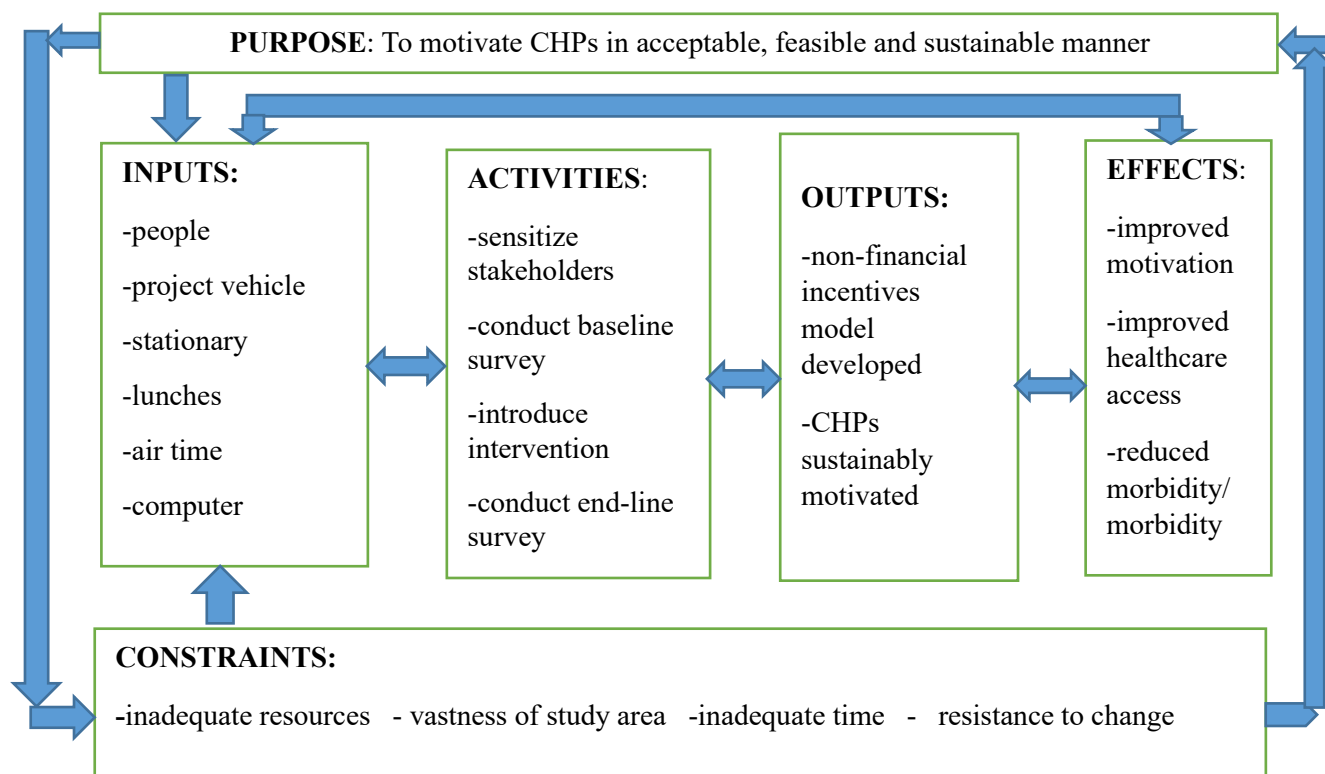


Figure 3

Non-financial Incentives Logic Model

Source: Researcher, 2023

This model identifies key implementation phases namely; planning, execution, and review. Each phase involves actions that affect CHP motivation, such as resource allocation, partnership formation and evaluation. During the planning phase, activities involved are; identification of appropriate stakeholders, setting specific outcome targets, avoiding overpromising the esteemed beneficiaries, coordinating efforts of stakeholders, continuous assessment of potential efficacy of the intervention, establishing priorities for allocating resources, and program timelines. During the implementation phase, activities involved are; establishing partnerships required, agreeing on roles and duties. The last phase involves monitoring and evaluation of the planned activities

A study conducted by Jigssa *et al.* (2018) in Ethiopia, found out that health system, community, and individual elements contribute to CHPs motivation; inherent desire to have a good social standing (81.86%). Non-financial incentives were also shown to be important in motivating and retaining CHPs. It further showed that non-financial incentives, such as establishment of career development opportunities, are critical to the motivation and retention of CHPs in countries where they do not get stipends.

Research in Uganda by Brunie *et al.* (2014) on motivation of CHPs, found out that while CHPs wished to be monetarily compensated, they believed that incentives such as recognition by the community and the acquisition of new knowledge and skills exceeded the drawbacks of lacking financing. It also discovered that recognition assists CHPs in being acknowledged at the community or facility level, and thus motivating them. This recognition strategy was defined as a community award system, where CHVs were given preferential treatment at different community meetings, as well as acknowledging them within their facilities. It further

demonstrated that award mechanisms for the top performing CHPs, such as certification, gifts, a wall of fame, and possibilities for exchange visits, as well as any sort of assistance that would allow their transportation from one location to another, such as bicycles or motorbikes, have a substantial impact on their motivation.

Likewise, research conducted in Tanzania by Kok *et al.* (2019) on motivation of CHPs, revealed that a range of variables inspired voluntary community-based health mobilizers. The majority of them were driven to do their job by a strong desire to help their communities. The most often reported extrinsic motivators were community and supervisor recognition, the availability of supporting resources, trainings, identification, supervision, and feedback. It also determined that while becoming a community-based mobilizer is optional, incentives, particularly those of a non-financial character are key motivators.

2.9 CONCEPTUAL FRAMEWORK

A conceptual framework is a diagrammatic tool used to depict research constructs and their interactions, and it is beneficial in intellectual structuring and organizing thoughts. A good conceptual framework captures real-world elements that are simple to recall and use (Dynes *et al.*, 2012). It also demonstrates the relationship between the independent, dependent, and intervening variables in the research (Kithuka *et al.*, 2016).

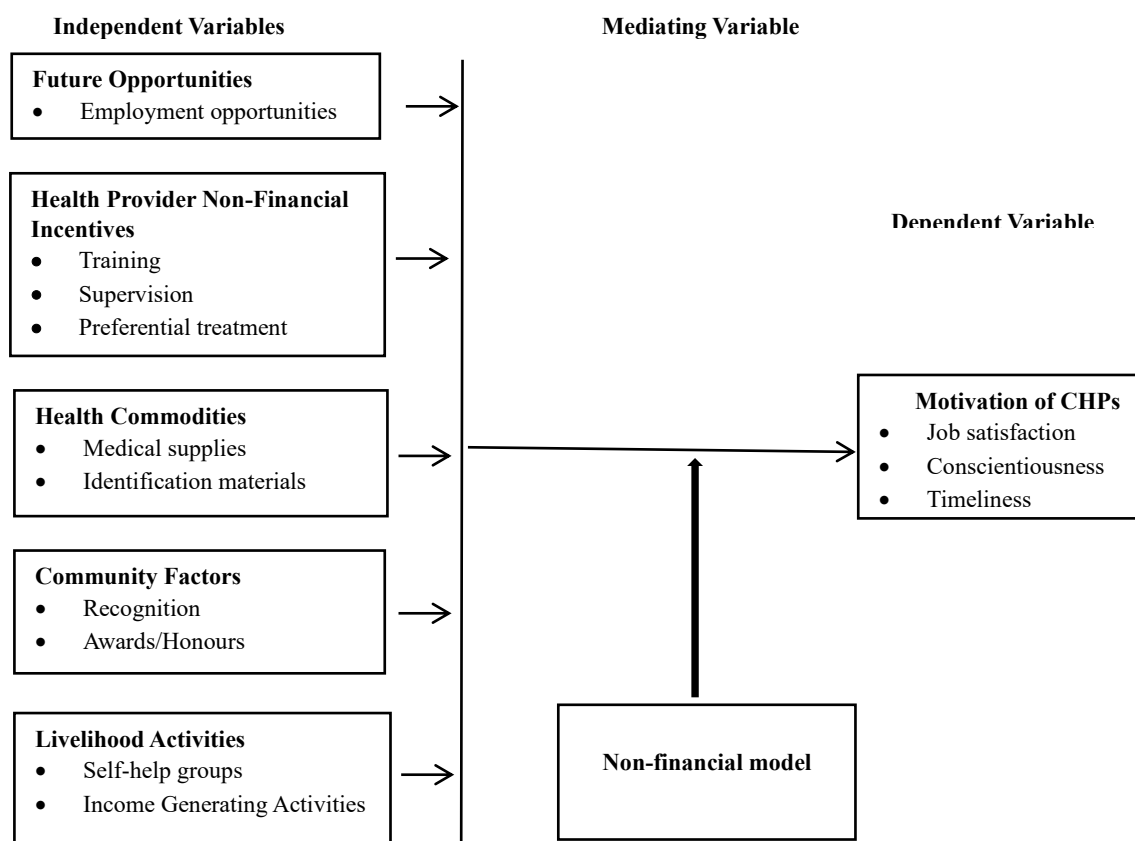


Figure 4
Conceptual Framework

Source: Researcher, 2023.

3.0 METHODOLOGY

3.1 Research Design

This study adopted a cross-sectional design to collect data at a single point in time, which is suitable for assessing the current status of non-financial incentives and their influence on the motivation of CHPs.

3.2 Study Location

The research was carried out in Voi sub county, one of the four sub counties of Taita Taveta County. Voi sub county was chosen because it has the largest population (31%) of the county population of 111,831 people and largely (70%) covered by Tsavo National Park covering, with challenges of inaccessibility to healthcare services (KNBS, 2019).

3.3 Target Population

The primary population consisted of 310 CHPs operating in Voi sub-county, while the secondary population included 4 County and 4 Sub-County Health Management Team members. Cluster sampling was used to select CHPs, while purposive sampling was applied for key informants from health management teams.

3.4 Data Collection Tools

Tools used were researcher-administered questionnaires for the CHPs and key informant interviews for the CHMT and SCHMT members respectively. Both qualitative and quantitative data was collected for this study.

3.5 Data Analysis Techniques

Quantitative data from closed-ended questionnaire items were analysed using SPSS version 26. Descriptive statistics (frequencies, percentages) were generated and presented in tables and charts. Qualitative data from interviews were transcribed and analysed thematically using content analysis. Responses were coded manually into themes aligned with the research objectives.

3.6 Ethical Approvals

Ethical clearance was obtained from the Kenya Methodist University Scientific and Ethical Review Committee (SERC). Further approval was secured from the National Commission for Science, Technology and Innovation (NACOSTI), and the Taita Taveta County Department of Health. All participants were informed of the purpose of the study, assured of confidentiality, and asked to provide informed consent. They were allowed to decline answering any uncomfortable questions or to remain anonymous throughout the process.

4.0 RESULTS

Table 2

Reliability Test

Scale	Original Tool			Refined Tool		
	N	Items	KR-20 / Cronbach's alpha	N	Items	Cronbach's alpha
Future Opportunities	26	2	-.048	30	7	.715
Health Provider Non-Financial Incentives	21	4	.541	29	8	.741
Health Commodities	24	2	.793	30	7	.891
Non-Financial Incentives Model	22	10	.776	30	9	.785
CHPs Motivation	18	12	.853	29	12	.810

A reliability index of 0.70 or above was considered a sufficient degree of dependability for the study instruments (Cronbach, 1951)

Table 3

Response Rate

Details	Before Intervention		After Intervention	
	N	%	N	%
Questionnaire Survey				
Questionnaires Issued	310	100	310	100
Questionnaires Returned	300	96.8	302	97.4
Questionnaires Excluded	7	2.3	6	1.9
Questionnaires Included	293	94.5	296	95.5
Key Informant Interviews				
CHMT Invited	4	100	4	100
CHMT Participated	3	75	2	50
SCHMT Invited	3	100	3	100
SCHMT Participated	2	66	2	66

Response rate, exceeding 90% threshold was considered adequate (Dillman *et al.* (2014),

Table 4

CHPs Selection and Prior Experience

Variable		Before Intervention (N=293)		After Intervention (N=296)		Chi-Square Test (N=589)	
		F	%	F	N %	χ ²	p
Were you chosen by the community to serve them as CHP?	Yes	286	97.6%	290	98.0%	0.089 ^a	0.765
	No	7	2.4%	6	2.0%		
By the time of your recruitment, did you have any previous experience on community volunteerism?	Yes	247	84.3%	256	86.5%	0.564 ^a	0.453
	No	46	15.7%	40	13.5%		

Majority (97.6% & 98.0%) of CHPs being selected by their community reflects a common practice of community-driven recruitment, which fosters a sense of recognition, responsibility, and intrinsic motivation. High percentage (84.3% & 86.5%) of CHPs with prior volunteer experience suggests that many enter their roles with a level of readiness that may influence their motivation and effectiveness.

Table 5

CHPs Future Expectations

Expectation	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Z-Value	P-Value	Significance of Change
Career Experience	4.64 ± 0.635	4.73 ± 0.585	2.104	0.035	Significant
Professional Networking	4.61 ± 0.629	4.58 ± 0.722	0.158	0.874	Not Significant
Permanent Job Expectations	4.44 ± 1.034	4.40 ± 1.004	-0.852	0.394	Not Significant
Social & Relationship Skills	4.63 ± 0.673	4.71 ± 0.525	1.134	0.257	Not Significant
New Friends & Contacts	4.60 ± 0.693	4.62 ± 0.674	0.174	0.862	Not Significant
Community Ties & Support Network	4.72 ± 0.535	4.64 ± 0.694	-0.778	0.437	Not Significant
Pride, Identity & Accomplishment	4.53 ± 0.817	4.43 ± 0.975	-0.687	0.492	Not Significant

Only career experience expectations showed a significant improvement post-intervention ($p = 0.035$), suggesting that the intervention may have reinforced their belief in career growth opportunities. The other areas did not exhibit statistically significant changes, indicating that CHPs remained confident in the benefits of their role, with the intervention strengthening their career-related optimism, highlighting the need for non-financial incentives that support professional growth to sustain their motivation and commitment. These indicate potential areas for further program enhancement.

"CHPs gain valuable experience in community health, which can potentially lead to permanent jobs in the health sector. However, the pathway to permanent employment is not clearly defined, and this uncertainty may affect their motivation." KII 1

This statement underscores the valuable practical experience CHPs acquire through their community health roles. It suggests that while CHPs build skills and knowledge that are relevant to formal health sector jobs, the lack of a structured career pathway can leave them uncertain about their future prospects.

Table 6

Health Provider Non-Financial Incentives

Non-Financial Incentives	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Z-Value	P-Value	Significance of Change
Trained as a CHP	4.47 ± 0.927	4.71 ± 0.566	3.202	0.001	Significant
Refresher/Update Trainings	4.20 ± 0.898	4.49 ± 0.811	4.925	0.000	Significant
Certificates for Trainings	2.61 ± 1.350	3.19 ± 1.228	5.402	0.000	Significant
Assigned a Mentor	4.38 ± 0.787	4.58 ± 0.819	4.632	0.000	Significant
Regular & Constructive Supervision	4.41 ± 0.783	4.68 ± 0.584	4.993	0.000	Significant
Engagement with Peers	4.35 ± 0.737	4.55 ± 0.677	4.143	0.000	Significant
Additional Responsibilities & Skill Growth	4.24 ± 0.848	4.55 ± 0.697	5.463	0.000	Significant
Access to Medical Services Without Waiting	2.86 ± 1.525	4.09 ± 0.758	9.453	0.000	Significant

All the measured aspects showed a statistically significant improvement post-intervention ($p \leq 0.001$), indicating a positive impact on training, mentorship, supervision, peer engagement, skill development, and access to medical services. All these aspects help to sustain the interest as well as the motivation of the CHPs because they contribute to guiding, mentoring, instructing and encouraging CHPs to improve their competencies and ultimately their performance. *"We conduct 5-day class-based trainings using the national curriculum, funded by partners. This training helps CHPs feel more confident in their roles."* KII 2

Table 7

Health Commodities

Provision of Resources	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Z-Value	P-Value	Significance of Change
Bag pack for carrying health commodities	4.72 ± 0.654	4.80 ± 0.470	1.194	0.233	Not Significant
Work identification materials (Badge/T-shirt/Caps)	3.90 ± 1.237	4.34 ± 1.102	5.567	0.000	Significant
Protective gear (gloves, mask, apron, etc.)	4.39 ± 0.776	4.69 ± 0.592	5.701	0.000	Significant
Medications	4.59 ± 0.680	4.75 ± 0.591	3.988	0.000	Significant
Monitoring health tools for reporting	4.51 ± 0.867	4.72 ± 0.636	3.455	0.001	Significant
Health educational materials	3.98 ± 1.127	4.59 ± 0.658	7.542	0.000	Significant
Growth monitoring tools	4.71 ± 0.510	4.83 ± 0.431	3.485	0.000	Significant

Significant improvements were observed in the provision of work identification materials, protective gear, medications, monitoring health tools, health educational materials, and growth monitoring tools ($p \leq 0.001$). No significant change was observed in the provision of bag packs for carrying health commodities ($p = 0.233$), suggesting it was already well-provided before the intervention. Providing CHPs with essential working tools such as medical kits, and identification items enable them to serve their communities, and this brings respect and a sense of pride and enhanced social status to them. *"The adequacy of supplies impacts CHPs confidence in service delivery. If they feel equipped, they are more motivated to serve."* KII 2

Table 8

Community Non-financial Incentives

Community Support	Before Intervention (Mean $\pm$ SD)	After Intervention (Mean $\pm$ SD)	Z-Value	P-Value	Significance of Change
Desire to Give Back to Community	4.63 $\pm$ 0.652	4.76 $\pm$ 0.598	3.441	0.001	Significant
Motivation from Community Health Improvements	4.67 $\pm$ 0.539	4.67 $\pm$ 0.593	0.326	0.745	Not Significant
Community Gratitude for CHV Services	4.56 $\pm$ 0.631	5.75 $\pm$ 0.521	4.286	0.000	Significant
Community Support in Advocacy for CHVs	3.55 $\pm$ 1.206	3.98 $\pm$ 1.138	4.839	0.000	Significant
Community Ensuring CHV Safety	3.98 $\pm$ 0.989	4.14 $\pm$ 1.148	3.422	0.001	Significant
Receiving Certificates of Commendation	2.76 $\pm$ 1.496	3.13 $\pm$ 1.147	2.749	0.006	Significant
Expressions of Gratitude from Community	3.95 $\pm$ 1.108	4.43 $\pm$ 0.865	6.107	0.000	Significant
Family Support in CHV Roles	4.51 $\pm$ 0.700	4.67 $\pm$ 0.642	3.526	0.000	Significant

Significant improvements were observed in community appreciation, advocacy, safety guarantees, gratitude expressions, family support, and recognition (certificates). No significant change in motivation due to witnessing health improvements ($p = 0.745$), indicating this was already a strong motivating factor before the intervention. Community recognition is a valuable tool in motivating and retaining the CHPs because it increases their status in their respective communities. Above all, CHPs become most successful in their career when they receive respect from the community members they serve

"While some community members appreciate the work of CHPs, others have trust issues, which can affect CHPs' motivation." KII 2. *"The community praise us when giving them tablets at home"* (R291)

Table 9
Support for Livelihood Activities

Economic Empowerment	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Z-Value	P-Value	Significance of Change
Belonging to a Self-Help Group	3.98 ± 1.220	4.45 ± 0.969	6.061	0.000	Significant
Free Entrepreneurship Training	2.87 ± 1.487	2.84 ± 1.629	0.022	0.983	Not Significant
Provision of Capital for Income Generating Activities (IGAs)	1.99 ± 1.181	2.06 ± 1.436	-1.084	0.278	Not Significant
Access to Free/Reduced Trading Licenses	1.57 ± 0.836	1.36 ± 0.864	-5.280	0.000	Significant
Access to Government Procurement Opportunities (AGPO)	1.71 ± 1.020	1.44 ± 0.937	-4.915	0.000	Significant
Opportunities to Showcase Work (Expos, Trade Fairs, etc.)	1.70 ± 1.003	1.47 ± 1.021	-4.669	0.000	Significant
Access to Markets for IGAs Output	1.85 ± 1.170	1.55 ± 1.106	-4.882	0.000	Significant

Significant improvements were observed in self-help group membership, reduced cost of trading licenses, access to government procurement opportunities (AGPO), participation in expos/trade fairs, and access to markets. No significant change in entrepreneurship training ($p = 0.983$) and capital provision ($p = 0.278$) which is associated with programmatic and budget constraints by the county government and partners, suggesting that these areas still need further strengthening post-intervention.

"Some CHPs engage in IGAs like table banking and poultry farming, supported by funding from partners and occasional government engagements" (KII2). "The minimal support for IGAs from the county government is demotivating. CHPs feel unrecognized and unsupported in their efforts to improve their livelihoods" (KII1).

Table 10
Perceived Importance of Non-Financial Incentives

Importance of Non-Financial Incentives	Before Intervention (Mean ± SD)	After Intervention (Mean ± SD)	Z-Value	P-Value	Significance of Change
Skills Recognition & Certification	4.32 ± 0.839	4.55 ± 0.744	4.196	0.000	Significant
Priority Access to Social Services	3.85 ± 1.307	4.14 ± 1.221	3.304	0.001	Significant
Supportive Supervision & Performance Management	4.47 ± 0.654	4.61 ± 0.611	3.209	0.001	Significant
Ongoing Training during CHU Meetings	4.52 ± 0.633	4.70 ± 0.541	4.038	0.000	Significant
Performance-Based Awards	4.33 ± 0.859	4.52 ± 0.798	3.779	0.000	Significant
Provision of Kits & Supplies	4.55 ± 0.699	4.69 ± 0.582	3.070	0.002	Significant
Uniforms & ID Badges for CHPs	4.68 ± 0.554	4.70 ± 0.564	0.974	0.330	Not Significant
Support for CHP Livelihoods	4.59 ± 0.628	4.67 ± 0.570	1.833	0.067	Not Significant
Support for CHP Self-Help Groups	4.66 ± 0.613	4.70 ± 0.553	0.899	0.368	Not Significant

Significant improvements were observed as compared during pre-and post-intervention in training, supervision, performance recognition, and logistical support. Access to social services was perceived as more important post-intervention. These suggest that CHPs increasingly valued formal recognition of their skills, likely seeing it as a means to enhance their credibility and career prospects, CHPs placed greater emphasis on continuous capacity building and structured mentorship, which suggest a growing recognition of the convenience and efficiency that such incentives provide. No significant change in the perceived importance of uniforms ($p = 0.330$), ID badges ($p = 0.067$), and livelihood support ($p = 0.364$), suggesting sustained recognition of their value.

"Motorbikes to ease transport" (R75), "Baiskeli itarahisisha kazi yangu ya nyanjani (A bicycle would make my fieldwork easier)" (R81), "Being given certificates" (R213), "Gumboots, raincoat, SHA card" (R236), "SHA card will support me" (R267),

Table 11

Motivation of CHPs

CHPs Motivation	Before Intervention (Mean $\pm$ SD)	After Intervention (Mean $\pm$ SD)	Z-Value	P-Value	Significance of Change
Accomplishing Something Worthwhile	4.48 $\pm$ 0.809	4.57 $\pm$ 0.695	1.411	0.158	Not Significant
Satisfied with Positive Impact of Work	4.58 $\pm$ 0.559	4.67 $\pm$ 0.564	2.429	0.015	Significant
Satisfied with Colleague Support	4.54 $\pm$ 0.599	4.46 $\pm$ 0.847	0.190	0.849	Not Significant
Satisfied with Community Recognition	4.53 $\pm$ 0.588	4.60 $\pm$ 0.692	2.733	0.006	Significant
Proud to Work for County Government	4.42 $\pm$ 0.879	4.24 $\pm$ 1.091	-1.664	0.096	Not Significant
Inspired by County Government	3.95 $\pm$ 1.161	3.64 $\pm$ 1.346	-2.780	0.005	Significant
Proud to Work for the Community	4.67 $\pm$ 0.564	4.74 $\pm$ 0.581	2.330	0.020	Significant
Inspired by the Community	4.55 $\pm$ 0.544	4.66 $\pm$ 0.595	3.124	0.002	Significant
Reliability at Work	4.61 $\pm$ 0.566	4.61 $\pm$ 0.695	1.023	0.306	Not Significant
Efficiency in Task Completion	5.56 $\pm$ 0.580	4.70 $\pm$ 0.528	3.275	0.001	Significant
Taking Initiative	4.62 $\pm$ 0.588	4.69 $\pm$ 0.621	2.159	0.031	Significant
Hard Work Ethic	4.80 $\pm$ 0.427	4.81 $\pm$ 0.425	0.527	0.599	Not Significant

Significant improvements were observed in CHVs' satisfaction with their work's positive impact, recognition from the community, pride in serving their community, inspiration from the community, efficiency in task completion, and taking initiative. No significant change was noted in their sense of accomplishment, support from colleagues, reliability, or work ethic, while inspiration from the county government significantly decreased ($p = 0.005$).

Overall, the findings indicate that CHPs are highly motivated and satisfied with their roles, take pride in their affiliation with the community, and exhibit strong work conscientiousness. The results highlight notable improvements in perceived impact, community recognition, and intrinsic motivation following the intervention. However, the decline in CHPs' perception of the county government's ability to inspire them suggests a need for stronger institutional support. Enhancing organizational encouragement and recognition could further boost CHPs motivation and sustain their commitment to delivering quality community health services.

Table 12

Pearson Correlation

Variable	Before Intervention (r-value, p-value)	After Intervention (r-value, p-value)	Change/Observation
Future Opportunities → CHPs Motivation	.374**, p = 0.000	.449**, p = 0.000	Strengthened correlation post-intervention.
Health Provider Non-Financial Incentives → CHPs Motivation	.297**, p = 0.000	.626**, p = 0.000	Significant increase in correlation, indicating greater influence post-intervention.
Health Commodities → CHPs Motivation	.455**, p = 0.000	.472**, p = 0.000	Consistent positive impact.
Community Non-Financial Incentives → CHPs Motivation	.444**, p = 0.000	.483**, p = 0.000	Slight increase, reaffirming the community's role in CHPs' motivation.
Livelihood Activities → CHPs Motivation	-.286**, p = 0.000	-.059, p = 0.314	Weakening negative correlation, suggesting reduced impact.
Perceived Importance of Non-Financial Incentives → CHPs Motivation	.546**, p = 0.000	.740**, p = 0.000	Stronger correlation post-intervention, reinforcing its mediating role.

Post-intervention, the perceived importance of non-financial incentives showed a stronger mediating effect on CHVs' motivation, with increased influence from future opportunities, health provider incentives, health commodities, and community support, while the negative impact of livelihood activities weakened

Table 13

Regression of CHPs Motivation on Perceived Availability of Non-financial Incentives

Group	R	R ²	Std. Error	F-Value	Sig.	Predictors (Standardized β , p-value)
Before Intervention	0.661	0.436	0.34473	44.452	0.000	Community Non-Financial Incentives (β = 0.312, p = 0.000); Health Commodities (β = 0.258, p = 0.000); Health Provider Non-Financial Incentives (β = 0.131, p = 0.008); Future Opportunities (β = 0.130, p = 0.010); Livelihood Activities (β = -0.326, p = 0.000)
After Intervention	0.746	0.556	0.31369	72.740	0.000	Health Provider Non-Financial Incentives (β = 0.471, p = 0.000); Community Non-Financial Incentives (β = 0.236, p = 0.000); Health Commodities (β = 0.207, p = 0.000); Future Opportunities (β = 0.125, p = 0.008); Livelihood Activities (β = 0.108, p = 0.007)

The explained variance in CHVs motivation improved from 43.6% to 55.6% post-intervention. Health Provider Incentives Became the Strongest Predictor (β = 0.471, p = 0.000), indicating its increased importance. Livelihood Activities Shifted from Negative to Positive, suggesting that post-intervention, they contributed positively to motivation.

Table 14

Mediating Role of Perceived Importance of Non-financial Incentives on CHPs Motivation

Group	R	R ²	Std. Error	F-Value	Sig.	Predictors (Standardized β , p-value)
Before Intervention	0.692	0.479	0.33207	43.802	0.000	Perceived Importance of Non-Financial Incentives ($\beta = 0.262$, $p = 0.000$); Community Non-Financial Incentives ($\beta = 0.230$, $p = 0.000$); Health Commodities ($\beta = 0.180$, $p = 0.000$) - Health Provider Non-Financial Incentives ($\beta = 0.156$, $p = 0.001$); Future Opportunities ($\beta = 0.097$, $p = 0.046$); Livelihood Activities ($\beta = -0.240$, $p = 0.000$)
After Intervention	0.815	0.665	0.27322	95.452	0.000	Perceived Importance of Non-Financial Incentives ($\beta = 0.440$, $p = 0.000$); Health Provider Non-Financial Incentives ($\beta = 0.274$, $p = 0.000$); Health Commodities ($\beta = 0.136$, $p = 0.001$) - Community Non-Financial Incentives ($\beta = 0.150$, $p = 0.000$); Livelihood Activities ($\beta = 0.082$, $p = 0.020$); Future Opportunities ($\beta = 0.079$, $p = 0.058$)

The explained variance improved from 47.9% to 66.5% post-intervention. Perceived Importance of Non-Financial Incentives Strengthened as the Key Predictor ($\beta = 0.440$, $p = 0.000$ post-intervention). Livelihood Activities Shifted from Negative to Positive Impact, becoming statistically significant ($\beta = 0.082$, $p = 0.020$ post-intervention). Community and Health Provider Non-Financial Incentives Maintained Significance, reinforcing their role in CHVs motivation.

Table 15

Hypothesis Testing for CHPs Motivation Before and After Intervention

Null Hypothesis (H_0)	Before Intervention		After Intervention	
	Regression	Decision ($p < 0.05$)	Regression	Decision ($p < 0.05$)
H_0: Future Opportunities do not significantly influence CHPs' motivation.	$B = 0.088$, $t = 2.006$, $p = 0.046$	Reject H_0 (Significant)	$B = 0.078$, $t = 1.907$, $p = 0.058$	Fail to Reject H_0 (Not Significant)
H_0: Health Provider Non-Financial Incentives do not significantly influence CHPs' motivation.	$B = 0.136$, $t = 3.244$, $p = 0.001$	Reject H_0 (Significant)	$B = 0.328$, $t = 6.391$, $p = 0.000$	Reject H_0 (Strong Significant)
H_0: Health Commodities do not significantly influence CHPs' motivation.	$B = 0.161$, $t = 3.583$, $p = 0.000$	Reject H_0 (Significant)	$B = 0.146$, $t = 3.234$, $p = 0.001$	Reject H_0 (Significant)
H_0: Community Non-Financial Incentives do not significantly influence CHPs' motivation.	$B = 0.200$, $t = 4.328$, $p = 0.000$	Reject H_0 (Significant)	$B = 0.135$, $t = 3.825$, $p = 0.000$	Reject H_0 (Significant)
H_0: Livelihood Activities do not significantly influence CHPs' motivation.	$B = -0.146$, $t = -5.057$, $p = 0.000$	Reject H_0 (Significant Negative)	$B = 0.052$, $t = 2.342$, $p = 0.020$	Reject H_0 (Significant Positive)
H_0: Perceived Importance of Non-Financial Incentives does not significantly influence CHVs' motivation.	$B = 0.235$, $t = 4.826$, $p = 0.000$	Reject H_0 (Strongest Positive)	$B = 0.434$, $t = 9.658$, $p = 0.000$	Reject H_0 (Strongest Positive)

Before the intervention, Perceived Importance of Non-Financial Incentives significantly mediated Health Commodities, Community Non-Financial Incentives, and Future Opportunities, while Livelihood Activities had a strong negative mediation effect and Health Provider Non-Financial Incentives were not significant. After the intervention, Health Provider Non-Financial Incentives became the strongest mediated factor, Community Non-Financial Incentives and Health Commodities remained significant, while Livelihood Activities lost mediation significance, and Future Opportunities became marginally significant.

5.0 CONCLUSION

The objective of the study was to determine the influence of non-financial incentives on motivation of CHPs for provision of community health services in Taita Taveta County. The findings of the study indicate that CHPs' have got high expectations of gaining career experience and belief in career growth opportunities, and have got high satisfaction in key areas like training, mentorship, supervision, peer engagement, and opportunities for additional responsibilities. Access to medical services among the CHPs without waiting in line has highly improved, and are satisfied with essential supplies they get from the department of health and other partners in the county. Key health commodities such as backpacks, medications, monitoring tools, and protective gear are sufficient, however, there are gaps with timely replenishment of these supplies. Community gratitude for CHPs' is adequate, reflecting a stronger recognition of their efforts, however many CHPs still feel under-recognized by the community. The researcher therefore recommends that the department of health to enhance non-financial incentives that support professional growth and have clear and transparent pathways to permanent employment for CHPs. The department of health should also strengthen impactful non-financial incentives such as trainings, mentorship, supervision, and peer engagement, enhance certification after trainings, and improve resources for training programs, and strengthen health commodities supply chain

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