Using community health workers in community-based growth promotion: what stakeholders think

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Abstract

The Nutrition and Malaria Control for Child Survival Project is a community-based growth promotion project that utilizes Community Health Workers (CHWs), referred to as Community Child Growth Promoters (CCGPs), as the principal change agents. The purpose of this study was to identify perceptions of key stakeholders about the project and the role of the CCGPs. The study employed qualitative methods: focus group discussions with CCGPs and care givers, exit interviews with care givers, and key informant interviews with health workers and CCGPs. All stakeholders interviewed expressed appreciation for the project and the role of the CCGPs. Respondents indicated that the project, through the CCGPs, had improved access to growth promotion services for children in their communities and made community mobilization for health programs easier. Caregivers appreciated the role of the CCGPS because they were their own people, who spoke their language, understood their situations better, treated them better and were readily accessible. CCGPs on their part believed they were playing a very important role in their communities and were happy with their prestigious position; though they hoped for incentives. This appraisal adds to the evidence on the important role played by CHWs in the developing world.

Background

An estimated 1.3 billion people worldwide lack access to basic healthcare, often because of a lack of health workers [1]. The worst hit regions are Africa and Asia, where there is a severe shortage of health workers. One strategy proposed to address the health worker crisis is the use of community health workers (CHWs) [2]. CHWs are known by different names in different countries, but generally they are community health aides, selected from their communities, trained and working within those communities [3]. CHWs have been used for many years in healthcare delivery in many areas with experiences ranging from large-scale national programs to small-scale community-based initiatives and from health promotion activities to disease management activities. Although evidence for their effectiveness is mixed, they have been found to be effective in widening access and coverage of health services in remote areas as well as improving health outcomes especially in the area of child health [3–7]. Although many CHW programs have been described, few have documented what the various stakeholders of these programs think about their roles. A study in Lesotho which documented CHW’s perceptions of their work suggest that most CHWs evince an overall positive experience as lay health workers, though a few report sometimes feeling overwhelmed [8]. Another study among CHWs...
in Pakistan however reported high job stress, with about half of the CHWs interviewed expressing very little to moderate job satisfaction. The major reasons for the lack of job satisfaction were inadequate logistics, and late and inadequate salary [9]. However, these studies have not documented the views of CHWs and/or other players such as health workers and beneficiaries of the projects regarding the projects and the role of the CHWs. We believe that the perceptions of stakeholders about a project and its key players have important implications for project performance. Hence, as part of a rapid appraisal of a community-based growth promotion project in Ghana, we assessed the perceptions of key stakeholders about the project and the role of the principal change agents, the CHWs. This article presents the results of this component of the appraisal.

**Project description**

The Nutrition and Malaria Control for Child Survival Project (NMCCSP) is a community-based child growth promotion project that uses CHWs, referred to as Community Child Growth Promoters (CCGP), as the principal change agents at the community level. The project is a response to the high incidence of malaria and malnutrition in children under 2 years in Ghana [10]. The overall goal of the project is to reduce mortality among children under the age of 2 years in target communities through improved utilization of selected community-based health and nutrition services for children under 2 years and pregnant women [11].

CCGP are volunteers who are recruited from the target communities and trained over a period of 5 days to implement the project in their respective communities. Their work is completely voluntary. Individuals selected as CCGP must be resident in the given community, be able to read and write, be respected by the community, demonstrate some commitment to the community’s welfare, be willing to do voluntary work and have some experience in service delivery or community development activities. A major role of the CCGPs is to organize monthly growth promotion sessions in their communities. During these sessions, CCGPs are required to weigh all children under 2 years, record the weights on growth charts and assess if children were gaining adequate weight. The results form the basis for counseling on appropriate nutrition using a counseling guide. They are also expected to identify children whose vaccinations are not up to date and sick children and refer them to the appropriate healthcare providers. In addition, CCGPs are required to make home visits to follow up on issues identified during growth promotion sessions and to mobilize their communities for health promotion activities [11].

The NMCCSP is World Bank funded project being implemented by the Ghana Health Service in selected districts across the country. The selection of districts is guided by technical criteria based on various health indicators. District and sub-district Health Management teams are responsible for supervising the CCGPs. The Upper East Region is one of the regions in which the project is being implemented [11].

**Methods**

This assessment was performed in the Bongo District of the Upper East Region, with the approval of the Upper East Regional director of health services. At the time of the assessment, the project was being implemented in six of the nine districts in the region. The main purpose of the appraisal was to review the implementation of the project in these districts to help guide the scale up to the rest of the districts in the region. One district, the Bongo district, was chosen for this appraisal because of financial, logistical and time constraints. But more importantly, Bongo was the first district in the region to rollout the project and thus had gone through most of the phases of implementation.

**Assessment area description**

Upper East Region is 1 of the 10 administrative regions in Ghana. It is located on the northeast border of Ghana in the Guinea savannah belt. Bongo district is one of the nine districts in this
region with Bongo as its capital. Bongo is the smallest district in the region in terms of land size (an area of 459.5 km²), but one of the most densely populated districts in the country; population density of 187 persons/km² compared with the national average of 79.3 persons/km². The projected population of the district in 2010 was 85,944, with 17,190 women of reproductive age and 3,438 children under 1 year. Bongo district is entirely rural, with over 90% of the people engaged in subsistence farming. There are a total of 132 communities scattered in small dispersed settlements and the land terrain is mostly rocky. There are two climate seasons—dry and wet—which play a critical role in seasonal farming, nutrition and the spread of malaria. The District has a very poor road network with many rivers and streams, broken-down bridges and culverts, making accessibility very difficult especially during the rainy season (June–August). The healthcare delivery system is built around one district hospital in the district capital serviced by 4 health centers, 2 community clinics, 1 reproductive health clinic, 13 completed Community-based Health Planning and Services compounds and several outreach points. For the purpose of health service delivery, the district is divided into six sub-districts namely Bongo Central, Bongo-Beo, Bongo-Soe, Namoo, Zorko and Valley Zone [12,13].

**Data collection**

We used rapid appraisal methods in this assessment due to time, financial and other logistical constraints and also because the nature of the information required could be obtained through a rapid appraisal. Rapid appraisal methods fall on a continuum between very informal methods such as casual conversations or short site visits and highly formal methods such as censuses, surveys, or experiments. Rapid appraisal methods tend to be qualitative though they may include some quantitative approaches [14–16]. We conducted semi-structured interviews with health workers and CCGPs, exit interviews with caregivers and focus group discussions (FGDs) with CCGPs and caregivers. Selection of all respondents was based on their availability and willingness to participate. Only health workers who were involved in the project in one way or another were interviewed.

**Interviews**

We conducted four semi-structured interviews with all four health workers at the district level who were directly involved with the project and with four of the sub-district leaders (two of the sub-district leaders were not available during the time of the interviews). We visited one community in each sub-district based on which communities had growth promotion sessions during the period of fieldwork. We then interviewed at least one Community Health Nurse (CHN)—a total of eight CHNs were interviewed—and two or three CCGPs at the growth promotion sessions. A total of 16 health workers (7 males and 9 females) and 15 CCGPs (11 males and 4 females) were interviewed. We also conducted exit interviews with two or three caregivers (all female) in each community (total of 15 exit interviews). We informed all CHNs and CCGPs at each site of the purpose of the visit and sought their permission for the interviews. We approached caregivers participating in the growth promotion session after they had received their services and asked if they were willing to be interviewed about the project. Only those who consented verbally were interviewed.

**Focus groups**

We conducted 1 FGD with 10 CCGPs from all six sub-districts. We invited two CCGPs from each sub-district with the help of the sub-district leaders, but two CCGPs from two sub-districts could not honor the invitation. All CCGPs at the FGD were male. Another FGD was held with 12 caregivers (all female) recruited from one community during a growth promotion session.

No incentives were provided except for the focus group with CCGPs where a token was given to cover cost of transportation to the district capital where the FGD took place. We did not collect any identifying information on respondents. Interview guides with similar questions were used for all the interviews and focus groups with some variations to
accommodate group-specific issues. Findings from the FGDs and first few interviews also informed subsequent interviews. Questions to Health workers and Caregivers included what they thought about the NMCCSP and the role of the CCGPs and any other information they thought relevant. We asked CCGPs why they thought the NMCCSP was being implemented in their communities, what their role was, what they thought of their role and any concerns they had.

The lead author conducted all the interviews with health workers and CCGPs. The third author and a national service personnel at the district health directorate assisted with the interviews of caregivers in some communities. The focus group was facilitated by a research assistant with experience in facilitating focus groups. The first author was present at both focus groups and took notes. The responses to the interviews were hand written, while those of the focus groups were tape recorded and then transcribed. We used a thematic approach for the analysis. The responses from the interviews were captured in a spreadsheet and organized by the type of respondent (health worker, CCGP, or Caregiver). These were then examined for emerging themes and patterns. We used ATLAS ti to analyze the FGDs because of the larger volume of the data.

Findings

The findings are organized to reflect the views of each group of respondents with a description of the main themes emerging from the analysis of responses from each group.

Health workers

The main theme that emerged from interviews with health workers related to the ‘supportive role of the CCGPs and the NMCCSP as a whole in healthcare delivery in the district’. Although they had concerns about issues related to program implementation particularly inadequate logistics, the health workers were all generally appreciative of it and the role of the CCGPs. All health workers interviewed thought the NMCCSP was a very good initiative. They indicated that it had increased coverage for child welfare and safe motherhood services and attributed the success to the fact that the CCGPs live in the communities and thus are able to trace defaulters. In addition, respondents identified the following as major achievements under the project: community mobilization for health education and other programs are faster and much easier; people in the communities are more informed of health issues as volunteers reinforce health messages in the community; increased awareness of best practices in child care including immunizations; mothers are increasingly more knowledgeable about their children’s growth and health; faster identification of underweight children as well as referral of sick children to appropriate healthcare facilities; control of malaria and malnutrition is much improved; increased use of long lasting insecticide-treated nets; improved breast feeding practices; and additional resources for the district. Many CHNs indicated that the CCGPs were of immense help in organizing outreach clinics and tracing defaulters through home visits. They mentioned that though some CCGPs had dropped out largely because of lack of incentives, most of those still engaged in the project were doing very well.

Caregivers

A major theme identified from interviews and the FGD with caregivers was one of ‘appreciation’. All caregivers interviewed were full of praise for the project. They noted that the presence of the CCGPs was highly beneficial to them. Their expression of appreciation clustered around the following sub-themes:

Identity of the CHWs: according to some caregivers, they liked the CCGPs because they were their own people helping in healthcare, the CCGPs understood their circumstances better and were readily available and accessible for health advice. Speaking the same language was also very important to some caregivers as one caregiver said she is happy with them because:

...they speak frafra (the local dialect) to you.
(Female caregiver, FGD)
Attitudes of CCGPs: some caregivers also mentioned that the CCGPs treated them better and with more respect than the formal health workers. This ‘better treatment’ however also led to a situation whereby some mothers frequently asked their older children to take their babies for the growth promotion sessions even though the project encourages mothers to be present for these sessions in order to maximize the impact of counseling. They indicated that whenever they were not feeling well themselves, they could comfortably send their babies with their older children for weighing without problems because the growth promoters would take their babies as opposed to some of the nurses whom some women said did not even want to touch their babies. The following quote from a caregiver makes the point:

It used not to be good because anytime we came and it was only the nurse women that were attending to us, you could not send your small child and say you are not yourself (i.e. not well). If you were not yourself and you sent your small child and when the nurse women were going to weigh the child, they would insult you. But as they (CCGPs) are there, if you are not yourself, you bring the child and they would collect the child and weigh for you. (Female caregiver, FGD)

Improved access to child welfare services: some caregivers also reported that the project had improved access to child welfare services as many hitherto had to walk long distances for these services. This is because growth promotion services are conducted at central points within the communities and since CHNs come to these sessions to provide vaccination and vitamin A supplementation, caregivers no longer have to travel to the health centers or clinics for routine child welfare services. A few women who had come from surrounding communities however felt the location was still far for them and wished the growth promotion sessions will be organized in their communities. Caregivers also mentioned that the project had decreased the time spent at child welfare clinics as the CCGPs assist the CHNs to speed up the process at the growth promotion sessions.

Increased education about child care: some caregivers also reported that they feel better educated on how to take care of their children and other health issues. They mentioned that the CCGPs encourage them to go for weighing sessions and they can tell when their children are not growing well and what to do about it. As one respondent said:

What they do and I am happy is that when you get there and they weigh the child, if they see that the child’s weight is not plenty, they teach you. They teach you that when you get home, you should do this or that so that the child would have good health. That is what would give us all happiness. (Female caregiver, exit interview)

Involvement of CCGPs beyond growth promotion sessions: one of the stipulated roles of the CCGPs under the project is home visits to follow up on issues identified during growth promotion sessions. Although some caregivers reported that they had never been visited at home, those who had been visited were highly appreciative of it. In addition, though the project does not require CCGPs to take women or children to health facilities, some reported that CCGPs sometimes help them get to health facilities; something they were very happy about as reflected in these quotes:

They have been going round and attending to us. Caring for our children well... my child was sick and I went to the doctor and collected medicines. He picked up and left us at home and the next day, he came to see the child... they came to see me and when they came to see me, my husband said that it was good. (Female caregiver, exit interview)

... When I was going to deliver, they took me to go and deliver so I am happy with them. (Female caregiver, FGD)

A need for expanded services: growth promoters do not provide antenatal services but they identify pregnant women and refer them for antenatal care.
Also CHNs who come for the growth promotion sessions only provide vaccination and Vitamin A supplementation to children. Some of the women however wished that there were nurses at the growth promotion sessions to provide antenatal care in their communities so that they do not have to travel to the health facilities for antenatal care. One respondent said:

I am happy but there should be a nurse here. You can be pregnant and you go and they tell you that you they cannot take care of you well so when you are pregnant, going there is a problem. (Female caregiver, FGD)

**CCGPs**

The themes identified from interviews and FGDs with CCGPs were directly related to questions they were asked. The first two themes: the ‘need for the project and their specified roles’ emerged from response to the questions on why the project was being implemented in their communities and what role they played. The other themes emerged from the question on what they thought about their role.

**Need for the project**

In general, CCGPs understood the need for the project in their communities, the reasons for the specific target groups and the goals it sought to achieve (as described under project description). This is illustrated by the following quotes from two CCGPs:

This new project came to our community because most of our children especially those under five years suffer from malaria or malnutrition so this project came up to see the ways that we can pass to improve their health . . . . (Male CCGP, FGD)

Children and pregnant women are the main people. They are at risk of getting malaria and malnutrition. Because at that time, zero to twenty four months, that is zero to two years, we have to pay proper attention to those children and advise mothers to send them to the growth promotion centers or even weighing sessions . . . . If they are getting inadequate feed, then there is something wrong with the children because at that age, these children cannot speak. They cannot talk to the mother or to the parents that this is what is happening to me. By all means with the weighing card, you can at least go through it and advise the mother that there is something wrong with the child so send the child to the clinic for further advice. (Male CCGP, FGD)

**Specified roles**

CCGPs also understood their role in the project and many mentioned that they were playing a very important role in their communities and were happy about that. They defined their role to include mobilization of community members for growth promotion sessions, performing various activities during these sessions and embarking on home visits.

Our role is just simple. We normally tell the mothers to come out for the weighing and then we weigh the children and after the weighing, we counsel them and then we refer them. I mean that those that are malnourished children and then we do the follow ups and home visits for those that default for that month. (Male CCGP, interview)

For the nutrition side, we normally advise the mothers to practice exclusive breastfeeding and then complementary feeding and then for the malaria side, we also advise the pregnant women to sleep under treated nets. (Male CCGP, FGD)

Some CCGPs also mentioned community meetings to disseminate health information as well as serving as a link between their communities and the Ghana Health Service.

We also hold community meetings to tell community members about children that are growing and also the children that are not
increasing in weight. Whenever we hold any meeting and we identify any problem, we are the link between the community and the Ghana Health Service. We inform the Ghana Health service of what is happening in our community and they would come to see what can be done. (Male CCGP, FGD)

Perceived contribution
When asked what they thought about their role, CCGPs mostly talked about the contributions they thought they were making in their communities. Some reported contributing to the growth and development of children in their communities because the number of malnourished children and the incidence of malaria and diarrhea had declined. They attributed these outcomes to the counseling and education on best feeding practices, the use of long lasting insecticide-treated nets and proper hand washing. Many respondents also attributed increasing antenatal attendance and supervised deliveries to the fact that they were resident in the community and could identify pregnant women and encourage them to go for care. Some reported having contributed to a reduction in fetal and infant deaths, increasing awareness of health issues and getting more men to support growth promotion in their communities. Yet others mentioned that they were helping their community members who previously had to travel long distances to have their children weighed or did not go at all. As one CCGP said:

Most of our communities are under remote areas where the clinics or hospitals are far. To reach the hospital is just too far for them to reach there or get there.... (Male CCGP, FGD)

Personal gain and development
Some CCGPs also described how engagement in the project had benefited them personally. They indicated that they had learnt a lot through the project, which had earned them a lot of respect in their communities. In addition, it had given them the opportunity to build a relationship with health workers in the district and with other people in their communities.

It is good to know that it also helps us to learn a lot of things and new things from the health staff. We always met them and we discuss. We know the signs and symptoms of some of the sickness and in the community, everyone respects you. They believe that you are with the nurses, you are part of them, so you know everything like a nurse knows, so anything that they have, whether it is a problem that they have or anything, they do tell us.... So I see it that the growth promoter is a very good thing and also let us know and make friends at the district. Like as we are sitting, if we were not growth promoters but we would not meet like this and we would not know ourselves so I think that is the good thing. As a growth promoter, you promote yourself and your community. (Male CCGP, FGD)

Prestige
Another theme that emerged from responses to the question about what they thought about their role was prestige. Some CCGPs felt they had gained a prestigious position in their communities by virtue of their selection and role in the project as illustrated in this quote:

.... I see myself as a very important person in the community because if there are any problems with their health side, even midnight, they would come and wake me up so I see that I am also important person in the community. (Male CCGP, FGD)

One respondent actually mentioned that this could potentially earn him a political position in the future:

I am happy because in my community, if they mention the chief, assembly person and any two opinion leaders, by all means they would mention my name too. They would add my name to the list and I believe that one day,
God willing if I contest assembly elections, I am going to sweep. (Male CCGP, FGD)

**Dissatisfaction about lack of incentives and inadequate logistics**

When asked if they had any concerns, the discussion mostly centered on the lack of material incentives for them. Despite the feeling of importance, almost all CCGPs were unhappy about the fact that the project did not provide them any incentives. CCGPs said some of their colleagues left because the project provided no remuneration of any sort. Moreover, most of them had no other jobs and so sometimes had to migrate to the relatively richer (southern) part of the country to find jobs and a better livelihood in the dry season. The result increased burden of work on the remaining CCGPs as they still have to organize monthly growth promotion sessions and undertake all project-related activities. Some reported having to forfeit their own activities (going for extra classes and farming) to be present at growth promotion sessions even though they were not paid. There was a general consensus that even though they had accepted the positions because they wanted to help their communities, they still needed some form of incentives, monetary, or otherwise. This view was expressed by several CCGPs during the interviews and the FGDs:

Actually, this work is not even supposed to be voluntary because it is very difficult. It is a difficult task because the home visits alone is not easy neither to talk of going for weighing. You would talk till your head is aching but so far as we have committed ourselves that we are going to volunteer to help our community, we have to dedicate ourselves to the community, do everything that you are supposed to do to help the community grow up so that in future or very soon, your community name would be lifted up in the health sector. (Male CCGP, FGD)

I believe that they should give us something small to be washing our clothing... Something like a monthly allowance... the project should also help us to settle down like youth employment or some small work. (Male CCGP, interview)

During the rainy season like this, we need rain coats... And wellington boots because during rainy season, we always get into water... Torch lights... bags to be putting our registers in... Bicycles for home visiting.... Like something plastic. Maybe you would be going for a weighing session and maybe rain would meet you on the way and you would, see that that would make the registers spoil... We also need radios to be listening to news so that we would be conversant with information. (Male CCGPs, FGD)

Some CCGPs were also concerned about inadequate tools for their work, the lack of conducive growth promotion sites and inadequate seating for growth promotion sessions. Another problem is that when they come up for the meetings, there are no benches for them to sit on so sometimes they sit on the rocks and others sit on the ground so that is why some people don’t come. They don’t like to come and sit on the ground. They cannot wash their clothing and come and sit on the ground to listen to you... Another problem is that the sitting place. You may go there and rain would come and drive you away because we don’t have a room to sit in. (Male CCGP, FGD)

**Community support**

This theme emerged directly from a probe about whether they had enough support to perform their work. Some volunteers reported getting some support from their communities to facilitate their work but others said they were not getting enough support. In terms of mobilization for growth promotion session, spread of information was mainly by word of mouth with the help of the village announcer in some communities. Some volunteers however
complained of not getting enough help to disseminate information because of perceptions that they were being paid. Some also talked about getting material support from their communities as voiced by this CCGP:

There is an adage that says that “a good name is better than riches”. If you are able to educate your community or you are committed and help your community to be well and they have their health or they are in good health conditions, you have done a lot. We have experienced so many things. Because of my health, during harvesting season like this, I am just... The food is just plenty for me. They see the work that I am doing and because of that they have been giving me food so I feel that if you are committed it helps a lot. (Male CCGP, FGD)

This was however not a consensus among all the CCGPs which was partly due to the misunderstanding about the volunteer role of the CCGPs in some communities as reported by another CCGP: ‘They think that we are working for money so nobody cares’ (Male CCGP, FGD).

Discussion

CHWs represent an important health resource with great potential for providing and extending basic healthcare to underserved populations [3,7]. As in the case of the NMCCSP, they can potentially bridge the human resource gap in healthcare [4,5]. It is however important to understand what these CHWs think about their role in various projects as this could potentially impact their performance. Moreover, understanding the perceptions of other stakeholders—such as health workers who work with them as well as the beneficiaries of the project—concerning the projects and the role of these CHWs is important in highlighting the potential for a project’s acceptability and success. In this article, we have presented the findings on the perceptions of key stakeholders about the NMCCSP as well as perceptions about the role of the CCGPs (the CHWs in this project). The main theme that emerged from interviews with health workers is the supportive role of the CCGPs to the health sector. This was supported by CCGPs description of their role and contributions to their communities. Improved access to child welfare services and increased education about child care mentioned by caregivers also lend support to this assertion. Caregivers also appreciated the role of the CCGPs because of their identity, their attitudes toward them and their involvement with them beyond the growth promotion sessions. They also expressed a need for expanded services. CCGPs discussed their role in relation to their contributions to the welfare of mothers and children in their communities, personal gain and development and prestige. They also expressed their concerns about the lack of incentives, inadequate logistics for program implementation and little community support.

Although the evidence on the effectiveness of growth monitoring is mixed, there is some evidence that growth monitoring in addition to counseling can lead to improved outcomes [17,18]. In Ghana, like many other developing countries, growth monitoring is offered through child welfare clinics which tend to be located in health facilities. Unfortunately, children in remote areas may not have access to these services due to difficulty in physically accessing these health facilities. Using CCGPs to provide these services within their communities thus fulfills an unmet need [5]. The results of this assessment confirm that CHWs are an acceptable alternative in remote areas where access to health care is very poor. The appreciation of health workers of the role of the CCGPs is especially important considering that a supportive health system is essential to the success of CHW programs [3]. Even though we did not evaluate project outcomes, health workers and CCGPs thought the project had led to positive improvements in growth monitoring and promotion, the health of children, as well as health behaviors of caregivers. This is consistent with the evidence that CHW programs can lead to positive outcomes especially in the area of child health and especially in developing countries where preventable conditions are still the major causes of child morbidity and mortality [3].
In addition, CHWs bridge language barriers and caregivers are more comfortable because they are not seen as strangers. Some CCGPs even go beyond their defined roles to help caregivers get to health facilities whenever they were able to do so. This may be motivated by a sense of responsibility toward their communities or a need to strengthen their relationships with community members to facilitate their work. This has been observed in other CHW programs where CHWs go beyond their basic roles by becoming more involved with families and building relationships with them [19]. But this familiarity may sometimes prove inimical to the overall success of the project. For instance, caregivers may resort to tasking their older children with the responsibility of taking their babies for growth promotion. However, one may argue that this may be better than not taking the children at all because caregivers are unable to make it themselves for one reason or another.

The recognition that they play an important role in their communities is an important motivating factor for the CCGPs. Despite this feeling, they still hope for some incentives. The lack of incentives is a possible cause of the high attrition of the CCGPs as found in many CHW programs that use volunteers [9]. This is not surprising given that both monetary and non-monetary incentives are important in CHW performance [3,20,21]. The NMCSSP does not provide remuneration for the CCGPs even though some CCGPs and health workers think they are playing a major, time-consuming role that deserves some form of remuneration. This is an issue that needs serious consideration. Although it may appear cheaper not to pay volunteers in the short term, it might actually be more expensive as the high attrition would require frequent reselection and training of new volunteers. Attrition also leaves little opportunity to build on experience and develop skills over time through refresher training. In addition, it creates a disconnect in the relationships established among the CHWs, the community and the health system [3,21].

Monetary incentives may increase retention, given that many CCGPs have limited alternatives to other means of livelihood. But monetary incentives can lead to other problems especially when remuneration is deemed inadequate or distribution is irregular or inequitable [21]. Providing remuneration might even affect community support since some volunteers mentioned less support from their communities because of the perception that they were being paid. The alternative is non-monetary incentives tailored to the local context [5,21]. Relatively small things can provide a sense of authority and pride in their work and increased status in their communities [21]. This is evident from the items CCGPs mentioned: rain coats, boots and identification badges or shirts would not only motivate volunteers and perhaps increase retention but will also facilitate their work. Providing adequate logistical support will help ensure the CHWs feel competent to do their jobs [21]. The fact that a good number of the volunteers were still at post despite the lack of material incentives is an indication of their commitment. But providing appropriate incentives will go a long way to motivate them and increase retention and effectiveness. Other sources of motivation for the CCGPs included the respect accorded them by community members, support from community members such as occasional gifts, the opportunity to gain new knowledge and hope for future benefits. These are similar to motivation factors for CHWs reported in the literature [3,21].

It is unclear from the information available to us why perceptions that CCGPs are being paid should affect community support. But this may be because community members feel CCGPs are making some sacrifices for them when they know their role is voluntary and so willing to support them. Perceptions that they are being paid on the other hand may be interpreted as that ‘they are just doing a job’ hence there is no need to help them. Further research is however needed to fully understand this.

**Limitations**

The main limitation of this assessment is that it was a rapid appraisal and so bears the limitations of rapid appraisal techniques. Although limited in terms
of issues related to validity, reliability and generalizability, rapid appraisals are relatively low-cost, can be quickly completed and good at providing in-depth understanding of issues. They also provide flexibility by allowing evaluators to explore relevant new ideas and issues that may not have been anticipated in planning the study [14]. Taking steps to reduce bias during data collection and analysis, and triangulation of data collection methods and sources helped to maximize the validity of the information obtained [15,22]. Also due to the limited time and personnel for the assessment, the number of interviews and focus groups were relatively small. However, there was consistency in the information obtained from the various sources which increases our confidence in the information obtained.

Respondents were not randomly selected, thus we cannot rule out some selection bias. For instance, all caregivers who participated in this appraisal were selected at the growth promotion sessions. It is thus possible that they already had a positive view of the project and that is why they go to the sessions. Those who did not participate may hold different views, which this appraisal did not capture. However, attendance at the growth promotion sessions was generally very high and CCGPs indicated that they were able to reach almost all the women in their communities. The high turnout at the growth promotion sessions coupled with the fact the CCGPs did not mention participant responsiveness as a challenge gives us some confidence that the findings can be generalized to the target population. In addition, the FGDs included caregivers in only one community hence has limited generalizability. However, the results of the interviews from other communities were largely consistent with those from the focus group.

We cannot also rule out social desirability bias especially if respondents projected a positive image of the project to please the interviewers. However, we did create a comfortable and less formal environment for the interviews and FGDs in order to facilitate full participation. The discussions were open and frank, especially regarding the project limitations and there were no indications that respondents were being strategic in any way. We therefore believe these are honest opinions of the respondents. This assessment was performed in a rural district in Ghana and thus may not be generalizable to other settings. We do not assert that this was a very rigorous study, but we believe the findings are credible and important enough to share with others in the field.

Conclusion

Although the original purpose of this evaluation was to provide information to guide the scale up of the project in the Upper East Region, it highlighted perceptions about community-based health promotion projects and the role of CHWs; findings we think are relevant for actors involved in similar initiatives in other developing country settings. The findings are particularly important in light of several problems related to program implementation that were identified in this appraisal, including inadequate logistics, poor infrastructure for growth promotion sessions and poor supervision. The knowledge that despite these problems, the project was still acceptable to staff of the health sector, the CCGPs—the main change agents in the project—and the beneficiaries of the project motivated efforts to identify ways for effective implementation of the project activities. We recommended among other things providing some incentives for the CCGPs and ensuring adequate logistics for the implementation of the project.

The results of this appraisal add to the growing evidence on the important role being played by CHWs in the developing world. It highlights the fact that they are accepted in communities and can potentially increase the cultural competency of health programs. It also adds to the evidence on the factors that motivate CHWs. We hope the results presented here will generate more interest in understanding what various stakeholders think about the specific roles of CHWs in various interventions in more diverse settings through more rigorous research. This evidence might help to address the
inconsistencies in the literature about the effectiveness of CHW programs.

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Conflict of interest statement

None declared.

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