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Do Good, Feel Good

Analyzing the performance motivation of community health workers in rural South Africa

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Abstract

This study contributes to fill the gap in the existing community health worker literature by offering a more nuanced perspective on performance motivation of healthcare workers from rural South Africa. Specifically, it focuses on the various work incentives and perceived organization support that shape work performance of healthcare workers and, therefore, organizational effectiveness. By following a qualitative research design employing traditional ways of data collection, such as participant observation, focus group discussions, semi-structured face-to-face interviews with healthcare workers, senior members and program supervisors, and emergent method of co-current social research in form of an art session, the study was built upon the stories and experiences of 26 rural healthcare workers.

Merging self-determination theory with perceived organizational support theory, a conceptual framework was created that draws attention to specific rewards and supportive resources that an organization can offer in order to ensure the well-being of healthcare workers, and maintain high performance. Through the framework, organizations have a potential to gain a more comprehensive picture on their employees' performance motivation. In fact, it might potentially shape the way organizations look at their support system and its impact on a more holistic level.

Keywords*:* rural community, health, healthcare worker, motivation, job satisfaction, organizational support, work performance, South Africa

Word count: 14973

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CHW	Community health worker
HIV	Human Immunodeficiency Virus
ICF	Informed Consent Form
MM	Mentor Mother
MMZ	Mentor Mother Zithulele
NGO	Non-governmental organization
POS	Perceived organizational support
SAHR	South African Health Review
SDT	Self-determination theory
SOCHARA	Society for Community Health Awareness Research and Action
TB	Tuberculosis
WHO	World Health Organization

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"Yesterday I was clever, so I wanted to change the world.
Today I am wise, so I am changing myself." Rumi

1. Introduction

Worldwide, health achievements have been remarkable in the past half a decade. Global life expectancy has increased more in the past 50 years than in any preceding more extensive period of time (Laxminarayan et al. 2006: 1193). This rapid improvement has been derived from reduced health risks due to better housing, sanitation, education and advances in medical science. During this era, the basic healthcare delivery strategy got based on different pillars as well; as shortage of medical professionals and healthcare facilities became apparent, the potential of local capacity through community involvement, and active participation were drawn attention to (Perry et al. 2014: 402). The public health discourse started focusing on community health worker (CHW) initiatives since higher professional circles noticed the positive implication of the programs. In fact, in the past couple of decades several countries decided to scale up CHW programs, and some of them have shown especially impressive health results; in Brazil, Bangladesh and Nepal, parallel with the expansion of the national CHW program, the most rapid achievement in reducing child mortality under 5 years of age have been observed since 1990 worldwide (Perry et al. 2014: 404). As such, a mutual agreement has been made on the potential benefits of engaging and linking community members into healthcare delivery since it can not only help to overcome the shortage of medical professionals, but also to identify and address local health needs better (Lie et al. 2011: 420).

Even though, the field has started recognizing the integral and crucial role that CHWs can play in the healthcare delivery and their potential, programs tend to be looked at from the perspective of service recipients. Impact evaluations, that aiming to access health outcomes, are often one-sided, and pay little or no attention to the agents of change. Being personally involved in one of these research projects, with a purpose to evaluate an extensive CHW program in South Africa, I realized that there is a need to take another angle into account while assessing program outcomes. By trying to understand the situation and personal experiences of the CHWs, that deliver the actual service out in the field, my study intends to fill the gap in the existing CHW research,

and make a small contribution towards the discourse.

One of the main angles of this particular study lies in incentives, as motivation is one of the main links between people and change. Understanding the range of incentives, both internally driven promoting a sense that the work is worthwhile and externally regulated by rewards, affecting work performance of CHWs is crucial in order to sustain long-term community health programs (Gagné, Deci 2005: 331-332). The other main angle of the study focuses on the nature of organizational support that is present at work, and how CHWs perceive it. Having a thorough understanding on perceived organizational support is important since it has a meaningful impact in what level organizational membership and role status are incorporated into employees' social identity (Eisenberger, Rhoades 2002: 69). Indeed, work motivation and perceived organizational support seem to have a strong impact on the work performance of CHWs.

Drawn from the research problem and purpose, I aim to reflect on the following question in the study: *What are the underlying factors that do impact CHWs' performance at work?* In order to answer to the main research question the following sub-questions guide the study:

1. *Why do people join CHW programs?*
2. *How do CHWs perceive their support from the organization?*

Considering the aim of this particular study, South Africa is an interesting case to have a closer look at. Today, life expectancy at birth is lower than it used to be in the 1990s due to the persistently high maternal and child mortality rate, HIV/AIDS prevalence and the wide-spread of TB epidemic (WHO 2015: 50). Also, many dimensions of disparity in regional comparison can be observed; infant mortality rate shows a huge variation between urban centres and rural areas for instance (Benatar 2013: 154). Healthcare facilities seem to struggle to respond to such pronounced health needs, especially in the rural context where there is a chronic shortage of medical professionals. In line with the co-current global health discourse, namely how community involvement can play a vital role in promoting health and wellbeing of children and families, recent years of health policy development in South Africa has been drawing increasing attention to the local CHW initiatives. In fact, regional actors

started considering a possible scale-up of CHW programs that have a proven positive record in terms of health outcomes, program efficiency and future sustainability. As such, by trying to provide a more comprehensive picture on the existing CHW programs in the specific context, perhaps this particular study has a potential to contribute towards the future development of community based health services in South Africa.

Following the introduction, the study has been structured into six chapters. The second section provides a thorough insight to the development of community health worker concept, and an in-depth discussion on the health challenges and future service strategies in South Africa. In addition, the particular CHW program, that the study is built upon, is elaborated on. Following the contextual background, methodological choices of the study, including methods, reliability, limitations and ethical consideration, are discussed in the third chapter. In the forth section, self-determination theory and perceived organizational support theory are introduced as the foundation of the study. By merging them together, the conceptual basis of the study is drawn up. In the fifth chapter, findings are analyzed through the lens of the theoretical frame. The final chapter then concludes the main finding and puts them into perspective in relation to the co-current development discourse.

2. Background

This section presents a discussion on the development of CHW concept; moreover, provides a contextual background on the major health challenges, and future healthcare delivery strategies in South Africa. In addition, the Mentor Mother Zithulele program being the particular case that the study is built on, is introduced and elaborated on.

2.1 Community engagement in healthcare delivery

The first CHW initiate goes back to 1920s of China where village health volunteers and communicators, being the forerunner of “barefoot doctors”, aimed to bring positive changes in the community (Perry et al. 2014: 400). Perry et al. (2014: 402) describe that the success of the program led to its rapid growth in the 1950s. Lie et al.

(2011: 420) point out that the shortage of medical professionals had become apparent in the 1960s, and as the idea of "barefoot doctors" seemed to be a potential solution to the problem, other countries started implementing the model. These 'one at a time' projects, in fact, showed impressive results; thus CHW programs started expanding. Liu et al. (2014: 421) also highlight that after the Declaration of Alma-Ata in 1978, that underlined the importance of primary health care and community-based health initiatives, the then-current political environment were supportive towards scaling-ups of CHW programs; therefore, initiatives in many countries, such as Brazil, Guatemala, Bangladesh, Peru etc., managed to grow into nationwide programs. In the 1980s, the CHW discourse, however, went through a drastic change in the time of economic recession (Perry et al. 2014: 403). The loss of financial and political support for primary healthcare improvement, especially the large-scale national CHW programs, became evident (Perry et al. 2014: 403). International organization, most notably the World Bank, pushed countries to replace 'basic needs' approach to development with the free market solutions. Lehmann and Sanders (2007: 5) describe this period as a time when primary healthcare improvements were addressed through decentralization of healthcare services, expansion of health facilities and highly skilled health workers. Such an upgrading process of primary healthcare, however, was especially challenged in rural areas where there was a chronic shortage of medical professionals (Lie et al. 2011: 421). The continuous failure to tackle this core problem finally led back to community initiatives built on local capacity. Pallas et al. (2013: 1) point out that now the field acknowledges the "integral and crucial role" that CHWs can play in service delivery. Currently, the most urgent need is to have a more comprehensive view on CHW discourse; as such analyzing the effectiveness of previous and ongoing initiates; furthermore, doing research on the key factors of community-based intervention are priorities that should get a strong emphasis (Lehmann, Sanders 2007: 2).

Liu et al. (2011: 421) suggest that management side of CHW programs is one of the most crucial, yet often neglected aspects. Indeed, the first CHW initiatives were often unsuccessful due to poor technical and financial support for supervision and trainings. Gradually, the importance of CHW program management, especially the aspects of recruitment, selection, training, supervision and governance, has been recognized. Indeed, these factors can determine the success or failure of an initiative (Lehmann,

Sanders 2007: 17). First, there is a strong agreement that CHWs should be chosen from the communities they will serve, moreover, that communities should have a power to influence the selection process of their CHWs. However, the Society for Community Health Awareness Research and Action (2005: 5) points out that direct and meaningful participation of communities in the selection process is difficult to achieve as local bureaucrats and/or village chiefs have usually got the actual power to influence the outcome of the process. Lehmann and Sanders (2007: 18) also argue that while the selection of CHWs from local communities is common practice, participatory selection processes remain an ideal that is relatively rarely practiced, especially in large-scale programs. Second, Bhattacharyya et al. (2001: 22) suggest that competence-based training are much more effective in order to acquire specific skills and knowledge. Also, refresher training just as important as the initial training; in fact, a number of studies have found that if regular refresher training is not available skills and knowledge can be quickly lost (Lehmann, Sanders 2007: 19). Third, Lehmann and Sanders (2007: 20) put an emphasis on supervision and the regular and reliable support that are given to CHWs. Curtale et al. (1995: 1120) describe that "continuous supervision diminishes the sense of isolation that CHWs usually experience in the field and helps to sustain their interest and motivation to do their assigned tasks". Nerveless, supervision costs are often overlooked, underestimated, or not adequately planned for. Also, supervisors' role and tasks are often ill-defined and, therefore, poorly implemented (Lehmann, Sanders 2007: 20). Finally, Lehmann and Sanders (2007: 21) suggest that ownership of CHW programs at the strategic level is extremely important. Sustainability and long-term program impacts are embedded in the ownership and active participation of communities; however, just as importantly, they also require guidance from the national level (Tulenko et al. 2013: 849). Collaborative frameworks, plans and strategies are meant to harmonize and co-ordinate the actions of multiple stakeholders in order to improve healthcare coverage and delivery. Tulenko et al. (2013: 849) imply that districts and sub-districts have got an important role to facilitate co-ordination and ensure synergy among multiple stakeholders and their activities.

Lehmann and Sanders (2007: 26) point out that currently, there is no doubt about the important role that CHWs play in community development, nor if their contribution improves the access of basic health services. In fact, evidences are out on improved

health outcomes due to CHW interventions; however, keeping in mind that "[CHWs] do not consistently provide services [that] likely to have substantial health impact and the quality of services they provide is sometimes poor" is important for the future development of community-based initiatives (Lehmann, Sanders 2007: 26).

2.2 Health challenges and healthcare strategies in South Africa

Daniels (2012: 12) describes the heritage of South African apartheid as a factor that continuously keep having a strong impact on people's health status in the country. During the era of apartheid through the removal of public healthcare, and the expansion of private sector, the physical wellbeing of black South Africans and the rural population were pushed into a particularly marginal state. In 1994, the democratic transition had an attempt to create a more equitable health system with free public healthcare services for all, yet structural imbalance could not be challenged in the past two decades. In fact, the already existing inequities remained embedded in the South African system. Coovadia et al. (2009) draw upon a significant disproportion in resource availability in the private sector compared to the public one: according to the national statistics, 46% of all healthcare expenditure is connected to the private sector even though less than 15% of the population can actually afford to use those services. In addition, Sanders and Chopra (2006: 73) draw attention to the large differences in terms of health outcomes between different areas of South Africa, for example in infant mortality rates, 27 per 1000 live births is registered in the Western Cape in contrast with 70 per 1000 live births in the Eastern Cape. While regional differences are huge, variation on a sub-district level is also substantial: the infant mortality rate in the former Transkei homeland area in the Eastern Cape is 99 per 1000 live births, compared to 28 per 1000 live births in a metropolitan area in the Eastern Cape (Sanders, Chopra 2006: 73).

Currently the biggest health challenges of the country are the high maternal and child mortality, HIV/AIDS, TB epidemic and non-communicable diseases (Ngcwabe, Govender 2014: 134). South Africa is one of the countries where maternal and child mortality rates were successively rising up until recent years. Although some improvement has been noted since 2006, McKerrow and Mulaudzi (2010: 69) suggest that expecting reduction in childhood mortality to be achieved solely within the health

system is unrealistic. Even though 64% of the population is entirely dependent and 80% primarily dependent on public healthcare services, only less than 20% of all health professionals serve the public sphere in South Africa (Ijumba: 2014: 31). As such, positive change inevitably requires a more integrated approach; providing a better access to the existing health facilities through extension services, and embracement of local capacity seem to be the only way to achieve long-term impacts (McKerrow, Mulaudzi 2010: 70).

Ijumba (2014: 32) points out that in the early 1990s, while the South African healthcare system was going through a rapid transformation, CHWs were not included in the human resource planning strategy. Small-scale CHW programs run by various non-governmental organizations (NGOs) and community-based organizations, however, remained visible. Then in the wake of HIV epidemic, the shortage of medical professionals disabled the healthcare system to give an adequate response to the raising problem. Daniels (2012: 13) implies that the new discussion on the importance of CHWs, and their potential integration into the healthcare strategy started in the late 1990s during the desperate times of the HIV crisis. Indeed, from 2003 separate CHW policies have been tabled, and government has been providing funds for some of the CHW programs. Even though, government has been trying to show a certain level of responsibility for the existing CHW programs, NGOs keep running and coordinating the services. This, in fact, caused some confusion; particularly it made program accountability and supervision unclear in some cases, and raised questions regarding program sustainability (Daniels 2012: 14). In 2011, in search of finding a solution to these issues, the government decided to incorporate CHWs into the formal health system in a broader range with the purpose of re-engineering the primary healthcare system in the country.

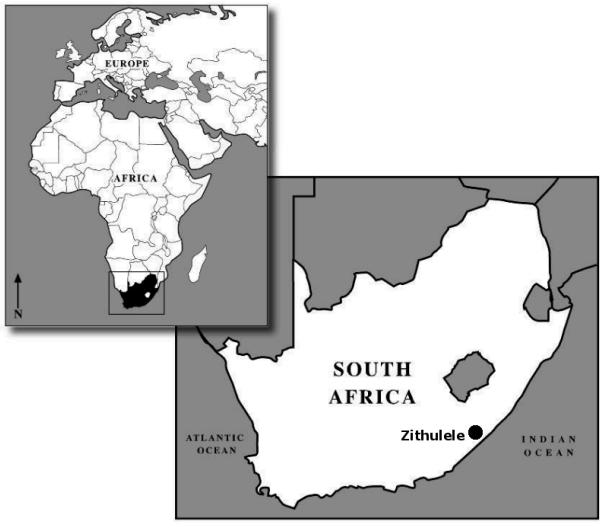
2.3 The Mentor Mother Zithulele program

Philani Nutrition Centre Trust is an NGO that has been offering clinic-based free services to women and children in the informal settlement of Cape Town since 1979, and in the Eastern Cape since 2010 (Philani 2014). The fundamental mission of the organization is to promote good maternal, child health and nutrition, support pregnant mothers and rehabilitate underweight children in a caring environment. In the early phase of its operation, Philani recognized that some of the worst cases of child

malnutrition had not been reached through the clinic-based nutrition rehabilitation program because vulnerable mothers often had no intention and/or energy to seek help; furthermore, they were unable to identify the symptoms of malnutrition, and were not aware of its short and long term consequences either. As such, a CHW program called the Mentor Mothers (MM) was set up in order to be able to reach and support all disadvantaged children in communities. The MM program utilizes the positive peer deviant model: local women are recruited and trained in various topics, such as nutrition, breastfeeding support, HIV and basic child health. With medical knowledge gained, MMs start making visits in their neighborhoods, and become sources of ongoing social support to their peers. By supporting mothers and their infants, monitoring child nutritional status and development and referring to clinic care, MMs make fundamental healthcare services to be seen more accessible for people in their communities (Tomlinson 2014: 19).

In 2002, at its initial stage, the MM program started operating in the outskirt of Cape Town in the Western Cape. Then in 2010, the initiative was implemented in Zithulele catchment area, named as Mentor Mother Zithulele (MMZ) program, in the Eastern Cape in order to see how the concept works in the rural context where the access to health services was hindered by various factors, such as distance, poor socio-economic conditions etc. Picture 1 illustrates the exact geographic location of the MMZ operation.

Picture 1 – Geographic location of Zithulele where the MMZ program is operated



Source: The Author adapted from Daniels 2012: 11

Currently, MMs in the Western Cape support 1203 underweight children and 3693 pregnant mothers while the Eastern Cape team offers support to around 3000 households (Philani 2014).

3. Methodology

This section describes the research approach and design of the study; furthermore, discusses the methodological choices, processes, research validity and reliability that the study is built upon. In addition, research limitations and ethical considerations are paid a close attention to.

3.1 Research approach

The research approach of the study is *qualitative* since I intend to explore and understand underlying factors of performance of CHWs, such as their drives and motives, in the context of rural South Africa (Creswell 2003: 4). The study is based on a particular *case*: the Mentor Mother Zithulele (MMZ) program that is implemented in the former Transkei area in the Eastern Cape. The *object of analysis* is motivation with primary focus on CHWs' work incentives, and the potential influence of organizational support affecting their performance. The CHWs taking part in the MMZ program can be identified as the *subject of analysis*. Looking at the contextual properties of this particular study, individuals are classified as the *units of analysis.*

For the purpose of the study, I was present in the field for a period of ten months. Such an extensive time period spent in the context strongly supported the progress of the study; I was given a chance to gain a better understanding of the particular setting, social dynamic and cultural components before starting the actual research work. With my personal understanding of the fluid nature of reality, I took a *constructivist* ontological position in the study (Bryman 2008: 19). As motivation seems to be influenced by both individual and community features, complexity of views had to be taken into account while conducting the research; therefore, its epistemological orientation is broadly *interpretivist* (Hennink et. al 2011)

3.2 Sampling Strategies

The primary sample includes the CHWs taking part in the MMZ program; however, in a latter phase of the data collection, I created a secondary sample by involving the MMZ program supervisors and senior members in order to cross-validate my data. The selection of participant was based on *purposive sampling* technique since the research aim was to get the opinion of a targeted population (Silverman, Marvasti 2008: 166). In addition, I applied *heterogeneity sampling* when choosing the specific participants taking part in the study in order to create a mixed group of MMs based on their age, years of experience, work location etc. Such diverse palette of sample seemed to be important in order to make sure that a variety of opinion is present in the study.

Through the primary sample, 22 MMs got involved in the research. The additional sample, including senior members and program supervisors, was created after being out in the field for six months, and a well-founded trustworthy relationship had been built with them through mutual respect and understanding. Through my continuous daily interactions with people working for the MMZ program, I managed to establish a deep and authentic connection with the senior MMs and supervisors; therefore, this channel of information seemed to be extremely valuable for the research. Through purposive sampling technique, 4 senor members and supervisors, that had a strong insight on issues regarding work incentives, performance motivation and perceived organizational support, have been asked to have an interview with in order to gain an understanding on the issues from their perspectives. The list of participants can be seen in Appendix 1.

3.3 Research Methods

In order to understand performance motivation of CHWs, a range of different research methods was used for this study. As Baxter and Jack indicate (2008: 554) "each data source is one piece of the puzzle, with each piece contributing to the researcher's understanding of the whole phenomenon". *Multiple data sources* involved participant observation, focus group discussions with MMs and semi-structured face-to-face interviews with MMs as well as with the senior members and program supervisors; furthermore, art session with MMs and their supervisors.

3.3.1 Participant observation

Spending ten months out in the field gave me the unique opportunity to be able to gain an extensive amount of participant observation for the purpose of study. Observations were primarily made at office facilities; however, I was also given the chance to conduct home visits with MMs regularly, and observe them during their fieldwork. Information collected through observation added a deep insight to the analysis; in fact, participants' behavior, remarks and comments during interviews and focus group discussions were strengthened and supported with the information derived from observation; therefore, interpretation of data became much easier and potentially more reliable (Mikkelsen 2005: 88)

3.3.2 Focus groups

Two different focus group discussions with six MMs were held in order to elaborate on the following topics: (1) the nature of work that needs to be performed as a CHW (2) qualities of a good CHW, (3) what makes one want to become a CHW, (4) work rules and principles, (5) prior expectations and reality, (6) best part of working as a CHW, (7) difficulties of working as a CHW (8) ways to overcome difficulties at work (9) and potential reasons to leave the program. Questions during the discussions were open-ended and translated into isiXhosa that gave participants an opportunity to express their opinion in a more relaxed environment. The preliminary guide of focus group discussion is shown in Appendix 2.

Focus group sessions were organized outside of the office facilities in a neutral place[1], and lasted for around 60-minutes. The discussions were facilitated by a local interpreter with the support of two local designated note takers – while one of them was focusing on verbal inputs, the other one was taking notes on the nonverbal components. In addition, I was present at both sessions as an observer. The discussions were audio recorded with prior informed consent of all participants – Informed Consent Form (ICF) is shown in Appendix 3. Transcription and translation were done externally; two employees of the Department of African Languages and Literature at the University of Cape Town took part in the process.

[1] The arrangement of a neutral place outside of the office facilities was important in order to make MMs feel safe, and their critical reflections could be encouraged.

3.3.3 Semi structured face-to-face interviews

Following the focus group discussions, semi-structured face-to-face interviews were been conducted with six MMs in order to gain information about their experiences from a more detailed, personal angle. Even though the initial plan was to conduct ten semi-structured face-to-face interviews, at the end I managed to collect only six of them due to various difficulties, such as the geographic distances, tight working schedule, challenging weather conditions and personal problems. Nevertheless, face-to-face interviews highlighted the personal stories, peculiar feelings and perceptions of healthcare workers regarding their work, the particular challenges they face on a daily basis; furthermore, how these difficulties are mostly resolved. Even though a semi-structured interview guide was followed during the interviews, a high level of flexibility was allowed in order to be able to incorporate additional information on the emerging themes (Bryman 2008). Interview guide with MMs can be seen in Appendix 4. The interview place was outside of the office facilities in a neutral place, and lasted for approximately 30-60 minutes. Interviews were carried out in English language, and audio recorded with prior informed consent of the participants[2].

Additionally, semi-structured face-to-face interviews have been conducted with four senior members and program supervisors in order to cross-validate the data. Questions tried to cover the same topics that interviews with MMs focused on (Appendix 5 – Interview guide with MM supervisors). Face-to-face interviews with MM supervisors were audio recorded with their prior consent given[3]. These interviews were also set in a neutral place, carried out in English language, and lasted for approximately 60 minutes.

3.3.4 Art session with MMs and senor members

The previously presented research methods intend to collect information primarily through verbal channel. However, my initial thought was that understanding people's psychological needs, drives and perceptions cannot be based on verbal channel to such a large extent; in fact, I was convinced that traditional methods being merged with additional descriptive accounts could potentially enrich the study. Reading up on

[2] ICF is shown in Appendix 3.
[3] ICF is shown in Appendix 3.

emergent methods of co-current social research, I came across the method of art and drawing session that aims to transform research into a more dynamic, active experience in order to "encapsulate the multi-dimensionality of the human experience" (Deacon 2000: 95). By adapting certain art therapy excises, I tried to gain a better understanding of participants' feelings towards their work, patterns of teamwork, roles and the basic rules of interaction at work (Appendix 6 – Activity plan for art session with MMs and senor members). Clearly, verbal channels also provided information regarding these themes, however, my presumption was that an art session could do it in a subtler, more authentic way. In addition, it had a potential to cross-validate other verbal sources. The session aimed to involve four MMs and two senior members; however, two of the participants could not make it at the end because of personal problems. The art session was organized in the main office[4], and lasted for 60 minutes. A local interpreter took the role of facilitator at the art session with the help of two designated note takers: one of them was focusing on verbal inputs while the other one was taking notes on the nonverbal components. With prior consent of all participants[5], I could take a photo of the art pieces for the final analysis.

3.4 Data Analysis

The data collection, transcription and translation process was followed by *thematic analysis* through familiarization with the data and identification of emerging themes and patterns (Creswell 2007: 149). Indeed, this first phase of the analysis created an initial coding based on the emerging topics. The data was then divided according to its source, and looked at separately. The information collected on the focus group discussions and interviews with MMs has been organized by questions to be able to look across all answers, and identify consistencies and differences. Similarly, the data composed on the interviews with the MM supervisors/senior members was organized according to categories, and patterns were identified. Additionally, the data derived from art session was analyzed separately.

In the second phase of the analysis, the initial codes got assigned to the preset categories that were originated from the theoretical foundation. In the final stage, the

[4] Since art session did not deliver information in a sensitive way with direct verbal contents, office seemed to be a suitable place to hold the session.

[5] ICF is shown in Appendix 3.

different sources of information, namely MMs' opinions, inputs of senior members & supervisors, and information gathered from the art session, were merged together.

3.5 Reliability and validity of data

In order to ensure reliability of the finding of this study, *triangulation of data sources* has been used (Mikkelsen 2005: 197). Gaining information on MMs' perception and experiences was done through various methods, such as participant observation, focus group discussions and semi-structured face-to-face interviews, and at art session. Furthermore, cross-validation of data has been achieved through merging the data based on MMs' inputs with the opinions of senior members and program supervisors.

In addition, *recording* the discussions and interviews aimed to increase data reliability. By having the full, exact dialogue of different sessions and its transcriptions, the richness of information was possible to be maintained in the process of analysis since I could go through them many times. I transcribed the English interviews, however, the transcription and translation of data collected in isiXhosa was handled differently; external language specialist at the University of Cape Town were approached and assigned for the task. By not involving the same interpreter team that took an active part in the data collection, the soundness of information tried to be maximally ensured.

3.6 Ethical Considerations and limitations

Ethical dilemmas are always present in any types of research, however, as Creswell (2003: 64) points out qualitative research, that aims to understand perceptions, beliefs and behaviors, makes it even more pronounced. As I was present in the field for a period of ten months, I invested a lot of time to gain *trust* from the locals. My entry process in the field was similar to Sultana (2007: 378) who described hers as a "considerable effort to blend in as much as [she] could, ever conscious of [her] difference and the power relations inherent in that". From the very beginning, I made it clear that participation in my research is entirely voluntary, and all has the possibility to withdraw from the research at any time. Protecting participants' confidentiality was strongly emphasized, and became an essential part of the research process (Hennink et. al 2011: 64).

My own *positionality* was another ethical component to think about throughout the research process. Creswell (2003: 186) suggests the presence of researcher may bias responses due to the way he/she is perceived by the participants. As such, thinking critically about positionality of the researcher as well as the researched is extremely important. Indeed, the potential negative implications of me being an outsider, a white Eastern European woman in terms of research outcomes were clear from the beginning. Also, I worked for Philani Nutrition Centre Trust first as an intern, then an evaluation coordinator right before and in parallel with the field research[6]; therefore, I was likely to be associated with the organization. As these dispositions were set from the start, I needed to find a way to negotiate them while reflecting on the issues of ethical research practice (Hopkins 2007: 286). In order to understand my own position, similarities and differences between the research participants and myself were important to be reflected on. Differences, alongside basic characteristics such as age, skin color, marital status, nationality, upbringing etc., were fairly evident from the beginning; however, points of connection were more subtle, and required more time to emerge, and to be noticed. Nevertheless, I was given the time to discover interweaving points of the locals' identity with my own; in fact, I found that being seen as a person that makes an active effort to become part of the context, and build meaningful a connection with locals is a way to overcome issues and dilemmas of positionality in the research process.

In addition, *language barriers* required careful consideration. As I could not speak isiXhosa in an appropriate level, interpreters needed to be involved in the focused group discussions and art session. Finding the right interpreter is crucial regarding research outcomes, since there is always a risk of misunderstandings, inaccuracies and data distortion in case of translation. Of course, I was aware of the hampering effect of the presence of a third person, even if all works out the best. My data collection was supported by 3 local interpreters that managed to work together as an extraordinary team, and showed a high level of sensitivity towards the research participants, furthermore, provided me with steady support and critical reflections throughout the research process.

[6] I got involved in one of Philani's research projects that was, however, completely separate from the MMZ program. Being aware of issues of positionality, I wanted to make sure that I am not directly connected to the program.

My final and most striking consideration was how the results could translate for the *benefits of participants* (Hennink et al. 2011: 77). On a more holistic level, the aim of this research is to contribute to the future development and a possible scaling-up of CHW programs. However, in order to have a more direct and visible implication of the research, I have decided to prepare a separate report with the summary of findings for the organization that highlights MMs' voices, reflections and considerations regarding their work activity and organizational support. As such, I tried to ensure that research results are not missed out on, and the relevant actors have the possibility to take them into consideration at strategic decisions in the future.

4. Theoretical foundation

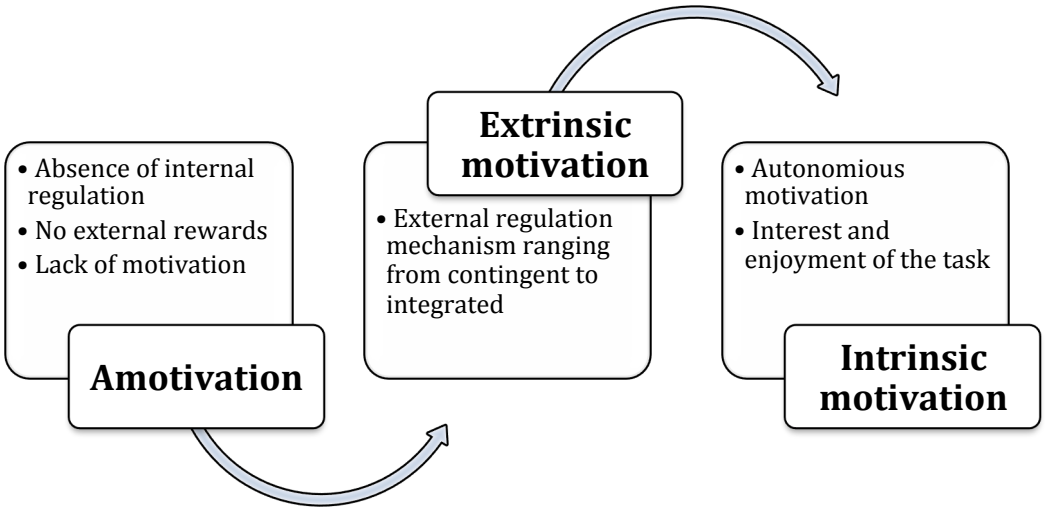
The following section introduces two theories that the study is built upon: (1) self-determination theory and (2) perceived organizational support theory. Both theories are strongly connected to work performance, even though they look at it from a different point of view; while self-determination theory focuses on the various incentives that influence employees' work effort, perceived organizational support theory looks at employees' perception of the reward system that an organization establishes in order to keep up a high level of performance and productivity at work. Nevertheless, the intervening points and complementing nature of these two theories helped me to create a solid frame for the analysis that will be discussed in the final part of this section.

4.1 Self-determination theory

Motivation is a complex concept; it is usually not directly observable, but can only be inferred from observing behavior. Self-determination theory (SDT), evolved in the 1970s, is a macro theory of human motivation that mainly focuses on people's inherent growth tendencies and their innate psychological needs (Appleford 2013: 198). Research applying SDT has been increasing since the 2000s. Central to this theory is the distinction between intrinsic and extrinsic motivation (Ryan, Deci 2000: 233). The self-regulatory process of intrinsic motivation, that derives spontaneous satisfaction from the activity itself, is autonomous. As such, intrinsic motivation is the type that engages individuals in a task out of pure enjoyment. In contrast, extrinsic

motivation is usually externally regulated; in fact, there is concrete reward, such as money, fame, phrase, that is gained after a task being completed. However, boundaries are not as sharp as it seems, from the stage of amotivation to intrinsic motivation a continuum can be drawn up, and internalization of extrinsic motivation can be described as a rather natural process as Figure 1 shows (Gagné, Deci 2005: 334).

Figure 1– Stages of motivation and the continuum of SDT



Source: The Author adapted from Gagné, Deci 2005 and Appleford 2013

Ryan and Deci (2000: 336) indicates that one of the main aims of SDT is to specify necessary conditions for promoting individual growth, integrity and wellbeing. According to their research, the internalization of extrinsic motivation requires the satisfaction of the three basic psychological needs: (1) competence, (2) autonomy and (3) relatedness (Appleford 2013: 198). These basic needs have a potential to balance and utilize each other. Psychological climate, that combines the three basic needs in an optimal manner, in fact works towards intrinsic motivation, therefore, supports individuals' growth-orientated behavior (Gagné, Deci 2005: 334).

Competence reflects on individual's ability to master specific tasks and activities. Developing skills and knowledge that relate to the specific task one is assigned to do, can happen through formal trainings and courses or informal channel, such as supervision and observed best practices at work (Baard, Deci et al. 2004: 2046). Autonomy suggests a specific condition that allows a person to make his/her own

choices while undertaking an activity or task (Baard, Deci et al. 2004: 2046). More specifically, it involves the management at work to understand and acknowledge employees' perspectives, and provide them with open and meaningful work-related information; furthermore, encourage self-initiatives (Appleford 2013: 203). Relatedness is based on the establishment of mutually beneficial relationships that helps one to interact and feel connected to others. (Baard, Deci et al. 2004: 2046). Relatedness, in fact, moderates autonomy, encourages symmetry, and helps to balance first-person viewpoint since consideration is shown towards the wellbeing of others. Relatedness also creates a sense of security that makes self-expression and self-efficacy more robust (Deci, Ryan 2000: 235).

Competence, autonomy and relatedness are partly predicted from individual differences in causality orientation, and partly predicted from aspects of social environment, such as work climate (Gagné, Deci 2005: 337). Psychological climate at work has a strong potential to make a meaningful impact on the motivational level and attitude that one has towards his/her work. The literature, in fact, suggests that the most effective workplaces are the ones that provide autonomy, competence and relatedness supporting environment (Baard, Deci et al. 2004: 2064). Research does show that work climate, that promotes the satisfaction of basic psychological needs, facilitates the process of internalization and enhances the motivation of individuals; moreover, leads to work engagement, increased work effort and more effective performance in general (Gagné, Deci 2005: 337).

As the interest towards SDT started growing, and was more widely researched, concerns were raised about the three basic psychological needs that are in the center of the theory. One of the claims is that these needs are far too general; in fact, theorists such as Pyszczynski, Bauer, McAdams etc, suggest that deconstruction of the categories is essential in order to create a more integrative framework. Ryan and Deci (2000: 324), however, believe that "the utility [of the basic psychological needs] comes largely from the fact that they do apply so generally and so aptly across multiple domains of human experience". As such, deconstruction of the basic need would rather detract from an "integrative and parsimonious framework" according to them (Ryan, Deci 2000: 324). Another claim is that the three basic needs that SDT is built upon, often conflict, and there might be an inherent contradiction among them.

The mutual necessity of autonomy and relatedness might seem a paradox in certain situations for instance. However, Ryan and Deci (2000: 327) argues that the social world is often structured in a way that a basic need is hold against another, even though they have a potential to integrate different aspects of an action in order to maintain adaptive behavior. As much as autonomy enables a person to exercise power and make decisions according to his/her own preference, relatedness helps to understand that moderation of personal autonomy is essential to some extent since freedom extends only to where others' freedom begins. By merging aspects of basic rights and responsibilities together, complementary nature of the three basic needs can be identified.

4.2 Perceived organizational support theory

Perceived organizational support (POS) theory suggests that employees tend to create an image of the organization based on the following factors: (1) legal, moral and financial responsibility of the organization for the actions of its agents through tangible rewards; (2) organizational precedents, traditions, policies and norms providing continuity and prescribe role behaviors through intangible supportive resources; and (3) the way organization exerts power over individual employees. Eisenberger and Huntington (1986: 500) indicate that this image "represent[s] an employee's distillation of views concerning all the other members who control that individual's material and symbolic resources". As such, POS shapes social environment at work through employees beliefs how much the organization values their contributions and cares about their wellbeing (Eisenberger, Rhoades 2002: 68). If employees believe that the organization appreciates their work, cares about their well-being and job satisfaction, and as such, try to create a social environment where they can fulfill basic socio-emotional needs, they will incorporate organizational membership and role status into their identity. That, in fact, leads to a positive reciprocal dynamic; therefore, increased performance will be observed at work (Eisenberger, Rhoades 2002: 69, Kataria et. al 2013: 34).

In order to create a work environment that contribute to employees' sense of wellbeing, organizations have to take into consideration three element of human needs: (1) needs that based on human existence and personal control, (2) needs that

are related to the development of human potential and capabilities and (3) needs that are associated with interpersonal relationships in the workplace (Waseem 2010: 3265; Biswas, Bhatnagar 2013: 28). Satisfaction of these basic needs depend on the support system that the organization creates for its employees. Monetary rewards usually target the satisfaction of needs for existence and personal control; supervisory support and a balanced leader-member relationship help to fulfill the need for relatedness; moreover, opportunities for further education and career development work towards employees' growth needs (Waseem 2010: 3266). Indeed, these tangible and intangible rewards take part in the creation of a positive psychological climate at the workplace, thus employees can make a better sense of their job, and perform better as Figure 2 represents (Eisenberger, Rhoades 2002: 69).

Figure 2 – The conceptual model associating the latent construct of organization effectiveness

Source: The Author adapted from Kataria et. al 2013: 35

Critiques of POS, however, claim that the scope of the theory is too limited as it attributes employees' performance to a few attitudinal variables. In fact, external factors are not taken into account even though they might have a strong impact on employees' performance and organizational effectiveness (Biswas, Bhatnager 2013:28). Shore & Shore (1995: e15) suggest that one of the external factors that significantly influence employees' performance is the inherent imbalance that exists due to the nature of employment relationship. As employers are more powerful partners in the exchange than employees, personal bias is always present in the

perception of organizational rewards and supportive resources. Nevertheless, Eisenberger and Aselage (2008: 6) point out that even if external factors slightly shape employees' perception and, therefore, performance at work, research still shows a clear correlation between organizational support and work performance.

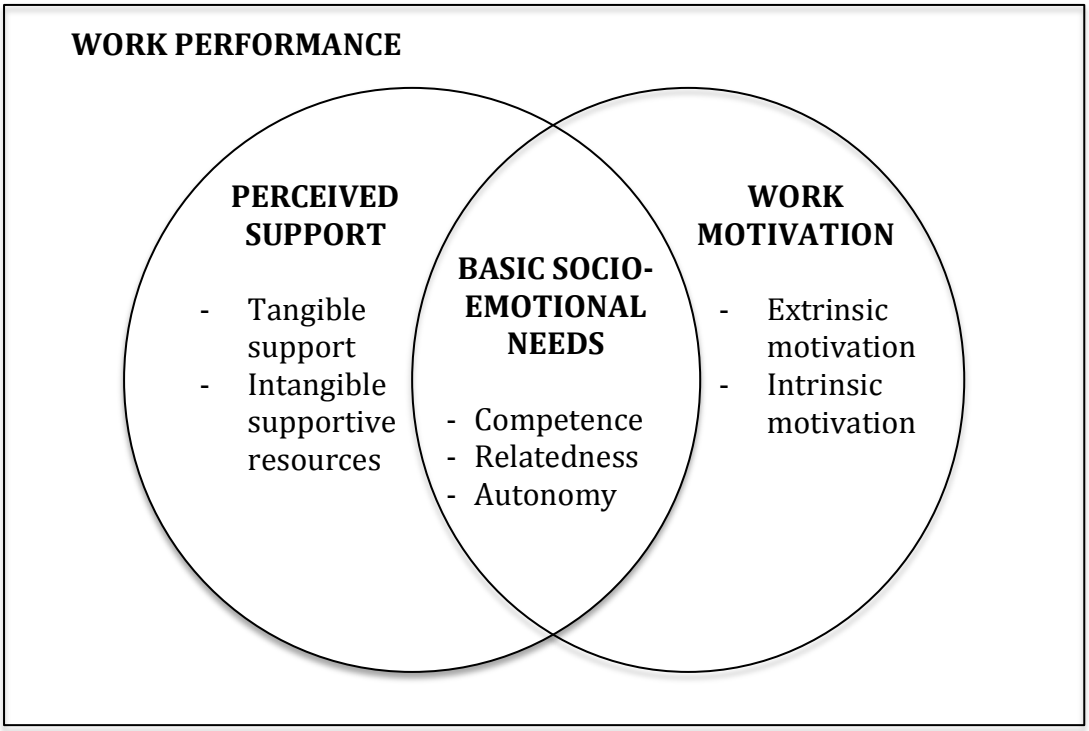
4.3 Merging the theories

This study builds upon SDT and POS theory since they both have been derived from a need of understanding factors influencing employees' performance at work even though they clearly have a different standpoint (Appleford 2013: 198, Eisenberger, Rhoades 2002: 69). SDT focuses on the various motives of individual actions, the necessary conditions and the general process why and how a person gets engaged in a task or activity. On the other hand POS theory draws attention to organizational reward system, and tries to explore how it potentially influences performance at work. Indeed, the scope of approach shows a big difference: while SDT looks for individual work experience determinants, such as inner drives, fulfillment of expectation etc.; POS theory rather focuses on organizational determinants, such as supervision, monetary rewards etc. However, there is a point of intersection regarding the two theories, namely the basic socio-emotional needs that employees thrive for. Needs that based on human existence/autonomy, needs that are related to the development/competence, and needs that are associated with interpersonal relationships/relatedness are identified as core elements in both cases.

SDT and POS theory have an inherent difference in their orientation: while POS theory indicates that perceived support of an organization determines the psychological climate at work, and, therefore, the fulfillment of employees' basic socio-emotional needs; SDT highlights that the satisfaction of basic socio-emotional needs influences the level of motivation that individuals have towards their tasks. The basic needs are, in fact, mediators between work environment and work performance. As such, I argue that the mediating nature of social environment can be a basis for SDT and POS theories being merged together in order to gain a more complete understanding of performance motivation at work – the conceptual basis is represented in Figure 3. Through this scheme that worked as a primary tool to

structure the research data, the analysis and the results will be presented in the following chapter.

Figure 3 – The merging point of SDT and POS theory



Source: The Author

5. Results and Analysis

The data analysis focuses on two aspects in line with the research sub-questions, namely (1) work motivation, specifically why people join CHW program, and (2) perceived organizational support, specially the way CHWs perceive their support from the organization. The presentation of results is structured according to these two major dimensions.

5.1 Work Motivation

In order to be able to handle the data systematically, work motivation has been approached from the angle of two preset categories derived from the self-determination theory: (1) intrinsic factors and (2) extrinsic factors of motivation.

Throughout the familiarization process, specific themes have emerged in order to gain a more thorough understanding why people join CHW program.

5.1.1 Intrinsic factors of work motivation

As commonly expressed in the interviews and focused group discussion, harsh reality of rural areas makes life extremely difficult and fragile. Challenges clearly include physical and social isolation, lack of access to basic healthcare and social services, information and resources. The majority of CHWs referred to the strength and hard-working nature of local people; however, they suggested that deep poverty and structural imbalance make progress extremely difficult for families under such circumstances. In this troubling environment, all CHWs expressed the significance of becoming a health worker in order to make a contribution to "[their] people" and "bring change to the struggling homes". One of the MMs described her role as a CHW the following way:

> "…We assist our people deep in the rural areas. Deep out in the field where the hospital cannot reach, where the social services cannot reach. These people cannot stand for themselves; some of them are afraid of cars, some of them are afraid of coming to the hospital and talking about their problems. But now the Mentor Mother program is there so they've got us to rely on at least…" (MM14)

More specifically, making *health contribution* was a common theme that frequently appeared during the interviews, and seemed to be a strong incentive to join the MMZ program. Two third of the research participants, that were involved in the semi-structured interviews and focus group discussions, emphasized the importance of health education, and diffusing health related information in the area. Half of the participants mentioned that their contribution works towards the establishment of a link between communities and healthcare facilities; they pointed out that many people in their neighborhoods do not take active use of the clinics and hospitals. The one sided relationship between patients and health facilities was often referred to; according to MMs, the usage of healthcare services primarily depend on clients, however, distances and lack of knowledge hinder the access part. As such, individuals often get stuck in a situation or they simply fall out of the scope of the healthcare system. This aspect, which was problematized by several CHWS, also shows up in the following lines:

> "…I wanted to join the program because I saw that people are dying during labor in our village. The reason is that people give birth at home because they have never been to the clinic to do any bookings. I saw the need so that I wanted them to see that they can save their lives by booking at the clinic, and giving birth there because they can get help from the clinic [….] I realized the significance of becoming a healthcare worker in our village…" (MM3)

The interviews and focus group discussions also drew upon the *unique connection to children* that people seem to have in the particular context. Two third of the participants mentioned that their activity was driven from the need of improving children's wellbeing. Participants referred to the fact that so many children die in a very early age, and they implied that it was something that could be changed in the future. They were convinced that offering a bit of a support to families could make a big impact. At the art session, while participants were drawing vivid pictures of sick and deprived children symbolizing their work in the community a mutual agreement on children being core values of the community was established. As one of the MM highlighted while drawing her picture:

> "… I don't want to see suffering children. I feel hurt when I see a child who is suffering because of parents. Children are blessings…" (MM22)

Emphasizing work as a process to *build trust* inside the community another major pattern being identified. Half of the participants said that being trusted by the community is the most engaging part of the daily work; furthermore, a consensus was reached that the most surprising part is the deep level of acceptance and trust which was the community response to their work effort. Social stigma related to certain health conditions, especially HIV, was elaborated on; in fact, many of the participants described that a lack of trust is responsible for people not daring to go to the clinic to be tested, or to take medication because they are worried what their families and neighbors would think about them. Such negative dynamics generated by the lack of trust also shows up in the following lines:

> "…People were unable to talk about their status[7]. It was difficult for a person to talk about their status to people but as time progressed being a Mentor Mother people started feeling free to share their problems including their status. I saw that they begin to see that I was building a relationship with them and they begin to trust me. I was not expecting that people would trust me with their private matters and secrets…" (MM7)

[7] HIV status

As much as a fundamental need for trust and acceptance was expressed by CHWs in order to deliver healthcare services, the understanding that giving and gaining trust is a continuous process came up in the most of the interviews, focus group discussion and at the art session. In fact, they implied that all has got potential to contribute to the growth of trust inside the community. Being respectful and reliable under all circumstances, the inappropriate nature of judgments, building up an open and clear communication with families, being humble all the time, moreover, the necessity of investing time in relationships were identified as core elements to build trust in the community. At the focus group discussion, one of the MMs gave an excellent summary of the trust building process while trying to explain how relationship with clients can be nurtured on a long run:

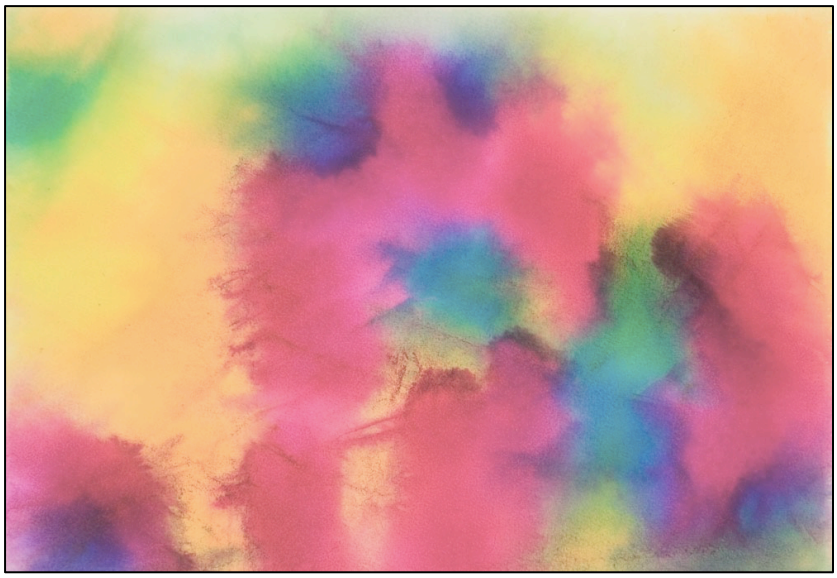
> "…When you are a healthcare worker you need to take people at their word. You should not use the information on the card against the person. You might see the information on the card and still behave as someone who is not aware, so that the mother can tell you herself that she is positive. What you saw does not matter […] You can only ask her or talk to the person about things they told you. You should hear what they say and get satisfied. You should work with what the mother is telling you and teach her about what she told you. That is how you can make a difference…" (MM5)

In addition, trust was described as a core element of community transformation and development. Four participants pointed out that people's lives in the community started to progress because they realized that relying on others, and sharing problems can be part of life. Trust was often implied together with religious beliefs when its positive implications were mentioned. In addition, senior members and program supervisors confirmed that the community started changing due to MMs' work effort; they suggested that improvements can, of course, be measured on individual scale, however, there is a clear transformation on community level as well. In fact, they highlighted that basic interaction patterns changed among people in the community, and now villagers seem to be more open towards each other. Moreover, there are times when people start discussing an issue that used to be a taboo previously. The thought of structural transformation clearly appears in the following lines:

> "…The most engaging part is to assist people out there. If you can go with them in the community you find that the community trusts them because some of them would tell you 'if I talk to a Mentor Mother I know that my problem and secret will be hidden until the day I am assisted' […] Things started to change around because they are trusted; that is the one that is happening here…" (MMS2)

Picture 2 represents one of the MM's artwork symbolizing her work with a description of "trust always finds a way through the dark and pain".

Picture 2 – An abstract painting of trust that symbolizes community healthcare work



Source: MM20

Although gaining trust can be a strong incentive, not leaving up to clients' expectations certainly has a demotivating impact as well. One third of the participants mentioned that one of the most challenging parts of their work is coming across families that do not let the relationship grow into a deeper level. Help being refused, intervention plan not being followed, and unable to meet families' expectations seem to create a sense of disempowerment among CHWs. One fourth of the participants implied that a lack of trust from the community side would be an instant call for them to leave the program, as one of the Mentor Mothers explained:

> "…When would I choose not to be a Mentor Mother? If I was told we are people that misuse and abuse the government's money because there is no point in doing what we are doing, it has no purpose or value, then I would quit and let others run with this task…"(MM1)

A more personal, self-richening aspect of joining the program and working as a CHW was described in the semi-structured face-to-face interviews. Becoming a MM strongly shapes women's *self-image* as they do experience growth on several aspects of live due to trainings and through their daily work. One fourth of the respondents mentioned the significance of the medical knowledge gained during their initial and

refresher trainings; furthermore, they elaborated on the impact it had on their lives, especially having the power to make a difference in their neighborhoods. In fact, CHWs' self-perception was different in comparison with the time before they joined the program; all mentioned how proud they were of the person they have become, and emphasized the fact that they did manage to grow as a person according to their own standards. This sense of worthiness was captured in an interview with one of the MMs:

> "…There are many times when I am happy at work. I find time to converse with people during fieldwork, and get to know the people that I visit. I get happiness from visiting and talking to them. All children come to me during household visits; I weigh them and check if things are okay. I also play with the children. I can often see that parents are happy, and they think I am here for a reason. Now that is the time of happiness…" (MM5)

At the art session, many of the art pieces touched upon the aspect of personal growth: MMs drew pictures about educating mothers, and sharing their knowledge with others. Picture 3 is a special piece that delivers the message of self-growth in a very direct way. The MM, that painted the picture, said that it was about "[her] life that slowly grows".

Picture 3 – An abstract painting symbolizing personal growth due to community work

Source: MM20

Self-image transformation also influenced the perception of MMs on their *future perspectives*. Two third of the participants mentioned that advancing in their work

through further education is extremely important; in fact, becoming a nurse or social worker was not just a dream with a sense of disconnection from reality, rather a plan with defined steps in order to make things happen. Being part of a structured work environment where diffusion of knowledge and self-productivity are especially encouraged and rewarded, seems to open up future horizons as one of the senior program members highlighted:

> "…While working with them we encourage them not to look at just the employment part but becoming someone better in the future. They can continue with this and become a nurse or a social worker. They get to know the first steps how to move forward, and the training is really good as well…" (MMS3)

Another personal life-fulfilling dimension of joining the program is *self-efficacy* that was identified. Being able to diffuse the knowledge that CHWs learnt and standing up for others seem to give them a sense of worthiness that was often described with abstract terms, sometimes underpinned with deep religious beliefs. In fact, half of the participants emphasized work as an opportunity to advocate for others.

> " …The best part of my work is the clinical knowledge. Just to look at the clinic card and to know when to go for immunization. I didn't know it at that time how it goes, the nurse used to tell me when I had a child. But now I am the one who tells the parents when they must go for immunization, and then what to do when the child is sick or the child has diarrhea, like a severe diarrhea on a Saturday when the clinic is close. Now they know what to do. So I am very excited to be there for them…." (MM13)

Two participants also pointed out the importance of their advocacy work in order to push the structural imbalance that is set around them. They commented on their work as "the engine of change" that trying to make further transformation inside society.

5.1.2 Extrinsic factors of work motivation

A mutual agreement was made among MMs: joining the MMZ program is a good way to generate *income,* and bring money into one's household; in fact, it came up in all interviews and focus group discussions at one point. One fourth of the participants stated that even though they were not really sure about the nature of work at first time they had heard about the job opportunity, they wanted to apply for it anyway. The semi-structured face-to-face interviews gave participants an opportunity to open up and elaborate on the daily struggles they face in such a resource scarce environment; furthermore, what it meant for them to find a stable job, and being able to support

their families. Also, four of the participants highlighted the fact that the job is set in their villages; therefore, they do not have to live their homes behind, and move to the city, unlike many people from their community, in order to get a job. Even though financial security seems to be an important aspect, only 15 percent of the participant suggested that the level of financial compensation would be a direct reason for them not wanting to be a CHW anymore. Thus, as much as income generation matter at the time CHWs joined the program, the drive of carrying on their work activity supposedly undergoes a strong transformation; in fact, the underlying factors and motives seem to get much more complex.

Building up *interpersonal network* was another reason people wanted to join the program. Four participants talked about the importance to build stronger connection to people in their areas as it gives them a sense of security. Also, the benefits of knowing "who is good at what" as it was described by one of the Mentor Mothers, can be extremely useful on the long run since external help is often not available. Once the system starts failing individuals on a regular basis, reciprocal relationships and social network seem to be regarded with an extremely high value as one of the MMs described:

> "…The best part at work is definitely going out in the field; so much better than staying in the office all day. Going out, meeting people and chat […] When it comes to difficulties they know that they have got someone to rely on in their neighborhood. If I needed help so do I…" (MM16)

Regarding the significance of community health work from an extrinsic point of view, another theme has been identified: the change in social position in their community. One fourth of participants implied that they were unprepared for the *work acknowledgment* that they received; as people in the village got to realize the importance of the health knowledge, interventions and their connections at the clinics and the hospital, they started appreciating them and their work more. Key thoughts, such as being respected and being listened to appeared several times during the sessions. In fact, the community perception of their position was explicitly described in a positive way – as it is shows up in the following lines as well:

> "…People from my village respect me a lot, I did not expect that. For example one person calls me at 11pm and told me 'Please, so and so is not feeling well. Can you help to call an ambulance?' […] I have grown, and I keep growing. I

never knew that when I talk to people they could listen to me so attentively…." (MM14)

Institutional recognition was another theme identified in the process of analysis. Almost all MMs mentioned that being part of the organization and getting positive feedbacks for their work from the supervisors and manager, are important features of the job. The other side of institutional recognition ties to the healthcare facilities that CHWs get connected to in a formal way due to their work. Receiving recognition from clinics and hospitals was mentioned by half of the participants; therefore, it should be considered a rather a significant incentive when people decide to join CHW programs.

5.1.3 Summary of results of work motivation

In the process of analysis, ten specific factors evoked to explain why people join CHW programs. On the intrinsic palette, CHWs' effort to achieve health benefits in their areas, improve children's wellbeing and build a sense of trust among their neighbors were identified; these motives, in fact, aim to *contribute to the community* as a whole. Being embedded in personal values and believes of CHWs, these incentives do not depend on external regulatory processes. Other intrinsic factors, such as self-image, future perspective and self-efficacy rather work towards CHWs' *life fulfillment*. Self-regulation is extremely pronounced in this case as well. Even though these incentives are not completely independent from the social environment, the experience of growth is a really intimate, personal process, therefore, measuring or comparing one's individual journey to an other person's is difficult, if not even impossible.

On the extrinsic palette, income generation and interpersonal network help to create *personal security* for CHWs. These incentives are under external regulation, and once rewards are not present anymore, the activity is not likely to be carried on. In addition, *social position*, that includes work acknowledgment and institutional recognition, are situated at the other end of the spectrum comprising extrinsic work motivation. Summary of results is highlighted in Table 1.

Experiences of CHWs draw attention to basic needs that have to be satisfied in order to stay motivated. Being connected to the families in the area, in both physical and emotional terms, is essential in order to contribute to the community, and gain a particular social position. In case, a sense of relatedness is not present, such as families

do not welcome CHWs because of a lack of trust, health workers are not likely to continue their activity according to the findings of this study. Feeling competent in an activity is vital in order to build self-esteem, and foster self-efficacy. In addition, having a sense of autonomy makes CHWs be able to initiate changes in their neighborhoods.

Table 1 – Emergent categories and sub-categories of work motivation

Why do people join the CHW programs?			
Intrinsic Factors		***Extrinsic Factors***	
Contribution to the community	**Life fulfillment**	**Personal Security**	**Social position**
- Health benefits - Unique connection to children - A sense of trust built inside the community	- Self-image - Future perspectives - Self-efficacy	- Income generation - Interpersonal network	- Work acknowledgement - Institutional recognition

Source: The Author

Interestingly enough, if the intrinsic and extrinsic factors are compared to each other, similarities can be noted. Building trust in the community seems a deeper variation of interpersonal network. Similarly, self-image might be a more internalized version of work acknowledgment. The analysis, in fact, highlighted an interesting paradox: even though income generation matter a lot at the time CHWs join the program, only a small minority of them would live the work purely because of financial reason. My supposition is that the meaning of the work activity undergoes a strong transformation, and gets much more complex over time. In line with SDT, the results of this study might suggest that initial motivation to join a CHW program lies in extrinsic factors; however, under optimal social conditions, these factors are internalized, and get embedded into a deeper psychological level.

5.2 Perceived Organizational Support

The perceived organizational support theory differentiates (1) tangible rewards and (2) intangible supportive resources; therefore, the analysis has been built around these preset categories. In the process of analysis, specific categories and themes have

emerged in order to understand the nature of support at work, and how CHWs perceive it.

5.2.1 Tangible rewards

As it has already been described in the previous section, gaining better financial security seems to be an important aspect when people join CHW programs. Even though money does not seem to be a major incentive or disincentive to carry on the work activity – it was not mentioned even once while discussing the most rewarding, nor the most challenging part of working as a CHW; furthermore, only 15 percent of the participants suggested that they would not want to be part of the program merely because of the level of financial compensation – *salaries* seem to deliver an important message how much one is appreciated by the organization. During interviews, half of the participants referred to the symbolic connection between salary and work recognition, such as more "money would make [them] feel more important". Indeed, one third of the participants suggested that one of the changes they would definitely propose at work is an increase in salaries. In all cases, however, the issue of money was put into a bigger perspective, such as how sufficient income is needed in order support their families. Through financial compensation, a particular condition can be created that is supportive towards work activity. As one of the senior members of the program highlighted:

> "Not much I would change at work. They have got good Mentor Mothers; I would just give them higher salaries. At least they could face most of the challenges at home. There are 6 or 7 NGOs in our area and Mentor Mothers are paid the worst among all. They do feel unappreciated. Four of our ladies already left the program for another job. They liked being Mentor Mothers but they leave because of the money. You cannot compare R1000 to R2000. It is sad…"(MMS3)

Similarly to financial compensation, *work equipment* provided by organizations delivers a symbolic message to CHWs. This message, however, seems to come through in a much more direct way than salaries; one third of the participants suggested that the most challenging part of the work is originated in the inadequate work equipment, such as the lack of rain gear, rain boots, proper shoes and transport facilities. Long discussions on the insufficient work equipment were being carried on in both focus group discussion that let CHWs raise their concerns and frustration regarding the issue, and highlighted their feeling of insignificance regarding the

position they have in the organizational structure. One fourth of the participants drew parallel between the lack of equipment, and not being taken care of by the organization. More than half of the participants said that one of the certain changes they would initiate is to distribute better work equipment in order to make daily work easier out in the field.

5.2.2 Intangible supportive recourses

Emphasizing *training* as a way of getting direct work support through diffusion of knowledge was another important pattern identified. Regarding the initial training all participants highlighted the applied nature of medical knowledge that was gained, and how useful this knowledge turned out to be in their everyday work. While describing the impact of the training, one fourth of the participants took a step aside from work, and put it on a more holistic level, such as becoming more empowered in several dimensions in live, and more competent in general:

> "…The training took a month and it was really good because they taught things that we are doing now like advising moms at home to breastfeed, going for immunization. If the child is not well we know what to do, and when to take him to the clinic. […] Yes, the training really gave me power…" (MM16)

Moreover, half of the participants pointed out that refresher trainings are essential since information tend to be forgotten over time. In addition, 90 percent of the participants expressed a desire to take new courses, and get more information on a health related subjects that the initial course did not cover.

Anther theme regarding intangible supportive resources offered by the organization was *personal support*. Conducting household visits, which were often described as challenge and source of frustration, seem to require continuous guidance and support from senior members and supervisors. Three fourth of the participants suggested that the way difficulties are handled is primarily shaped by supervisors and the office. The rest of the participants could not identify any external channel to help coping with problems; in fact, they expressed a sense of isolation and helplessness when things do not go well. In addition, one third of the participants suggested that the most challenging part working as a MM lies in the limited personal support, such as not having enough time to be spent with supervisor and other colleagues, furthermore, not given a deep level of understanding and empathy towards them who are out in the

field. Indeed, senior members and supervisors also identified how important MMs' daily support is. As one of the seniors members reflected upon the issue:

> "…When challenges arises and they cannot talk to anybody, that is difficult. They feel so bad. How can I put it? When the challenges arise they need someone to listen to them and they need someone to rely on: 'I have got this problem. How can you help me?' Sometimes we have no time for this because we are tired and that's when we fail them. […] If we've got a problem – that's what I experienced from my own life – it is difficult to help other people. We'll end up failing them by cheating, not doing what we are supposed to do…" (MMS1)

Furthermore, some of the CHWs pointed out that their daily struggles are pretty similar to the ones they visit. Unless their personal problems are listened to, they cannot find solutions to others' problems either. Three fourth of the participants wished they could spend more time with other MMs as peer support would be useful to find solution to problems, or even just being able to share them – as one of the MMs described:

> "…Yes, it is all about team and supporting each other. If someone is struggling go and say 'How can we help you? How can we assist each other in order to overcome this burden?' Then even the workload becomes much easier instead carrying everything on your own shoulder. Do you understand?" (MM9)

Not having sufficient personal support, that weakens relatedness at work, has a negative impact on work incentives. Half of the MMs implied that being left without support of others would be a valid reason to consider leaving the program.

Consistent *work rules* seem to have a big potential to add to CHWs daily satisfaction at work. There was a mutual agreement on the significance of clear work principles in order to know what is expected in which situation. Half of the participants suggested that having a clear intervention protocol is essential; furthermore, it has to be openly communicated inside the organization in order to know where personal boundaries should be set. Indeed, three fourth of participants implied that the most challenging part of the work is due to inconsistent rules. One of the MMs implied that the nature of work is already challenging enough, however, not knowing what to do in a particular situation makes it even pronounced:

> "...There are many challenges, especially in the office. Sometimes you don't know you are going right or wrong. […] Then home visits can be very difficult because you learn something and after a week it changes. We focus on this and then that. Oh, things change every day…" (MM15)

CHWs also emphasized the importance of realistic *work targets*. The number of expected daily visits, fixed number of monthly case follow-ups and the generally high caseload are all tend to work towards a program that is rather rigid and unrealistic. MMs seemed to agree that one of the most challenging parts of the work is based on a disconnection between the expectation of management and reality in the field. They elaborated on the fact that trying to live up to unrealistic targets is extremely demotivating and undermines everyday work – as one of the MM explained:

> "…They don't understand what is going on really. They don't realize how far the distances are. For instance work is very difficult on rainy days and if I do only 3 visits they still ask me why. I don't know. I wish they would come with me and walk the distances, the miles that I actually do every day. Then something would click in their minds…" (MM13)

Half of the participants suggested that stepping away from rigid work expectation is inevitable on a long run; in fact, they expressed their hope of creating a more flexible work environment that has a potential to reflect on the reality of the field. In addition, one fourth of the participants stated that if foundation of the program remains embedded in unrealistic expectation that would perhaps make them question their position in the MMZ program, and if is worth to keep working as MMs.

The interviews and focus group discussion has given an opportunity to better understand what *management approach* at work would be preferred by CHWs. Half of the research participants described their organization rather hierarchical, and suggested that it sometimes hinders to find solution to problems, or to adopt unexpected situation. In order to create a more suitable working environment, MMs suggested that they could be more involved in shaping the future of program, such as being able to reflect on program expansion, work targets and expectations as well as other major decisions of the organization. Four further participants wished they could choose the topics of future trainings and their potential timelines. Indeed, an organization that is based on participatory approach was more likely to be described with positive terms by the research participants.

Finally, an emphasis on *career growth* appeared from time to time in the interviews. Having the opportunity to progress at work through further education, and being able get a higher position in the organization seems to be important aspect according to MMs. Half of the participants suggested that sound knowledge and high performance

are essential in order to be promoted. One third of the MMs, however, highlighted that being promoted can take too long even though somebody might be clearly suitable for the position. Two participants elaborated on the difficulties regarding promotion, especially that compensation is not really in line with the new complex task that is expected from them. It appears in the following lines described by one of the program coordinators:

> "…Being promoted is hard. It is a risk. I check all the folders, and check their mistakes. If something is not right then I am the one who has to answer to questions. […] The most stressful part is to know all the Mentor Mothers and realize that they are not the same. One has to understand them. One Mentor Mother is not like another one, if this is doing quite well with everything, do not expect the other one does the same because they might be in a different situation…" (MMS4)

Being able to advance at work, attending trainings and getting a position where one can support other CHWs, however, was really desirable among most MMs.

5.2.3 Summary of results of POS

In the process of analysis, eight specific factors have been identified based on the perceived support that CHWs experience at work. Salary and work equipment primarily shape the *financial support* that the organization offers to CHWs. These concrete material rewards stand on the tangible spectrum of perceived organizational support. On the other side, trainings and personal support are part of the *daily work support* that can be seen rather elusive, but has a very strong impact on CHWs' wellbeing and work outcomes. Other intangible supportive resources include *work expectation* compressing organizational rules and targets. These particular supportive resources shape work activity and, therefore, performance at work. Finally, management approach and career growth opportunities primarily construct the organizational *decision-making processes* that can is on the intangible spectrum as well. The outline of result is presented below in Table 2.

Table 2 – Emergent categories and sub-categories of POS

How do CHWs perceive their support from the organization?			
Tangible Rewards	***Intangible supportive resources***		
Financial support	**Daily work support**	**Work expectation**	**Decision-making processes**
- Salary - Work equipment	- Trainings - Personal support	- Work rules - Work targets	- Management approach - Career growth

Source: The Author

According to the result of this study, organizational support system work towards the satisfaction of specific human needs. A sense of relatedness inside the organization can be created through financial support and daily work support. Trainings, personal support and career growth make a person feel competent at work, while work expectation and management approach enables individuals to make decisions regarding work-related issues. The experiences of CHWs suggest that a well-functioning support system of an organization can satisfy employees' needs for relatedness, competence and autonomy.

6. Concluding Remarks

This study, while limited in scope, contributes to the CHW discourse through experiences and reflections of the agents of change on their work. By focusing in on the stories and personal insight of 26 rural healthcare workers living in the former Transkei area, I offer a more nuanced perspective on performance motivation of CHWs from rural South Africa. Indeed, several factors impacting sustainability of community-based health initiatives are highlighted in the study.

Through SDT, Ryan and Deci (2000: 228) advances an explanation of human motivation that tries to describe internal factors influencing the choices that people make, by specifying necessary conditions of social environment to internalize incentives. While my results reproduce and confirm these necessary work conditions,

and indicate motives that the community health activity is potentially driven by, personal stories of CHWs revolve around the necessary conditions of work environment, and draw attention to the dimension of perceived organizational support that helps fulfilling employees' socio-emotional needs, therefore, influencing work performance.

The study suggests that the engagement in CHW programs is triggered by various incentives. Intrinsic factors, such as achieving health improvements, improving children's wellbeing and building a sense of trust in the community, suppose a strong connection built up among CHWs and local people; furthermore, require particular knowledge in order to make CHWs feel competent in their daily work. The motive of life fulfillment, which refers to self-image, self-efficacy and future perspective of CHWs, also assumes a sense of competence at work, furthermore, a certain level of autonomy that enables CHWs to make decisions according to their best judgments, and foster self-initiatives. On the extrinsic palette, one of the theme emerged from the accounts of CHWs is personal security, specifically income generation and interpersonal network. Even though incentives are externally regulated, needs of autonomy and prior connection established with the community are presumed for the presence of these motives. Similarly, extrinsic factors, such as work acknowledgment and institutional recognitions suppose that a solid relation is built with the local community, other members of the organization and healthcare facilities in the area. While the analysis confirms the necessary conditions of social environment after Ryan and Deci, some contradictions can be noted; the experience of CHWs implied that both intrinsic and extrinsic motivation require the satisfaction of basic psychological needs of autonomy, relatedness and competence to some extent. Prior studies of SDT suggested that only intrinsic motivation and internalization of extrinsic motivation require the presence of these necessary conditions of social environment; however, this particular study re-approaches the theory, and proposes that all human motivation build upon a rather complex social environment.

Looking at POS theory, Eisenberger (1986: 500) implies that organizational tangible rewards and intangible supportive resources shape social environment at work that translates into employees' wellbeing and work productivity. Findings of this study are in line with POS theory; on the tangible end, financial support including salary and

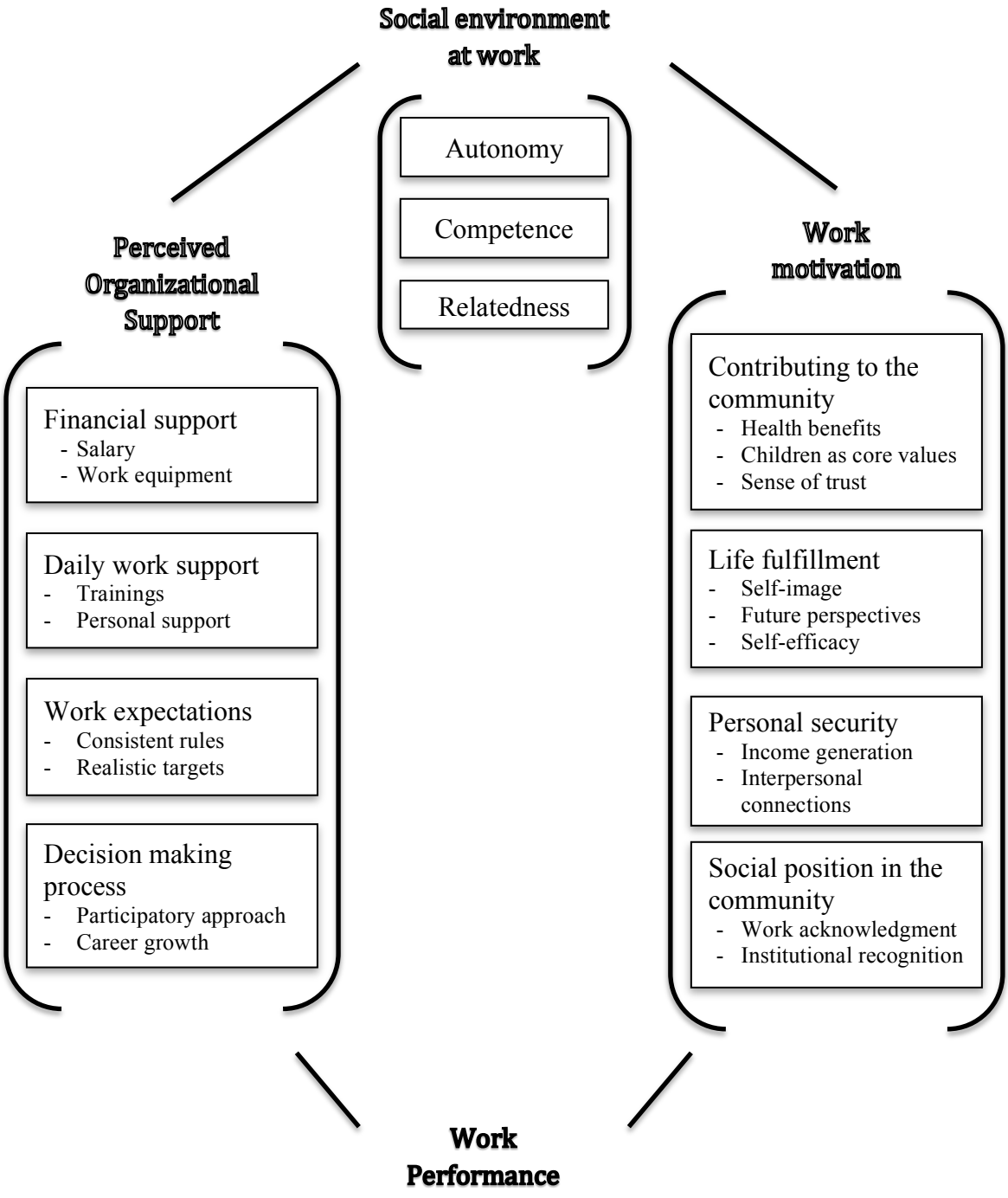
work equipment sends a message to employees about how much the organization appreciates them, and that builds up a certain level of connection among members in the organization. Similarly, on the spectrum of intangible supportive resources, daily work support compressing trainings and personal support that the organization offers, works towards relatedness; furthermore, develops employees' competence at work. Work expectation including organizational rules and targets, determine the level of autonomy that employees have at work on a daily basis. Finally, management approach and career growth opportunities primarily construct the organizational decision-making processes; influence the level of autonomy at work as well as personal competence.

The experiences on motivation and perceived organizational support form different strands of the same testimony, yet they come together to form a more complete picture of performance motivation of CHWs. By merging the findings based on SDT and POS, a scheme can be drawn up that is represented in Figure 4. This framework, in fact, shows that social environment at work being a mediator between the organizational support system and employees' motivation; furthermore, gives a representation of the various factors influencing work performance. Indeed, this particular scheme has a potential to be used by organizations in order to gain a more comprehensive picture on employees' performance motivation, and a better understanding of the organizational dynamic; furthermore, it can help shaping the organizational support system on a long run.

Being aware of the limitations of this study should, however, be emphasized. First, the study scope with its limited size of sample was one of the hindrances to a deeper analysis. As such, the research aim was not to evaluate employees' motivation level, but investigating factors that have an impact on their performance motivation. Clearly, further investigation could provide a better understanding of the relationship between the different elements of organizational support and work motivation. Second, qualitative analysis built upon individual experiences cannot be generalizable in a traditional way, but results need to be looked at through the context. Indeed, current finding reveal the motives of individuals that join CHW programs in rural South Africa, and factors that makes CHWs more acutely aware of their own agency in a way that translates into high work performance. Broader interpretation of the

findings has to be taken with caution though; further research may be needed in order to investigate performance motivation of CHWs set in a different context, such as urban centers, different geographic locations etc.

Figure 4 – Framework of performance motivation based on SDT and POS



Source: The Author

The findings of this study aim to reflect on the limited scope of co-current CHW discourse that pays little or no attention to people that work out in the field on a daily basis, and function as the "engine of change" in their communities. It is crucial that organizations start realizing that measuring program impacts cannot be done under rigid evaluations focusing merely on service recipients. Understanding the needs of different actors, including CHWs, is in fact inevitable in order achieve substantial health impact, and provide the quality of services. Clearly sustainability of community-based initiatives cannot be based on facts that are isolated from the complex nature of social reality. One of the research participants pointed out that CHWs often experience the same problems in their personal lives that service recipients have; however, organizations do not want to face it, and take this issue into consideration. It is time to come to the realization that without a clear understanding of the basic needs of the agents of change, initiatives fail to live up to program expectations, and above all, to a basic moral standpoint.

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Appendices

Appendix 1 – List of Participants

Participant	Date of session	Type of session
MM1	03.02.2015	Focus group discussion
MM2	03.02.2015	Focus group discussion
MM3	03.02.2015	Focus group discussion
MM4	03.02.2015	Focus group discussion
MM5	03.02.2015	Focus group discussion
MM6	03.02.2015	Focus group discussion
MM7	26.02.2015	Focus group discussion
MM8	26.02.2015	Focus group discussion
MM9	26.02.2015	Focus group discussion
MM10	26.02.2015	Focus group discussion
MM11	26.02.2015	Focus group discussion
MM12	26.02.2015	Focus group discussion
MM13	10.03.2015	Semi-structured interview
MM14	17.03.2015	Semi-structured interview
MM15	21.04.2015	Semi-structured interview
MM16	24.04.2015	Semi-structured interview
MM17	07.05.2015	Semi-structured interview
MM18	08.05.2015	Semi-structured interview
MM19	05.05.2015	Art session
MM20	05.05.2015	Art session
MM21	05.05.2015	Art session
MM22	05.05.2015	Art session
MMS1	10.04.2015	Semi-structured interview
MMS2	17.04.2015	Semi-structured interview
MMS3	23.04.2015	Semi-structured interview
MMS4	28.04.2015	Semi-structured interview

Appendix 2 – Focus group discussion guide with MMs

1. What does a Mentor Mother do?
2. What are the most important characteristics needed to perform these tasks well?
3. What were the most attractive sides of being a Mentor Mother before you joined the program?
4. What has been different from your prior expectation?
5. What are the most important rules at work?
6. What are the your most rewarding moments at work?
7. How would you describe are the most difficult moments at work?
8. How do you usually overcome these difficulties?
9. Imagine that you decide not to be a Mentor Mother anymore. What potentially could make you decide so?
10. What would you say about this picture?[8]

11. What do you think is happening in the picture?

[8] Consent was received in order to use all pictures during the discussions.

12. What the following pictures makes you think of?

13. How do you feel about this picture?

Appendix 3 – Informed Consent form

Thank you so much for your participation in this research. My name is Anna, and I study at a university in Sweden. As part of my studies, I would like to get to know more about your experiences working as a community health worker, and understand your personal gains, and challenges you face at work. By sharing your feelings and experiences, you teach me what areas of community healthcare work need to be paid more attention to in the future. As such, your participation is really valuable.

Your participation in the research is completely voluntary. You may refuse to answer any question, or decide to stop taking part in the research at any time. All information given during this session is confidential, thus names will never be mentioned to anyone, neither in the final study. The session will last about an hour, and with your permission, I would like to take some notes and record it.

Please feel free to take some snack and juice during the session. After the session, reimbursement for your travel cost will be given. Also, with a R15 airtime, I would like to say thank you for your time and effort given.

Appendix 4 – Interview guide with MMs

1. Getting to know personal history
    a. Family background
    b. Personal values and beliefs
    c. Plans for the future
2. How did you get to know about the Mentor Mother program?
3. When and why did you become interested in it?
4. How was the training? Looking back what would change if you could?
5. How do you find working as a Mentor Mother?
    a. Positive aspects
    b. Negative aspects
6. What is the most important thing that happened at work since you became a MM?
7. When you face challenges at work whom you can discuss it with?
8. How would you describe your supervision at work?

    a. Positive aspects
    b. Negative aspects
9. Who is the closest to you at work?
10. How much time do you spend with other Mentor Mothers? How much do you know them?
11. What changes would you like to see at work?
12. Are you planning to propose these changes?
    a. If yes – Whom do you plan to talk to?
    b. If not - Why? What hinders it?
13. Is there anything at work that you don't understand and would like to know more about it?

Appendix 5 – Interview guide with MMs supervisors/senior members

1. Getting to know personal history
    a. Family background
    b. Personal values and beliefs
    c. Plans for the future
2. How do women usually get to know about the Mentor Mother program?
3. Why do they become interested in the program?
4. Could you tell me about the trainings?
5. How is it working as a Mentor Mother according to you?
    a. Positive aspects
    b. Negative aspects
6. When Mentor Mothers face challenges at work whom they can discuss it with?
7. How would you describe Mentor Mother supervision at work?
    a. Positive aspects
    b. Negative aspects
8. How much time do Mentor Mothers spend with other? How much do they know each other?
9. What changes would Mentor Mothers like to see at work according to you?
10. Do they sometimes propose changes?
    a. If yes – What kind of changes? Whom do they talk to?

b. If not - Why? What hinders it?

11. Is there anything at work that you don't understand and would like to know more about it?

Appendix 6 – Activity plan for art session with MMs and supervisors

1. What feelings are in your heart?
    a. Participant are given a heart template and asked to choose 6 different emotions that primarily determine their daily work.
    b. Participants asked to choose 6 different colors symbolizing the emotions
    c. Participants are asked to color their heart in a proportion that expresses the intensity of their feelings.
2. Symbolic drawing
    a. Participants are asked to draw something that symbolizes being a Mentor Mother.
    b. Then a discussion is hold to understand why they chose that specific symbol.
3. Joint picture of Philani
    a. Participant will be asked to draw a joint picture or make a collage of Philani without talking to one another.
    b. Discussion is hold at the end of the exercise to let them explain (1) the meaning of their final work and (2) how they felt in process of creation.
4. "Life size" collage representing work out in their community
    a. Participants are asked to create collages of their work as a MM with the use of various media and pictures
    b. Discussion is hold afterward in order to understand what they tried to express and the reason of choices