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Research Article

Perceived Barriers and Facilitators to Implementation of Maternal and Child Health Care by Community Health Workers in Rwanda: A Qualitative Study

Emery Hezagira [1], Alphonse Habineza [1], Lucie Uwimana [1], Erigene Rutayisire [1*]

[1] Public Health Department, Mount Kenya University Rwanda

*** Correspondence:** Erigene Rutayisire, Public Health Department, Mount Kenya University Rwanda

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Abstract

The motivations and barriers experienced by community health workers (CHWs) during the delivery of maternal and child health (MCH) services are less documented in Rwanda. This study aimed to explore the barriers and facilitators of implementing MCH care as perceived by CHWs. A descriptive qualitative study was conducted, and semi-structured interviews with follow-up probing questions were used to collect data. A number of 24 interviews were conducted with CHWs from three selected sectors of the Gicumbi district including four supervisors of CHWs from each selected health center and one at the district hospital. Three focus group discussions with CHWs from each site were also conducted. Ethical approval was obtained from Mount Kenya University and permission to collect data from the study sites was granted. NVIVO software was used for analysis, and then the content analysis was adopted to identify themes merging from the interviews and focus group discussions. The study findings revealed emerged factors that facilitate the CHWs to deliver MCH services to their communities: liking their work, trust by the community, respect from the community, the willingness to help, desire to gain knowledge, being human, and sacrifice for the wellness of the community. On the other hand, the findings indicated that the work of CHW has various barriers including working many hours, lack of equipment, lack of knowledge, unsatisfactory salary, heavy workload, lack of working space, lack of facilitation for communication, family conflicts, lack of specified working time, and beliefs.

Keywords:
Barriers; Facilitators; Community health workers; maternal health; Child Health

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Introduction

Community health worker (CHW) interventions have been shown to be effective in areas of maternal and child health (MCH), mostly in relation to infant and neonatal mortality. Worldwide, Community Health Workers are used as a strategy to address the shortage of health workers and render certain basic health services to their communities. Depending on the specific needs of countries and communities, CHWs' profiles vary in terms of activities, scope, training among others. The WHO definition of CHWs is that they should be "members of the communities where they work; selected by the communities; answerable to the communities for their activities; supported by the health system but not necessarily a part of its organization and have shorter training than professional workers."[1].

Investment in the Community Health Program (CHP) is one of the "best buys" in primary healthcare and has many health benefits, as well as economic and societal gains [2,3]. Community Health Program contributes to increasing coverage of essential healthcare services and reduces the number of patients treated at facilities through task shifting while creating short-term cost savings in other parts of the health system [4].

Globally, the COVID-19 pandemic has provided a unique scope to understand the working conditions of community health workers (CHWs) involved in the provision of healthcare services including maternal and child health services for community people (Panda & Mishra, 2007). During the pandemic, community health workers (CHWs) have undertaken a series of new tasks in addition to their routine services, including maternal and child health (MCH) services. Community health workers (CHW) faced increased challenges in delivering maternal and child health services during the current COVID-19 pandemic. In addition to routine services, they were also engaged in pandemic management [5].

Most community members felt that CHWs could not be trusted because of their lack of professionalism and inability to maintain confidentiality [2,6]. Familiarity and the complex relationships between household members and CHWs caused difficulties in developing and maintaining a relationship of trust, particularly in high HIV prevalence settings. Professional staff at the clinic were crucial in supporting the CHW's role; if they appeared to question the CHW's competency or trustworthiness, this seriously undermined CHW credibility in the eyes of the community [2,7].

In South Africa, community health workers (CHWs) are a component of the health system as in many countries, providing effective community-based services to mothers and infants. However, implementation of CHW programs at scale has been challenging in many settings [8]. The acceptability of CHWs conducting household visits to mothers and infants during pregnancy and after delivery, from the perspective of community members, professional nurses and CHWs themselves has been challenged. In this country a qualitative study has been conducted in five rural districts in KwaZulu-Natal among

others primary health care clinics, has been selected where participants were purposively selected to participate in 19 focus group discussions based on their experience with CHWs or child rearing. Poor confidentiality and trust emerged as key barriers to CHW acceptability in delivering maternal and child health services in the home has been reported [9].

Rwanda started the Community Health Program in 1995 after the Rwandan Genocide against the Tutsi. At that time, there were no policies, strategies, or operational guidelines on how to implement such a program [3], [10]. Since 1996, Rwanda adopted a decentralized policy to take health services closer to the people in order to improve health from participatory approach. The Community Health Worker (CHW) is therefore one of the key players in the country's health sector and works under the direct supervision at a given health center [11]. The community health program implementation strengthens the decentralization of health structure and services down to district level and the village (imidugudu). CHWs are essential in addressing the significant shortages of skilled health workers especially in low resourced and fragile health systems. The purpose of community health programs is to increase access to premier health care and improve access in rural areas in Rwanda [12]. The CHWs practicing community health programs are trained to perform community-based provision of family planning (CBP), integrated community case management (ICCM), Community based nutrition program (CBNP), Community based maternal and newborn health (CB-MNH), and financial motivation by Community based performance financing (CB-PBF) through CHWs cooperatives. CHWs are the direct contact to mothers in the communities. They provide basic maternal health services such as education and information on the access and utilization of health facilities for maternal health care. Such information includes the use of antenatal services, information and services on family planning, behavior change, delivery in health facilities as well as maternal mental health [13]. The work of CHWs in the area of maternal health combined with other government initiatives was aimed to help Rwanda meet the 5th Millennium Development Goal "Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio". Despite such a tremendous reduction of maternal deaths, Rwanda still ranks among the countries with high rates of maternal mortality [14].

Rwanda has successfully implemented one of the most robust CHP globally. The program established in 1995 was rolled countrywide in 2005 [15]. The CHP in Rwanda aims to increase the uptake of a range of low-cost, community-based interventions for maternal and child health, promote healthy behaviours in the community, and link the population with health services. The CHP in Rwanda is coordinated at the national and decentralized level to support CHWs who operate at the village level. Currently, there are about 58,567 CHWs, which is an increase from the 12,000 CHWs at inception in 2005 [16].

The program is designed to follow up 150 to 200 households at the community level (per village level), which estimates, to be about 1 CHW per 200 people. Each village in Rwanda is estimated to have 4 CHWs in rural areas and 3 CHWs in urban areas: a male female CHW pair (called binômes) to provide basic care and low-cost community interventions for integrated community case management (ICCM) of childhood illness, a CHW in charge of maternal health (Agent de Sante Maternelle, ASM), and a CHW in charge of health promotion focusing on health promotion [3]

However, community healthcare workers' perspective on healthcare, the challenges they face to provide quality health services, and opportunities to improve motivation and provide adequate care are rarely investigated in resource-constrained settings of sub Saharan Africa [17].

While CHW programs have long been an underfunded afterthought, they are now front and center as the emerging foundation of health systems. Despite this increased attention, CHW programs continue to face the same pressing challenges: inadequate financing, lack of supplies and commodities, low compensation of CHWs, and inadequate supervision [18].

Rwanda's maternal CHWs are heavily responsible for promoting equitable access to maternal health services. Consequently, they may be required to use their own resources for their practice, which could jeopardize their own socio-economic welfare and capacity to meet the demands of their families. Considering the unpaid and untrained nature of this position, we highlight the factors that threaten the sustainability of CHWs' role to facilitate equitable access to maternal care. These threats introduce turbulence into what is a relatively successful community-level health care initiative [19]. However, there are limited studies conducted in Rwanda on barriers and facilitators faced by community health

workers in implementation of maternal and child health care services. Thus, the researcher explored barriers and facilitators faced by community health workers on implementation of maternal and child health care services.

Methods

Research Design

The present study used descriptive qualitative design to guide this study [20]. Descriptive qualitative approach describes the main concept(s) of the study according to participants' perceptions. In qualitative studies, participants elaborate what they know about the phenomenon of interest through a one-to-one interview or a focus group. The study used the qualitative design because it intends to understand the barriers and motivation as perceived by community health workers. Moreover, the study intends to understand what community health workers experience as barriers or motivators. Thus, descriptive qualitative is the best method that was used to collect data among community health workers in charge of Maternal and child health care delivery in Gicumbi district which is the study setting.

The Gicumbi district lies north of Kigali, straddling the major road from Kigali to Kampala. It is a hilly district. The district borders the districts of Burera, Nyagatare, Gatsibo, Rwamagana, Gasabo, Rulindo, and the country of Uganda. The total population in Gicumbi is 362 331 inhabitants with 172 144, or 47% are men and 190 187, or 53% are women. The density is 437 inhabitants per km^2. Gicumbi district is one of five (5) districts of the Northern Province.

Target Population and Study Setting

The present study targeted Community health workers working in selected sector of Gicumbi district. Like for the rest of Rwanda, CHWs in Gicumbi district were elected by their fellow citizen that they can contribute in delivery of primary health care services at village level. CHWs in Rwanda do not have a special health training. However, after their election they get training about their intended tasks. The CHWs of Gicumbi district have no special characteristics compared to other districts; they were randomly selected to be involved in this study. Gicumbi district has 21 sectors and each sector has 4 cells and each cell has 5 villages. The district is having approximatively 2250 CHWs. The estimated number of CHW in three sectors of Rukomo, Byumba and Bwisige is 278 CHWs.

Sample Size

Gicumbi was randomly selected to represent other Districts and three Sectors represent other Sectors of Gicumbi. The sample size for this study was selected from three randomly selected sectors of Gicumbi district namely: Rukomo, Byumba and Bwisige. These three sectors have 278 CHWs according to the report of Gicumbi district health report. Regarding the sample size of qualitative studies, Morse suggests a sample size of six to ten participants. Thus, the researcher first targets the maximum sample of 10 participants. However, sample size can be determined by data saturation; a sampling point at which no additional information is obtained and redundancy is achieved [21]. Therefore, the final sample size was determined by data saturation. Thus, 20 CHWs, four supervisors of CHWs at health centers and district level participated in this study.

Sampling Technique

In this study the researcher assumes that all CHW in Rwanda have similar characteristics and only differ on location. Due to this regard, stratified sampling was used to select participants for this study. Basing on locations CHWs are located into 30 different Districts. Thus, Gicumbi District was randomly chosen from these 30 Districts. Three Sectors were also randomly chosen from 21 Sectors that make-up Gicumbi District. Researchers rely on stratified sampling when a population's characteristics are diverse, and they want to ensure that every characteristic is properly represented in the sample. In this regard the population difference is location of CHWs, thus random sampling process was used to avoid any bias of selection. The researcher considered districts as strata and then sectors as strata. Thereafter, the probability simple random sampling, allowed the researcher to select Gicumbi District and from Gicumbi District to select three Sectors: Rukomo, Byumba and Bwisige. To get the required sample from the selected Sectors, the researcher contacted the supervisor of community health worker at

District level. The supervisor availed the lists of all community health workers of the randomly selected three Sectors. The researcher wrote the name of all potential participants on a small paper. Each small paper was folded and put into a basket and thereafter the researcher randomly chose 20 participants. The chosen participants were contacted through the phone call and those who agreed to participate in the study, the researcher scheduled the interview with them. The potential participants who did not agree to participate or were not accessible on the phone were replaced by randomly selecting more participants from the basket. The researcher first scheduled interview with 10 participants and thereafter scheduled interview with one participant and continuously added one participant until the data saturation point is reached. CHWs who were involved in one-to-one interview at each health center were also involved in a focus group. Moreover, the supervisors of CHWs at health center and at district hospital were involved in one-to-one interview.

Data Collection Instruments

The instrument for this study was a semi-structured interview guide. The researcher used semi-structured one-on-one interviews with audio recording. The researcher developed semi-structured interview guided by specific objectives of the study.

Procedure for Data Collection

As the majority of Rwandans use local language *"Kinyarwanda"*; semi-structured interview was translated into Kinyarwanda. Within a single session of 60 to 90 minutes, the interviewer encouraged the participants to talk freely on pre-established sub-topics guided by experiences of working as community health workers. The guide also involved probing questions to elicit more detailed meaning about the barriers they face while providing maternal and child health care services and what they perceive as facilitators. The researcher recorded the interview to avoid any distraction that could result from noting the conversations which were used to make transcripts that are required for analysis. However, field notes were taken for noting participant's body language and expressions during the interview or afterwards by another person. The interview was conducted by two people: one recording the interview and another one taking the field note for any possible body language the participant may present during the interview. The interview was in Kinyarwanda and transcribed in Kinyarwanda. Before translating the interview into the English language, the researcher went back to participants and read to them the transcripts for member checking. The last Kinyarwanda version after member checking was translated into English for analysis.

Data Analysis

The study analysis used nVIVO software. Moreover, the study analysis used content analysis. The content analysis was appropriate to this study because it explicitly breaks down the texts into words, groups of words, or sentences as a smaller component unit to make codes [22]. This approach facilitated the understanding of texts as they were narrated by CHWs. All codes with related meaning about barriers or facilitators as perceived by community health workers during maternal and child health care delivery were put together as emerging categories and then themes.

Ethical Consideration

The study ethical clearance was sought from Mount Kenya University (MKU). The ethical letter from the MKU was presented to the Director General of Byumba District Hospital in Gicumbi district for permission to start data collection. After getting the permission letter from the District Hospital, the researcher started to recruit the participant as planned with the help of the supervisor of community health workers at District Hospital in Gicumbi district. The researcher explained to each participant and requested him/her to consent for participation. Moreover, the study respected the rule of anonymity and confidentiality. The latter rule was clarified to participants before the start of the interview. The participants were informed that names and addresses for identifying each semi-structured interviewee guide will be replaced by codes to ensure anonymity. Names and addresses were kept separate for future communication and follow-up. The responses to the survey were kept strictly confidential and locked in a filing cabinet in the principal investigator's office. The participants were informed of their right to

Table 1. Demographic characteristics of CHW participants

Variable	Variable category	Frequency (percentage)
Age	31 – 40	11 (55)
	41 – 50	9 (45)
Level of education	Primary level	14 (70)
	Secondary level	6 (30)
Working experience	5 – 10 years	8 (40)
	11 – 15 years	12 (60)

Source: Researcher, 2022

withdraw from the study at any time they feel to do so. The participants were informed that findings will be presented as group data only to ensure that identification of individual response is impossible.

Results

Demographic Characteristics of Respondents

Among the 20 CHW who participated in this study, 11 are between 31 and 40 years of age, and 9 are between 41 and 50 years of age. The majority of CHW participants (n=14) have completed primary school, and the remaining six have completed secondary school. The majority of CHW have experience ranging from 11 to 15 years (n=12). Supervisors of CHWs at the level of health centers and at hospital level hold bachelor's degrees. The summarized demographic characteristics of CHWs are depicted in table 1.

Themes

The study purposely interviewed participants to elicit the facilitators and barriers CHWs experience during the delivery of maternal and child health services at the community level. The categories were generated from the data findings emerging from participants' responses, then grouped logically into major themes (Table 2).

Facilitators to Implementation of Maternal and Child Health Care Services By Community Health Workers

Participants shared their experiences of working as CHW. During the interview of one-on-one and focus group discussion participants narrated factors that motivate them to give the maternal and child health services to their community. The supervisors of CHWs at health center and at district hospital levels also gave their perception regarding the factors that facilitate CHWs to deliver maternal and child health service to the community. The following factors emerged as categories that facilitate the CHWs to deliver maternal and child health services to their communities: liking their work, trust by the community, respect from the community, the willingness to help, desire to gain knowledge, being human, and sacrifice for wellness of community.

Liking their Work

Community health workers and their supervisors at health center and district hospital revealed that CHW like their work. Community health workers who participated in this study indicated the love of their work and they are happy to serve their community. One CHW said that "*Being a community health worker is about saving lives and loving the population. For me, being a community health worker was a choice based on my love for the community and the importance to this profession to my community. The choice of being a community health worker is open to everyone*".

Table 2. Emerging categories and themes

Codes	Categories	Major themes
	Liking their work	Facilitator
	Trust by the community	
	Respect from the community	
	The need to help	
	Knowledge increase	
	Human personality	
	Sacrifice to the community	
	Earning for living	
	Working many hours	Barrier
	Lack of equipment	
	Lack of knowledge	
	Unsatisfactory salary	
	Heavy workload	
	Lack of working space	
	Lack of facilitation for communication	
	Poor attitude by some community members	
	Family conflicts	
	Lack of specified working time	
	Believes	

Source: Researcher, 2022

Trust by the Community

Participants also revealed the trust their community has in them as a major factor that pushes them to continue working as community health workers. One participant said "*We are trusted by the people. We are always open to hearing complaints from the public. In addition to giving them what we have, we are also trained to do for them the things that may be of benefit to them. In terms of their health, for example, family planning issues, they are free to say what they think. They trust us and tell us everything."*

Respect from the Community

Participants demonstrated that community health workers are motivated to accomplish their job because of the respect the community attributes to this service. A participant said that "*they respect us too much. If they see a CHW, they ask him the problems they could ask from the health care professional. When you reach to their respective homes, they take care for you. Even if it is not all of them, I cannot say that many people they respect us because CHW service we deliver."*

The Willingness to Help

Through the one-to-one and focus group interviews, participants of this study revealed a strong willingness to serve as CHW. During elections, CHW volunteer to serve by delivering maternal and child health service despite difficulties involved with the task. A participant highlighted that "*this program is important because as you care to a mother, you are also caring a child. This service may decrease the neonates who die during delivery. So, I like this volunteerism work due to its incredible role because for reducing maternal and child mortality".*

Knowledge Increase

Participants in this study demonstrated that the knowledge they gain when they become CHW is important to them and the entire community. A participant indicated that *"to be a community health worker is good .It helps you to get more knowledge because you attend various trainings. Then I become a CHW it benefited me a lot, it helped me to know many things that I couldn't have known if I wouldn't had the opportunity to become a CHW." Another participant said that "as a community health worker, I gained skills of how to maintain hygiene and importance of hygiene in life".*

Human Personality

Participants in this study indicated the importance of having the human personality in delivering maternal and child health services. Regarding this personality the supervisor of CHWs said that "*for me they accomplish well their responsibilities of focusing on care of maternal and child health. This requires having humanity characters by which you should be able to sacrifice for others. For example, a woman may have a plan to come today on 14th July for family planning issues where at the same day a CHW has a plan for going in farming activities. She may reach at his/her home for that care at an hour that she/he is in preparations to go to his/her farm. It is a humanity which may encourage this person to first provide him a service and then go to his/her activities*."

Sacrifice to the Community

Sacrifice to serve the community was also an important factor that pushes community health workers to give the health service to mothers and their children. A participant said that *"this work requires the sacrifice for others and always focusing on the reason we have been selected by our community. Although, we do not have a known salary we are not demotivated because of the sacrifice to keep serving our community and we know clearly that we are the health care volunteers. So, it is better to keep working courageously."*

Earning for Living

Community health workers revealed the importance of earning some amount during the delivery of this service as a motivation to continue serving. A participant said that "*there is a PBF that our government give to us, when a CHW accompanies a mother for delivery, she is counted as your client and get from her a PBF of 200 Rwf. It means for a month if you take 20 pregnant women it means that you may get from them 4000 Rwf. Even if she is your client and come to deliver to health center without your presence, she stays counted as your client. This helps us to get money. In general, the community health workers are happy as we are not working for nothing. It should be better if we get it through our mobile money account directly."*

Barriers To Implementation of Maternal and Child Health Care Services by Community Health Workers

Participants in this study indicated that the work of community health workers has various barriers. Participants mentioned the following as barriers of serving as a community health worker: working many hours, lack of equipment, lack of knowledge, unsatisfactory salary, heavy workload, lack of working space, lack of facilitation for communication, poor attitude by some community members, family conflicts, lack of specified working time, and beliefs.

Working Many Hours

Participants indicated the challenges of working for many hours when giving the service of maternal and child health service. Their work does not have specified time, at times they work in night hours. A participant said that "*we even work at nighttime as the people are free to come whenever it is needed".*

Lack of Equipment

Participants also indicated a barrier of accessing the equipment they use for their work of serving as community health workers. They indicated the challenge of accessing equipment like old telephone, they do not have rainy coat, boats, the files for keeping their documents, and some medication they use for managing health conditions. Participants also indicated that the rapid SMS they were using to report health related cases is no longer working. A participant reported that "*before, they used to give us the boots, now it has stopped. They used to give us the rainy clothes, it has stopped. What I may say in short is that they may give us the materials to be used to accomplish our tasks and if possible, give a bicycle to help us in moving from a place to a place."*

Unsatisfactory Salary

Community health workers who participated in this study revealed how the law payment they get is a barrier to them. A participant said that "*for changes, our government may increase the amount pay per each client. For example, if now for a pregnant mother who is going to deliver, they pay us 200 Rwf, they should increase it to 1000 Rwf as the things are too expensive nowadays*". Another participant highlighted that "*my advice is that this PBF given should be increased, it is too small. Frankly speaking, it should be increased and should be better if it is given regularly each month*".

Heavy Workload

Participants indicated a heavy workload as a barrier they meet during implementation of maternal and child health services. Participants indicated that sometimes local authorities give them extra duties that they were not elected for. In this regard a participant said that "*some time they request to counting the families with unproper toilets, counting those who have been bitten by snakes, to be present in all programs related to a growth of children, to count all children who has a school dropout, to encourage people to join EJO HEZA program, and counting the families who have not paid their community-based health insurances. This increases the workload to us".* Similarly, another participant indicated that "*there are many services we ought to provide that are not part of our responsibilities as the community health workers. We help them to encourage people to have hygiene and proper hygiene. We encourage people to get the community-based health insurances, counting the school dropped out students in your villages".*

Lack of Working Space

Participants indicated the working space as a barrier to them. A participant said that "*to care for our clients in our family houses is a barrier because of lack of privacy and confidentiality. We provide health services when our children are watching".* Another participant said *"I have a small house and I do not have enough space to put health material I use and when a patient comes at home I do not have a space where I can sit her comfortably. So, government should build us good houses".*

Lack of Facilitation for Communication

Participants also indicated communication as a challenge. A participant said that "*Airtimes for calling at the health center is a problem, if we are calling for help or calling the supervisor of CHWs when we need him/him it is a problem".* Another participant said *"The other barrier is that before, we had been given a free way of communication between us, the community health worker. But now, it is not possible. I mean that the way of using CUG is not possible for all of us. CUG is the way health workers communicate to each other but this service is not working in some areas. This is a barrier in communication and in reporting*".

Poor Attitude by Some Community Members

Participants also highlighted the barrier of some community members with poor attitude regarding the work of community health workers. "*Some may disrespect you simply because they believe that the community health worker cannot provide any medical advice and that he should only address their health problems with medical staff."* Another participant said *"There may be a time when the perception of people is totally different from what you have been expecting, including the perception of people in the majority."*

No Specified Working Time

Participants indicated the lack of a known time for working as a barrier. A participant indicated that "*the barriers are the inability of some people to respect time when you have planned it, they do not respect an appointment, they come at any time".*

Personal Beliefs

Personal beliefs were also identified as a barrier to the work of a community health worker. A participant indicated that *"It may be difficult to visit someone with mental health problems, or to deliver a family planning campaign to a home where family planning is viewed as a sin. While you may see it as necessary for that family, they may not want to even understand the family planning program. Besides teaching them the importance of the program, there's nothing else you can do for them. Then you let them decide for themselves. Others say their churches do not accept family planning programs."*

Discussion

The purpose of this study was to explore barriers and facilitators community health workers face during the provision of maternal and child health care services. Data collection used a one-on-one interview on 20 community health workers, four supervisors of community health workers at health center level, and at district hospital level.

Participants shared their experiences of working as community health workers. During the interview of one-on-one and focus group discussion, participants narrated factors that motivate them to give the maternal and child health services to their community. The supervisors of community health workers at health center and at district hospital levels also gave their perception regarding the factors that facilitate community health workers to deliver maternal and child health service to the community. The following factors emerged as categories that facilitate the community health workers to deliver maternal and child health services to their communities: liking their work, trust by the community, respect from the community, the willingness to help, desire to gain knowledge, being human, and sacrifice for wellness of community. On the other hand, participants in this study indicated that the work of community health workers has various barriers. Participants mentioned the following as barriers of serving as a community health worker: working many hours, lack of equipment, lack of knowledge, unsatisfactory salary, heavy workload, lack of working space, lack of facilitation for communication, poor attitude by some community members, family conflicts, lack of specified working time, and beliefs.

The findings from this study align with previous findings about the community health facilitators conducted by [14], [23] which showed that community health workers were highly respected by the beneficiaries because they were closely involved with the community. Similar to the previous studies conducted in Rwanda [24], community health workers were motivated by community respect, in addition to Rwanda's community performance-based financing. Similarly, a study that was conducted in Eastern Uganda by [11] indicated that community health workers were motivated by community appreciation, being called doctors, monetary incentives, and material incentives. Respect and monetary incentives were key factors that motivated community health workers to continue delivering maternal and child health services. In this study, participants revealed that the small money given to them when they report a pregnant woman at a health service is very important to them, and they are happy about it.

In this study community health workers revealed the trust and respect as motivating factors for them to continue delivering maternal and child health services. A participant in this study said "*We are trusted by the people. We are always open to hearing complaints from the public. In addition to giving them what we have, we are also trained to do for them the things that may be of benefit to them. In terms of*

their health, for example, family planning issues, they are free to say what they think. They trust us and tell us everything." The study by Lutwama and colleagues [6] also emphasized the importance of trust and respect towards the community health workers in motivating them to keep the job.

On the other hand, participants in this study demonstrated challenges of working as community health workers. They revealed the lack of material, lack of privacy, and unsatisfactory allowance. A participant indicated that *"the first barrier is the shortage of materials like those to be used in rainy season. For example, there are time by which you may be requested to visit a patient while your t-shirt or shoes are too old. When you go there with those old clothes and equipment, they may consider you as being dirty."* A study conducted by [19,25] supports this finding and indicates that community health workers use their resources for providing maternal and child health services. This study warned that such a situation could jeopardize the delivery of maternal and child health services if it is not addressed. In this study, participants indicated the possibilities of communicating health care services using their airtime. They also indicate the serving for a long time. When such situations are not handled appropriately, they can result in poor services of maternal and child health services by community health workers.

Conclusions

The study responded to the research questions of understanding the facilitators and barriers as perceived by Community health workers and their supervisors at the levels of health centers and district hospital. The following factors emerged as categories that facilitate the community health workers to deliver maternal and child health services to their communities: liking their work, trust by the community, respect from the community, the willingness to help, desire to gain knowledge, being human, and sacrifice for wellness of community. On the other hand, participants in this study indicated that the work of community health workers has various barriers. Participants mentioned the following as barriers of serving as a community health worker: working many hours, lack of equipment, lack of knowledge, unsatisfactory salary, heavy workload, lack of working space, lack of facilitation for communication, poor attitude by some community members, family conflicts, lack of specified working time, and beliefs. The Ministry of Health and health partners should address the challenges of lack of equipment, low allowances, working for many hours, communication challenge, and appropriate places for delivering maternal and child health services.

Competing Interests

The authors have declared that no competing interests exist.

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