VSO and Community Health Volunteering: Position Paper

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1. Executive Summary

This Policy Briefing Paper aims to clarify VSO’s position on the volunteer element of community health provision and highlights VSO’s unique contribution in this area. The human resources for health crisis and the demands of the health Millennium Development Goals (MDGs) have highlighted and expanded the role and numbers of community volunteers in low income countries. The paper sets out VSO’s position on community health volunteering and the approaches needed for best practice implementation, while acknowledging that roles and activities are enormously diverse within and across countries.

The paper draws together existing VSO statements and experience in the field, with particular input from a recent survey of successful VSO CHV programmes (see country references in the text), as well as research and evidence from WHO and other global partner agencies. It comes at a time when the WHO Report 2006 found that sub-Saharan Africa has only 3% of the health workers and 24% of the burden of disease. The paper identifies the high potential for community health volunteering to address population health issues, whilst also highlighting structural and capacity issues which prevent full realization of that potential. A position paper such as this also has to cover differing views in different countries on topics such as remuneration and recognition of HIV and AIDS family carers.

For the purposes of the paper volunteer health workers are deemed to be volunteers who do not routinely receive a salary but may receive other benefits. The paper examines motivation, retention and attrition of volunteers. It emphasizes the vital importance of good management and support, and the need to integrate volunteer health workers within the national health system. The paper covers the role of national leadership and policy and the potential contribution of VSO at all these levels. The weaknesses that are identified are emblematic of the ‘fragile health systems and weak economies’\(^1\) of many low income countries and thus apply to the health system as a whole. It is also important to recognize that advocacy for sufficient trained and motivated health workers must proceed alongside these developments for a balanced health system, with community volunteers as “the bridge that links the rural and poor communities to health providers” (Bangladesh 2).

The primary focus of this paper is on primary care, while acknowledging that volunteers may play a role in hospital and be involved in task shifting, these issues will be addressed in another position paper. Similarly, the role of traditional healers and traditional birth attendants will be addressed in another paper.

There is much in the paper of relevance to national and youth volunteering programmes which address health challenges and it is recommended that these programmes are harmonized where appropriate.

This paper provides the rationale for a VSO global position on community health workers, with detailed approaches as part of that position. When this has been agreed at a corporate level, the next step will be to articulate VSO’s position as a short publication for external use in much the same manner as the HIV and AIDS series.

Much of the health work being carried out by VSO in a range of countries is inspiring and this summary concludes with the aims of Namibia’s National Policy on Community Based Health Care\(^2\), which is “to further empower communities

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1. WHO, Community Health Workers: What do we know about them, 2007
2. VSO Namibia, Summary of MOHSS’ policy and guidelines on Community Based Health Care and Standards on Home Based Care, 2008
to take charge of initiatives that will promote public health, reduce morbidity and mortality among children, adolescents and adults as well as to enhance community ownership of joint efforts and self-reliance in resource mobilization and problem solving. This policy initiative continues to be supported by VSO Namibia.

2. Purpose

The purpose of this paper is to set out VSO’s global position on the volunteer element of community health care provision. As a development agency whose prime contribution is working through volunteers, VSO is uniquely placed to contribute to the debate. The paper aims to identify VSO’s strategic approach to the use of community health volunteers, and to provide guidance on best practice. It draws on significant learning from VSO’s health, HIV and AIDS, disability and national volunteering programmes, as well as input from other international agencies working in the field.

3. Background

3.1 Definition

World health agencies have found it difficult to define community health volunteers due to the variety of practice in different countries.

The WHO report on human resources in 2006\(^3\) did not consider ‘volunteers as part of the workforce because of the difficulties it poses with regard to establishing the boundaries of what constitutes a health system.’ But its follow-up report specifically on community health volunteers in 2007\(^4\) says that ‘the umbrella term “community health worker” (CHW) embraces a variety of community health aides selected, trained and working in the communities from which they come.’

The recently adopted EU Resolution on ‘The role of volunteer activities in social policy’ has a definition that states that ‘volunteer activities’ may be formal or informal, but are undertaken of a person’s own free will and without concern for financial gain. Volunteer activities need to be clearly distinguished from paid employment and should by no means replace it.\(^5\)

VSO has similar definitions for national volunteers and youth volunteers, who contribute to a range of VSO interventions, including health.\(^6\) As a working definition for this paper, volunteer health workers are deemed to be volunteers who do not routinely receive a salary but may receive other benefits. The paper will use the term ‘community health volunteers’ throughout to clarify the position of these workers, whilst recognizing that different countries use different terminology and will continue to do so.

Potential categories for inclusion in the definition are community health workers (CHWs a frequently used term), village health workers, national volunteers, volunteers working in Faith Based Organisations (FBOs) and HSAs (health surveillance assistants).

The primary focus of this paper is on primary care, while acknowledging that volunteers may play a role in hospital and be involved in task shifting, these issues will be addressed in another position paper. Similarly, the role of traditional healers and traditional birth attendants is not touched on here, but will be the subject of another paper.

3.2 Health System Pressures

The health worker crisis, particularly in low income countries, has led to investment in community health volunteers as a way of increasing human resources and bringing services closer to the people. The efforts to reach the MDGs (Millennium Development Goals) in setting targets for national improvements in maternal and child health, and incidences of HIV AIDS, malaria and tuberculosis have added to the need for coverage, as has increasing population. Community health volunteering provides cost effective human resources for much of what is needed eg prevention, promotion and rehabilitation but it is not a panacea.

\(^4\) WHO, Community Health Workers: What do we know about them, 2007
\(^5\) EU Resolution, The Role of Voluntary Activities in Social Policy, 2011
\(^6\) VSO, Local Volunteering Responses to Health Care Challenges: Lessons from Malawi, Mongolia and the Philippines
There is widespread agreement that “the fundamental reason for poor health outcomes is fragile health systems and weak economies.” To create a fully functioning health system, many factors are involved which have an effect on the impact and sustainability of community health volunteering. These factors include national policy, (including the need for social protection that recognizes the contribution made by unpaid carers and volunteers), predictable resourcing at a reasonable level (from donors and government), management capacity at all levels down to the district and its health centres, sufficient numbers of professional staff valued and properly managed. Vision is needed as to what can be achieved with limited resources, which addresses all groups and geographical areas of the country, and which can be sustained from within the cultural norms of the people, to provide much of the resource with proper support and education. Within this context community health volunteers can be very valuable but they must sit within a strategic primary health care framework.

4. The Character of Community Health Volunteering

4.1 The Work of Community Health Volunteers

The roles and activities of community health volunteers are enormously diverse within and across countries and constantly expanding. They support three of the four primary care functions of prevention, promotion, cure and rehabilitation with only the curative function usually delivered by others.

The following gives just some examples drawn from the Namibian Policy on Community Based Health Care (2008): preventative care and health promotion on health education, hygiene and nutrition, immunization and prevention of mother to child transmission, treatment adherence, provision of emotional and psychological care, assist access to health and social services, support referrals to other agencies, support with activities of daily living.

In Bangladesh community health volunteers are being used by the VSO Environmental Health Advisor to improve community access to health services at times of flood and emergency situations. Different facets of volunteer health work are illustrated in the case studies in section 10.

In general VSO does not work directly with community health volunteers but with partners managing the volunteers. In Bangladesh, however, VSO is partnering directly with community organisations, with NGOs as resource partners.

4.2 Motivation, Retention and Attrition

Community health volunteers are often poor people drawn from their communities. Their motivation ranges from a genuine desire to help their community, a desire for self-advancement or attendance at training simply for the allowances. Most volunteers depend on subsistence farming to feed their families and are keenly aware of the ‘opportunity cost’ of attending training and carrying out health work for the community. ‘Motivation’ among the poor particularly translates as money and to a lesser degree benefits in kind, as we know from Maslow’s hierarchy of needs. Volunteers can be lost after training due to lack of motivation and support. Programme cost effectiveness is threatened by high attrition and the need to recruit and train replacements.

Many successful programmes use multiple incentives over time to keep CHVs motivated. In most VSO countries community volunteers receive no salary but receive allowances for training and transport, and some incentives in kind such as food, T-shirts and umbrellas. They may be paid when asked to help a particular national programme such as immunization (as evidenced by VSO programmes in Burkina Faso, Cambodia), in others motivation is centred around the opportunity to also access income generation projects (as evidenced by VSO Zimbabwe, and RAISA’s work with home based carers). All countries were clear that no-one should be further impoverished as a result of volunteering and many felt that remuneration should be higher.

Non-financial motivation measures such as good management and supervision are as key to retention as material motivation for an effective and sustainable community health programme. “Well trained and motivated CHVs are critical for delivery of many community-based newborn care interventions. High rates of CHV attrition undermine programme effectiveness and potential for implementation at scale.” (Bangladesh 1)

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7 WHO, Community Health Workers: What do we know about them?, 2007
8 VSO Namibia, Summary of MOHSS’ policy and guidelines on Community Based Health Care and Standards on Home Based Care, 2008
9 The Regional AIDS Initiative of Southern Africa, (RAISA)
Training must be of a good standard and fully equip the volunteer for what is expected of them. As an example “To be effective CHWs must gain mastery of a range of information and skills related to maternal and newborn care and know how to adopt counseling strategies to households with varying composition and needs.” (Bangladesh 1) The kit issued to community health volunteers must be relevant to the tasks assigned to them, with a good standard of replenishment for effectiveness in the field and as a mark of value for the care given.

Recognition of competencies and a clear career path would be the right way forward and maintain motivation.

Effective supervision and management is one of the most crucial, yet often most neglected, factors of CHV programmes. Unfortunately this is an area where delivery and capacity are often poor, which can all too often lead to attrition. It is very often the interface to the formal health system where support is lacking.

Small-scale projects are often successful because they manage to establish effective support and supervisory mechanisms for CHVs, often including a significant amount of supervision and oversight by the community itself. National programmes are rarely able to achieve this consistently, because supervision is not sufficiently costed or planned for and the greatest need for supervision exists in the most remote areas, where health services are most overstretched and ill-equipped.

4.3 Support within Health Systems

Many volunteers are managed and supported locally, in projects with only very loose links to the formal health system. Many are attached to their local health centre or village health committee, with varying degrees of support.

“Where strong community health programmes (Mongolia, Uganda and Malawi) have emerged one of the strengths has been the fact that the volunteers are linked in some way to the national health system and are increasingly seen as an essential component to improving community health outcomes. By being part of the Primary Healthcare Strategy the voices of community health volunteers are more likely to be heard, and volunteers are easier to access when local or national government is considering the development of pro-poor policies.” (VSO Programme Development Adviser - Health). This is also one of the key messages from the WHO/GHWA global consultation into community health workers which was to develop some key messages about planning, attraction, retention and performance management of community health volunteers. 10

Where community health volunteers are seen structurally as part of the national health system, they are most likely to receive structured supervision and training, with beneficial effects on motivation and retention.

“The community should not be left out of these networks. Village health committees if formed, strengthened and their capacity built, can play a key role in the supervision of CHWs and resource mobilisation.” (Kenya) In Nepal the village health committee is key to the structure whereby the volunteers are managed, providing “monthly supervision, resupply of consumables for first aid kits, advice and feedback.” (Nepal)

At its most effective community health volunteers’ work will be delivered in collaboration with partners in the local community (village and religious leaders) and with other sectors such as education and social care. Many NGOs, CBOs and FBOs actively complement the work of the government (see Tanzanian case study) and set up volunteer networks, particularly in poorer or more remote areas. These too need to interface to community and government organisations such as village health committees and the education sector to succeed eg in care of orphans.

4.4 National Policy and Volunteerism

The contribution of “volunteering can be strengthened if informal forms of volunteering are made visible in national policy and planning.”11 Countries may opt for a policy specifically on community based care (Namibia 2008) or a National Volunteering System (Burkina Faso 2007) within which community health volunteering sits as one manifestation of volunteering.

National policy is required to ensure that some of the important enabling factors, such as being part of the national health system and protection for volunteers, are agreed at national level. Where a country does not have a clear

10 WHO and GHWA, Integrating Community Health Workers in National Health Workforce Plans, Key Messages, 2010
11 VSO, Position Paper for UN General Assembly marking the tenth anniversary of the International Year of Volunteers, 2011
national policy on volunteerism VSO will lobby, with other agencies, for a policy to be formalized and agreed, for example as in Mozambique.

4.5 Regulation and Legal Status

A National Volunteering Law may be the first major step in recognizing the contribution of volunteers to the development process (Mozambique 2010). The law formalizes the involvement of the private sector, government employees and community members and defines accountability and responsibility. A National Volunteering Law may need to address existing legislation eg labour laws. In Mozambique a VSO volunteer is working with the national volunteering committee to support the rollout of legislation.

4.6 Social Protection

In recent years, social protection has emerged as a major focus in efforts to reduce poverty around the world. It can be understood as a set of public actions, which address income poverty and economic shocks, but also social vulnerability. Social protection can take the form of care grants, cash for food transfers, access to income generating activities, initiatives to promote access to services eg access to health care for grandmothers acting as carers, remission of school fees for children being cared for by grandmothers. Social protection is particularly relevant to recognition of the role of community health volunteers, and family members acting as carers for people with HIV and AIDS.

5 Benefits, Risks and Issues

VSO countries overwhelmingly felt that building community health volunteering was a valuable and sustainable initiative. The risks that VSO countries and global agencies identify are primarily about implementation of community health volunteering.

5.1 Benefits

Link between the formal health system and the community - “The CHVs are a bridge that links the rural and poor communities to health care providers.” (Bangladesh 2) “Results confirm that CHVs provide a critical link between their communities and the health and social services system.”

Contribution to improved population health – “The CHVs have made a major contribution to the achievement of the Health Sector in reducing under-five and maternal mortality” (Nepal). “Pit latrine and hand washing has increased and no cholera outbreaks have been reported in the last 2 years’ (Malawi, where volunteers work with HSAs (Health Surveillance Assistants). At country and global level, however, progress in child and health mortality and incidence of TB and malaria is very slow, being based on poor foundations in fragile health systems.

Cost effective and part of the solution to health worker shortages – The WHO 2007 report says that there is a dearth of information on the cost effectiveness of CHV programs, with only a few studies around TB and immunization. The same report notes that economic “analyses are insensitive to a range of social benefits (including community mobilization) which often constitute the strength of CHW programs.”

“I think in Burkina Faso, we have a lack of health workers (lack of nurses, midwives, doctors etc) so the government is obliged to use community health workers to reach all the population.” “There is an amount of evidence showing that CHVs can add significantly to the efforts of improving the health of the population, particularly in those settings with the highest shortage of motivated and capable health professionals.” (Mongolia and Zimbabwe).

Access to health care and addressing the health agenda – “They are a very key group in terms of health education and awareness activities and they complement where government is not able to reach.” (Burkina Faso). “In Ethiopia, the use of community health volunteers has been seen as a crucial link to bring down essential healthcare packages to grass root level.” “CHVs are key in areas where the government is thinly spread. A village clinic has one government staff member, if the community was to depend on this, they would never access the services.” (Kenya)

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12 VSO, Advocating the Passage of a National Volunteering Law, Mozambique, 2011
14 WHO and GHWA, Global Experience of Community Health Workers for Delivery of Health Related MDGs, 2010
15 WHO and GHWA, Global Experience of Community Health Workers for Delivery of Health Related MDGs, 2010
16 WHO, Community Health Workers: what do we know about them?, 2007
Community Empowerment – A community volunteering programme “develops community cohesion and this can develop into a stronger voice from the community members because they share the same issues and concerns.” (Cambodia 2) In Rwanda significant improvements in maternal health have been built on national policy and community empowerment. 17

Role for Youth – Volunteering is a good way to develop future citizens and for them to obtain some training for future advancement.” In VSO Bahaginan in the Philippines national youth volunteers worked alongside health workers to raise awareness of TB and to encourage greater take-up of treatment, “which helped to ensure that messages were accessible to other young people.”18 “VSO Bangladesh is encouraging its youth club members with knowledge on primary care issues to provide information to community people as part of national volunteering.” (Bangladesh 1)

5.2 Risks

Exploitation - “It is not appropriate to place unreasonable levels of health service provision on untrained and unsupported volunteers.” (VSO Programme Development Adviser - Health) “Programmes that are delivered through CHV should recognize their participation, at the same time governments must be pushed to train and post adequate health workers.” (Kenya)

Lack of management and resources – “I know that URC (University Research Council) are withdrawing their direct support for malaria volunteers in Anlong Veng, and they know that the work will not continue to anywhere near the same standard .. I assume it is simply funding issues that they are withdrawing their support.” ((Cambodia 1) The WHO Community report notes that “Large scale CHW systems require substantial increases in support for training, management, supervision and logistics.” 19

Community ownership – Volunteers can suffer from lack of clarity on their role and expectations (preventive v curative care). The WHO report on community workers states that “by their very nature CHW programmes are vulnerable unless they are driven, owned by and firmly embedded in the communities themselves. Where this is not the case, they exist on the geographical and organizational periphery of the formal health system, exposed to the moods of policy swings without the wherewithal to lobby and advocate their cause, and thus are often fragile and unsustainable.”20

Overuse of Volunteers “The volunteering spirit is at threat these days in Nepal as many agencies with to implement their intervention through FCHVs and that might be detrimental to the voluntary nature of their service and raise unnecessary expectation.” “In parts of Cambodia the health volunteers may also be community representatives for land, fishery and education .. we must make sure that they are not expected to do more than is possible.” (Cambodia 1) In health the role of the CHVs may be expanded beyond their time and capability.

Relying on community health volunteers for community mobilization - Several sources point out that for best results the community needs first to be mobilized (Rwanda).21 “Evidence suggests that CHW programmes thrive in in mobilized communities but struggle where they are given the responsibility of galvanizing and mobilizing communities.” 22

5.3 Issues

Undermining of professional health workers – In Tanzania there was some opposition to the skilling up of community health volunteers in case they disadvantaged professional staff; however, other countries such as Bangladesh saw them as a “bridge that links poor and rural communities to health care providers and can in no way replace the professional health workers.” Ultimately national policy will determine the approach taken by each country.

Remuneration – the question of whether CHVs should be volunteers or remunerated in some form remains controversial. While volunteers may only spend some of their time on their duties, communities may demand full time performance. There are also issues around those caring for family members and not the wider community. In the HIV and AIDS context VSO recognises the burden of care on women and girls and feels that they should be recompensed by

17 ODI, Policy Brief, Improving Maternal Health when resources are limited: Safe Motherhood in Rural Rwanda, 2012
18 VSO, VSO and Youth, 2012
19 WHO, Community Health Workers: what do we know about them?, 2007
20 WHO Community Health Workers: what do we know about them?, 2007
21 ODI, Policy Brief, Improving Maternal Health when resources are limited: Safe Motherhood in Rural Rwanda, 2012
22 WHO Community Report, 2007
the state. The issue thereafter is whether such a social protection system can be afforded. The WHO/GHWA study 2010 makes a strong case for a range of incentives for CHVs but falls short of promoting financial incentives, arguing that donor funding is unsustainable in the long run and that government financing is not yet sufficient to fill the gap. A first step on a career path for volunteer care givers is the introduction of stipends either by NGOs or by the government, as in South Africa. To develop community volunteering at scale countries have to answer questions such as affordability and density of CHVs in the country. Paid CHV programmes are working at scale in Ethiopia, Malawi and Rwanda, whereas volunteers with incentives operate at scale in Nepal and (just beginning) Uganda. Different countries must be able to adopt a system that suits with their national policies and preferences.

*Gender Sensitivities* – HIV and AIDS work in RAISA countries tries to get men to take more of the burden of care. In some cultures, however, this is not considered appropriate at present. In Nepal, for instance, as in Pakistan ‘lady workers’ are needed for female patients.

6 **Enabling Conditions for Best Practice**

Enabling conditions include:

* A Primary Healthcare Strategy – which addresses the four fundamentals of prevention, promotion, cure and rehabilitation to cover all sectors of the population and how their needs are to be met. The role of community health volunteers should be set down as complementing the formal health system and the interface between the two made clear.

* National Policy on Community Health Volunteering – either based on community health or volunteering in general. Policy will require some support from law as in Mozambique, where a supportive environment is provided for HIV and AIDS volunteers amongst others.

* Policy coherence - which helps to establish clear lines of authority, between the different agencies responsible for implementation. This Policy should be coherent from the top down, with mutually reinforcing national and local development policies, thus enabling accountability.

* Coordination of partner activity at national and local level – aligning donors, civil society and multiple projects behind the national plan for health care development. Health policy should be designed in country, in accordance with good practice as in the Aid Effectiveness Principles agreed in Paris, and subsequently in Busan.

* Support of local community – Villager leaders and other opinion formers should be included in planning and implementation of community health volunteer programmes. Community Health Committees should be set up if not already existing, as part of the supportive structure validating and supporting the work of CHVs. These structures should be designed to strengthen health outcomes and be supportive of citizen participation and behavior change eg use of family planning.

* Adequate training and clear guidelines on titles and roles – that “CHVs are properly managed, trained and provided with ongoing support by their associated health centre and government department. (Cambodia 1) There should be clarity as what work they are doing, who they should report to and what they are entitled to.

* Sufficient numbers of health workers – building up of a community health volunteering service must be accompanied by sufficient numbers of professional staff being recruited and posted to the areas served by the volunteers; this will contribute to onward referral to the health system as a whole.

8 **VSO’s Position**

VSO strongly supports community health volunteering as a strategy for enabling access to quality healthcare for all groups, particularly the poor and marginalized. It is fully in alignment with People First and the increasing emphasis on volunteering within countries to address social and economic goals.

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24 WHO/GHWA, Will we Achieve universal access to HIV/AIDS services within the health workforce we have?, 2010
Community health volunteering is one way of addressing the HRH crisis, but it is not a panacea. VSO and partner organisations will continue to advocate for increased numbers of skilled and motivated professional health workers, equitably distributed throughout the country.

VSOs’ approach will be flexible and responsive to the country context and will adopt the following approaches, depending on the current situation and as part of a continuum of progress:

**National Level**

VSO believes that good programmes should:

*Strategy* - support governments in taking responsibility for community health volunteering, as part of the national health system. Ensure the support of the Ministry of Health for a sustainable and meaningful community health volunteer programme. Provide support in developing a holistic strategy, which covers all levels of implementation. Alternatively start with a pilot and provide evidence of impact for further replication.

*National policy* – work with the government on its policy towards volunteering, either in general or specifically on community health volunteering. Work with the government to identify a social protection policy. Identify changes to the law that may need to be made to support the policy. Support policy with an implementation plan and standards for recruitment, training and supervision.

*Part of national health system* – formally include community health volunteers as part of the outreach to the whole population, managed at district and local health centre level. This should include 2-way referral to hospital facilities and back into the community from the hospital eg for rehabilitation or palliative care. Staff at district and local health centre level should be trained to properly value and manage the volunteers.

*Part of a Primary Healthcare Strategy* – community health volunteering is at its best within a Primary Healthcare Strategy. There should be targets for specific outcomes and measures and structures put in place for their achievement and sustainability. Primary Care should be the prime focus of the country’s health system as the means of improving the nation’s health.

*Tailor the service to the country* – take account of the local context of each country to build on strengths and identify gaps, to feed into the specifics of each country’s approach to community health volunteering and its implementation, and its approach to sustainability and remuneration.

*Build on grass roots research for good practice* – carry out research with front line health workers and users to identify opportunities for improvement and best practice, as in the VSO Valuing Health Workers programme. Use this evidence base to develop national policy on community health volunteering.

*Work strategically with government* – work with the existing government structure from top to grass root level to enhance VSO’s visibility and programme acceptability both by government and big donors. Draw different level intervention activities (community, service, policy) together in an holistic way and thus bring impact.

**Local Level**

VSO believes that good practice is to:

*Combine top-down and local participation* – provide national leadership, policy and structure to include institutionalizing and mainstreaming community participation and ownership. Address community mobilization as part of the enabling environment for community health volunteers.

*Make best use of existing infrastructure* – build on existing institutions at village level and make best use of national and local customs, which support the ethos of community volunteering and input by the community. Work with district health officers and use local government links to other sectors eg education and social care.

*Involve village health committees* – as a key part of the structure validating the work of the volunteers in the community. Harness their reach into the community and their position as the lowest tier of local government.
Collaborate widely with partners and other sectors – co-opt opinion formers such as village and religious leaders, provide them with education for a leadership role in support of behaviour change and the volunteers. Ensure good links with other sectors such as education and social services for all round improvements in population health.

Resources

VSO believes that it is good practice to:

Plan for resources – acknowledge that large scale programmes take significant resource to be properly implemented. Identify what needs to be done and how. Encourage the government to progress towards allocating 15% of the national budget to health improvement (Abuja declaration).

Make best use of limited resources – follow the example of Rwanda in achieving a lot with a little (where impressive progress has been made in maternal health, by a combination of policy coherence and strong use of existing culture and institutions at local level). Work towards simplicity and innovation; be creative in using existing institutions and customs. Plan for sustainability within the community for when NGO or government start-up funds cease.

Volunteer Support

VSO believes that good programmes should:

Recognise the value of community volunteers- plan carefully for implementation of policy. Ensure that proper structures are in place at all levels to train and support health service staff in valuing volunteers.

Clearly define volunteer roles and responsibilities – volunteers should understand from the beginning that they are volunteers and not workers. They should be protected, however, by agreed conditions, incentives and ongoing support. They should be accountable for the work they have undertaken to do, to a supervisor linked to the formal health system. Their role should not be expanded ad infinitum; they should not be overworked.

Provide good training and support –. Community health volunteers should receive quality training appropriate to their role, with regular refresher training, as well as ongoing supervision. Utilise national standards where available and define clear strategies and procedures for training and supervision at the outset of the programme.

Recognition of competencies – the scheme should set standards of work, and performance manage volunteers accordingly. There should be accreditation of skills and experience, either through local certificate or accreditation through a national scheme. There should be provision for a career structure.

Support family carers – home based carers looking after family members are entitled to training, health kits and recompense for lost earnings. Where possible this should be enshrined in a country’s social protection policy.

Support gender free volunteering while recognizing cultural preferences – promote volunteering by men and women, especially in non-traditional roles eg home based care of PLHA. Where cultural preferences are strong align services and volunteering accordingly to ensure uptake and access to services.

VSO Support

VSO believes that VSO International and Programme Offices should:

Add value with policy, management and support – VSO will work at all levels to enhance VSO visibility with government and big donors. Prime contributions will be on strategy and policy, and soundly based management and support for volunteers.

Select good partners – from civil society and NGOs, who share VSO’s values and support VSO’s position on working with community health volunteers. Choose partners who can add leverage to overall impact.

Pursue incremental implementation – and build on interest from country offices that see potential in having a strong community element in their health programme.

25 ODI, Improving Maternal Health when Resources are Limited: Safe Motherhood in Rwanda, 2011
Use Monitoring and Evaluation – to review and develop programmes and in particular to provide feedback to stakeholders on success and impacts. Provide evidence to government for wider replication of pilots within the country as a whole.

Advocate in support of valuing community health volunteers – include an advocacy element wherever VSO works eg in government, civil society organizations and local health services to ensure that the volunteers are valued, adequately supported and suitably remunerated for the work they do. Tailor advocacy to the continuum of progress in any one country.

Bring the full value of VSO to bear – by sharing experience with other countries, which are further along the continuum of a community health service supported by volunteers. Use policies, structures and approaches from similar countries as a starting point.

Harmonise programmes with national and youth volunteering – in support of population wide improvements in health. Take a strategic approach country wide to the different levels of intervention to bring maximum added value to community health programmes. Use national volunteers at different levels to assist implementation of plans.

9 Strategic Direction and Global Advocacy

Within VSO community health volunteering will maintain and extend its links with other forms of community volunteering such as youth volunteering and national volunteering. It will contribute to VSO’s global stance on volunteering and initiatives such as ‘Valuing Volunteering’, a major piece of research with partners which aims to look critically at how volunteering impacts on poverty.

VSO will continue to work with other global agencies for increased numbers of trained health workers through partnerships and consortia such as Action for Global Health, the Health Workforce Advocacy Initiative and United Nations Volunteers. This is a way of bringing maximum voice to bear on the crucial issue of human resources for health and forming opinion. This work takes place at global level eg the United Nations General Assembly and other global and regional forums, with a view to influencing national decision makers and other stakeholders such as donors. The focus is increasingly coming to bear on national health plans, behind which everyone can align and which will include community health volunteers as part of the response to health system challenges.

10 Next Steps

This paper provides the rationale for a VSO global position on community health workers, with detailed approaches as part of that position. When this has been agreed at a corporate level, the next step will be to articulate VSO’s position as a short publication for Programme Offices and external audiences in much the same way as the HIV and AIDS series.

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Sri Lanka – Chandima Kulathunge, Programme Manager, Mental Health
Zimbabwe – Samuel Nyikahadzoi, National Volunteering and Education Programme Manager.

Malawi, Mozambique, Rwanda and Tanzania input came from VSO publications.

Input and review were received from Policy, Advocacy and National Volunteering.
Appendix  VSO Case Studies

Preventive Health, Malawi

Village health committees have encouraged community initiatives in water and sanitation, maternal health and HIV and AIDS in 4 pilot districts of Mwanza, Nsanje, Ntcheu and Rumphi. The VHC are composed of 10 volunteers, 5 men and 5 women supported on a zonal basis by the Health Surveillance Assistants attached to the hospital and linked to the district environmental health department. VSO health prevention and management teams worked in the four districts, and liaised with the Ministry of Health on VHC training and reporting.

At community level the project working from Mwanza Hospital carried out a primary health care survey, education and leadership training for VHCS, held inter-household competitions and initiated model villages. Training and support for HSAs has been an important part of the support network. HSAs reside within their catchment area and the combined team effort has resulted in an increase in pit latrines and hand washing, more deliveries in hospital and in particular – no cholera outbreak for the last two years.

Community Care and Education, Tanzania

Community health volunteers in Ndanda, Mtwara region carry out home based care, support of orphans and prevention of HIV and AIDS for 22,000 people in 6 villages.

Set up by a VSO volunteer working with the parish, the hospital and the village leaders it was quickly decided to extend home based care to all long term conditions eg heart disease which lessened stigma and extended the beneficiaries. Village leaders nominated 2 volunteers per kitongoji, a village sub-unit. 64 volunteers, half men half women, half Moslem half Christian came to the launch of the programme on Worlds AIDS Day. They receive monthly refresher training, supported by two nurses trained in HBC and HIV and AIDS counselling. There is regular supervision in the villages and reporting to the village leaders, as well as liaison with the District Health Officer.

Volunteers expressing a particular interest in working with children were selected from the Home Based Care volunteers to work with orphans or Most Vulnerable Children. Based on individual assessment and progress tracking the children are provided with shelter, nutrition, health and particularly support to go to school and in some cases further education.

Volunteer peer educators have set up weekly health clubs in the primary schools which address HIV and AIDS and life skills, and Stepping Stones behaviour change courses for secondary schools and villages. Working together with the hospital, village events over a wide area provide testing and information and awareness through drama.

“The people have been helped to help themselves.” Parish priest

Strengthening Primary Health Care in Mongolia

Mongolia is comprised of an area of high steppe so low income families have to cope with low temperatures and a cold dusty environment. The national health system faces constraints both in the number of health workers and the infrastructure available. Faced with these challenges the health ministry is encouraging new thinking and pilot projects to find more effective ways of using resources.

The Chingeltei District Health Unit engaged 2 VSO international volunteers to improve primary health care through the district’s family group practice clinics in 18 sub-districts or khoroo. It was agreed to establish a model khoroo in an area with a high proportion of impoverished residents, a large geographic area and a poor infrastructure. In a new venture the health system has begun to work with volunteers to help deliver basic primary health care and prevention services. A social worker trains volunteers to promote proper nutrition, physical fitness, home care for the aged and disabled, and avoidance of risky behaviours. Project coordinators meet volunteers on a monthly basis to assess their performance.

Some CHVs have basic equipment such as a blood pressure monitor, so that patients do not need to leave their homes; an important facet of their work is being able to refer patients correctly to doctors when necessary. Others concentrate on health promotion activities, using key messages and puppet shows. The project has been replicated in three other districts. Results include reduced incidence of certain diseases, increase in attendance at local clinics, increase in value attached to CHVs by health professionals, increased government recognition of the value of CHVs.