Working with volunteers

to improve maternal, newborn and child health

Key messages: **Volunteering is a valuable asset, putting local knowledge, skills, dynamism, creativity and a concern for others to good use.**

1. Well designed and managed community volunteer programmes can be effective and sustainable, with benefits that extend beyond the health sector.
2. Programmes that help volunteers to address the social determinants of health complement health services and medically trained health providers. The concept of a 'community health team' is gaining traction in Northern Nigeria.
3. Finding the best ways to reward community volunteers is vital in high poverty contexts. Communal rather than individual incentives may protect the volunteer effort and provide an alternative to putting volunteers on salary.

Context and challenge: community volunteerism faces many barriers

Volunteer health programmes are promising because they are grounded in relationships of trust, solidarity and reciprocity at community level. Nigeria has a long and impressive track record of health-related volunteers, where ordinary people willingly give their time to help others. Volunteering is a valuable asset, providing a means to put local knowledge, skills, dynamism, creativity and a concern for others to good use. But for volunteer programmes to work effectively, particularly on a large scale, they need to be well designed and carefully managed. (Ludwick et al, 2013; Bhattacharyya et al, 2001). [1,3]

The UK aid and Norwegian government-funded Programme for Reviving Routine Immunisation and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) has since 2008 supported one of the largest and longest-lasting community health volunteer initiatives in Northern Nigeria covering three states (Katsina, Yobe and Zamfara). This document describes the work of the volunteers and the impact they had in the PRRINN-MNCH states and considers whether some common concerns about volunteer programmes – high drop-out rates, high opportunity costs, and poor motivation – apply there.

At the start of the PRRINN-MNCH programme, many barriers prevented communities using MNCH services. These included:

- Lack of awareness of newborn and maternal danger signs
- Families unprepared for safe pregnancy and delivery
- Lack of information on routine immunisation services and motivation to use them
- In some places opposition to immunisation from husbands and religious leaders
- Lack of male involvement in women's health
- Deep-seated concerns about the quality of care at health facilities
- Physical and financial access barriers which delayed the response to maternal emergencies

Routine immunisation rates were low; institutional delivery rates were extremely low; and frequent failures to respond to maternal health emergencies resulted in high maternal and newborn death rates.

The response: training volunteers to help themselves and raise community awareness

Between 2010 and 2013 PRRINN-MNCH and its government partners trained 30 community health volunteers per community in 806 intervention

THIS DOCUMENT IS ONE OF A SERIES OF TECHNICAL BRIEFS THAT DRAW ON THE ACTIVITIES, RESULTS AND LESSONS LEARNED FROM THE PRRINN-MNCH PROGRAMME

sites in 45 local government areas in Katsina, Yobe and Zamfara states. The volunteers were trained to build social approval within the community for MNCH-related behaviour change. This primarily involved:

- Raising awareness of maternal, newborn and child health and routine immunisation
- Support for the establishment of community systems to make care more accessible and affordable
- Setting up community monitoring systems so communities could track changes in their area.

The training used simple participatory methods and tools to help volunteers learn key facts and train others in an engaging way. It was supported by a structured programme of coaching and mentoring support so the volunteers could apply what they had learnt, and to help maintain their motivation. Approximately 24,000 community health volunteers were trained over three years.

The volunteers focused initially on the MNCH situation in their own communities. Participatory community discussion groups allowed ordinary people to reflect on the challenges they faced and consider what could be done to improve women's and children's health. With the help and encouragement of the volunteers, many communities went on to establish community systems to address the key barriers that they faced in accessing services. These included:

- Community emergency transport schemes
- Blood donor schemes
- Emergency savings schemes
- A system of mother's helpers

These systems enabled pregnant women with a complication to access health services without delay, so the volunteers quickly saw the positive impact of their work. Motivated by a new-found confidence that they really could make a difference, some of the volunteers went on to share what they knew with neighbouring communities, increasing the total number of intervention sites reached in Katsina, Yobe and Zamfara to 2,398.

Communities supported by community health volunteers increased by 200% in two years at no cost to PRRINN-MNCH and its government partners.

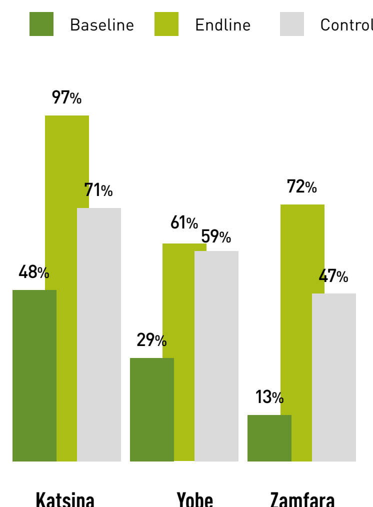
PRRINN-MNCH and its government partners also trained volunteer drivers from the National Union of Road Transport Workers (NURTW) to establish a community-based Emergency Transport Scheme (ETS). This provided 24-hour emergency transport cover at the lowest possible cost. The service was vital in a context where few alternative transport options existed for rural communities. Training of 3,200 drivers in Katsina, Yobe and Zamfara states focused on:

- The 'three delays' that prevented women from reaching care quickly: delay in seeking care; delay in reaching care; delay in receiving appropriate care at the health facility
- How the ETS worked
- Appropriate handling of pregnant women and their carers
- Communicating with health providers
- How to report on ETS activity

Once trained, these drivers went on to train other drivers in their own and neighbouring communities.

NURTW drivers who trained as emergency drivers went on to train many additional drivers who all gave up their time to save women's lives.

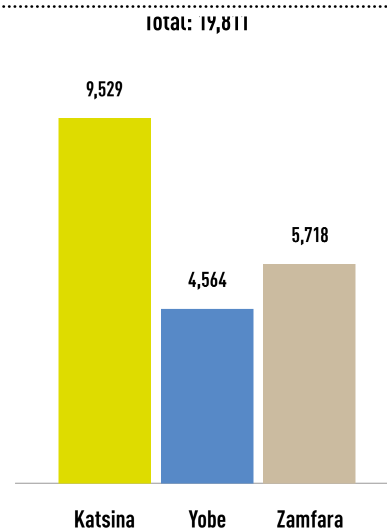
Fig 1: Women with plan for maternal emergency (current/recent pregnancy)



Source: PRRINN-MNCH KAP surveys (PRRINN-MNCH, 2013a)

More women are now making plans in case they suffer a maternal emergency.

Fig 2: ETS transfers Dec 2009 - Sep 2013



Source: PRRINN-MNCH community monitoring system data 2013b

The increase in transfers by volunteer drivers helped avert many potential maternal deaths.

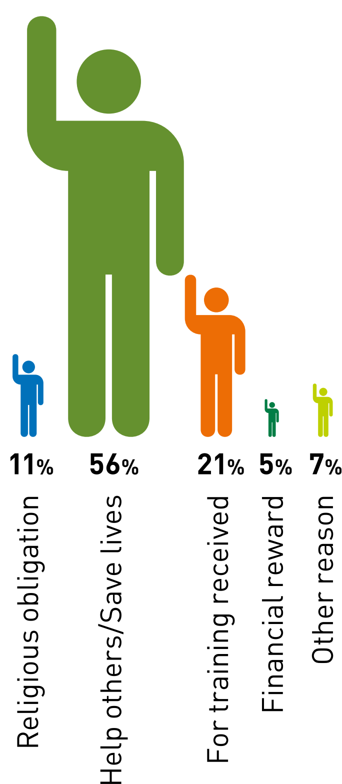
Fig 3: Percentage of children never immunised

Source: PRRINN-MNCH KAP surveys (PRRINN-MNCH 2013a)

	Baseline	Endline
Katsina	75	33
Yobe	80	48
Zamfara	83	37

Increased skilled birth attendance rates have led to a dramatic fall in children who have never been immunised.

Fig 4: The main motivation for volunteering



Results: communities are better prepared for issues in pregnancy

Significant positive changes in health-seeking behaviour happened as a result of the work of community health volunteers. A knowledge, attitudes and practices (KAP) baseline survey in Katsina, Yobe and Zamfara in 2011 and followed up in 2013 (endline) found that communities were now far better prepared for a maternal emergency (Fig 1).

Between December 2009 and September 2013, 19,811 ETS transfers were recorded by the community monitoring systems in the three states. Most were women with a maternal complication. The volunteer drivers therefore helped to avert many potential maternal deaths (Fig 2).

A household survey by PRRINN-MNCH in 2013 (following a baseline survey in 2009) found that skilled birth attendance rates increased from 11% to 24% in Katsina, Yobe and Zamfara states. There were also dramatic falls in the proportion of children who had never been immunised (Fig 3).

Implications for policy: volunteers can promote self-help within communities

Some critiques of volunteer community health worker approaches suggest they are incompatible with the drive to professionalise the health workforce. However, initial baseline assessments highlighted the many barriers that prevent women and their families using essential MNCH services – and the need for solutions that extend beyond improved service delivery.

Salaried community health worker schemes often fail to stimulate the necessary changes in MNCH social norms since they usually rely on a single trained health worker per community. Where health budgets are severely constrained, training a larger group of community health workers is usually not feasible.

PRRINN-MNCH research found that communities with active community health volunteers and ETS drivers improved some newborn and child health indicators just as much as communities with both volunteers and community-based service delivery.[2]

Other critiques claim it is wrong to treat community members as cheap labour that is used to fill gaps in service provision. In the PRRINN-MNCH intervention sites the community activities were designed to reignite the concept of self-help. Far from being an 'instrument' of the health system, community health volunteers focused

on building capacity and confidence so each community could devise their own strategies to address MNCH challenges. It was expected that this would lead to sustainable changes in social norms and behaviours.

Sustaining payments to lay community health workers may not be possible for governments operating with constrained health budgets.

Positive changes in health-seeking behaviour inspired by PRRINN-MNCH volunteers confirm that the volunteer model is both appropriate and effective. But if the approach is to be scaled up further in Nigeria, it is important to examine three key issues:

- What motivated the volunteers to work so hard in support of their communities?
- What aspects of the volunteer approach contributed to its effectiveness?
- What are the prospects for sustaining the work of the volunteers in the long-term, particularly beyond the end of an externally funded programme?

A 2012 study in Katsina, Yobe and Zamfara answered the question of motivation and gave some insights into the others (Fig 4). More than half the community health volunteers and ETS drivers were primarily motivated by a concern to help others and save lives (55% and 56% respectively).

The second most important motivating factor was the training that the volunteers received from PRRINN-MNCH and its partners at state and LGA levels (24% and 19% respectively). A further 12% of ETS drivers and 10% of community health volunteers said they were motivated by religious obligation. Very few volunteers mentioned financial incentives as their main motivation for joining the programme.

Voices of community volunteers in the PRRINN-MNCH states

"I stick to the programme because of the training I received. The training has shown that I have something to share with my community; also, I am encouraged by the appreciation shown by the community. Our work has spread to neighbouring villages. Helping the community is the most important thing to me because I have seen that the community complies. They go for routine immunisation and that makes me very happy."

"I will work as a volunteer forever. Apart from sickness or if I travel out of the community."

"I will continue to be a volunteer until the end of my life."

"Volunteerism is good and God rewards good."

"Day and night, I am always willing to do my work."

"The training has impacted on my personal life. My children are immunised, and I educate my passengers on the importance of antenatal care, routine immunisation and the maternal danger signs."

The volunteer research also looked at how much time was spent by volunteers on MNCH-related activities. Just over 65% of the community health volunteers spent two hours or less per week – many argued that they could easily fit their volunteering obligations around their other activities.

However 66% of the ETS drivers, spent two hours or more per week on voluntary work. Most of them also argued that they were fully prepared to fit their voluntary work around their other activities.

Another criticism of volunteer community health approaches is that they suffer high attrition rates and hence their effectiveness may be short-lived. But research found the opposite, with markedly low attrition rates: 1.5% in Zamfara, 0.3% in Katsina, and 14% in Yobe.

In all three cases the volunteers had been working for 2-2.5 years. The higher attrition rate in Yobe is not unexpected considering the high level of insecurity in this state which has had a devastating effect on volunteers' ability to move around their communities, and which has undermined local livelihoods.

Depending on the state, between 96% and 100% of volunteers said they intended to continue their voluntary work. This bodes well for the future sustainability of volunteer activities. It may be that an early emphasis on the voluntary nature of the work helped to sift out individuals who might have been more motivated by financial gain.

In all the states, research identified that individuals who "live from hand to mouth" – casual workers, including those who had to travel to find work – were unlikely to be able to volunteer.

Several factors contributed to the effectiveness of the volunteer approach, including:

Quick, visible impact: Community mobilisation began with a focus on safe motherhood. This is a very emotive issue and the results of community mobilisation efforts were usually visible immediately as maternal delays were addressed leading to fewer deaths of mothers and newborns. These quick impacts acted as a major stimulus for the community volunteers to continue their work.

For many volunteers, quick and highly visible results including lives saved were major motivating factors.

Strong emphasis on volunteerism: The volunteer selection process and later, the volunteer training, placed considerable emphasis on the fact that the work was purely voluntary and that volunteers were working for the betterment of their own communities. Hence individuals motivated primarily by the prospect of financial gain were filtered out early in the process.

Emphasis on self-help: The approach placed significant emphasis on communities working together to identify solutions using their own energy and resources. The idea of 'self-help' was strongly promoted, encouraging communities to think of volunteering as a worthwhile and valuable activity rather than something that had been imposed from outside.

Time-bound inputs: Volunteers were required for a small number of hours per week and the initial period of intensive activity, when community discussion groups were rolled out across the community, was relatively short (about 12 months). Once the discussion groups had ended, subsequent volunteer activities could be flexible and not particularly time intensive. This approach differs from some other schemes where volunteers are expected to continue working at an intensive pace indefinitely.

Mentoring and coaching support: A system of ongoing mentoring and coaching support, intensive at first and becoming lighter over time, helped to maintain volunteer motivation. Mentoring and coaching teams helped to troubleshoot implementation problems, allowing the volunteers to avoid downturns in activity, and provided supportive feedback and encouragement. Research highlighted that volunteers considered this external support to be crucial.

Many volunteers said that after their initial coaching, an occasional visit by external officials (local government health department or NURTW) was all that was needed to encourage them to continue.

Community recognition: Communities were encouraged to recognise and reward the volunteers and ETS drivers for their efforts. Public recognition can be a major motivator, while informal recognition and respect can have the same effect. Many volunteers said the respect they received from other members of the community encouraged them to keep working.

Mutual support: With a large number of volunteers in every community, they could always rely on other volunteers for support and encouragement. This mutual support system is vital to the long-term sustainability of volunteer efforts, reducing reliance on external systems.

Although deeply committed to their voluntary work, many undertook these activities in a context of wide and deep poverty. They were aware that improved maternal, newborn and child health helped reduce household expenditure, and cited this as an impetus to do their work. Yet thoughts on how to sustain and support their families were never far from their minds, with some volunteers requesting further support from the programme to establish income-generation and similar activities.

For some of the ETS drivers, occasional failures to reimburse petrol costs

caused them to request support so they did not have to subsidise the scheme from their own pocket. Claims for additional (usually financial) incentives can quickly escalate when volunteers feel under-supported and under-appreciated. PRRINN-MNCH demonstrated that effective management and support of volunteers can help to manage these concerns.

In recognition of the financial hardships faced by many of the volunteers, PRRINN-MNCH is currently testing whether a social fund, which provides a group incentive in the form of a cash transfer, will help to maintain

volunteer motivation in the long-term. In contrast to the individual payments in salaried community health worker schemes, the social fund provides an incentive to a group of community health volunteers. The volunteers are encouraged to establish revolving funds or income generation activities and to use the proceeds to put the community emergency MNCH response systems on a sustainable footing.

The social fund can also provide non-monetary 'rewards' for community volunteers (eg a community celebration in support of volunteers or prizes/ certification for high-achieving volunteers). The aim of the fund is to determine whether alternative methods of rewarding volunteers other than salaries have a positive impact on volunteer motivation and retention in a high poverty context.

The PRRINN-MNCH social fund pilot is at an early stage but a similar scheme implemented in Zambia as part of the UK aid-funded Mobilising Access to Maternal Health Services in Zambia Programme, had a positive effect on volunteer motivation (MAMaZ, 2013).[4] Schemes like this may provide a solution for governments that cannot afford to pay lay community health workers.

Conclusion

PRRINN-MNCH and its government partners found that volunteer schemes work well if well designed and appropriately supported. They can generate positive changes at community level that extend beyond improvements in health, by building social capital and cohesion and by empowering individual volunteers with the capacity and confidence to apply their training in other areas of their life.

The work of community health volunteers and ETS drivers extended beyond the usual medical and health education duties of salaried community health workers and addressed the social determinants of health (the conditions in which people are born, grow, live, work and age). It is important for health policy-makers and planners to think in terms of the complementary roles that can be played by community health volunteers and salaried community-based health workers.

The concept of a 'community health team' is gaining traction in the PRRINN-MNCH states.

A key question is whether volunteer health worker schemes can be sustained beyond the end of externally funded programmes. In the PRRINN-MNCH states, supervision of facility-based front-line health workers is often irregular unless external funds are provided for fuel and other costs.

Unless state and local governments begin to budget appropriately for monitoring and supervisory support, ongoing supervision of and support for volunteer health worker schemes will be impossible.

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Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

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