Members of the programme team who had worked in other parts of Africa had seen first-hand that volunteer community health worker (VCHW) approaches could be both effective and sustainable if well-designed. A further consideration was how affordable a community-based maternal and newborn health initiative would be for government if a large budget was needed for salaries. Hence a decision was made to move ahead with a volunteer model, but to monitor some issues very closely, namely: volunteer motivation; the amount of time the volunteers spent on their activities; volunteer drop-out rates; and the prospects for sustaining the volunteer effort. These had all been cited as weaknesses of VCHW approaches.

MAMaZ worked with district partners to test how to generate sustainable demand for maternal and newborn health services in six rural districts. The programme was a whole was implemented in support of the Ministry of Community Development and Mother and Child Health’s (MCDMCH) Safe Motherhood Action Group (SMAG) initiative.

Community volunteers (called ‘Mama SMAGs’) were trained by the programme to facilitate a community mobilisation process with the aim of creating social approval within the community for positive behaviour change. The community engagement approach involved awareness-raising on essential aspects of maternal and newborn health, support for the establishment of community systems to tackle barriers of access and affordability, and the introduction of a community monitoring system which allowed participating communities to track the changes that were underway. Riders associated with a community-based emergency transport system comprised a second group of volunteers. In total, over 3,000 volunteers were trained by MAMaZ and its district partners in 289 intervention sites across six districts.
DEBATES ABOUT VCHWS IN THE LITERATURE

In recent years, there has been a renewed interest in community health worker programmes. This is partly because of the ongoing human resources crisis facing many low-income countries, and partly because of the growing evidence that these programmes can be very effective in certain contexts. VCHWs have been supported to play a vital bridging role between health facilities and the communities they serve; to create demand at community level for essential, including life-saving, health services; to increase awareness of preventive health care; and in some cases to administer basic first aid and provide other basic services, such as for malaria, family planning, or maternal and child health.

However, attitudes towards VCHW programmes vary considerably. VCHW models have been criticised for treating the volunteers as a large pool of ‘free resources’ which can be harnessed in support of the achievement of national health targets. Critics of this approach find this approach utilitarian and argue that it is wrong to treat VCHWs as cheap labour. Others argue that salaried CHW models are simply unaffordable to most low-income countries in a context where health budgets are under severe pressure. High volunteer attrition (drop-out) rates reported in some programmes are another concern, and are considered incompatible with the need to create sustainable models of health service delivery.

Other perspectives about VCHWs are more positive. Some point out the many non-financial benefits to be derived by the volunteers, and the way in which volunteerism can help to build strong communities. Indeed, it is common to see volunteerism referred to as ‘the glue that binds communities together’ in the non-health literature. Others argue that the concerns about drop-out rates are usually de-linked from an understanding of different programme approaches. Hence, a failure to retain volunteers over long periods is not necessarily an issue in programmes where the volunteer role is designed to be time-bound. Also, in some situations, including in MAMaZ, training a large number of volunteers may be adopted as a risk avoidance strategy in case of multiple drop-outs.

The concern about high attrition rates has generated a large literature on the appropriate mix of financial and non-financial incentives to support VCHWs. Non-financial incentives are sometimes associated with tangible benefits such as training or assets such as stationery or transport, or intangible benefits, such as personal growth and development. What are in effect essential tools of the trade also tend to get categorized as ‘incentives’ (e.g. transport, protective clothing, stationery).

MAMAZ’S EXPERIENCE

With the debates about the limitations of volunteer approaches in mind, MAMaZ undertook a special study into volunteerism in its programme districts in December 2012. The study included a quantitative research component with a sample of 428 volunteers and a qualitative research component with a sample of 62 volunteers. The aim of the study was to try and understand whether any of the commonly heard concerns about VCHW approaches applied in the programme districts. The findings were quite striking:

- Contrary to the often-heard concerns about volunteers being overworked, 69% of volunteers in the MAMaZ programme districts worked for three hours or less per week.

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**Volunteerism** is the act or practice of doing volunteer work in community service.

**VCHW Attrition Rates**

Attrition rates ranging from single digits up to 77 percent were reported in various studies in the 1980s. In Bangladesh Khan et al. reported attrition rates of 31-44 percent among VCHWs working in a large Bangladesh Rural Advancement Committee programme.

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1 Bhattacharyya, K., et al, 2001, Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention and Sustainability, Published by BASICS II for USAID, Arlington, Virginia.

• Most of the volunteers felt that their contributions were manageable and could be fitted in easily with their other responsibilities;

• Altruism, and specifically a concern to save lives, was the main driver behind the commitment of 71% of the volunteers in the MAMaZ intervention sites. Only 2% of volunteer respondents mentioned ‘incentives’ as a reason for their participation in the programme;

• The volunteer attrition rate was 5.4% across the six programme districts, which is extremely low compared to other VCHW programmes;

• All except one volunteer indicated that they planned to continue their volunteering activities in future. This included volunteers who had been working for up to 20 months;

• There was a high level of confidence among volunteers that it was within their power to bring about change, plus an enormous amount of enthusiasm for the methods that they had been trained to use in order to mobilise the community.

**Altruism is a Primary Motivator For MAMaZ Volunteers**

“I volunteered just to save lives. I am sacrificing my time because I want to save lives.”  Female Lead Mama SMAG, Choma

“What motivates me to volunteer? The desire I have to help people, especially women. The desire in myself is what makes me work.”  Female Lead Mama SMAG, Serenje

“I am motivated to work because of the love I have for the community. I want to work together and fight these issues in the way the MOH wants to do it.”  Male ETS Rider, Serenje

“I want people to have a healthy life. I think people should die of other things, not maternal problems.”  Female Mama SMAG, Choma

The volunteerism study found that the volunteers were largely self-motivated. This is important since it implies that their activities are more likely to be sustained over time. Many of the volunteers mentioned that they were motivated by the quality and relevance of the training they had received. In their minds, the training addressed the key challenges that they faced at community level, increased their knowledge, and developed their capacity to support a change process. They felt that the participatory methods that they had been taught to use (‘body tools’, song and mime) were easy to remember and enjoyable to use. They also found the emphasis on facilitating group discussions, rather than giving long presentations, very effective. The fact that the volunteers could see the results of their work almost immediately was also an inspiration. Reports that maternal deaths were no longer happening in the community, that fewer babies were dying, and that more women were opting for a facility delivery were reflected in the findings of an endline survey conducted by MAMaZ and its partners.

In intervention sites where up to 30 volunteers had been trained, the volunteers worked together as a team and created a mutual support network. The reliance on each other for support and encouragement – and the sense that their work was now ‘in their blood’ – suggest that what began as an externally-supported change process had become a grassroots and largely self-sustaining campaign to save lives.
The experience of MAMaZ and its district partners suggests the following:

• Volunteer approaches can be a highly effective way to stimulate MNH behaviour change at community level;

• Community members are often motivated to work for the good of their community for reasons other than economic gain. MAMaZ’s experience is that despite the many hardships faced by rural communities, a great deal of altruism exists. If harnessed effectively, this can not only be put to good use in order to save lives, but also to build stronger communities;

• A carefully designed community engagement process which addresses the concerns of local communities, plus a training approach and methods which are effective and enjoyable to use, provide the bedrock for a successful VCHW programme;

• Careful management of volunteer expectations from the outset by emphasizing the self-help nature of their work is crucial;

• Although volunteers may not be paid on an individual basis, there are other ways to recognise their efforts. MAMaZ and its district partners introduced a Social Fund which communities could apply to for grants which could be used to strengthen the community systems they had established. These community grants acted as an incentive for the volunteers to continue their work;

• It is important not to mix up financial and other in-kind incentives with essential ‘tools for the job’ such as wet weather clothing and gum boots for emergency transport scheme drivers, torches for volunteers who need to travel at night, and stationery and pens for record keeping. Any volunteer programme needs to provide these ‘basics’;

• The volunteers formed a support network and provided encouragement and advice to each other. Being able to access this support helped to transform the change process into one that was fully under local ownership.

Many MAMaZ Volunteers Intend to Continue Volunteering

“But my work can’t just end. When new people come to the community, I have to make sure that they have the knowledge.”
Female Mama SMAG, Choma

“I think I will continue with my work as a SMAG. I can only stop if I went blind or grew too old to work.”
Male Lead Mama SMAG, Serenje

“I intend to continue with my works. This work is now like part of my blood I can’t stop doing it”. Male Lead Mama SMAG, Choma

Evidence of Behaviour Change in the MAMaZ Intervention Sites

• Delivery with a skilled health worker increased from 43% to 70%³

• Proportion of women receiving four or more ANC visits increased from 30% to 40%

• 1,190 women (equivalent to 14% of reported deliveries) used the community emergency transport system to get to a health facility⁴

Main Motivation for Volunteering

71% helping others and saving lives
17% the training that I received
7% other
3% personal satisfaction
2% incentives

³ Results are from baseline and endline surveys conducted by MAMaZ.
⁴ By December 2012.

For further information on MAMaZ please contact Health Partners International, info@healthpartners-int.co.uk

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