

Village Health Volunteers: Key Issues Facing Agencies in Malawi

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In March 1991 the International Eye Foundation and Adventist Development & Relief Agency conducted a workshop on village health volunteers, bringing together representatives from Malawi-based non-governmental organizations, the Ministry of Health, and USAID. The participants discussed recruitment, training, rewards, retention, and roles of village health volunteers. This paper presents background data on village health volunteers in Malawi and elsewhere and reviews the key issues facing health care providers in working with village health volunteers. A copy of the workshop report can be obtained from IEF or ADRA.

Introduction

Village health volunteers (VHVs) form an integral part of community-based health programmes developed and implemented by a number of non-governmental organizations (NGOs) and the Ministry of Health (MoH) in Malawi. The use of volunteers is not new; publications on teaching community health volunteers are available from the MoH^{1,2}. It is unfortunate that there is a paucity of information in the existing literature on the use of volunteers for health promotion; this lack of research serves to minimize its importance. It also correctly implies that the role of the village health volunteer is not well understood. There is considerable disparity among different agencies in recruitment, support and supervision, working conditions, and hours for village health volunteers.

There is a sound public health policy established in Malawi although there are not enough trained people (or other resources) to teach, counsel, treat, and motivate the community to good health. It has been shown elsewhere that some form of com-

munity-based health worker can make primary health care services more accessible to everyone^{3,4}, although large-scale programmes have met with great difficulties in implementation^{5,6}. Rigorous evaluations of village health volunteer programmes are few worldwide and have not been conducted in Malawi. Defining who these village health volunteers are in Malawi will help us identify some of the problems inherent in using non-paid community health workers. For the sake of clarity, throughout this paper "agency" will be used to describe both governmental and non-governmental organizations.

In Malawi a basic profile of a VHV would include the following characteristics:

1. A VHV is a literate, respected resident of the village.
2. A VHV receives no pay for services rendered but receives some form of incentive from the supervising agency.
3. A VHV provides services less than 10 hours per week.
4. A VHV has initiation training lasting up to one week with periodic workshops.
5. A VHV is generally responsible to the supervising agency.
6. A VHV is often, although not always, a woman.
7. A VHV does not "volunteer" in the Western sense of the term. A VHV in Malawi is generally selected by the village health committee and then approved by the community.
8. A VHV usually provides preventive services: growth monitoring, vitamin A distribution, health education, etc.
9. A VHV gains status in the community for these activities.

General Considerations

Keeping in mind the above description of a VHV we may consider some of the key issues in the recruitment, supervision, and support of village health volunteers.

WHY DO VILLAGERS VOLUNTEER?

Crucial to assessing the success of a programme is determining who is selected for training and how they are selected. In many countries religion is an

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important factor motivating villagers to volunteer. Experience from different non-secular NGOs in Malawi (e.g. the Catholic church, Adventist Development and Relief Agency, World Vision) confirms this. In Malawi, compliance with authority is also a common motivating factor in village health volunteer programmes that rely on village leaders and village health committees to "select" volunteers. This is not to say that the selected volunteer does not want the position; on the contrary, the status that the volunteer gains is desired by most villagers.

In most developing countries (including Malawi) a desire for employment is the most significant motivating factor for volunteers⁷⁻¹¹. However, most programmes assume that volunteers will remain as such and not become salaried workers; there are no career structures nor opportunities for a volunteer within an agency's programme. Will prestige and praise for good service be sufficient reward? There is little evidence to think so. The longer a volunteer remains in the system the greater concern she/he has for legitimization of her/his status. As a consequence, high attrition rates and low activity rates are reported from large national VHV programmes in Sri Lanka¹² and Indonesia¹³. Anecdotal information in Malawi suggests that high attrition rates are not common but the absence of systematic evaluation limits our ability to assess the true attrition rate in Malawi as well as the reasons for this attrition.

VILLAGE HEALTH PROVIDERS AS VOLUNTEERS OR AS PAID WORKERS: THE USE OF INCENTIVES

Experience in Malawi suggests that agencies prefer to use volunteers rather than paid village health workers. Since the MoH is financially unable to support a paid community health worker, non-governmental agencies are hesitant to train and finance people that cannot be supported after the conclusion of their programmes. It is interesting that only on rare occasions have communities been approached to pay these people.

In reality, even "volunteers" require some financial support; honorariums, uniforms, shoes, and per diems serve as a form of payment given by some NGOs and the MoH. Agencies prefer to provide development or establishment costs (non-recurrent) leaving subsequent operation and maintenance (recurrent) costs to be sustained from local resources. Perhaps the community which benefits from the volunteers should be looked to for financial support of these volunteers. There are few examples of sustained community financing of

health workers¹⁴ but the concept deserves consideration in Malawi.

What is an appropriate, affordable, and acceptable incentive for VHVs? One must consider the duties of a VHV: a volunteer with a small population or few tasks can provide services effectively on a part-time basis. Part-time work means that the VHV can continue to do normal daily work to sustain their families. Most agencies are willing to underwrite the cost of training and supervision of village health volunteers. Because even part-time salaries can be a heavy expenditure most agencies are looking for ways to have the community share the costs or, failing that, introduce affordable incentives. Tangible incentives include uniforms, shoes, badges, certificates, and soap. Training itself may be an incentive, both for the skills acquired or as a time when the volunteer receives some financial reward, generally in the form of a per diem. There has been little exploration into the issue of possible intangible incentives. There is no MoH policy regarding incentives in Malawi and there is considerable variety in what is provided. This has led to dissatisfaction among VHVs.

COMMUNITY INVOLVEMENT IN HEALTH IN MALAWI

In Malawi only a few programmes use direct community involvement to improve health in the rural areas; villagers have little input into decisions regarding priorities in health care delivery. Most agencies have their own agendas (growth monitoring, child survival, AIDS prevention, vitamin A delivery, etc.) and communities have not been directly involved in the process of expanding health to the village level. Furthermore, the community has no role in the supervision of the VHV; health care responsibilities are transferred to the agency that is training the volunteer. In essence, the volunteer becomes an agent of the agency. This lack of direct community involvement is typical of most developing country community-based health worker programmes (whether volunteer or paid) and villagers have little say in what their health worker is taught to do^{4,15}. Annett and Nickson have summarized the reasons for involving the community in health care planning, implementation, and evaluation¹⁶. These include:

1. Community involvement increases resources available for health; villagers are often more willing to help meet the costs of services they value.
2. Community involvement is necessary to achieve culturally appropriate and acceptable services.

3. Community involvement extends coverage beyond the formal health system.
4. Community involvement breaks the cycle of dependency on agencies.

Formal linkages between the VHVs and the village health committees may serve to reinforce the roles of both groups in community development.

SERVICES TO BE PROVIDED BY A VHV AND GUARANTEEING QUALITY

A VHV is seen by most agencies in Malawi as an agent for health education, encouraging better nutrition, and recently, AIDS prevention and child spacing. Some PHAM hospitals (e.g. Trinity Hospital, Muona) have had constructive experiences with providing basic drugs (especially aspirin and anti-malarials) to VHVs. Providing some curative services help establish a VHV's credibility in the community. Furthermore, a community is unlikely to compensate a VHV for time spent on preventive services¹¹. However, the provision of drugs to VHVs is not common in Malawi.

Guaranteeing quality of care in a community-based health care system is difficult. It is clear from evaluations in different settings that supervision and support are generally too weak^{4,17,18}. Against the backdrop of a short training period, lack of confidence, and possession of few skills, a consistently high level of support and supervision appears to be needed. Lack of training in supervisory skills and a high turnover in supervisory staff tend to weaken the support and supervision provided by agencies in Malawi. Experience elsewhere has demonstrated that as supervision becomes more irregular the VHVs tend to concentrate on curative services and perform fewer and fewer preventive tasks¹⁷.

Summary

The multiplicity of fundamentally different volunteer programmes is an indication that there has not been developed one ideal system of village health volunteer in Malawi. Operational research is needed to answer some basic issues in community-based health care in Malawi.

1. What is the true attrition rate for VHVs in different programmes in Malawi?
2. What factors are associated with attrition or low activity in VHVs in Malawi?
3. How does a VHV's expectations of future employment affect performance, attrition, and status in the community?
4. What are the true costs (non-recurrent and recurrent) of a programme that relies on VHVs?

5. Can communities (through the village health committee) have input into which duties VHVs are trained to do?
6. What is the minimum technical supervision necessary for supporting VHVs?

Answers to these questions, and others, would assist agencies in designing, implementing and sustaining primary health care programmes at the community level. This information would also assist the MoH in developing policy regarding village health volunteers and community-based health care in Malawi.

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