

Enhancing the coordination of Community Based Volunteers

Research Findings Dissemination Event

Intercontinental Hotel, Lusaka

Thursday 28th August, 2014



Event Agenda

Timing	Item
09.00 – 09.30hrs	Registration and tea and coffee
09.30 – 09.40hrs	Welcome remarks and introductions
09.40 – 09.50hrs	Opening remarks by the Honourable Minister of the Ministry of Community Development, Mother and Child Health, Emerine Kabanshi
09.50 – 10.00hrs	Introduction to the Research
	Research findings:
10.00 – 10.30hrs	<ul style="list-style-type: none">• Community Based Volunteers Skills Audit Survey Report
10.30 – 11.00hrs	<ul style="list-style-type: none">• Structures and Linkages Study at District and Community Level
11.00 – 11.15hrs	Tea and coffee break
11.15 – 11.30hrs	Recommendations based on the research findings
11.30 – 12.15hrs	Panel Q&A session on the research findings and recommendations <ul style="list-style-type: none">• MCDMCH: Simmy Chapula, Chanda Mulenga• VSO: Phil Thomas, Thera Rasing
12.15 – 12.30hrs	Next steps
12.30hrs	Lunch

Introduction to the Research

Who are Community Based Volunteers (CBVs)?

CBV definition

- CBVs are defined as **active** local Zambian persons from the communities who are delivering services in the fields of community development, health and/or social welfare to their community on a voluntary basis, i.e. they are not getting formally paid for the services they deliver
- The CBVs can be working directly under one of the departments of MCDMCH, and/or through an CSO (CBO, FBO or NGO)
- Exclusions : International Volunteers

Active definition of a CBV for the research

- A volunteer was considered active if s/he had seen at least 1 client in the last 12 month

Background to the Research

- As a country Zambia has been utilising Community Based Volunteers for a long period of time, for activities linked to the HIV and AIDS epidemic such as home based care and HIV prevention, through to improving adult literacy and identifying beneficiaries for social cash transfer initiatives
- Community Based Volunteers are crucial to the Ministry (MCDMCH) in helping to deliver its work to communities in the areas of community development, primary health and social welfare, whether working directly under the Ministry or with local, national and international CSOs
- Estimates exist on the number of Community Based Volunteers (at least 100,000 CBVs in Zambia), but less information about who these volunteers are, their work, skills, and activities

Research project (1)

- MCDMCH commissioned a research project to establish how to:
 1. Enhance the **utilisation** of the community based volunteers
 - Understand the profile of this volunteering workforce in terms of its skillset and training needs
 2. Enhance the **coordination** of the community based volunteers
 - Understand the current linkages between the volunteer structures and the district entities, and identify how the current organisational systems can be strengthened

Research project (2)

Research Project commissioned by MCDMCH

2 parallel tracks

CBV Skills Audit Survey

- Objective: Assess the skillset of the CBVs, and set up a baseline of data about the CBVs to enable planning of activities to enhance the utilization of the CBVs in the districts
- 30 districts

Structures and Linkages Study

- Objective: enhance the coordination of CBVs, and identify how the current structures can be strengthened at ministry, district and community level
- 5 sample districts (Serenje, Ndola, Kasempa, Mwense, Kasama)



A draft national strategy to improve the management and coordination of the CBVs

Thanks!

Achievements

- Exemplary commitment shown by the provinces and districts to carry out the research, particularly the larger skills audit survey
- A lot of goodwill was deployed to overcome any hurdles during the data collection process (weather, equipment etc.)

- In numbers:

Skills Audit survey

- Over 23,000 CBVs were interviewed
- 78 district officers worked on the project
- Over 870 data collectors carried out interviews

Structures and Linkages study

- 51 district staff were interviewed
- 205 CBVs were interviewed

Community Based Volunteers Skills Audit Survey

Summary of survey findings

Sampled Districts

Provinces	Districts
Central	Kabwe (URBAN); Mumbwa; Serenje / Chitambo
Copperbelt	Kitwe (URBAN); Masaiti; Ndola (URBAN)
Eastern	Lundazi; Mambwe; Petauke / Sinda
Luapula	Chiengwe; Mwense / Chipili; Samfya
Lusaka	Luangwa; Lusaka (URBAN)
Muchinga	Chinsali; Isoka
Northern	Kasama; Luwingu; Mungwi
North Western	Kasempa; Mwinilunga; Solwezi
Southern	Livingstone (URBAN); Namwala
Western	Kalabo / Sikongo; Mongu

Methodology (1)

Staffing of the survey

- **Supervisors:** 3 district officers (1 from each of the 3 departments of MCDMCH) per district were trained to implement the survey in their district
- **Data collectors:** had to be either one of these positions – Community development assistant (CDA), Community Health Assistant (CHA), or Health centre staff

Data collection

- **Posts:** data collection revolved around the health centres in the districts
- **Mobility of the data collectors:** data collectors were completely static
- **Survey monitoring:** done at 3 levels – district, provincial and HQ

Timeline of the survey

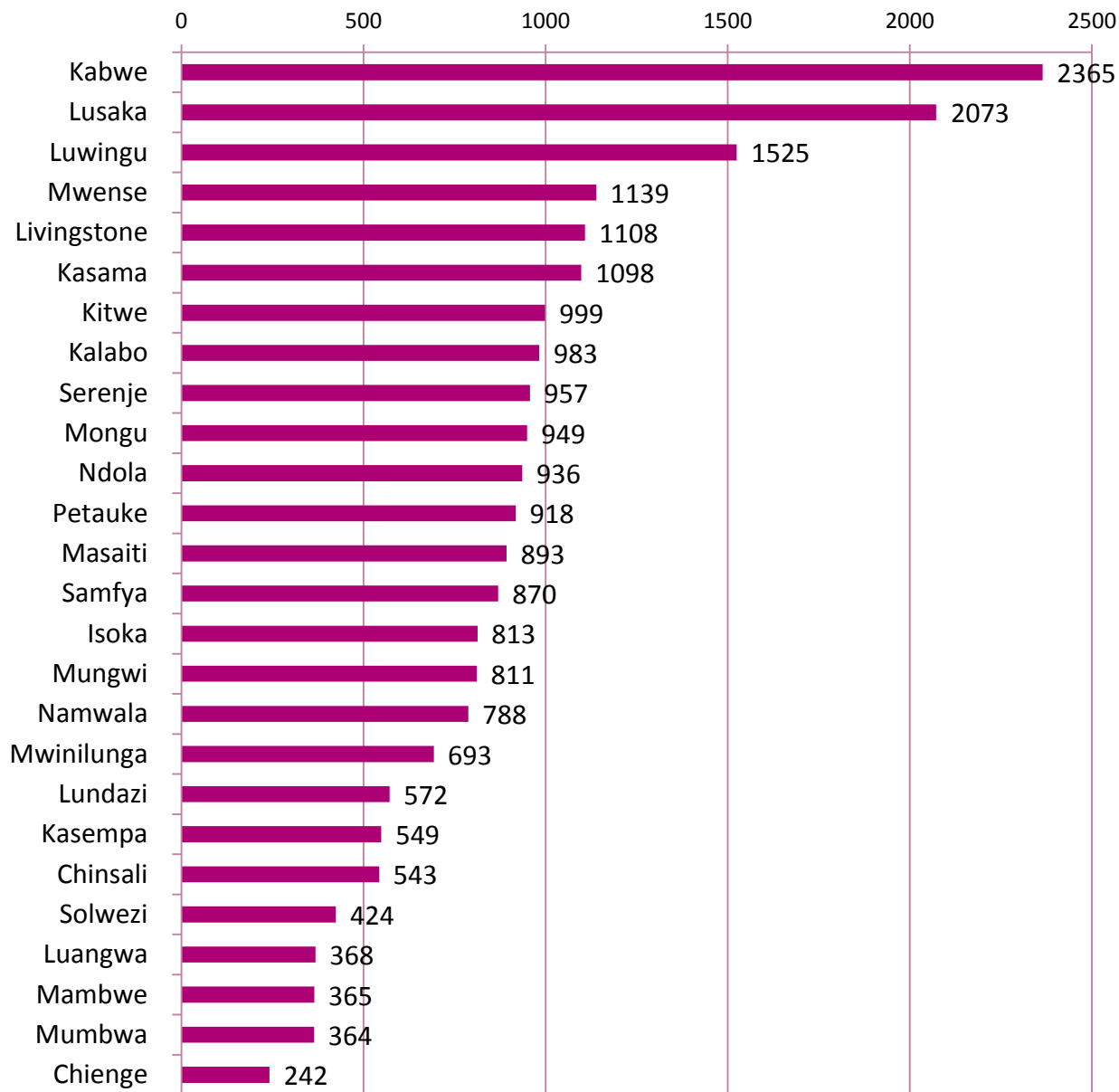
- November 2013 through to January 2014; data entry cut off point was May 2014

Methodology (2)

Questionnaire

- 4 page questionnaire; majority closed questions, a few open ended questions
- Topics covered included:
 - Profile of the CBVs – age, gender, location etc.
 - Programmes that the CBVs are involved in
 - Committees that the CBVs are members of or aligned to
 - Training the CBVs have received and frequency
 - Incentives and motivation

CBVs per District

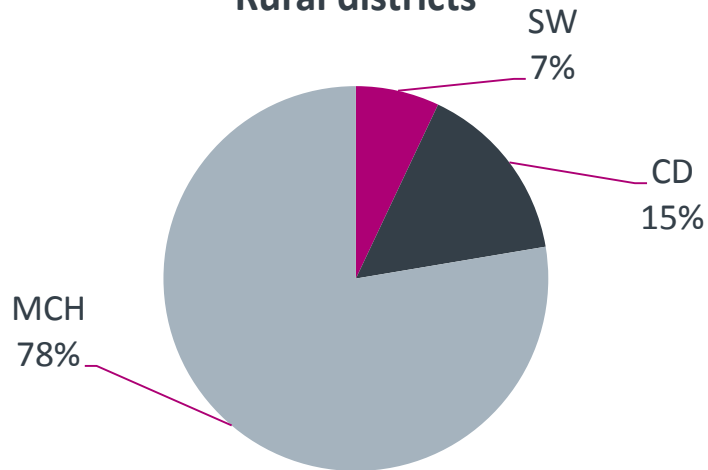


Data collected

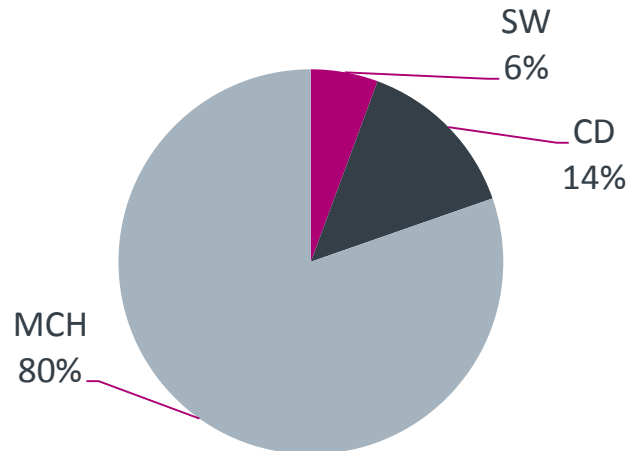
The data collection efforts varied a lot from a district to district.

With some districts over-delivering, and some districts under-delivering.

**% of CBVs per department
Rural districts**



**% of CBVs per department
Urban districts**



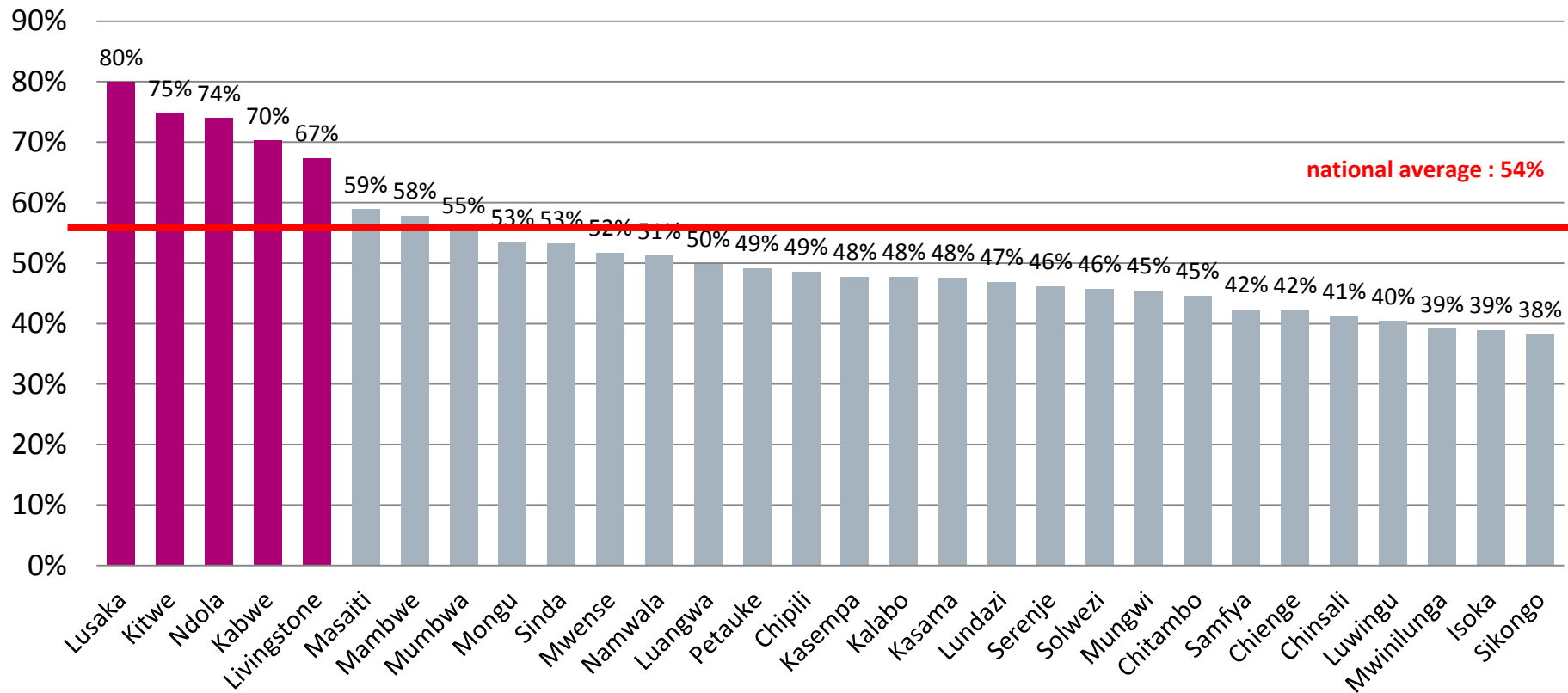
Completeness of the data by department

When looking at the completeness of the data, we need to evaluate the completeness by sector.

The Health (MCH) sector was very well represented in the survey. In contrast, few CBVs seem to work for SW or CD programmes.

Dominance of Female CBVs in Urban districts

% female CBVs per district

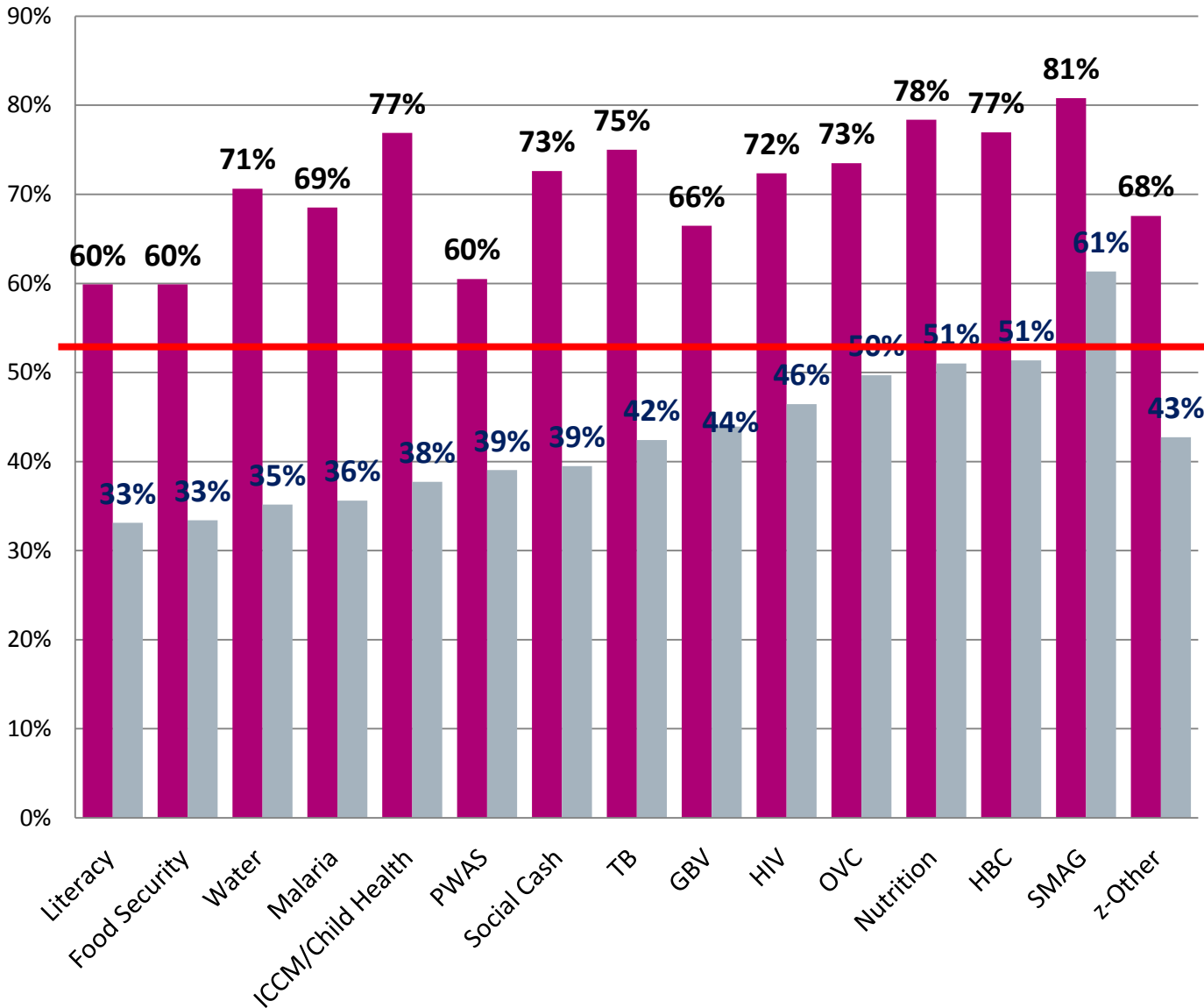


- The 5 urban districts tend to have a majority of female CBVs (Kabwe, Kitwe, Ndola, Lusaka, Livingstone), whilst a greater proportion of CBVs in rural districts are male.

Base Size 23,404 CBVs interviewed

% of Female CBVs per programme

■ URBAN Districts % ■ RURAL Districts %



Under-representation of female CBVs in Rural districts

In rural districts, only the SMAG programme has a clear majority of female CBVs.

Other programmes, like social cash transfer, food security pack, water and sanitation, PWAS, literacy, malaria, iccm are heavily dominated by male CBVs.

Factors that explain the gender disparities between rural and urban districts

Women have lower literacy levels

- Women may not think that they can become a CBV because of their lower education level; even when women are encouraged to take part

Culture and home duties discourage women to become CBVs in rural districts

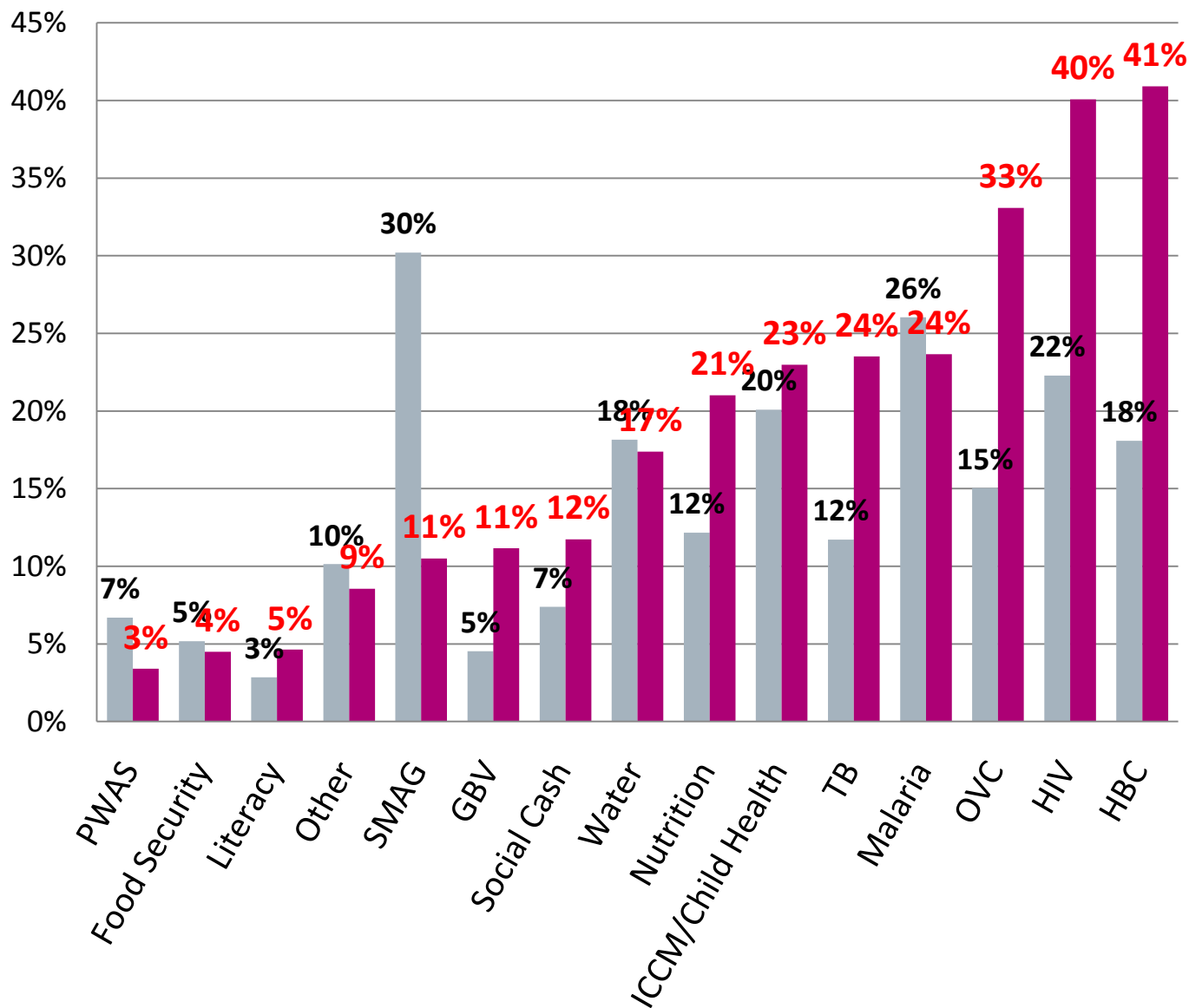
- Young women are not always allowed to speak in local gatherings, and therefore cannot take part in voluntary work
- Pressure of home related activities (taking care of children, field cultivation) discourages women from becoming CBVs
- In urban districts women are contributors to income generation at household level
 - More likely to take up a CBV role, with the hope that it will materialise into a real job, or to take advantage of the incentives given to contribute to the income of the household

Survey timing

- Carried out in the rainy season; meant that the survey may have missed out some female CBVs who were in the fields for cultivation

% of CBVs in each programme

■ Rural % ■ Urban %



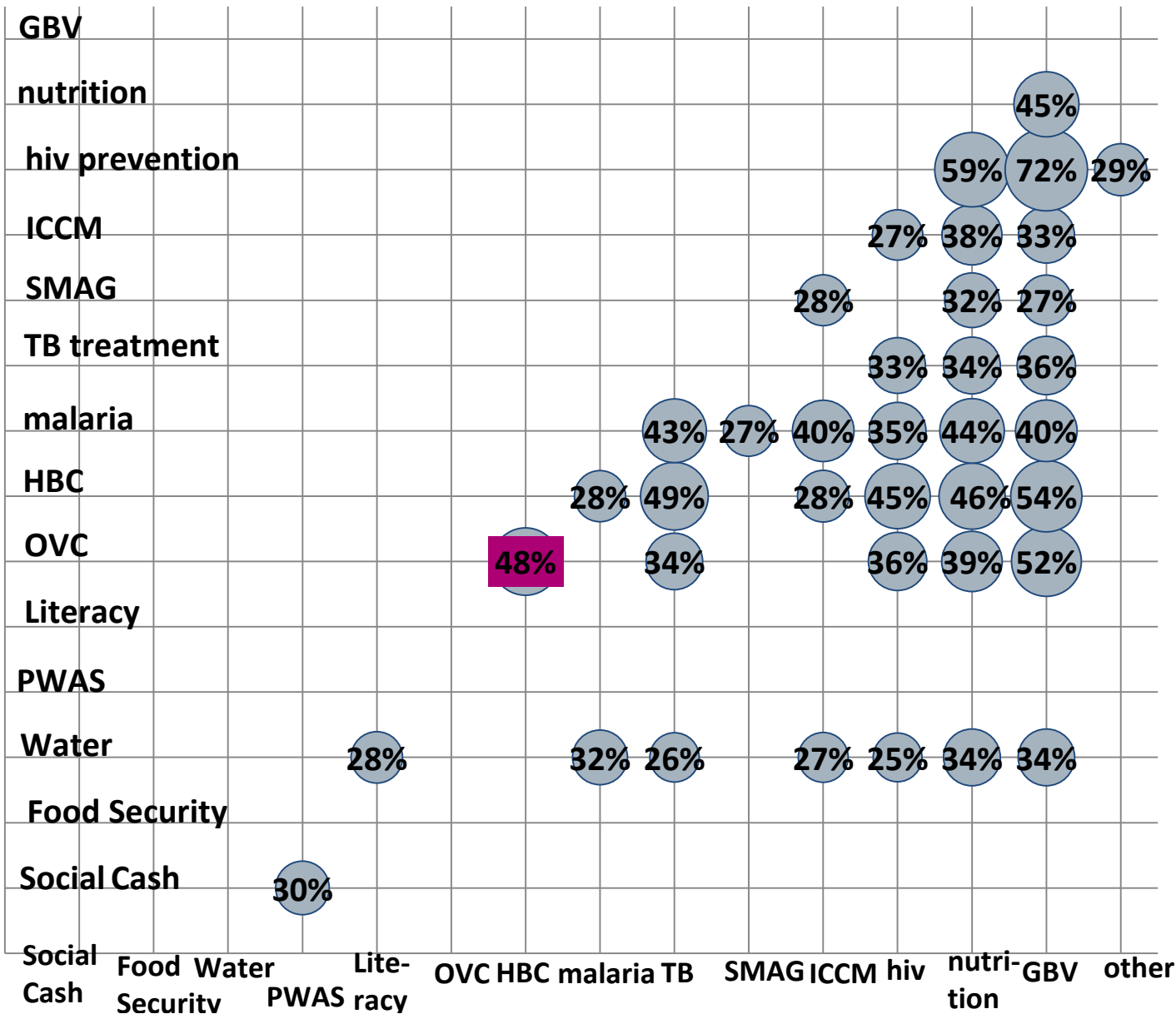
CBVs per programme

The programmes that dominate in the Urban districts are HIV prevention, Home Based Care, OVC, and Malaria.

While in Rural districts, the dominant programmes are SMAG, Malaria, HIV, and ICCM.

In both cases, a vast majority of the CBVs work for health programmes. In contrast, very few seem to work for SW or CD programmes.

Biggest overlaps between programmes

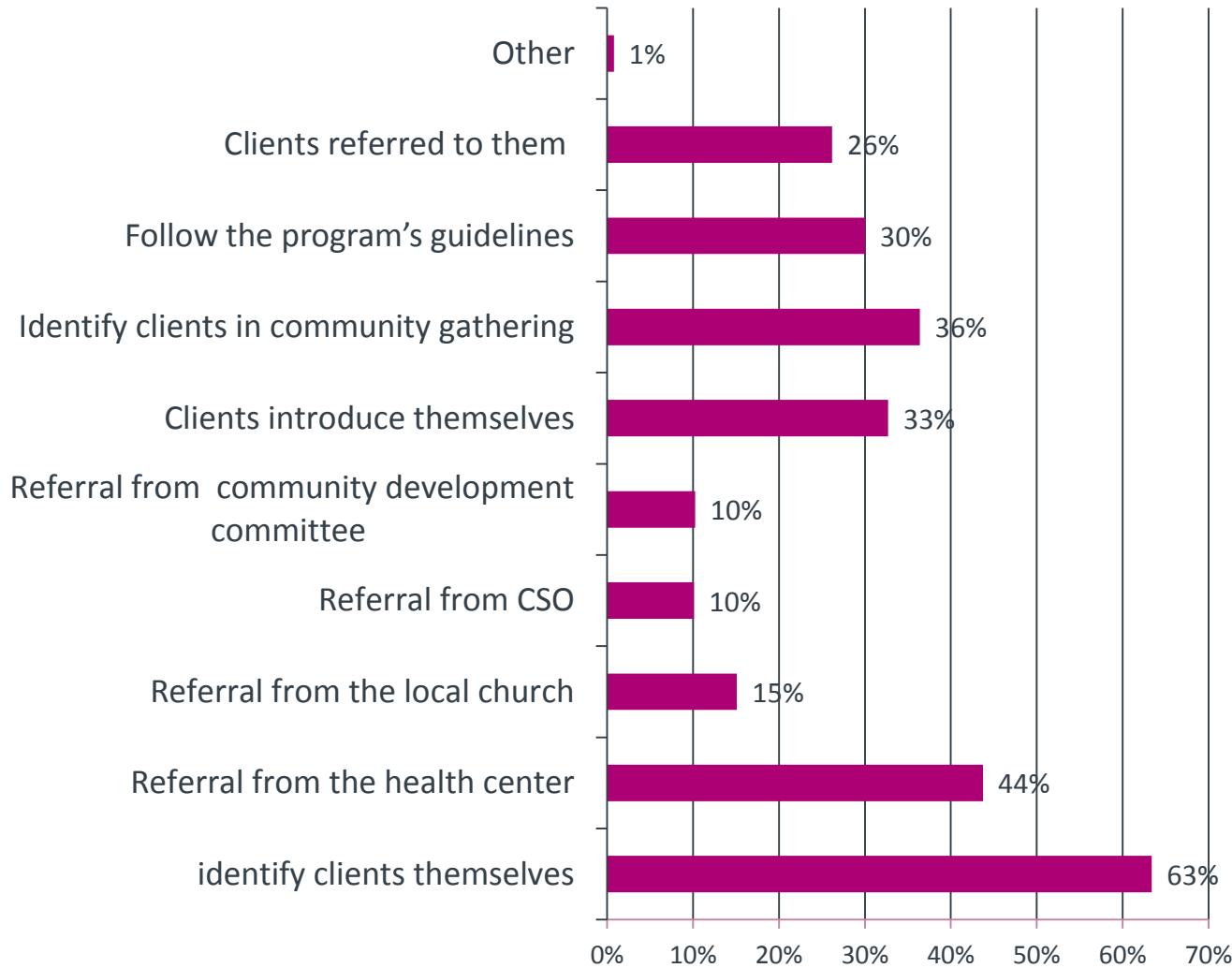


Programme overlaps

- HIV & Nutrition/GBV/HBC
- TB & Malaria/HBC
- HBC & OVC/GBV

How to read these figures:
 Example: Out of the CBVs that work for OVC, 48% also work for HBC programmes

How do volunteers identify their clients?

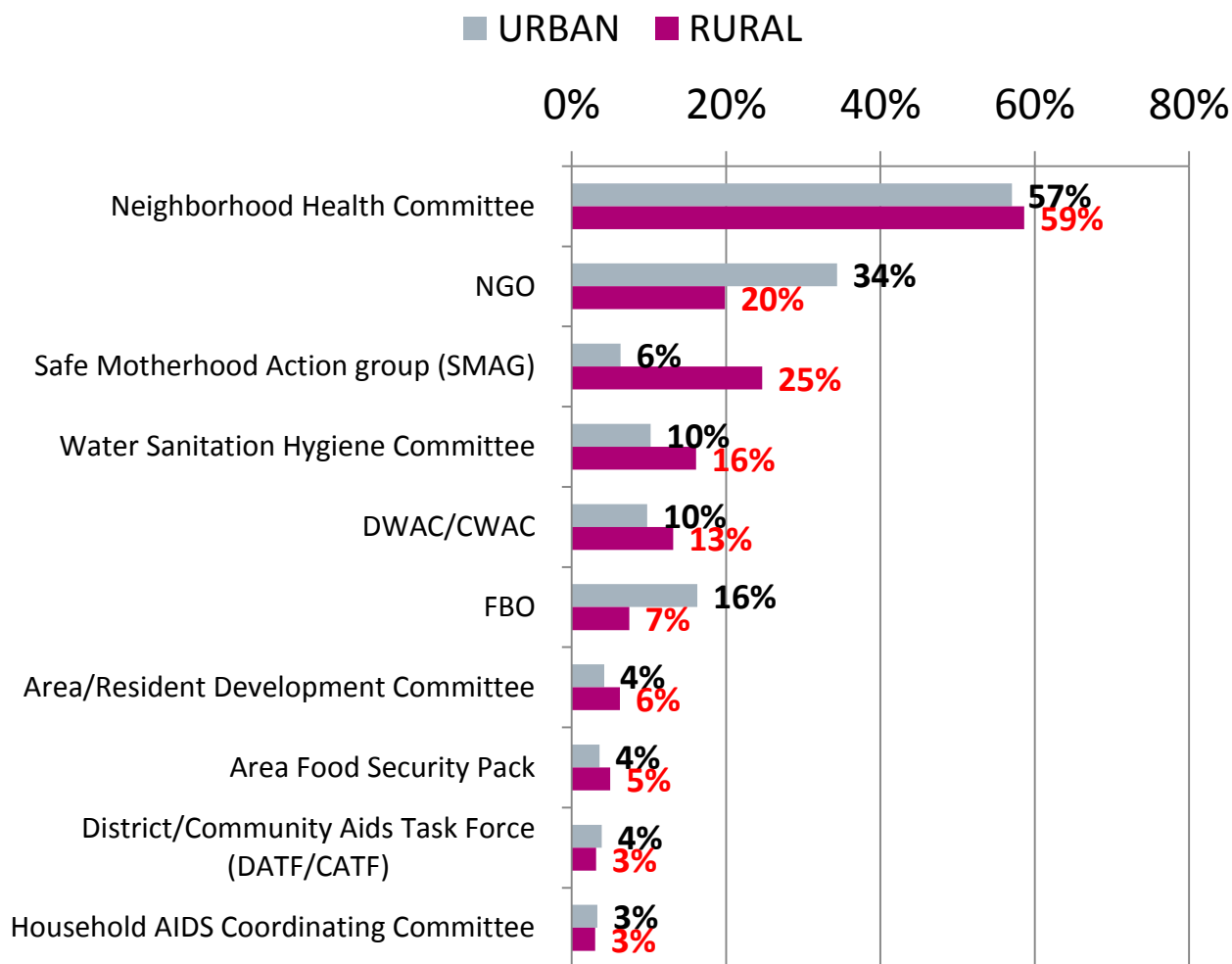


Identification of clients

Some notable differences per programme:

- CBVs in literacy and GBV programmes stated that they follow the programme guidelines as their primary mean to identify clients
- CBVs in TB programmes use information from their health centres, and community gatherings as their main means of identifying clients
- CBVs in HIV prevention programmes get most of their clients through referrals.

% of CBVs in committees and/or organisations

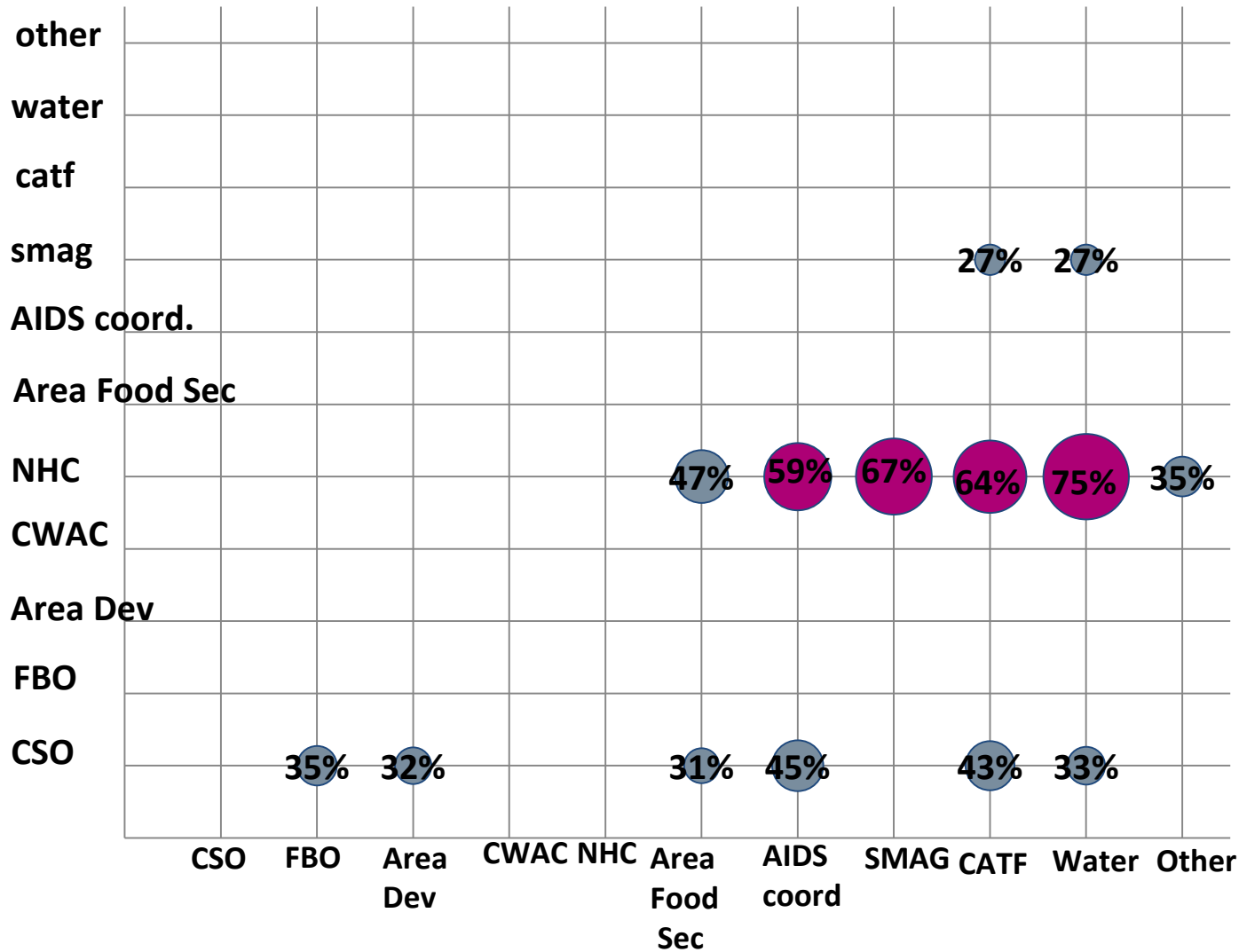


Links to committees and/or organisations

The largest committee is the NHC; both in urban and rural districts

In all committees, the proportion of CBV supervised is high, ranging between 94% to 99%.

Biggest committee and/or organisation overlaps

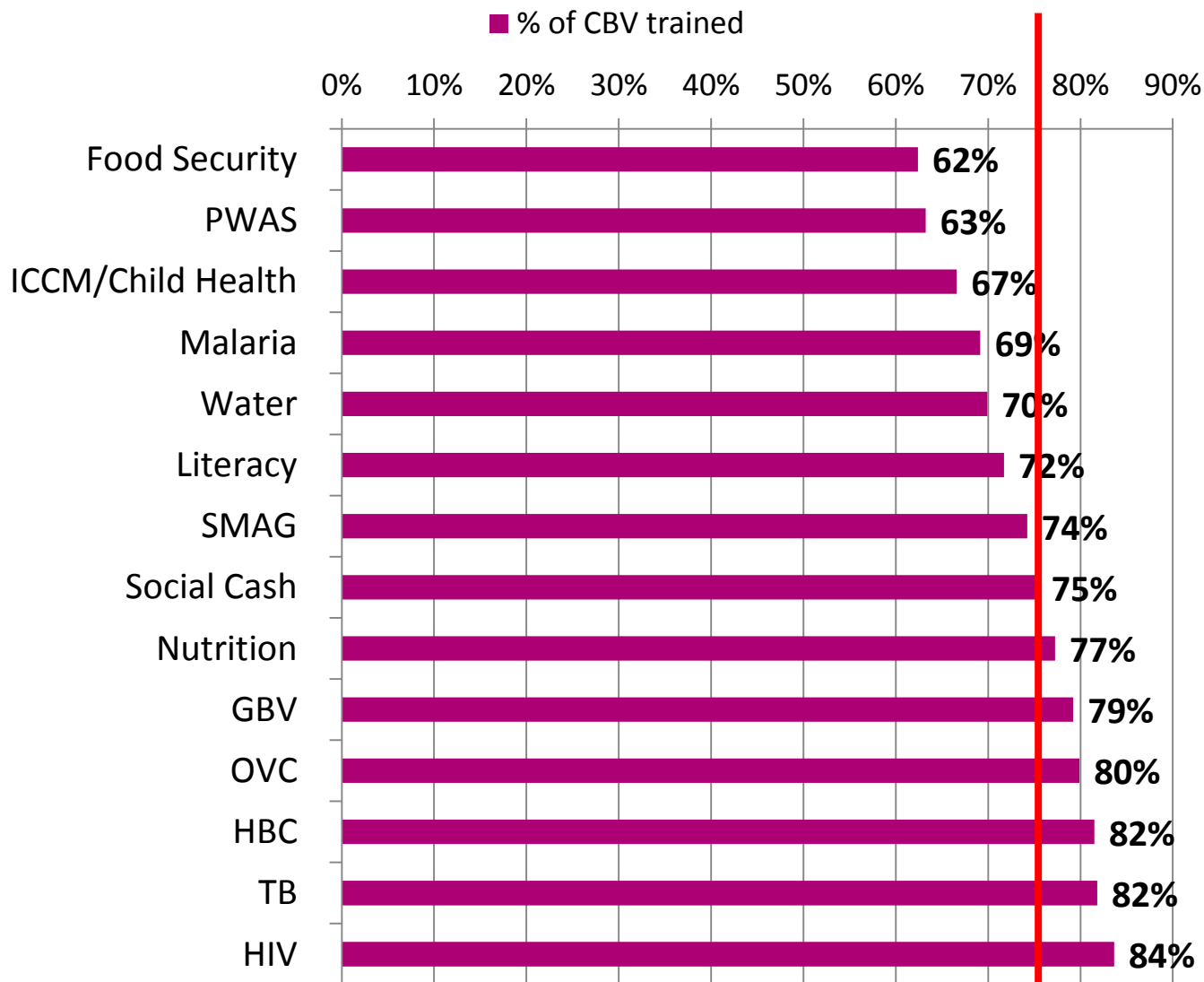


Committee overlaps

Analysis of the biggest committee overlaps suggests opportunities to merge some of the health related committees

CBVs involved in the NHC are over 40% likely to also belong to the SMAG, AIDS coordinating committee, CATF, or the Water sanitation committee.

In which programmes where CBVs are working are they most likely to be trained?



Base Size 23,404 CBVs interviewed

national average : 74%

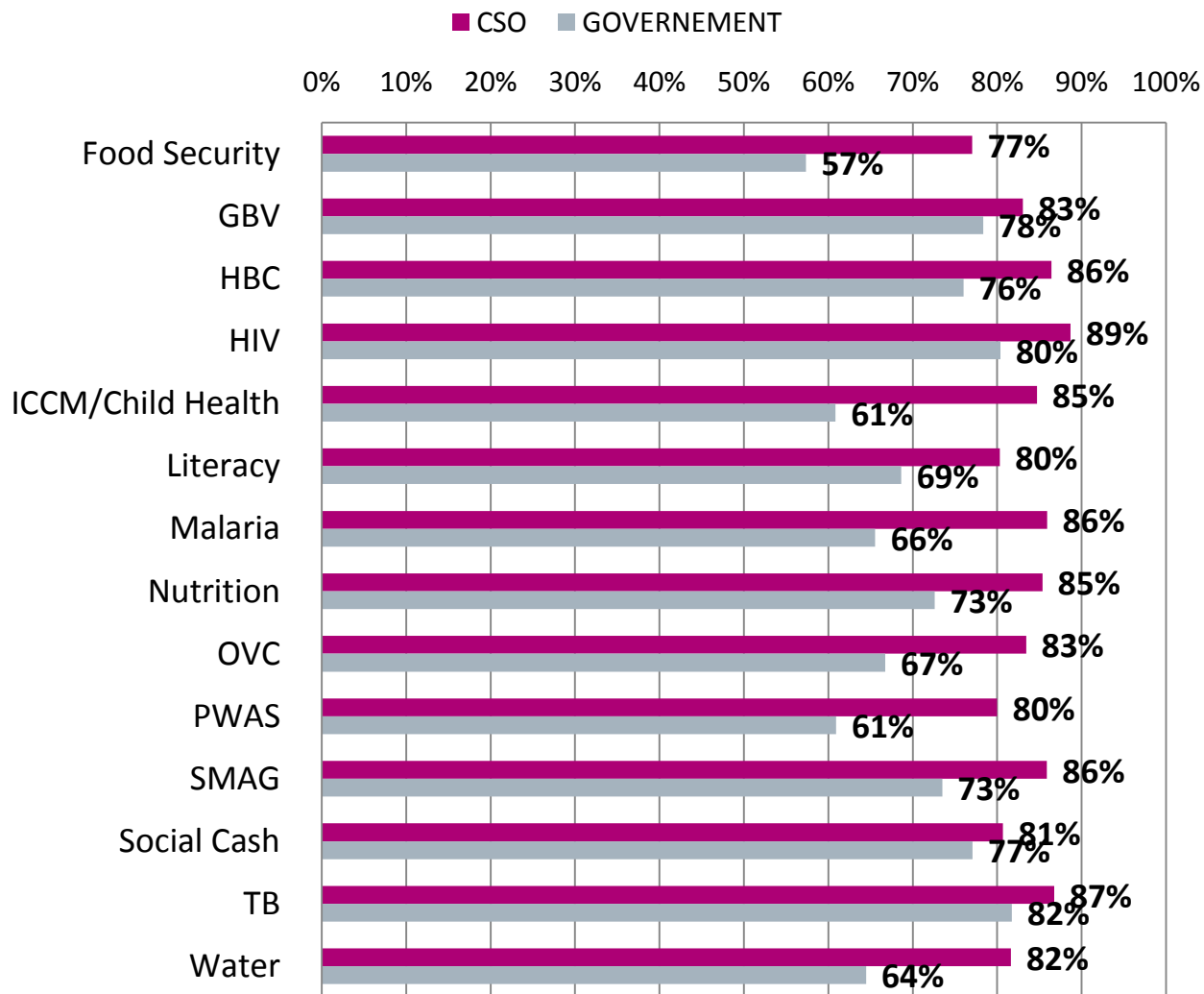
Training linked to working on a programme

Discrepancies in the overall training level of the CBVs on different programmes.

CBVs in OVC, HBC, TB, HIV, GBV programmes are more likely to be trained.

On the other hand, CBVs in Food Security, PWAS, and ICCM are less likely to be trained.

Is the CBV more likely to be trained if s/he works with Government or with a CSO



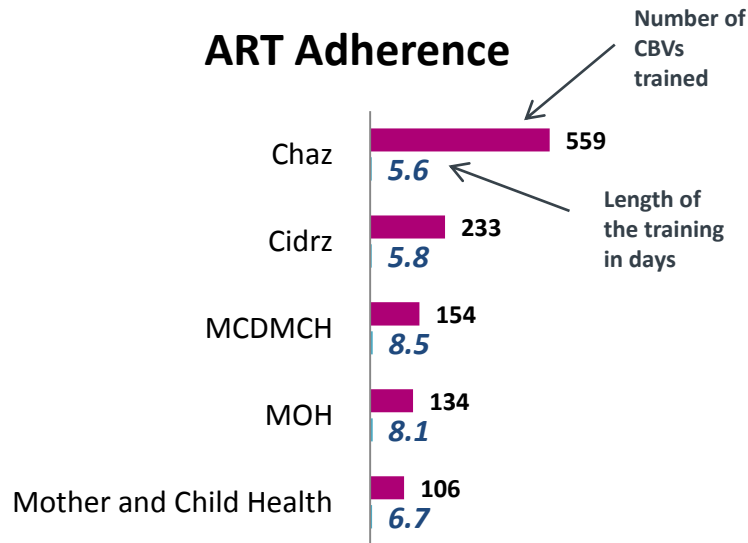
Training linked to government and CSOs

CBVs are more likely to be trained if they work under a CSO

Training of CBVs

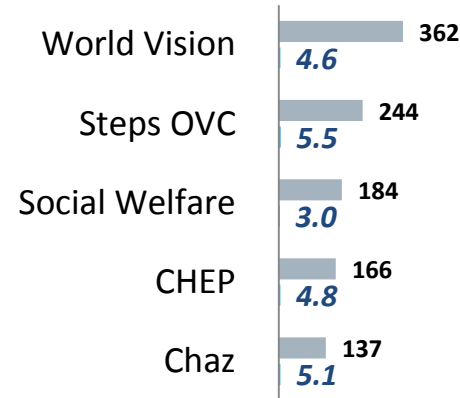
- **Volume:** CBVs have been trained in several training areas, whose overlapping characteristic suggests new training curriculums to enable CBVs to provide an integrated service of care to the communities
- **Recency:** There are differences per training area in terms of how recently the CBVs have received their last training
 - For example: Social Cash transfer in 2013 compared to first aid in 2005
- **Length:** Most trainings are around one week long (from 4-7 days on average); variability of training length within one training area
- **Untrained:** Discrepancies in the overall training level of the CBVs on different programmes
 - Some programmes have a very high percentage of CBVs who have NOT received any training before starting to work on these programmes
 - For example CBVs in PWAS and Food Security have the highest proportions of untrained CBVs, 48% and 39%, respectively

ART Adherence



In ART adherence for instance, the average training delivered by CHAZ (the biggest trainer in that area) is around 5 days, while MOH and MCDMCH delivers a training of around 8 days

OVC Care



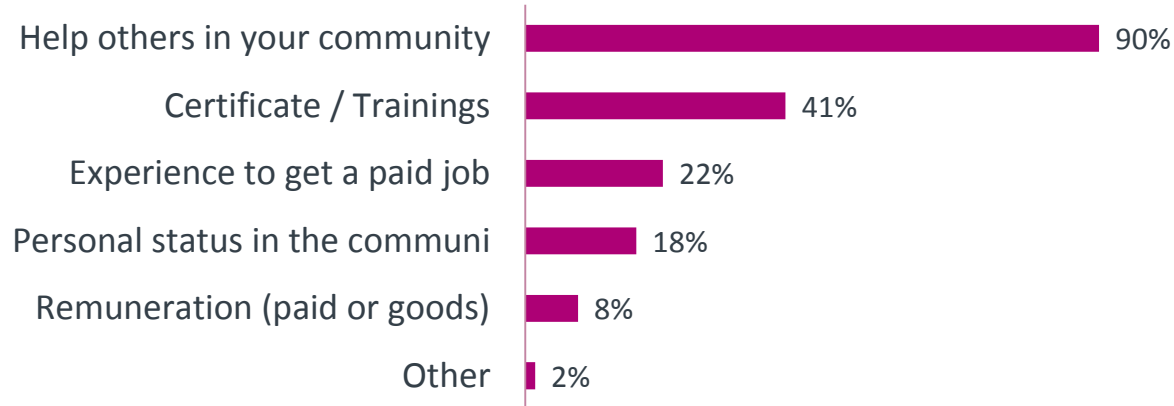
In OVC Care, the trainings delivered by CSOs like Care, Steps OVC, CHEP average around 5 days. While the same training run by Social Welfare last 3 days.

Differences between trainers

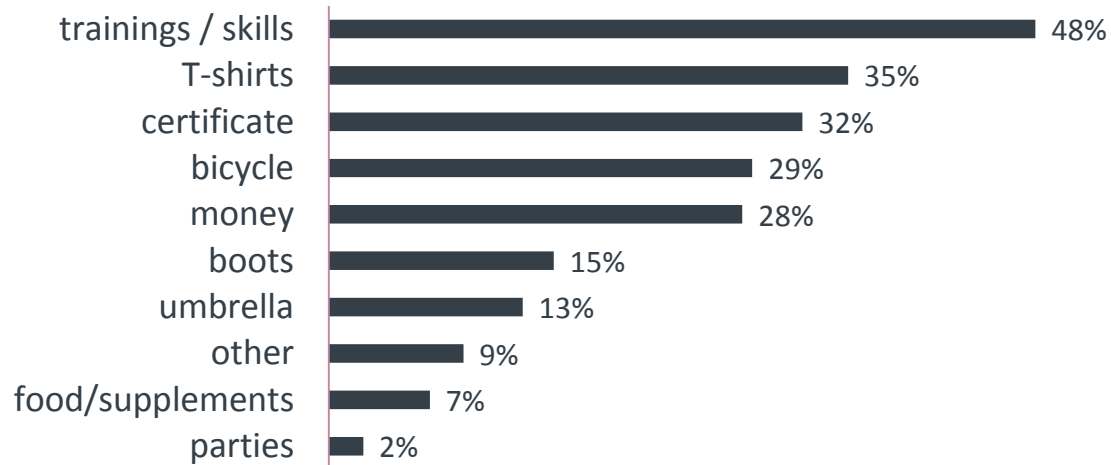
Not only, are there big differences from training area to training area, but within one training area, there are also big differences to notice depending on who delivered the trainings.

- Ultimately, this may create disparities in the way the CBVs are trained, and calls for an harmonisation of training curriculums, to maximise the impact of the CBV towards their communities.

What motivated the CBV to become a volunteer?



What incentives did they get?

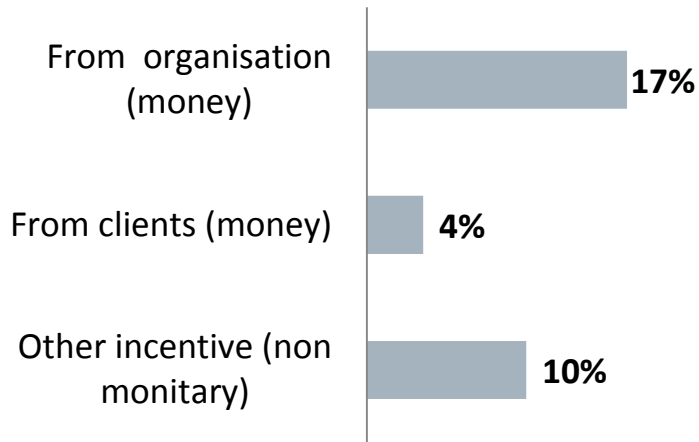


Incentives and motivation of CBVs

Most CBVs stated Helping other in the communities as their biggest motivator, followed by trainings and certificates.

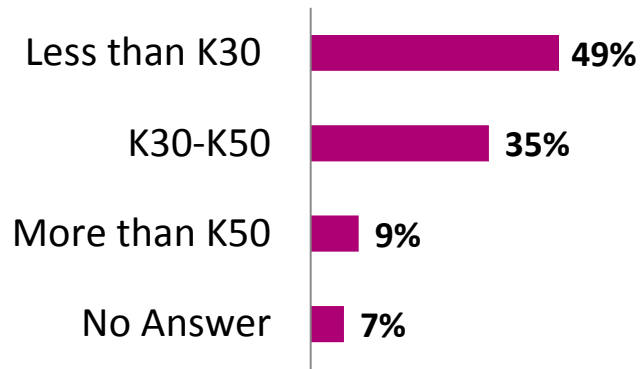
The incentives they got varied a lot depending on who run the training. Trainings and gaining new skills are commonly the biggest incentive mentioned by CBVs.

Do they receive compensation?



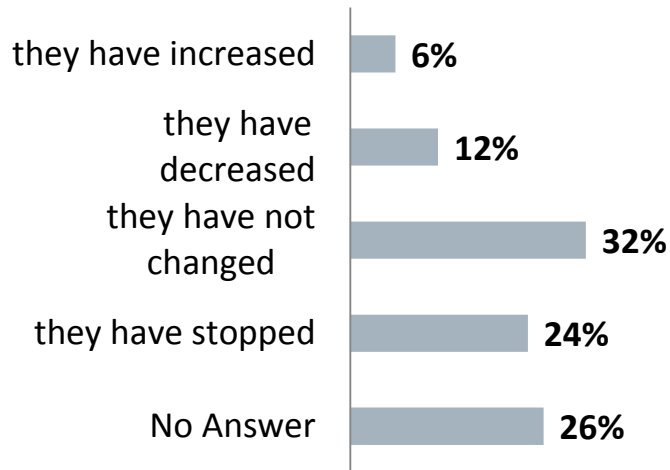
Based on 7,231 CBVs responding to this question

Have much compensation do they receive?



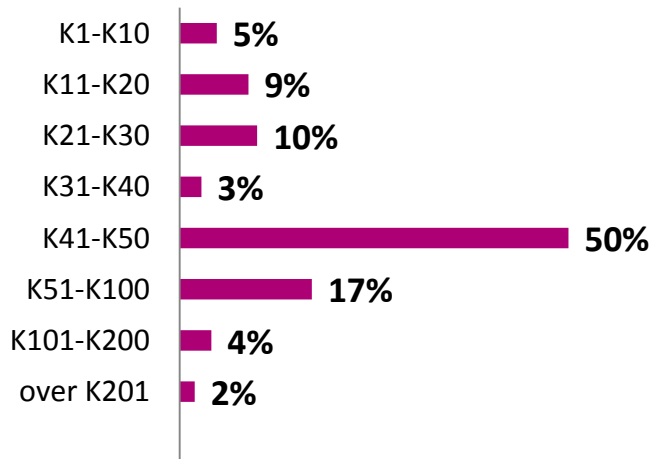
Based on 4638 CBV responding to this question

Have the incentives changed?



Based on 23,404 CBVs responding to this question

Have much incentive would they like to receive per day?



Based on 18 837 CBV responding "Yes" to wanting to be paid an incentive

Incentives

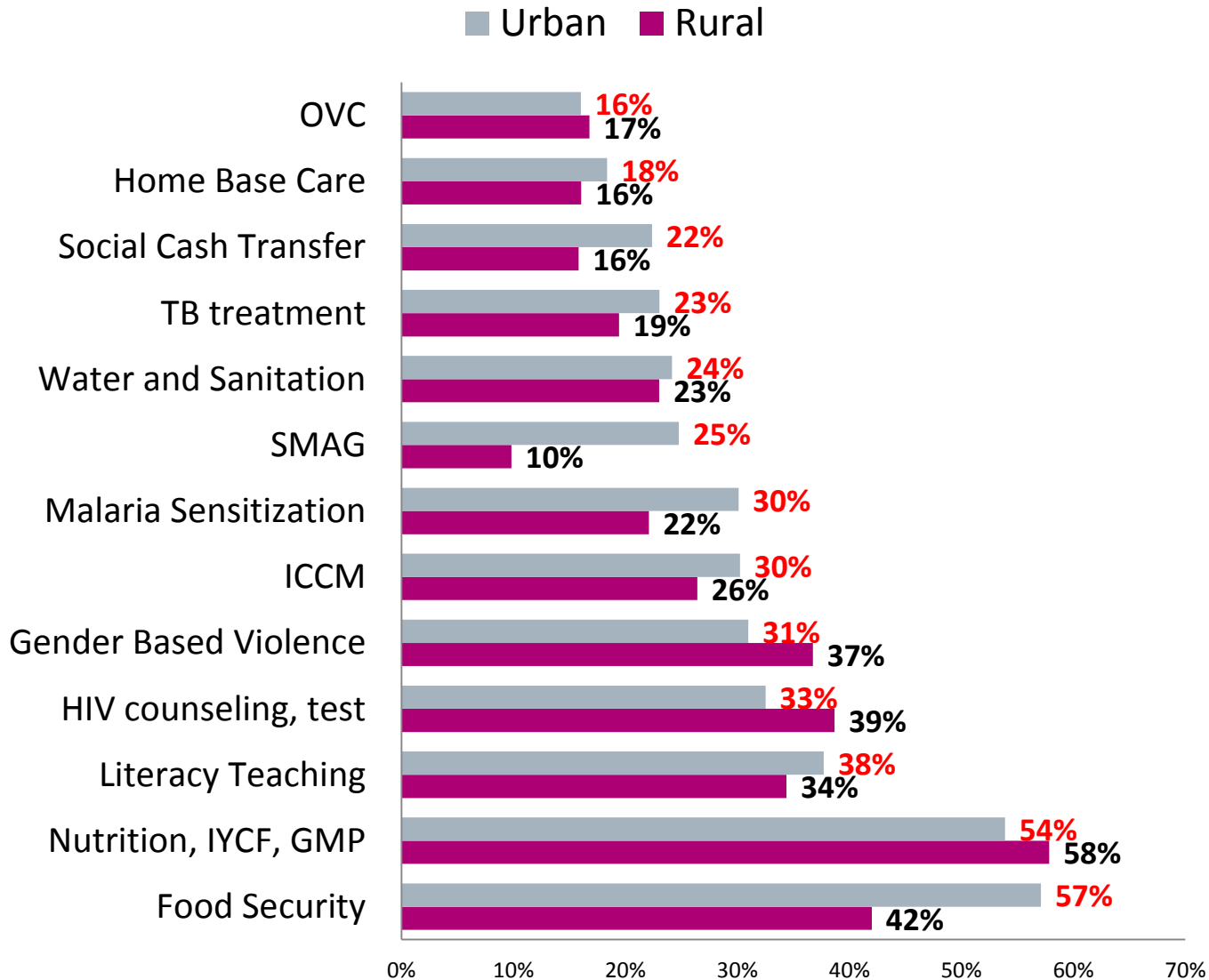
A small proportion of CBVs receive money (usually less than K30 per day) or goods from their organisation or their clients in exchange of their services.

Over 35% stated that their incentives have decrease or stopped completely over time. Only 6% declare that their incentives have increased.

Ideally, they state that they would like to get K50 per day.

Proportion of CBVs Dropping out

(Trained in training area but not working in corresponding program)



Base Size 23,404 CBVs interviewed

Drop outs

Drop out rates varies a lot per programme

Changing incentives levels impact the drop out rates under the different programs

Note: Drop out is measured by checking the volunteers who have received a formal training in a training area, but do not state to work under the corresponding program currently

Structures and Linkages Study

Summary of research findings

Objectives of the Structures and Linkages Study

- To obtain more insights in the structures and linkages between district and community structures in the areas of community development, health and social welfare
- To seek ways and strategies as to how collaboration between the 3 ministry departments can be enhanced
- To find strategies as to better utilise and coordinate Community Based Volunteers in the communities

Research methodology

- Fieldwork in 5 districts: Kasempa, Ndola, Serenje, Mwense, and Kasama
- 45 Interviews with members of staff in the districts: CDO, CDA, SWO, DMO, EHT, HIO, planner, DC, DWAC member, CHA
- 5 ACC chairpersons and 1 Community Health Worker
- 28 Focus Group Discussions with CBVs
 - FSPC, Women's Associations, CWAC, NHC, SMAG, TB/ART adherence counsellors, and CHW – total 205 CBVs
- Consultation of stakeholders at national level
- Literature review of relevant studies on CBVs and ministry documents

Understanding the linkages between the 3 departments (1)

Working relationships

- In most districts there is a good working relationship between the departments of CD and SW
- There is little working relationship between CD/SW and MCH
- Difficult to adapt to new situation of merging the 3 departments. Especially for MCH (department transferred from MoH to MCDMCH)
- Staff at district level have experienced challenges adapting to this new situation, with limited direction from HQ on how to cooperate and what was expected of them

Situation at the 3 departments

- Gaps in resources:
 - Human resources (especially at CD and SW)
 - Office equipment
 - Transport
 - Office space

Understanding the linkages between the 3 departments (2)

Potential reasons for the reported limited cooperation

- Inadequate communication within the ministry
 - from HQ to district level
 - within the 3 departments at district level
- Gaps in terms of information, guidelines and policy from the HQ on how to cooperate with the other departments
- Lack of knowledge about MCH programmes among CD/SW staff and lack of knowledge about CD/SW programmes among MCH staff
- Unclear boundaries and unclear mandate, esp. MCH
- Different backgrounds of staff (qualifications and experience)
- Concern about the distribution of resources
- Reluctance to share information within the 3 departments
- Physical distance: departments often in separate locations/buildings in a district

Programmes at all 3 departments

- Gaps in cooperation between the 3 departments leads to duplication and fragmentation of service delivery in the communities
- Similarity between community programmes:
 - within the programmes at the MCH
 - within the 3 departments
- Concerns identified about identification and coverage of beneficiaries
- Possibilities to combine some programmes. For example:
 - Same aims and beneficiaries, e.g. Food and nutrition (MCH) could be combined with FSP (CD)
 - CWAC and NHC could be combined
 - Psycho-social counselling – done by all 3 departments

Community Based Volunteers (1)

Number

- There are large numbers of CBVs, but not all of them appear to be active
- Many groups of CBVs operate in a community
- Most groups of CBVs consist of 10-20 members
- Activities of CBVs in the communities could be better coordinated and organised

Multiple roles

- Many CBVs often have multiple roles (e.g. SMAG members, TB/ART adherence councillors or malaria control agents,) often with limited coordination/engagement with NHC
- Some CBVs work under multiple committees under the 3 departments
 - For example, NHC members are also CWAC members (SW)
- No sharing of a register of beneficiaries – potentially leads to assistance of the same beneficiaries and missing out on others

Community Based Volunteers (2)

Duplication and fragmentation of CBV activities

- Limited common meetings take place
- Limited sharing of information
 - about their planned and executed activities
 - about their beneficiaries
- Many CBVs do not have a work plan
- The NHC is meant to oversee activities on health, but this is often not the case
- NGOs with different interests further re-enforce fragmentation and lack of coordination of the groups of CBVs
- Competition among CBVs

Community Based Volunteers (3)

Resources

- Health centres and district teams have limited resources to coordinate activities and arrange meetings with CBVs
- Unfavourable relationships where some health centres prefer certain groups of CBVs to deliver activities
- Unclear roles and rules of engagement between health centres and programmes/groups of CBVs

Community Based Volunteers (4)

Preferences and rivalry among CBVs

- Different resources and remuneration for CBVs
- Different training curriculums are provided by programmes under MCDMCH and different NGOs

Unclear how often CBVs go into the communities

- Health CBVs usually work in a health facility and indicated that most (potential) beneficiaries come to them (do not go into the community)
- Almost all CBV claimed they did not have transport to go into the communities

Supervision

- Most CBVs feel that supervision given is inadequate
 - Usually consists of reading reports submitted by CBVs
 - Supervisors have little time to act upon the reports submitted
 - Often supervisors are based a long distance (at the district office) from the CBVs

Community Based Volunteers (5)

Drop-outs of CBVs

- High drop-out rates
- No or little incentives but high expectations
- Feeling of not being appreciated
- Lack of supervision

Elections for CBV

- Most CBVs are elected by the community
- Some CBVs appointed by the headman or health authorities
- Sometimes coercion is used to be elected
- Sometimes the community is not involved in the election

Unclear effects of CBV activities

- Limited measurement in terms of the
 - Effects of CBV activities
 - Need for CBV activities
 - Number of CBVs needed

Community Health Assistants (CHAs)

- CHAs are a new cadre of health staff based out of Health Posts

Challenges linked to supervision

- CHAs experience problems concerning their position and level of supervision
 - Understaffing at health facilities means there is insufficient supervision
 - Unclear reporting structures – district and/or national level

Acceptance of CHAs – by the community and by CBVs

- Tasks of CHAs: need to collaborate with CBVs on community activities; and coordinate CBVs under MCH
 - Of the CHAs interviewed they work mainly in the health facilities – occasionally go out into the communities
- Challenges where CHAs have to coordinate CBVs who are often older
 - Community level experience, knowledge and contacts of CBVs compared to CHAs
 - Linked to CHAs receiving a salary vs. CBVs working as volunteers

Recommendations

Enhancing collaboration

Guidelines for the 3 departments

- Put in place clear national guidelines/strategy on coordination and management for staff within the 3 departments from national through to community level in accordance with the realignment of MCDMCH
 - Clear structure
 - Clear job descriptions
 - Clear channels of communication
 - Clear guidance on Government/CSO engagement to support programme delivery
- Put in place clear national guidelines/strategy on the coordination and management of CBVs

Coordinator role and team at district level

- Put in place a district level coordinator and coordinating team to oversee the 3 departments. This could be led by the DCMO

Enhancing collaboration – at community level

Combining the tasks of CBVs linked to the merger of programmes

- Several tasks of groups of CBVs could be combined, following the merging of programmes

Supervision of CBVs

- The CDAs could be given the task to develop and supervise common action plans in the communities. The CDAs could facilitate a platform or meetings for different groups of CBVs to enhance cooperation between CBVs
- The CDAs could supervise all CBVs (including those in the health sector). Therefore the CDA could be better trained on how to supervise CBVs, and have a broader training including health and social welfare issues

Committee structures should be simplified

- Based on a new community level coordination structure an overall committee could be designated to supervise the CBVs. The CWAC could be given this role; meaning that other committees such as the NHC could be disbanded
- In addition a common point of contact for all CBVs would help to facilitate better coordination of the volunteers

Programmes

A simplification and combination of the programmes being delivered in the communities.

- Overlaps between programmes suggest that some programmes may be good candidates for being combined
- Look into synergies between programmes, as well as how they could be combined. For example:
 - MCH programmes on HIV and TB, HBC and PMTCT have overlaps and offer areas for synergies, as well as the programmes on SMAG, PMTCT, Family planning and Community Based Distributors
 - Programmes on Food and Nutrition (MCH) could be combined with FSP (CD)
 - Psycho-social counselling could be done by one department (potentially Social Welfare)

Training and selection criteria

Harmonisation of training curriculums

- Combining training areas into a multi-faceted training curriculum would help the CBVs to provide better integrated services to the communities. This should include guidelines for standardised training packages for each programme
- CBVs should receive refresher training at standard intervals based on national guidelines
- All CBVs delivering services should have received a standard package of training

Re-assessment of the selection criteria for programmes to allow more women to become a CBV

- The selection criteria could include a revision of the minimum education level required to recruit CBVs and /or could include a quota based recruitment criteria

Incentives

Harmonisation of basic incentives given to CBVs

- Provide guidelines for a common and equal system of remuneration for CBVs; for both CBVs affiliated to the Ministry and to CSOs

Management of CBVs

Development of a CBV MIS system

- Setting up a good data management information system for CBVs
 - Link to HMIS or separate system
 - Roll out the survey to the remaining districts in Zambia that were not part of the original survey to complete the picture of the state of the skills and structures of CBVs in the country
 - Use of CBV data to inform micro planning at district levels and support the management of CBVs

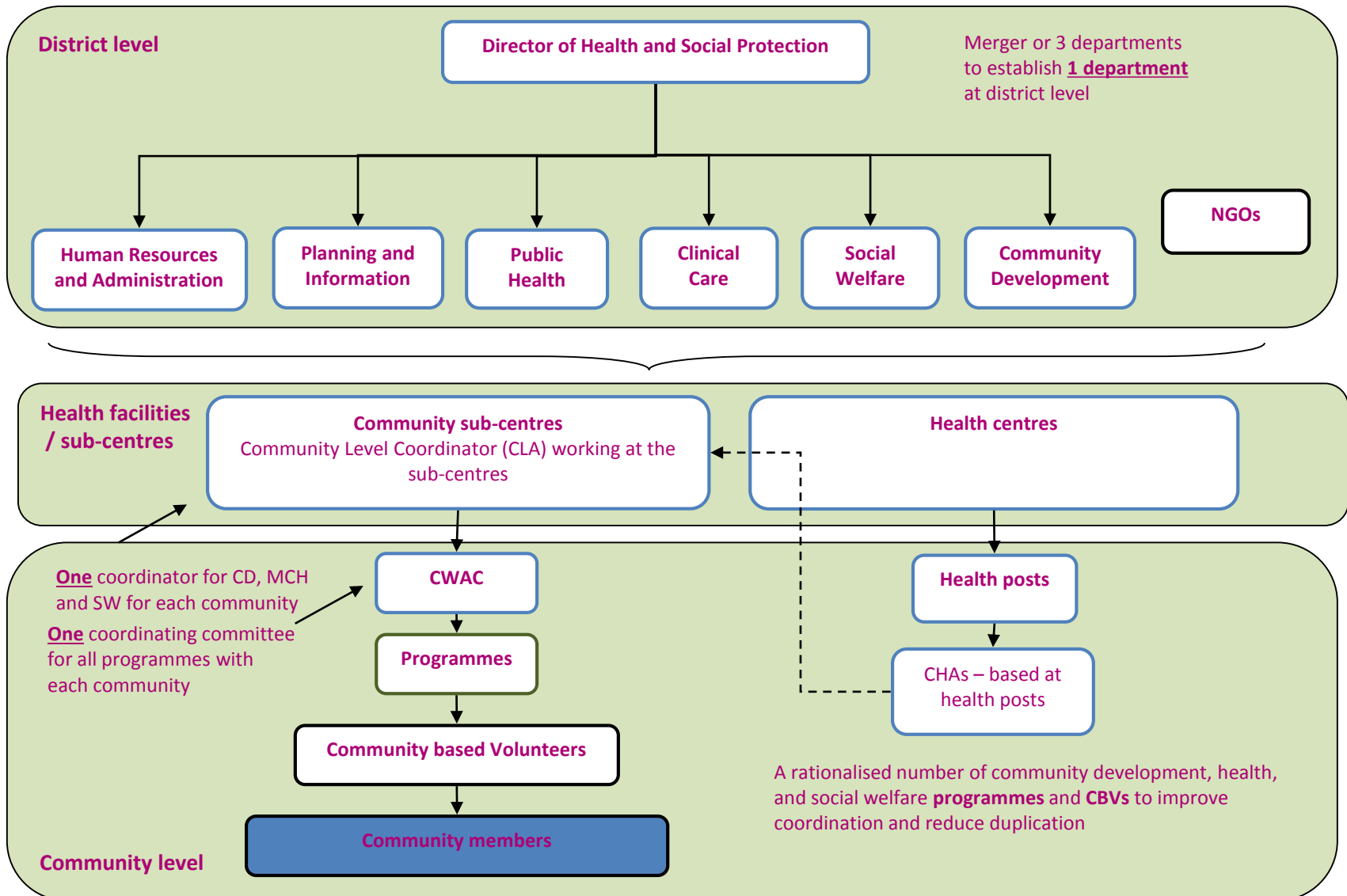
Evidence and impact

- Set up baseline studies to assess the needs for CBV activities in the communities, to assess the number of CBVs in the community/health facilities, and to measure the effects of the CBVs' activities in the communities

CBV guidelines/strategy

- Further develop strategy paper on the management and coordination of CBVs at district and community level in line with the realignment of MCDMCH

District and Community level structures – Option



Panel session on the research findings and recommendations