

Enhancing the coordination of Community Based Volunteers to promote integrated community development, health and social welfare services

August 2014

This report presents research from the Structures and Linkages Study that was carried out for the Ministry of Community Development, Mother and Child Health





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Report on the Structures and Linkages Study

Research for the Ministry of
Community Development, Mother and Child Health

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Table of Contents

Table of Figures.....	iii
List of Abbreviations	iv
Acknowledgements.....	vi
Definition of a Community Based Volunteer	vii
Executive Summary: Structures and Linkages Study	viii
1 Introduction.....	1
1.1 Introduction to the research.....	1
1.2 Background of the research.....	1
1.3 Objectives of the research	1
1.4 Definitions of Terms: Community Based Volunteers.....	2
1.5 Research report.....	3
2 Literature review	4
2.1 Research on CBVs in the health sector in Zambia	4
2.2 CBVs in the Community Development and Social Welfare sectors.....	5
2.3 Relationships between CBVs and health facilities	6
2.4 Definitions of volunteers and voluntarism	7
2.5 Questions on Motivations of CBVs, Ethics and Sustainability.....	8
2.6 MCDMCH and MoH Policies on CBVs	9
2.7 Realignment of the MCDMCH departments of CD, MCH and SW.....	11
3 Research Methodology.....	13
3.1 Sampling of five districts.....	13
3.2 Interviews.....	13
3.3 Focus Group Discussions (FGDs)	15
3.4 Data analysis	15
3.5 Limitations of the study	16
3.6 Consultations with stakeholders.....	16
3.7 Literature review.....	16

4	Research Findings: The Ministry’s Departments and Programmes	17
4.1	General situation and (lack of) cooperation between the three departments	17
4.2	Programmes of the Ministry of Community Development Mother and Child Health	23
5	Research Findings at Community level: CDAs, CHAs and CBVs.....	30
5.1	Ministry’s members of staff at community level: CDA and CHA	30
5.2	Committees of Community Based Volunteers: CWAC and NHC	32
5.3	Issues concerning Community Based Volunteers in the communities.....	34
6	Possibilities for cooperation at District and Community level	43
6.1	Possibilities for collaboration between the three departments.....	43
6.2	Possibilities for combining programmes of the three departments.....	47
6.3	Possibilities for combining various groups of Community Based Volunteers	51
7	Conclusions and Recommendations	53
7.1	Overall conclusions	53
7.2	Recommendations	56
	References	62
	Appendix A: Interview Guides	64
	Appendix B: Questions for Focus Group Discussions with CBVs	79

Table of Figures

Table 1: Summary of interviews by district	14
Table 2: Summary of Programmes.....	24
Table 3: CWAC and ACC numbers.....	33
Figure 1: Existing District and Community Structure (relating to MCDMCH).....	58
Figure 2: Proposed new District and Community Structure – Option 1	59
Figure 3: Proposed new District and Community Structure – Option 2	60
Figure 4: Proposed new District and Community Structure – Option 3	61

List of Abbreviations

ACC	Area Coordinating Committee
ACDO	Assistant Community Development Officer
ART	Anti-Retroviral Therapy
ASWO	Assistant Social Welfare Officer
CBO	Community Based Organisation
CBV	Community Based Volunteer(s)
CD	Community Development
CDA	Community Development Assistant
CDE	Classified Daily Employee
CDO	Community Development Officer
CHA	Community Health Assistant
CHAI	Clinton Health Access Initiative
CHW	Community Health Worker
CPs	Cooperating Partners
CWAC	Community Welfare Assistance Committee
DAPP	Development Agency from People to People
DC	District Commissioner
DCMO	District Community Medical Officer
DDCC	District Development Community Committee
DFID	UK Department for International Development
DHIO	District Health Information Officer
DMO	District Medical Officer
DWAC	District Welfare Assistance Committee
EHT	Environmental Health Technician
FBO	Faith Based Organisation
FGD	Focus Group Discussion
FP	Family Planning
FSP	Food Security Pack
FSPC	Food Security Pack Committee
GMP	Growth Monitoring Promoters
GRZ	Government of the Republic of Zambia
HBC	Home Based Care
HCAC	Health Centre Advisory Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IHTO	Information Health Technologist Officer
JICA	Japan International Cooperation Agency
MCDMCH	Ministry of Community Development, Mother and Child Health
MCH	Mother and Child Health
MCDSS	Ministry of Community Development and Social Services
MoH	Ministry of Health
NGO	Non-Governmental Organisation
NHC	Neighbourhood Health Committee
OVC	Orphans and Vulnerable Children

PCMO	Provincial Community Medical Officer
PCS	Psycho-social counselling
PMO	Provincial Medical Officer
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPTCT	Prevention of Parent to Child Transmission (of HIV)
PWAS	Public Welfare Assistance Scheme
SCT	Social Cash Transfer
SMAG	Safe Motherhood Action Group
SWO	Social Welfare Officer
TB	Tuberculosis
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VSO	Voluntary Service Overseas
WA	Women's Association
ZISSP	Zambian Integrated systems Strengthening Programme
ZKR	Zambian Kwacha revised
ZPCT	Zambian AIDS Prevention Care and Treatment
ZPI	Zambian-led prevention initiative

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Definition of a Community Based Volunteer

Community Based Volunteers (CBVs) were defined as:

Active Zambian citizens from the communities who are delivering services under programmes in the field of community development, mother and child health, and/or social welfare to their community on a voluntary (unpaid) basis.

Executive Summary: Structures and Linkages Study

I) Introduction to the research

This report is the result of a study conducted within the Ministry of Community Development, Mother and Child Health (MCDMCH) in conjunction with VSO (Voluntary Service Overseas). The research focuses on the community structures that aim to provide service delivery in the communities, and how Community Based Volunteers (CBVs) could be better utilised and strengthened, in order to provide better services in the communities.

In October 2011, the Ministry of Community Development and Social Services (MCDSS) was realigned, and the Department of Mother and Child Health (MCH) was moved from the Ministry of Health to the Ministry of Community Development and Social Services, which became the Ministry of Community Development, Mother and Child Health (MCDMCH).

The Ministry depends on CBVs to help deliver services in the communities in the fields of community development, health, and social welfare. A CBV is a local Zambian person who delivers services in the fields of community development, primary health care, and/or social welfare to their community on a voluntary basis i.e. they are not formally paid for the services that they deliver.

The Ministry seeks ways to enhance cooperation between the Departments of Community Development, Mother and Child Health, and Social Services to strengthen community health systems, and to improve the coordination and utilisation of CBVs, in order to lead to better service provision in the communities.

II) Objectives of the research

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

In order to achieve these objectives, the following actions were carried out:

- Qualitative research in five sample districts to better understand the working relationships, structures and linkages between community structures in the areas of community development, health and social welfare
- A skills audit of Community Based Volunteers in 30 districts in Zambia (The findings are presented in a separate report).

III) Research Methodology

Fieldwork for the qualitative Structures and Linkages Study was conducted in five districts: Kasama, Kasempa, Mwense, Ndola and Serenje. Although this is a small sample, the research findings can be

generalised because the districts operate in the same way and the data gathered were consistent among the sampled districts, meaning that it is likely that research in other districts would give the same results. In these five districts, 45 interviews were conducted with members of staff at the districts: Community Development Officer (CDO), Community Development Assistant (CDA), Social Welfare Officer (SWO), District Community Medical Officer (DCMO), Environment Health Officer (EHT), Information Health Technologist Officer (IHTO), Planner, District Commissioner (DC), District Welfare Assistance Committee (DWAC) members and the Community Health Assistant (CHA), five Area Community Committee (ACC) chairpersons and a Community Health Worker (CHW).

Also, 28 Focus Group Discussions (FGDs) were held with a variety of groups of CBVs including: Food Security Pack Committee (FSPC), Women's Associations (WA), Community Welfare Assistance Committee (CWAC), Neighbourhood Health Committee (NHC), Safe Motherhood Action Group (SMAG), TB/ART adherence counsellors, and Community Health workers (CHW). A total of 199 CBVs were included in the FGDs. When combined with the CBVs that were interviewed, a total of 205 CBVs were included in this study.

In addition, stakeholders were consulted and a literature review of relevant studies on CBVs and Ministry documents was carried out.

IV) Research Findings and Conclusions

The research found that there are some challenges between the three ministry's departments, which leads to a lack of cooperation and overlap of programmes.

a) Departments of Community Development (CD), Mother and Child Health (MCH), and Social Welfare (SW)

It is clear that there is a limited working relationship between the departments of MCH and CD/SW. Since the departments of CD and SW have been within one ministry since 1964, in most districts there is a good working relationship and cooperation between these departments.

There are several reasons for this lack of cooperation:

- District members of staff reported experiencing a lack of information, guidelines and policy from the ministry headquarters as to how to cooperate with the other departments, and what is expected of them. There is a lack of communication within the ministry, both from headquarters to district level and within the three departments. Therefore, the members at district level felt that they are left alone in this process of expected cooperation at district level
- A lack of knowledge among CD and SW staff about MCH programmes and among MCH staff about the CD and SW programmes
- Many MCH and CD/SW staff members showed a lack of interest in the other departments' programmes, possibly because the members of staff come from different backgrounds
- Different types of funding are accessed by the three departments
- Distrust exists among several staff members of the three departments, meaning they are reluctant to share information and a fear of having to share resources, especially for MCH staff;

members of staff at the CD and SW departments are 'jealous' about the MCH having more resources.

However, certain members of staff saw the need to work together because they are in one ministry, though they are unsure how or where to start. Some members of staff have made individual attempts to have meetings between the departments, but in the districts sampled in this study these efforts have failed, so there are no meetings and no information sharing about each other's activities.

The lack of cooperation and information sharing at district level is impacting on programmes: it leads to fragmentation of service delivery and to the duplication of programmes in the communities.

b) Programmes under the three departments of CD, MCH and SW

Currently, there is a lot of overlap between the programmes under CD, MCH and SW in the community, while also several programmes within the MCH department have similarities. Moreover, almost all programmes focus on the same beneficiaries (vulnerable/poor people).

Community Based Volunteers (CBVs)

The activities and service delivery of the CBVs in the communities are not integrated, but separated. There are many CBVs, but not all are active. There are many groups of CBVs in a community, meaning a group of volunteers who work in the same field, e.g. malaria, TB/ART, Food Security, and under either the same departments in the Ministry or an NGO/FBO. Most of these groups consist of 10-20 CBVs per group.

Many CBVs have multiple roles and are members of more than one group of CBVs. In addition, many groups of CBVs focus on the same (type of) beneficiaries, usually vulnerable, poor people or the chronically ill in the community. These multiple roles of individual CBVs and groups of CBVs give several opportunities for cooperation and better coordination of the activities of CBVs in the communities and to strengthen the work of CBVs.

There is competition and a lack of common vision among the CBVs as to how to deliver their mandate. The research found that different groups of CBVs do not work together. There are no common meetings of the various groups of CBVs, and there is no sharing of information about their activities, and about the beneficiaries they have reached. The lack of a common vision is due to the fact that some groups of CBVs only do what they have been trained to do, while at the same time other individual and/or groups of CBVs go beyond their tasks. In addition, different groups of CBVs are supported by different organisations. This blurs the situation and the activities of the CBVs.

Many CBVs do not have a work plan and/or a job description. The lack of a job description and/or a work plan results in duplication and gaps in activities. The NHC is supposed to oversee the activities concerning health in the communities, but this is often not the case. The different organisations with different interests further re-enforce the isolation of the groups of CBVs.

CBVs have different resources, remuneration and different trainings. This is due to the fact that the groups of CBVs are affiliated to different NGOs and to MCDMCH. The CBVs consider this dependency on resources of different partners as unfair, and it causes rivalry between the different groups of CBVs. This unfairness in sharing limited resources and poor communication between groups of CBVs is perpetuated

by different NGOs. Hence, there is tension among the different groups of CBVs, whereas some groups of CBVs tend to be dominant in the community.

Health centres have limited resources to coordinate and arrange meetings with CBVs. There are differing relationships between the health centre and certain groups of CBVs; some health centres favour certain groups of CBVs to others, and there are unclear roles and rules of engagement between health centres and groups of CBVs.

It is unclear how often CBVs go into the community. The CBVs who work in the health sector usually work in a health facility, while other CBVs indicated that most potential beneficiaries come to them instead of the CBVs going into the community. Moreover, all CBVs claimed they did not have transport to go into the communities.

The CBVs lack proper supervision. Supervision is very superficial as supervisors have little time to read reports submitted by the CBVs and to act upon them.

There is a high drop-out rate of the CBVs, predominantly due to a lack of incentives and subsequent motivation of CBVs, who often feel unappreciated. All CBVs wished to receive allowances, and many indicated they wanted to be on the government's payroll. This raises questions about their motivations and ethical questions as to how to deal with CBVs. Moreover, it also raises questions as to how sustainable it is for the ministry to depend on CBVs (with a high drop-out rate) for service delivery in the communities.

There are different methods of elections to become a CBV, which are perceived sometimes to be unfair. Some people use coercion to be elected, while sometimes medical staff appoint CBVs without consulting other community members.

The training of the CBVs varies, from one day to three weeks. Many CBVs indicated they wished to have more training, particularly as trainings are seen as an incentive.

The impact of the activities of the CBVs is unclear. There is no measurement of the need for activities, for the number of CBVs required, and on the effects of the CBVs' activities in the communities.

V) Recommendations

Based on the analysis of the findings, the recommendations made concern collaboration between the departments, synergising programmes, and cooperation between the CBVs. Recommendations related to the restructuring of positions and activities at district and community level are displayed diagrammatically in the main report (see Chapter Seven).

a) Concerning collaboration between the three departments

At national level

- The Ministry should put in place clear guidelines/policy on how the departments should cooperate, and sensitise staff at district level about what is expected of them in accordance with the realignment of MCDMCH. It should be emphasised that the three departments are equal.
- The Ministry should take the lead in facilitating communication and providing information to districts (and provinces). Information could be provided by general newsletters from

headquarters, by circular letters and by headquarters staff visiting the three departments in the district, and not only the department they are affiliated to.

At district level

- At district level, in order to meet the need for more communication and to enhance cooperation between the three departments and to share information, a coordinator or coordinating team should be appointed as an overall body. This could be led by the DCMO
- A district coordinator or coordinating team should organise regular meetings of the three departments and emphasise the importance of information sharing, while it should also plan, coordinate and budget for common activities
- There should be one focal point to which potential beneficiaries can be referred. This would enhance departmental cooperation and improve service delivery
- There is need for a Social Welfare Officer in health centres. This would enhance cooperation between the departments of SW and MCH, and improve service delivery
- The ministry (at all levels) should look into synergies between programmes, as well as how they could be combined. MCH programmes on HIV and TB, HBC and PMTCT could be combined, as well as the programmes on SMAG, PMTCT, Family planning and Community Based Distributors. Also, the programmes on Food and Nutrition (MCH) could be combined with FSP (CD). Psycho-social counselling could be done by one department (preferably Social Welfare).

b) Concerning Community Based Volunteers

At community level

- Several tasks of groups of CBVs could be combined, following the merging of programmes. This would decrease the number of CBVs but probably would stabilise the number of active CBVs
- The CDAs should be given the task to develop and supervise common action plans in the communities. The CDAs should facilitate a platform or meetings for different groups of CBVs to enhance cooperation between CBVs
- The CDAs should supervise all CBVs (including those in the health sector). Therefore the CDA should be better trained on how to supervise CBVs, and have a broader training including health and social welfare issues
- The CWAC should be appointed as the overall committee to supervise the CBVs and to identify potential beneficiaries and problems in the communities. This means that the ACC and the NHC could be disbanded
- The ministry should provide guidelines for standardised training, and ensure that the groups of CBVs have a standardised training with regular (once every three years) follow-up
- The ministry should ensure that CBVs have a clear job description, as well as set out the criteria for becoming a CBV (not only grade 7/literate, because not everyone is required to write reports)
- The ministry should provide guidelines for a common and equal system of remuneration for CBVs; both CBVs affiliated to the ministry and to NGOs. The distribution of remuneration of CBVs affiliated to NGOs could be done through the ministry

- The ministry should take the lead in enforcing the policy on how to work with NGOs including the registration of NGOs through the Department of Registrar of NGOs
- CHWs could be upgraded with more training so that they could become assistant nurses, by way of a new cadre
- The ministry should facilitate baseline studies to assess the needs for CBV activities in the communities, to assess the number of CBVs in the community/health facility, and to measure the effects of the CBVs' activities in the communities. This should be demand driven.

1 Introduction

1.1 Introduction to the research

This report is the result of a study conducted within the Ministry of Community Development Mother and Child Health (MCDMCH), and carried out in conjunction with VSO (Voluntary Service Overseas). The research focuses on the community structures that aim to provide service delivery in the communities. These include the Departments of Community Development (CD), and Mother and Child Health (MCH), and Social Welfare (SW) at district level and the Community Based Volunteers (CBVs) working for these departments. The aim of the study was to scrutinise how the three departments could work together and how the CBVs could be better utilised and strengthened, so as to provide better services in the communities.

1.2 Background of the research

Since Zambia's Independence in 1964, the Ministry of Health (MoH) has been responsible for all health services and the former Ministry of Community Development and Social Services (MCDSS) was responsible for the provision of community development, social services, and the promotion and preservation of culture. Its mission was to provide socio-economic empowerment to the poor and vulnerable, and promote sustainable development.

In October 2011, MCDSS was realigned, and the promotion of culture was moved to the Ministry of Tourism and Chiefs and Traditional Affairs. MoH was divided into Health (concerning the main [level 1] hospitals) and Primary Health Care including Maternal and Child Health issues. The latter, known as Mother and Child Health (MCH), was transferred to MCDSS, which became the Ministry of Community Development, Mother and Child Health (MCDMCH). With the transfer of MCH to the other two existing departments within the ministry, MCDMCH was considered a new ministry (MCDMCH 2013b). The realignment was considered necessary in order to properly react to the need to holistically address the issues of extreme poverty and health by using existing and available community and primary health care structures in an integrated manner.

In addition, due to the under staffing at health facilities and government staff at the three departments (Community Development, Mother and Child Health, and Social Welfare) at district level, the need for voluntary workers in these sectors has been growing, and subsequently the ministry largely depends on the work of CBVs. The number of CBVs has increased rapidly in the past decade. Therefore, the ministry sees the need to streamline the work of the various groups of CBVs. In this regard, the ministry sought ways to strengthen community health systems, and to improve coordination and utilisation of CBVs, which will lead to better service provision in the communities.

1.3 Objectives of the research

The merging of the departments of Community Development, Mother and Child Health, and Social Welfare has not yet led to an appropriate level of collaboration between these departments; neither at

the Ministry's headquarters, nor at Provincial and District levels. This is reflected in their programmes on community development, primary health care, and social welfare in the communities. For this reason the Ministry sought ways to improve cooperation between the three departments at all levels, including at community level. Therefore, more insight was needed into the relationships and linkages between the community structures in the areas of community development, health, and social welfare.

Moreover, the Ministry wanted to strengthen existing structures and improve the coordination and utilisation of CBVs as a key way to deliver on its mandate. In order to assess how the coordination and utilisation of CBVs can be enhanced, there was need to develop a baseline of who these volunteers are, how they work, their tasks, their background, their training, their skills, and performance. The need for more information about CBVs has increased due to the large number of CBV; their numbers are estimated by MCDMCH sources to be at least 100,000 CBVs for the whole of Zambia.

Therefore, the objectives of this research were:

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

In order to achieve these objectives, the following actions were carried out:

1. Research in five sample districts to better understand the working relationships, structures and linkages between community structures in the areas of community development, health and social welfare
2. A skills audit of Community Based Volunteers in 30 districts in Zambia (The findings of the Skills Audit are presented in a separate report).

1.4 Definitions of Terms: Community Based Volunteers

There are many different names for Community Based Volunteers (CBVs). The names differ not only according to their tasks, but more confusingly, according to the different organisations that they work with such as MCDMCH, NGOs, FBOs and CBOs. Therefore, reference to CBVs in the literature is inconsistent. Their names are for instance: Community Health Workers (as a generic name, not a specific category), care givers, health advisors, health promoters, growth monitoring promoters, home based care workers/caregivers, lay health counsellors/advocates, community distributors, malaria control agents, TB treatment supporters/counsellors, HIV counsellors, ART adherence counsellors, and so on. For all these in this study the name CBV is used.

In this study the following definition is used:

A Community Based Volunteer (CBV) is a /Zambian citizen who delivers services in the fields of community development, primary health care, and/or social welfare to their community on a voluntary basis i.e. they are not formally paid for the services they deliver.

1.5 Research report

This report is composed of seven chapters. Following this introductory chapter the report is structured as follows:

- Chapter two provides an overview of the literature on CBVs in Zambia and documents from the government on strategies within MCDMCH and MoH
- Chapter three explains the research methodology used
- The following chapter, chapter four, presents the research findings concerning the three departments of the ministry and their programmes at district level
- In Chapter five the findings at community level and community structures such as CDAs, CHAs and CBVs are discussed, as well as issues concerning various groups of CBVs
- Chapter six suggests possibilities for cooperation at district and community level, and combining programmes, in order to avoid duplication of programmes and better utilise and strengthen CBVs and community structures
- Chapter seven sets out the conclusions and recommendations from the research.

2 Literature review

This chapter gives an overview of the literature on Community Based Volunteers (CBVs) that has been used for this research. The literature consists of research reports, reports by NGOs, and relevant government documents concerning CBVs in Zambia. CBVs in Zambia have frequently been the topic of study, especially in the past decade. However, many of these reports have not been published, and are therefore hard to find (Cockburn, Krupa and Saunders 2012). Yet, there are a number of (recent) documents on CBVs.

The first part of this chapter examines CBVs in the health sector, and then in the community development and social welfare sectors, and pays attention to the relationship between the CBVs and health facilities. The next part defines voluntarism and discusses motivations of CBVs, questioning the sustainability of service delivery by volunteers. The last part of this chapter discusses the ministry's lack of a policy on CBV, and discusses problems concerning the realignment of the new ministry.

2.1 Research on CBVs in the health sector in Zambia

The majority of the research on CBVs focuses on volunteers working in the health sector, which is not surprising because the majority of CBVs work in the health sector. Since the 1978 Alma Mater Declaration on primary health care, Zambia, as well as other developing countries, has utilised Community Health Workers (CHWs) or volunteers to alleviate the workload of where the number of clinicians is scarce, especially for the provision of basic, preventive and curative health services (MoH 2010). This was further developed by the government's policy, developed in 1991 by the MoH to promote community involvement as a means of bringing essential health care closer to the family. For this reason, the Neighbourhood Health Committee (NHC) was established in 1991.

Within the health sector, most studies predominantly focus on volunteers working in HIV and AIDS projects, since these are the majority in the health sector. For instance, Rasing (2009a and 2009b) has studied Home Based Caregivers and volunteers working in other HIV-related projects in Zambia, while the CAN (2013) studied Home Based Caregivers working for HIV positive people, and ZPI (2013) conducted research among CBVs working for STEPS OVC, who predominantly work in the field of HIV and AIDS.

The large number of CBVs working in the field of HIV and AIDS is due to a long existing and growing lack of medical staff at health facilities, and to the HIV and AIDS epidemic that started in the early 1980's, which overburdened the already limited number of medical staff and the lack of sufficient beds in health facilities. These reasons are combined with the fact that in Zambia, until the late 1990s, there was no medical treatment available for HIV and AIDS, so people with HIV and AIDS were left to die in their homes. This created the need for caregivers who would care for these bedridden patients in their homes. Therefore, Home Based Care was established in the late 1980s and early 1990s. This was initially set up by FBOs from the Catholic Church, but was soon taken over by other mainstream churches, and later by NGOs (Rasing 2006 and 2007, Van Dijk et al 2014).

Due to the availability of free ART in Zambia since 2003, the work of the Home Based Care has drastically changed from caring for bedridden patients to sensitisation of the community about HIV prevention, testing and counselling (VCT) and adherence counselling (see Rasing 2009a). In addition, other types of CBVs in the health sector were established such as malaria agents, and later on a wide range of CBVs were established specifically focusing on child health, care for mothers and new born children. Even though there is an equal need for CBVs across all programme areas, HIV and AIDS programmes have the most CBV support, while environmental health and malaria programmes have the lowest support (MoH 2011).

The establishment of many programmes and subsequently many groups of CBVs resulted in a large and unregulated informal health sector, which consists of numerous trained and untrained CBVs (MoH 2011). The Human Resource for Health Strategic Plan 2011-2015 (MoH 2011) indicates that 32% of rural health centres and 48% of urban health centres rely on CBVs. About half of them work part time.

2.2 CBVs in the Community Development and Social Welfare sectors

Studies on CBVs in the community development and social welfare sectors have been conducted less often than those in the health sector, and documentation available on these studies are therefore few. Research on social cash transfer (SCT) – a social welfare programme for which beneficiaries are identified by CBVs in the Community Welfare Assistance Committee (CWAC) – within the former MCDSS was conducted by Chandang’oma and Kakoma (2008). Beazley and Carraro (2013) conducted research on various Community Development and Social Welfare programmes executed by volunteers in the current MCDMCH.

Chandang’oma and Kakoma (2008) indicate that the SCT had first started as a pilot project in five districts in 2003. SCT has been piloted as part of the strategy towards the provision of social assistance to households that cannot be reached by labour-based schemes such as food or cash for work or micro-credit. The authors indicate that the main objectives of the SCT are: 1) to assist the most destitute and incapacitated households in society and meet their basic needs, particularly health, education, food and shelter, and 2) to generate information on the feasibility costs and benefits and all positive and negative impacts of the SCT scheme as a component of the Social Protection Strategy in Zambia.

The authors state that the delivery of the SCT largely depends on the CWAC, a community volunteer structure at zone level, and on the Area Coordinating Committee (ACC) at the sub district level for the service delivery to the beneficiaries. These volunteer structures are primarily responsible for the targeting and identification of beneficiaries among the most destitute and incapacitated households in their communities. The demands of the SCT scheme on the volunteers who themselves are vulnerable have become more apparent in recent years. This situation is not unique to SCT but also among other programmes using community volunteers for the delivery of the programmes at grassroots level. There is need for the structures of CWAC to stay motivated over time. According to Chandang’oma and Kakoma (2008) CBVs involved in SCT do more work than CBVs involved in Public Welfare Assistance Scheme (PWAS). Moreover, the authors claim that CBVs can make a valuable contribution to community development, more especially when they have been identified and proven to increase access to and

coverage for social assistance services. However, for them to be more productive there is need for the programmes to carefully select the members through community participation and involvement.

Beazley and Carraro (2013) are slightly more critical in their report, especially when they write about the delivery of services, identification of beneficiaries and criteria for beneficiaries to be part of programmes like SCT and PWAS. They claim that the identification of PWAS beneficiaries by CWAC members seems to be arbitrary and not transparent (Beazley and Carraro 2013: 78). This is partly due to the lack of a proper poverty assessment as criteria to be part of the PWAS scheme. Further, their report indicates that for the Food Security Pack (FSP), of which beneficiaries are identified by the Food Security Area Committee and should be 'vulnerable but viable', it is difficult to assess whether the beneficiaries are really 'vulnerable and viable'. Each community defines vulnerability differently, and it is the Food Security Area Committee who decides whether a household is vulnerable.

Hence, the ministry's poverty index criteria for SCT and PWAS are unclear, while identification of beneficiaries for certain CD and SW programmes and schemes by the CWAC and Food Security Pack Committee (FSPC) seem to be arbitrary.

2.3 Relationships between CBVs and health facilities

ZISSP (2011) conducted an extensive study on mapping CBVs. The study was carried out in nine districts, one in each province in Zambia. In each of these districts three health centres were selected, where the volunteers worked from. The target groups were managers at the District Health Offices (DHO) and health centre levels, including the Health Centre Advisory Committees (HCACs). At community level the target groups were members of the NHC, Safe Motherhood Action Group (SMAG), and other groups of CBVs (ZISSP 2011: 6). The report indicates that training of CBVs was usually done at the beginning of a programme without any follow up. Most of the training focused on general health work done by specific groups and organised according to partner needs rather than community needs (ZISSP 2011: 17). The study also looked at the relationships between the health centre and the CBVs, the relationships between the different groups of CBVs, and the extent to which various interest groups worked together to find out what challenges and opportunities existed (ZISSP 2011: 21).

The study found that there are some tensions between the health centres and CBVs. The CBVs seem to be left out in planning actions, which was said to be due to limited resources. It was assumed by the DHO that the NHC would inform other CBVs about the actions in the community, but this rarely happened according to ZISSP (2011). The CBVs, however, blamed the health centres and the DMO for neglecting their suggestions. The study found that at health centre level the main challenges in working with CBVs were:

- limited resources to coordinate and arrange meetings with CBVs
- unfavourable relationships between the health centre and some groups of CBVs, and
- unclear roles and rules of engagement between health centre groups of CBVs.

This was made worse by a lack of documentation on the roles of the CBVs. This meant that stronger groups of CBVs tended to dictate what was needed to be done thereby causing frustration for weaker partners.

At community level the major challenges in working with the health centre related to a lack of incentives and motivation from the health centre staff, despite the CBVs helping with various tasks both at community and health centre levels. Most CBVs felt abused and unappreciated by health centre staff (ZISSP 2011: 21). Another challenge was the failure by health centre staff to keep scheduled appointments. This demoralised CBVs who travelled long distances only to find that meetings were cancelled. This was both attributed to the health centre staff being too busy with patients and to a lack of interest of health centre staff. Also, it was stated that some health centres favoured certain groups of CBVs to others. The lack of trust between the CBVs and health facility staff is also mentioned by Mungunda (2013). He states that this is due to previous experiences, such as health facility staff using project money or money that was entitled for CBVs, for fuel or for their own purpose.

The ZISSP report mentions that different groups of CBVs do not work together, which is contributed to lack of common vision, unfairness in sharing limited resources, and poor communication between groups of CBVs perpetuated by supporting partners (ZISSP 2011: 22). The absence of a common vision of the different groups of CBVs may be due to the fact that the groups are only doing what they have been trained to do, and are supported by different partners. Subsequently, they also have different resources. The CBVs consider this dependency on resources of different partners as unfair, and it causes rivalry between the different groups of CBVs. Also, the training depends on the partners. This causes issues of superiority and inferiority for the ones who have been trained more or longer than others. For instance, ZISSP mentions cases in which the NHC considers itself superior to CHWs and even to health centre staff (ZISSP 2011: 36).

In addition, there were no common meetings of the various groups of CBVs. There is no platform of sharing what they are doing, which results in duplication, gaps of complementary work and gaps in information. So, there is a high number of CBVs, but they rarely work together. The different partners with different interests further re-enforce the isolation of the groups of CBVs. Hence there should be clear guidelines on the roles of CBVs, proper and equal training for all CBVs, and equal sharing of resources.

ZISSP (2011) further claims that most of the health information collected tends to ignore information generated at community level. Yet, a key element in the community health system strengthening is supporting community based data collection (ZISSP 2011: 32).

2.4 Definitions of volunteers and voluntarism

The literature on Community Based Volunteers is inconsistent about the terminology of a CBV. MoH refers to these volunteers as CBV or Community Health Volunteers (2010 and 2011), while MCDMCH refers to them as volunteer caregivers (MCDMCH 2013c). USAID (2013) uses the term 'informal community volunteers', as opposed to 'formal health workers', who are elsewhere referred to as Community Health Assistants (CHA) (CAN 2013, CHAI 2013 and 2014, MoH 2013). In addition, they are also called health promoters, community health advisers, lay health advocates, community health representatives, and peer health educators (MoH 2010: 8). The CAN report refers to CBVs as 'community caregivers' (CAN 2013: 8), although they also use the term 'community based volunteers' (CAN 2013: 9).

MCDMCH defines volunteering as: “the commitment of time and energy for the benefit of society and the community. It is undertaken freely and by choice, without concern for financial gain” (MCDMCH 2013c: 28).

The Zambia-led Prevention Initiative (ZPI) (2013), in defining voluntarism, stated that commonly volunteerism is typically characterised as helping behaviour that is planned and enduring, non-obligated and thus distinct from family care giving or compelled social service, and neither economically necessitated nor impelled by monetary rewards. Such definition clarity, however, is often absent in reality. For instance, compensated CHW are usually considered volunteers. At the same time, many volunteers receive material or cash incentives while others do not. In addition, many volunteers join programmes explicitly in the hope of future employment, or, at the very least, with an expectation to receive material benefits from being a volunteer (ZPI 2013: 2).

Therefore, ZPI (2013) defined three types of voluntarism: the ‘pure’ volunteer, who has an unpaid helping behaviour and who does not seek material self-interest. The second type is the ‘paid’ volunteer type, or the volunteer with reservations. These volunteers expect or desire salaried employment or a monthly cash stipend. Thirdly, the ‘incentivised’ or partial volunteer that has a desire for a salary, cash allowances or food support. The majority (60%) of the volunteers in the ZPI study are ‘incentivised’ volunteers, while 21% were considered ‘pure’ volunteers and 19% expressed their wish to be formally employed or receiving regular cash payment (ZPI 2013: 30).

2.5 Questions on Motivations of CBVs, Ethics and Sustainability

The study conducted by ZPI (2013) explicitly focused on the motivations of CBVs working in the STEPS-OVC programme, especially working with OVC and People Living with HIV and AIDS (PLHIV). The objectives of the study were to understand the factors related to individuals becoming and remaining volunteers, to discern different motivations for becoming a volunteer, to see whether motivations and expectations were fulfilled, and to identify factors associated with volunteer retention. The findings are similar as found by Rasing (2009a) and CAN (2013). There is a variety of motivations, which are basically to help others in the community. Therefore, the CBVs feel embarrassed when they have to visit their clients empty-handed, especially when they see that the people they visit are in need of food, particularly when they are on ART. This affects their work, meaning that they do not visit as many clients as they are supposed to do (ZPI 2013: 31, see also Rasing 2009a). Female volunteers visit more clients than male volunteers, while there is no difference in urban and rural CBVs (ZPI 2013: 32). In addition to wanting to help people in the community, almost all CBVs wish to have some material or financial benefit. This is especially seen as a way to keep them motivated. This is not surprising. Most CBV are bread winners, and are usually self-employed as farmers, traders or doing other business, and supporting children and/or dependents, as found by Mungunda (2013).

Chandang’oma and Kakoma (2008) also pay attention to the motivation of the volunteers. They claim that CBVs should get some form of incentives, but preferably not in monetary form, since that may lead to uncommitted CBVs. The authors are in favour of providing equipment for the CBVs to do their job properly, such as bicycles and raingear. In addition, they suggest Income Generating Activities (IGA) and funding for the CBVs. However, Mungunda (2013) shows that the CBVs themselves prefer being

rewarded in cash, and not through an IGA. Nevertheless, it is the responsibility of government to sustain incentives in the long term (Chandang'oma and Kakoma 2008). This goes especially for the CWAC members and the NHC, since these are working voluntary for the government. Furthermore, the authors claim that the public perception of volunteering should be improved. There should be a healthy balance between rewarding the volunteers for their effort and encouraging them to contribute towards the development of their communities.

In this respect, several studies and stakeholders have begun to question the morality of using volunteers to perform important tasks in the community without being compensated, while using their own time and effort (Chandang'oma and Kakoma 2008, Beazley and Carraro 2013, CAN 2013, and ZPI 2013). This is especially so, since the services they provide are for the 'poor and vulnerable' people in their communities who they are supposed to identify and/or assist, while most volunteers are 'poor and vulnerable' themselves. Interesting is the ZPI (2013) conclusion that when voluntarism is defined as non-obligated or economically necessitated (see above), the question should be asked how much choice CBVs have. It can be assumed that exercise of choice and voluntary action is compromised for individuals who are faced with severe material needs and limited livelihood options. From this perspective, the ethics of continued reliance on poor volunteer workforces to deliver basic public health services in the name of sustainability must be examined, as ZPI (2013: 37) report.

Moreover, mainly due to a lack of incentives, there is a high turnover of CBVs (ZISSP 2011, CARE Zambia 2013, and ZPCT 2013). CARE Zambia is the only organisation that mentions the percentages of drop-outs. It indicated that the drop-out rate is between 5% and 45% annually, with the lowest percentage for volunteers who receive monetary incentives, such as volunteers working for ZPCT II and PRISM, while the highest drop-out rate is among the SCORES project, which does not give incentives (for community school teachers).

Compensation is one of the factors that contribute towards a motivated volunteer's structure. But the question is whether this is sustainable, as both Chandang'oma and Kakoma (2008) and ZPI (2013) indicate. Yet, these studies also raise questions about the sustainability of a health care system and social welfare system depending on voluntary services. For these reasons, there is need to reconsider voluntary services in the communities, and MCDMCH policies.

2.6 MCDMCH and MoH Policies on CBVs

The literature shows that many groups of CBVs work in isolation and lack a common vision. This is worsened by some partners who select special groups while leaving others unaware of the activities in the community. There is competition and rivalry rather than unity in the communities. This is partly due to the lack of a job description and clear roles for the CBVs. The literature also shows that there is need for a clear policy.

The Human Resource for Health Strategic Plan (MoH 2011) does not mention the utilisation or the strengthening of CBVs. Therefore, and in line with the other SADC countries, MCDMCH is in the process of developing a National Volunteer Caregivers Policy (MCDMCH 2013c). The aim of this policy is to support the legitimate needs of volunteer caregivers in order to have an adequately motivated community based health workforce that will contribute to improved quality of care for people living

with HIV and AIDS and other chronic illnesses. The draft policy objectives are: to offer a framework for standardised practice in managing caregivers within organisations; to protect and uphold the rights of caregivers; to set parameters to guide caregivers during the course of their duties, to recognise and motivate caregivers and create a supportive and enabling environment for them to operate in for quality and access to care; to facilitate and ensure that the rights of clients and patients to quality health care are upheld; and to ensure that the rights of families and caregivers to accurate information, education, rest and respite are realized through effective service delivery (MCDMCH 2013c: 11-12).

The Ministry seeks to formalize and rationalise the work of community health workers or volunteers “by recognizing volunteer caregiving as a remunerable activity” (MCDMCH 2013c: 1). The policy is aimed to be the national regulatory framework that will define minimum working conditions for CBVs. The policy will include specific roles and responsibilities of CBVs, guidelines for selection and recruitment of CBVs within communities, for training and capacity building, as well as recognition and retention of CBVs, and, through a government financed budget, provide remuneration to CBVs in cash or kind as a way of appreciating and recognising them (MCDMCH 2013c: 1). This is needed to improve service delivery and motivation of CBVs.

Even though CBVs have been playing a major role in the service delivery of primary health care, prevention and support since 1978, their role in the health sector has not been formalised (MoH 2010). Hence, the effectiveness of this approach is constrained by a lack of formal linkages with the health system and no formal accreditation or remuneration for CBVs (CAN 2013: 19). MoH has sought to approach and solve this issue by installing a new category of formally trained, deployed and remunerated health workers, the Community Health Assistants (CHAs) (MoH 2010, CAN 2013, MCDMCH 2013, MoH 2013). These CHAs are trained for one year, and are the link between the community and the health facility.

A limitation to the integration of CBVs in the public health system is the absence of a national community information system (C-HMIS), which means there is no database or register on CBVs. Therefore, the full integration of CBVs is a challenge (CAN 2013). At district level, coordination of activities of the CBVs is usually the responsibility of Environmental Health Officers. Since 2012, an initiative started by MoH and MCDMCH to collect and use the web-based data reporting system using mobile phones by CHAs through the District Health Information System (DHIS2).

MoH/MCDMCH lacks a community health focal person, and also an official policy to guide the CBVs (MoH 2010).¹ Further, implementing partners have different policies for training, recruitment, remuneration, and incentives for CBVs. Moreover, programmes funded and managed by implementing partners are typically on contracts for two to five years. In terms of training, there seems to be no standardised training in terms of a handbook and length of the training. MoH (2010) situational analysis showed an ad hoc system of CBVs has clearly contributed positively to the health issues in the communities, but there is a severe lack of coordination. Training and focus of the CBVs seem to be based more on the programmatic priorities of organisations and their donors than on the health needs

¹ The HRH programme of DFID was in the process of hiring these people for MOH and MCDMCH but staff changes meant this has not been installed, as was indicated during a meeting with DFID.

of the community, as observed by the DMOs (MoH 2010: 10). Furthermore, there is a lack of minimum requirements for training and supervision. In the past decade, many CBVs have been trained by MoH. However, due to several factors, such as a lack of incentives, lack of availability of kits, absence of follow-up trainings, many CBVs have been de-motivated and/or have stopped. Many of these factors can be contributed to a lack of coordinated national programme to guide the CBVs (MoH 2010: 10).

The National Health Strategic Plan (NHSP) 2011-2015 is aligned with the Sixth National Development Plan 2011-2015, and aims to increase access to health services through expanding a number of programmes, such as maternal, new born and child health immunization, malaria, TB, HIV and AIDS prevention, treatment and care, neglected tropical diseases, environmental health and non-communicable diseases. The NHSP contains an investment plan for health infrastructure development, including 650 new health posts (the lowest level health facility), the rehabilitation of 500 health facilities, and the upgrading of additional health centres and hospitals (MoH 2013: 22).

2.7 Realignment of the MCDMCH departments of CD, MCH and SW

In order to enhance strategies concerning CBVs in the communities, there is need for more cooperation between the Ministry's three departments. Wyatt (2013), whose research was conducted during the time that fieldwork for the present study was being carried out (end of 2013), has a similar topic of study to this research. His study focuses on the realignment of the tasks between the MoH and the Department of MCH at the MCDMCH, and the realignment of the three Departments of Community Development, Mother and Child Health, Social Welfare at the MCDMCH. He states that there is an unclear division of tasks between the MoH and MCDMCH, such as the training of medical personnel, and the allocation of physical assets such as vehicles, while the Provincial Health Officers report both to the MoH and to the MCDMCH.

A critical issue in the realignment of the MCDMCH is more communication: at district level the officers of Community Development, Mother and Child Health, Social Welfare have had little or no guidance of what is expected from them as one ministry. The report sets out a proposed strategy, but is a starting point for discussion rather than a culmination of a process (Wyatt 2013: i). Wyatt indicates that the realignment process is likely to be affected by the government's decentralisation agenda, in which the devolution of primary health care responsibility will be handed over to District Councils, which will probably start in 2014. The revised National Decentralisation Policy (NDP) envisages a large scale transfer of central government functions and matching resources to District Councils.

Wyatt suggests that since MCDMCH is responsible for the services delivered by district hospitals, health centres and health posts, and in communities by staff attached to those facilities, then MCDMCH must have full responsibility for the financial and physical resources needed to operate these facilities and services. Currently, the budget and supply chain for drugs and other medical equipment are still accounted for by MoH. Wyatt claims that support is also needed to establish coordination mechanisms at national and provincial level.

Wyatt states that the transition of MCH to MCDMCH is not yet complete (at the end of 2013); as regards to the ministry's assumption of complete control of district and community health services and their integration with its other core functions, as well as the division of responsibilities between MCDMCH

and MoH. There are still weaknesses that hinder MCDMCH to deliver services efficiently and effectively (Wyatt 2013: 3). The National Health Care Package (NHCP) presumes the existence of a holistic health care system, with the majority of health care being provided at the community level, in health posts, health centres and level 1 hospitals.

In terms of human resources there is need for realignment as well, since without proper planning and preparation, approximately 28,000 former MoH staff were transferred into MCDMCH, while for the Department of Human Resources within MoH there was no integration plan and no transfer of resources (Wyatt 2013: 17). Moreover, staff members at the Departments of Community Development and Social Welfare tend to feel that 'their' Ministry has been overwhelmed by staff from the health sector, while former MoH staff feel they have been exiled to what used to be seen as a relatively under-resourced and ineffectual ministry (Wyatt 2013: 8).

Wyatt (2013) indicates that there should also be more cooperation between the various groups of CBVs within the departments of the MCDMCH. As ZISSP (2011) noted, the different groups of CBVs fail to work together in delivering health services, while there is potential for synergies among various groups of CBVs and partners because many of them have similar roles.

Guided by the aforementioned studies, the research team carried out an in-depth study of government members of staff and CBVs in five districts in Zambia. The methodology for this study is explained in the next chapter.

3 Research Methodology

This chapter explains the research methodology used in this study on structures and linkages between districts and communities for service delivery. The research predominantly used qualitative research methods and analysis.

3.1 Sampling of five districts

In order to develop a good picture of the structures and linkages between the three departments of the MCDMCH and to explore how CBVs are working in the community, a sample of five districts was drawn from the 103 districts that were in place at the time of the research in Zambia. Even though this is a very small sample, it is considered to be representative, because the departments of the MCDMCH in the districts are all organised and operate in the same way, and based on the assumption that there is much similarity among the CBVs in these districts.

The districts were selected purposefully. Although the sample was small, the districts included were selected purposefully to provide a representative picture of the Zambian districts according to the number of city councils, municipalities and rural districts. The sample included one city council, one municipality, and three rural districts. In addition, because the data on CBVs had to be compared with the data gathered in the Skills Audit (see separate report) the sampled districts had to be included in the sampled districts for the Skills Audit. The sample included the following districts: Ndola (city council, Copperbelt Province), Kasama (municipality, Northern Province), Kasempa (rural district, North Western Province), Serenje (rural district, Central Province) and Mwense (rural district, Luapula Province).

In each of these sampled districts fieldwork was carried out for five days. Fieldwork was conducted between October and mid December 2013. The fieldwork included interviews, Focus Group Discussions and, to a limited extent, observation.

3.2 Interviews

In each district semi-structured interviews were conducted with members of staff from the three departments and some other stakeholders (see Appendix A). In total, 51 semi-structured interviews were conducted: 45 with government staff and six with CBVs. The people interviewed in each district are listed below and summarised in Table 1:

- The District Commissioner (DC)
- The District Administrative Officer (DAO) in one district where the DC was unavailable.

In the department of Community Development:

- The Community Development Officer (CDO)
- A Community Development Assistant (CDA)

In the department of Social Welfare:

- The Social Welfare Officer (SWO)

- One chairperson of the District Welfare Assistance Committee (DWAC), who is a government member of staff working at the Department of Social Welfare
- Another DWAC member attended a Focus Group Discussion with CWAC.

In the department of Mother and Child Health:

- The District Medical Officer (DMO) (or referred to as the District Community Medical Officer [DCMO])
- The Environmental Health Technician (EHT)
- The Information Health Technologist Officer (IHTO)
- The Planner (only working in four of the five sampled districts)
- The Community Health Assistants (CHAs) in three districts; in two districts two CHAs and in one district one CHA). In the other two districts there were no CHA.

Besides these interviews with government staff, in each district interviews were conducted with:

- The chairperson of the Area Coordinating Committee (ACC), a volunteer who is related to the department of Social Welfare.

In addition, one interview was conducted with a Community Health Worker (CHW), who worked individually in the district.

Table 1: Summary of interviews by district

Interviewees	Districts				
	Kasama	Kasempa	Mwense	Ndola	Serenje
District Commissioner		1	1	1	1
District Administrative Officer	1				
Community Development Officer	1	1	1	1	1
Community Development Assistant	1	1	1	1	1
Social Welfare Officer	1	1	1	1	1
Chairperson, District Welfare Assistance Committee		1			
District Community Medical Officer	1	1	1	1	1
Environmental Health Technician	1	1	1	1	1
Information Health Technologist Officer	1	1	1	1	1
Planner (Health)	1		1	1	1
Community Health Assistants		1	2		2
Chairperson, Area Coordinating Committee	1	1	1	1	1
Community Health Worker		1			

3.3 Focus Group Discussions (FGDs)

In each district Focus Group Discussions (FGDs) were conducted with several groups of CBVs (see Appendix B). The groups were randomly selected, based on the information of the CDO, DCMO and SWO in each district. Since there should be consistency in the groups of CBVs per district, in all districts the same groups were selected. In total 28 FGDs were conducted. The FGDs had between 5 and 11 participants, with an average of 7 per group. The total number of participants was 199; 98 men and 101 women. In two cases the CDA was present, while in three other cases the Environmental Health Technician and in one case a nurse in-charge were present. During two FGDs with the Food Security Pack Committee, the Agricultural Extension Officer was present. In the other FGDs these staff members were asked to leave, so that the participants could talk freely without their supervisor listening. The FGDs were conducted in the vernacular with the assistance of an interpreter. The FGDs were conducted in the sub-centres, in the health facilities, in an office of the district, or just outside of the district office.

The FGDs were conducted with the following groups of CBVs:

- Food Security Pack Committee (FSP) in all the five district; in some districts their beneficiaries also participated
- Women's Association: There were four FGD conducted with the Women's Associations; one district was left out for organisational reasons
- Community Welfare Assistant Committee (CWAC) in all the five districts
- Neighbourhood Health Committee (NHC) in all the five districts
- Safe Motherhood Action Group (SMAG) in all the five districts
- TB/ART adherence counsellors in four districts
 - In one district, it was not possible to organise a FGD with these volunteers due to organisational reasons
 - These groups were often a mixture of TB treatment supporters, ART adherence counsellors, and Home Based Care givers. Because the majority were working as TB treatment supporters and/or ART adherence counsellors, in this research they are referred to as TB/ART adherence counsellors.
- Community Health Workers (CHWs)
 - CHWs are not the equivalent to what in some literature is mentioned as a general term for Community Health Workers or Community Caregivers, but is a specific group of CBVs who have had a training in basic primary health care, are entitled to give simple medication and basic treatment, and who work individually in the community
 - In one district a separate FGD was conducted with four CHWs, and in another district there were three CHWs who were included in the FGD with the NHC
 - In one district, the CHW lived far from the sub centre where the other CBVs lived and worked, so therefore this CHW was interviewed separately (see above).

3.4 Data analysis

The data gathered during fieldwork in the five sampled districts were recorded and transcribed by the researcher, and analysed according to content analysis. The data gathered from the government

employees were consistent, both within each interview and across the sample. The data from the FGD with the CBVs, however, were consistent across the sample, but were inconsistent during almost each FGD (see below). This makes it rather difficult to fully analyse the data. Therefore, by way of triangulation, alongside the analysis, observations during the FGD and information from others, such as CDO/CDA, SWO, DCMO/EHT and nurses-in-charge, with whom interviews were held, are included to adequately analyse the data.

3.5 Limitations of the study

The data from the FGDs with the CBVs were inconsistent. During the FGD a lot of contradicting remarks were made. For instance, CBVs under the NHC claimed that they had reached everyone, or brought patients to the health facilities with their own transport, but later in the discussion said they had no transport and could therefore not reach all people in need. Others said beneficiaries would come to them because people in the community know them as CWAC members, while later in the discussion they said they needed identity cards because most people in the community did not know them. Also, a FSP committee claimed that their beneficiaries were predominantly women, because they were the most vulnerable. When asked about the numbers of male and female beneficiaries, they said their number was equal, because it had to be gender balanced.

It was clear that the CBVs gave socially acceptable answers, giving a positive picture about their work, while at the same time indicating they could not do their work properly due to a lack of material support and incentives. They had high expectations that their participation in the research would lead to more incentives, both during the FGD meeting and afterwards; almost all CBVs tried to focus the discussion on the lack of incentives.

3.6 Consultations with stakeholders

Discussions were conducted with stakeholders who work with CBVs including:

- The directors at Ministry level of the Departments of Community Development, Mother and Child Health, Social Welfare, Planning, the Registrar of NGOs, and Human Resources
- Other members of staff in the Departments of Community Development, Mother and Child Health, and Social Welfare
- Selected NGO staff members working with CBVs: CARE International, Steps OVC, Catholic Relief Services (CRS), Clinton Health Access Initiative (CHAI), UNICEF, Innovations for Poverty Action (IPA), FHI 360, Zambia Integrated Systems Strengthening Program (ZISSP), Zambia-led Prevention Initiative (ZPI) and Zambia Prevention, Care and Treatment Partnership (ZPCT).

3.7 Literature review

In addition, a desk top study was conducted by reading and using relevant literature about research on CBVs as well as related government documents; see Chapter two.

4 Research Findings: The Ministry's Departments and Programmes

This chapter deals with the linkages between the three departments of the ministry. It depicts the general situation of the three departments, and how the three departments are currently working. As stated in Chapter 3, fieldwork for this research was done in five districts (Kasempa, Ndola, Serenje, Mwense and Kasama). Since the organisation of the districts and the answers given during the interviews were similar and consistent, the information from these districts can be generalised to the situation in other districts. The first part of this chapter concerns the staff and working relationships in the three departments, while the second part of the chapter explains the programmes of each department.

4.1 General situation and (lack of) cooperation between the three departments

4.1.1 Overall lack of (human) resources and lack of cooperation between the departments

Generally, two major issues play an important role in the three departments: a lack of resources, including human resources; and a lack of cooperation, predominantly between CD/SW and MCH. Although the situation seems to be slightly better for the MCH department, all three departments indicated they are understaffed and lack office equipment, as well as transport to go into the field.

In districts where fieldwork for this research was carried out (Kasempa, Ndola, Serenje, Mwense and Kasama), there is cooperation between the departments of Community Development and Social Welfare. There is, however, no cooperation between the departments of CD/SW on the one hand, and MCH on the other.

During the interviews it became clear that in all the five districts, there are a number of complaints about and reasons why there is no or very little cooperation. These reasons concern:

- The lack of information from the ministry's headquarters, and lack of guidelines or a policy on how to work together
- Different backgrounds of the staff at CD/SW and MCH
- A lack of interest in each other's work and activities and lack of knowledge about MCH activities among CD/SW staff and about CD/SW activities among MCH staff
- A lack of willingness to cooperate
- Different resources and funding for the different departments
- Different attitudes of staff at CD/SW and MCH
- An unclear mandate, especially among MCH staff concerning the other two departments
- The physical distances between the office buildings.

A salient detail is that all staff interviewed, especially those working at the department of Mother and Child Health, still claimed they were working at the Ministry of Health, and not at the Department of Mother and Child Health in MCDMCH, while equally staff at CD/SW referred to MCH as Health or Ministry of Health.

4.1.2 The situation at the Department of Community Development

The Department of Community Development in several districts is understaffed. In addition, the departments at district level have limited resources such as transport, while some do not have any means of transport at all. Also, in several districts it was found that there was little office space and little office equipment. Many officers claimed that there was also a lack of resources to carry out programmes.

The members of staff at the Department of Community Development at district level are the District Community Development Officer (CDO) and two Assistant Community Development Officers (ACDO). These officers are based at the district level. The districts have sub-centres where the Community Development Assistants (CDA) work from. However, several sub-centres are not staffed, or in several cases the CDA does not work in the sub-centre regularly but works from the district level due to a lack of accommodation at the sub-centre, and only visits the sub-centre once in a while. The frequency of the visits varies a lot; from once a week to not at all, as was the case in a certain sub centre in Kasempa.

Also, the frequency of the field visits of the CDO varies. The CDO are supposed to visit the sub-centres once a month, but many only visit once every six months due to a lack of time and lack of transport.

The CDAs are supervised by, and report to, the CDO, while the CDO reports to the Province. Also, at district level the CDO reports to the District Commissioner (DC). However, this is usually done verbally in the District Development Coordinating Committee (DDCC) meetings with all departments in the district.

4.1.3 The situation at the Department of Social Welfare

The Department of Social Welfare, too, is understaffed, and there is a lack of resources. The Department at district level consists of one District Social Welfare Officer (DSWO) and one Assistant Social Welfare Officer (ASWO). There are no officers working in the field. To know what is happening in the field, the SWO depends on volunteers. The main person to inform the DSWO is the chairperson of the Area Coordinating Committee (ACC). This chairperson receives information from the committees of volunteers in the community, which is the Community Welfare Assistant Committee (CWAC). A large part of assistance and identification of people in need in the community goes through the ACC chairperson, who is assisted by the ACC members and the CWAC members.

The ACC and CWAC send applications to the SWO and the District Welfare Assistance Committee (DWAC), who provide assistance that was asked for and is needed. The DWAC consists of government staff from the Departments of Community Development and Social Welfare of the MCDMCH (including the Department of Zambian Agency of Persons with Disabilities (ZAPD), which is a sub-department of Community Development), the Ministry of Education, and the Ministry of Local Government and Housing.

The DSWO reports to the SW department at the Provincial level, and verbally to the District Commissioner (DC) in the District Development Coordination Committee (DDCC) meetings.

4.1.4 The situation at the Department of Mother and Child Health

The Department of Mother and Child Health at district level seems to be fairly well staffed in comparison to the other two departments in the sample districts. Because this department has a lot of programmes funded by various donors the department has a fair amount of resources and equipment. This department runs a lot of health facilities and programmes.

The Department of Mother and Child Health is headed by the District Medical Officer (DMO), also called District Community Medical Officer (DCMO). Other staff members are one or more Environmental Health Technicians (EHT), and one or more Information Health Technologist Officers (IHTO). Most districts also have a Planner, and at some districts there is also a Health Coordinator.

Each district has several health facilities such as health centres and health posts. Some of these health centres are staffed by a nurse-in-charge. The EHT usually supervises the health facility staff in the districts, including the Community Health Assistants (CHA), who work in rural health centres and health posts only. For reason of supervision and guidance the EHT visits the health centres regularly.

4.1.5 Relationships between the Departments of Community Development and Social Welfare

In several districts where fieldwork for this research was carried out there is cooperation between the Departments of Community Development and Social Welfare, for instance in Kasempa, Mwense and Kasama. In some districts, however, (e.g. Ndola and Serenje), the working relationship between the departments of Community Development and Social Welfare can be improved. In these cases there is no sharing of reports, transport, and often not even knowledge about what the other department is doing.

The Departments of Community Development and Social Welfare have been part of one Ministry since 1964, at that time called the Ministry of Rural Development until 1991 when the departments formed the new Ministry of Community Development and Social Services (MCDDS). Therefore, they usually have good working relationships. In the majority of the districts members of staff interviewed claimed that their working relationships are good and they work together well. This is shown by the fact that the CDOs and SWOs have regular meetings, discuss work related issues, go to the field together to cut down on transport costs or in case one department does not have transport, refer potential clients to each other's department, and sometimes share office space, such as in Kasempa and Mwense. In addition, in certain cases the CDA in the sub-centres assist in Social Welfare programmes.

4.1.6 Working relationship between the departments of Community Development, Social Welfare and Mother and Child Health

There is no, or very little, cooperation between the Departments of Community Development and Social Welfare on one side, and the Department of Mother and Child Health on the other. Almost all members of staff interviewed indicated that they were still working as before, when MCH was not part of the Ministry. "There is no working relationship with the MCH department. We work as if we are not in one ministry", a CDO said. Another DCO claimed: "We do not work together with staff at MCH. We work separately." A SWO reported that "I work with the CDO, but not with people from MCH" whilst a

Planner at MCH claimed “We do not work with Social Welfare and Community Development. They are different from our department.” Another Planner said: “We have no working relationship with Community Development and Social Welfare. I don’t know what they are doing. We work separately.” These quotes show that they work in their own department, separately from the other two departments.

The members of staff at district level were told by the ministry headquarters to collaborate, but did not know how to. Hence the situation remained as it was before, yet all staff knew that they were supposed to work together as one ministry. Only in certain districts there is some collaboration, but only on specific projects, such as during Child Health Week, as was the case in Kasempa and Serenje.

4.1.7 Lack of information, guidelines or policy from the Ministry’s headquarters

All the officers interviewed claimed there are issues concerning the lack of information from the ministry’s headquarters in Lusaka. This information concerns especially the way the three departments should work together. All the officers interviewed expressed the need for clear guidelines or a clear policy on how to collaborate with each other. “We lack clear guidelines from the headquarters. We don’t know how to collaborate or what is expected from us” said a CDO. Another CDO claimed: “We were not informed on how to work together with the other departments. We just have to find out own ways.” A SWO claimed: “There is need for a policy from the Headquarters on how to work together. We need instructions on how to work together.” A Planner indicated: “I don’t know what we have in common with Community Development and Social Welfare, so I don’t know how to work together.”

Most claimed they were just informed about the merging of the three departments in the new ministry MCDMCH by the media. “We only heard it from the media that we were now in one ministry, and supposed to work together. We were not informed by the headquarters” as was reported by a SWO. Other staff expressed their disappointment that no one from the Ministry, neither the Minister nor the Permanent Secretary, had informed them as departments in the districts, not even through the Provincial Officers.

Many members of staff claimed that it was difficult for them to adapt to this new situation of the merging of the three departments into one ministry, in particular the addition of MCH to the Departments of CD and SW. They felt they themselves had to find ways as to how to go about in this new situation, without getting instructions from the ministry on how to cooperate. They indicated they lack information from headquarters as to what was expected of them.

Some officers claimed that they have tried to get in touch with officers from the other departments, mainly out of personal interest, but these attempts have failed. Certain officers claimed that they tried to have meetings with officers of the other departments, but failed due to the fact that either no one came to the meetings or they did not know what should be discussed, meaning they did not know about each other’s programmes, and did not know what they had in common. Also, some officers stated that when they asked staff members from other departments for meetings to share reports, they had the feeling that they thought they wanted to “steal” information. This reluctance to share information shows a lack of trust and confidence in one another, and is a hindrance to cooperation.

4.1.8 Different backgrounds of staff at the Departments of Community Development, Mother and Child Health, and Social Welfare

The members of staff at the Departments of CD and SW have a different background than the members of staff at MCH. The officers at the departments of CD and SW have a background of diplomas or degrees in Social Work or Social Sciences, such as Community Development. The staff members at the department of Mother and Child Health, however, have a background of a degree in Medical Studies, or diplomas and certificates in medical related fields. Therefore, they are more focused on health issues and less on development issues.

Moreover, they are on a different salary scale. Both having a degree in a more scientific study and having a higher salary than their colleagues in the Social Sector lead to different attitudes. Several members of staff at MCH looked down upon the members of staff in the departments of CD and SW. This goes especially for the younger staff such as Planners and Information Health Technologist Officers. Some of them made statements like: “our programmes are better”, “the other departments can help us”, or “programmes of the other departments might fit in our programmes, but the MCH programmes do not fit in the other departments’ programmes”. Yet, except for the MCH staff members in Serenje, none of the MCH staff members knew what programmes the other two departments deliver.

4.1.9 Lack of interest in and knowledge about the other department’s work and activities

The aforementioned different background of staff is one of the reasons why there is a lack of interest in and knowledge about each other’s work and activities. During the interviews with the officers it became clear that only very few know about each other’s programmes. Usually the CD staff knew of the programmes of SW, and vice versa, but they only vaguely knew about the programmes of MCH. The most mentioned programmes were on nutrition, but hardly any other programmes. The staff at MCH did not know any of the programmes in CD or SW, with the exception of MCH staff members in Serenje, who had knowledge about the programmes of their colleagues in the other two departments.

Generally, the staff in CD and SW did not show much interest in the programmes under MCH and vice versa. A few officers claimed they had invited staff from the other departments for meetings, but either no one came, or they said they had nothing to discuss, since they had nothing in common. Interestingly, these claims were occasionally made by members of staff in the same district, reproaching each other for not showing interest or not attending their meetings when invited. Also, one MCH staff member claimed she invited the CDO in the district to go with her into the field, using transport from MCH. However, she claimed this was refused due to missing lunch allowances, which, according to this officer, revealed that the CDO lacked motivation. These remarks show that there is tension within the three departments of the ministry at district level, especially between MCH on the one hand and CD and SW on the other, but also, to a lesser extent, between CD and SW. Staff members of the three departments reproach each other for having a lack of interest and lack of motivation to work.

4.1.10 Lack of willingness to cooperate between the Departments of Community Development, Mother and Child Health, and Social Welfare

The lack of interest in and knowledge about each other's programmes leads to a lack of willingness to cooperate. During most interviews officers showed a reluctance to cooperate, especially between CD and SW, and MCH. In particular during some interviews with certain MCH staff members it was expressed that MCH (referred to as Health staff or Health Programmes) were better than the ones from CD or SW. Moreover, it was frequently stated by most staff members that the three departments had nothing in common. The majority of the staff members did not see the linkages between the three departments. When asked about the linkages between the three departments a DCMO stated that: "There are no linkages at the level of the district, but the linkages are more in the community, and at the clinics."

Members of staff did not think there is an overlap in the programmes of the different departments. However, after explaining the programmes of the other departments, the staff members realised that they have a lot in common, and that several of the programmes done by one department are similar to the ones done by another. Only when staff members realised that they had much in common, they then expressed a willingness to cooperate.

An attempt to know more of each other's programmes and the work together in the district is the formation of the District Social Welfare Committee (DSWC). This committee consists of a staff member of the departments of Community Development, Mother and Child Health, and Social Welfare, and a staff member each of the Ministry of Education and the Ministry of Agriculture. However, this committee and its membership do seem not to be consistent in all districts.

4.1.11 Different resources for the Departments of Community Development, Mother and Child Health, and Social Welfare

The lack of willingness to collaborate, especially in the department of MCH, is also due to the fear for less funding and resources, as was emphasised by MCH staff members. MCH receives more money for programmes from donors than the other two departments. Several staff members at MCH claimed that they received less programmes related money than before when they were within the Ministry of Health, and expressed their fear of having to share their funding and resources with the other two departments.

The members of staff at CD and SW, on the other hand, expressed their feelings of 'jealousy' of the MCH concerning their funding, resources and means of transport, while they themselves had little funding, and a lack of transport and office equipment.

This unequal distribution of resources emphasised the difficulties sensed in attitudes, background and a lack of openness towards each other, and stressed the lack of motivation to collaborate, especially from the side of the MCH department.

4.1.12 Unclear boundaries of management and mandate

Frequently the MCH members of staff interviewed claimed that it was not clear which department had what mandate, and where the boundaries between the departments were, especially concerning their programmes in the community. They did not know which programmes and activities the other two departments had. Also many said they wanted to keep their mandate as it is now. It seems that no department is willing to give up its mandate.

This results in duplication, such as having the same programmes or reaching the same people in the community. For instance, a SWO stated that “MCH responds to many cases that Social Welfare and Community Development are already doing” and “The weakness within the ministry is that there is no feedback from the departments.” These statements reveal that there is duplication of programmes, and the need for meetings to share information about each other’s programmes in the community, and subsequently, the need for more cooperation.

In addition, several DCMOs mentioned examples in which MCH and SW should work together. For instance, there are a lot of cases in which people are referred to a clinic or hospital, but cannot pay for transport, especially transport back to their homes. This means that people wait until a car from the district comes and takes them to their home village. Some DCMOs claimed that they were frequently called that there are people from their district in clinics or hospital elsewhere, waiting for transport. In these cases, they should be referred to Social Welfare. However, this is difficult when people are already in a clinic at a long distance from their homes. Therefore, some DCMOs claimed that there is need for a SWO in health facilities.

4.1.13 Physical distances between the office buildings within three departments

The physical distance of the three departments is also a constraint to cooperation. In several districts, the departments of CD and SW are in the same building or close together, while in other districts they are separated but the offices are not far from each other. The offices of MCH, however, are in a separate building, sometimes near to CD and SW, but often a long distance away. This is a hindrance to cooperation.

Many members of staff indicated that since they are now in one ministry, the three departments should be together in one building. This would help to facilitate meetings, to get to know each other and each other’s programmes, as well as enable referrals and collaboration.

4.2 Programmes of the Ministry of Community Development Mother and Child Health

In the following section, the programmes of the three departments are briefly explained. The programmes that depend on CBVs that were included in the study will be elaborated. In this way, it will become clear where there is duplication and similarities in these programmes, and help to show how the different departments could work together. Table 2 summarises these programmes.

Table 2: Summary of Programmes

Programmes	Summary of Activities
Community Development	
Food Security Pack	<ul style="list-style-type: none"> Farming input donation, identifying and supervising beneficiaries by FSP – 2 years
Women's Empowerment Programme	<ul style="list-style-type: none"> Women's clubs on income generating activities, supervised by Women's Association
Functional Literacy and Skills training	<ul style="list-style-type: none"> Teaching adults literacy and skills
Community Self help	<ul style="list-style-type: none"> Development projects by and for community
Psycho-social counselling	<ul style="list-style-type: none"> Counselling (for youth) by CDO/CDA
Social Welfare	
Public Welfare Assistance	<ul style="list-style-type: none"> Food donation, beneficiaries identified by CWAC
Social Cash Transfer	<ul style="list-style-type: none"> Monetary donation, beneficiaries identified by CWAC
Child Protection	<ul style="list-style-type: none"> Safe homes are sought for abused children by SWO
Probation services	<ul style="list-style-type: none"> For youth delinquencies by SWO
Psycho-social counselling	<ul style="list-style-type: none"> Counselling by SWO
Mother and Child Health	
Health centre support	<ul style="list-style-type: none"> By DCMO
Clinical care	<ul style="list-style-type: none"> By nurse-in-charge / CDE
Immunisation programmes	<ul style="list-style-type: none"> By health staff
Food and nutrition programme	<ul style="list-style-type: none"> Food donated to malnourished people, and lessons on nutrition are given by CBVs
Malaria control	<ul style="list-style-type: none"> Malaria sensitisation by CBVs
HIV/AIDS/TB/ HBC counsellors	<ul style="list-style-type: none"> Sensitisation, counselling, testing, palliative care by CBVs
Safe Motherhood	<ul style="list-style-type: none"> Sensitisation on pregnancy, ANC/PNC. Under 5 clinic, by CBVs
PMTCT	<ul style="list-style-type: none"> Sensitisation on PMTCT by CBVs
Traditional Birth Attendant	<ul style="list-style-type: none"> CBV who assist with labour during pregnancy
Family planning / peer educators	<ul style="list-style-type: none"> Sensitization and some methods are given on family planning by CBV
CGM / ICCM /IMCI	<ul style="list-style-type: none"> Children are checked on their physical growth and are sometimes treated for common illnesses by CBVs
Water and sanitation	<ul style="list-style-type: none"> Sensitisation on healthy water and sanitation by CBVs
Psycho-social counselling	<ul style="list-style-type: none"> Counselling by CBVs
Community Based Distributors	<ul style="list-style-type: none"> Marketing and sensitisation of family planning products by CBVs
Spraying of houses	<ul style="list-style-type: none"> Houses are sprayed to avoid mosquitoes by CBVs

4.2.1 Programmes of the Department of Community Development

Food Security Pack

In the Food Security Pack programme (FSP) the beneficiaries are given farming inputs such as seeds and fertiliser to do farming. This programme is meant for vulnerable but viable people who have a field and are able to work in the field, but have no money to buy farming input. The Food Security Pack Committee (FSPC) identifies such people, and lists them for farming input. Together with the CDA and the Agriculture Extension officer of the Ministry of Agriculture, the beneficiaries are taught about farming. The beneficiaries have to pay back 60 kg per lima, or ZKR 65 per bag of the surplus. They receive farming inputs for two years, after which they are supposed to be self sufficient. They usually become small scale farmers.

The FSPC identifies potential beneficiaries in the community, links them to the CDA or CDO, supervises them and ensures they pay back the surplus. With this money either new inputs are bought, or it is used for income generating, school fees or other items needed for the poor people in the community. Some FSPC only meet just before or during the rainy season, while others indicated that they meet the whole year round. Usually they meet once a week for about two hours, and occasionally check the fields of beneficiaries, for which they spend another two to four hours on average. The FSPC members get farming inputs as an incentive. However, the committee in Serenje claimed it did not receive anything.

Women's Empowerment Programme

In the Women's Empowerment Programme women's clubs are assisted with income generating projects. Each district has several clubs, chaired by the Women's Association executive committee. Upon approval of their proposals, they receive funding from the ministry. The members contribute a small amount, which is put into a bank account. At times the clubs get a certain amount of money for their income generating projects, which they have to pay back with 10% interest. The Women's Association reports to the CDA and/or the CDO, who supervises them.

The Women's Association is an umbrella organisation that coordinates several Women's Clubs that have income generating projects, such as poultry, farming and tailoring. Although they are called 'Women's clubs' men can also join these groups. Each club reports to the Women's Association. The Women's Association meets once a week, and once a month with the Women's clubs. The Women's Association sees to it that the money donated to the women's clubs is paid back, and that the clubs work well. The Women's Associations included in this research had between 11 and 25 Women's clubs, while each club had around 20 members.

The Women's Association claimed their incentives are the money they receive from their income generating projects, as well as the respect they get in the community.

Functional literacy and skills training

In this project illiterate people are taught by (semi-)professional volunteers how to read, write and do mathematics. In addition, they learn some skills needed for income generating activities. During fieldwork in the five districts, the literacy classes were only done in Kasama. In the other districts, the literacy classes had stopped, due to lack of incentives for the teachers.

Community self help projects

In these projects certain people in the community, such as widows, or the entire community, is assisted. This can be projects on income generating, learning skills, but also build houses or a community hall. In these projects the government gives money, while the beneficiaries give labour, such as constructing houses, making bricks or do any other activity.

Psycho-social counselling (PCS)

Psycho-social counselling is usually provided to youth who have committed some sort of criminal behaviour or activity.

4.2.2 Programmes of the Department of Social Welfare

Public Welfare Assistance Scheme (PWAS)

In the Public Welfare Assistance Scheme (PWAS) the government gives food to people who cannot provide for themselves. The main beneficiaries are disabled people, elderly people, widows and extremely poor families who look after several orphans. The beneficiaries are identified by a community committee called the Community Welfare Assistant Committee (CWAC), which refers beneficiaries to the SWO. The SWO ensures that the potential beneficiaries meet the requirements as prescribed in the ministry's guidelines and that the beneficiaries will be assisted with food supplies.

Social Cash Transfer (SCT)

The Social Cash Transfer was originally meant for elderly people who are 65 years and above, who have no means of income. The beneficiaries are identified by the CWAC, and receive the money (about K80 per month) from the government through the SWO. Part of this money is donated to the government by donors. During the time of the research the Social Cash Transfer programme was expanded (a scale up of about 700%) by the government, with donor money, predominantly from UNICEF, and is no longer only for elderly people.

Child Protection

In this programme the government provides homes or places of safety where children who are abused by their relatives are kept and provided for, while their abusers are arrested and prosecuted.

Probation Services

Probation services are provided for the youth delinquents. They are assisted in court cases by the Department of Social Welfare.

Psycho-social Counselling (PSC)

This type of psycho-social counselling is given to people with psychological problems such as widows, orphans, and women who are abused by their husbands.

4.2.3 Programmes in the Department of Mother and Child Health

The programmes of MCH are conducted both in the health facilities and in the community.

Health centre support

Health centre support includes supervision of health centre staff by DCMO, performance assessment and monitoring programmes at the health centre and at other levels.

Clinical care services

Clinical care services include the treatment of patients, antenatal and post-natal care (ANC/PNC), and the under five clinic.

Outreach services

There are many outreach services in the community. These are the majority of the services provided by CBVs. Most of these services provided are both done in the health facility and in the community. They include the following:

- **Immunisation programme:** This is carried out both in the health facilities and in the community. This programme is especially for young children. The CBVs are not allowed to carry out the actual immunisation, but assist in this programme
- **Food and nutrition programme:** In this programme food is donated by the ministry through CBVs to malnourished adults and children, and lessons on nutrition are given to adults including mothers and caregivers
- **Malaria control programme:** Voluntary malaria control agents sensitize the community about malaria, and how to avoid it. Occasionally, there is distribution of and teaching about mosquito nets
- **HIV/AIDS and TB, adherence counsellors/support workers (ASW)/Home Based Care (HBC):** The programme on HIV, AIDS and TB entails control, prevention, treatment and care of HIV, AIDS, and TB. The CBV sensitize the community about early testing, symptoms, how to avoid getting infected, stigmatisation and visit HIV positive people to encourage them to take their drugs as prescribed. Some groups of CBVs also sensitise about HIV prevention from mother to child (PMTCT). In addition, they provide Home Based Care services for bedridden HIV and AIDS or TB patients, and their caregivers are counselled how to provide better care

There are several and different types of TB and ART adherence counsellors. They often work together as one group, because TB patients are often HIV positive. Several of these TB and ART adherence counsellors also take care of the people affected by HIV, such as children and orphans. They counsel them and sensitize relatives of orphans on how to look after these orphans. In some cases they refer them to the SWO

The TB and ART adherence counsellors work both in the community and in the clinic. For instance, the CBVs that work for ZPCT II are supposed to work two days a week in the community and one day a week in the clinic. The TB and ART adherence counsellors in Ndola, however, claimed that due to the many TB and/or HIV and AIDS patients in the clinic, they worked at least three days a week in the clinic. Even though many of these groups of CBVs

comprise of about 15-20 members who are divided per ward, they claim they work almost every week day

Most of these TB and ART adherence councillors have been trained by various organizations, both by MoH and by several NGOs and FBOs. They report to the health facility and/or to the NGO they work for. They are supervised by the in-charge of the clinic, or the EHT.

- **Safe Motherhood Programme/Safe Motherhood Action Group (SMAG):** In the programme on safe motherhood pregnant women (and their husbands) are sensitised on issues concerning pregnancy and delivery. The programme is done both in the health facilities and in the communities by the SMAG, which encourages pregnant women to deliver in the health facilities, to go for antenatal care (ANC) and post natal care, and to the under five clinics. They also emphasise that men should support their wives during their pregnancy and delivery. Some SMAG groups also teach about PMTCT and/or family planning. Although the SMAG are supposed to work mainly in the community and to a lesser extent in the health facility, they mostly work in the health facility, where they do early booking for pregnant women, antenatal care and post natal care, and under five clinics

The SMAG groups usually have about 10-30 members per group. Since they work in small groups of two – four people, they usually only work two to four hours a week. The SMAG report to the in-charge at the health facility, and are supervised either by the nurse-in-charge or by the EHT in the district. The various SMAGs are trained by several NGOs. They get some incentives, such as bicycles, T-shirts, raingear, and bags

- **Prevention of Mother to Child Transmission (PMTCT counselling):** CBVs sensitise the community about how to prevent the transmission of HIV from HIV positive mothers to their (unborn) children. This is also done in the health facility
- **Traditional Birth Attendant (TBA):** TBAs often work as CBVs in the community to assist women to deliver. Some of them also work in the health facilities, but there they do not have an official role because they are not officially medically trained
- **Family Planning, including Peer Educators training (Adolescent reproductive health):** In this programme CBVs sensitise the community on issues concerning family planning. This is both done in the health facility and in the community
- **Child Growth Monitoring (CGM), including Child Health/Integrated Child Care Management Illness (ICCM/IMCI):** These programmes are mainly done in the health facility, and to a lesser extent in the community. Health centre staff and CBVs check children on their physical growth progress
- **Water and Sanitation Programme:** CBVs sensitise the community on water and sanitation, such as the use of chlorine, clear wells, how to test drinking water, and the use and construction of pit latrines

- **Psycho Social Counselling (also called lay counselling):** This is done for anyone who needs to be counselled. There are different names of counselling, but the general term is psycho-social counselling. Counselling is done by CBV
- **Community Based Distributors:** These are CBVs who do social marketing (through SFH) of family planning products and other items like chlorine. They also refer to the health facility. The CBVs who sell products keep 50% of the income. In addition, they get the equivalent of 20 US dollar per year
- **Spraying of houses:** This is done to avoid the spread of mosquitoes and other insects, and is done by volunteers at specific times.

The above mentioned programmes are executed by CBVs working in collaboration with MCDMCH staff from the three departments.

Even though the above mentioned programmes are run in many districts, not all sub-districts and zones are reached, which leads to a lack of programme coverage. In some districts, in order to avoid incapacitated households being left out this is solved by providing another type of assistance. For instance, where the PWAS does not cover an area, vulnerable households may receive food security packs even if they do not have labour available for using the agricultural inputs. Better programme coverage would mean recipient targeting could be more appropriate. This remains an issue for coordination between the Ministry's departments at all levels.

5 Research Findings at Community level: CDAs, CHAs and CBVs

The previous chapter depicted the three departments and their different programmes. This chapter will focus on CBVs, who execute the programmes in the communities. The first part of this chapter will examine the key players of service delivery in the communities: the CDA, CHA, CWAC, NHC, and CHW. The second part of the chapter will deal with issues concerning the various groups of CBVs. Attention will be paid to the duplication of their activities and the unclear roles and responsibilities of various groups of CBVs.

5.1 Ministry's members of staff at community level: CDA and CHA

5.1.1 Community Development Assistant (CDA)

The CDAs are paid government staff working at community level. They are supervised by, and report to, the CDO in the district. The CDAs work at the sub-centre, while also some CDAs work at the district office. The CDAs supervise all projects from the CBVs under the Department of Community Development in one or more sub-centres. The CDAs compile their reports, and send them to the CDO. In some districts, the CDAs also supervise the CBVs working under Social Welfare, specifically the Social Welfare Assistant Committee (SWAC).

5.1.2 Community Health Assistants (CHA)

The CHA is a recently established cadre of paid government staff working both at the community level and in health posts. They are not volunteers, but supervised, provided with supplies and remunerated by the government. Whilst their status and payment arrangements vary from CBVs, both CHAs and CBVs play a role in the service delivery in rural communities.

In August 2011 the government, in line with the 2010 National CHW Strategy (see chapter 2) and in conjunction with the Clinton Health Access Initiative (CHAI), began training CHAs. After one year of training, they return to their rural communities to provide basic community and facility-based preventive and curative health services. In order to be eligible for the programme, applicants must be between 18 and 45 years of age, have completed grade 12, and demonstrate literacy in English. It was expected that many of the existing CBVs would apply to become CHAs, though it has been found that few CBVs meet these eligibility requirements as established by the government.

Initially the CHA's salaries were supported by DFID, but after one year the government formally took over the payment of their salaries. Therefore they are not considered volunteers. However, the CHAs have not been paid since August 2013, since the government took over the payment of their salaries. Many of the CHA interviewed said: "I have not been paid for the past 6 months" or "I have not been paid since August." The CHAs were therefore left uncertain about their payment. They still worked, but this has led to a lack of motivation. In 2014, however, DFID has paid the salaries for six months, after which the government has taken over these and the CHAs are now on the government payroll.

The first class of CHAs was deployed in August 2012, and there are still a number of challenges yet to be resolved in relation to this cadre and their relationships with CBVs. In particular, participants outlined

challenges related to division of their working time, supervision, reporting, community acceptance, their tasks and their cooperation with voluntary organisations and CBVs in the community.

CHAs are supposed to divide their work between the community and the clinic, and officially work 80% of the time in the community, and 20% in the health post (rural health facility). However, the CHAs interviewed reported that their time was largely spent in health facilities with limited community outreach. Some CHAs perform outreach in the community every afternoon (during week days), while others only visit communities once in a while, as was mentioned during the interviews. The evaluation study by CHAI (2014a and 2014b) on the CHAs concluded that indeed none of the CHAs met the intended division of time, and predominantly worked in the health facilities; although it varies depending on whether the health facility is staffed with a nurse-in-charge.

The CHAs are supposed to be supervised both within the health facility and within the district. At the district level a district health officer, usually the Environmental Health Technician supervises the CHAs. At the health facility, the CHAs are supposed to be supervised by either the nurse-in-charge of the rural health facility, or by the parent health clinic, which is a clinic usually at a distance of 20 km from where the CHA works. However, since the rural health facilities are understaffed and the in-charge is usually the only one working there, there is hardly any supervision of the CHAs in the health facility. In one rural health facility included in this research the two CHAs working there were supervised by the CDE (Clinical Daily Employee). The research conducted by IPA (2012) confirmed that in certain cases the CDE supervise the CHA. However, the CDE have had less training and are of a lower rank than the CHA.

Moreover, where the supervision takes place in a parent clinic, under which the health post falls, there is little supervision, which means the in-charge at the parent clinic does not know what the CHA does and how s/he works. This also applies to the Environmental Health Technician. Even though the Environmental Health Technician is supposed to work from the health facility, they often work at the district level and only occasionally visit health facilities.

The CHAs use standardised registers to collect information about community health and on their own activities. The data from these registers are then reported via mobile phone to a central database and in paper format to the District Community Medical Office, principally to the Environmental Health Technician. However, during the interviews many District Community Medical Officers and Environmental Health Technicians complained that the CHAs do not report to them regularly, creating challenges for district-level supervision and management of CHAs. The DCMOs and EHTs emphasised that there is need for a clear government policy on the supervision of the CHAs.

The CHA cadre was established in response to many of the challenges facing CBVs, including the lack of coordination that exists between CBVs trained and managed by various entities. Therefore, one of the intended roles of CHAs is to coordinate the activities of the CBVs that work in the health sector. According to several DCMOs and EHTs interviewed this leads to problems. A DCMO said that “There are many problems with the CHAs. The community does not accept them,” whilst another DCMO stated that “There are many challenges with the CHAs. We don’t know how to solve them.” An EHT said that “We experience challenges with the CHAs. They are young women, and not much accepted by the

community and the volunteers.” This leads to major problems and tensions, which are caused by three factors:

- The CHAs are predominantly young women and men, who have been identified and elected by the community where they have grown up. The CHAs have to coordinate the people who are much older than they are, who have seen them growing up and who have identified the person to become a CHA. Within Zambian society, which is very hierarchical, a younger person cannot supervise an elderly person
- The CHAs have to coordinate other CBVs, such as the NHC. However, CBVs who are members of the NHC have been working for many years in the community; hence they know the community very well, often better than the CHAs. In addition, the CBVs are not used to and may not want to have a daily coordinator
- The CBVs and members of the NHC have worked for many years as volunteers, many being unpaid, while the CHAs have now been introduced with a salary.

5.2 Committees of Community Based Volunteers: CWAC and NHC

As set out in the previous chapter, the majority of the programmes are under the department of MCH. Subsequently, the majority of CBVs work under MCH (also refer to the Skills Audit report). They are centred around health facilities, and work both in these health facilities and in the community. The departments of CD and SW have fewer programmes, and therefore fewer CBVs. The CBVs under CD and SW work in groups linked to the community wards or sub-centres.

One of the complaints often mentioned during the interviews was that there are too many CBVs. This means that many district officers, i.e. the CDO, SWO, EHT or MCH coordinator, are unable to supervise them properly, or to check their work. This is especially for the CWAC and the NHC, which are explained below.

5.2.1 Community Welfare Assistance Committee (CWAC)

The CWAC is a committee existing of volunteers. The SWO depends on the CWAC and their representatives in the Area Coordinating Committee (ACC) for its work in the community. The task of the CWAC is to identify the most vulnerable and poor people in the community and report them to the SWO to ensure that poor people get assistance to meet their needs through schemes/programmes like PWAS and SCT. Occasionally the CWAC assist in cases of problems such as defilement, which they report to the police, or they negotiate between teachers and children/parents when children are excluded from school. In several cases they follow up when SCT money or other assistance is given, to see whether it is used for the purpose it was asked for.

Some CWACs work together with health facilities or with the NHC, claiming that they “work together because we do the same job”, as was expressed by a CWAC member. The CWAC members go door to door in the community, but since they are known to the community usually people come to them in case of problems. The CWAC work in wards and are the gatekeepers in the community. Generally, the CWAC meets once a week during one to two hours, and when a small group of CWAC members visit

(potential) beneficiaries they generally spend another four to six hours a week, so in total they work four to eight hours a week.

The CWAC have two representatives in the ACC to whom they report. The ACC compiles these reports and sends them to the SWO. This is done quarterly. This means that certain beneficiaries who are in need have to wait for three months before the SWO receives a report and can act upon their case, after which it still takes some time before the beneficiary actually receives assistance. This structure and the frequency of quarterly reports, however, is needed for the SWO to streamline and lessen the work and time spend on supervision of the ACC and CWAC volunteers so that they have more time for other issues. Several SWOs claimed that there are too many CWAC members and CWAC committees. Each CWAC comprises of at least 10 members. The figures given for the CWAC during the research are as follows.

Table 3: CWAC and ACC numbers

District	Number of CWAC	Number of ACC	Total CWAC members
Kasama	115	15	1,150
Kasempa	96	17	960
Mwense	60	11	600
Ndola	118	23	1,180
Serenje	187	28	1,870

The five districts selected give a total figure of 5,760 CWAC members. This indicates that there are many CWAC members (on average over 1,000 per district). Some SWO claimed that in some wards the CWAC is inactive, while in other wards some CWAC members are inactive. The SWO in Serenje had discussed with the CWAC members that there should be less members per CWAC, suggesting that seven would be the maximum. However, the CWAC members themselves did not want this and said at least 10 members are needed.

5.2.2 The Neighbourhood Health Committee (NHC)

The NHC is another committee existing of volunteers. It is considered an umbrella organisation that looks into health issues in the community. Hence, the NHC is not attached to a programme, unlike other CBVs working for the MCH. The way the different NHC work varies, but generally the NHC sensitizes the community about health and hygiene and how to avoid certain diseases, sensitise about malnutrition, encourage the sick to go to the clinic for medical advice, inform the clinic about outbreak of diseases, perform village inspections in the context of environmental health, e.g. toilets, pit latrines, rubbish pits, safe drinking water and the general cleanliness of areas. Some NHC also inspect food stalls at markets, to see if they sell safe food.

The NHC is the link between the community and the health facility, especially in areas where there is no Health Centre Advisory Committee (HCAC). In areas where there is a HCAC the NHC has two representatives on this body. The NHC work in zones, where each zone has one or two NHCs and each NHC has 10 members.

The NHC members usually meet once a week for one to two hours and spend about two hours in the community per week. However, some NHC only meet once every two weeks, and go into the community for two hours once a month.

The NHC members either had no training, or were trained for one or two days by medical staff at the district. However, many NHC members have other voluntary jobs, for which they have been trained. As NHC members they do not get incentives, apart from special occasions such as during Child Health Week or World AIDS Day, when they get K40 for their activities. Many NHC members have been members for a long time, ranging from 3 to 15 years.

5.2.3 Community Health Workers (CHWs) (also called Community Health Volunteers)

The CHWs are a separate group of CBVs, who are also not attached to a specific programme. They work as individuals in the community, and often collaborate with a health facility. The CHWs ensures that the community is healthy, samples and tests drinking water, sensitises people about diseases such as malaria and diarrhoea, looks after patients in the community, and refers them to health facilities. The CHW is the only volunteer who is entitled to give first aid and give simple medication. The CHW has completed grade 7 and has been trained for six weeks, and reports to the health facility.

5.3 Issues concerning Community Based Volunteers in the communities

There are several issues concerning the roles and activities of the CBVs in the communities. Many CBVs have no job description which leads to unclear roles and responsibilities. Several CBVs have multiple roles which lead to a blurred situation. There is some rivalry, competition, or preference among the CBVs. There is a lack of a common vision among CBVs as to how to deliver their mandate in the community, and a lack of meetings and sharing of information, which leads to duplication of activities and assisting the same beneficiaries. Also, the lack of training, supervision and incentives leads to lack of motivation and a high drop-out rate. Below these and other issues will be elaborated.

5.3.1 Lack of a job description and duplication of activities of Community Based Volunteers

The roles, activities and responsibilities of the various groups of CBVs were explained to them by their trainers or supervisors, and are not or almost never written down in a clear job description. None of the 28 groups of CBVs claimed to have a formal, written job description. The roles of the CBVs under CD and SW were reasonably clear, although some CBVs seem to take on other roles as well. For instance, some Food Security Pack Committees, whose role is to identify potential beneficiaries for FSP, claimed that they also look after orphans. Some Women's Associations claimed to work on food and nutrition projects and are involved in Food Security Pack activities. Also, some CWACs claimed to do income generating projects, and to provide farming input.

Among several groups of the CBVs under the department of MCH the roles and responsibilities were even more blurred, and several groups seem to go beyond their tasks and responsibilities. For instance, some SMAGs claimed to sensitise the community about HIV and AIDS, or test drinking water. Some NHC members claimed they sensitise the community about HIV and AIDS, teach pregnant women about ANC and encourage them to deliver in a clinic, work on programmes linked to nutrition, malaria control, and

psycho-social counselling, or look after orphans. In addition, TB and ART adherence counsellors are involved in OVC care, and organising school fees for orphans. Moreover, several CWAC and NHC claimed that they identify the poor and vulnerable people, and the chronically ill, to refer them to service providers such as the health facilities or the SWO. As a result of the often unclear roles there is much similarity in the activities of many groups. A CWAC member stated: “We work hand in hand with the NHC, because we both identify the same beneficiaries and we both work for vulnerable people.”

Hence, many groups of CBVs do not stick to their tasks and roles. This is due to several reasons. Concerning the organisation of CBVs, they lack a clear, written job description, proper supervision, detailed reporting and reading of these reports by the supervisors. Many CBVs work in different groups. Also, CBV take on unofficial multiple roles out of personal interest: they wish to get respect or have authority in the community, which is obtained through being active in the community. “People want to be regarded as being better than others, and some community based volunteers want to be seen as better than other volunteers” as one CDO stated. Hence they want to do more or other tasks than what they are supposed to do, which leads to preferences and rivalry.

Beside a lack of a clear job description, almost all CBVs claimed they did not have a contract. However, during a meeting with ZPCT II, it became clear that CBVs under this initiative – of whom many were included in the FGDs – have a letter of ‘employment’. When asked about their contracts, many CBVs indicated that they were supposed to be given certain incentives which they had not received, but none of the groups indicated their tasks or hours that should be spent on their voluntary job. The only exception was the TB and ART adherence group in Ndola, who claimed they were supposed to work one day at the clinic and two days in the community.

From the above it is clear that due to a lack of clear job description and CBVs wanting to be seen and ‘being better than others’ many CBVs go beyond their designated tasks. This not only leads to rivalry, but more importantly, to duplication of activities in the community. However, the fact that many groups of CBVs do not stick to their roles and responsibilities, provides possibilities for combining the tasks of several groups and enhancing their collaboration.

5.3.2 Multiple jobs of the CBVs/CBVs being member of different groups of CBVs

During the FGD it became clear that many CBVs have two or three voluntary jobs (also see the Skills Audit report). Many CBVs have multiple roles and are members of several groups of CBV. For instance, a large number of the NHC members indicated they were also malaria controllers, SMAG members, TBA, TB and ART adherence councillors, CHW, or had other roles for MCH or NGO/FBO. Some CWAC members are also NHC members and several members of the Women’s Association have been members of the FSP, or have been beneficiaries.

All CBVs who have multiple roles indicated that there were no clashes or problems when having multiple roles, stating that when they would have two meetings at the same time or had to work at the same hours (the latter was only mentioned once), they choose what they thought was the most important one, while other CBVs could go to the other meeting. However, when such answers were given, there was some tension in these groups. Obviously, the individual CBVs choose which job or meeting s/he considers more important, which leads to tensions.

Almost half of the officers at the district claimed that it was not a problem that CBVs had more than one job, indicating that not many people would like to work as a volunteer, and otherwise there would be a large lack of volunteers. Moreover, they indicated that the requirement to become a CBV is being literate, and in certain communities there are none or very few people who are literate.

Slightly more than half of the members of staff at the district level indicated that it was not good that CBVs had more than one job. Some said a CBV could have two jobs, but not more, because when CBVs had more than one job they did not show commitment and would not work when they were supposed to, and are therefore were unreliable. Moreover, the requirement of being literate is not necessary, because not all CBVs have to write reports, since they usually work in small groups.

5.3.3 Elections for Community Based Volunteers

The large majority of CBVs indicated that they were elected by the community, which is in line with the 85% of CBVs who reported that were elected in the skills audit. Two CBVs said they were appointed by the headman, and two CWAC members said they were appointed by the health authorities.

However, after a FGD with a SMAG group who claimed they were all elected by the community, the two CHAs working in the health facility in that specific community revealed that there had been no election for the SMAG, but the nurse-in-charge had appointed the SMAG members, without consulting either the community or the CHA. The TBAs in that community were not appointed as SMAG members, and therefore they had stopped working in the community, which led to tensions.

In another district, a CDA revealed that during elections for CBVs several people used coercion to make sure that community members voted for them. This CDA indicated that such cases had happened several times in that community. People feared certain persons, and therefore did not vote for others. So they elected the ones they actually did not want. In some cases, people in the community had quarrelled over the elections, but most of the time they avoided quarrelling and just voted the ones who indicated that should be elected, even though they did not want them. The CDA claimed that attempts to discuss this with the community and the people concerned had failed, though did emphasise that everyone should get a fair chance to be elected.

5.3.4 Duration of being a Community Based Volunteer

Many members of CBV groups claimed to have been members for a long time. The FSP committees have an average of one to three years, while all the others have a membership of generally much longer. The SMAG were established two to four years ago, and therefore they are members for two to four years. The Women's Associations have been executives for an average of two years, while the CWAC membership ranges from 3 to 20 years, with a majority of a membership of 6 to 8 years, while some had between 10 and 20 years. The NHC members also had a long membership, ranging from 2 to 12 years. This is in line with the findings of the skills audit research, which shows that 26% of CBVs have been a volunteer for more than 10 years.

Discussions considered whether a long membership should be allowed. The benefit of a long membership is that the CBVs are very much involved, knowledgeable and aware of what happens in the

community. On the other hand, regarding the sometimes unfair elections of a CBV, it would be fair to limit the duration and give opportunities to others.

5.3.5 Training of Community Based Volunteers

A major issue in the FGDs concerned training, or rather the CBVs claimed a lack of training.

- **Food Security Pack Committee:** The FSP committee is trained, either by the CDA or CDO, and/or by the Agricultural Extension officer. Some FSP members claimed to have trainings the whole year through at regular times, while other groups claimed they were only trained a few months before the rainy season. This training includes how to cultivate the land and where and how to sell the surplus. In addition, the FSP committee had orientation training for one day by the CDO on how to identify vulnerable potential beneficiaries, which is the main aim of the FSP committee
- **Women's Associations:** They have had trainings on several subjects, such as different projects for income generating, entrepreneurship, and leadership training. These trainings were given by the CDOs. The duration of the trainings was between two to five days. The trainings were either given by the CDA or CDO, or an NGO hired for this purpose by the CDO
- **CWAC members:** They were trained by the SWO for one day, during which they were told about their tasks, responsibilities, and how to identify the most vulnerable people in the community
- **NHC members:** They received orientation training for one day by a MCH officer. In addition, many NHC members have other voluntary jobs in the health sector (or as CWAC member) for which they have been trained
- **SMAG:** The members of a SMAG have been trained by different organisations. The duration of the training varied from one to three weeks
- **TB and ART adherence counsellors:** These counsellors have been trained by various organisations; the duration of the training varied from one to three weeks
- **CHW:** The CHWs have been trained for six weeks, either by the health staff at the district, at a health centre or by another organisation.

However, almost all groups interviewed indicated that because many CBV had left, and new members have been elected to join their group, these new CBV have not been trained. In some cases, the other group members train them.

Despite the fact that all groups have had some form of training, either a one day orientation training or a longer training, and many of them had had follow ups, usually after three to five years, the majority of the CBVs indicated they wanted to have more training. However, when asked what they would like to learn, they either said they did not know, or gave unclear and uncertain answers. For instance, CWAC members who had worked for several years identifying the most vulnerable in the community, indicated that they would like to learn how to identify the most vulnerable people, and SMAG members indicated they would like to learn how to do HIV counselling. Also, a SMAG group indicated they would like to know about PMTCT to teach this at the clinic, while at the same clinic there is already a specific group of volunteers whose task is to teach about PMTCT, as was explained by the EHT who attended part of the

FGD, emphasising they should avoid rivalry. When it was suggested that the nurse-in-charge could teach the SMAG on the spot about PMTCT, they were not interested.

Moreover, a CDA explained that after the Women's Association had frequently asked for a specific training, he organised such training on the spot. However, no one attended this training. As was frequently indicated by other ministry staff, CBVs want trainings because trainings come with incentives such as allowances, meals, accommodation, and certificates. Generally, this seems to be more important than gaining knowledge from training.

5.3.6 Drop-out rates

All the groups of CBVs indicated that many volunteers had left. No figures could be given, however. Only a SMAG group in Mwense claimed they had started with 48 SMAG members, while now there are only 16 remaining. This is a drop-out rate of 35%. This is in line with the figures given in the research conducted by CARE (2013), which claimed that the drop-out rate is between 5% and 45% annually, while a drop-out of 5% or just above is only among the CBV that are given monetary incentives.

During the FGD all CBVs indicated that many of their CBV members had left due to the lack of incentives. A Women's Association added to this reason that some people did not want to work, and did not see the benefit of working for income generating projects. Some government employees claimed that, especially when a NGO starts working in the district and gives incentives, many CBVs leave their voluntary position to work as CBV for this new NGO.

5.3.7 Supervision

The large majority of the CBVs claimed they were supervised well. Only three groups claimed there were some problems with their supervisors:

- one CWAC claimed the supervisor did not usually agree with their list of vulnerable people they had identified and gave very short notice when s/he visited the community
- another CWAC stated the SWO did not help them with writing proposals and did not listen to their complains and reports
- one SMAG reported that their supervisor, the nurse in-charge, did not read or respond to their reports, since s/he was often away for workshops or other issues.

However, it seems that supervision is superficial, and mainly consists of reading and compiling reports, and submitting them to the district or other authorities.

Many supervisors claimed there are too many CBV sand too many groups, which means they cannot supervise them all. This was especially amongst the SWO and the EHT. For this reason, the CWAC have representatives in the ACC, which is a body between the SWO and the CWAC.

Not all supervisors are trained to give supervision. For instance, during the research it became clear that there are several CDA who were not trained at all, hence they could not properly supervise the CBVs. In the clinics and health facilities, the same problem occurred. Apart from not having been trained as supervisors, health facility staff are often working on their own, or are very few in number since health facilities are understaffed. Therefore, many CBVs are supervised by the EHT in the district. This means

that there is no supervisor on the spot, so the supervisor does not see how the CBVs work and visits them infrequently.

The introduction of the CHAs has not solved this problem of supervision. The CBVs working under MCH are supposed to be supervised by the CHAs. However, currently only 307 CHA are working, with another 285 due to start in August 2014. As the CHAs only work in rural health facilities, this means CBVs in other districts are left out. Moreover, many CBVs do not accept the supervision of the CHAs, because the CHAs are usually much younger and the CBVs have been working for a longer period of time in the community and are more experienced.

The CHAs themselves, in turn, also lack supervision. In most cases they have no supervisor in the health facility, while the supervisor in the parent clinic is hard to reach, and their supervisor at the district does not know how they work and only see the CHA at certain times.

In conclusion, there is a lack of supervision of all CBV, mainly due to the heavy work load and long distance of the supervisors.

5.3.8 Incentives

All CBVs included in the research indicated that they did not receive incentives. However, meetings with NGOs made clear that their CBVs do get a small amount of money, usually K150-250. Moreover, in certain groups it was clear that CBVs had received incentives such as T-shirts, *chitenge*, bicycles, and money for transport or refreshments during meetings. Only after probing, CBVs would admit that they had been given such items. Nevertheless, all CBVs indicated they wanted to have bicycles (even if they already had one), gumboots, T-shirts, raincoats, umbrellas, bags, torches, reflector coats, and money. A large majority of CBVs indicated they wanted to be on the government payroll. It was only mentioned twice that they wanted kits including working tools such as gloves and other items needed to carry out their job.

In addition to this list of items, some CBVs claimed that their 'incentives' were the development of the community, the reduction of poverty in their communities, and the decrease of diseases and deaths in the community. Three CBVs mentioned that the community did something in return to them, such as slashing the fields of CBVs, and a few times it was mentioned that the beneficiaries gave some presents or money in return for the services provided by the CBVs. This is in line with the data collected from the Skills Audit research.

5.3.9 Community Based Volunteer engagement and motivation

The lack of incentives and the long lists of requests made by all groups of volunteers during the research raises the question of the motivation and engagement of CBVs. Some CBVs said they wish to serve and/or develop the community. Also, many CBVs wish to gain respect in the community, to get knowledge from trainings, to get certificates, to have more opportunity to get a paid job, and some have religious reasons. The latter reason was only mentioned by two CBVs out of the 205 included in the research.

Several CBVs see the need in the community, but even more in the health facilities, due to a lack of health facility staff. Hence they try to fill the gaps. In addition, they prefer to work in the health facilities instead of in the community, because it gives a higher status to be considered as the 'assistant' of the nurse-in-charge. Moreover, while working in the health facility, they are allowed to wear a certain type of uniform which all CBVs preferred, because they thought it gives more status. So, both a personal type of motivation and a motivation of 'filling the gap' makes that most CBVs wish to work in the health facilities rather than in the communities.

Motivation is related to the way CBVs work. During the FGDs it became clear that many CBVs mainly work in the health facilities, and rarely go into the communities. When asked about the time spent on their voluntary work, almost all said that they meet once a week for two hours. Hardly any of the groups mentioned their time spent in the community. Only after probing and specifically being asked how they work in the community, the CBVs indicated that they sometimes go into the community. Considering that they rarely mentioned their work in the communities, it is difficult to assess how much time they spend working in the communities.

Interestingly, a group of CBVs that worked from an urban health facility claimed that they send monthly reports to a specific donor, but the donor had indicated that they 'did not work' as the group members expressed it. The response from the donor may be an indicator that the group, who is supposed to work mainly in the community, and only to a lesser extent in the health facilities, does not work in the community. The general impression after the fieldwork is that indeed work in the community is done to a very little extent.

The main reason why they hardly ever went into the community was that they did not have transport, and even when they had transport such as bicycles, they complained that they were either obsolete or were their personal bicycles, which they did not want to use for their voluntary work. This is in line with the data from the Skills Audit, which indicates a large number of CBVs do not use their bicycles. Also, when given bicycles these are attached to a certain project and cannot be used for another voluntary work as many indicated.

5.3.10 Hierarchy among the Community Based Volunteer groups

In addition to the motivation to join a certain group as a CBV, it is important for the CBVs which specific group they join. This is related to the hierarchy among the various groups of CBVs, as well as to the incentives. For example, the CWAC has an important role in the community, and was often called the 'gate keepers' of the community. Several CWAC members claimed that they were only CWAC members and not worked in other groups, because being a member of CWAC was time consuming. However, being a CWAC member gives a lot of status.

Among CBVs that work under MCH, the NHC is the highest body. In some districts there is also the HCAC which is the link between the community and the health facility, but these HCAC do not exist everywhere. Hence in many districts the NHC is the most important and the umbrella organisation of all CBV related to health issues, and is supposed to have a coordinating role. Hence many people wish to join the NHC. The SMAG are also popular among CBVs. Many SMAG get incentives given by NGOs, which seems to be the most important reason for people to join this group.

5.3.11 Effectiveness of Community Based Volunteer work in the community

All CBVs claimed that their work in the community has had a lot of impact and effect in the communities. Food Security Pack committees, for instance, said their beneficiaries were now able to provide food for themselves, have three meals a day, sell their surplus so that they can pay school fees and other items needed. Women's Associations claimed that due to their work people now have money to buy several items and pay school fees (even up to tertiary education level). The women in one Women's Association claimed that they no longer depend on their husband's income, but bought things for themselves. CWAC members claimed that due to their work some people received monetary assistance such as Social Cash Transfer, with which they had built their own houses and paid school fees.

These statements, however, are difficult to measure. Even more difficult to measure are the statements made by CBVs working in the health sector. All of them claimed that there are fewer diseases due to their work. For example:

- People now had clean drinking water due to the work of the NHC
- There were hardly any malaria cases due to their sensitisation
- There were no deaths caused by HIV and AIDS due to sensitisation about HIV and AIDS, people on ART adhere to their drug regimes
- The surroundings in the villages are now clear due to sensitisation of the community by the NHC
- The SMAG claimed that now almost all women deliver in the health facilities and there are no deaths due to pregnancy and delivery any more in their communities.

However, whilst improvements in these areas may have taken place in the communities visited there is insufficient evidence available currently to directly link the work of CBVs to any such improvement and impact.

5.3.12 Duplication of services to beneficiaries

It is known that several beneficiaries receive assistance from multiple sources or organisations. Asked how the various groups of CBVs tried to avoid this, they all answered they have registers of the beneficiaries, and check these registers when someone asked them for assistance. This avoids duplication of assistance from the same group of CBVs. However, it does not avoid beneficiaries receiving assistance from different organisations. None of the groups of CBVs check their register with other groups or with other NGOs or FBOs. During the research several examples were given of beneficiaries who received assistance from more than one organisation; while other beneficiaries were potentially left out. For instance, a few SWOs claimed that they had organised school fees for several orphans. However, when the funds arrived and were distributed they found out that World Vision had just paid school fees to the same children. This led to frustration among the SWOs because certain people had been assisted twice, whereas others in need were left out. Another Social Welfare Officer claimed that the children know amongst each other who are sponsored. One Social Welfare Officer claimed s/he asked some children who were the potential beneficiaries at schools, but the children did not want to say anything about them being sponsored. Generally, it is well known in the community

who is a beneficiary. However, this is kept from officials. Some CWAC members claimed they asked teachers at schools, who were willing to tell them which children were beneficiaries.

There is no cooperation between the different groups of CBVs, and no sharing of registers or information which beneficiaries have been given. This leads to duplication of services provided to the same beneficiaries, while others in need are left out. Hence, in order to get better service delivery in the communities, there is need for more cooperation between the various groups of CBVs. The collaboration of different groups of CBVs may also lead to more collaboration between the three Departments of Community Development, Mother and Child Health, and Social Welfare within MCDMCH. Collaboration can cut down the costs, enhance the relationships within the community, and lead to more effective service provision. This will be the topic of the next chapter.

6 Possibilities for cooperation at District and Community level

The previous chapters showed that there is a lack of cooperation between the three departments, and there is duplication of services in the communities. This chapter will explore possibilities for cooperation between the three departments of MCDMCH, and combinations of programmes in these departments, and set out options for improving cooperation between the different groups of CBVs.

Better communication at all levels is a key issue for cooperation. A possibility to enhance cooperation between the three departments is to restructure the ministry at district level and to have an overall coordinator, who would organise meetings between the departments, develop joined up programmes and a collective budget. Also, the programmes that have the same aims and focus on the same (types) of beneficiaries could be synergized. All programmes in the communities could be coordinated and supervised by the CDAs, who would organise regular meetings with the CBVs. Since the CDAs work at grassroots level this would facilitate supervision. In addition, CBVs need to have a more structured and broader training on adequate service delivery, community development and health issues in the communities.

6.1 Possibilities for collaboration between the three departments

As stated in the previous chapter, despite or due to the lack of knowledge about each other's work and outreach activities within the three departments, the majority of the staff interviewed saw the need to work together since they are now in one ministry. Also, many of them said it would be good to know more about CBVs and how they work. As one government employee commented: "We need to seek good cooperation between the district and the CBVs. We need to know who the CBVs are and be aware of what they are doing."

6.1.1 Communication as a key to cooperation

During the interviews for this research, it became clear that there are a number of reasons why there is no or very little cooperation between the departments. The major reasons are the lack of communication, lack of information from the ministry's headquarters, and a lack of guidelines or a policy on how to work together as one ministry.

A key issue for cooperation is communication:(1) horizontal communication between the three departments at all levels; (2) vertical communication from the headquarters to the districts; (3) communication between the government employees and the CBVs; (4) communication between the different groups of volunteers in the community.

Government employees indicated there the lack of communication is a major reason why there is little cooperation between the departments. Therefore, the ministry's headquarters has a major role to play in this process of improving collaboration by providing information and facilitating communication.

6.1.2 Communication, information, guidelines or policy from the Ministry's Headquarters

All members of staff at district level indicated that collaboration within the three departments should be stipulated or guided from above from the ministry's headquarters. Since all instructions come from

headquarters, members of staff at district level expect clear instructions on cooperation from the Ministry, as well as more communication on what is expected of them.

Many claimed that it was difficult for them to adapt to this new situation of the merging of the three departments in one ministry, in particular the addition of MCH to the department of CD and SW, while especially for MCH it is a new situation to be separated from the MoH and to be expected to work with the departments of SW and CD. All members of staff in the three departments felt they had to find ways as to how to go about in this new situation, without getting instructions from headquarters on how to cooperate. They said a lack of information on how to go about and what was expected of them.

Some members of staff indicated that collaboration could also start from district level. The problem, however, is that they do not know where to start from or how to find ways to cooperate. Therefore, even though there have been some attempts by members of staff at district level, they expect guidance from headquarters. Thus, all members of staff emphasised that there is a need for clear guidelines or a clear policy from headquarters on how to work together.

6.1.3 One structure and one coordinator within the Ministry

Almost all members of staff emphasised that there should be one structure within the ministry, meaning that the three departments should have the same structure. Examples were given of the Ministry of Local Government and Housing and the Ministry of Gender and Child Development, that both have several departments that are equal. Only a few members of staff from MCH claimed that there should be a hierarchy within the ministry, with MCH staff on top. The majority, however, indicated that there should be one structure and there should be equality between the three departments.

Also, the majority of interviewees indicated that there should be one district coordinator or one head of the three departments, and not a head of each separate department, as it is now. The position of the three heads of department could become department managers or have other titles.

A coordinator for the three departments would have the benefit of emphasising and facilitating cooperation between the three departments. A coordinator would facilitate regular meetings within the three departments, and facilitate the sharing of knowledge about each other's programmes. This would meet the need for regular meetings with members of staff of the three different departments, and need to know each other's programmes. These meetings should be embedded in a structure (for instance, one a week). This would help to avoid duplication of programmes.

Moreover, with a coordinator and joined up programmes in place, the unclear boundaries and mandate, as perceived by MCH staff, would hopefully be clarified, and communication and collaboration improved.

6.1.4 One coordinated and integrated action plan

A few officers indicated that, next to a coordinator, there should be a coordinating team, to support the coordinator as head of department. This team would consist of people from the departments of CD, MCH and SW, and would know about all of the programmes carried out by the three departments, as well as by NGOs working in each district. The objective of this team would be to put in place a

coordinated action plan for the district, and monitor its implementation. In the action plan all the outreach activities to be executed in a district should be linked together. This facilitates integration of activities in the communities, while some specific outreach activities could be done separately when needed, but are still known to the members of staff. This would help to avoid duplication of activities, avoid beneficiaries getting assistance from several departments at the same time, and hence benefit the community.

6.1.5 One common budget and equal sharing of finances within the three departments

The members of staff under CD and SW frequently stated that there should be equal sharing of funding. In the current situation, MCH programmes receive more funding than CD and SW programmes. A coordinator or coordinating team should, in addition to a common action plan, develop a common budget in which the allocation of resources in the districts is based on the issues identified and the costs linked to them. The budget should also include an appropriate allocation of resources such as cars, fuel, maintenance, computer equipment, and so on.

The issue of a joint coordinated budgeting (which will lead to more equal sharing of funding) will be facilitated after the process of decentralisation has been enacted, when government funding of projects will go through the District Councils.

6.1.6 One focal point for clients

The majority of the members of staff interviewed indicated establishing a focal point (in which the three departments are combined), which clients can be referred could improve service provision. This could be a special office at the district level or in a health facility; similar to the one stop focal point that has been installed in the hospitals.

One focal point would facilitate referring clients to other MCDMCH departments. Moreover, it would avoid cases such as patients remaining in or around clinics or hospitals for a long time when they cannot pay transport to return to their homes and who therefore wait a long time (weeks or months) for a district vehicle to come and take them home. In addition, it would avoid duplication of people getting assistance from different departments as is the case now.

6.1.7 Cooperation with NGOs

From the fieldwork it became clear that there is need for more and better cooperation and communication between the ministry and NGOs. In the districts where fieldwork was carried out, there were both positive and negative experiences of working with NGOs. The positive experiences were when the NGOs had introduced themselves to the district, usually the DC and the department to which their programmes was most related to (usually MCH). In situations where an NGO left a district they informed the department in advance, so that the department could take action to take over the project.

In all districts it was frequently stated that some NGOs neglect the ministry departments in the districts; they do not introduce themselves when they start working in the district, do not report to the ministry staff about their activities, and do not inform the ministry in advance when they plan to leave or stop funding a project.

For instance, members of staff claimed that employees of a certain NGO had not introduced themselves when they started working in the districts, they had the same programmes as the ministry, and their beneficiaries were the same people as the beneficiaries from the ministry; hence beneficiaries were given support twice while others were left out. They also gave a lot of incentives to CBVs, which resulted in withdrawal of CBVs from the ministry, while at the end of the project the ministry was not informed, so both the CBVs and the beneficiaries were (suddenly) left without any assistance. In Kasama, a ministry employee who was also a Gender Focal Point Person claimed that an NGO had organised a workshop on gender in the district, but had not invited the focal point person. Even after s/he had asked and explained why s/he wished to attend the workshop, s/he was refused, seeing this as a clear example of how this NGO do not wish to cooperate with the ministry.

In general, there is need for more cooperation between the ministry and NGOs. The ministry's policy on registration of NGOs should be more enforced, stipulating that all NGOs working in the district should introduce themselves to the DC and the department to which their programme is related. In addition, there should be a way of registering the NGOs working in each district. Some members of staff suggested that the Registrar of Societies could play a role here, while others said that the Registrar of Societies only works in Lusaka even though at the districts the Registrar uses the SWO to recommend NGOs and find out if they really work there. But this is mostly for NGOs that work in the field of social welfare.

Better cooperation between the ministry and NGOs could improve service delivery in the districts and avoid duplication of programmes and beneficiaries. Moreover, it would avoid competition between CBVs, who are likely to leave their voluntary job for the ministry if NGOs give more allowances.

Moreover, better cooperation with NGOs would give the ministry more ownership of programmes in the districts. Ownership and timely information about ending a project or programme would give opportunity to the ministry to prepare to take over the project or programme. This would help to facilitate the durability of projects and sustainability of service delivery.

6.1.8 One common way of remuneration for the Community Based Volunteers

A major concern in all districts is the high drop-out rate of CBVs. This is especially a concern when they have received training, and are replaced by others who have not yet been trained. All members of staff and the large majority of CBVs claimed that the high drop-out rate was mainly due to a lack of incentives. The majority of the members of staff and all CBVs included in this study indicated that there should be some sort of remuneration, and that this should be equal for all CBVs.

Remuneration could be given in terms of transport allowances for meetings, visiting communities or delivering reports, refreshments during meetings, transport, raingear, bags to carry their reports or other material needed, and proper kits in case of physical care, such as the Home Based Care volunteers who work with bedridden patients.

Some members of staff indicated that CBVs should get an allowance according to the number of beneficiaries they have identified or assisted, or the number of hours they spend a week or month doing voluntary work. The latter, however, is difficult to measure and to check. One CDO suggested that the

ACC chairman should be paid a monetary allowance because the ACC chairperson is the direct assistant to the SWO; the 'highest' volunteer position.

Although allowances will never be enough, it would help CBVs to feel more appreciated and subsequently reduce the drop-out rate. The issue of allowances is an important issue and should be looked into carefully. Moreover, it raises ethical questions for the ministry dependence of voluntary work for service delivery, as well as the sustainability of service provision.

6.1.9 Measuring the effects of the work of Community Based Volunteers

There should be a way of measuring the effectiveness of CBVs working at community level; delivering reports is not a good way to measure activities and effects. It seems that not all supervisors read the reports, and only in a few cases CBVs were able to give figures about how many beneficiaries they have assisted. Moreover, it is very unclear how often CBVs go into the community to do outreach activities. Many CBVs do not have an action plan. When asked how much time they spent weekly on their activities, almost all CBV indicated they had meetings once a week. Only after probing they indicated that they also go into the community. In addition, it is unclear how effective sensitisation of the community on certain issues such as diseases and hygiene is.

The work of CBVs in the health facilities should also be measured, as measuring this work would give more of indication as to how much the CBVs are needed to fill the gap of the lack of health personnel. Hence, the ministry should find a way to measure the activities and effectiveness of the CBVs. This would give more insight into the demand of the community for service delivery by the CBVs.

The research has also shown that many CBVs are inactive. This applies both for certain groups of CBVs as well as for certain members within a group. There should be a clear policy on what to do with CBVs who are inactive. It seems that the community cannot always avoid having members in their midst who are inactive. The district can play a role in this but the headquarters should also look into this matter.

6.2 Possibilities for combining programmes of the three departments

As was set out in the previous chapter, there are many programmes of the Departments of CD, SW and MCH in the community (and in the health facilities). The majority of them aim to assist vulnerable people, usually poor people, children, orphans, women, widows, elderly people, malnourished people, or people who are chronically ill. During the interviews for this research, it became clear that several of the programmes in the three departments (partly) overlap each other and some duplication exists. Therefore, certain programmes and activities in the community could be combined. The benefit of combining certain programmes would be to cut down on financial and human resources, while at the same time the activities and work in the community would be better streamlined and organised. Combining programmes and activities could help to enhance supervision, and lessen the burden on the supervisors. In addition, it would enhance cooperation between the three departments, as well as enhance cooperation between CBVs to lead to better coordination of service provision in the communities.

6.2.1 Health, social welfare and community development

Health, social welfare and community development are related. When people are physically and mentally healthy, they can earn a living, pay for their needs and those of their children, which will reflect on the development of the community at large. Food security is related to health; having access to food is often a prerequisite for health, a person's social wellbeing and development. Therefore, several programmes under the Departments of CD, MCH and SW could be integrated. Below some suggestions are made as to which and how certain programmes could be combined.

In a new structure, for all programmes, the CWAC should identify the beneficiaries, because they already identify the poor and vulnerable people, and they are the highest committee overseeing all activities concerning welfare in the communities.

6.2.2 Programmes on food and food security

Food and nutrition programme with the Food Security Pack

The most frequently mentioned programmes that could be combined are that of the Food Security Pack (FSP) from CD with the Food and nutrition from MCH. Both programmes aim at food security for their beneficiaries, and both focus on vulnerable and/or malnourished people. In the FSP they are given farming input, while in the Food and nutrition programme of MCH they are given food temporarily. Generally, it is stated that it would be better to give farming inputs and/or teach people how to cultivate their own food, than give food directly. Therefore, especially for the people who are viable, these two programmes could be combined. The FSP committee could also be disbanded because the CWAC would take over their role to identify beneficiaries.

6.2.3 Programmes concerning food security and social welfare

Food and Nutrition programme, the Food Security Pack and the PWAS/SCT/CWAC

Another common suggestion by interviewees was that the Food and Nutrition programme of MCH, the Food Security Pack of CD and the PWAS of SW could be combined, since the beneficiaries of these programmes are all vulnerable, poor and/or malnourished people. In the PWAS the beneficiaries are given food, which would not be necessary if they would be given farming inputs through the FSP in the Department of Community Development.

A similar suggestion was made to combine Food and Nutrition programmes of MCH, the FSP of CD and the SCT of SW, because food security and social welfare are linked, while SCT is often given to people who have no means to buy food. When food donation from MCH stops, the beneficiaries usually go to SW.

The combination of the FSP and CWAC, meaning the identification of FSP beneficiaries, comes close to a situation as it was previously. From 2003-2008 the CWAC and FSP were combined. In 2008, with the replacement of the Heads of the Departments of SW, CD and Agriculture, the new heads changed this, but this was not made official. All the FSP committees are still supervised by both an Agricultural Extension Officer from the Ministry of Agriculture and a CDA.

Programmes on food security and income generating activities

Some officers suggested that the FSC could also be combined with Women's Associations. Women's Associations or women's clubs often have agricultural activities as income generating projects. Many members of Women's clubs used to be beneficiaries of FSP. After two years, when they were no longer entitled to be beneficiaries, they organised themselves as Women's clubs to carry out income generating activities. Also, they often have had trainings in and are knowledgeable about nutrition, balanced diets and the preservation of food.

In order to merge the activities of Women's clubs with food and health issues there needs to be cooperation with the NHC. In some districts or sub-centres, Women's clubs claimed that they already cooperate with the NHC.

6.2.4 Programmes on Social Welfare and Mother and Child Health

CWAC and Neighbourhood Health Committee

Several officers claimed that the CWAC and the NHC could be combined because they identify the same type of people, i.e. the poor and vulnerable. Although the NHC is supposed to look more at health matters in the community, many NHC members claimed that they also identify people in need of other services, while the CWAC claimed they also identify people who need medical care or identify chronically ill people as beneficiaries for a Social Welfare programme. Moreover, several CWAC members are also NHC members. Hence in many cases their tasks are similar. In areas where the NHC is well established, there are no CWAC, so here the NHC is used by the SWO. This shows some collaboration at community level between the departments of SW and MCH.

In addition, both the CWAC and the NHC are committees that have an equally high position in the hierarchy among the groups of CBVs; the CWAC is the only and highest body for Social Welfare in the community, while the NHC is the highest body for MCH in the community. The CWAC are often called the 'gatekeepers' of the community, while the NHC is the overall body for issues concerning health in the community, and is supposed to plan and oversee activities of other groups of CBV working in the health sector.

Moreover, the CWAC members have representatives in the ACC, who report to the Department of Social Welfare. The NHC report to the DCMO and the health facilities, and have representatives in the HCAC, which is an organisation that is considered to be a go-between the community and the health facilities. However, whilst all health facilities are meant to have a HCAC, in practice this is not the case.

Psycho-social counselling

Since the three departments all provide psycho-social counselling, this could be combined and carried out by one group of trained CBVs. Trainings of counsellors could include different types of psycho-social counselling needed depending on the beneficiaries.

6.2.5 Outreach programmes of the Department of Mother and Child Health

In addition to trying to find ways to combine the various programmes of the three different departments and streamline the activities in the community, the various outreach activities and programmes of MCH could also be combined. The current situation in which many CBVs work in various programmes and have multiple roles provides opportunities for combining several of these programmes and tasks.

HIV and AIDS, TB and PMTCT

HIV and AIDS and TB are already often taken as one programme. Also, some CBVs do counselling and/or testing aimed at prevention, and/or do Home Based Care, while other groups of CBVs specialise in PMTCT. However, there is no consistency in the roles and tasks of the CBVs here. Therefore, all sensitisation on, testing of, and treatment and care of HIV, AIDS and TB related issues could be combined.

Communicable diseases, hygiene and Water and Sanitation programme

Community sensitisation on communicable diseases, thus prevention and care of all communicable diseases such as HIV, AIDS, malaria and diarrhoea could be combined. Also, sensitisation on these diseases could be combined with information on hygiene, such as sensitisation on clean water and sanitation, the use of chlorine, clear wells, how to test drinking water, and the use and construction of pit latrines.

HIV and AIDS, PMTCT and Family Planning

These three programmes could be combined, since they all deal with sexual and reproductive health, and are therefore related. Moreover, many HIV positive people are concerned with and would like to have more information on PMTCT and family planning.

PMTCT, Family Planning and Community Based Distributors

Since most Community Based Distributors distribute and sell family planning products and teach about family planning issues, the tasks of these distributors could be combined with sensitisation on family planning and PMTCT.

SMAG, PMTCT, Family Planning and TBA

The CBVs part of the SMAG work with pregnant women (and their husbands/partners). Therefore sensitisation of women and men on PMTCT and family planning could be included in their work. Some SMAG groups already do this. Also, more TBAs could be included in SMAG, and more TBAs could be given tasks to teach the community about family planning (provided they are trained in these issues).

SMAG and Maternal Mortality Committees

MCH is currently organising a new programme on maternal mortality and subsequently establishing a new group of CBVs as Maternal Mortality Committees. However, instead of installing another group of CBVs, it would be better to add this task to the tasks of the SMAG because the SMAG work with pregnant women with one of their aims being to reduce maternal mortality.

Child Growth Monitoring (CGM), Food and nutrition and Immunisation programmes

The Child Growth Monitoring programme could be combined with programmes on Food and nutrition, since these two are related; child growth depends on food and nutrition. These programmes are carried out on a continuous basis. The Child Growth Monitoring and Food and nutrition programmes could also be combined with the immunisation programmes that focuses on children, and are executed at regular intervals.

6.3 Possibilities for combining various groups of Community Based Volunteers

In order to combine the tasks of CBVs, as mentioned above, there is need for trainings in all these issues. In addition, there is need for better and more regular supervision of these CBVs.

6.3.1 Trainings of Community Based Volunteers

In order to officially combine various tasks of CBVs, there is need for better and combined training of the CBVs. Only after a proper training on many health and health related issues can these tasks be combined.

Many of the current trainings are fragmented, e.g. CBVs are only trained on HIV treatment or malaria treatment. Several issues CBVs have to deal with, however, cannot be treated separately, because many health issues are related. It often happens that CBVs come across cases that they do not know how to deal with. For instance, several SMAG members now do not know how to deal with HIV positive pregnant women, while many HIV counsellors do not know how to assist pregnant women who are HIV positive, or HIV positive women who wish to become pregnant but fear that they will transmit HIV to the child.

As became clear during the research, several CBVs have had more than one training in a number of topics, such as malaria, HIV or Safe Motherhood. This is not only due to the fact that they wish to have many different roles, but also because CBVs feel the need for more knowledge as to better serve the community and filling the gaps, especially in the health sector.

This means that there is a need for more profound and longer trainings. Thus, trainings in multiple issues, such as HIV and AIDS, TB, malaria, hygiene, food and nutrition, child growth etc., should be combined. Trainings should include several health related issues, as well as issues on social wellbeing. This would be more in line with the need of the CBVs, with a holistic attitude, and would therefore answer the need of the community for better service provision.

In the Social Welfare and Community Development sectors trainings on food and nutrition, social welfare, community development and/or income generating issues should also be combined.

6.3.2 Supervision

The research highlights a lack of proper supervision: supervisors often have many tasks, there are too many CBVs under their supervision, and they are often at a large distance. Hence they are unable to provide proper supervision to the large number of CBVs. In many cases, supervision is only done by submitting, and usually, reading reports. However, this is not proper supervision. CBVs indicated that

there is need for better supervision and feedback, while the supervisors complained that there are too many CBV to give proper supervision. In addition to assess the performance of CBVs, better supervision and feedback is also a means to feel more appreciated.

A way to avoid these large numbers of CBVs is to make smaller groups of CBVs, to better select CBVs, and to combine their tasks, which can be done after a more holistic training. This would facilitate the work of the supervisors, and reduce the time spent on supervision. Supervision would then not only be done per group, but also for individual CBVs.

Moreover, supervisors would be focused to work more with CBVs and have fewer other tasks. Officers could be appointed especially for the task of working with and supervising CBVs. This task could be given to the CDA.

6.3.3 Assessments of the number of Community Base Volunteers

Currently, there are many different groups of CBVs and a large number per group (usually 10-20). Several CBVs, however, are inactive. Moreover, there is a high drop-out rate. Smaller groups of CBVs would enhance supervision.

There is need for assessments of the number of CBVs. This could be done per district by the health facilities/DCMO/EHT, the CDO and the SWO. Measurement should be done on the needs for services provided by CBVs, and the demand per health facility/district.

The election of CBVs should be reviewed, as well as the number of CBVs and the demand for them from communities and health facilities. It is envisaged that if CBVs have a better and more all-round training, there will be less need for a large number of CBVs. Both better training and better supervision are likely to decrease the large number of inactive CBVs, as well as the high drop-out rate.

6.3.4 Upgrading of certain categories of Community Based Volunteers

In addition to the above, there is need to upgrade several categories of CBVs, such as the CDE, CHA, and CHW. These often work as volunteers or receive very little salary, while they do a lot of work as the assistants of the nurse-in-charge of the health facility. They often work to fill the gaps of a lack of medical staff. They have been trained longer than other CBVs, often have work experience for a long time, and usually work independently. They might be upgraded to the level of assistant nurse, and receive a salary accordingly. This would contribute to decreasing the shortage of health staff.

7 Conclusions and Recommendations

In this chapter conclusions are drawn based on the findings of the fieldwork for the structures and linkages study. The first part of this chapter presents conclusions concerning departmental cooperation within MCDMCH, after which conclusions concerning CBVs are drawn. The second part of this chapter provides recommendations. Both the conclusions and recommendations will form the basis for the development of a draft strategic plan on the utilisation of Community Based Volunteers for the MCDMCH.

7.1 Overall conclusions

The objective of this study was to scrutinise the structures and linkages between districts and community structures in the areas of community development, mother and child health, and social welfare and to find ways to enhance cooperation and strengthen community structures. This entails two areas: cooperation between the ministry staff at the three departments at district level; and strengthening CBVs working in the communities to deliver their services.

From the previous chapters it can be concluded that there is a lack of communication within the ministry both from headquarters to district level, and between the three departments operating at district level. Staff at district level lack clear guidelines or a policy from headquarters on how to cooperate across the three departments.

In most districts there is a weak working relationship between CD/SW and MCH, and no sharing of information. The current lack of cooperation leads to duplication and fragmented service delivery. There is need for a coordinator to organise meetings between the three departments in which information can be shared, and common activities in the communities can be planned. There are several possibilities for synergising programmes executed in the communities, such as programmes with the same aim and focusing on the same beneficiaries.

Also the different groups of CBVs do not cooperate, they have no meetings, and there is no information sharing. The groups of CBVs lack a common vision as to how to deliver services in the communities. This is partly due to the different NGOs and the Ministry under which the CBVs implement their activities. Moreover, because the groups of CBVs are affiliated to different NGOs and the ministry they also have different resources, different remuneration and receive different trainings. These conclusions are elaborated on below.

7.1.1 The Departments of Community Department, Mother and Child Health, and Social Welfare

The establishment of MCDMCH – the merging of the Department of MCH with the Departments of Community Development and Social Welfare – has lead to several tensions. Generally, staff at the Departments of CD and SW feel overwhelmed with the addition of MCH to their ministry. The Departments of CD and SW have been in one ministry since 1964, and they have a good working relationship in most districts. In almost all districts, however, there is no working relationship between

CD/SW and MCH. MCH staff feel exiled from the Ministry of Health to what is generally considered a lesser profile ministry. This is one of the hindrances for cooperation between the three departments.

There are several other reasons for this lack of cooperation. A key issue is the lack of communication at all levels: horizontal – between the three departments; and vertical – from headquarters to district level. The members of staff lack clear guidelines and information from the headquarters as to how to collaborate and what is expected of them. Since all instructions at district level come from headquarters, staff members at district level also expect information and guidelines from headquarters on collaboration with the other departments at the ministry. Now most members of staff feel left alone in their attempts to cooperate at district level. Hence, there is an urgent need for headquarters to establish clear guidelines or a policy on how to cooperate within the three departments.

The lack of knowledge about and interests in CD/SW programmes of MCH staff and MCH programmes of CD/SW staff are both a reason for and a result of a lack of cooperation. Other reasons are the different background of the members of staff, different types of funding, and fear of having to share resources, particularly MCH that has more resources than the other two departments. This leads to distrust among members of staff from the different departments, and a reluctance to share information with other departments, which are again hindrances to cooperation.

The lack of cooperation and reluctance to share information leads to fragmented service delivery and duplication of activities in the communities. There is similarity between the programmes of the three ministry's departments, which could be overcome by aligning and/or combining these programmes. This would avoid duplication of programmes with the same objectives and focusing on the same beneficiaries. Moreover, combining programmes would streamline activities in the communities, strengthen community structures, and enhance better service delivery.

In order to improve cooperation and coordinate common activities, there is need for an overall district coordinator or coordinating team, who organises regular meetings of the three departments and who facilitates information sharing and plan a common budget.

7.1.2 Community Based Volunteers

The activities and service delivery of CBVs in the communities are fragmented. There is rivalry and a lack of common vision among CBVs as to how to deliver on their mandate. This applies to CBVs working under the three ministry departments.

In line with the ZISSP (2011) report, this study found that the different groups of CBVs do not work together, which has contributed to lack of common vision. Some groups of CBVs only do what they have been trained to do, while at the same time many CBVs and/or groups go beyond their tasks, which is mainly due to their multiple roles.

There are no common meetings of the various groups of CBVs. There is no sharing of information about their planned and executed activities, while many CBVs do not even have a work plan. The NHC is supposed to oversee the activities concerning health in the communities, but this is often not the case. This results in duplication and gaps in activities. The different partners with different interests further re-enforce the isolation of the groups of CBVs.

The CBVs consider the dependency on resources of different partners as unfair, and it causes rivalry between the different groups of CBVs. This unfairness in sharing limited resources and poor communication between groups of CBVs is perpetuated by different NGOs. Hence there is a lot of tension among the different groups of CBVs, whereas some groups of CBVs tend to be dominant in the community. In addition, there is no sharing of information about the register of beneficiaries of each group of CBVs. This leads to assistance being given to the same beneficiaries.

It is unclear how often CBVs go into the community. The CBVs who work in the health sector usually work in a health facility, while other CBVs indicated that most potential beneficiaries come to them instead of the CBVs going into the community. All CBVs claimed they did not have transport to go into the communities. There is also no measurement of the needs for activities, for the number of CBVs required, and on the effects of the CBVs' activities in the communities. Hence it is unclear what the benefits and impact of the CBV activities in the community are.

Many groups of CBVs lack proper supervision as supervisors have little time to read reports and act upon them due to their own heavy workload. Moreover, they are usually at a long distance (at the district office) from where the CBVs are based.

There is a high drop-out rate of CBVs, predominantly due to a lack of incentives and subsequent motivation by CBVs, who occasionally feel unappreciated because they do not receive (enough) incentives. All CBVs expressed a need for allowances, and many indicated they wanted to be on the government payroll. This raises questions about their motivations, but also raises ethical questions as to how to deal with CBVs who identify or assist poor people in the communities, while they are considered poor themselves. It remains an issue as to how sustainable it would be for the government to give monetary incentives to CBVs, but it is also a question as to how sustainable it is for the ministry to depend on CBVs (with a high drop-out rate after their training) for service delivery in the communities.

The majority of CBVs have had some training, varying from one day to three weeks. The majority also wished to have more training as trainings are seen as an incentive. Most CBVs wanted to have more trainings, but in unrelated subjects (e.g. in matters they had been doing for many years, or subjects that had nothing to do with their voluntary work). Also, the training typically depends on the partners. This causes issues of superiority and inferiority for the ones who have been trained more or longer than others.

The majority of CBVs have no job description. Many CBVs have multiple roles, and the groups of CBV do not stick to their jobs but go beyond. This holistic point of view and the multiple jobs that the groups of CBVs have, give several opportunities for cooperation and better coordination of the activities of CBVs in the communities and to strengthen CBVs. The multiple roles are partly related to the sometimes unfair elections for CBVs. Some people use coercion to be elected, while sometimes medical staff appoint CBVs without consulting other community members.

Collaboration between the different groups of CBVs in the community can reduce the costs and the need for (human) resources, can enhance better relationships in the community and can improve more effective service provision.

The CHAs experience several problems concerning their supervision, as well as their acceptance by the community and CBVs.

7.2 Recommendations

In order to restructure the linkages and strengthen CBVs there is need for realignment of positions of members of staff at community level, and synergy of programmes and activities of CBVs. In addition, there are several issues that MCDMCH should look into. Options for possible new structures at district and community level, including restructuring positions and activities, are given at the end of this chapter. Other suggestions for the Ministry to consider in order to improve service delivery are the following.

7.2.1 Concerning collaboration between the three departments

- The ministry should develop clear guidelines/policy on how the three departments can cooperate, and sensitise staff at district level about what is expected of them in accordance with the realignment of MCDMCH. It should be emphasised that the three departments are equal
- The ministry should take the lead in facilitating communication and providing information to districts (and provinces). Information could be provided by general newsletters from headquarters, by circular letters and by headquarters staff visiting the three departments in the district, and not only the department they are affiliated to
- At district level – in order to meet the need for more communication, to enhance cooperation between the three departments, and to share information – a coordinator or coordinating team should be appointed as an overall body. This could be the DCMO
- A district coordinator or coordinating team should organise regular meetings of the three departments and emphasise information sharing, while it should also plan, coordinate and budget for common activities
- There should be one focal point to which potential beneficiaries can be referred. This would enhance departmental cooperation and improve service delivery
- There is need for a Social Welfare Officer in clinics. This would enhance cooperation between the departments of SW and MCH, and improve service delivery
- The ministry (at all levels) should look into aligning and/or combining programmes. MCH programmes on HIV and TB, HBC and PMTCT can be combined, as well as the programmes on SMAG, PMTCT, Family planning and Community Based Distributors. Also, the programmes on Food and Nutrition (MCH) can be combined with FSP (CD). Psycho-social counselling can be done by one department (potentially Social Welfare).

7.2.2 Concerning Community Based Volunteers

- Several tasks of groups of CBVs can be combined, following the synergy of programmes. This will decrease the number of CBVs but probably would stabilise the number of active CBVs
- The CDA should be given the task to develop and supervise common action plans in the communities. The CDA should facilitate a platform or meetings for different groups of CBVs to enhance cooperation between the CBVs

- The CDA should supervise all CBVs (including those in the health sector). Therefore the CDA should be better trained on how to supervise CBVs, and have a broader training including health issues
- The CWAC should be appointed as an overall committee to supervise the CBVs and to identify potential beneficiaries and problems in the communities. This means that the ACC and the NHC could be omitted
- The ministry should provide guidelines for standardized trainings, and ensure that the groups of CBVs have a standardised training with regular (once in 3 years) follow ups
- The ministry should emphasise that the CBV have a clear job description, as well as set out the criteria for becoming a CBV (not only grade 7/literate, because not everyone writes reports)
- The ministry should provide guidelines for a common and equal system of remuneration for CBVs, both CBVs affiliated to the ministry and to NGOs. Distribution of remuneration of CBVs affiliated to NGOs could be done through MCDMCH
- The ministry should take the lead in enforcing the policy on how to work with NGOs including the registration of NGOs through the Department of Registrar of NGOs
- CHWs could be upgraded with more training so that they become assistant nurses
- The ministry should facilitate baseline studies to assess the needs for CBV activities in the communities, to assess the number of CBVs in the community/health facility, and to measure the effects of the CBV's activities in the communities. This should be demand driven.

Figure 1: Existing District and Community Structure (relating to MCDMCH)

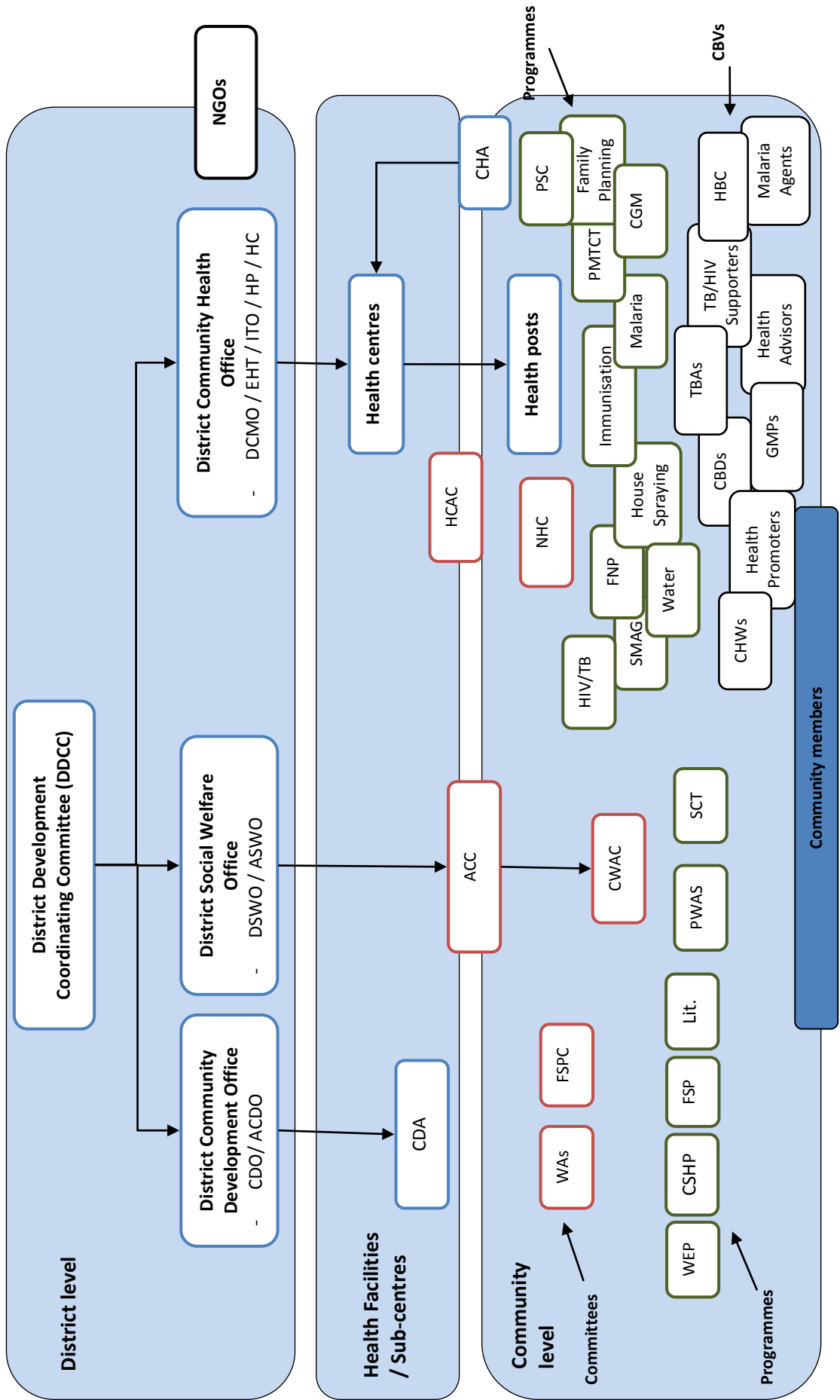


Figure 2: Proposed new District and Community Structure – Option 1

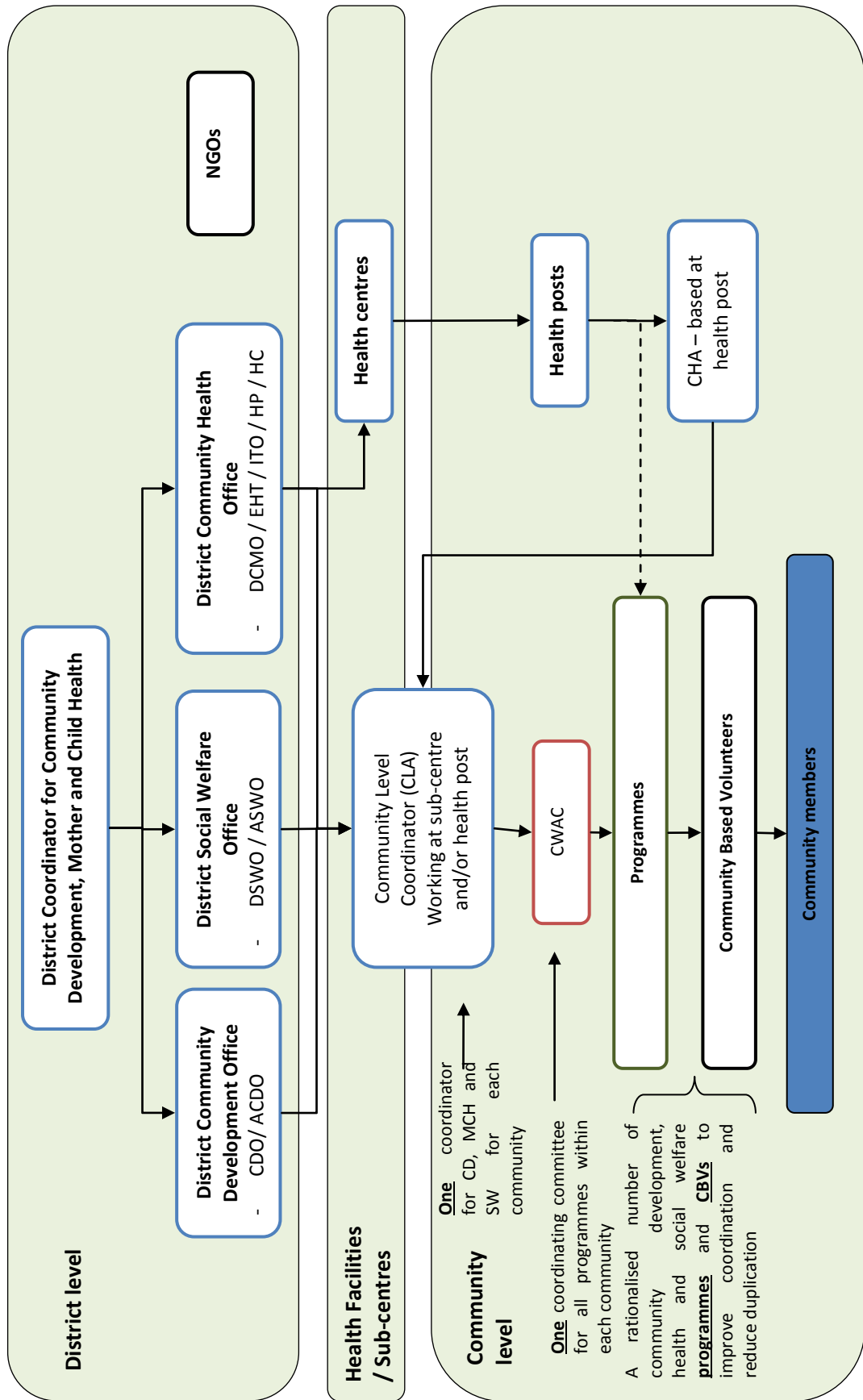


Figure 3: Proposed new District and Community Structure – Option 2

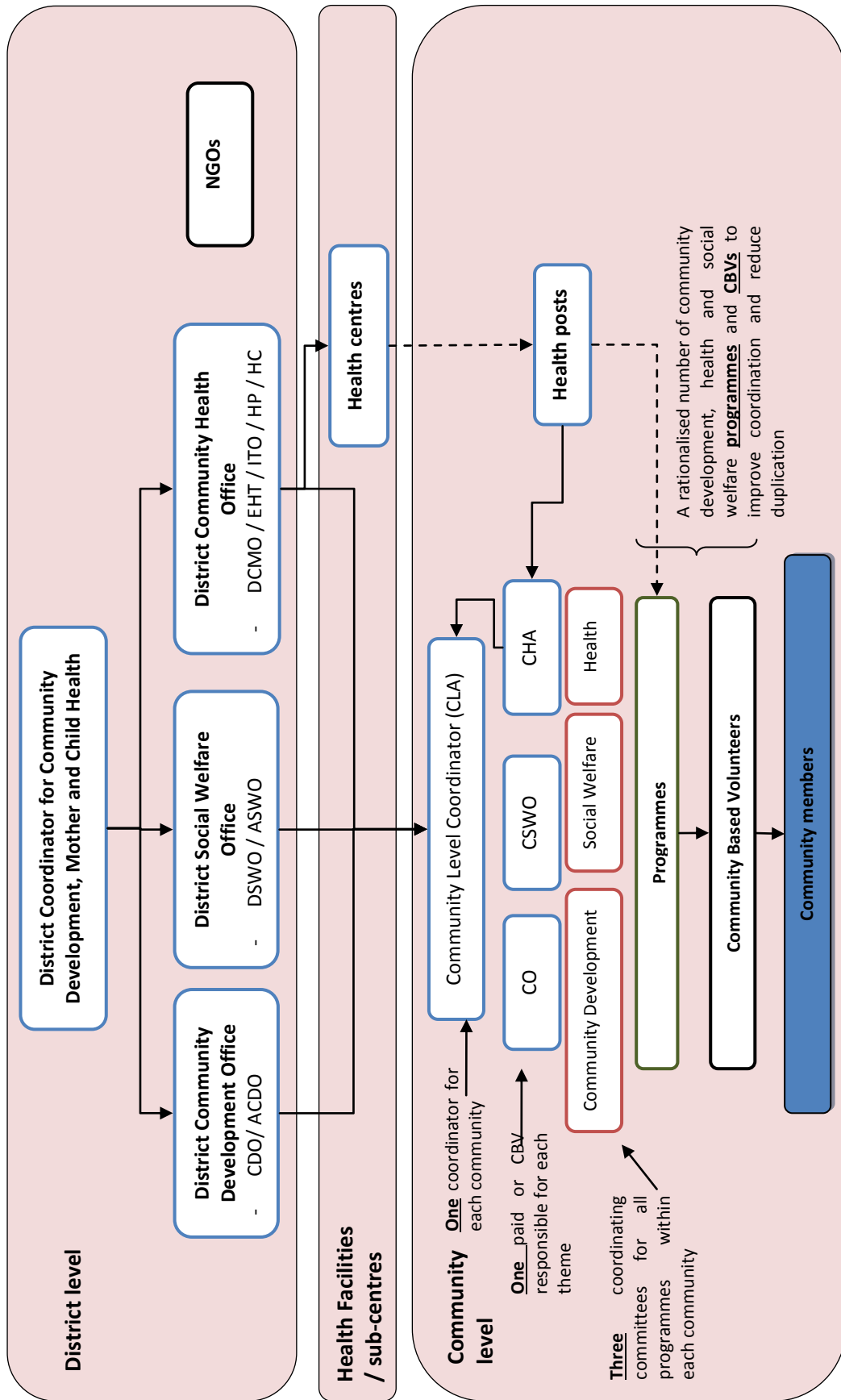
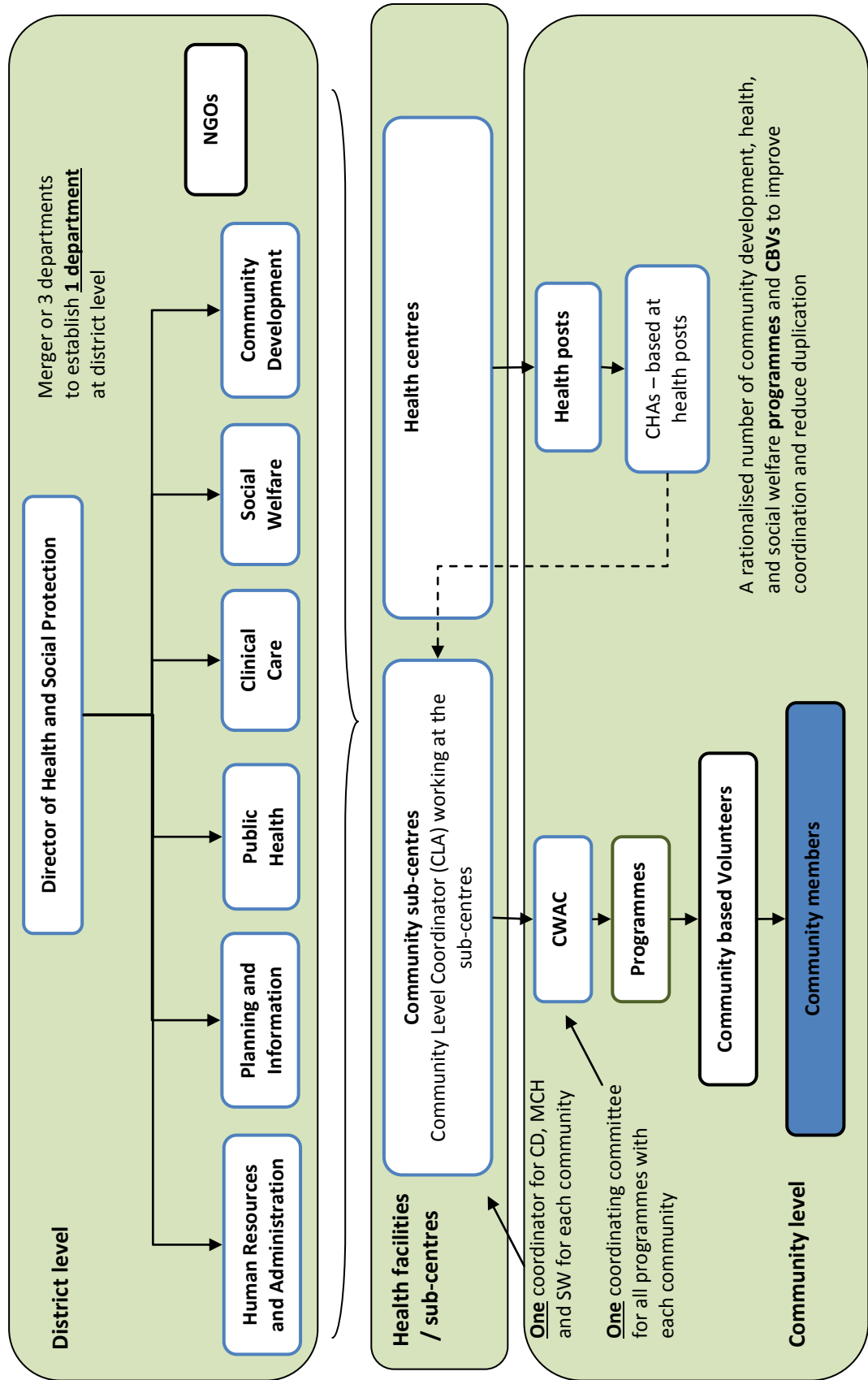


Figure 4: Proposed new District and Community Structure – Option 3



References

- Advancing Partners & Communities (2013)** *Country Profile: Zambia Community Health Programmes*. Arlington, VA.
- Beazley, Rodolfo and Carraro Ludovico (2013)** *Assessment of the Zambia Social Protection Expansion Programme Targeting Mechanisms*.
- CAN (Caregivers Action Network) (2013)** *Community Caregivers: The backbone for accessible care and support*.
- CARE Zambia (2013)** Working with and through Community Health Volunteers.
- CHAI (2013)** CHA HF Listing
- CHAI (2014)** *Evidence on the impact of CHA deployment on the Zambian health system*. Draft report.
- Chanda Pascalina, Krupa Eugene, Hamainza Busiku, Armstrong Brian, Cocosila Mihail, Ally Mohamed and Sekelani Banda (no date)**. The effect of ICT devices on community health services in Zambia. Research Proposal.
- Chandang'oma, Kaimfa and Kakoma, Josephat (2008)** *Sustainability of Voluntarism for a National Scaled-up Social Cash Transfer Scheme*.
- Cockburn Kristen, Krupa Gene and Duncan Saunders (2012)** *Community Health Workers (CHWs) in Zambia: A "Grey Literature Review"*.
- IPA (2012)** Community Based Health Volunteers in Zambia.
- Ministry of Community Development Mother and Child Health (2013a)** *Strategic Plan for the Ministry of Community Development, Mother and Child Health 2013-2016*.
- Ministry of Community Development Mother and Child Health (2013b)** Newsletter: A new Ministry is born. *Newsletter*, vol. 1, no. 1. April-June 2013.
- Ministry of Community Development Mother and Child Health (2013c)** *Zambia National Caregivers Policy, Draft 1*.
- Ministry of Health (2009)** Community Health Worker Partner Survey Consolidation.
- Ministry of Health (2010)** *National Community Health Worker Strategy in Zambia*.
- Ministry of Health (2011)** *Draft Human Resources of Health Strategic Plan 2011-2015*.
- Ministry of Health (2013)** National Community Health Assistant (CHA) Strategy in Zambia.
- Mungunda, Sitwala (2013)** ZPCT II Trip Report.
- Rasing, Thera (2006)** A way to heal? Pentecostal Churches and HIV/AIDS in Zambia. Research report for Prisma, The Netherlands.

- Rasing, Thera (2007)** The role of Christianity in the context of HIV/AIDS: Dealing with HIV/AIDS in Pentecostal Churches and mainstream churches in Zambia. *Word and Context*, nr.6, pp.33-49.
- Rasing, Thera (2009a)** *Caring Women: Home Based Care in urban and rural Zambia*. Research report for Cordaid.
- Rasing, Thera (2009b)** *Synergies between six HIV/AIDS projects in Zambia*. Research report for Cordaid.
- USAID (2013)** *Country Profile Zambia: Zambia Community Health Programmes*.
- Van Dijk Rijk, Dilger Hansjurg, Burchardt Marian and Thera Rasing (2014)** *Religion and AIDS treatment in Africa: Saving souls, prolonging lives*. London: Ashgate Publishing Ltd.
- VSO (2013)** Enhancing Coordination of Community Based Volunteers to promote integrated health, community development and social welfare services. Project proposal.
- Wyatt Andrew (2013)** *Operationalization of Realigned Functions of Ministry of Community Development Mother and Child Health: Report and action plan*.
- ZISSP (Zambia Health Systems Strengthening Programme) (2011)** *The Community Health Services Mapping Report*.
- ZPCT II (Zambia HIV Prevention, Care and Treatment Programme II) (2013)** Getting the most from Community Based Volunteers: The ZPCT II Project in Zambia.
- ZPI (Zambia-led Prevention Initiative) (2013)** *Motivations for entering volunteer service and factors affecting productivity: A mixed method survey of Steps-OVC volunteer HIV caregivers in Zambia*.

Appendix A: Interview Guides

Interview guide for interview with the District Commissioner (DC)

Cooperation between CD, SW, MCH

- 1 How is the relationship between the 3 departments of the Ministry MCDMCH (Social Welfare, Community Development, Mother and Child Health in the district?
- 2 How are the linkages between SW, CD and MCH before they meet in the DDCC?
- 3 What could be done to improve cooperation between the 3 departments in the Ministry at district level?
- 4 Could there be one structure/one Terms of Reference (ToR) for SW, CD and MCH?
- 5 What would the Terms of Reference for the 3 departments be like?
- 6 In what way could be ensured that all organisations (and all CBVs) are included in the ministry's structure at district level?
- 7 What could be done to improve the services provided in the district?
- 8 Should there be 1 station for SW, CD and MCH where people can be referred to? Explain.
- 9 Should there be 1 station/focal point to which SW, CD and MCH officers report in the district? (Other than the DDCC?)
- 10 Which programmes of SW / CD/ Health in the district could be integrated?
- 11 Which other departments than SW/CD/MCH or organisations work in the communities with CBVs in the district? Could their activities be combined with those of the MCDMCH?

Relationships between the district and other organisations in the district

- 12 How is the working relationship between the district and other organisations in the districts? (committees, zones, wards. etc.)
- 13 How many committees such as ACC, CWAC, NHC, SMAG are therein your District?
- 14 Who should lead the groups/actions in the community?
- 15 To whom should these groups report?
- 16 Is there duplication within these committees? /is there overlap in the district regarding organizations doing the same things?
- 17 What should be changed in order to streamline the work and organization of the committees such as ACC, CWAC, NHC etc. in the district?
- 18 On which programmes could they work together?

Relationships with NGOs/FBOs

19 Which other organisations, e.g., (international) NGOs, FBOs, CBOs are working in the district?

20 How is the relationship between these NGO, FBOs, CBOs and the MCDMCH in the district?

21 How is the communication between the NGOs, FBOs, CBOs and the district? (meetings, reports, etc.)

22 How could a system be developed to identify which new organisations (both local and international NGOs) are working in the community? (e.g. Could the Registrar of Societies play a role here, e.g. inform the district, or let Registrar of Soc. see to it that new organisations have permission from the district to organize themselves and work in the district.)

23 Should the MCDMCH have more ownership of projects/activities in the district? How can this be achieved?

24 What could be done to ensure that NGOs involve the ministry/district in their projects as soon as they start working in the district?

25 What happens when a NGO/FBO pulls out/stop funding?

Ideal situation in the district

26 What would be the ideal situation to enhance coordination between MCH, SW and CD in the district? (and at Provincial and national level?)

27 Who keeps the budget in the district? (now and in the ideal situation?)

Thank you for your cooperation.

Interview guide for interview with District Community Development Officer

Cooperation between CD, SW, MCH

- 1 How is the relationship between the 3 departments of the Ministry (MCDMCH) Social Welfare, Community Development, Mother and Child Health in the district?
- 2 Are there regular meetings with the departments (SW, CD, MCH) in the district?
- 3 How often are these meetings?
- 4 Are these meetings officially imbedded in a structure?
- 5 What is discussed at these meetings?
- 6 How are the linkages between SW, CD and MCH before they meet in the DDCC?
- 7 What could be done to improve cooperation between the 3 departments in the Ministry at district level?
- 8 Could there be one structure/one Terms of Reference (ToR) for SW, CD and MCH?
- 9 What would the Terms of Reference for the 3 departments be like?
- 10 In what way could be ensured that all organisations (and all CBVs) are included in the ministry's structure at district level?
- 11 What could be done to improve the services provided in the district?
- 12 Should there be 1 station for SW, CD and MCH where people can be referred to?
- 13 Should there be 1 station/focal point to which SW, CD and MCH officers report in the district? (Other than the DDCC?)
- 14 Which programmes of SW / CD/ Health in the district could be integrated?

Relationship with other organizations in the district

- 15 How is the working relationship between the district and other organisations in the districts? (committees, zones, wards, etc.)
- 16 How many committees such as ACC, CWAC, NHC, SMAG are therein your District?
- 17 Is there overlap in the district regarding organizations doing the same things?
- 18 Who should lead the groups/actions in the community?
- 19 To whom should these groups report?
- 20 What should be changed in order to streamline the work and organization of the committees such as ACC, CWAC, NHC etc. in the district?
- 21 On which programmes could they work together?

22 Under CD there is a Resident Area Coordinating Committee, an Area Coordinating Committee, an Area Food Security Committee, and a Water and Sanitation programme. Could these be combined and reformatted to one or two organisation?

23 Could these committees/new organisation be combined with the CWAC? (SW)

24 To whom should such an organisation report?

25 Could the Food Security Pack be combined with SW programmes?

26 Should the organizations that work on income generating projects be combined?

Relationships with NGO/FBOs

27 Which other organisations, e.g., (international) NGOs, FBOs, CBOs are working in the district?

28 How do you (as CDO) relate to these NGO, FBOs, CBOs in the district?

29 How is the communication between the NGOs, FBOs, CBOs and the District? (meetings, reports, etc.)

30 How could a system be developed to identify which new organizations (both local and international NGOs) are working in the community? (e.g. Could the Registrar of Societies play a role here, e.g. inform the district, or let Registrar of Soc. see to it that new organisations have permission from the district to organize themselves and work in the district.)

31 Should the MCDMCH have more ownership of projects/activities in the district?

32 What could be done to ensure that NGOs involve the ministry/district in their projects as soon as they start working in the district?

33 What happens when a NGO/FBO pulls out/stops funding?

34 What does the district do to avoid overlap /to avoid that the CBVs do the same jobs in the same area?

35 Are there any gaps in the communities concerning facilities/organisations/volunteers?

Which gaps? Which facilities? Which communities?

36 What does the district do to avoid gaps in the services provided in the district?

37 How can competition among the CBVs be avoided?

Training and remuneration of CBV

38 How can it be ensured that there is one system of remuneration for CBVs? (both within the ministry and the different NGOs)

39 Should it be avoided that a CBV works in several groups? If yes, how could this be avoided? Who should see to it?

40 Who provides trainings for CBVs in CD? (Food Security Pack, Water and Sanitation, other)

41 How can a Community Development curriculum/training for CBVs working in CD be organized and put in place? Who should do this?

Ideal situation of cooperation within the 3 ministry departments

42 What would be the ideal situation to enhance coordination between MCH, SW and CD in the district?
(and at Provincial and national level?)

43 Who keeps the budget in the district? (now and in the ideal situation?)

Thank you for your cooperation.

Interview guide for interview with District Social Welfare Officer

Cooperation between CD, SW, MCH

- 1 How is the relationship between the 3 departments of the Ministry (MCDMCH) Social Welfare, Community Development, Mother and Child Health in the district?
- 2 Are there regular meetings with the departments (SW, CD, MCH) in the district?
- 3 How often are these meetings?
- 4 Are these meetings officially imbedded in a structure?
- 5 What is discussed at these meetings?
- 6 How are the linkages between SW, CD and MCH before they meet in the DDCC?
- 7 What could be done to improve cooperation between the 3 departments in the Ministry at district level?
- 8 Could there be one structure/one Terms of Reference (ToR) for SW, CD and MCH?
- 9 What would the Terms of Reference for the 3 departments be like?
- 10 How could be ensured that all organisations (and all CBVs) are included in the ministry's structure at district level?
- 11 What could be done to improve the services provided in the district?
- 12 Should there be 1 station for SW, CD and MCH where people can be referred to?
- 13 Should there be 1 station/focal point to which SW, CD and MCH officers report in the district? (Other than the DDCC?)
- 14 Which programmes of SW / CD/ Health in the district could be integrated? (e.g. when someone is admitted to the hospital but cannot afford to pay, is MCH, but SW should support? / e.g. SW should support people with HIV, how do they get statistics on which people to support, from clinic/health officer, or general community?)

Relationship with other organizations in the district

- 15 How is the working relationship between the district and other organisations in the districts? (committees, zones, wards. etc.)
- 16 How many committees such as CWAC, ACC, NHC, SMAG are therein your District?
- 17 Who should lead the groups/actions in the community?
- 18 To whom should these groups report?
- 19 Is there duplication within these committees / Is there overlap in the district regarding organizations doing the same things?

20 What should be changed in order to streamline the work and organization of the committees such as CWAC, ACC, NHC etc. in the district?

21 On which programmes could they work together?

22 Could the CWAC and DWAC be combined with organisations under CD? (e.g. Resident Area Coordinating Committee, Area Coordinating Committee, Area Food Security Committee, and Water and Sanitation programme)

23 To whom should such an organisation report? (now to DSWO?)

24 Could SW programmes be combined with the Food Security Pack under CD?

25 Is there overlap between the Women's empowerment Groups and SMAG (Health)? Could these groups be combined and/or combined with other organisations?

26 Should the organizations that work on income generating projects be combined?

Relationships with NGO/FBOs

27 Which other organisations, e.g., (international) NGOs, FBOs, CBOs are working in the district?

28 How do you (as SWO) relate to these NGO, FBOs, CBOs in the district?

29 How is the communication between the NGOs, FBOs, CBOs and the District? (meetings, reports, etc.)

30 How could a system be developed to identify which new organisations (both local and international NGOs) are working in the community? (e.g. Could the Registrar of Societies play a role here, e.g. inform the district, or let Registrar of Soc. see to it that new organisations have permission from the district to organize themselves and work in the district.)

31 Should the MCDMCH have more ownership of projects/activities in the district?

32 What could be done to ensure that NGOs involve the ministry/district in their projects as soon as they start working in the district?

33 What happens when a NGO/FBO pulls out/stop funding?

34 What does the district do to avoid overlap / to avoid that the CBVs do the same jobs in the same area?

35 Are there any gaps in the communities concerning facilities/organisations/volunteers?

Which gaps? Which facilities? Which communities?

36 What does the district do to avoid gaps in the services provided in the district?

37 How can competition among the CBVs be avoided?

Training and remuneration

38 How can it be ensured that there is one system of remuneration for CBVs? (both within the ministry and the different NGOs)

39 Who provides trainings for CBVs in SW?

40 How can a curriculum/training for CBVs working in SW be organized and put in place? Who should do this?

41 How can the different programmes focusing on OVCs be standardized/better organised?

42 Could the different organizations that work with OVC be combined in one or a few organisation?

43 How can the trainings of CBVs working with OVCs be standardized?

Ideal situation within the 3 departments of the ministry

44 What would be the ideal situation to enhance coordination between MCH, SW and CD in the district? (and at Provincial and national level?)

45 Who keeps the budget in the district? (now and in the ideal situation?)

Thank you for your cooperation.

Interview guide for interviews with District Medical Officer, District Environmental Officer/District Health Information Officer/ District Planner

Cooperation between CD, SW, MCH

- 1 How is the relationship between the 3 departments of the Ministry (MCDMCH) Social Welfare, Community Development, Mother and Child Health in the district?
- 2 Are there regular meetings with the departments (SW, CD, and MCH) in the district?
- 3 How often are these meetings?
- 4 Are these meetings officially imbedded in a structure?
- 5 What is discussed at these meetings?
- 6 How are the linkages between SW, CD and MCH before they meet in the DDCC?
- 7 What could be done to improve cooperation between the 3 departments in the Ministry at district level?
- 8 Could there be one structure/one Terms of Reference (ToR) for SW, CD and MCH?
- 9 What would the Terms of Reference for the 3 departments be like?
- 10 How could be ensured that all organisations (and all CBVs) are included in the ministry's structure at district level?
- 11 What could be done to improve the services provided in the district?
- 12 Should there be 1 station for SW, CD and MCH where people can be referred to?
- 13 Should there be 1 station/focal point to which SW. CD and MCH officers report in the district? (Other than the DDCC?)
- 14 Which programmes of SW / CD/ Health in the district could be integrated? (e.g. when someone is admitted to the hospital but cannot afford to pay, is MCH, but SW should support? / e.g. SW should support people with HIV, how do they get statistics on which people to support, from clinic/health officer, or general community?)

Relationship with other organizations in the district

- 15 How many committees such as NHC, SMAG are therein your District?
- 16 Is there duplication within these committees?
- 17 Who should see to it that all the SMAGs are (trained to) do antenatal (ANC) care and make sure women go to the clinic for post natal care?
- 18 Is there overlap between the SMAG and Women's Empowerment Groups? Could the SMAG be combined with women's groups or other organisations?
- 19 What should be changed in order to streamline the work and organization of the committees such as NHC, SMAG, ACC, CWAC, etc. in the district? (Do they have a job description?)

20 On which programmes could they work together?

21 What are the specific tasks of the NHC?

22 What are the specific tasks of the HCAC (Health Centre Advisory Committee)?

23 How do the various HCAC (Health Centre Advisory Committee) cooperate with the NHC?

24 How is the relationship between CHA (Community Health Assistant) and the Neighbourhood Health Committee (NHC)? How do CHA and NHC cooperate? How are tasks and responsibilities shared between CHA and NHC? Is there overlap between their tasks?

25 How do CHA cooperate with CBVs? Are there guidelines for the CHA?

26 How could the CBVs/CHW and the CHA work together better? (e.g. could their outreach be done together, e.g. when the CBVs give a lesson in the community, could this be done together with the CHA who could advice or give more details?)

27 How can the district Community Health Office/Medical Officer see to it that the CHAs are properly supervised (in the health centres)?

28 How does the DATF relate to the (MCH dept.) in the district? (reports to PATF and NAC)

Relationships with NGO/FBOs

29 Which (international) NGOs and FBOs are working in the district?

30 How is the relationship and communication between these NGOs and FBOs and the MCDMCH in the district? (meetings, reports, etc.)

31 How could a system be developed to identify which new organisations (both local and international NGOs) are working in the community? (e.g. Could the Registrar of Societies play a role here, e.g. inform the district, or let Registrar of Soc. see to it that new organisations have permission from the district to organize themselves and work in the district.)

32 Should the MCDMCH have more ownership of projects/activities in the district?

33 What could be done to ensure that NGOs involve the ministry/district in their projects as soon as they start working in the district?

34 What happens when a NGO/FBO pulls out/stop funding?

35 How can it be avoided that the CBVs working for different organisations are doing the same jobs in the same area?

Coordination of CBVs

36 How could there be a structure so that all departments in the district and all CBVs in the district know the scope of the work of the CBV, where and what they do?

37 Who should see to it that each organisation in the district has a job description and sticks to it?

38 How is the supervision of the different groups of CBVs organised? Does the district play a role in the supervision? How is the supervision of CBVs by CHA going?

39 How could cooperation between the different groups of CBVs be enhanced?

40 Could the CBV/CHW combine the tasks that are now separated? (e.g. work as gatekeepers in communities, give advice on nutrition, prevention of diseases, HIV, TB, malaria, counselling, etc?)

41 How could the various groups of CBVs work more according to target visits in the communities instead of random as is done now?

42 How could the geographical area in the district be better divided between the various groups of CBVs? Do the NHC see to it that the geographical area is divided properly among different groups of CBVs?

43 What does the district do to avoid gaps in the services provided in the district?

44 How can competition among the CBVs be avoided?

45 How can it be ensured that there is one system of remuneration for CBVs? (both within the ministry and the different NGOs) (in line with the forthcoming Community Health System Strategy / Volunteer Caregivers Policy)

Thank you for your cooperation.

Interview guide for Community Development Assistant (CDA)

Cooperation between CDA and Dept. of SW/MCH

1 Where do you as CDA work?

2 How can the work of the CDAs be followed and assessed? (both in the district and in the community)

3 Who gives you assignments? (district, Community Development Officer, community, take initiative yourself?)

4 To whom do you as CDA report? (only to CDO?)

5 How is your working relationship with SWA/SWO? Do you cooperate?

6 In which projects/programmes could you cooperate with Social Welfare?

7 Which programmes of CD could be combined with programmes in Social Welfare? (e.g. could the Food Security Pack (CD) and CWAC/DWAC be combined? Could Water and Sanitation programme be combined with Women's Clubs under SW?)

8 How is your working relationship with the MCH department? Do you cooperate with the MCH?

9 In which programmes could you work together with MCH? (e.g. SMAG, nutrition)

Relationships with CBVs

10 Do you cooperate with CBVs? How? Which groups/tasks? How many groups?

11 Do you supervise CBVs?

12 Are you trained to supervise them?

13 Do they report to you? What happens with their reports? Are the CBVs listened to?

14 Should it be avoided that a CBV works in several groups? If yes, how could this be avoided?

15 How can it be avoided that different groups of CBVs are doing the same tasks?

16 Do the CBVs have a job description? Would it be necessary to have a job description?

Relationship with NGO/FBOs

17 How is your working relationship with NGOs/FBOs in the district?

18 How do the different NGOs/FBOs relate to each other? Do they cooperate?

19 How is the competition between the CBVs of different NGOs?

20 How is the competition between the CBVs who work for the Ministry and who work for NGOs?

Coordination and remuneration of CBVs

21 How are the different groups of CBVs in CD trained? By whom?

22 Do you think their training is adequate and up to date?

23 How would you assess the motivation of the CBVs?

24 How is the turnover of CBV? Have some CBVs stopped working due to the lack of or reduced incentives?

25 What happens when a NGO/FBO pulls out/stop funding?

26 From your experiences in the field, what should be changed to better coordinate the work of the CBVs?

27 From your experiences in the field, what should be done to utilize the CBVs in a better way?

28 How could the CBVs be strengthened? What could be done in terms of capacity building? What could be done in terms of remuneration/payment?

29 How would you assess the impact of the CBVs in the communities? (examples, numbers of clients/families helped, etc.)

Thank you for your cooperation

Interview guide for Community Health Assistant (CHA)

Tasks and position of CHA

1 How long have you been working as CHA in this district?

2 What are your main tasks as a CHA?

3 Where do you mainly work?

4 By whom are you supervised? How can the district Community Health Office/Medical Officer see to it that the CHAs are properly supervised (in the health centres)?

5 Would there be any changes when you as CHA would be paid?

Cooperation with other organizations

6 How is the relationship between the CHA and the Neighbourhood Health Committee (NHC)?

7 How do you as CHA cooperate with the NHC?

8 How are tasks and responsibilities shared between CHA and NHC?

9 Is there overlap between their tasks?

10 What are the specific tasks of the NHC?

11 What are the specific tasks of the HCAC (Health Centre Advisory Committee)?

12 How do the various HCAC (Health Centre Advisory Committee) cooperate with the NHC?

13 Could the HCAC and the NHC be combined?

14 How do you as CHA cooperate with the SMAGs?

15 What should be changed in order to streamline the work and organization of the committees such as NHC, SMAG, ACC, CWAC, etc. in the district? (Do they have a job description?

16 On which programmes could they work together?

Relationship with CBV

17 How do you as CHA cooperate with other groups of CBVs/CHW? (TBA, HBC, OVC, councillors, TB, malaria, HIV)

18 How could the CBVs/CHW and the CHA cooperate more? (e.g. could their outreach be done together, e.g. when the CBVs give a lesson, could this be done together with the CHA who could advice or give more details?)

19 Should the tasks of some different groups of CBVs/CHW by combined? (e.g. work as gatekeepers in communities, give advice on nutrition, prevention of diseases, malaria, TB/HIV, testing, counselling, HBC)

20 From which focal point do the different groups of CBV/CHW work? (health centre, NGO, FBO, diocese)

21 How can it be avoided that the CBVs are doing the same tasks in the same catchment area?

22 How is the supervision of the different groups of CBVs organised (by you as CHA)?

23 Does the district play a role in the supervision?

24 Should it be avoided that certain CBV work in more than one group? If yes, how could this be avoided? Who should see to it?

25 How is the turnover of CBV? Have some CBVs stopped working due to the lack of or reduced incentives?

26 Do the CBVs report to you? What happens with their reports? Are the CBVs listened to?

27 What happens when a NGO/FBO pulls out/stop funding?

Trainings of CBV

28 How are the trainings for the different groups of CBVs/CHW? Are they adequate?

29 Do the CBVs/CHW have regular updates of their trainings?

30 How would you assess the skills of the CBVs/CHW?

31 How can a curriculum/training for CBVs/CHW be organized and put in place? Who should do this?

32 How would you assess the effects of the CBV/CHW in the communities? (examples, numbers of clients/families)

33 What improvements could be made to enhance the services in the district?

Thank you for your cooperation

Appendix B: Questions for Focus Group Discussions with CBVs

Questions for Focus Group Discussion with SMAG

Introduction: aim of the Ministry's research on CBVs, aim of this Focus Group Discussion

Rules in the group: one person speaks at a time, etc.

Time: 2 hours

Please introduce yourself.

1 What are the tasks of the SMAG?

2 Please explain **how** you work

3 Please describe **what** you do. (job description)

4 How much time do you spend weekly on this job as SMAG?

5 How long have you been a SMAG member?

6 How were you selected/appointed for this job? By whom?

7 Have you been trained for this job?

8 By whom have you been trained?

9 How long was your training?

10 Do you have regular follow ups of the trainings?

11 When were your first and last training?

12 Do you think the trainings are adequate for your job?

13 What are the conditions/agreements with the organisation that trained you?

14 Do you think you could do more and other jobs in your field? If yes, which?

15 To whom do you report as SMAG?

16 Do you get supervision? By whom?

17 What happens with the reports?

18 Do you think your supervisor/others listen to your reports/findings?

19 What is your motivation to become a SMAG member?

20 What are your incentives?

21 How have the incentives changed over time?

22 Have some CBVs/CHW stopped working due to the lack of or reduced incentives?

23 How is your working relationship with other CBVs/CHW in the district? Do you have meetings with them? How often?

24 From which focal point do you work? (Health centre, district, other)

25 How do you identify people that need your assistance?

26 Which other tasks apart from those related to Safe Motherhood do you do?

27 Is there overlap in the work you do and the work other organization do? (e.g. Women's clubs, income generating projects).

28 Do you work as CBV with another organisation? If yes, with which?

29 Are there gaps in terms of people or communities in need that are not reached?

30 What do you do to avoid overlap and to fill gaps of people left out of services?

31 How is your working relationship with the District Officers? (Medical Officer, CHA)?

32 What impact does your work have in the community?

33 What improvements do you see?

34 What changes should be made concerning the work of CVBs in the district?

35 What changes could be made to improve the provision of services in the district?

Thank you for your contribution.

Questions for Focus Group Discussions with CWAC members

Introduction: aim of the Ministry's research on CBVs, aim of this Focus Group Discussion

Rules in the group: one person speaks at a time

Time: 2 hours

Please introduce yourself.

1 What are the tasks of the CWAC/DWAC?

2 Please explain **how** you work?

3 Please explain **what** you do? (job description)

4 How much time do you spend weekly/monthly on this job?

5 From which focal point do you work? (Social Welfare Office, district, zone, ward, other)

6 How do you identify people that need your assistance?

7 How long have you been a CWAC/DWAC member?

8 How were you selected/appointed for this job? By whom?

9 Have you been trained for this job?

10 By whom have you been trained?

11 How long was your training?

12 Do you have regular follow ups of the trainings?

13 When were your first and last training?

14 Do you think the trainings are adequate for your job?

15 Do you think you could do more and other jobs in your field? If yes, which?

16 To whom do you report?

17 Do you get supervision? By whom?

18 What happens with the reports?

19 Do you think your supervisor/others listen to your reports/findings?

20 What is your motivation to become a CWAC/DWAC member?

21 What are your incentives to be a CWAC member?

22 How have the incentives changed over time?

23 Have CWAC/DWAC members stopped working due to the lack of or reduced incentives?

24 Do you do other voluntary work for another organisation? If yes, what job, which organization?

25 How is your working relationship with other organizations in the district/ward/zone? (NHC, SMAG, GVT and NGO/FBO, other)

26 Do you cooperate with other organizations? How?

27 Is there overlap in the work you do as CWAC/DWAC and the work other organization do? (e.g. Women's clubs, income generating projects)

28 Are there gaps in terms of people in need that are not reached?

29 What do you do to ensure that no one is left out of the services needed?

30 What do you do to avoid overlap/people receiving the same assistance?

31 How is your working relationship with the District Officers? (Social Welfare/others)

32 What impact does your work have in the community?

33 What improvements do you see? (examples)

34 What changes should be made concerning the work of CVBs in the district?

35 What changes could be made to improve the provision of services in the district?

Thank you for your contribution

Questions for Focus Group Discussion with Neighbourhood Health Committee (NHC) members

Introduction: aim of the Ministry's research on CBVs, aim of this Focus Group Discussion

Rules in the group: one person speaks at a time, etc.

Time: 2 hours

Please introduce yourself.

1 What are the tasks of the Neighbourhood Health Committee (NHC)?

2 Please explain **how** you work?

3 Please explain **what** you do (job description)

4 How much time do you spend weekly/monthly on this job as NHC member?

5 How long have you been a NHC member?

6 Were you elected/appointed for this job? By whom?

7 Have you been trained for this job? By whom?

8 How long was your training?

9 Do you think the trainings are adequate for your job?

10 Do you think you could do more and other jobs in your field? If yes, which?

11 Do you get supervision? By whom?

12 To whom do you report?

13 What happens with your reports?

14 Do you think you as NHC member are listened to?

15 What is your motivation to become a NHC member?

16 What are your incentives?

17 How have the incentives changed over time?

18 Have NHC members stopped working due to the lack of or reduced incentives?

19 From which focal point do you work? (Health centre, district, other)

20 How is your working relationship with other organization/NGOs/FBOs in the district? Do you have regular meetings with them?

21 How is your relationship with the CHAC?

22 Do you have meetings with them? How often?

23 How is your relationship with the CHA? How do you cooperate with the CHA?

24 How is your working relationship with the District Officers? (Medical Officer, SW, CD)

25 How do you identify people that need your assistance?

26 Is there overlap in the work you do and the work other organizations do? (e.g. Women's clubs, SMAG, HBC)

27 Are there gaps in terms of people or communities in need that are not reached?

28 How do you ensure that everyone who is in need is assisted?

29 What do you do to avoid overlap of people getting the same services?

30 What impact does your work have in the community?

31 What improvements do you see? (examples)

32 What changes should be made concerning the work of CVBs in the district?

33 What changes could be made to improve the provision of services in the district?

Thank you for your contribution

Questions Focus Group Discussion with CBVs/CHWs

Introduction: aim of the Ministry's research on CBVs, aim of this Focus Group Discussion

Rules in the group: one person speaks at a time, etc.

Time: 2 hours

Please introduce yourself.

1 What are your tasks as a CBV/CHW?

2 Please explain **how** you work?

3 Please explain **what** you do? (job description)

4 How much time do you spend weekly/monthly on this job as CVB/CHW?

5 How long have you been working as a CBV/CHW?

6 Were you selected/appointed for this job? By whom?

7 Do you have a contract? With whom?

8 Have you been trained for this job? By whom?

9 How long was your training?

10 Do you have regular updates of trainings?

11 What are the conditions/agreements with the organisation that trained you?

12 Do you think the trainings are adequate for your job?

13 Do you think you could do more and other jobs in your field? If yes, which?

14 What is your motivation to become a CBV/CHW member?

15 What are your incentives?

16 How have the incentives changed over time?

17 Have CBVs you worked with stopped working due to the lack of or reduced incentives?

18 Do you get supervision? By whom? Where does your supervisor work? (clinic/health centre, district, etc?)

19 Do you all report to the same supervisor? (Will s/he be overburdened?)

20 What happens with the reports by the CBVs? Are they used?

21 Do you think the CBVs listened to?

22 From which focal point do you work? (Health centre, district, other)

23 How is your relationship with the CHAC?

24 Do you have meetings with them? How often?

25 How is your relationship with the CHA? How do you cooperate with the CHA?

26 How is your working relationship with the District Officers? (Medical Officer, SW, CD)

27 How do you identify people that need your assistance?

28 Is there overlap in the work you do and the work other organizations do? (e.g. Women's clubs, SMAG, HBC)

29 Are there gaps in terms of people or communities in need that are not reached?

30 How do you ensure that everyone who is in need is assisted?

31 What do you do to avoid overlap of people getting the same services?

32 What impact does your work have in the community?

33 What improvements do you see? (examples)

34 What changes should be made concerning the work of CVBs in the district?

35 What changes could be made to improve the provision of services in the district?

Thank you for your contribution

