



TANZANIA HUMAN RESOURCE CAPACITY PROJECT:

MOST VULNERABLE CHILDREN/ PARA-SOCIAL WORKER PROGRAM RFVIFW

July 2012

*Tools orientation training at Dodoma Hotel with PSWs from
Kongwa District, April, 2011*

Submitted by: Sherise Lindsay and Laura Guyer
Training Resources Group, Inc.



IntraHealth International • 6340 Quadrangle Drive, Suite 200 • Chapel Hill, NC • 27517 • USA • 919.313.9100 • www.intrahealth.org

THRP MVC/ PSW Program Review

Executive Summary

To address the acute shortage of Social Welfare Officers at the village level, the Tanzania Human Resource Capacity Project (THRP) has worked in close cooperation with several partner organizations and with the Government of Tanzania since 2008 to develop and mainstream a new cadre of volunteer Para-professional Social Workers (PSW) into existing local government structures. Key collaborative partners in the program include the American International Health Alliance (AIHA); the Tanzanian Institute for Social Work (ISW); the Jane Addams College of Social Work (JACSW); the Department of Social Welfare (DSW) of the Ministry of Health and Social Welfare; and the Prime Minister's Office Regional Administration and Local Government (PMO-RALG). The overall effort was designed to support the roll out of Tanzania's National Costed Plan of Action (NCPA) for Most Vulnerable Children (MVC) 2007-2010.

The initial emphasis of the program was to train PSWs and PSW Supervisors to provide the basic social welfare services to Tanzania's most vulnerable children (MVC). Concurrent with PSW training, the THRP aims to strengthen the existing local government infrastructure to connect village level need to ward and district level support over the life of the project. Managing the program through four components (Partnership, Training, Advocacy and Monitoring and Evaluation), THRP has developed a cadre of PSWs and supervisors in three regions (Dodoma, Mwanza, and Iringa) and is expanding into a fourth (Mtwara) and has worked with select USAID-funded organizations to expand further into select districts in Mara, Tabora and Kagera.

As a result of an extensive literature, review of available M&E data, and program partner input, both by interviews and the partner debrief workshop, the following are overarching recommendations for consideration by stakeholders in creating a programmatic path forward:

Workload and Role: Ensure the PSW role remains sustainable by limiting it to part-time and ensuring the volunteer's ability to generate enough income to support livelihood

Incentivization, Disincentivization and Motivation: Examine the impact of having different incentive packages for volunteers all funded by the same donor with an eye towards potential standardization and alignment between volunteer programs.

Retention/Attrition: Continue to champion promising PSWs movement into the Social Welfare Assistant (SWA) role and publicize this career path to recruit new PSWs. Explore root causes for higher attrition in urban areas and show ongoing appreciation for volunteer efforts.

Local Government Ownership: Continue local government engagement by advocating for and continuing to implement social welfare sensitization training, mapping organizations with LGA linkages and continued piloting of the Matching Grants program.

Supervision: Work with Supervisors to ensure PSWs are given consistent feedback to strengthen their work and investigate the possibility of PSW supervisors coming from the community. Also pursue revising the current PSW Supervisors' curriculum to strengthen giving feedback to PSWs and working more collaboratively with LGAs and MVCCs.

Training: Continue the PSW model as it is currently being implemented by the Twinning Center and advocate for other IPs to use this model in delivering PSW programming. Also continue offering the new PSW Update refresher to PSWs.

Volunteer Selection/ Selection Criteria: Continue utilizing the current criteria for PSW participant selection as it has enabled exemplary PSWs to be identified for moving into the SWA role at the ward-level and is seen as the baseline needed for PSWs to be functional in their role.

Peer Support and Networks: Use PASONET as a recruitment and promotional tool for incentivization and motivation, as well as a mechanism to track and map PSWs in transition.

Advocacy: Reengage the Commissioner of Social Welfare and lobby for more support at all levels. For example, hiring District SW officers to oversee SWAs, supporting further resource allocation and incentivization.

Monitoring and Evaluation Review available M&E tools and work with donors and GoT partners to create metrics that will demonstrate impact. Continue to establish a tracking system for PSW and PSW Supervisor demographic data, so this information can be used for strategic planning purposes, including standardizing the demographic fields of PSW cohorts.

Table of Contents

Executive Summary.....	2
Acronyms	5
Background	7
Broad Context	7
Summary of Literature Review	11
Summary of the PSW/MVC Program Timeline – Programmatic Alterations.....	29
Summary of Monitoring and Evaluation Data Available.....	34
PSW Demographics by Region	34
Local Government Social Welfare Awareness and MVC/PSW Data	35
Summary of In-country Interviews with PSW Program Stakeholders	37
Program Review Recommendations Emerging From Data and Partner Input by Thematic Area.....	41
Appendix 1: Overview of Themes from the Literature Review vis-à-vis the PSW/MVC Program*	45
Appendix 2: Literature Review.....	49
Review of Current Literature – Thematic Areas and Practices	50
Appendix 3: Bibliography	71
Appendix 4: Local Government SW Awareness and MVC/PSW Support	73
Appendix 5: PSW Demographics by Region	80

Acronyms

AIHA American International Health Alliance

CARE Cooperative for Assistance and Relief Everywhere

CHW Community Health Worker

DSW Department of Social Welfare

DQA Data Quality Audit

FHI Family Health International

IMCI Integrated Management of Childhood Illness

IP Implementing Partner

ISW Institute of Social Work (Tanzania)

JACSW Jane Addams College of Social Work

LGA Local Government Authority

MOH Ministry of Health

MNCH Maternal, Newborn and Child Health

MVC Most Vulnerable Children

MVCC Most Vulnerable Children Committee

MSW Master in Social Work

NCPA National Costed Plan of Action

NGO Non-governmental Organization

OVC Orphans and Vulnerable Children

PEPFAR President's Emergency Plan for AIDS Relief

PMO-RALG Prime Minister's Office Regional Administration and Local Government

PSW Para-Social Worker

SWA Social Welfare Assistant

SWW Social Welfare Workforce

THRP Tanzania Human Resource Capacity Project

USAID United States Agency for International Development

VHC Village Health Committee

VHW Village Health Worker

WEI World Education International

Background

Broad Context

The current push is to shift high impact interventions to lower cadres of skilled and unskilled workers to optimize the accessibility and efficiency of health services. Promoting engagement of health care workers at both the community and facility level remains central to this initiative, as it contributes to higher quality of care, increased productivity and lower rates of attrition. An urgent need also exists in the African context to develop models of community health programs that link to the broader public health sector and incorporate performance measures and quality improvement methodology for maximum impact and sustainability. In response to the health workforce crisis worldwide, USAID has set the goal of ‘increasing by at least 100,000 the number of functional (trained, equipped and supervised) community health workers and volunteers serving at primary care and community levels’ by 2013. As new programs emerge or existing programs scale up, assessing the functionality of CHW programs and volunteers becomes increasingly important. However, evaluating CHW programs often proves to be difficult particularly since defining characteristics, roles and responsibilities for community health workers can vary vastly depending on the context. To effectively evaluate CHW programs, identifying key characteristics attributed to program success or failure is essential.¹

As HIV/AIDS has swept across parts of the African continent in the last 25+ years, leaving devastation in its wake, one critical consequence has been an exponential increase in the number of orphans and vulnerable children (OVC). By 2007, 15 million children worldwide had lost their parents to HIV, with nearly 12 million of those in sub-Saharan Africa.

Often the care of children orphaned by HIV falls to the extended family, with grandparents, aunts and uncles, or older siblings heading ever-expanding households. Today, most OVC live in some type of family setting rather than in institutions, and require a continuum of care that can include health and psychosocial support, protection, education, nutrition, and more. This increasing burden has begun to fray the indigenous social safety nets of most African countries, creating a crisis of care.

Theoretically, a country’s national social welfare system should be able to fill the breach, providing basic services needed by OVC and their caregivers. Yet, in sub-Saharan Africa, most social welfare systems are rudimentary at best and the social welfare workforces of most African countries are both under skilled and under resourced.

In 2008, the President’s Emergency Plan for AIDS Relief (PEPFAR) was authorized to increase the number of health care professionals and paraprofessionals in countries receiving aid; among these are paraprofessionals trained to work in social services. These lay people, Para-Social Workers (PSWs), receive specialized courses giving them foundational skills in basic social service delivery for OVC. Consequently, in order to meet the needs of an over-burdened social welfare system and a growing OVC population,

¹ Fazila K. Shakir. Community Health Worker Programs: A Review of Recent Literature. USAID Health Care Improvement Project/URC, 2010, page 1

several African countries have pursued growing this cadre. In between a social worker and a volunteer, PSWs can be quickly produced and can access communities effectively to provided needed services.²

Tanzania PSW Initiative

As a result of Family Health International's (FHI) 2006 assessment³ of Tanzania's social welfare system the Social Work Partnership for Orphans and Vulnerable Children in Tanzania was established. The assessment highlighted

Tanzania has a well-conceptualized committee structure and linkages to identify and provide services for children, especially most vulnerable children (MVC). However, no matter how well it is conceptualized, it is not well functioning. Other linkages do not support this system; there is little administrative support; and there is no oversight. As of today, the projected system will mobilize the community to identify vulnerable children but there are few resources to provide needed services for children. ... Strengthening child welfare planning, budgeting, and programming processes and raising the profile of children's issues and the Department of Social Welfare will assist the child welfare system to compete fairly and evenly alongside other compelling needs in the Tanzania of the future...

Sustainability can be achieved in several areas: a strengthened service delivery system of district and village MVCCs; strengthened DSW policies incorporated into standards and curricula; trained paraprofessionals and professionals; strengthened university and paraprofessional training programs; a developed system to track children and services; developed standards for service models; data management to guarantee that children receive adequate services; local governments experienced in a purchase of services model to direct NGO service providers; and a rational and coherent network of NGOs who have a shared vision and whose services are rationally distributed to the MVC population (bold added).

In response to this, the MVC program was designed under the assumption that given the possibility of professional development and an eventual career path in social work, volunteers would offer their time and services to be trained and deployed as Para-Social Workers. In order to make these services sustainable, and to have impact where it is needed most, the program was designed to field one volunteer in each village, with supportive supervision at the ward level. PSW supervisors were to be tasked with overseeing the numbers of PSWs within their wards. Likewise, PSW Supervisors were to serve in a voluntary capacity; however, this role potentially fast-tracked them to moving into a similar government position at the ward level which was in process of approval– the Social Welfare Assistant.

After careful deliberation at a partnership meeting in February 2009, program partners agreed that selection criteria for participation in the program needed to reflect minimum civil service requirements in order to ensure the possibility of future government employment. However, under the guidance of PMO-RALG's Human Resources Department, the program was advised neither to pay nor provide incentives to the volunteers. The goal was to catalyze local government to step up to their legislated mandate in social welfare service provision, and motivate and incentivize volunteers.

² Desk Review of the Twinning Center PSW Programs, Guyer and Singleton, December 2011

³ Lucia Correll, Family Health International Trip Report. FHI, February 2006.

Another assumption was the anticipation that the USAID-funded MVC implementing partners (AfriCare, FHI, Pact and WEI from September 2010) would pick up components of the PSW program that replicated and reflected THRP and AIHA/JACSW/ISW's model and scale up in their respective districts. This scale up did not happen. For some partners it was because the model was too expensive for the funding they had obligated (Pact). For others, they chose discreet pieces to replicate (WEI and the Advocacy model). Still others decided to simply leverage the PSWs already trained and weave them into programming (Africare in Dodoma). Finally, FHI simply chose not to do any PSW training at all.

Rationale for a Program Review

Moreover, both external and internal evaluations need to be carried out on regular basis to improve the services and analyze the need of various logistics, supplies and training according to the requirements. Ideally, programs should evaluate their own performance on annual basis, while a third party evaluation could be recommended in every 4-5 years, which would generate a neutral and free from bias findings⁴

At its inception in 2007, the program to develop a cadre of PSWs was considered a pilot activity to serve as an emergency HR stop gap measure, ensuring basic social welfare provision to MVC at the village level. ISW and the JACSW developed and tested the initial training curriculum, targeting participants already associated with NGOs, FBOs, and civil society working with children already. From 2007-2008, the PSW program was delivered to various districts in various regions, with no strategic plan and providing no supervision to PSWs. By mid-2008, USAID requested IntraHealth's Capacity Program (which later became the THRP) to take over the strategic oversight of program delivery; THRP rolled out the program on a regional basis and added elements to build capacity and strengthen LGA structural support, thereby creating some measure of sustainability. The approach to integrate village level social welfare services into the government system hadn't been applied in Tanzania before and remains to be formally evaluated.

The environment has changed since the program's inception. Building on three years of program implementation, IntraHealth is now working on complementary initiatives to strengthen the professional SW workforce in Tanzania, as are other members of the original program partnership. In keeping with creating a viable career path for promising PSWs, in late 2009 the government approved the Scheme of Service for the Social Welfare Assistant. This creates the potential for a publicly employed social worker at the ward level, thereby supplanting the role of the PSW Supervisor. In July of 2012, the DSW began to operationalize the strategy to link PSWs to becoming SWAs via a certificate program at Kisangara delivered by faculty from ISW.

⁴ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization. Pages 8-9.

Furthermore, other implementing partners, primarily USAID-funded, have reached out to initiate similar PSW training programs, a welcome expression of interest that contribute to potentially scaling up the program. Most importantly, funders have renewed interest in galvanizing the social work profession through expanding emerging schools of social work, strengthening the professional association, building the capacity of the ISW and creating demand for a national SW workforce strategy.

Given the changing environment and several years of implementation, it is opportune to reflect on where the PSW program has come from, how it is doing currently and what its future direction could and should look like. A serious program review offers the opportunity to critically analyze the information available, reflect on successes, and revisit key assumptions augmented with external perspectives and literature. The timing is appropriate to reflect on program strategies, techniques, and approach to establish priorities for the remaining years of THRP and improve program performance and potential for results.

Program Review Purpose

Training Resources Group, Inc. (TRG) was asked to undertake this program review on behalf of THRP, and TRG consultants Laura Guyer and Sherise Lindsay were identified to oversee the SOW. The purpose of the program review is to provide program guidance to the PSW partnership for the remaining period of the THRP and to identify key recommendations for USAID consideration beyond the THRP timeframe. The objectives include:

1. To critically analyze program efforts, successes—what works, what is not working? And within this analysis:
 - Review current program status against initial expectations;
 - Aggregate data produced from the program;
 - Present findings from the literature as additional perspective;
2. To identify priority strategies to optimize program results over the next two years of activities (mid-course corrections); and
3. To develop recommendations for consideration beyond the current PSW program formulation.

Program Review Methodology

The program review exercise began by doing an extensive literature review of data in other fields and sectors that speak to key aspects of the PSW program for lessons learned, as well as looking at what M&E data was available from the MVC/PSW program since its inception. With this information, a draft report was created to identify overarching reflections on successes and challenges. This data was used to develop an interview protocol with key stakeholders who were identified to share perspectives that would best inform the overall findings of the report. Stakeholders reviewed the literature's promising practices and challenges and vetted them against the current practices of the MVC program, with emerging reflections and recommendations resulting for further consideration.

The findings of this final report will be used to support THRP in conducting a full stakeholder meeting to review and strategize/plan for the remainder of the project.

Summary of Literature Review

As part of reflecting on the PSW/MVC program, a literature review surfaced best practices from volunteer and para-worker initiatives both in developing and developed contexts. In the review of the literature, emerging themes surfaced around the following topic areas:

- Workload and role
- Incentivization and Disincentivization
- Motivation
- Retention/Attrition
- Local Government Ownership
- Supervision
- Training
- Volunteer Selection/ Selection Criteria
- Peer Support and Networks

Below you will find a summary of themes in each area along with an assessment of how the MVC/PSW Program aligns with those best practices or faces similar challenges. **Appendix 1** provides a selection of specific quotes on which the themes are based.

1. WORKLOAD AND ROLE

The literature suggests, that if the community health volunteer role is not a paid full-time position, that the tasks should be contained enough for the volunteer to balance income-generating activities and family responsibilities. It is not only important to avoid overloading volunteers, but also to ensure that they, the community and others in the healthcare system understand the boundaries of their role and how those roles intersect with others.

MVC Program Findings

Although initially, the PSW role was envisaged to be half-time, on review, the current expectations of a PSW implies a full-time volunteer position. The PSW roles and responsibilities include⁵:

- To provide outreach and update/identify OVC in collaboration with MVCC members
- To engage clients/children and families
- To do case management and case conference
- To identify resources
- To deliver basic social welfare services to MVC, including psychosocial support
- To assess strengths and needs and provide
- To serve/to link OVC and children affected with HIV/AIDS to service providers
- To raise community/caregivers awareness and knowledge on HIV/AIDS prevention, stigma reduction, PMTCT and adherence to medication for the effected
- To raise community awareness on child rights, law of the child, child development policy and other related policies

⁵ *Debrief for the Tanzania Commissioner of the Department of Social Work, THRP and JACSW, Guyer and Linsk, September 2010*

- | | |
|---|--|
| <ul style="list-style-type: none"> support, referring clients to needed services. • To collect information/data regarding MVC and to share with the local leadership as well district leadership • To be an active participant of the MVCC | <ul style="list-style-type: none"> • To prepare and to keep records and reports regarding OVCs in the village • To mobilize their community at different levels, and to start and manage their own community MVC funds • To network with other PSWs and other OVC volunteers for resource/experience sharing in the interest of the child |
|---|--|

As community health volunteers, Tanzania’s PSWs are a hybrid of the volunteer and CHW definitions above. They are volunteers that come from and are sustained by the community. MVC PSWs are volunteers, yet they play an indispensable role in the system that cares and supports OVCs. Clarity of role is important as in Tanzania, the MVCC often has difficulties helping the community understand the PSW role and the resulting limited resources available to carry out that role; the MVCC in turn may not understand its role in supporting PSWs and MVCs. Once trained or informed by the District Advocacy Team, the MVCC has expressed renewed commitment to provide support.⁶

However, some community leaders are unfamiliar with MVC issues and managing expectations can be challenging. Communities often expect PSWs to provide material support as experienced with other community volunteers working with local NGOs. Therefore, PSWs have to manage the expectations of their respective communities and MVCCs, a role beyond the scope of their PSW training.

2. INCENTIVIZATION AND DISINCENTIVATIZATION

The literature often advocates for a mixture of monetary compensation and non-monetary compensation to incentivize volunteers to stay with the program. Non-monetary incentives often include: volunteers having their views listened to; being given the tools they need to do their work; being lauded in award ceremonies for public recognition; having access to income-generating funds; and being given name badges to identify their role in the community.

MVC Program Findings

PSWs are not provided with monetary compensation due to a directive from PMO-RALG that volunteers are not to be paid; furthermore, an integral part of the program design has been to emphasize the LGAs responsibility in incentivizing and maintaining PSWs, thereby making the cadre sustainable rather than reliant upon donor funding.

However, some PSWs are offered some of the incentives outlined in the literature. For example:

PSWs have been included in the redesign of both M&E tools and PSW curriculum. For further specifics reference the literature summary on Motivation.

Some communities have created income-generation projects to support the work of PSWs and MVC.

⁶ Monitoring and Evaluation Visit, Mwanza and Dodoma Regions, Summary Report. Tanzania Human Resource Capacity Project, November–December 2011.

In Tanzania, PASONET serves as the PSW network, a unique association that has helped retain PSWs, keeping them connected and enthused . It is a powerful activist force that helps PSW volunteers engage, continue learning from one another, and stay connected to the larger National Social Worker Association of Tanzania.

On the other hand, the PSWs lack tools, transport, stationary, and photocopying access to fully discharge their duties. PSWs have asked for identity cards but we are unaware if they have received them.

Furthermore, other volunteer programs provide stipends to their volunteers which creates an inequitable work environment and raises competition amongst volunteer programs, often serving the same beneficiary and funded by the same donor.

According to the baseline survey of Iringa Region in 2011, *“Incentives/motivations given to volunteers include:*

- *Capacity building on MVC identification and Children’s rights*
- *Exemption from village taxes and development work*
- *TUNAJALI volunteers receive allowance of TZS 20,000/-per month”*

3. MOTIVATION

Clarifying volunteer motivation is a complex endeavor as volunteering is both a leisure pursuit and has elements of a work pursuit. These dual aspects of volunteering have an impact on motivation. Literature states that most volunteers are not simply motivated by their desire to help others. They are looking for satisfaction through environmental (hygiene) factors or motivating factors. The literature highlights the following satisfaction factors for volunteers:

Hygiene/Environmental	Motivators
<ul style="list-style-type: none"> • Status in community • Sufficient time off to perform livelihood and household functions 	<ul style="list-style-type: none"> • To help others • Develop skills • Receive training • Acknowledgement given by others • Stepping stone to a paid job • Exposure to outside world • Report backs on the success of efforts • Be involved in program design, implementation, and decisions about monitoring and evaluation • Career path with increasing responsibilities • Sense of trust and belonging

MVC Program Findings

Motivational factors the MVC Program has modeled from the literature include:

In 2011, the PSW curriculum was vetted and revised to reflect most current practices in working with HIV/AIDS as well as incorporating newer Tanzanian legislation vis-à-vis MVC. This revision was done with the input of key stakeholders and PSWs.

In 2010, M&E tools were redesigned with the input of key stakeholders and PSWs to ensure that reporting was more accurate and capturing the real experience of PSWs. Each year, an annual M&E dissemination meeting on the PSW program has included key stakeholders and PSWs to reflect back accomplishments and challenges.

The PSW program has had a career-path focus since its inception, and with the securing of the Social Welfare Assistant role, moving PSWs into this position is one of its greatest achievements. This included:

- Securing a SWA Scheme of Service approved by the Civil Service Commission
- Developing a one-year certificate program, developed by ISW in collaboration with JACSW
- Refurbishing Kisangara Training Institute, thereby showing the commitment of the GoT to train and absorb SWA
- Fielding the first class of 35 SWA students, all of whom are PSWs, in July 2012

The literature also suggests that career enhancement opportunities should be offered on completion of minimum education level and experience required to reach the next level and may be used as incentive for career development. The initial criteria for PSW selection is engineered to reflect foundational civil servant requirements for eventual career development which is proving beneficial in regards to fulfilling the SWA role.

Furthermore, according to the baseline study carried out between December 14, 2008 and March 25, 2009 in Dodoma Municipality and Chamwino Districts all PSWs showed 100% willingness to offer a range of social services to OVC/MVC on a voluntary basis. The following were the reasons mentioned as motivational by the Para-Social Worker Trainees:

- *OVC/MVC were seen by the PSW as being part of the community in which they live; therefore, provision of social services to them was seen as something that is part of their obligation.*
- *PSWTs were interested in sharing the knowledge and skill that they will acquire from the PSW training with various stakeholders in their communities in order to improve the welfare of the OVC/MVC.*
- *Some of the PSWTs were interested in offering voluntary services to OVC/MVC because they strengthen the economic status of the OVC/MVC, as well as their households.*
- *Provision of social services to the OVC/MVC was seen by the PSWT as a way forward in reducing the challenges facing the OVC/MVC in their respective villages/streets.*
- *Other PSWTs pointed out that the motive behind their provision of voluntary services to OVC/MVC is just the passion they have for serving the OVC/MVC and other vulnerable groups in their communities.*

- *Lastly, many PSWTs sad that they wish to become full social workers in the future, so this opportunity was a stepping stone towards their career advancement (page 6)*

Conversely, recommendations from the 2012 Data Quality Assessment Report to strengthen PSW motivation include:

- *Motivate PSWs to retain and increase their work morale through provision of incentives; this was cited by the majority of the assessment participants, including PSWs themselves, as a way to fully implement activities of agencies.*
- *Provide PSWs medications and other services with which to assist OVC. Most of the PSWs reported they found it difficult to discharge their caring duties, as they did not have the means to alleviate OVC suffering, for example, through medications.*⁷

4. RETENTION/ATTRITION

The literature does not provide an optimum retention or attrition rate for volunteers or CHWs. Instead, the literature suggests optimal retention/attrition rates must be determined programmatically looking at trends across a sector and context.

However, the literature does provide factors that have an impact on retention/attrition of volunteer programs. These factors parallel motivation factors closely.

- | | |
|--|--|
| <ul style="list-style-type: none"> • Possibility to transfer volunteers to paid positions/supervisor positions • Not being overloaded with volunteer work • Participating in social gatherings • Volunteer recognition/appreciation events • Regular information/education sessions • Having a physical space for volunteers to use • Good communication between staff and volunteers • Close friends or relatives staying at the volunteer organization can make someone stay | <ul style="list-style-type: none"> • Knowing the impact of the volunteer's activities • Being screened and appropriately matched to the volunteer job • Having an effective orientation • Quality of interpersonal relationships • Being recruited by another volunteer • Bicycles, tool kit, job aides and M&E tools, promotion of volunteer work, elevated status in the community⁸ |
|--|--|

MVC Program Findings

The issue of retention and attrition of PSWs is one that is has created much discussion without a clear understanding of the actual numbers or reality of assessing attrition/retention within volunteer programs.

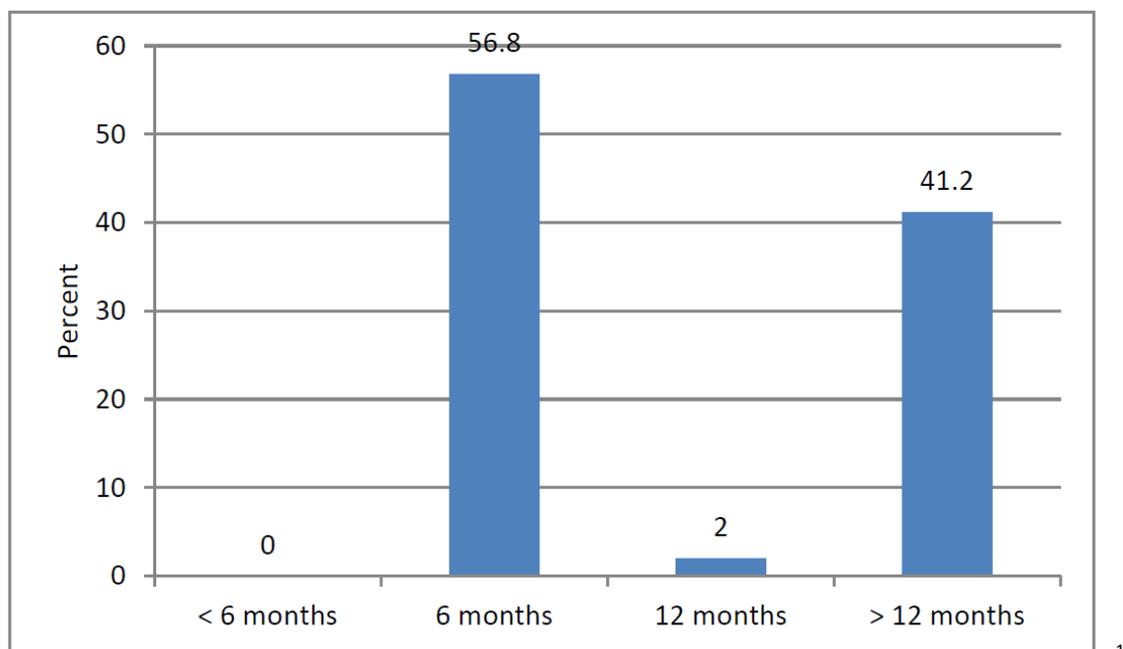
The 2011 Annual Dissemination Report refers to *“High drop Outs of PSWs due to various reasons including further study, transfer, marriage and migration”*⁹

⁷ MEASURE Evaluation, IntraHealth Data Quality Assessment Report, February 2012, page 16

⁸ WellShare International presentation “Strategies for Retaining Community Volunteers: Clarifying Roles and Responsibilities for Enhanced Organizational Performance” Presented at NUPITA End of Project Conference, January 11-13, 2012 Kampala Uganda, slide 5

The 2012 Data Quality Assessment Report, states that “well more than half of the PSWs interviewed responded they had started working six months ago (56.8 percent), followed by those who had started working as PSWs more than 12 months ago (41.2 percent), and a minority (2 percent) who had started working from 6 to 12 months ago. None of the PSWs interviewed had started working within the past six months”

Figure 4: Length of time worked as para-social workers



10

However, the actual attrition rates from the first three regions fielding PSWs are as follows:

Dodoma Region (PSW Training: 2008-2009)

- Dodoma MC – 45%
- Chamwino – 28%
- Bahi – 35%
- Kondoa – 25%
- Mpwapwa – 20%
- Kongwa – 50%

Mwanza Region (PSW Training: 2009-2010)

- Mwanza City – 40%
- Geita – 24%
- Sengerema – 19%
- Misungwi - 10%
- Kwimba – 10%
- Magu – 17%

⁹ Norah Kaaya, Tanzania Human Resource Capacity Project, MVC Program, Annual Dissemination Report, October 2011, page 10

¹⁰ MEASURE Evaluation, IntraHealth Data Quality Assessment Report, February 2012, page 8

Iringa Region (PSW Training: 2010 -2011)

- Ludewa – 13%
- Makete – 0%
- Njombe DC – 8%
- Njombe TC – 10%
- Iringa DC – 23%
- Iringa MC – 36%
- Kilolo – 18.5%
- Mufindi – 6%

As the literature states, there is no ideal attrition/retention rate. Therefore, we are unable to determine whether or not the PSW/MVC program has high, low or appropriate retention/attrition rates as it is a new program, unlike any other before, and cannot be compared cross-sector or anywhere else in Africa. Likewise, as the role has no specific time-of-service parameters and is open-ended, attrition is inevitable as almost no one ever serves as a volunteer indefinitely.

However, what we can determine from the numbers is while urban areas boast a noticeably higher attrition rate, rural districts only range between 0% - mid-20%. One can posit that since the program demands PSW criteria that include literacy and higher education, in urban areas PSWs are positioned to find employment more easily, therefore moving out of their PSW roles. However, this is conjecture unsupported by current documentation.

Given the reality of the numbers, the MVC program evidences the following best practices from the literature that support volunteer retention:

- The Social Welfare Assistant role is evidence of the transition of a volunteer role to a paid position as part of the Tanzanian Government.
- PASONET also offers opportunities for social and professional gatherings.
- The MVC Program also offers PSWs refresher trainings on a regular basis.

Possible practices where the literature suggests the MVC program might strengthen retention:

- Strengthening supervision
- Volunteer recognition – awards and name tags/cards
- Tools to execute their jobs including transportation

5. LOCAL GOVERNMENT OWNERSHIP

The literature strongly suggests that effective CHW programs should be owned and driven by the community and be accountable to the communities they serve. Community engagement is paramount and most effective through links with community councils or committees.

Aspects that increase local government ownership are:

- Recruiting locally
- Building on existing systems in country (connect to broader systems)
- Utilizing Village Health Committees
- Joint Care Groups and VHC meetings
- Having the CHW programs owned and driven by the community; CHWs accountable to the communities they serve
- Sensitizing and training of health professionals to redress perceptions of CHWs as low-level

(communities need help in supporting the VHCs)

- Engaging village headmen
- Using volunteers as key ways to get needed data from community
- aides, to avoid typical misunderstandings regarding their health promoting and enabling role within the community
- Sharing decision-making among the program's governing body, staff, and community health workers

The majority of the literature referred to village health committees (or analogous structures) as pivotal to the success of community health workers. In general, the village health committees are a community governance forum to link, discuss, and determine financing needs for multiple well-being initiatives in the community (health, sanitization, small business development). The VHCs are also responsible for selecting and supporting the community health worker.

MVC Program Findings

The Most Vulnerable Children Committees (MVCCs) and the Local Government Authority (LGAs) are the closest analogous structures working with PSWs and serving MVC.

According to the baseline study of Chamwino Districts and Dodoma Region:

On average, each MVCC is comprised of 12-15 members who are selected by the community itself during a public meeting in their respective villages or streets. The main criterion to be selected as a committee member is the spirit of providing services to OVC/MVC on a voluntary basis....it was also observed that there is a mixed understanding on the exact roles that those committee members are supposed to perform amount the members themselves, with only a few members knowing exactly what their roles are; however, the following were mentioned as perceived roles of these committees:

- *Identification of OVC/MVC in their respective locations;*
- *Identifying various social needs of OVC/MVC in their areas;*
- *Developing various strategies on how to overcome a range of problems facing OVC/MVC in their areas;*
- *Establishing various income-generating activities as reliable sources of income to OVC/MVC and their households;*
- *Ensuring various support donated by different donors/supporters truly reaches the OVC/MVC;*
- *Identifying and working together with various organizations that are providing different services to OVC/MVC in their villages/streets; and*
- *Visiting and providing psychosocial support to OVC/MVC to enable them to cope with the difficult situation that is facing them. (page 9)*

Recruiting locally is part of the PSW selection criteria. Village elders were engaged in community entry with MVCCs being tapped to assist in PSW participant selection.

Sensitization training is also offered to Regional Secretariats and District Council leadership to cultivate ownership of the PSW program and strengthen their awareness of their role in serving MVC and, subsequently, supporting PSWs. District Councils are asked to create action plans that invite them to plan ahead for resource allocation for both MVCs and the PSW program.

The PSW program is only as sustainable as its ability to be owned by the GoT. The MVC program has actively collaborated with LGAs in Dodoma, Mwanza, and Iringa to sensitize, strategize, and support PSWs and PSW supervisors, as well as MVC in their respective constituencies. To that end, the following approach has been taken to advocate on behalf of the PSW cadre and MVC overall.

1. Sensitization Training

The MVC program developed LGA Sensitization Training on MVC in collaboration with PMO-RALG; ISW; and DSW. Regional Secretariats as well as key district officials participate in the training with an end deliverable of making resource commitments and action plans in support of MVC and PSWs.

2. Follow-up Advocacy

After sensitization training, the MVC Program's LGA Specialist and district Advocacy teams use district action plans to follow up and ensure that LGAs are keeping their commitments to MVC and PSWs.

3. Facilitate Clarity on the Role of LGAs in Support of MVCs

Since there is interdependence between the child, family and the surrounding environment, the LGA component of the MVC program aims to look at the structures, systems, strategies, and mechanisms which can make MVC issues, social welfare activities, and the PSW cadre sustainable.

Furthermore, the LGA Specialist conducts a SWOT analysis of the strengths, opportunities, weaknesses and threats for each district in order to inform future advocacy.

Challenges have been identified at both the district and ward levels¹¹:

Key Challenges at District Level

- *Social Welfare component (in all districts) is under health and community department hence lack of autonomy, budget line and clear structure in reporting line.*
- *Inadequate communication and support between the district Advocacy Team and PSWs*
- *No plan and inadequate budget line for supporting MVC and PSWs. (in Most of the districts)*

Key Challenge at Village/Ward Level

- *Majority of village/ward leaders are not aware of their roles in mobilizing resources to support MVC in their communities*
- *The MVC agenda is not given a priority in village/ward budget plans.*
- *Poor cooperation from some families and village leaders and high expectation for materials support.*

¹¹ Norah Kaaya, Tanzania Human Resource Capacity Project, MVC Program, Annual Dissemination Report, October 2011, page 9

In addition, the March 2012 Iringa Region M&E and Advocacy Follow-up visit report also highlighted the following ward and district level challenges:

Major Challenges-Village/Ward Level

- *Lack of Transport for PSW limit their efficiency*
- *Little knowledge on MVC issues to community members hence Low level of community participation and support to MVC*
- *Lack of stable income for PSWs (Allowances)*
- *Minimum supervision of PSW from District and Ward level*
- *Limited number of service providers (NGOs) in the districts*
- *In most villages, leaders do not have clear records MVC numbers hence they do not know the extent of the problem to plan for*

Major challenges – District level

- *Advocacy team have never visited wards where follow ups was conducted hence community awareness on MVC issue is very low*
- *Most NGOs are providing services in town areas and do not reach villages which are very far where there is a great need.*
- *Limited number of SWO at district and ward level to support MVC/PSWs activities*
- *Limited budget for supporting MVC as compared to the need*
- *Inadequate supervision support of District Officials to ward/village level*

For initial M&E findings regarding the impact of MVC Program practices in cultivating Local Government Ownership, please consult **Appendix 2**.

Finally, the Matching Grant program was introduced this year in the hopes of engaging LGAs in budgeting for MVC/PSWs with the THRP matching their budget line and, over time, gradually reducing project funding while ensuring that LGAs have an established line item in their annual budgets for social service provision. While initial data is only anecdotal, it seems promising that this practice will encourage LGAs to prioritize the needs of MVC and possibly offer further incentives in support of PSWs.

In short, we can see in each region examples of the following:

- An increase in LGA awareness of Social Welfare service provision through an increase in hiring of official Social Workers at the district level;
- Examples of districts increasing their budgets to provide support for MVC;
- Incidents of LGAs and communities supporting both PSWs and MVC through various income-generation projects and direct support.

While we do not have enough data to conclusively say that LGAs and MVCCs are making this program sustainable, we can say that the program shows heightened awareness over the course of three years as evidenced by resource investment and mobilization by Local Government in both supporting the PSW program and services for MVC.

6. SUPERVISION

Uniformly, the literature suggests that supervisory oversight of volunteers is critical to their success. Likewise, in some CHW programs, effectively supervised volunteers had attrition rates two to three times lower than CHWs who were unsupervised.¹² Supportive and impactful supervision in a volunteer program is comprised of the following promising practices:

- Feedback
- Defined responsibilities and requirements
- Supervisors visit volunteers in field once a week (accompany to locations)
- Self-selection of supervisor by volunteers
- Exit interviews when volunteers leave
- Participatory manner that ensures a two-way flow of information
- Supervision by the community – ideally, supervisors should be members of the community
- Supervisors should be selected according to set criteria, and should be trained and equipped with supervisory skills.
- The most important element of supervision is ensuring the two-way flow of information

Conversely, inadequate supervision offers commensurate concerns to volunteer retention. The following hallmarks of inadequate supervision pose challenges to keeping volunteers engaged and effective in the field:

- Heavy responsibilities/work load in other areas (especially if the supervisor is job sharing)
- Inappropriate training in the field
- Inaccessibility to villages and CHW
- Uncoordinated supervision visits
- Lack of transport
- Lack of per diem
- General shortage of staff to fill these roles

MVC Program Findings

Initially, the PSW program had no component for supervision. However, in 2008 when the program was retooled, supervision became a cornerstone of the program. The MVC Program sees the oversight of PSWs in the field as a key aspect of capacitating PSWs fully. PSW Supervisors are trained in leadership and supervision skills, as well as in the foundational PSW training.

Likewise, as they are placed at the Ward level, their role has now been subsumed by the newly endorsed government role of Social Welfare Assistant. Therefore, exemplary PSW Supervisors can work towards applying for this position after the completion of a one-year certificate program through the Tanzanian

¹² Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 19

Institute of Social Work; scholarships for this certificate are supported by USAID and offered to promising PSWs and PSW Supervisors.

More specifically, PSW Supervisors reflect the following promising practices:

- Defined responsibilities and requirements
- Supervisors should be selected according to set criteria, and should be trained and equipped with supervisory skills.

Criteria for PSW Supervisor Selection is as follows¹³:

Para-Social Worker Supervisor Selection Criteria
<i>18 + years (no upper age limit)</i>
<i>Form Four education and above</i>
<i>Willingness and ready to volunteer</i>
<i>Residing in target Ward</i>
<i>Reputable and accepted by the community</i>
<i>Additional criteria proposed by LGAs</i>
<i>Local Government Extension Workers preferred</i>

To date, the MVC Program has trained 504 PSW Supervisors. However, the efficacy with which they are functioning in their roles varies widely. While this criteria positions PSW Supervisors to apply for a civil service position, it also inherently leads to some of the issues identified in the literature. The following challenges have been identified as germane to PSW supervisors:

- Heavy responsibilities/work load in other areas (especially if the supervisor is job sharing) – as most PSW Supervisors are Ward Extension Officers who already have a full work portfolio, PSW Supervisors struggle to make time for their PSW supervisory responsibilities.
- Inappropriate training in the field - While they may (or may not) enjoy taking on the role of PSW Supervisor, they are only notionally trained to carry out that work and don't have much time given their other responsibilities.
- Inaccessibility to villages and CHW
- Uncoordinated supervision visits
- Lack of transport - Like PSWs, Supervisors don't have the necessary resources, tools, or transport to conduct oversight of the PSWs fully.
- Lack of per diem
- Lack of meeting consistently – PSWs report a range of meeting consistency with their Supervisors from weekly, to monthly, to every 2 months, to never.
- Lack of two-way conversation – High numbers of PSWs report NEVER discussing certain critical issues such as developing a service plan, resource allocation, and more with their Supervisor.

¹³ Debrief for the Tanzanian Commissioner of the Department of Social Work , Linsk and Guyer, September 2010

Furthermore, District Social Welfare Officers often don't provide needed support to the PSW Supervisors. Unfortunately, finding good and consistent PSW Supervisors may be more the exception than the rule.

However, it is hoped that with the advent of the Social Welfare Assistant replacing this role, a dedicated and trained Social Work colleague will provide more thorough and consistent supervision for PSWs in the future.

7. TRAINING

Training is essential to CHWs being able to perform their job. The literature posits that training is viewed by volunteers as a stepping stone to future employment and a key motivational tool. Consistently, this growth and development is seen as an important incentive for CHWs.¹⁴ The literature identifies the following to be effective in training:

- Offering training regularly and continuously, including refresher training
- Using adult participator learning methodologies and problem-solving approaches
- Curricula, tools and methods to address each specific task
- Hands-on management of real cases
- Mentoring and coaching
- Pairing with others with more experience
- Looking at the diversity of intervention they deliver in community, they should be classroom trained for at least 6 months with an additional 6 months of hands-on-training which gives practical flavor to their theoretical lessons
- Training venue that mirrors the setting of the volunteers residence (urban or rural)

Training has challenging aspects to be managed as well, including:

- Too much time devoted to training leaves communities without volunteer support
- Training methodologies that are too theoretical, too classroom based or too complicated are ineffective and can prove to be a disincentive, especially if the material is unfamiliar to the learner
- Lack of general and skills-based training is often cited as a barrier to effective CHW performance (Walt et al 1989; Gilson et al. 1989; Kaseje et al. 1987; Robinson and Larsen 1990).

MVC Program Findings

The Social Work Partnership for Orphans and Vulnerable Children (OVC) in Tanzania was established in 2007 as an AIHA HIV/AIDS Twinning Center partnership of the Tanzanian Institute of Social Work (ISW) and Chicago-based Jane Addams College of Social Work/MATEC developed competency-based training for a cadre of Para-Social Workers. In March of 2007 an initial training was launched for Social Officers

¹⁴ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001,, page 21

as well as a symposium of best practices on psycho-social care of vulnerable children in Tanzania. At that time the USAID director, Pam White emphasized the need to apply this training for para-professionals to bridge the gap between the existing void of social welfare services and the need for social workers to manage MVCs. Subsequently the notion of building a cadre of para-social workers was further developed.

A basic curriculum was established and piloted in July of 2007. The training was the result of the Twinning Program between the Jane Addams College of Social Work and the Tanzania Institute of Social Work, with faculty from both schools working collaboratively to design and create the PSW curriculum.

The curriculum teaches a base of knowledge and practical skills to assist vulnerable children, especially those affected by HIV. Trainings were then conducted for Temeke, Kinondoni, Ilalla, Iringa, Mbeya and Mtwara/Lindi for the first phase of the project. During this time over 500 para-social workers were trained.

PSW Training Model

8-12 month training program:

- Introduction to Para-Social Work Training: **9-days** competency based
- Introduction of Para-Social Work Supervision: Supervisors designated by local government complete Introduction to Para-Social Work and have an additional 4 days of training in supervision skills.
- Supervised field experience (6 months)
- Para-Social Work Follow-up Training (5 days plus additional day for supervisors)
- Ongoing monitoring, support, evaluation and technical assistance

PSW Curriculum Focus

- Integrated case management model
- HIV AIDS focus
- Collaboration with the existing social welfare structure within communities and LGA

The skills taught in 'Introduction to Para-Social Work' include:

- (a) *outreach and identification,*
- (b) *assessing needs,*
- (c) *case management and resource linkages,*
- (d) *counseling,*
- (e) *family support, and*

(f) *ongoing service coordination.*

In August of 2008, USAID invited the Intrahealth Capacity Project to join the PSW partnership of AIHA/ISW/and JACSW in order to expand the scope of PSW trainings and to introduce the added component of working with PMORALG and Local Government Authorities to make PSW training sustainable.

Furthermore, USAID recognized the need for PSWs to have supervision at the Ward level; ISW and JACSW subsequently designed a 4-day PSW supervisors' course to accompany all PSW training.

An additional five-day follow-up curriculum has been developed and piloted, *Para-Social Work II: Practice Skills to Intervene with Vulnerable Children and Families in Special Circumstances*. This program provides an opportunity for learning more advanced skills, case analysis based on their experience to date and a number of additional or expanded topical areas including: stigma reduction, HIV disclosure, working with HIV infected children and families, working with local government, law of the child, child protection, as well as learning to use the Child Status Index as an assessment tool.

Training-of-Trainers

- More than 90 Trainers who have completed TOT workshop focusing on Introduction to Para-Social Work, 48 of the newer trainers will receive follow-up practicum training in the next 60 days. Trainers are also completing training to be completed in the same period for Para-Social Work II and Supervision training.

Pre and post-test analyses show that significant learning is occurring both in PSW I and II courses. The methodology used in both courses reflects the majority of promising practices offered by the literature.

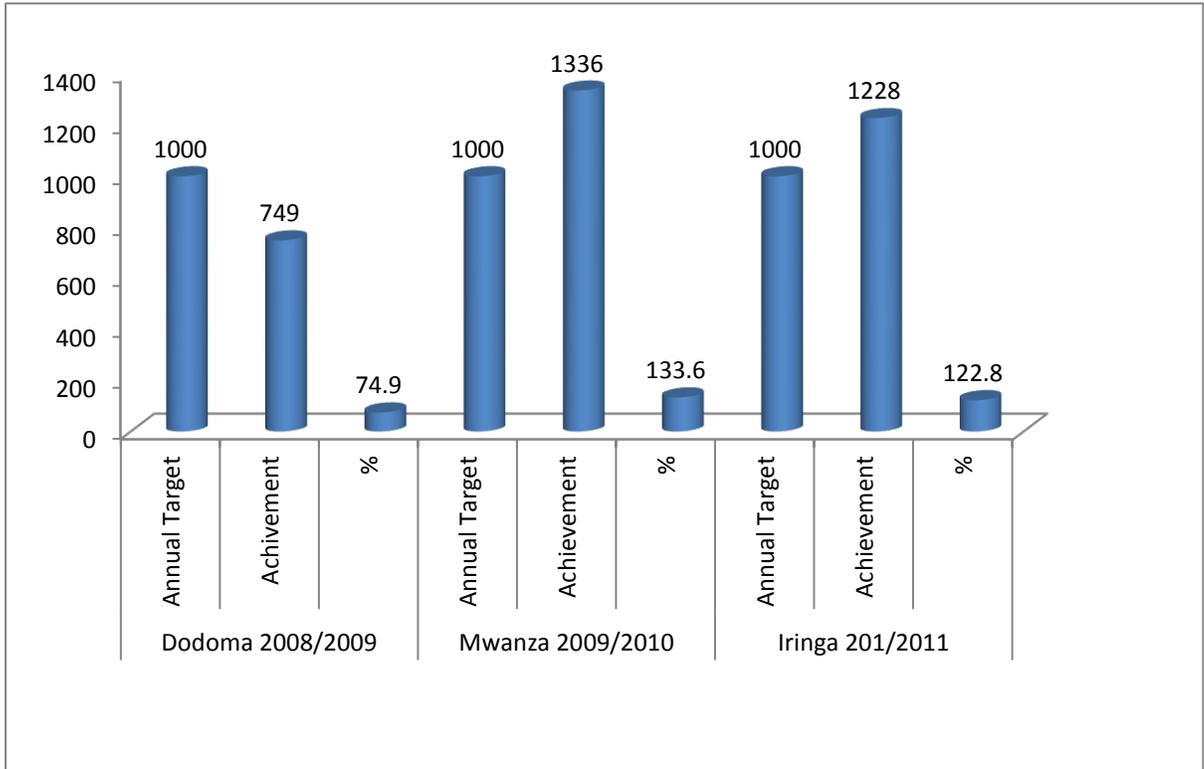
Conversely, given the challenges of supervision and the critical role that supervisors play in PSW retention, the supervisor's curricula may need to be revised accordingly.

The following statistics are from the 2011 Annual Dissemination Report¹⁵:

Since October, 2008 to September, 2011, the Program has trained about 3313 Para-social workers including 518 Para Social worker Supervisors. Below find the number of PSWs trained on Pre service program per region;

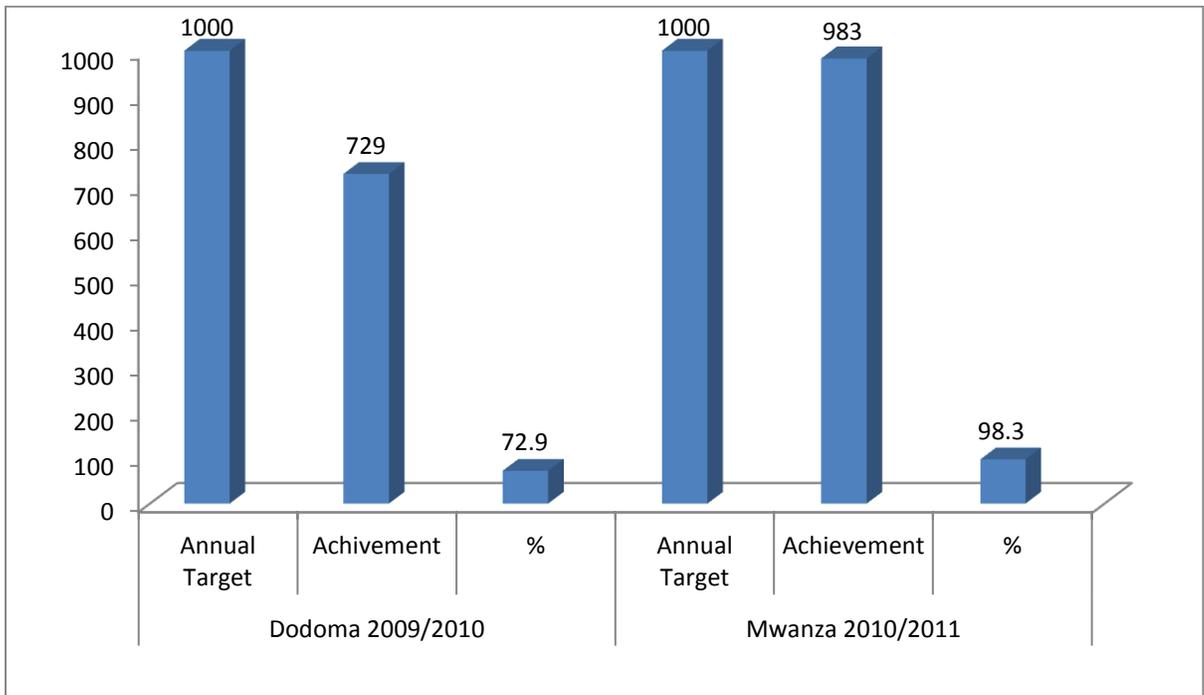
¹⁵ Norah Kaaya, *Tanzania Human Resource Capacity Project, MVC Program, Annual Dissemination Report, October 2011*

PSWs Trained on Pre-Service since 2009-2011



In addition to that PSWs trained on in service training were 1712 and 320 PSW Supervisors as follows;

PSWs Trained on In-Service Training since 2009-2011



2562 PSWs from Dodoma, Mwanza and Iringa were oriented on the revised data collection and reporting tools.

According to the DQA, when the volunteers were “queried about the last day they had attended training, more than three-quarters (78.4 percent) of the 51 PSWs who responded to this question said they had attended training in the past six months, a few (21.6 percent) said they had attended training in the past 12 months, and none had attended training in the past three months. Of 51 respondents who were questioned about training, more than half had received in-service training and the rest pre-service training”¹⁶

8. VOLUNTEER SELECTION/SELECTION CRITERIA

The literature points out that the criteria for volunteer selection varies depending on local and national context; however, successful examples point to core criteria that work, including volunteers:¹⁷

- Come from the community they serve (permanent resident)
- Are selected by community members - directly chosen by the households that they will work with, if possible
- Are recruited for training on the basis of standard and transparent criteria for selection
- Demonstrate involvement in and willing to work with the community
- Are interviewed to assess aptitude, competence and motivation
- Are married females, 20-35 years old often don’t leave the community (because of young children)
- Are literate
- Are involved in local government and getting their buy-in is an important success factor

MVC Program Findings

The MVC program subscribes to all the aforementioned success criteria, e.g..

PSW Selection Criteria

Para-Social Worker	Para-Social Worker Supervisor
<i>18 – 35 years of age</i>	<i>18 + years (no upper age limit)</i>
<i>Form Four education and above</i>	<i>Form Four education and above</i>
<i>Willingness and ready to volunteer</i>	<i>Willingness and ready to volunteer</i>
<i>Residing in target village</i>	<i>Residing in target Ward</i>
<i>Reputable and accepted by the community</i>	<i>Reputable and accepted by the community</i>

¹⁶ DQA 2012, page 9

¹⁷ *What Works for Children in South Asia Community Health Workers*. United Nations Children’s Fund (UNICEF), Regional Office for South Asia, 2004, page 30

<i>Additional criteria proposed by LGAs</i>	<i>Additional criteria proposed by LGAs</i>
	<i>Local Government Extension Workers preferred</i>

PSWs may be selected from:

- Community-based volunteers
- Home-based care workers
- MVCCs– Most Vulnerable Children Committee members
- Community justice Facilitators volunteers
- Any with above qualification doing child-related activities

Note: Gender balance is considered with regard to the numbers of the PSWs in the Ward.

The criteria were initially crafted to ensure compliance with minimal requirement for civil service employment. These requirements have proven to be challenging to meet in some rural areas and have impacted both the number of supervisors available as well as PSWs.

However, subsequent interviews confirmed that PSW stakeholders believe the current criteria needs to remain unchanged as it is the baseline for minimal competence in delivering PSW services to MVC; furthermore, with the advent of the SWA role, it is the doorway to possible civil service employment.

9. PEER SUPPORT AND NETWORKS

A key motivator identified in some CHW groups is interaction with other CHWs. Peer support is seen as a conduit for in-service training, mentoring, and bonding. Examples of successful support networks include:¹⁸

- Pairing CHWs
- Creating CHW teams
- Group meetings
- CHW Associations/Committees

MVC Program Findings

PASONET, the PSW Association, has been cited as a programmatic success and has proven to be popular with PSWs in the field. Unfortunately, beyond the repeated citing of PASONET as a motivational tool, there was no other data that reported practices of peer support (supervision is not considered peer support).

¹⁸ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 24

Summary of the PSW/MVC Program Timeline – Programmatic Alterations

Since its inception in 2008, the PSW program has proven itself to be iterative, incorporating real-time data to make programmatic changes to meet goals and achieve greater impact. What follows is a list of program alterations with a description of why the change was made with subsequent results. Likewise, where appropriate, findings from the literature supporting these changes have been noted:

Initial PSW I Course Alteration and Addition of Supervisors

- When: July 2008
- Why: In 2007, the first PSW course was for those already working for civil society organizations to “top up” their skill sets to serve MVC. After a yearlong pilot, it was determined that the reach of this program needed to go farther into the rural areas as a stop-gap human resource measure and supervisors needed to be trained to support and oversee the work of PSWs.
- Impact: Trainings were conducted regularly in Dodoma Region with all districts being covered by September 2009. Subsequently, Mwanza and Iringa Region were covered as well. A cadre of PSW Supervisors began to be trained at the Ward level.
- Connection to the literature: Supervision is cited consistently as a key factor in effective volunteer programs and, when done effectively, an important factor in volunteer retention.

PSW II Course Addition

- When: September 2008
- Why: This was not part of the initial program proposal offered to USAID in August 2008. However, the DSW requested it be added to ensure that PSWs had a complete understanding of basic social welfare service delivery and six months of practice under their belts; therefore, in September 2008, planning for the curriculum and eventual implementation began.
- Impact: All PSWs trained by the Twinning Program and THRP have completed both PSW I and PSWII training, thereby qualifying them more fully to serve their communities.
- Connection to the Literature: The literature suggests that ongoing training and refresher training are key incentives to retaining volunteers.

PSW Supervisors Shift from Volunteers to Ward-level Officers

- When: 2009
- Why: In order to meet the established criteria and to strengthen retention, Ward level Extension Officers were trained to take on the PSW supervisory oversight.
- Impact: Supervision has ranged in quality and consistency.
- Connection to the literature: The literature suggests that when you job share you cannot guarantee the quality of the supervision you will receive. As a result, the literature cites that attrition is 2 to 3 times higher for volunteers without effective supervision than those with.

SWA Role Approved and Certificate Program begun with PSWs Being Identified for Initial Training and Employment

- When: late 2009
- Why: The DSW and PMORALG worked collaboratively to create a new role at the Ward level for ensuring quality delivery of SW services in the community; in a way, this is the government-endorsed role of the PSW Supervisor.
- Impact: Currently, USAID is funding 30+ promising PSWs in their 9-month SWA certificate program and there is an MoU with the MoH that assures these graduates they will be absorbed and placed with a government job upon completion of their certificates.
- Connection to the Literature: Volunteer programs are more effective and volunteers more committed and stay longer when the program leads to a possible job.

Creation of PASONET

- When: Late 2009
- Why: The Para-Social Workers Network (PASONET) is a network of PSWs that was established by PSWs themselves for the purpose of sustaining social welfare service provision to MVC. Additionally, PASONET was formulated to serve as a platform for advocating for the rights of MVC and PSW issues in Tanzania.
- Impact: PASONET has had impact in a range of ways including:
 - Facilitating the formation and operation of PSW Network (PASONET) in Dodoma, Mwanza and Iringa
 - Networking among PSWs has improved
 - PASONET has elected PSW leaders at district and regional levels
 - The Network has facilitated PSWs attending TASWO meeting (the national Social Workers Association) on the process of establishing the Social Workers Council.
 - PASONET made a presentation of on their activities during the THRP annual data dissemination meeting for LGAs and partners
 - The Network facilitated PSWs attendance at the PSW update meeting in Dodoma
- Connection to the Literature: Peer support networks are viewed as a promising practice that both motivates and instructs; PASONET is an excellent example of a grass roots network that keeps PSWs engaged, learning, and active.

Expanded LGA Sensitization training - 1 day to 2 days

- When: 2010
- Why: With the initial delivery of the LGA Sensitization training on raising awareness of local government to their role in providing services to MVC, there was not enough time to do adequate action planning with participating district council members. Therefore, the training was expanded to ensure this critical step was done thoroughly.
- Impact: In concert with Advocacy Team follow-up, we are seeing more detailed LGA plans coupled with demonstrated cases of follow through in resource support.
- Connection to the Literature: There is strong evidence to suggest cultivating specific buy-in by Local Government results in a more sustainable volunteer program.

Revision of M&E Tools

- When: February 2010
- Why: The Data Quality Assessment of November 2009 surfaced numerous challenges with the M&E tools being used. Double counting of services offered, gaps in reporting, and processes that made verifying data impossible were amongst the many challenges identified. It was recommended that key stakeholders convene to review the tools; amend them so they gathered the most useful information; and agree on methodologies for familiarization and implementation.
- Impact: Data has been more consistently submitted and verified in follow-up visits by THRP, However recent M&E reports from all the regions indicate challenges in the flow of reporting from village to ward to district and to PMO-RALG.
- Connection to the Literature: The literature holds that when volunteers are included in programmatic decisions, such as the revision of M&E tools, their level of commitment and belonging to the program increases significantly.

New IPs Deliver PSW Program – Scale up – Joint Trainings

- When: August 2010
- Why: USAID divided its OVC Portfolio, including PSW training, among 4 Implementing Partners – FHI, Africare, Pact, and WEI. The goal was to scale-up the PSW program more quickly and expansively.
- Impact: When the new IPs proposed to take on PSW training, they were given different training parameters than the Twinning/THRP PSW training. Specifically, the new IPs were asked to:
 - Train PSWs only at the ward level (Pact has chosen to train at the village level but only in a few districts)
 - Not conduct PSWII training
 - Not pursue advocacy as a strategy (although Pact supported Awareness training in partnership with IntraHealth THRP)

These differences made any kind of comparative M&E impossible. Likewise, the DSW stepped in to insist on some kind of quality control and mandated that any IP offering PSW training in Tanzania had to use the ISW-approved PSW training curriculum and use ISW-trained trainers.

However, the new IPs are leveraging the expertise of already trained PSWs with some district councils insisting that PSWs be tapped rather than training new volunteers (*AfriCare and its subsidiary NGOs have been instructed to use PSWs rather than other volunteers and not train new volunteers by Njombe DC*).

- Connection to the literature: The literature speaks to the critical nature of aligning volunteer programs with local government and ensuring ongoing training/refresher courses. By not replicating the PSW model used by ISW, key components that underpin retention and sustainability were lost as well as quality assurance.

Creation of Advocacy Teams

- When: 2010
- Why: There were a number of reasons Advocacy Teams were established including:
 - To put a consistent advocacy mechanism in place
 - To bring other sectors on board
 - To cover more areas as the program expanded
 - To facilitate LGAs ownership of the program
 - To offer more support to the District Social Welfare Officer
 - To ensure sustainability of LGA advocacy activities
- Impact: The impact of advocacy teams has been multi-fold including:
 - Formation and training of District Advocacy Teams in 22 District Councils in Dodoma, Mwanza and Iringa
 - Advocated for establishment of MVC Community Funds in 43 villages of Mwanza and 42 villages in Dodoma
 - Advocated for planning and budgeting for MVCs and PSWs from District Council's own budgets with 11 out of 22 District Councils in Dodoma, Mwanza and Iringa having budgeted for PSW/MVC from their own resources
 - Advocated for importance of hiring Social Welfare Officers and their roles in supporting children in 27 District Councils of Dodoma and Mwanza regions- Most District Executive Directors understand the roles of Social Welfare Officers and there is significant increase in hiring of Social Welfare Officers in the District Councils (see M&E data appended)
 - Raised awareness of the Program/MVC in Dodoma, Mtwara, Mwanza and Iringa; specifically, conducted awareness meetings with Regional and District Leaders
- Connection to the Literature: The literature states clearly that Local Government Ownership is essential to a program's success. This is an area where the MVC/PSW program has made notable headway and has data demonstrating examples of success.

Expansion of Training Days in PSW 1 – 8 Days to 9 Days

- When: 2011
- Why: For the purpose of accommodating new materials which are relevant to the PSWs work such as: M&E sessions and techniques on how to enter to the community after the training. Also, comments from participants cited some critical topics weren't given enough time; thus the course was expanded to deepen content knowledge.
- Impact: Improved reports in regard to services provided to the MVC, as well as reported commitment of PSWs to the program.
- Connection to the Literature: The literature on training cites incorporating the input of volunteers in course content as a key motivational factor, and when participants can play a role in strengthening and designing training, their motivation increases exponentially.

Revision of Curriculum

- When: Late 2011
- Why: To update course content especially in the area of HIV/AIDS and other new and relevant policies such as the Child Right's Act and UNICEF's recent finding on Violence Against Children Report, as well as new procedures for PSWs.

- Potential Impact: Improved quality of services provided to MVC, as well as increased number of MVC served.
- Connection to the Literature: Again, whenever volunteers can play a role in determining the programmatic aspects of their work (i.e. participating in course revision) commitment as well as service delivery and relevance increase.

PSW Update Course Addition

- When: 2011/2012
- Why: PSW's having completed both PSW I and II need ongoing refresher training
- Impact: Beyond skill and knowledge transfer by sharing updated information on Tanzanian legislation, policy and more in regards to OVC, this course reportedly generates enthusiasm and renewed commitment to service.
- Connection to the Literature: This practice is highly supported in the literature as ongoing training serves as a prime motivator and continues to bond PSWs as a functional cadre, allowing for exchange of promising practices and support.

Start Matching Funds Program with LGAs

- When: 2012
- Why: To encourage LGA commitment and sustainability as well as model how they can mobilize and allocate resources for MVC and PSWs in their respective areas.
- Impact: Initial anecdotal data shows we're beginning to see increased prioritization of MVC/PSW issues on district agendas as well as increased resource commitment at the LGA and community levels.
- Connection to the Literature: This activity, in concert with the work of Advocacy Teams, is serving to strengthen even more Local Government Ownership, a key practice noted in the literature.

Changing Roles within the MVC Program Team (especially LGA Officer)

- When: Ongoing
- Why: With program expansion and changing programmatic priorities, as well as the initial MVC Program model being tested, roles within the program had to shift and change by necessity. This was particularly true of the LGA Specialist role as it moved from being dedicated to LGA follow-up to supporting Advocacy teams who took over LGA follow-up.
- Impact: The program has delivered its targets consistently over the course of the project's life.

Summary of Monitoring and Evaluation Data Available

Since 2008, the MVC/PSW Program has collected data, as per its mandate, both on the demographics of PSW participants and on Local Government statistics and commitment to supporting both MVC and PSWs. The program collects output data to measure performance of PSWs in terms of how many are active, type of service and referrals the PSW do and the level of support that PSWs receive from their supervisors through the program's routine monitoring system.

It is important to note that the MVC/PSW Program and the THRP was never asked nor equipped to do an impact assessment on the lives of MVC or their caregivers as a result of PSW support. Initially, it was agreed that any future impact assessment in this regard would need to be carried out by qualified social workers familiar with all the tools available to PSWs as well as the National Quality Improvement Guidelines as established by GoT.

Therefore, the data available from this program looks solely at the demographic make-up of PSW participants, services provided, as well as LGA engagement.

Initial Reflections on the M&E Data...There is more Monitoring than Evaluation

When examining the data, it became clear that the MVC program has acquired vast amounts of data, yet has struggled to aggregate it in any way that offers meaning for strategic planning purposes. Only now is the program establishing a database that will make the entry and reporting of data both standardized and easy to access. Likewise, demographic data sets were never standardized from region to region, which made the disaggregation of cumulative Excel spreadsheets a challenge. Therefore, demographic data reported here is our best attempt to standardize demographic categories across the three regions in hopes of identifying patterns and trends.

PSW Demographics by Region

See *Appendix 5*

Demographic Data Reflections

1. Profile of the Typical PSW Participant

The current M&E data suggests that cross-regionally, the typical PSW is:

- Male (Dodoma – 64%; Mwanza – 66%; Iringa – 55%)
- Under 30 years old (Dodoma – 61%; Mwanza – 56%; Iringa – 69%)
- Unmarried (Dodoma – 64%; Mwanza – 53%; Iringa – 67%)
- Possibly engaged in farming, or some other form of income-generation activity (Dodoma – 53.5%; Mwanza – 72%; Iringa – 46%)

Possible Implications:

Given this profile, it would be wise to compare this to the demographics of children being served, especially vis-à-vis gender, as sometimes there is a correlation between the gender predominance of PSWs and the gender being most served amongst the MVC population. Likewise, when looking at attrition rates, particularly in urban areas, this profile may hold implications.

2. PSW Attrition Rates

Repeatedly, high attrition rates of PSWs were cited by stakeholders and program staff alike. As stated in the Desk Review, it is important to note that the literature suggests there is no discernible appropriate retention/attrition rate for volunteer programs and that any suitable rate must be created in programmatic context.

Therefore, cross-regionally, it is clear that there are much higher attrition rates in urban areas rather than rural, with urban attrition of PSWs ranging from 36%-45%. However, in rural areas there is a significantly less attrition with rates ranging from 0% - 23%. We do not have hard data to explain these differences and those PSWs who have left the program cited a number of reasons for departure with no consistent cause being identified. Reasons ranged from marriage to new employment to schooling. Likewise, statistically it was a small sample set responding to the questions regarding why they have left with few volunteers in a few districts of each region being queried; further research would be advisable in this regard.

Possible Implications:

Given the fact that the PSW criteria calls for participants selected to have the minimum qualifications for civil service employment, it is not surprising that PSWs with these basic skills can find opportunities and employment elsewhere, particularly in urban areas. Likewise, a goal of the PSW program is to inspire a career development path, and it would be important to track the number of PSWs pursuing options in other social welfare service fields as well.

Whether or not the attrition rates are acceptable is a point worthy of discussion. In the opinion of these authors, the attrition rates could be lowered to more acceptable standards with the addition of an incentives package to support PSWs in doing their job. However, given the fact the goal of the PSW program is to create a career path, one could posit that in urban areas, the PSW training has created alternative employment possibilities and actually is achieving its goal in spite of a higher attrition rate.

Local Government Social Welfare Awareness and MVC/PSW Data

See **Appendix 4**

Initial data suggests that advocacy efforts and work of the PSWs is having discernible impact in raising both the awareness of Local Government as well as catalyzing the districts and communities to provide incentives and support for MVC and, in some instances, PSWs. Indicators for this supposition follow:

1. Increase in hiring District Social Welfare Officers

When the PSW program began, the role of District Social Welfare Officer (DSWO) was cited as key in making the program functional by providing oversight to PSW Supervisors and by serving as an advocate for MVC and PSWs when mobilizing resources for district budgets. However, in 2008, only slightly more than half of the DSWOs in Tanzania were hired. The MVC/PSW data (please see **Appendix 4**) shows that in each region, from the time the program begins until now, there is a notable increase in the district's willingness and ability to hire the needed DSWOs.

Possible Implications:

Illustrative Examples of Community Support

2011 MVC /PSW M&E and Advocacy Follow-Up Visit Reports

Dodoma Region – Kongwa DC

Mkoka ward has mobilized the community to contribute for MVC support and they have Tshs 12,000/=; they also have opened an account for MVC funds. They are planning to contribute more from January 2012 whereby every household will be required to contribute 1,000 per month

Mwanza Region – Geita

Magenge village in Kaseme Ward has mobilized the community to contribute for MVC fund – 345,500 /=-; they have also opened an account

Iringa Region – Kilolo DC

In Mtitu village (through SILC group) members are contributing Tshs 500 per week for supporting MVC; so far, they have collected Tshs. 2.1 million.

This encouraging finding suggests that the PSW program and attendant advocacy, through sensitization training, the work of the LGA Specialist and Advocacy teams, has increased Local Government's awareness and willingness to resource both MVC and PSWs. While wider data should be aggregated to substantiate this finding, it is heartening to see such growing numbers cross-regionally.

2. Clear examples of LG Districts and Villages Supporting MVC and PSWs

The MVC/PSW program has gathered clear examples of where districts cross-regionally have built in PSW and MVC support into their annual budgets. Likewise, discreet success stories of communities that have worked to create income generation activities or incentives to support MVC are cited for each region. Again, there needs to be

further data gathered to reflect a complete picture of each region; however, initial findings are promising. For specific examples of LGA budgeting and community resource mobilization please consult the tables of **Appendix 4**.

Possible Implications:

The initial data suggests that the PSW program and advocacy strategy catalyze both district government and village communities to commit their resources into supporting MVC and, in some instances the PSWs themselves. This is key as the project was designed to be sustainable by getting buy-in and resource mobilization to support PSWs through the local government and community MVCC. To see concrete examples of this evolving in all three regions is encouraging, and in regions/districts/communities where there is more commitment and resource allocation, it would be wise to research what has proven most effective in those instances.

Summary of In-country Interviews with PSW Program Stakeholders

From April 16th – April 28th, 2012, 13 interviews were held in Tanzania to gain the perspective of key PSW Program stakeholders. Interview participants were chosen for their history with the program and the institutional memory they could offer. Likewise, a range of partners were consulted to ensure comprehensive reflections of both the successes and challenges of the program over time.

Interview participants included:

- Elizabeth Lema, USAID
- Commissioner Makala, DSW
- Mama Kamote, DSW
- Philbert Kawamama, DSW
- Charles Matiko, FHI
- Sally Chalamila, AIHA
- Leah Omari, ISW
- Claude Njemba, ISW
- Furaha Dmitrios, ISW
- Herbert Mugumya, Africare
- Datus Ng'wanangwa, Africare
- Mama Hellen Macha, PMO-RALG
- Dr. Nathan Linsk, Twinning Center Consultant

Common Interview Questions

1. What are the major successes of this program?
2. What are the outstanding challenges of this program that need to be addressed?
3. What programmatic changes have been made since the program's inception? Why were those changes made? Did they have the desired impact?
4. Are there any programmatic changes that need to be made currently? If so, what changes are needed?
5. What is the most important aspect of the program to ensure the sustainability of the PSW cadre?

After reviewing the cumulative data collected from these conversations, the following themes emerged.

Note: As themes were identified, we have noted where they echo a promising practice or literature identified challenge)

PSW Program Successes

- Model is unique and being replicated elsewhere in the world

Interviewees expressed pride that the PSW model was a unique response to a critical HR emergency, and was being replicated in countries like Nigeria and Ethiopia.

- The program is thriving 5 years after inception

Some interview participants noted that often new programs are short-lived, with a project life span of 2-3 years. The PSW program, conversely, is continuing to thrive in Tanzania.

- The Social Welfare Assistant role (*literature review promising practice*)

A significant accomplishment cited by multiple respondents was that the Social Welfare Assistant's role was finalized and mainstreamed into Ward-level government as a paid position. The acquisition of this role creates a possible career path for promising PSWs, and USAID has begun to incentivize this professional development by offering exemplar PSWs scholarships to complete their SWA certificate program for eventual job placement with the GoT.

- Strengthened capacity of ISW (*literature review promising practice*)

The Twinning Center has excelled at capacitating ISW faculty and staff through repeated ToTs and practicums, resulting in a cohort of qualified Tanzanian trainers and facilitators who can deliver all courses of the PSW program.

- Raised awareness of SW in the GoT (*literature review promising practice*)

Several interviewees reported a sense that GoT awareness of the Social Welfare Workforce had been raised considerably as a result of the PSW program. The THRP referred to its data collection on local government employing District Social Welfare Officers and noted a clear increase in hiring from the time of the PSW program beginning to the present.

- PSW's working hand-in-hand with MVCC's to provide SW services (*literature review promising practice*)

Some felt the program had succeeded at mainstreaming the PSWs into the village by working in concert with Most Vulnerable Children Committees to provide foundational case management and social welfare service provision.

- More children are being served

Uniformly, interview participants reflected a great point of success is the fact that, quite simply, more vulnerable children are being served in Tanzania.

- PSWs see a possible career path (*literature review promising practice*)

With the advent of the Social Welfare Assistant role, there is a clear path to professional development for PSWs, thereby keeping them engaged in their volunteer role.

- District councils now see their role more clearly and are working collaboratively (*literature review promising practice*)

Again, initial data shows an increase in district councils understanding and working towards fulfilling their role in serving most vulnerable children (MVC), either by allocating resources for MVC directly or incentivizing the PSWs in their area. Those interviewees who work most closely with LGA and village counterparts also shared increased commitment to support and the work of advocacy teams was cited as playing a critical role in this forward movement.

- PASONET (*literature review promising practice*)

The creation of the PSW Network has served to connect PSWs across regions and has proven to be a source of collaboration and development for PSWs.

PSW Program Challenges

- Funding (*literature review potential challenge*)

In a resource-constrained donor environment, the PSW program is struggling to maintain its level of training using its complete model of multiple training, supervision, etc., as it is viewed by donors and partners as being “too expensive.”

- USAID has not strategically aligned volunteer programming

Several interview participants cited PSWs being demotivated and disincentivized as they see fellow volunteers in other programs, similarly funded by USAID, receiving stipends, bicycles, and other means of support. Likewise, even in Dodoma region, with the Pamoja Tuwalee program overseeing some of the trained PSWs, you have some PSWs now receiving stipends (if they fall in Pamoja Tuwalee's assigned districts) and some not, creating differentiation between PSWs – all sponsored by the same donor.

Interviewees felt this reflected a lack of strategic visioning on the part of the donor, especially in regards to sustainability, and in future programmatic development, looking more broadly at aligning donor- funded volunteer programs could be beneficial.

- Lack of data to demonstrate impact in the lives of MVC, beyond success stories (*literature review potential challenge*)

As this kind of impact assessment was not under the purview of the MVC/PSW program, there is no data to review. However, it has been repeatedly raised by interview respondents as well as the OVC Technical Working group that impact data from MVC and caregivers is needed. This may result in needing to conduct a formal Public Health Evaluation as the metrics, rigor, and expertise needed to do this thoroughly will require resources.

- Incentivization challenge (*literature review potential challenge*)

Numerous interviewees felt that the lack of monetary incentivization was a key factor behind attrition. These views sprang from conversations with PSWs as well as an intuitive sense that the volunteer aspect of the program is unsustainable, especially when volunteer service is open-ended with no clear finish date of service completion.

- SWA absorption into the GoT

Significant concern was noted regarding the GoT (and this includes PMO-RALG and DSW) ability to hire the trained Social Welfare Assistants emerging from ISWs SWA Certificate program. While USAID is currently funding 30+ promising PSWs with scholarships to complete the SWA certificate program, only recently has the GoT agreed to place those graduates with SWA positions upon graduation. Furthermore, the GoT projects needing 6,000 SWAs yet has only endorsed doing SWA certificate training at one government institution (Kisangara); this institution can only accommodate 30-35 participants for the 9-month certificate program, so quickly building capacity to fill this role is problematic.

- MVCCs aren't consistently helpful (*literature review potential challenge*)

The Most Vulnerable Children Committees (MVCC) at the village level were cited as critical to a PSWs success. Unfortunately, while some MVCCs were remarkably supportive of PSWs, others were reported as abdicating their responsibilities to MVC to the PSW or, even worse, working against the PSW.

- Varied LGA & Community buy-in (*literature review potential challenge*)

Since the PSW program is purely voluntary, it is built on the belief Local Government and village committees (MVCCs) will incentivize PSWs. Interviewees felt there had been a varied response to this, and that to make this program sustainable, even more local government buy-in would be needed.

- Varied quality of PSW Supervision (*literature review potential challenge*)

PSW supervision was identified as a significant challenge. There was a lack of consistency in frequency and quality to PSW supervision and respondents identified this as a critical area to give focused attention.

- Lack of advocacy at the national level (*literature review potential challenge*)

While at the inception of the PSW program in 2008 there was strong central government support with unheralded partnering between the DSW and PMO-RALG, that partnering and prioritizing the PSW program has faded. This has resulted in misinformation about the program, and concern over its viability continuing into the future.

Furthermore, it is critical that political will be re-established at the national level with key central government colleagues like the Commissioner of Social Welfare; the Assistant Commissioner of Social Welfare; and the Director of Human Resources for PMO-RALG. Without their support, aligning resources and local government support will be almost an impossibility.

- Sustainability (*literature review potential challenge*)

Interview respondents voiced genuine concern over the sustainability of the program for a variety of reasons including: diminishing funding for quality training; lack of key central government counterparts prioritizing and advocating on behalf of the PSW program; no strategy for filling behind areas where attrition is highest; no remuneration for PSWs; and other implementing partners not delivering PSW training while not using the full PSW, thereby compromising the quality of training and subsequent PSW experience.

- Lack of clarity regarding who “owns” the PSW program (*literature review potential challenge*)

When queried who has ownership of the PSW program, interview respondents offered a range of answers from ISW to DSW to USAID to IntraHealth to the GoT and the communities themselves. Given that the majority of those interviewed helped conceive and deliver the program from its start in 2008, the lack of clarity about program ownership is somewhat disconcerting, and speaks to a loss of direction regarding eventual sustainable ownership by the GoT.

- Lack of clarity on the future of PSWs in Tanzania (*literature review potential challenge*)

There was a range of beliefs about the future of the PSW program by interview respondents. Some felt that as an emergency HR measure, they will be needed for decades to come until the SW system has built a critical mass of qualified social workers in key positions, particularly filling the new SWA role. Others felt in 10 years the PSW program will be obsolete with SWAs doing the PSWs job. The

extreme difference in perception of the future of the PSW program speaks to a lack of clarity of vision by stakeholders and begs dialogue to reach agreement and understanding for a path forward.

Program Review Recommendations Emerging From Data and Partner Input by Thematic Area

As a result of the literature and M&E review, as well as the partner input, both by interviews and the partner debrief workshop, the following are recommendations for consideration by stakeholders in creating a programmatic path forward:

Workload and Role

- Explore if the PSW workload constitutes a full-time position as it is currently being implemented, as it was originally conceived to be a half-time role. If so, reexamine volunteer's ability to generate enough income to support livelihood, as this may have possible implications for retention.
- Incorporate suggestions and input on income-generating activities in PSW curriculum and revise work planning in the PSW course to include livelihood activities.

Incentivization, Disincentivization and Motivation

- Strengthen this aspect of the program – this theme is most predominantly missing.
 - Work with USAID to examine the impact of having different incentive packages for volunteers all funded by the same donor with an eye towards potential standardization and alignment between volunteer programs.
 - Continue to use advocacy strategies at both the local and central level to lobby for incentivizing PSW volunteers.
- Examine creating an incentives package in concert with local government/MVCCs that provide PSWs with basic environmental support to do their job. The literature suggests a bicycle could be the greatest motivator.

Retention/Attrition

- Continue to champion promising PSWs movement into the SWA role and publicize this career path to recruit new PSWs.
- As data is accrued, explore root causes for higher attrition in urban areas.
- Promote volunteer appreciation as a tool for retention with MVCCs and local government authority. For example, pilot using volunteer badges or cards identifying them as PSWs and giving them some status within the community.
- Use PASONET to help track PSW movement and attrition.

Local Government Ownership

- Continue focused advocacy and facilitated action-planning for PSW support with regional and local government.

- Continue to accrue M&E data on PSW program's impact on local government hiring of SWW roles, especially in regards to District Social Welfare Officers and the new SWA role.
- Continue implementing social welfare sensitization training at local government levels and explore including key MVCC members as well.
- Map organizations working with LGAs for possible linkages.
- Continue piloting the Matching Grants program and monitor its impact on LGAs budgeting for MVC and PSWs in the next fiscal year.

Supervision

- Investigate the possibility of PSW supervisors coming from the community as currently the majority of them are extension officers posted at the Ward.
- As much as possible, ensure the supervisor role is filled by the SWA.
- Work with Supervisors to ensure PSWs are given consistent feedback to strengthen their work
- Revise the Supervisors' curriculum and ensure design has strengthened components on LGA and feedback – work with ISW to do this soon

Training

- Continue the PSW model as it is currently being implemented by the Twinning Center
- Continue the new PSW update training
- Advocate for other IPs to use this model in delivering PSW programming

Volunteer Selection/ Selection Criteria

- Do not change the criteria for PSW participant selection as it has enabled exemplary PSWs to be identified for moving into the SWA role at the ward-level
 - Stakeholders report that the current selection criteria are the minimal criteria needed for satisfactory mastery of PSW content.

Peer Support and Networks

- Continue supporting PASONET
- Use PASONET as a recruitment and promotional tool for incentivization and motivation; this network has the potential to track and map PSWs in transition and can ensure PSWs trained remain connected to a broader PSW cadre

Advocacy

- Stakeholders agreed that reengaging the Commissioner of Social Welfare is an important piece of strengthening the program. It was agreed that he should participate in a field trip to visit PSW training, meet PSWs in the field and liaise with other local government counterparts in order to familiarize him fully with the program.
- Due to priority changes over the course of the last year (a focus on Kisangara and beginning the SWA certificate program; establishing a National Council of Social Workers to professionalize the discipline, etc.), an advocacy strategy to reestablish the PSW program on DSW and PMO-RALG's strategic agenda is needed. More specifically, the DSW and PMO-RALG need to be fully re-engaged. This strategy should complement the advocacy strategy currently being deployed at the local level.

- After engaging the Commissioner more fully with the PSW program, it will be essential to lobby for more support at all levels. For example, hiring District SW officers to oversee SWAs, supporting further resource allocation and incentivization, etc.

Monitoring and Evaluation

- Review available M&E tools and work with donors and GoT partners to create metrics that will demonstrate impact. This may include doing a formal public health evaluation in conjunction with the OVC TWG for USAID.
- Continue to establish a tracking system for PSW and PSW Supervisor demographic data, so this information can be used for strategic planning purposes, including standardizing the demographic fields of PSW cohorts.
- Use available data for looking at trends in PSW recruitment, particularly regarding gender and the possible implications of service to MVC (boys vs. girls receiving PSW services).

Appendices

Appendix 1: Overview of Themes from the Literature Review vis-à-vis the PSW/MVC Program*

*NOTE: WHERE NEITHER BOX IS CHECKED INFORMATION AVAILABLE IS INCONCLUSIVE

<i>Workload and Role</i>	MVC Program
1. Tasks contained enough for volunteers to balance income-generating activities & family responsibilities	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. The community and system of affiliation (social welfare, in this case) understand the boundaries of the volunteer's role and how that role intersects with others.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Volunteers understand exactly what their role is.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<i>Incentives and Disincentives...Non-monetary incentives that have impact</i>	MVC Program
4. Having volunteers' views listened to	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
5. Being provided the tools necessary to perform work	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6. Award ceremonies and public recognition	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Access to income-generating funds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Some
8. Name badges or cards identifying the volunteer's role in the community	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
<i>Motivation...Satisfaction factors impacting motivation</i>	MVC Program
9. Status in the community	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Some
10. Enough time off to perform livelihood functions	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
11. Training	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
12. Career path – stepping stone to a paying job	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
13. Exposure to the outside world	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

14. Report back on the success of efforts	<input type="checkbox"/> Yes <input type="checkbox"/> No ✓Some
15. Be involved in program design, implementation, and decisions about M&E	✓Yes <input type="checkbox"/> No
16. Sense of trust and belonging	<input type="checkbox"/> Yes <input type="checkbox"/> No ✓Some
Retention /Attrition Factors	MVC Program
17. Possibility for volunteers to transfer to paid positions or supervisory positions	✓Yes <input type="checkbox"/> No
18. Not being overloaded with work	<input type="checkbox"/> Yes ✓No
19. Volunteer recognition/appreciation events	<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Regular information/education sessions	✓Yes <input type="checkbox"/> No
21. Appropriate physical space for volunteers to use	<input type="checkbox"/> Yes ✓No
22. Good communication between staff and volunteers	<input type="checkbox"/> Yes <input type="checkbox"/> No
23. Close friends or family at the volunteer organization	<input type="checkbox"/> Yes <input type="checkbox"/> No
24. Knowing impact of activities	✓Yes <input type="checkbox"/> No
25. Appropriately screening and matching volunteer to job	✓Yes <input type="checkbox"/> No
26. Effective orientation	✓Yes <input type="checkbox"/> No
27. Quality of interpersonal relationships	<input type="checkbox"/> Yes <input type="checkbox"/> No
28. Being recruited by another volunteer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Local Government Ownership	MVC Program
	✓Yes <input type="checkbox"/> No

29. Program is owned and driven by the community and volunteers are accountable to the community they serve	
30. Village committees are functional and support the selection and oversight of community volunteers.	<input type="checkbox"/> Yes <input type="checkbox"/> No ✓Some
31. Village committees are pivotal to success and serve as the governance link to determine financing needs, volunteer selection and support and a forum to facilitate information dissemination and flow	<input type="checkbox"/> Yes <input type="checkbox"/> No ✓Some
Volunteer Supervision...effective supervision includes	MVC Program
32. Feedback to the volunteers	<input type="checkbox"/> Yes ✓No
33. Defined responsibilities and requirements	✓Yes <input type="checkbox"/> No
34. Regular field visits	<input type="checkbox"/> Yes ✓No
35. Exit interviews with volunteers leaving the program	<input type="checkbox"/> Yes <input type="checkbox"/> No
36. Two-way flow of information	<input type="checkbox"/> Yes ✓No
37. Supervisors ideally should be members of the community & selected according to a transparent set of criteria	<input type="checkbox"/> Yes ✓No
Training...effective training	MVC Program
38. Training is viewed as a stepping stone to future employment	✓Yes <input type="checkbox"/> No
39. Is offered regularly and continuously	✓Yes <input type="checkbox"/> No
40. Uses adult participatory methodology & problem-solving approaches	✓Yes <input type="checkbox"/> No
41. Curricula, tools and methods to address each specific task	✓Yes <input type="checkbox"/> No
42. Hands on management of real cases	✓Yes <input type="checkbox"/> No
43. Mentoring and coaching	✓Yes <input type="checkbox"/> No

44. Pairing with others having more experience	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
45. Classroom training coupled with 6 months of hands-on training	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
46. A training venue which mirrors the setting of volunteer's residence (urban or rural)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<i>Volunteer Selection Criteria...Successful criteria include</i>	MVC Program
47. Volunteers coming from the community they serve (permanent resident)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
48. Selected by community members	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
49. Recruited on the basis of standardized and transparent criteria	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
50. Demonstrated involvement in and willingness to work with the community	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
51. Are literate	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
52. Are involved in local government and get buy-in	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<i>Peer Support and Networks...successful support includes</i>	MVC Program
53. Pairing community volunteers	<input type="checkbox"/> Yes <input type="checkbox"/> No
54. Creating volunteer teams	<input type="checkbox"/> Yes <input type="checkbox"/> No
55. Holding group meetings	<input type="checkbox"/> Yes <input type="checkbox"/> No
56. Creating volunteer associations/committees/networks	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

Appendix 2: Literature Review

Definitions

We begin with the definitions for volunteer, community health worker and para-professional social worker:

Volunteer

The three criteria given below are broad enough to include virtually all forms of volunteering found around the world, yet they effectively distinguish volunteering from other forms of behavior that may superficially resemble it.

- It is not undertaken primarily for financial gain
- It is undertaken of one's own free will
- It brings benefits to a third party as well as to the people who volunteer¹⁹

Community Health Worker (CHW)

WHO has elaborated the definition of CHWs as *“they should be members of the communities where they work, should be selected by communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers”*²⁰

Para-Professional Social Work (PSW)

*The term para-professional social work is used below to include work by community-level people who have been trained in basic social service modalities to work with vulnerable children and families, but lack professional-level education and training for independent work as social workers. These workers may have a range of names, including para-social workers, social work assistants, psychosocial care workers, etc., and the actual position title may need to be adapted to local cultural and policy context.*²¹

In our review of the literature emerging themes surface around:

¹⁹ Alan Dingle. *Measuring Volunteering: A Practical Toolkit*. A joint project of Independent Sector and United Nations Volunteers, 2001. page 9.

²⁰ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization. Page 13

²¹ Linsk, Nathan, Zena Mabeyo, Leah Omari, Donna Petra, Bonnie Lubin, Abeb Assefa Abate, Lucy Steinitz, Theresa Kaijage, Sally Mason. *Para-social work to address most vulnerable children in sub-Saharan Africa: A case example in Tanzania*. *Children and Youth Services Review* 32: 990-997. 2010.

- Workload and role
- Incentivization and Disincentivization
- Motivation
- Retention/Attrition
- Local Government Ownership
- Supervision
- Training
- Volunteer Selection/ Selection Criteria
- Peer Support and Networks

Promising practices were compared to the PSW program in Tanzania. Finally, for each theme key questions are outlined that, once answered, will inform the program review.

Review of Current Literature – Thematic Areas and Practices

WORKLOAD AND ROLE

The literature suggests, that if the community health role is not a paid full-time position, that the tasks should be contained enough for the volunteer to balance income-generating activities and family responsibilities.

Try to maintain a reasonable workload of carefully defined duties that take just a few hours a week²²

Your organization’s volunteers are not just free or low-cost labor, and they should never be exploited. Though their roles and their relationship with your organization differ from those of paid staff, they require good supervision, training, and support. Be sure to check current labor laws and make sure that your use of volunteers is not misunderstood as hiring staff below the minimum wage²³.

However, providing CHWs with too many tasks and responsibilities should be avoided as it can lead to impaired performance. Conversely, there may also be a trade-off whereby adding simple services will have an expected impact on health outcomes.²⁴

Since the literature states that there are four categories of volunteering, it is helpful to be explicit about the roles expected from volunteers in each area as to ensure that those roles are not overwhelming. The volunteer types/areas include:

- *Mutual aid (also called self-help)*
- *Philanthropy or service to others*
- *Campaigning and advocacy*
- *Participation and self-governance²⁵*

²² *The Way We Care: A Guide for Manager of Programs Serving Vulnerable Children and Youth*. Family Health International, 2009. Pages 111-112.

²³ *The Way We Care: A Guide for Manager of Programs Serving Vulnerable Children and Youth*. Family Health International, 2009. page 110.

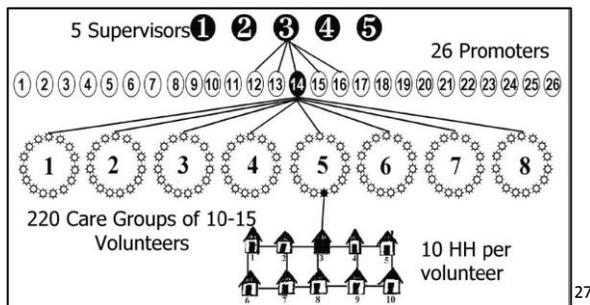
²⁴ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 6

¹¹ Alan Dingle. *Measuring Volunteering: A Practical Toolkit*. A joint project of Independent Sector and United Nations Volunteers, 2001, pages 9-10

It is not only important to avoid overloading volunteers, but also to ensure that they, the community and others in the healthcare system understand the boundaries of their role and how those roles intersect with others.

This suggests that for optimal selection, it is important to explicitly state for which tasks CHWs are responsible. This is of particular significance as unclear expectations and ill-defined roles for CHWs are often cited as main causes for failure of many CHWs programs.²⁶

In the Care Group model, regardless of the size of the project population, ratios should remain constant: one volunteer per 10–15 households, and 10–15 volunteers per group. Each paid staff person can oversee about eight groups, or about 80–120 volunteers. These volunteers can then reach 800– 1,800 households, depending on the population density of their village. World Relief staff begin the program by conducting a census of beneficiaries (women of reproductive age and children under five years) in order to assure full and equitable coverage of households, and to help managers allocate staff to defined geographic areas. The diagram below illustrates how 32 program staff in Mozambique educated and provided services to 130,000 people, with 10 households per volunteer.



INCENTIVIZATION AND DISINCENTIVATIZATION

Literature Promising Practices

For sustainability of community volunteers, should the volunteers receive monetary compensation? Given the current economic environment as well as the emphasis on donor fiscal responsibility, it is not surprising this question was often addressed in the literature. It should also not be surprising that there is a lack of consensus on the answer. Irrespective of whether the program provides financial incentives or not, incentives impact motivation and retention.

It is clear that CHWs should be compensated for their work. Furthermore, salaries or stipends and career perspectives are strong incentives for sustained performance. There is no evidence that volunteerism is sustainable for long. It has also been found that volunteer CHW attrition is high and

²⁶ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 5

²⁷ *Community Approaches to Child Health in Malawi, Applying the C-IMCI Framework*. CORE Group, April 2009., page 7

often linked to exploitation of poor communities, especially women. The use of part-time volunteer CHWs who receive income from other sources may also lead to high turnover, and the demand for their services can often outstrip their availability. While communities ought to be involved in selecting and supporting CHW services, it is ill-advised to finance CHWs directly through the communities they serve. This approach is rarely successful and the prevailing evidence reflects failure of related community financing schemes. Additionally, the attrition rate of CHWs can be twice as high for community-paid CHWs as compared to those paid through government).²⁸

The literature often advocates for a mixture of monetary compensation and non-monetary compensation to incentivize volunteers to stay with the program.

*All child survival programs face the reality that volunteers expect per diems and other rewards. But to give monetary rewards subtracts from program funds available for essential programming, and robs volunteers of the inner motivation vital for sustainable change. So, programs that use volunteers must set workload expectations that do not interfere with making a living, while finding ways to cultivate sustainable intrinsic rewards that foster community identity and recognition, rewards that do not end abruptly with the conclusion of external funding cycles.*²⁹

*OVC projects should consider the incentives valued by volunteers as a means to improve OVC services. Bicycles can improve travel, training expands the volunteer's skills set, and cows are valued by the highest performing volunteers.*³⁰

*...the success of volunteers visiting MVC households can be greatly enhanced through small incentives. Considering that even volunteers are not well off, we recommend providing them with some incentives that may be beneficial to their well-being, such as transportation and a supportive working environment. These steps will motivate them to do more for others in the community.*³¹

Keeping in mind the dearth of health workers and the rising need of CHWs to meet the health care demands, it is imperative to prevent dropouts from training programs. Much of the literature tends to imply that volunteers are the ideal to which most CHW schemes aspire, and assumes that there is a sufficient pool of willingness to conduct voluntary social service in rural areas and informal settlements. However, the reality is different, probably in acknowledgement of the fact that as a rule CHWs are poor people, living in poor communities, who require income. Evidence shows that most programs pay their CHWs either a salary or an honorarium and almost no examples exist of sustained community financing of CHWs. Even NGOs tend to find ways of financially rewarding their CHWs. Moreover, control on attrition can be achieved with regular and performance based financial

²⁸ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 6

²⁹ *Community Approaches to Child Health in Malawi, Applying the C-IMCI Framework*. CORE Group, April 2009., page 24

³⁰ *Caring for Caregivers: Understanding Rwandan OVC Volunteers in a Faith-Based Setting*, Catholic Relief Services, 2009, pages 1-2

³¹ Florence Nyangara, Elizabeth Lema, *Slowly but Surely: Evaluations of Three Programs Supporting Most Vulnerable Children in Tanzania Show Some Benefits*. November, 2009, page 11

incentives and hiring CHWs as full time employees rather than part time volunteers. They should also be given a wage if they work as full time, and those working as part time should be given small incentives for their work. We would make a strong recommendation for ensuring the CHWs be paid adequate wages commensurate with their work load and timings. Performance incentives could be the other pay back option, which can also motivate them to work with full determination. Moreover, relatively small things, such as an identification badge, can provide a sense of pride in their work and increased status in their communities. In cases where possible, free health coverage for themselves and for their family should be provided. In the end, we would recommend that CHWs should be given multiple incentives over time to keep them motivated. We have also proposed some basic MDGS specific performance based incentives for CHWs.³²

In most of the programs reviewed in this paper, incentives were implemented ad hoc rather than as part of a systematic program. While multiple incentives are used in successful programs, new incentives are often proposed in reaction to a crisis of low morale rather than a part of an overall program effort to maintain high morale. Programs should consider a systematic effort to plan for multiple incentives over time to build CHWs' continuing sense of satisfaction and fulfillment. Programs might find it useful to identify the functions of each of the incentives using Pareek's model or some other model to understand the critical functions and how those might vary based on the CHW role and type of community. Intrinsic incentives work to promote a sense that the work is worthwhile, while extrinsic incentives include salary, increased status in the community, and the support of colleagues. Both intrinsic and extrinsic incentives clearly should be implemented and monitored. An incentives plan could address the multiple motives of achievement, affiliation, extension, influence, control, and dependency, as presented by Pareek. Alternatively, the plan could combine incentives targeted at different parts of the systems—monetary or nonmonetary factors that affect the individual CHW, community factors that encourage and support CHWs, and health system factors that support CHWs. Ideally, an incentive plan would include a combination of both approaches.³³

The VCS revealed a large percentage of volunteers, 63.5%, did not carry out the number and frequency of OVC household visits required by the project. This is likely due to long distances to travel to the children, caring for children in their household, volunteer workload, volunteers being unable to meet the children's material needs, lack of trust for volunteers by community members and OVC guardians among others. Despite these challenges, volunteers continued to work for the project and clearly express a very positive attitude towards being a volunteer and the desire to be able to increase their contact with children³⁴.

³² Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011 , page 34

³³ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 36

³⁴ Determinants of Motivation and Commitment of Volunteer Caregivers: A Survey of Project Volunteers in the Diocese of Kumbo, North West Province of Cameroon, Catholic Relief Services, page 6

...volunteers were typically assigned up to 10 households and at the time of survey had not received any compensation for their work: whereas [other volunteers] may have had as many as 15 households but while receiving incentives, such as transport reimbursements³⁵.

Non-monetary incentives often included volunteers having: their views listened to, the tools they need to do their work, award ceremonies for public recognition, access to income-generating funds, name badges to identify their role in the community.

Non-Monetary Recognition:

<p>Relationships</p> <p><i>Building strong relationships in the care group and with households is the foundation for effective community outreach. Promoters reflect core project values in the way that they interact with the care group and the individual volunteers. Volunteers internalize this as they build relationships with each other. Care group volunteers truly do care for one another, relying on the group for help and encouragement as they teach their community. (page 55)</i></p> <p><i>The volunteers enjoy the simple fun and friendship of care group meetings. They support each other in learning, making home visits and modeling positive behaviors for their neighbors and communities (page 61)</i></p>	<p>Group Goals</p> <p><i>The care group volunteers set shared goals and support one another in achieving those goals. By reaching goals and celebrating achievements, volunteers feel a renewed sense of purpose that strengthens the group identity. (page 61)</i></p> <p><i>The success of the care group depends on the strength of the group identity. Setting goals for the group to achieve together is an important tool for building the solidarity of the group. (page 61)</i></p>	<p>Community Recognition and Empowerment</p> <p><i>Community recognition and empowerment: Praise from the community raises volunteers self-esteem and helps convince them that their work is important. Being catalysts for community-wide action makes them feel connected to a movement larger than themselves. (page 61)</i></p>
<p>Elevated status</p> <p><i>Many care group volunteers benefit from an elevated social status in their village, as the community grows to appreciate the importance of preventative health and the impact of care groups. (page 62)</i></p>	<p>Exposure to outside world</p> <p><i>Care group volunteers come into contact with people from beyond their community, such as technical advisors, donors and evaluators, and these interactions help motivate volunteers. Visitors often praise volunteers at public events. Volunteers feel affirmed and important when outside visitors ask the care groups questions and discuss how they are changing their community. (page 63)</i></p>	<p>Gifts</p> <p><i>Giving a small gift on an annual basis is common with volunteer models. Though the care group model does not depend on gifts, a tangible “thank-you” is still important in making volunteers feel appreciated....Give presents that either assist volunteers’ role in doing their job or reinforce their identity as care group members. (page 63)</i></p>

36

³⁵ Florence Nyangara, Elizabeth Lema, *Slowly but Surely: Evaluations of Three Programs Supporting Most Vulnerable Children in Tanzania Show Some Benefits*. November, 2009, page 5

²³ Megan Laughlin. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. World Relief, 2004; p. 55-63

MOTIVATION

Clarifying volunteer motivation is a complex endeavor as volunteering is both a leisure pursuit and has elements of a work pursuit. These dual aspects of volunteering have an impact on motivation.

However, organisations also need to be clear about which element of volunteering they are emphasising. This is because as Pearce (1993) contends, volunteer work within formal organisations is inherently contradictory as it is both work and leisure. There is a work element in providing a service to others and a leisure element in choosing to be involved in an activity which is personally satisfying. Whichever emphasis is chosen has advantages and disadvantages.... Emphasising that volunteering is a form of work focuses the volunteers' attention on job performance and the achievement of organisational goals, but has the disadvantage in that organisations may be unable to 'reward' their volunteers... If the organisation emphasises the leisure element and presents the volunteer job as being just another kind of leisure pursuit, this may lead to a perception that it is an activity to be undertaken as and when the mood takes you. Such a perspective may lead organisations to identify jobs which have little responsibility attached to them, because of the likelihood that volunteers will be unreliable. This perspective may become a self-fulfilling prophecy in that volunteer jobs, which make little demands on volunteers, often yield few rewards and volunteers leave to seek more fulfilling activities (Pearce, 1993).³⁷

The literature states that most volunteers are not simply motivated by their desire to help others. They are looking for satisfaction through environmental (hygiene) factors or motivating factors.

One might presume that the majority of people who volunteer do so for altruistic reasons. However, researchers contend that "pure altruism" does not exist (Gidron, 1983; Meneghetti, 1995; Smith, 1981). The satisfaction and rewards acquired by volunteers are not unintentional by-products but accomplishments that are expected from the beginning....According to motivation theories, volunteers leave an agency because expectations that brought them to the agency remain unmet or because structures, processes, and relationships associated with the volunteer experience are insufficient.....Herzberg (1972) hypothesized that job satisfaction was affected by "hygiene factors" and "motivators." Hygiene factors relate to the work environment and include policies, workspace, work conditions, status, security, and compensation. Motivators are those attributes that cause workers to perform above and beyond the minimum requirements of the job. They involve such qualities as opportunity for advancement, a feeling of responsibility, the challenge of the job itself, recognition, and achievement.³⁸

³⁷ Joy Merrell. *Ambiguity: Exploring the complexity of roles and boundaries when working with volunteers in well woman clinics*. School of Health Science, University of Wales Swansea, South Wales, 2000., pages 99-100

³⁸ Irma Browne Jamison. *Turnover and Retention among Volunteers in Human Service Agencies*. SAGE, June 2003, pages 115-116

The literature highlights the following satisfaction factors for volunteers:

Hygiene/Environmental	Motivators
<ul style="list-style-type: none"> • Status in community • Sufficient time off to perform livelihood and household functions 	<ul style="list-style-type: none"> • To help others • Develop skills • Receive training • Acknowledgement given by others • Stepping stone to a paid job • Exposure to outside world • Report backs on the success of efforts • Be involved in program design, implementation, and decisions about monitoring and evaluation • Career path with increasing responsibilities • Sense of trust and belonging

In correlating performance with number of years as a volunteer, performance was highest among those who had been working from two to four years. Those who had been volunteering less than two years, or more than four years, had lower performance rankings. While this is a trend to be noted, the results were not statistically significant³⁹

Statistically significant factors directly related to high volunteer motivation and commitment were: previous experience caring for orphans, the positive quality of the volunteer’s childhood, higher volunteer education level and regular supervision with feedback. Unlike others, this study found volunteers with lower economic status, who worked in the informal sector, were more committed than those who earned more and worked in the formal sector. The greatest barrier to high motivation and commitment was distance between the volunteer home and that of the OVC. In most areas there were no significant gender differences in volunteer performance except the unexpected finding that men tended to make more household visits than did the female volunteers.⁴⁰

Why do people volunteer? Many volunteers of Catholic AIDS Action in Namibia were asked why they volunteer. Their answers included, “My neighbor needs me;” “This is what I believe God (or Jesus) wants me to do;” and “I may need the same help some day in the future.” Other organizations have found that people volunteer because they develop skills and receive training; they appreciate the acknowledgement given to them by others; and they like the status their knowledge and volunteer role gives them in the community. Others see volunteering as a stepping-stone to a paid job. This is fine if it is acknowledged up-front, and if the volunteer fulfills whatever commitment she or he has made to provide a specific level of service for a specified length of time after receiving training or another type of support.⁴¹

³⁹ *Caring for Caregivers: Understanding Rwandan OVC Volunteers in a Faith-Based Setting*, Catholic Relief Services, 2009, page 5

⁴⁰ *Determinants of Motivation and Commitment of Volunteer Caregivers: A Survey of Project Volunteers in the Diocese of Kumbo, North West Province of Cameroon*, Catholic Relief Services, page 6

⁴¹ *The Way We Care: A Guide for Manager of Programs Serving Vulnerable Children and Youth: Section IV Sustainability*. Family Health International. 2009, page 110

CHW programs should also provide opportunities for career mobility and professional development. These should include opportunities for continuing education, professional Global Evidence of Community Health Workers recognition, and career advancement. This can be through specific programmatic opportunities or access to educational and training scholarships.⁴²

Ideally speaking, it is said that service to the community as the primary motivation factor for volunteering. However, it is reported that training stipend, earning an income through selling medicines and possibility of future employment opportunities are the motivational factors for many CHWs. But, evidence has shown that monetary incentives often bring host of problems: money may not be enough, may not be paid regularly or may stop altogether (e.g. Nepal and India). Hence, non-monetary incentives are critical to the success of any CHW programs. Additionally, the role of CHW that required them to deliver curative services rather than just promoting utilization of available health services seems to greatly increase their motivation level.⁴³

Involve them in program design, implementation, and decisions about monitoring and evaluation. Report back to them on the successes of their combine efforts—for example, how many more people are being reached with their help. Provide training and public recognition. Offer a career path that has increasing responsibilities. For example, peer educators can be offered opportunities to become group leaders of peer educators, then coordinators of peer-education activities. Don't overwork them, and give them sufficient time off to perform livelihood and household functions.⁴⁴

RETENTION/ATTRITION

The literature does not provide an optimum retention or attrition rate for volunteers or CHWs. However, it does provide factors that have an impact on retention/attrition. These factors are parallel to the motivation factors.

- Possibility to transfer volunteers to paid positions/supervisor positions
- Not being overloaded with volunteer work
- Participating in social gatherings
- Volunteer recognition/appreciation events
- Regular information/education sessions
- Having a physical space for volunteers to use
- Knowing the impact of the volunteer's activities
- Being screened and appropriately matched to the volunteer job
- Having an effective orientation
- Quality of interpersonal relationships
- Being recruited by another volunteer

⁴²Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems. World Health Organization. page 9.

⁴³ *What Works for Children in South Asia Community Health Workers*. United Nations Children's Fund (UNICEF), Regional Office for South Asia, 2004, page 32

⁴⁴ *The Way We Care: A Guide for Manager of Programs Serving Vulnerable Children and Youth: Section IV Sustainability*. Family Health International. 2009, page 111

³² WellShare International presentation "Strategies for Retaining Community Volunteers: Clarifying Roles and Responsibilities for Enhanced Organizational Performance" Presented at NUPITA End of Project Conference, January 11-13, 2012 Kampala Uganda, slide 5

- Good communication between staff and volunteers
- Close friends or relatives staying at the volunteer organization can make someone stay
- Bicycles, tool kit, job aides and M&E tools, promotion of volunteer work, elevated status in the community⁴⁵

When volunteers leave, their departure affects continuity, client welfare, and agency morale (Eberhardt & Szigeti, 1990; Fischer & Schaffer, 1993). In addition, the high rate of volunteer turnover contributes to why paid staff members consider volunteers as transients who are subject to high levels of absenteeism (Brudney, 1993)⁴⁶

Professional advancement is another way out for controlling attrition among CHWs and ensuring continued interest and enthusiasm..... Career enhancement opportunities should be offered on completion of minimum education level and experience required to reach the next level and may be used as an incentive for career development.⁴⁷

Likewise, the volunteers should have a clear understanding of the roles and responsibilities of the other members of the team (e.g., social workers, therapists) and how their role fits with the roles of others. Ideally, volunteers and staff should train together to facilitate team building. At the very least, volunteers should be involved in team meetings when their patients/families are being discussed. More recognition of the volunteer role would help to reduce the problems of role and status ambiguity (i.e., they are not "just volunteers"); educating the other members of the team about what the volunteers actually do, the extent of the training they receive, and the value of having them, is key. Many volunteers also bring years of life and work experience (e.g., nursing experience) to the program.⁴⁸

Hospice palliative care volunteer programs have devised a number of different activities to retain their volunteers. These include planned social gatherings ...and volunteer recognition/appreciation events (e.g., pins for hours or years of service, gifts for volunteers) so that volunteers feel valued...Other activities that foster high-retention rates include holding regular (e.g., monthly) education/information sessions for volunteers, closure conferences following the death of a patient (i.e., acknowledging grief and sharing losses can help prevent burnout), having a physical space (e.g., a volunteer office) for the volunteers to use, and good communication between staff and volunteers..⁴⁹

⁴⁵ WellShare International presentation "Strategies for Retaining Community Volunteers: Clarifying Roles and Responsibilities for Enhanced Organizational Performance" Presented at NUPITA End of Project Conference, January 11-13, 2012 Kampala Uganda, slide 5

⁴⁶ Irma Browne Jamison. *Turnover and Retention among Volunteers in Human Service Agencies*. SAGE, June 2003., pages 115

⁴⁷ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization. page 35.

⁴⁸ Keeping hospice palliative care volunteers on board: Dealing with issues of volunteer attrition, stress, and retention. Claxton-Oldfield S, Claxton-Oldfield J. *Indian J Palliat Care* 2008;14:30-37, page 5-6

⁴⁹ Keeping hospice palliative care volunteers on board: Dealing with issues of volunteer attrition, stress, and retention. Claxton-Oldfield S, Claxton-Oldfield J. *Indian J Palliat Care* 2008;14:30-37, page 7

*Charities that use volunteers to recruit other volunteers have higher retention rates. Having volunteers represent the charity implies trust, evidence of a positive organizational culture, and confidence that the charity provides a worthwhile experience for volunteers*⁵⁰

*Valuing the time of volunteers led to improved retention because volunteers felt worthy in the community*⁵¹

*Turnover of peer volunteers, especially close friends and people who started volunteering in the same period, can lead to reduced commitment and to additional turnover (Blake & Jefferson, 1992; Cyr & Doerick, 1991). Volunteers who see their close friends leave think it might be time for them to stop volunteering as well, thus a domino effect may occur.*⁵²

LOCAL GOVERNMENT OWNERSHIP

*Without strong leadership and political support, CHW programs are vulnerable when taken to scale at the national level. Political support is multidimensional in nature, with resource availability often the most critical dimension.*⁵³

*Additionally, the literature is unanimous in its assertion that CHW programs be owned and driven by the community, and that CHWs be accountable to the communities they serve.*⁵⁴

*Community preparedness and engagement is a vital element that is relatively rarely practiced. From the outset, program should develop village health committees in the community that can also contribute in participatory selection processes of CHWs.*⁵⁵

Aspects that increase local government ownership are:

- Recruiting locally
- Building on existing systems in country (connect to broader systems)
- Utilizing Village Health Committees
- Joint Care Groups and VHC meetings
- Having the CHW programs owned and driven by the community; CHWs accountable to the communities they serve
- Sensitizing and training of health professionals to redress perceptions of CHWs as low-level

⁵⁰ Volunteer Management Practices and Retention of Volunteers. Mark A. Hager, Jeffrey L. Brudney. June 2004., page 11

⁵¹ WellShare International presentation “Strategies for Retaining Community Volunteers: Clarifying Roles and Responsibilities for Enhanced Organizational Performance” Presented at NUPITA End of Project Conference, January 11-13, 2012 Kampala Uganda, slide 7

⁵² The volunteer stages and transitions model: Organizational socialization of volunteers. SAGE, page 93

⁵³ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 4

⁵⁴ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 5

⁵⁵ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization. page 8.

(communities need help in supporting the VHCs)

- Engaging village headmen
- Using volunteers as key ways to get needed data from community
- aides, to avoid typical misunderstandings regarding their health promoting and enabling role within the community
- Sharing decision-making among the program's governing body, staff, and community health workers

*Good community-based programming builds on the existing systems in a country. Communities exist in the context of their national health system and civil structures. Good community-based programming should reflect that, connecting what is happening at the household and community level to the broader system for sustained improvements in health service utilization, prevention and appropriate home management of illness. Health information should flow in both directions, from the community to the health facilities and vice versa. While bolstering community programming with existing health and civil structures has potential to improve sustainability, in part from the mutual accountability created, it also establishes a template for scaling up that is likely to have relevance elsewhere in the country.*⁵⁶

Village Health Committees

The majority of the literature referred to village health committees (or analogous structures) as pivotal to the success of community health workers. In general, the village health committees are a community governance forum to link, discuss, and determine financing needs for multiple well-being initiatives in the community (health, sanitization, small business development). The VHCs are also responsible for selecting and supporting the community health worker.

*Effective community mobilization precedes and accompanies the establishment of successful CHW programs. Active involvement of communities in the selection of CHWs and the management of the program ensures stability as well as the accountability of CHWs to the community. A precondition for program sustainability is that communities formalize and effectively structure their involvement—for example, by establishing a village health committee. However, it may be that the community lacks the skills to do this, or that the structures adopted are undermined by distortions such as nepotism or discrimination (Lehman n.d.). Positive feedback and reward from the community can enhance CHW motivation and performance, as well as sustain trust and confidence. However, setting unrealistic expectations of what the CHW can do, in particular regarding the range of health services provided to the community, may often lead to program failure*⁵⁷

Care groups function best when they are linked to groups in the community that publicly support and take part in their work. To this end, project staff and care groups facilitate the establishment of village health committees. VHCs help ensure that care groups do not stand alone as the creation of a project; instead, VHCs integrate care groups into ongoing community life. (page 81)

Fostering relationships between care groups and VHCs encourages community leaders to publicly support volunteers, reinforce health messages and join them in taking action to improve health within

⁵⁶ Community Approaches to Child Health in Malawi, Applying the C-IMCI Framework. CORE Group, April 2009., page 21

⁵⁷ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011 , page 6

their community. This prepares VHCs to take on the responsibility of supervising care groups' on-going work once the project itself ends. VHCs' support also helps sustain care groups. (page 81)

The care group model empowers a group of trained volunteers to be a powerful community resource and problem-solving team — a team that can keep on working even after the project ends and promoters provide no more direct support. The care group is the main source of incentives and support, rather than project staff. (page 95)

Care groups make group action and problem-solving possible after the end of a project — this would be more difficult for an individual volunteer. (page 96)⁵⁸

As the VHCs matured, they each elected a leader known as the chef-de-saude (Chief of Health), and the VHC role has broadened to include community governance, determining financing mechanisms for community needs, regulation of latrines and sanitation systems, and conflict resolution. Vurhonga staff trained VHC members, who often organized training meetings for both VHCs and Care Groups together. These joint training sessions helped build mutual trust and respect between VHCs and the Care Groups, paving the way for the VHCs to rely on volunteers for regular training updates and to provide supportive supervision for the Care Groups as Vurhonga staff weaned their involvement and prepared for phase-out. (page 10)

After outside funding ends, for example, Care Groups can be supported by communities in various ways. In Rwanda, Care Groups were sustained by the MOH, who hired some of the World Relief staff into the MOH and through volunteer associations. In Malawi, Care Groups have continued with support from village headmen, village health committees, and HSAs in certain geographic areas. Even when Care Groups ceased meeting formally, the volunteers remained a resource to families in their communities. Based on documented outcomes of C-IMCI projects worldwide, MOH officials should be able to make a strong case for funding the initiation of effective C-IMCI projects to bilateral and multilateral donors, private donors and NGOs. MOH directors should then carefully examine which districts would make good candidates for pilot C-IMCI programs, select their NGO partners carefully, and choose local MOH officers who are interested in C-IMCI programs.⁵⁹

⁵⁸ Megan Laughlin. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. World Relief, 2004, p. 81-96

⁵⁹ *Community Approaches to Child Health in Malawi, Applying the C-IMCI Framework*. CORE Group, April 2009, pages 25-26.

SUPERVISION

Uniformly, the literature suggests that supervisory oversight of volunteers is critical to their success. Likewise, in some CHW programs, effectively supervised volunteers had attrition rates two to three times lower than CHWs who were unsupervised.⁶⁰

Supportive and impactful supervision in a volunteer program is comprised of the following promising practices:

- Feedback
- Defined responsibilities and requirements
- Supervisors visit volunteers in field once a week (accompany to locations)
- Self-selection of supervisor by volunteers
- Exit interviews when volunteers leave
- Participatory manner that ensures a two-way flow of information
- Supervision by the community – ideally, supervisors should be members of the community
- Supervisors should be selected according to set criteria, and should be trained and equipped with supervisory skills.
- The most important element of supervision is ensuring the two-way flow of information

Like paid staff, volunteers need to know what is expected of them and what they can expect in return. Some may want to know what training and incentives are in store, or if volunteering will put them in a good position for a paid job in the future. When you answer these questions, do not make promises you may not be able to keep. Many organizations have found it is best to put this kind of information in written contract that is signed by the volunteer and by a representative of your organization. To retain volunteers, you should be careful not to overload them. Try to maintain a reasonable workload of carefully defined duties that take just a few hours a week. Your contract with the volunteer should be reviewed in light of the actual work being performed, perhaps quarterly at first and then once a year. Like other staff members, volunteers need support and encouragement, including feedback, acknowledgement, and a sense of trust and belonging.

Promoters, usually recruited locally, comprise the foundational level of paid program staff. They daily span the boundary between the project and the community, working directly and closely with Care Group volunteers and community members and leaders in the field. Each supervisor supports and manages about five promoters. The supervisors visit their assigned promoters in the field every week, going with them to visit their Care Groups, households, health centers, village health committees, village headmen and other community members. The supervisors ensure quality, provide support to promoters and volunteers and, represent the program to local staff of the MOH and other government officers

⁶⁰ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 19

*within their supervision area. The total number of staff, therefore, varies with the coverage of the project, but the ideal ratio of staff to volunteers is fairly constant.*⁶¹

Other studies echo these views on effective means for supporting and retaining volunteers. Grossman and Furano identify three elements as crucial to the success of any volunteer program: screening potential volunteers to ensure appropriate entry and placement in the organization; orientation and training to provide volunteers with the skills and outlook needed; and management and ongoing support of volunteers by paid staff to ensure that volunteer time is not wasted.⁴ They conclude, “No matter how well intentioned volunteers are, unless there is an infrastructure in place to support and direct their efforts, they will remain ineffective at best or, worse, become disenchanted and withdraw, potentially damaging recipients of services in the process.”⁶²

Continuous support supervision of the volunteers helps the work remain important to the volunteers and boosts their self-esteem and willingness to continue volunteering.⁶³

The programs should have regular and continuous supervision and monitoring systems in place and supervision should be taught to be undertaken in a participatory manner that ensure two-way flow of information...⁶⁴

As the original project is being expanded to other parts of the country, one key lesson learned from this study is that the expanded project should not only focus on retaining volunteers, but should institute measures to ensure a high quality of services volunteers have to render. This should include, among other things, an objective supervision, monitoring, and evaluation of the performance of volunteers. Volunteers should be encouraged to suggest what they can do to improve the lives of orphans rather than imposing ‘standard’ strategies which may not be feasible or applicable. As the project expands to new geographical areas, the study highlights the need to not only focus on volunteers, but to incorporate objective supervision and monitoring and evaluation.⁶⁵

Inadequate supervision offers commensurate challenges to volunteer retention:

The following hallmarks of inadequate supervision pose challenges to keeping volunteers engaged and effective in the field:

- Heavy responsibilities/work load in other areas (especially if the supervisor is job sharing)
- Inappropriate training in the field
- Inaccessibility to villages and CHW

⁶¹ Community Approaches to Child Health in Malawi, Applying the C-IMCI Framework. CORE Group, April 2009., page 7-8

⁶² Mark A. Hager, Jeffrey L. Brudney. *Volunteer Management Practices and Retention of Volunteers*. The Urban Institute, June 2004, page 3

⁶³ WellShare International presentation “Strategies for Retaining Community Volunteers: Clarifying Roles and Responsibilities for Enhanced Organizational Performance” Presented at NUPITA End of Project Conference, January 11-13, 2012 Kampala Uganda, slide 7

⁶⁴ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization. page 9.

⁶⁵ Determinants of Motivation and Commitment of Volunteer Caregivers: A Survey of Project Volunteers in the Diocese of Kumbo, North West Province of Cameroon, Catholic Relief Services, page 7

- Uncoordinated supervision visits
- Lack of transport
- Lack of per diem
- General shortage of staff to fill these roles

It is equally acknowledged, however, that supervision is often among the weakest links in CHW programs. Among studies we reviewed, we found that small-scale projects were often successful because they manage to establish effective support and supervisory mechanisms for CHWs, often including a significant amount of supervision and oversight by the community itself. National programs, on the other hand, are rarely able to achieve this consistently..... In few CHW programs, we found that supervisors were formal health staff from the health services, who, however, may not understand the CHWs or their own role properly and furthermore may resent the additional task. The CHW programs without supervision system have shown gaps in program functionality in terms of inadequate documentation and linkages with overall health system... We would therefore recommend that supervisors should be the members of community, who again should be selected according to the set criteria. They should be trained and equipped with supervisory skills. Clear strategies and procedures for supervision and the activities with which supervisors will be charged should be well defined. The skills need to be taught so that health personnel, CHWs and community health committee members know what is expected of them as supervisors. Supervisors should be supportive and available to offer help where needed instead of merely policing whether CHWs are on duty or are carrying out the required quantities of work. Supervision should be taught to be undertaken in a participatory manner. Top-down mechanistic supervision emphasizes the social distance between supervisor and supervisee and leads to communication breakdowns and ultimately to program damage. The guidelines for supervision should include a list of supervisory activities. The most important element of supervision is ensuring the two-way flow of information. It is also vital that the supervisor acts as a role model so that their behavior can be copied. It is also recognized that experienced and competent CHWs may be allowed further training and opportunities for skills development to rise to a level of supervisors. In an ideal and realistic situation, one supervisor should head 20 to 25 CHWs which allows strong supervisory system as evident from lady health worker program (Pakistan) and BRAC (Bangladesh)...⁶⁶

Weak, inadequate, and inconsistent supervision is cited frequently as a cause of low rates of CHW retention (Frankel, 1992; Ofosu-Amaah 1983; Heggenhougen et al. 1987; Walt et al. 1989; Curtale et al 1995; Ojofeitimi 1987; Schaefer 1985)⁶⁷

⁶⁶ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization, page, 32

⁶⁷ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 20

TRAINING

Training is essential to CHWs being able to perform their job. The literature posits that training is viewed by volunteers as a stepping stone to future employment. Consistently, this growth and development is seen as a key incentive for CHWs.⁶⁸

The literature identifies the following to be effective in training:

- Offering training regularly and continuously, including refresher training
- Using adult participator learning methodologies and problem-solving approaches
- Curricula, tools and methods to address each specific task
- Hands-on management of real cases
- Mentoring and coaching
- Pairing with others with more experience
- Looking at the diversity of intervention they deliver in community, they should be classroom trained for at least 6 months with an additional 6 months of hands-on-training which gives practical flavor to their theoretical lessons
- Training venue that mirrors the setting of the volunteers residence (urban or rural)

Match a weak volunteer with a strong volunteer in order for the less-skilled volunteer to improve her teaching⁶⁹.

Minimizing distress may be the most important factor in increasing their satisfaction. Because satisfaction is related to involvement with the organization, minimizing distress can have advantages for both the volunteer and the organization itself..... Instead, attention might better be given to training methods that would prepare volunteers for distressing situations or provide them with strategies for coping with the distress they do experience. It might even be that some kinds of work are not appropriate for newer volunteers.⁷⁰

Looking at the diversity of interventions they deliver in community, they should be classroom trained for at least 6 months with an additional 6 months of hands-on-training which gives practical flavour to their theoretical lessons.⁷¹

⁶⁸ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001,, page 21

⁶⁹ Megan Laughlin. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. World Relief, 2004, p. 51

⁷⁰ Mark H. Davis, Jennifer A. Hall and Marnee Meyer. *The First Year: Influences on the Satisfaction, Involvement, and Persistence of New Community Volunteers*. SAGE, February 2003, page 259

⁷¹ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization .page 29.

Continuous training has been cited as ‘an essential prerequisite for an effective CHW program’ (Frankel 1992) and an important factor in retaining the motivation of workers.⁷²

For CHW programs to effectively perform, it is vital to lay due emphasis on training and supervision. Prior experiences have documented that low interest/use by the government, inconsistent remuneration, inadequate staff and supplies and lack of community involvement are key factors to negatively impact the CHW program.²⁷ These factors can be alleviated by certified training and supportive supervision, along with other incentives (financial and non-financial) to keep CHWs satisfied and motivated to perform their duties well. Furthermore, efforts geared to standardize training and certification for CHW programs, could further provide a career pathway and enable them to effectively contribute to their communities. A recent study by Kash et al.²⁷ have concluded that certified CHWs are potentially an important health task force towards improving access to health care and social services and improve utility of resources to the underserved.⁷³

The evaluations suggest that programs offering comprehensive volunteer training, ongoing support and supervision of volunteers, and following standardized curricula were more effective than those that did not....Therefore, a review process is urgently needed to ensure that volunteers’ training curricula are standardized, comprehensive, and coordinated across programs. This would help to ensure that volunteers are trained in a systematic manner and that they acquire a range of relevant skills that may ultimately enhance their effectiveness⁷⁴

Most observers of community-based contraceptive distribution programs agree that the quality and intensity of agents’ training is the most important single determinant of program quality and impact (Phillips 1999).⁷⁵

Training has challenging aspects to be managed as well, including:

- Too much time devoted to training leaves communities without volunteer support
- Training methodologies that are too theoretical, too classroom based or too complicated are ineffective and can prove to be a disincentive, especially if the material is unfamiliar to the learner
- Lack of general and skills-based training is often cited as a barrier to effective CHW performance (Walt et al 1989; Gilson et al. 1989; Kaseje et al. 1987; Robinson and Larsen 1990).

⁷² Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 23

⁷³ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization , page 13.

⁷⁴ Florence Nyangara, Elizabeth Lema, *Slowly but Surely: Evaluations of Three Programs Supporting Most Vulnerable Children in Tanzania Show Some Benefits*. November, 2009, page 11

⁷⁵ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 22

VOLUNTEER SELECTION/SELECTION CRITERIA

The literature points out that the criteria for volunteer selection varies depending on local and national context; however, successful examples point to core criteria that work, including volunteers:⁷⁶

- Come from the community they serve (permanent resident)
- Are selected by community members - directly chosen by the households that they will work with, if possible
- Are recruited for training on the basis of standard and transparent criteria for selection
- Demonstrate involvement in and willing to work with the community
- Are interviewed to assess aptitude, competence and motivation
- Are married females, 20-35 years old often don't leave the community (because of young children)
- Are literate
- Are involved in local government and getting their buy-in is an important success factor

*A widely-shared preference is to select CHWs from the communities they serve. Additionally, the community should have a say in their selection. The community's involvement is important in elevating the status of CHWs, as low status in the community limits the range and quality of their impact.*⁷⁷

The demographic results were compiled in order to gain a better understanding of the profile of volunteers for the OVC project. The study showed that 55% of the volunteers were female, and 45% male. Gender was not a significant factor in performance ranking of the volunteers. However, men did have both the highest and the lowest performance scores. Volunteers had low levels of academic attainment: 78% completed primary school and 18% secondary school. Only 4% had completed post-secondary education (Figure 1). Marital status varies with 64% of volunteers married, 22% single and 13% divorced (Figure 2). Married volunteers were slightly more likely to have higher performance ratings (73%), than the overall performance rating (64%). However, this was not significant. Finally, the volunteer profile was overwhelmingly dominated by farmers (90%), with only 10% of volunteers involved in other trades such as tailoring (2%), masonry (2%), teacher (2%), parish secretary (2%), and other (2%)⁷⁸

Having female volunteers helps establish a basis of common concern — the health of children — for home visits. Another advantage of female volunteers is that husbands of beneficiaries are more likely to be suspicious or jealous of male volunteers making home visits. Vurhonga finds that very young women often lack confidence during home visits, and they are not respected by older community members. Early in its experience, Vurhonga also encountered several problems with volunteers who were addicted to

⁷⁶ *What Works for Children in South Asia Community Health Workers*. United Nations Children's Fund (UNICEF), Regional Office for South Asia, 2004, page 30

⁷⁷ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 5

⁷⁸ *Caring for Caregivers: Understanding Rwandan OVC Volunteers in a Faith-Based Setting*, Catholic Relief Services, 2009, pages 3-4

alcohol, which negatively affected their attendance at care group meetings and the regularity of their home visits.⁷⁹

The study revealed that gender, marital status, education level and occupation had no significant effect on performance.⁸⁰

Although it is difficult to generalize CHWs across different countries, the CHW profile on which this report is based holds that they are predominantly female, have completed eight to 10 years of schooling, and have received training from a range of two weeks to one year.⁸¹

All the studies and CHW programs, that we reviewed, emphasized that CHWs should be chosen from the communities they will serve and that communities should have a say in the selection of their CHWs. As far as the selection of the CHW is concerned, we would recommend that they should be directly chosen by the households that they will work with.⁸²

It is recommended that CHWs should be recruited for training on the basis of standard and transparent criteria for selection. An advertisement in the most accessible local newspaper or local radio channel should be possibly made for walk-in interviews of interested candidates. Since being a permanent resident of that locality is the most important criteria for selection, therefore, evidences confirming their residency must be strictly and stringently examined during their first assessment, followed by cross confirmation of their educational certificate and work experience (if any). The assessment may include a test for literacy and numeracy as well as interviews to assess aptitude, competence and motivation. Candidates should be thoroughly gauged for their interest for voluntary work (depending on local national program), and serving their own community even in situation of no monetary rewards. It is also recommended that some process for community buy-in and ownership of this screening and selection process be instituted, free from political interference, so that the most suitable candidates are identified and there is local accountability.⁸³

b. The literature also cautions against selection processes that are not representative or overtly political.

Although all countries have had standard criteria for selecting CHWs that included involvement of community members in the selection process, most often the volunteers were appointed by local elites, political leaders, and health workers and were related to these people. Given this situation and the fact that the ethnic minorities or marginalized and poorer groups in the community get excluded from the

⁷⁹ Megan Laughlin. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. World Relief, 2004 p. 41

⁸⁰ *Caring for Caregivers: Understanding Rwandan OVC Volunteers in a Faith-Based Setting*, Catholic Relief Services, 2009, page 1

⁸¹ Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 5

⁸² Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011, page 25

⁸³ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization, page 27.

selection process, equitable involvement of community members in selecting CHWs and using their services appears to be critical to success CHW programs.⁸⁴

However, keeping criteria of primary education and incorporating adult education comprising of basic arithmetic, reading and writing should be considered into the training curriculum of the CHWs to ensure proper documentation, referrals and records keeping of the supplies. Moreover, CHWs who are involved in case management should be strictly scrutinize for their education level. In an ideal situation for giving a fair chance, candidate with at least primary level education should be given a preference.⁸⁵

PEER SUPPORT AND NETWORKS

A key motivator identified in some CHW groups is interaction with other CHWs. Peer support is seen as a conduit for in-service training, mentoring, and bonding. Examples of successful support networks include:⁸⁶

- Pairing CHWs
- Creating CHW teams
- Group meetings
- CHW Associations/Committees

Representatives of these committees organize themselves into district associations. The committees meet monthly to discuss experiences and mutually reinforce commitment. They raise funds to cover their own activities, organize training events, and advocate for health with government and the MoH. This arrangement has resulted in dedicated, well trained and active CHWs who have strong ties to the MoH but are not dependent on it.).⁸⁷

⁸⁴ *What Works for Children in South Asia Community Health Workers*. United Nations Children’s Fund (UNICEF), Regional Office for South Asia, 2004, page 30

⁸⁵ *What Works for Children in South Asia Community Health Workers*. United Nations Children’s Fund (UNICEF), Regional Office for South Asia, 2004, page 25

⁸⁶ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 24

⁸⁷ Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001, page 24

IDENTIFIED KNOWLEDGE GAPS AND LIMITATIONS IDENTIFIED IN THE LITERATURE

Knowledge Gaps Requiring Further Study⁸⁸

- *There is a remarkable dearth of information on the cost-effectiveness of CHW programs.*
- *Studies are needed to assess whether the CHW programs promote equity and access.*
- *Studies are required to assess the effectiveness of paid workers versus voluntary workers.*
- *Studies are needed to evaluate quality of care and effectiveness of health care provided by CHWs as compared to professional health care providers in the fields of health education, promotion and management of specific health problems.*
- *Given the global burden, specific studies on the potential role of CHWs in HIV/AIDS prevention and care, as there is very limited empirical information on this.*
- *Further systematic reviews are also required on factors affecting the sustainability of CHW interventions when scaled up; the effectiveness of different approaches to ensure program sustainability; and the cost-effectiveness of CHW interventions for different health issues.*
- *Additional analysis is required on the volume of work and type of activities and hence the number of CHWs required for such tasks. An example of this type of analysis is provided by a study in Bangladesh which assessed how many additional health workers would be needed to implement IMCI protocols. However, further studies are needed to determine the CHW workforce needed and their functional needs for MDG specific interventions.*

Limitations

The review identified a number of limitations. Firstly, most of the reviewed studies when implemented, neglected to document the complete description and characteristics of CHWs deployed, especially the level and amount of supervision provided to those workers, which could have helped us in identifying the importance of this factor and its association with other outcomes. Additional information on the initial level of education of CHWs, provision of refresher training, mode of training (balance of practical/theoretical sessions) would have provided greater assistance in understanding the threshold effect, if any, of these factors on CHW performance in community settings. Importantly, community ownership and supervision of CHWs is a key characteristic which is insufficiently described and analyzed in available literature. Secondly, studies related to the role of CHWs in HIV/AIDS prevention and care, mental health and food security and nutrition were scarce. Lastly, there were few evaluation studies/reports at scale and none had followed an a-priori experimental design or impact assessment process.⁸⁹

⁸⁸ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization, page 9.

⁸⁹ Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization, page 38.

Appendix 3: Bibliography

- 1) *The Way We Care: A Guide for Manager of Programs Serving Vulnerable Children and Youth: Section IV Sustainability*. Family Health International, 2009.
- 2) *Community Approaches to Child Health in Malawi, Applying the C-IMCI Framework*. CORE Group, April 2009.
- 3) Megan Laughlin. *The Care Group Difference: A Guide to Mobilizing Community-Based Volunteer Health Educators*. World Relief, 2004; 14:30-37.
- 4) Kathryn Bradbury. *Community-Based Solutions for Effective Malaria Control: Lessons from Mozambique*. The CORE Group, March 2005.
- 5) Stephen Claxton-Oldfield and Jane Claxton-Oldfield. *Keeping hospice palliative care volunteers on board: Dealing with issues of volunteer attrition, stress, and retention*. Indian Journal of Palliative Care, 2008.
- 6) Fazila K. Shakir. *Community Health Worker Programs: A Review of Recent Literature*. USAID Health Care Improvement Project/URC, 2010.
- 7) Mark A. Hager, Jeffrey L. Brudney. *Volunteer Management Practices and Retention of Volunteers*. The Urban Institute, June 2004.
- 8) Alan Dingle. *Measuring Volunteering: A Practical Toolkit*. A joint project of Independent Sector and United Nations Volunteers, 2001.
- 9) Correll, Lucia and Correll, Tim. Trip Report: Tanzania. January – February, 2006.
- 10) Joy Merrell. *Ambiguity: Exploring the complexity of roles and boundaries when working with volunteers in well woman clinics*. School of Health Science, University of Wales Swansea, South Wales, 2000.
- 11) Mark H. Davis, Jennifer A. Hall and Marnee Meyer. *The First Year: Influences on the Satisfaction, Involvement, and Persistence of New Community Volunteers*. SAGE, February 2003.
- 12) Irma Browne Jamison. *Turnover and Retention among Volunteers in Human Service Agencies*. SAGE, June 2003.
- 13) Karabi Bhattacharyya. *Community Health Worker Incentives and Disincentives: How They Affect Motivation, Retention, and Sustainability*. Published by Basic Support for Institutionalizing Child Survival Project (BASIC II) for the United States Agency for International Development. Arlington, Virginia, October 2001

- 14) *What Works for Children in South Asia Community Health Workers*. United Nations Children's Fund (UNICEF), Regional Office for South Asia, 2004
- 15) Gijs Elzinga, Paul Marsden and James McCaffery. *Community Health Workers within a Supportive Health Team: Guiding Principles*. CapacityPlus, IntraHealth International. August, 2011
- 16) Zulfiqar A. Bhutta, Zohra S. Lassi, George Pariyo and Luis Huicho. *Global Experience of Community Health Workers for Delivery of Health Related Millennium Development Goals: A Systematic Review, Country Case Studies, and Recommendations for Integration into National Health Systems*. World Health Organization
- 17) WellShare International presentation *Strategies for Retaining Community Volunteers: Clarifying Roles and Responsibilities for Enhanced Organizational Performance* Presented at NUPITA End of Project Conference, January 11-13, 2012 Kampala Uganda
- 18) *Determinants of Motivation and Commitment of Volunteer Caregivers: A Survey of Project Volunteers in the Diocese of Kumbo, North West Province of Cameroon*, Catholic Relief Services
- 19) *Community-based Orphan Care, Protection and Empowerment (COPE) Project, Final Program Report*, Africare, March 2005-June 2010
- 20) Florence Nyangara, Elizabeth Lema, *Slowly but Surely: Evaluations of Three Programs Supporting Most Vulnerable Children in Tanzania Show Some Benefits*. November, 2009
- 21) *Caring for Caregivers: Understanding Rwandan OVC Volunteers in a Faith-Based Setting*, Catholic Relief Services, 2009
- 22) *MVC Dodoma Municipality and Chamwino Districts Baseline Survey Report*, the Capacity Project, 2010
- 23) *Baseline Survey-Iringa Region* (presentation), Intrahealth, June 26th-July 15th, 2011
- 24) *IntraHealth Data Quality Assessment Report*, MEASURE Evaluation/JL Consultancy, Ltd, February 2012
- 25) Norah Kaaya. *Tanzania Human Resource Capacity Project MVC Program Annual Dissemination Report*, October 2011

Appendix 4: Local Government SW Awareness and MVC/PSW Support

The following data is sourced from regional 2011 MVC /PSW M&E and Advocacy Follow-Up Visit report-presentations as well as a data reports pulled from IntraHealth's MVC M&E database

Dodoma Region	# of District SWO before PSW Program	# of District SWO now	% increase of SWO	LGA had budget for PSW before program (yes/no)	LGA has budget for PSW program now (yes/no)	LGA incentives for PSW Amount budgeted or any other incentives -- DETAILS	Community support for MVC and/or PSWs
Dodoma Municipality	1	6	500%				YES
Bahi	0	0	0%				YES
Kondoa	0	0	0%	NO	NO	No budget	NO
Mpwapwa	1	1	0%	NO	YES	Budgeted TZS 15,000,000 for PSW bicycles	NO
Kongwa	0	0	0%	NO	YES	TZS 1,668,000 for MVC advocacy meetings at ward level	YES
Chamwino	1	2	100%				NO
Total for Dodoma Region	3	9	200%				

Community Support for MVC and/or PSWs in Dodoma Region

1. Kongwa DC

- Mkoka ward has mobilized the community contribute for MVC support and they have Tshs 12,000/= , they have also opened an account for MVC funds. They are planning contribute more from January2012 whereby every household will be required to contribute 1000 per month
- Hogoro ward has contributed 120, 000/= for MVC support and they have set apart 4 acres of land for MVC support. They are planning to use the money for farming activities from January 2012

2.Dodoma MC

- 10 out of 21 (50%) wards visited have established community funds for supporting MVC
 - Four wards (Mlowa Bwawani, Fufu,Mvumi Makulu, Mvumi mission) in Chamwino)
 - Three wards (Msisi, Mtita, Mundemu) in Bahi
 - Three (Majengo, Hazina, Kikuyu,) in Dodoma Municipal
- Three wards(Fufu, Majengo and Mundemu) have utilized the funds to supporting MVC
- Four wards (Mlowa Bwawani, Mvumi Makulu, Mvumi Mission and Hazina) there are suspects the contributed funds were used by treasurer for their personal use.
- 3 wards (Kikuyu, Mtitaa and Msisi) the funds are available but not utilized.

Mwanza Region	# of District SWO before PSW Program	# of District SWO now	% increase of SWO	LGA had budget for PSW before program (yes/no)	LGA has budget for PSW program now (yes/no)	LGA incentives for PSW – amount budgeted or any other incentives	Community support for MVC and/or PSWs
Ukerewe	1	1	0%	NO	YES	Budgeted 4,000,000 for PSW meeting	NO
Magu	2	1	-50%	NO	NO	NO	YES
Sengerema	0	1	100%	NO	NO	No incentives	NO
Geita	2	11	450%	NO	YES	Budgeted for PSW bicycles (7,000,000)-2012/2013 and support PSW with stationeries and facilitate PSW to conduct meeting	YES
Misungwi	2	2	0%	NO	YES	Support PSW in photocopy of reporting forms	NO
Kwimba	0	1	100%	NO	YES	Budgeted for PSW bicycles TZS 17,000,000)-2012/2013	NO
Mwanza City	9	11	22%	NO	YES	Budgeted for PSW bicycles TZS 10,000,000)-2012/2013n	NO
Total	16	28	75%				NO

Community Support for MVC and/or PSWs in Mwanza Region

1. Geita

- Magenge village in Kaseme Ward- Has mobilized the community to contribute for MVC fund-345,500/=. They have also opened an account
- Mnekezi Village in Kaseme Ward mobilized the community-70000/=

2. Magu

- Mkula-There is a plan that each household will contribute 500/=
- Kiloleli-The idea of having community fund was introduced through public meeting though not yet started
- Ng'haya -There was a proposal for each household to contribute at least 500/= (during the visit WEO were encouraged to start)
- Nyanguge-Muda village has 140000/=,Matela has 100,000/=,Nyaguge Village the plan is each household to contribute 150,000 per year(1,700 homestead)

Iringa Region	# of District SWO before PSW Program	# of District SWO now	% increase of SWO	LGA has budget for MVC – Amount budgeted (2011/2012)	LGA had budget for PSW before program (yes/no)	LGA has budget for PSW program now (yes/no)	LGA incentives for PSW – Amount budgeted or any other incentives - DETAILS	Community support for MVC and/or PSWs
Iringa Rural	0	0	0%					No
Iringa Municipality	1	2	100%	2,000,000	NO	NO	No budget	Yes
Kilolo	1	3	200%	3,561,250	NO	YES	TZS 2,000,000 for stationeries	No
Ludewa	0	3	300%	10,000,000	NO	YES	4,000,000	yes
Makete	8	7	-12.5%					No
Mufindi	1	2	100%	20,000,000	NO	YES	TZS 4,000,000 for supervision and stationeries	No
Njombe DC	2	3	50%	24,465,000	NO	YES	TZS 500,000 for stationeries	No
Njombe TC	0	0	0%					No
Total for Iringa Region	13	20	54%					No

Community Support for MVC and/or PSWs in Iringa Region

1. Iringa DC

- Kandutuna village in Mgama ward, has 100,000/= for MVC support.
- Itunundu village in Itunundu ward every household contributes 1000/= every month and so far has 45,000/=
- Kiwele ward; Each community member contributes 2400/= per annum whereby Kitapilimwa village last year had 240,000/=
- Nduli ward has 595,000/= for MVC support in the following villages; Ilambilole, Kisinga, Malimbi, Kinyang'anja and Mkungugu
- Kihorogota ward has 706000/- for MVC support at ward and in the following vilages;Kihorogato, Uhominaji,Ismani,Ndolela, Mikengwi and Igula
- Isakalilo village in Kalenga ward every community member contributes 500/ per year for MVC support and has 100,000/= at bank
- Nzihi Village in Nzihi ward every community member contributes 500/ per year for MVC support and has 100,000/= at bank
- Ulanda ward every community member contributes 50/=kwa mwezi and has 175 for MVC support in the following villageslbongomoyo, Kibebe, and Lupalama

2. Iringa Municipal

- Kitanzini ward, every household is contributing TZS 200 per month to support MVC
- Mtwivila ward; MVCC are selling water through their water kiosk and are supporting MVC
- Mwangata ward has 900,000/= whereby 400,000/= got from UNICEF and the rest from IGA eg. Selling water
- Makorongoni ward-Pwagaroad and Muhimba streets every household contributes 500/- for MVC support
- Mlandege ward-very household contributes 200/- per month for MVC support.

3. Kilolo DC

- In Mtitu village (Through SILC group); members are contributing TZS 500 per week for supporting MVC. So far they have collected TZS 2.1 mil

4. Mufindi

- In Mdabulo ward, every household agreed to contribute TZS 500 per year to support MVC, although not all household are contributing
- In Isalavanu ward, community members are contributing food for MVC (during harvest season); last year community contributed two sacks of maize which was used to support 10 families of MVC
- In Ifwagi ward, each household is contributing TZS 1000 or 5kg of maize or 10 kg of maize per month to support MVC
- In Idunda ward, each village contributed TZS 30,000 for opening account for MVC support
- In Igowole village, Igowole ward, each household is contributing TZS 2000 per year to support MVC

5. Makete DC

- In Mang'oto wards, every household is contributing TZS 100 per month to support MVC
- In Ihela village, Tandala ward, every household is contributing TZS 100 per month to support MVC, TZS 80,000 has been collected
- In Isapulano village, Isapulano wards, community members are contributing TZS 100 per month to support MVC
- In Kitulo ward, each village has opened an account for supporting MVC

6. Ludewa DC

- In Ludewa Ward community based groups like VICOBA every member contributes Tshs 2000 per month for MVC support. RC also gives a lot of support to MVC in education and shelter.
- In Ludende and Nkongobaki wards the MP is supporting 85 MVC for secondary education .
- Mndindi ward has Tshs 200,000/= for MVC support. Funds were generated through contributions from the community members from Njelela and Mndindi villages. They have agreed that each community member to contribute at least 200/=Tshs per month in all villages
- Mavanga village in Mavanga ward has Tshs 345000/= for MVC support. They have agreed to contribute 500/=per household per year.

7. Njombe TC

- Mfeke village in Utalingolo Ward- Each household has agreed to contribute tshs, 500 on quarterly basis for MVC care and support
- Ihalula Village in Utalingulilo Ward has st apart 3 acres for MVC support and they have planted maize and timber tree. They also have a pig project.
- Idunda Vilage in Yakobi Ward have pig project and 23 sacks of ulezi for MVC support . In addition on quarterly basis they normally do fundraising at village level for MVC care and support
- Yakobi Ward has Tshs 545000/- cash at hand for MVC care and support.
- Ngalanga Village at Iwungilo Ward have opened an account and has cash 180,000/=
- Iwungilo village has 5 entrepreneurship groups which has been contributing for MVC care and support
- Kihesa village at Njombe mjini ward has mobilized community funds for MVC support Tshs 90,000/= and has opened an account whereby every month each household contribute Tshs 500/=

8. Njombe DC

- Lupembe ward has Tshs 249,000/= for MVC support. The funds were generated through contributions from the community members from all 6 villages. They have agreed that each community member to contribute something every month for MVC support.

Appendix 5: PSW Demographics by Region

The following data is sourced from data reports pulled from IntraHealth's MVC M&E database

Dodoma Region	% of Non-Supervisors below 30 years old (U=unknown)	Gender % (F-Female, M-Male)	% Married (U-Unknown, M-Married)	% Farmers (F-farmers, U-Unknown)	Attrition
Dodoma Municipality	76%	41% F 59% M	27% M 29% U	47% F 12% U	45%
Bahi	73%	38% F 62% M	33% M 38% U	52% F 24% U	35%
Kondoa	51% 2% U	31% F 69% M	46% M 16% U	38%F 17% U	25%
Mpwapwa	68%	38% F 62% M	33% M 0% U	85% F 2% U	20%
Kongwa	35%	36% F 64% M	38% M 10% U	65% F 1% U	50%
Chamwino	64%	32% F 68% M	36% M 32% U	34% F 39% U	28%
Average of known data for Dodoma Region	61%	36% F 64% M	36% M	53.5% F	34%

Mwanza Region	% of Non-Supervisors below 30 years old (U=unknown)	Gender % (F-Female, M-Male)	% Married-M (U-unknown)	% Farmers (F-farmers, U-Unknown)	Attrition
Ukerewe	67% 1% U	45% F 55% M	100% U	93% F 5% U	
Magu					17%
Sengerema					19%
Geita					24%
Misungwi	35%	24% F 76% M	65% M 9% U	68% F 9% U	10%
Kwimba	60% 3% U	21% F 79% M	46% M 38% U	86% F 5% U	10%
Mwanza City	62%	47% F 53% M	31% M 46% U	42% F 21% U	40%
Average of known data for Mwanza Region	56%	34% F 66% M	47% M	72% F	20%

Iringa Region	% of Non-Supervisors below 30 years old (U=unknown)	Gender % (F-Female, M-Male)	% Married (U-unknown)	% Farmers (F-farmers, U-Unknown)	Attrition
Iringa Rural	67% U=.06%	F=41% M=59%	M=37% U=0.6%	F=41%	23%
Iringa Municipality	72% U=1%	F=61% M=39%	M=22%	F=9%	36%
Kilolo	75% U=2%	F=44% M=56%	M=22%	F=52%	18.5%
Ludewa	56%	F=31% M=69%	M=39%	F=50%	13%
Makete	73% U=.0.9%	F=39% M=61%	M=38%	F=55%	0%
Mufindi	60% U=0.6%	F=50% M=50%	M=37%	F=56%	6%
Njombe DC	67% 0.5%	F=45% M=55%	M=38%	F=61%	8%
Njombe TC	79%	F=38% M=62%	M=33%	F=46%	10%
Average of known data for Iringa Region	69%	F=44% M=56%	33% M	F=46%	14%