VALUING VOLUNTEERING - **MOZAMBIQUE**

"WHERE IS THE BREAD?" COMMUNITY VOLUNTEER RESPONSES TO HEALTH ISSUES IN MOZAMBIQUE

2014

IDS Institute of Development Studies

VSO

VSO at a glance

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The Institute of Development Studies (IDS) is a leading global organisation for international development research, teaching and communications. The *Valuing Volunteering* project is being conducted in partnership with the IDS Participation, Power and Social Change Team.

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Profound thanks and admiration for those *activistas*, volunteers, organisational staff and church members who offered their time and their voice so that we can understand and recognise better the vast work done by community volunteers. It is hoped that this document might go some way to increasing your voice where you want it to be heard most.

Abbreviations

HBC	home-based care
MOH	Ministry of Health
NGO	non-governmental organisation
PSAR	Participatory Systemic Action Research
PSI	Participatory Systemic Inquiries
SDB	*Secretario do Bairro*
VSO	Voluntary Services Overseas
VV	*Valuing Volunteering*

Contents

Executive summary

Volunteers play a key role in the health response to HIV/AIDS and HIV/AIDS-related issues in Mozambique. The number of volunteers attached to health- and HIV-related government and donor programmes delivering services or raising awareness of health issues has risen dramatically in the last 10 years in response to the HIV epidemic (Republic of Mozambique Council of Ministers, 2010–14).

This report focuses on a group of community health volunteers in Manica Province and how they are addressing health needs. It looks specifically at volunteers and *activistas* engaged as community health volunteers in the provision of home-based care. These volunteers are often working either directly on government health service programmes or as part of donor-funded programmes. The study explores the varied ways in which community health volunteers are responding to community needs and investigates the experiences of the volunteers, the organisation that mobilises them and the community members they volunteer for to understand further the question at the centre of *Valuing Volunteering*: how, when and why volunteering impacts on poverty.

Valuing Volunteering Mozambique found that these community health volunteers are carrying out an essential role in addressing health problems in their communities. By undertaking a wide variety of roles, volunteers are helping to support the health system in a substantial way. They facilitate linkage and access to formal health services, provide practical home support and identify needs in the community. They also help to support orphaned and vulnerable children and give emotional support and advice to families. Community members interviewed for this inquiry suggested that volunteers are often a lifeline for those affected by HIV/AIDS, and are helping communities to meet their health needs. Without the assistance of volunteers it was evident that the impacts of HIV could be far worse. This does raise concerns regarding the reliance on volunteers by the state health system, particularly if volunteers are relied on to fill gaps rather than augment and improve existing health services in the long term.

Valuing Volunteering Mozambique found that *activistas* and volunteers were also addressing community health needs that were not being directly addressed by formal programmatic approaches. These needs were often being met informally by volunteers using their own skills and personal resources. Social networks, and strong relationships with a range of stakeholders within their communities, were also found to be crucial in enabling volunteers to meet these needs. Volunteers used their relationships and social networks to identify needs, encourage support from different stakeholders and facilitate the mobilisation of necessary resources. This also allowed volunteers to become a bridge between the community and formal services.

In Mozambique, two terms are most commonly used to refer to volunteers: *activistas* or volunteers. Volunteers and *activistas* may have access to different opportunities and benefits such as training and subsidies. Although recipients of volunteer service did not consider there to be differences in the quality of services delivered, the discrepancies between the benefits associated with the two roles can lead to feelings of inequality and animosity between the volunteer and *activista*. This may have implications for the motivation of volunteers in the long term. In addition, volunteering may be perceived as a source of 'paid employment', dependent on individuals' education level, and with differing possibilities for training and financial 'reward'. With no standardisation of stipend levels, and some donors even offering stipends equivalent to a minimum wage, the term *activista* risks becoming more associated with paid employment than with voluntary service.

The degree of decision-making power and voice that the volunteer and *activista* have in terms of the design and implementation of programmes affects the ability of volunteers to respond to and meet community needs. Although the volunteers carrying out these health activities are having a large impact on health support to combat the effects of HIV, it appears that volunteers and *activistas* within these programmatic government and donor systems may have very little voice in deciding the areas around which they would like to volunteer, and have little ability to hold government to account. This is significant given issues around the inconsistent payment of stipends and the fact that volunteers are using their own resources to address problems not being tackled by formal programmatic responses. Discrepancies between the opportunities and benefits, such as training and subsidies, available to *activistas* and volunteers can lead some volunteers to feel disempowered and demotivated. Findings from the *Valuing Volunteering Mozambique* inquiry suggest that it is more difficult for individuals with less education, and possibly fewer connections, to access *activista* roles and the benefits associated with these. In the context in which they are volunteering, where the personal resources of volunteers may be relied on by the individuals they support in the community, this can be problematic and risks increasing the vulnerability of the poorest volunteers.

Valuing Volunteering Mozambique found that relying on volunteers' altruistic values and connections with their communities may be insufficient to sustain a volunteer-based approach in the long term. Pressures on the personal resources of volunteers (including their time and their emotional and financial resources) may limit their ability to sustain their volunteer efforts despite their good intentions. This study finds that greater recognition of volunteers and of the risks associated with volunteering are required for this approach to be made more sustainable.

1. Introduction

Volunteer programmatic approaches to combating health issues such as HIV/AIDS and HIV/AIDS-related problems are having an important impact on affected communities. This study explores the varied ways in which community health volunteers are responding to community needs in the province of Manica, in central Mozambique. This case study investigates the experiences of the volunteers, the organisation that mobilises them and the community members they volunteer for to understand further the question at the centre of *Valuing Volunteering*: how, when and why volunteering impacts on poverty.

This study focuses on an organisation that mobilises volunteers to deliver home-based care programmes in partnership with the Ministry of Health. The focus organisation is one of the biggest volunteering organisations in the country, with over 250 community volunteers, and was declared 'volunteer organisation of the year' in 2012. The scale of the organisation offers good opportunities to explore the impact of community volunteers on poverty across several locations. Moreover, the organisation is situated in the central region of the country, far from the main resource base and capital, Maputo. As the southern provinces are perceived to be more resource-rich, investigating volunteering in a context beyond this geographical area is an important inclusion within the *Valuing Volunteering Mozambique* research.

The organisation at the centre of this inquiry has partnered with VSO in the past, with VSO placing international volunteers to build the organisation's capacity (e.g. through the development of financial systems and project proposals). There were no international VSO volunteers placed with the organisation during the inquiry period, but existing links to the organisation provided opportunities and contacts that facilitated the undertaking of an inquiry in this geographical area. In order to protect their anonymity, the organisation at the centre of this inquiry and the volunteers involved asked for their names not to be published.

Theories of change

The volunteer organisation at the centre of this inquirydelivers home-based care (HBC) programmes in partnership with the Ministry of Health (MOH). The MOH's programme of training, a 12-day course, is therefore adhered to. On completion of this training, community volunteers are expected to support five HIV/AIDS-affected adults and five HIV/AIDS-affected children twice per week. As stated in the national HIV/AIDS strategy 2010–14, the government perceives home-based care to include:

> **'Clinical care (adherence to treatment, reference to Health Units, evaluation and possible handling of opportunistic infections, nutritional evaluation and clinical follow-up); the provision of preventive and promotional services; psychological care; spiritual care, and the provision of social services, including legal, social and food support'**
> Republic of Mozambique Council of Ministers, 2010–14, p. 57.

This contributes to the care and treatment pillar of the national response to HIV/AIDS.

The volunteers who gain access to the HBC training through the organisation are trained by a government-licensed HBC trainer before they can engage in any support work. The training covers three key areas:

- the general context of HIV/AIDS
- primary healthcare
- emotional support (VSO National Volunteering Case Study, 2014).

The organisation implements additional programmes which also aim to address HIV and its impacts or associated issues, although the specific focus of the different programmes may vary. These additional programmes are usually funded by international donors such as AIDS Alliance International, UNESCO and Save the Children. Volunteers are involved in two of these additional programmes: a programme to provide support to orphaned and vulnerable children, and a programme focused on HIV/AIDS prevention activities.

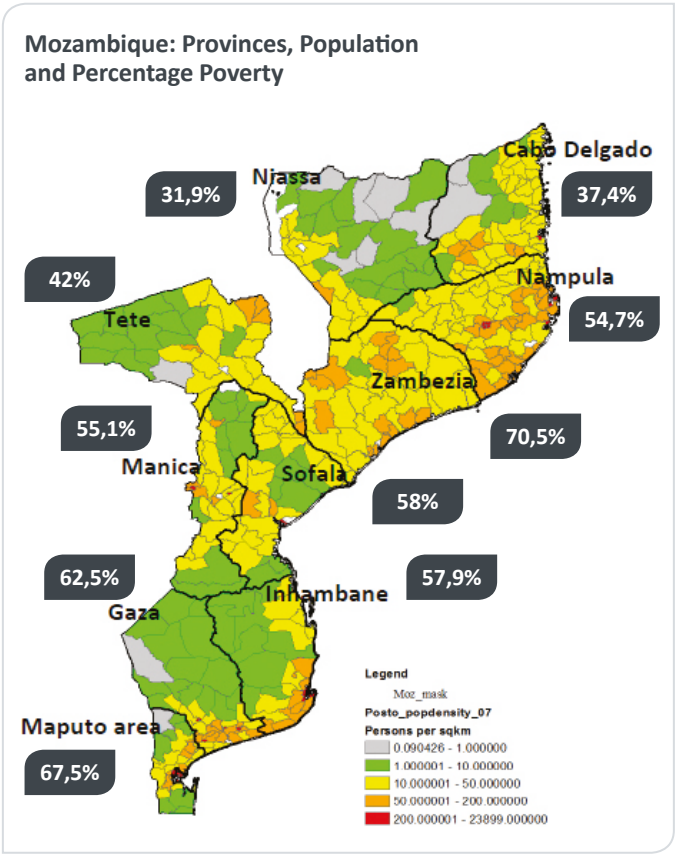
The volunteers who work through the organisation work as community volunteers. They are either implementing the government HBC programme or carrying out donor-funded projects in the two programme areas mentioned

Generally, the organisation's approach is that pastors in the community (who are associated with the organisation) mobilise community members to volunteer through the church. They are well placed to carry out this role because they are trusted and respected by the community. The community church member will then express an interest in volunteering and be recommended by the pastor for training. This training could be for the MOH HBC programme, or the volunteer could be considered for participation in a donor-funded HIV-related programme. Donor-funded programmes may provide different training, and may have a different focal area (e.g. purely orphan and vulnerable child support), than the ministry HBC programme. Having been trained, the volunteers aim to support community members in a variety of ways. This is explored further in the chapter on *Community health volunteer roles*.

Background

This inquiry was undertaken in Manica Province in the central region of the country in and around the city of Chimoio. The black circle in Figure 1 indicates the location of Chimoio. Poverty in the province in 2009stood at 55.1% out of a population of 1,735,351, and HIV prevalence was 15.3% (Instituto Nacional de Saúde (INS) of the Ministry of Health, 2009).

Figure 1: Map of Mozambique illustrating poverty levels across the country



The health system

The Manica inquiry looks specifically at volunteers and *activistas* engaged as community health volunteers in the provision of HBC. These volunteers often work either directly on government health service programmes or as part of donor-funded programmes.

As part of the HIV/AIDS treatment and care response in Mozambique, the provision of HBC by volunteers has significantly increased in recent years. This has been accompanied by an increase in the number of individuals benefiting from volunteer-provided services, as is outlined in the national HIV/AIDS strategic plan:

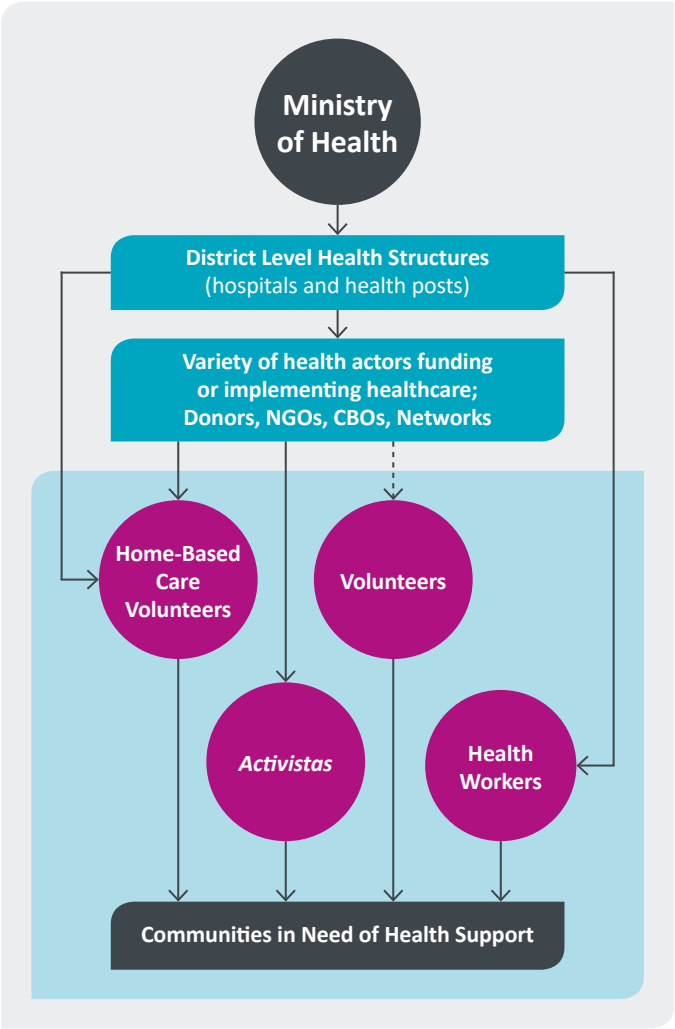
"Home Based Care provided by volunteers and health activists to patients with AIDS and their relatives grew considerably, rising from 17,790 beneficiaries in 2004 to 99,122 in 2008. Equally, the number of Health Units with connections to programmes providing Home Based Care rose from 79 in 2004 to 200 in 2008" (Republic of Mozambique Council of Ministers, 2010–14, p. 27).

This gives an indication of the importance of volunteers and *activistas* in tackling HIV/AIDS, and the way in which volunteering is integrated into the HIV/AIDS treatment and care response within the health sector in Mozambique.

Figure 2 provides a broad overview of the institutional layout that underpins the health system in Mozambique, and the place of volunteers within this, as described by *Valuing Volunteering Mozambique* inquiry participants (see the Appendix for a full diagram of the health system response to HIV/AIDS in 2010–14). The arrows represent the stakeholders who mobilise different types of volunteers and, in some cases, provide them with resources (e.g. financial subsidies). The blue dotted line references the fact that training and financial resources are only sometimes provided to volunteers.

Within this system, some community health volunteers can access training opportunities. Home-based carer volunteers receive 12 days' training which is accredited by the MOH. By law, home-based carers are entitled to a stipend provided by the MOH that is 50% of the minimum wage (approximately 1,500 *meticais* per month, equivalent to £36). However, many home-based carers said they were not receiving this stipend and regarded themselves as volunteers.

Figure 2: Where volunteers and *activistas* are placed within the health system in Chimoio



Some training not accredited by the MOH is available to *activistas* and volunteers; for example, if donors are delivering specific projects, there may be training provided through non-governmental organisation (NGO) partners. These projects may be focused on sexual reproductive health, nutrition, awareness raising, etc. Some *activistas* and volunteers may also receive a stipend to cover, for example, transport and phone costs.

There is a lack of consistency in terms of for whom and for what type of projects stipends are available. This depends on how the NGO partner allocates funding from donor budgets. There are also individuals volunteering in the system who have received no training and/or receive no stipend.

Usually organisations are not permitted to provide the 12-day HBC training. However, because the organisation participating in the inquiry has a strong relationship with the MOH, it has been accredited by the ministry to give this package of training.

The organisation

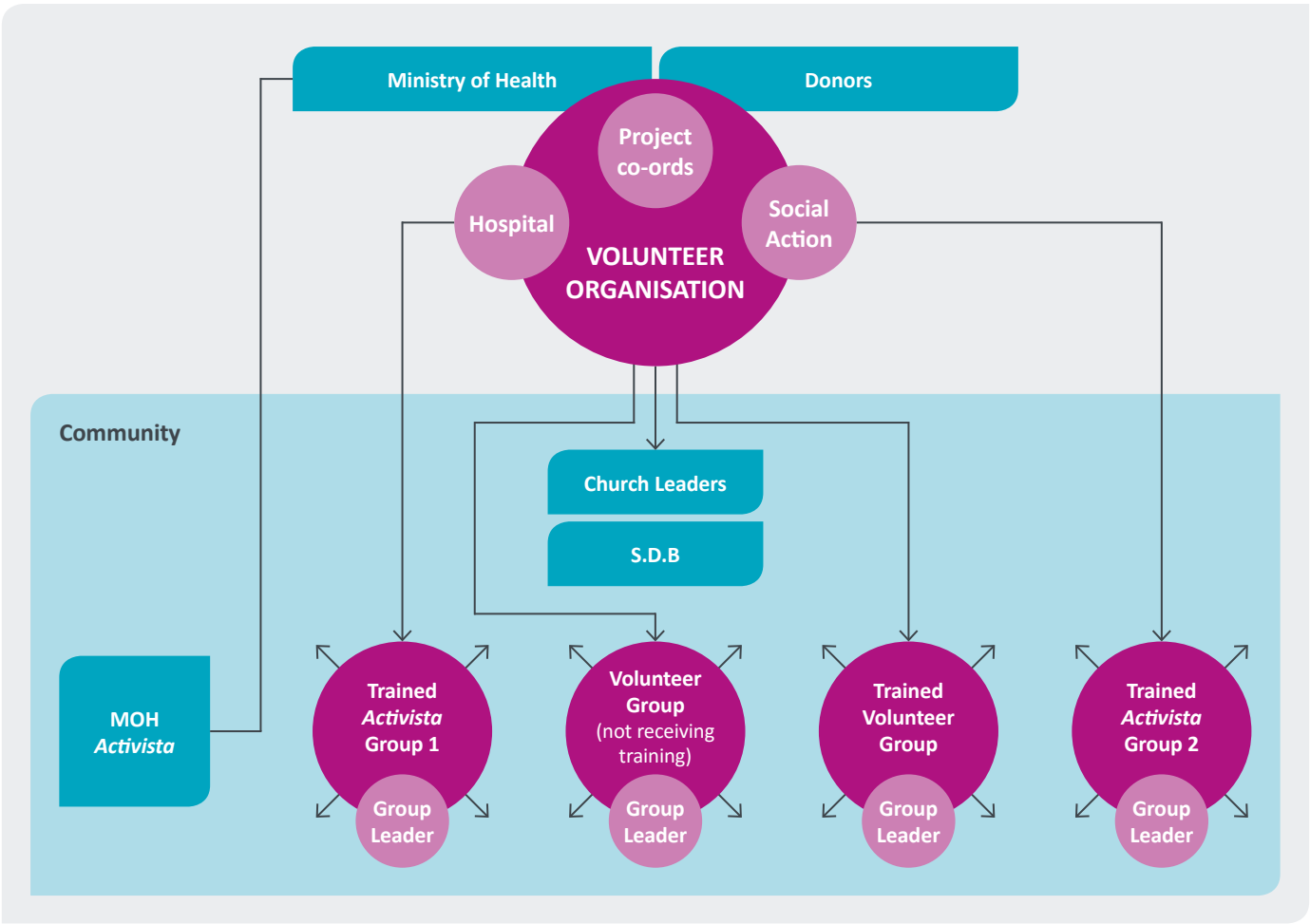
The organisation at the centre of this volunteering inquiry is an ecumenical religious organisation. Figure 3 shows where volunteers fit into the organisation's structure

The organisation is a network of churches that have come together to address health needs within their communities where the availability of public services to meet HIV-related impacts is limited. As one church leader described, they came together because "They wanted to do something more than pray and look to the sky, so they formed the network" (Pastor 1). The church leaders are the pastors of each of the churches and are responsible for mobilising and motivating the volunteers to work in the community. Trusted by people in the community, the pastors are well placed to organise those community members who recognise a need to do something practical to meet health needs in their locality. As one pastor highlighted, "To resolve the problems of the community [the organisation] knocked on the door of the church. It is the door to the community. The church tells the truth and so the community listen to the church" (Pastor 1). The volunteers belong to different churches but work together to try to support the response to HIV in their communities.

After 'mobilisation', people in the community may approach the pastor to tell them they are interested in volunteering. The volunteers then form groups in their communities and each group has a leader. These groups can include a mixture of people with different training, education and stipend levels. Currently there are 43 groups across 95 churches and approximately 250–300 volunteers mobilised by this volunteer organisation.

It is possible for trained volunteers to be deployed to the community directly by the MOH. However, participants in the inquiry felt that it can be very difficult for them to operate because the community don't know them and therefore are reluctant to trust them. It was the opinion of one pastor that for this reason "it is better to go through the churches" (Pastor 1). The dynamics of the relationships within these groups and between other stakeholders represented in Figure 3 will be discussed in later sections of the case study.

Figure 3. Where volunteers fit into the organisation's structure



Health volunteers

The volunteers and *activistas* who took part in the inquiry are predominantly health-focused community volunteers, mainly active in the area of HIV care and support and mobilised through the organisation described above.

Volunteers and *activistas*: Both volunteers and *activistas* work in the area of HIV care and support and are mobilised by the focus organisation of this inquiry. There are several key differences between the two types of volunteer role: *activistas* often have a higher educational level, more access to training and stipends and are more accountable to the organisation because they are required to submit reports and adhere to set working hours. The volunteers usually have a lower educational level, less access to training and stipends, but more autonomy to decide working hours because of fewer requirements to report to the organisation.

Selection process: *Valuing Volunteering Mozambique*'s inquiry found little evidence of formal application processes to become volunteers or *activistas*. Descriptions were given of the informal selection and recommendation process for *activistas*, which is applicable to both government- and donor-instigated health volunteer programmes.

The selection of *activistas* was described by volunteers as a closed process, where access can often depend on the recommendation of key individuals (e.g. church leaders) in the community. Often church leaders base this recommendation on whether they believe an individual is motivated, and the degree of acceptance the individual has in the community. This relatively closed process can make it difficult for some individuals to access *activista* opportunities (see chapter on *Volunteer Vulnerability*).

Volunteer roles: The specific ways in which *Valuing Volunteering Mozambique* found volunteers to be addressing and supporting HIV-related impacts are detailed in chapter on *Community health volunteer roles*. Health-focused community volunteers may also provide other forms of care and assistance, such as supporting orphaned and vulnerable children and grandparent-headed and child-headed households, an important role in communities affected by HIV/AIDS.

The *Valuing Volunteering Mozambique* inquiry in Manica province included both volunteers and *activistas* based in three different locations. In one inquiry location, the *activista* participants were implementing a donor-funded health project focusing on HBC. The volunteers involved in the inquiry were not receiving donor support at the time of the study. Some had received government training in the past or had previously taken part in donor-funded projects, whilst other volunteers were not trained formally. This shows that volunteers may still be engaged in informally addressing issues related to the programmatic areas outlined above, even though they are no longer mobilised by a specific funded project.

While it is difficult to generalise about the frequency with which volunteers provide care in the community, the Chimoio community volunteer group of 11 participants provide an example of the level of engagement of health volunteers: individuals volunteer two to three times per week, with visits varying in length. As a group, the volunteers cover around 50 houses in their area and have been volunteering in this capacity for between 14 and 17 years in their community.

2. Methodology

The *Valuing Volunteering* project used two research approaches to collect and analyse insights about volunteering: Participatory Systemic Inquiries (PSI) and Participatory Systemic Action Research (PSAR). Both approaches enable us to get under the surface of how communities operate and how change happens.

Participatory Systemic Inquiries (PSI) allow a system of actors, actions and contexts to be mapped as a baseline against which change can be assessed (Burns, 2012). When identifying the starting points (our baseline) for a project we might typically record those factors that have an obvious direct relation to our intervention. For example, if our aim is to increase girls' access to education, a 'traditional' baseline might record factors such as school enrolment, attendance and participation. PSI allows us to go deeper and reflect on how people, processes and the environment within which they are situated influence one another and the path to change. Doing this involves asking both broad and detailed questions which take us beyond the school walls and into the complexities of social systems, such as "Are girls supported by their family and the wider community to attend school?" "What are the power dynamics within the community and how might these influence girls' attendance in school?"

This data is then used to determine how different factors affect one another, with the aim of learning about why change is or is not happening. While causal links between each part of a system can be identified, they are frequently not linear relationships. By allowing us to observe volunteer practices as part of a wider system rather than in isolation, PSI challenges our assumption that if we do x it will automatically lead to y, and forces us to consider each intervention within the context in which it is taking place. For example, strengthening our understanding of the factors that impact on people's perceptions of volunteering was important in some inquiries to make sense of volunteers' effectiveness. A PSI mapping and analysis might take place over a 2–12-week period and can involve working with many different individuals and groups. In the *Valuing Volunteering* project we ran many different PSIs at the community, organisational and national levels. Where actors were motivated to respond to emergent findings, PSI formed the beginning of an action research process.

Participatory Systemic Action Research (PSAR) is an action research methodology which embeds reflection, planning, action and evaluation into a single process. The core principle behind action research is that we learn at least as much from action as from analysis. It incorporates iterative cycles of action and analysis, allowing us to reflect at intervals on a particular action or approach and adapt it according to what we've learnt. The action research used by *Valuing Volunteering* was participatory because it was led by individuals directly affected by or involved in volunteering-for-development initiatives, and they defined the action research process and questions. It was systemic because we assessed the impact of these actions by considering the knock-on effects for the actors, actions and contexts comprising the wider social system. PSAR typically takes place over a period of 18 months to three years.

Chimoio inquiry

This was a participatory systemic inquiry and was conducted over the course of three separate weeks of inquiry.

Participants

The inquiry included volunteer and *activista* participants attached to the volunteer organisation at the centre of the study. Two volunteer groups and one *activista* group were consulted in three separate geographical locations at varying distances form Chimoio city: group 1 were based in Chimoio city itself; group 2 were in a more rural location 30 minutes by bus from Chimoio; and group 3 were located in a very rural yet larger town two hours by bus from Chimoio. Staff from the organisation and staff from a local health post in the group 3 location (who work closely with the *activistas*) also participated in one-to-one, semi-structured key stakeholder interviews. Recipients of the volunteer services, and programme co-ordinators and pastors were also included in the investigation.

Valuing Volunteering Mozambique aimed to maintain consistency in the data collection approaches across the three groups in order to make comparisons possible. Each of the groups was organised by a pastor linked to the organisation upon *Valuing Volunteering Mozambique*'s request to meet with both volunteer and *activista* groups.

Participatory methods

A range of participatory methods was used during the systemic inquiry. For comparative purposes, the same methods were used with each of the three groups. The methods used were:

- one-to-one semi-structured interviews
- focus group discussions
- stakeholder Venn diagrams investigating different actors' levels of influence, communication systems and types of relationship within this volunteering system
- problem walls
- informal discussions
- resonance testing of emergent themes and quote walls.

On the first visit the information collected was used to develop a systemic map. This is a paper mapping activity that draws out emergent issues, themes and questions by mapping information obtained from different stakeholders, as well as factual information and observational data. This analysis was undertaken by the *Valuing Volunteering Mozambique* researcher and used for sense making and to illuminate emergent themes. A systemic map from this inquiry is shown below. This was later joined with similar maps from three other site locations in Mozambique in order to compare and validate findings from areas distant from the capital, Maputo.

After the initial analysis was completed, and the major themes drawn out, the findings were taken back to the community and certain themes were further investigated. Themes included: the vulnerability of the volunteer; sustainability; *activista* and volunteer roles. On the final visit, a participatory resonance testing session was held to ensure that the researcher's understanding accurately reflected what the participants had conveyed.

3. Findings

Community health volunteer roles

Mozambique faces a shortage of human resources for health, which has been exacerbated by the demands of major epidemics such as HIV/AIDS (MSF, 2007). *Valuing Volunteering Mozambique* found that community health volunteers attached to the organisation at the centre of this inquiry are carrying out an essential role in addressing health problems in their communities. By undertaking a wide variety of roles, volunteers are helping to support the health system in a substantial way. This chapter explores how volunteering emerged as a major contributor to tackling the HIV/AIDS epidemic, and describes the types of roles undertaken by volunteers.

Responding to emerging needs

In the district of Chimoio, the number of community health volunteers has increased in response to the HIV epidemic. Key stakeholders included in the *Valuing Volunteering Mozambique* inquiry in Chimoio, including community members, volunteers, organisational staff, pastors and health professionals, reported that this was due to a lack of capacity to respond to the emerging problems caused by HIV/AIDS. The limits of the government health system's existing capacity were recognised by both the community and the government. Community members were eager to respond, as one pastor from Chimoio describes:

> **"There are many more volunteers because of the increase in the HIV. It is a pandemic and there are other illnesses associated... The community were the ones who responded to the need. They did not wait for the Ministry of Health to ask them to come to respond but they did it themselves"**
> Pastor 1

A member of the organisation's staff further describes how volunteers were a crucial part of the response to HIV/AIDS:

> **"If there were no civil society organisations there would be huge problems with HIV. They have to reduce the impact of HIV. The Ministry of Health cannot do it themselves but the volunteers help"**
> Organisational staff, K1

The volunteer organisation was proactive in attempting to meet the rapidly changing needs of the community. Wanting to respond, and being aware of HBC training related to HIV health needs in Zimbabwe, members of the organisation spoke to the government and thereafter went to Zimbabwe to be trained. Upon their return they contributed to the first MOH home-based care booklet for responding to HIV.

How volunteers respond to HIV/AIDS

The ways in which volunteers and *activistas* attached to the volunteer organisation are working to address such HIV/AIDS-related health problems and fill health service gaps are many and varied. The key roles carried out by volunteers and *activistas* are outlined below.

Access to hospital: perhaps the role most often undertaken by *activistas* and volunteers is facilitating access to hospital care for people in their communities. Volunteers physically accompany them to the hospital, counsel them about the necessity to attend the hospital and/or make written referrals which the patient will carry with them to the hospital to present to the formal health employees (which allows the patient to be seen more quickly).

> **"They help me to go to the hospital"**
> SR1, Person living with HIV

> **"They guide the sick to the hospital... they have a reference book with information inside about the health of the sick person"**
> Health post staff NS1

Home care: this is often one-to-one care in the form of personal hygiene and bath giving, washing or providing soap. This may also include providing support to maintain environmental and household hygiene, for example cleaning the house, maintaining the garden and running errands such as food buying. Volunteers may also undertake home visits to see how someone is faring.

> **"They give me regular visits, no one else helps and sometimes they will give me soap for washing"**
> SR1, Person living with HIV

> **"We help care for people at home"**
> Group 1 volunteer

> **"They help with personal hygiene like giving baths"**
> Pastor 1

Imparting information: volunteers provide practical information about how family members can care for the sick, or how the sick can care for themselves and recover from illnesses. In some cases volunteers sensitise children about gender roles, as gender inequality has a large role to play in the perpetuation of HIV.

> **"We teach them how they can get better"**
> Group 3 *activista*

> **"They give practical information"**
> Pastor 1

Access and adherence to medication: this is in addition to hospital-based support to adhere to or access medicines. Often the volunteer or *activista* will encourage and support the individual to take their medication or maintain medication regimens. They even take on the role of bringing the medicines to the sick people in the community if the individual is unable to collect the medicines themselves because of prohibitive travel costs to the clinic, or for health reasons.

"We encourage them to take their medications. We will take medication to people in the community"
Group 3 *activista*

"They help us taking medicines"
Grandparent head of household 1

Support for orphaned and vulnerable children in the community: providing support to those orphaned by AIDS or to those whose parents are sick and unable to care for them is a key part of the role that volunteers and *activistas* play. Volunteers do this in a number of ways: giving moral support, help with trauma, educational support and help to gain access to school without having to pay matriculation costs. They provide guidance and some even conduct small projects. For example, one volunteer gave advice on how to cook after she recognised this was needed by those she provides support to. Volunteers help to obtain birth registration documents, and sometimes give school supplies. There were also several accounts of adopting some of the orphaned and vulnerable children into their own families.

"They help with supporting the children. They help in getting access to school and help from Social Action [government welfare], and getting the certificate of poverty so that they can go to school for free"
Grandparent head of household 1

Identification: the volunteers and *activistas* assume responsibilities for identifying sick people in the community, and ensuring they gain access to formal services such as hospital care, school or the police.

"We help identify problems and help make referrals for the poor and sick to access other services"
Group 1 volunteer

"Sometimes the sick are abandoned and so we will go to the community leaders to identify where their families are"
Group 3 *activista*

Familial relationship support: there were some accounts of counselling families who have found out there is a family member with HIV/AIDS (or a related illness), or for couples who are HIV discordant. This counselling can help families to stay together and prevent abandonment.

"We counsel the family to stay together"
Group 3 *activista*

"We are also helping couples to understand in the situation where one of the couple is HIV positive and the other is not. We are giving them counselling"
Group 2 volunteer

Conclusion

Community health volunteers working through the volunteer organisation are carrying out an essential role in addressing health problems in their communities. The organisation and the volunteers responded to a need they identified locally and this response has evolved to address a government shortfall in capacity to meet the increased health needs related to HIV. The range of roles and activities undertaken highlights the varied needs that have to be met in communities dealing with HIV/AIDS and shows how volunteers support the health system in a substantial way. Volunteers are identifying needs, providing a link to formal services and supporting treatment programmes. In addition, they are providing the vital social and emotional support that both individuals and families affected by HIV/AIDS require.

Implications

- Volunteers are facilitating linkage and access to formal health services, providing practical home support and identifying needs in the community. They also help to support orphaned and vulnerable children and give emotional support and advice to families.
- A significant part of the response to the HIV epidemic in Mozambique is being addressed by volunteers. Volunteers are responding in a variety of different ways.

Volunteer impact: are the volunteers meeting community needs?

During the *Valuing Volunteering Mozambique* inquiry, participants were asked what they thought would happen if there were no volunteers and what changes they thought volunteers brought. Their responses indicate the importance of the roles carried out by volunteers (as outlined in the previous section) and the vital contribution health volunteers make to mitigate the effects of a gap in health service capacity.

Participants were asked what would happen if there were **no volunteers**:

Increase in mortality
Almost all the participants highlighted that this would occur if there were no volunteers or *activistas*. One individual living with HIV highlighted:

"I would have been dead", further stating "don't stop doing this work or we will die"
SR1

Hospital impacts

"They would not go to hospital"
Group 1 volunteer

"People in the hospital would have a difficult time because the *activistas* are the link. They are mobilising people to get to hospital because the nurses are not able to go to the community"
NS, hospital staff

Impacts on children

"More children would be on the streets and trafficking would increase"
Pastor P1

Less information

"People would die without information"
Group 2 volunteer

and

"the community wouldn't know anything, like how to take medications"
Grandparent-headed household 2

Participants were also asked what **changes had been seen** as a direct result of the volunteers in the neighbourhood:

Reduction in deaths/ increased quality of life
The strongest evidence of the effects of volunteering comes from the statements by the recipients of volunteer actions:

"I used to feel a lot of pain but now things are better"
SR1

"The biggest change is that they told me how to live and I have health"
CR1 person living with HIV

Reduction in fear

"Before people had fear to go to the hospital. People in the community had fear about the disease but now they know about HIV and are taking tests"
Group 2 volunteers

Information, referring to before the volunteers and *activistas* were there to support:

"Lots of people died because they did not know things about the disease and how to treat it. Now they know and can live well together with their families"
Organisational staff K1

Recipients of both volunteer and *activista* services stated that they received support that they perceive to be highly valuable and even life-saving. In many cases this was the only healthcare support that they were receiving:

"We would not have anything... the only ones who help are the volunteers, the others do nothing"
Grandparent-headed household receiving support from a volunteer 1

"No one else helps"
SR1 person living with HIV receiving support from an *activista*

Conclusion

These statements reinforce the vital role played by health volunteers, who are often a lifeline for those affected by HIV/AIDS, and are helping communities to meet their health needs. Without the assistance of volunteers it is evident that the impacts of HIV could be far worse. This raises concerns regarding the reliance on volunteers by the state health system. If volunteers are relied on to fill gaps rather than augment and improve existing health services in the long term, this raises questions about whether volunteers are effectively being considered as low-paid employees.

Implications

- If volunteers are relied on to fill a health system resource gap in the long term, there are implications for the effectiveness of the HIV/AIDS response and for the wellbeing of volunteers, who may become seen as low-paid employees.

Community needs and non-programmatic volunteer responses

Valuing Volunteering V Mozambique found that *activistas'* and volunteers' local knowledge and connections mean that they are often at the forefront of meeting community needs that are not directly addressed by formal programmatic approaches. There is evidence that volunteers and *activistas* are meeting these needs informally by using their own skills and personal resources. Social networks and strong relationships with a range of stakeholders within their communities are also crucial in enabling volunteers to address these issues.

Using personal resources to meet needs

Often, decisions about focal areas for volunteer activities are made by donors, the government or partner organisations. This inquiry found that often these decisions are made without the engagement of the volunteers and community members who will be involved in the delivery of or will be in receipt of these activities. A problem analysis undertaken with each of the volunteer and *activista* groups participating in the inquiry revealed their perceptions of the most prominent community problems which were not being supported by donor or government volunteering:

1. **Lack of food for sick people**
2. **Lack of transport for sick people**/lack of access to school/materials for children
3. Lack of shelter/lack of medicines

With group consensus, deeper inquiry was undertaken into the first two issues, specifically exploring how these problems were being addressed in their communities. Volunteers and *activistas* described how they often drew on their own personal resources to meet these needs in the absence of formal programmatic responses:

"usually what happens is that the volunteer will give help to the community and they will use their own resources to do this, such as giving bread or money for the chapa (local minibus). If the volunteer gets a subsidy then they will use this to help the sick person instead of taking from their own resources"
P1

"a volunteer is very important because they do not wait for someone to give them resources, they sometimes give their own"
Group 1 volunteer

"sometimes we use our own money to help if we can"
Group 3 *activista*

"they gave us food once and clothes"
Child-headed household

"they gave us sweet potato"
Children whose mother is living with HIV

The issue of education is a secondary problem but is worth discussing in this case. It was highlighted a number of times that the volunteers will try to help gain access to school for vulnerable children within households where they are working. The process for doing this is to acquire a stamped poverty certification letter from three officials. In order to get the stamped letters there is often an 'ink bribe' whereby officials state that, to 'pay for ink' to stamp the letter, the person must pay each authoriser a sum which totals 200 *meticais*. The sick person in the community is very often unable to pay and volunteers will help to raise the funds, sometimes using their volunteer stipends to cover these costs.

"the volunteer will help when they can by clubbing together some funds to try to pay"
Grandparent-headed household

Working with others to meet community needs

As described above, volunteers and *activistas* mobilise their own personal resources and give direct practical help to meet community members' needs. They also described the role of other actors who are important in responding to community needs such as a lack of food or transport. Like the volunteers, these actors also play a key role in mobilising resources:

Volunteer group 1 responses:

Volunteers – sometimes they will club together in the volunteer groups to contribute a little of what each has to help buy food or to give to a family to buy food if they are in need. They will also give some of their own food to people when they can. If the volunteer has a *machamba* (small subsistence farm) then they will also give some of the food from this to the people they are helping.

The organisation – they will give money for food when they can. They also provide food and seeds, usually maize, to people who are in the projects, to plant for their orphans.

Social Action (government social services department) – they give maize, they give milk to children and they used to give blankets and mattresses.

The degree of practical support they give to individuals who are sick or affected by illness in the community shows the importance of the response from these actors.

The volunteers and *activistas* are part of a system of different stakeholders who are responding to the communities' needs. The extracts below show that there is a system of communication and mobilisation for support to meet these needs. For example, if the food or transport needs of sick people in the community cannot be resolved at each level it will pass to the next until it is solved, beginning with the family, and passing to neighbours, then volunteers and *activistas*, the *Secretario do Bairro* (SDB) and finally to the formal state services.

Volunteer group 2 responses:

"Usually if a sick person needs transport the first people to give support are the family. But there are many people without family in the *bairro* and in this case it is usually the neighbours who will help. If the neighbour is unable to help then they will go to the ***activistas* or the volunteers** to alert them that there is someone who needs to get to the hospital. Usually these people will help by giving little money that they can, if they don't have money themselves they will go around and try to find someone who can help with transport in the **community**. The volunteer will also go to the group leader and they will help to get other volunteers or other modes of transport from somewhere, like a bike or someone who has a car in the *bairro*.

"The role of the ***Secretario do Bairro*** is that he knows where the sick people are in the *bairro* and can identify them for the activstas/volunteers. They can also mobilise the other people and neighbours in the area to help. They will provide a letter to say that there is a sick person who needs transport and can you help."

Given the prevalence of child-headed and grandparent-headed households, *activistas* and volunteers play an important role in providing services which may previously have been undertaken by family members. The descriptions below show how volunteers and *activistas* are in a unique position to act as a link or a bridge between different stakeholders and/or formal state services:

***Activista* group responses**

Activistas – "We are the road and initiators of all in the community. All of the information must pass through us. If there is a barrier then we are the bridge and we transport everyone across the bridge" (Group 2 *activista*). They also give their own food sometimes and arrange access to the hospital for treatment for malnutrition.

Community leaders – *Secretario do Bairro* – "He has the power to mobilise people. If there is someone in the community who is suffering because of lack of food the *Secretario do Bairro* will mobilise the people to give a little of their money to help the person. They help to provide people to help. It depends on the individual *Secretario do Bairro*, some are more motivated than others" (Group 2 *activista*).

Social Action (government social services department) – give food and acknowledge the documents from the *Secretario do Bairro* about the poverty status of the people in the neighbourhood. It is necessary for Social Action to receive verification from the community leaders regarding the poverty status of a family or person before they authorise assistance.

Health centre – sometimes they will give food. When a person is inside the hospital they will be given food. They also provide support with malnutrition by giving food in the hospital.

Volunteers and *activistas* are linking with authority figures and permission-givers at community level, and helping to transfer information on problems that cannot be solved directly by the community. For example, they provide a link to the *Secretario do Bairro* (SDB) who also helps to mobilise resources in the community, or authenticates official documentation which is necessary for some state support to be provided. The volunteers play an important role in identifying issues, either independently, or with the help of neighbours and family, the SDB or Social Action. Finally, the extracts show how the volunteers and *activistas* bridge access between the community and formal services: often the volunteer or *activista* will help to facilitate access to formal health service providers for the individuals they are supporting.

The importance of relationships

The underpinning fabric of some of the relationships that support these volunteer actions at the community level is important to consider. Volunteers and *activistas* highlighted two different aspects of their relationship with the individuals they are trying to support in the community: help and trust. *Trust* was of particular importance and surfaced recurrently in this inquiry as fundamental to the effectiveness of the volunteer:

> **"they feel that we are confidential with the information that they share with us. They have trust"**
> Volunteer Group 1

This component of trust is not confined to the relationship between the volunteer and the individuals they are supporting, but also extends to the SDB. The SDB is the government representative at the community level. He will inform the government about all the activities occurring in the community and has to be informed of all volunteer activities before they can begin. This applies to both programmatic and non-programmatic responses to community health issues. For programmatic responses, the church leaders or the project coordinators will inform the SDB that volunteer activities will be occurring in the neighbourhood.

Further, the volunteer groups will go to the SDB to resolve any problems they might be having at the community level in performing their duties. Volunteers must consult with, inform and gain the permission of the SDB before performing any activities in the community. Without this it would be very difficult to meet community needs.

The SDB will also mobilise volunteers and community members to pool resources to help people in the community who are in need of food and to respond to transport-related issues by motivating them to offer their own vehicle or to contribute funds to gain access to transport. The *activista* group involved in this inquiry said that they share information about who needs help and support and where the families of the sick are in the case of abandonment. The *activistas* and the *secretario* will also keep each other informed on the location of those in need of support.

Activistas' and volunteers' relationships with the hospital and Social Action are depicted as more formal and professional types of relationships. However, the *activistas* mentioned that whilst their relationship with the broader institutions was formal, they had often built up strong personal relationships with the individuals they worked with in the hospital, such as the nurses. Regarding Social Action, the element of information sharing was highlighted when considering this relationship, in that the government social services department will give information to the *activistas* about who needs help. This is because often the volunteer or *activista* is also working to link people in need in the community with the formal social services that Social Action can provide, such as the poverty certificates and other services mentioned in the boxes above.

Conclusion

This section shows the strengths of community health volunteers: their responsiveness to local level needs, even when these are not directly addressed by formal programmatic approaches; their ability to build strong trusting relationships; and their access to social networks which allow linkages across a range of stakeholders to meet community health needs. This informal, non-programmatic response to community needs seems to be heavily reliant on trust, which facilitates the mobilising, linking and networking abilities of the volunteer. They use their relationships and social networks to identify needs, encourage support from different stakeholders and facilitate the mobilisation of necessary resources. They allow volunteers to become a bridge between the community and formal services. The volunteers' relationship with the SDB is of particular importance in facilitating volunteering at the community level in both programmatic and non-programmatic responses.

The wealth of local knowledge and connections that volunteers possess highlights the importance of ensuring volunteers have sufficient opportunity to feed into the design and implementation of programmatic approaches to ensure these are fully utilised. The degree to which volunteers' voice is taken into account is discussed in the chapter on Power of the volunteer in the *programmatic approach*.

Implications

- If volunteers are from outside the community, it would prove very difficult to develop, nurture, and capitalise on, the local connections and relationships which have such great importance in addressing community needs.
- Inclusion of the SDB in any community volunteer response is a vital element to consider when designing and implementing programmes that respond to community needs.

Factors affecting the motivation, wellbeing and effectiveness of volunteers and *activistas*

Valuing Volunteering Mozambique found that volunteers and *activistas* may have access to different opportunities and benefits. This chapter describes these differences and looks at the impact they have on the way individuals carry out their volunteering roles. This chapter also looks at how these differences affect the relationship between volunteer and *activista* and the perceptions of volunteering more widely.

Subsidies

Often whether an individual is named as an *activista* or a volunteer depends on whether they receive or may potentially receive a subsidy to support them in carrying out their volunteer work. Sometimes this is provided through the HBC volunteer position which pays 1,500 *meticais* a month (equivalent to half the Mozambican minimum wage). Stipends for health volunteers are not standardised and are extremely variable. For example, some donor-funded projects pay 3,000 to 3,500 *meticais* per month, which is equivalent to a minimum wage salary in Mozambique. Other projects do not provide any volunteer subsidies. An individual who is not named as an *activista* and instead is considered as a volunteer is less likely to be provided with a subsidy.

This has a multilayered impact. Firstly, it often leads to feelings of inequality and animosity in the relationship between volunteers and *activistas* as the quotes below demonstrate:

"*Activistas* are paid this is the only difference. Volunteers won't get paid but they can get an incentive. This creates a conflict due to the pay difference"
Kubatsirana staff D1

"*activistas* are proud; they say we won't work for nothing"
Group 1 volunteer

"they give orders to the volunteers" and "it is like people command me"
Volunteer

There were a range of responses from *activistas* with regard to their perceptions of their position in relation to volunteers: some state "we are superior" (Group 3 *activista*), whilst others said "we feel inferior but we are perceived by the volunteers and the community as being superior" (Group 3 *activista*). Some *activistas* felt that "volunteers think we have a lot of money" (Group 3 *activista*). As a result, one opinion is that "everyone is fighting to be an *activista*" (Organisational staff, D1) due to the access to monetary support that the *activistas* have. This highlights the competitive environment that differences in stipend entitlement can lead to.

Secondly, it can impact on perceptions of motivations and lifespan of volunteering activities.

"the *activista* is always led by money"
Pastor 1

"*activistas* don't work from the heart like the volunteers so people get tired of their insincerity"
Organisational staff, D1

"when the subsidy stops so does the *activista*"
Volunteer group

"the *activista* works with money and will sit when they don't have it"
Community member

There is a perception that the *activista* is only led by money and will cease volunteering when there is no monetary incentive. In contrast, volunteers felt that "we want money but we still work without it" (Group 1 volunteer), something reinforced by coordinators and recipients of volunteer support, stating that "the volunteer is always there" (Grandparent-headed household) and "the volunteer stays forever" (Pastor 1).

In terms of the motivation and commitment of the *activista*, the experiences of community members who have been supported by an *activista* appear to contradict widely held perceptions in the community. The *activistas*, people the *activistas* worked with and the community members who are supported by *activistas* all highlighted that "the *activista* is always there" (Community member supported by *activista*, SR1). This contradicts the perception that *activistas* leave once subsidies end. Some *activistas* expressed that it depends on the motivations of the individual *activista*; some will stay and some will leave when the stipend stops. This is discussed further in the *Sustainability* chapter.

It may be the case that the volunteer will still be motivated and committed to undertake voluntary service without a stipend. However, not receiving a stipend can impact on their effectiveness, because they do not have the time or financial resources to serve the community. For example, one health post staff felt that because volunteers have no stipend, it resulted in them "doing much less work and at a slower rate. This is only due to the lack of funds" (Health post staff, NS). While the volunteer might continue to volunteer irrespective of financial compensation, stipends may still enable them to undertake activities more frequently and enthusiastically.

This also raises questions about whether volunteering is seen as low-paid work. If the disparity between types of volunteering opportunities and the associated benefits is leading to a competitive environment for certain roles, does volunteering become perceived as low-paid work for community members from poor communities as a result?

Timetables and agendas

When *Valuing Volunteering Mozambique* talked to *activistas* and volunteers about their ways of working they highlighted that *activistas* usually have a timetable and agenda whereas the volunteer has more flexibility in their volunteer commitments. *Activistas* are linked to time- and finance-bound government or donor-led programmes which include mechanisms to ensure accountability and targets that need to be met. The majority of stakeholders who contributed to the inquiry mentioned the fact that the *activista* has a set agenda. This impacts on the way they carry out their role in a number of ways.

Activistas' full agenda reflects their increased obligation to the organisation paying them in that "they have an agenda and hours and have to meet organisational goals" (Group 3 *activista*). This is also reflected in their reporting obligations, whereby the *activistas* have an obligation as part of funded projects to provide monitoring reports to the organisation. Because these reports are submitted to donors, one volunteer expressed that there was a perception that the work of the *activista* is valued more than that of the volunteer. These reporting mechanisms allow *activistas'* work to be recognised, and as a result the programmes they are associated with may be more likely to maintain their funding. While this accountability may lead to greater value being placed on the work that they do by the donor, some volunteers felt that the increased time spent by *activistas* on reporting resulted in them spending less time in the community. One volunteer group commented to *Valuing Volunteering Mozambique* that "they (the *activistas*) spend less time with the sick" (Volunteer group) because of their full agenda.

Activistas felt that these obligations did not necessarily mean they spent less time in the community, and health staff working with *activistas* felt that it simply meant "the volunteer can choose to work" (Health post staff NS) and so may "have less work" (ibid). However, others suggested that the volunteers "have no set hours and so must plan well to fit their volunteering in to other activities like farming and family" (Pastor 1). This implies that because they do not receive a stipend, and do not have a set agenda for their work, there is increased pressure on the volunteer to carry out their daily activities *and in addition* fit in their volunteer duties. This is partly the nature of volunteering as opposed to paid work. However, in the case of the volunteers in this inquiry, a lack of financial compensation is problematic because there is evidence that time spent volunteering impinges on their survival needs. This is discussed further in the *Community needs and non-programmatic volunteer responses chapter*.

This raises some questions as to whether the *activista* is able to focus more on their volunteer role because they receive a stipend. The financial security provided by the stipend could alleviate the pressure of spending time on income-generating and livelihood activities, enabling them to concentrate on volunteering to a greater degree. Alternatively, the *activista* may still be pressured to engage in income-generating activities to the same degree as the volunteer, but has additional obligations placed on them, for example, compiling reports for donors and adhering to specific timetables.

Training and education

Activistas generally have more training than volunteers because they are mobilised by a specific donor- or government-led health programme. The following quotes demonstrate *activistas'* higher level of training:

> **"The *activista* is trained in basic information and they bring information [to the community]"**
> Organisational staff 1

> **"To be an *activista* we have to go on a course at [the organisation]. We had a training in home based care"**
> Group 3 *activista*

> **"*Activista* is trained and has a kit and medications and they are trained in how to give baths. The volunteer doesn't have training in giving baths and other things"**
> Group 2 *Activista*

This increased opportunity for training for the *activista* might also be linked to the generally higher level of education that the *activista* has, compared to the volunteer:

> **"The *activistas* have usually got more education than a volunteer even though the *activista* still does have a low level of education. The *activista* has a little bit of knowledge but the volunteer has no education"**
> D1

In reference to *activistas*: "they have academic information and they can learn information and different methodologies like the physiology of HIV etc. They have a more advanced education" (K1). This demonstrates that the *activista* must have the capacity to be able to learn new material that enables them to care for those in their communities.

Although this is not a 'hard and fast' rule, these quotes highlight that the ability to gain access to the subsidy and training that often accompany the *activista* role may be associated with the individual's level of education. Whilst even volunteers themselves state that "Volunteers have a low education" (Group 1 volunteer), it was also stated that "They must have a level of education where they know how to read and write but they should not have too elevated an education because those people do not like to volunteer. The ability to read and write is not always necessary as friends can help explain during trainings" (Pastor 1). While some volunteers did have training, whether this was dependent on education level is not ascertainable at this stage. Suffice to say there was agreement that volunteer education levels are low.

Conclusion

Findings show that *activistas* tend to have a higher educational level, more access to training and stipends and more accountability to their organisation in terms of reporting and adhering to set working hours. The volunteer may have a lower educational level, less access to training and stipends, yet may have more autonomy to decide working hours with less reporting obligations to the organisation.

When *Valuing Volunteering Mozambique* spoke to the individuals supported by the volunteers and *activistas* in the community, they did not perceive a great deal of difference in the activities performed by either. Most people were unaware that there is a difference between the two types of volunteer roles. Recipients of both volunteer and *activista* services stated that they receive support that they perceive to be highly valuable and even life-saving. In many cases it was the only healthcare support that they were receiving.

Although recipients of volunteer service did not consider there to be differences in the quality of services delivered, the discrepancies between the benefits associated with the two roles may lead to feelings of inequality and animosity between the volunteer and *activista*. This may have implications for the motivation of volunteers in the long term. In addition, volunteering may be perceived as a source of '(low-)paid employment', dependent on individuals' education level, and with differing possibilities for training and financial 'reward'. With no standardisation of stipend levels, and some donors even offering stipends equivalent to a minimum wage, the term *activista* risks becoming more associated with paid employment than with voluntary service.

Implications

- Volunteer resource providers should remain aware that *activista* roles may give individuals greater access to benefits and opportunities than volunteer roles. Organisations should aim to have a standardised application procedure. Rules regarding educational levels for volunteers should be clearly stipulated or, alternatively, additional training should be provided for volunteers with low educational levels to enable them to access *activista* roles.
- There is a need to clearly define the circumstances in which volunteering becomes a form of low-paid employment and to understand how, why and when community volunteers perceive it as such.

Power of the volunteer in the programmatic approach: decision making and voice

The degree of decision-making power and voice that the volunteer and *activista* have in terms of the design and implementation of programmes affects the ability of volunteers to respond to and meet community needs. Although the volunteers carrying out these health activities are having a large impact on health support to combat the effects of HIV, it appears that volunteers and *activistas* within these programmatic government and donor systems may have very little voice to decide the areas around which they would like to volunteer, and have little ability to hold government to account. This is significant given issues around the inconsistent payment of stipends and the fact that volunteers are using their own resources to address problems that are not being tackled by formal programmatic responses.

This section identifies the key organisations in the volunteering system and looks at volunteers' role and voice within these. It is important at this stage to refer again to the organisational diagram in the Background section. A description of how this system functions, the methods of communication, decision making and perceptions of power that different stakeholders have is necessary. In this section volunteers and *activistas* will be referred to simply as volunteers as the same rules apply to both.

The Ministry of Health

The role of the MOH and selection processes are discussed in the Background section. Following the selection process, the MOH receives the list of individuals selected by the pastors that the organisation would like to train. The ministry then gives permission to the organisation to proceed with the training. The package of training and theme of the volunteer activities are thus decided by the ministry. For these reasons, it was considered by one of the church leaders to have 'the most power' in this volunteer system. Without volunteer input into the design of the training, this may give volunteers little space to express any self-identified community problems linked to HIV/AIDS which these programmes may not be addressing.

When we consider responsibilities for paying stipends to trained volunteers, volunteers who are home-based carers are entitled by law to a stipend that is 50% of the minimum wage (approximately 1,500 *meticais* per month, equivalent to £36). The payment of this stipend is supposed to be the responsibility of the MOH; however, participants in this inquiry suggested that there is an expectation that it is the responsibility of the individual NGOs recruiting the home-based carers to raise this money and that it is often covered by independent donors:

"The government health service wanted to do home based care but they stated that the home based carer is supposed to get 50% of the national minimum wage which is 1500 *meticais* per month. Our organisation give this to *activistas* trained in home based care. The organisation has the obligation to pay this. This money comes from the project budget that that donors give. The majority of groups we don't pay because they have other incentives"
Organisational staff K1

The government has recognised the need to respond to HIV/AIDS through home-based care and has pledged that these volunteers will be compensated for delivering this service. However, it appears that it is often the responsibility of organisations, funded through donors, to meet this obligation. On several occasions, inquiry participants said they felt that the government had shifted its responsibility to the donors to financially cover a stipulation that they had committed to pay. It may be the fact that the structuring of the health system's budget means donor funds are used to cover a percentage of HBC stipends. The health system in Mozambique is part funded by external funds, as the World Health Organisation states:

"The Mozambican National Health System is financed through two main sources: Domestic funds from the state budget and External funds received from different mechanisms including budget support, the Common Fund, which is a basket fund where partners pool their resources, and various bilateral project support initiatives. Over recent years, there has been a steady increase in funding including the variety of funding mechanisms for health financing in Mozambique. The difference between the two funding sources is almost constant..."
WHO, 2014

It was not within the scope of the study to look at the funding streams of the national health and HBC system. However, the different funding streams are important to note because one of the main issues expressed by participants in the inquiry is that when there are no donors, often the trained volunteer has no access to this stipend even though the government stipulates that the home-based carer should receive 50% of the national minimum wage for providing voluntary service. The volunteers are left with little means through which to call the government to account and little recompense for the work that they often continue to undertake.

Donor-funded programmes

Consideration of the decision-making power of the volunteer within the donor-funded system of community health support also seems to be low. International donors fund health projects which draw upon volunteers at the implementation stage. Donors can deliver programmes through partnerships with the MOH, or, alternatively, with permission from the ministry, they will directly approach the organisation. Often, the donor will provide training for volunteers but this is dependent on whether this is included in the project proposal. Sometimes the donor-funded project will stipulate who can volunteer; for example, candidates may need to be educated to a certain level. The donor may provide funds, and manage and lead on project procedures such as monitoring and evaluation. Often the donor will approach the organisation with a project, or accept a proposal from the organisation that it would like to implement. The extract below describes the process:

"If a donor wants to work with us we have to look at the type of project to see who [which volunteer group] will receive the project. The representatives of donors come and they will say what groups they want to work with"
Organisational staff K1

For donor-funded projects, a project coordinator (who may also be a church leader) within the organisation will oversee the activities of the volunteers. The volunteers stated that they can discuss with the project coordinator any project-related problems they have in the community. They further highlighted that they believe that the project coordinator has the most power to decide the themes around which the volunteer will be working at the community level.

This demonstrates that there are few mechanisms that allow volunteers to input into the design and implementation of programmes. Although there are processes that allow volunteers to feed back on issues that arise during implementation, the areas of programme focus are decided by the organisation or donors. Volunteers also have little influence over who can access volunteering opportunities. Top-down decision making risks reducing the voice of the volunteer within these programmatic approaches and may lead to the volunteer having very little power to determine the areas around which their activities are centred.

Church leaders

Church leaders are also focal points for the volunteer groups to communicate with. They will often be responsible for transferring information and finances from the organisation to the volunteer groups to conduct their activities. It is often the church leaders who recommend that volunteers should receive training, but it is also possible for a community member to approach them and request training. Most of the volunteers involved in the inquiry said that it is usually the church leaders who decide on the themes around which they are working.

"The volunteer groups tell the co-ordinator... what the problems are. The co-ordinator... is also influenced by other donors. *Activistas* don't have the ability to talk to donors but the co-ordinator of [the organisation] does have the communication with the donors".
Health post worker, NS

This statement describes how one health service worker sees the system of decision making regarding the focus of volunteer work. The coordinator in the organisation (who is often also the pastor) plays an intermediary role: she is informed of the community problems by the volunteers but also has to take into account the donor's definition of the problem and project objectives. The coordinator provides a link, communicating what the volunteers are experiencing at the community level back to the organisation, which then links with the donors. They also have to coordinate the volunteers working within the donor-defined project or thematic areas. This suggests a hierarchical nature in the programmatic volunteering approach led by donors, the organisation and co-ordinators. Although the coordinator does provide a link to the organisation and, eventually, to donors, there are limited opportunities for the volunteer to express directly to the donors the problems that they are seeing in the community or experiencing as volunteers.

Different ways of working

One organisational staff member and pastor also explained some different but less utilised methods they have used for identifying needs in the community around which the volunteer might work. At times the organisation will conduct some research in the community through consultation with the volunteers and develop a proposal based on this. This will be submitted to potential donors.

Secondly, volunteers had, on occasion, brought community problems to the attention of the church leaders, either directly or via the SDB (the local community leader). Thereafter the church leaders and the organisation would plan a project and make a proposal that is sent to potential donors.

These processes are examples of volunteers being able to express the needs that they observe in the community and around which they would like to work. This potentially increases the voice of the volunteer within the process and allows them to be more responsive to the community needs of which they have in-depth knowledge as members of the same communities.

The two processes above give the volunteer more power and agency to decide their thematic areas, yet there still appears to be a rather stratified process through which this occurs. It was the feeling of some of the volunteers that when they voice problems they see in the community around which they would like to focus their activities, often little action is taken when it reaches the level of the organisation. The volunteers were eager to increase their voice at the organisational and donor level regarding the problems they see in their communities and the areas around which they would like to focus their work. The volunteers expressed that they would like to use the current document as a way to communicate this to the organisation and donors.

Conclusion

Evidence generated from *Valuing Volunteering Mozambique*'s inquiry suggests that the volunteers and *activistas* are filling a substantial and fundamental gap in the health service and are a crucial link to identifying the specific healthcare needs in a community. Yet despite their important role, there are limited channels or feedback mechanisms available to *activistas* and volunteers that enable their local level knowledge and experience to be fully utilised. They are also given limited space to voice their opinion on how and where their time and resource should be directed and best used. This is of particular significance given that volunteers are often providing services that fall outside the project parameters of donor- or government-led programmes. Furthermore, without mechanisms that enable volunteers to hold the government to account if their contribution is not fully recognised (e.g. the non-payment of stipends) there is a risk that their contribution will be taken for granted. This has implications for the sustainability of the approach and the general and financial wellbeing of the volunteer.

Implications

- Volunteers require a means to amplify their voice within programmatic approaches.
- This system might benefit from a more participatory approach that ensures volunteer and community knowledge and experience are taken into account.

Volunteer vulnerability

There can be large discrepancies between the opportunities and benefits, such as training and subsidies, available for *activistas* and volunteers. Usually, as shown above, *activistas* have access to stipends and more training. Findings from the *Valuing Volunteering Mozambique* inquiry suggest that it is more difficult for individuals with less education, and possibly fewer connections, to access *activista* roles. In the context in which they are volunteering, where the personal resources of volunteers may be relied on by the individuals they support in the community, this can be problematic and risks increasing the vulnerability of the poorest volunteers.

Access to opportunities

Volunteers expressed three main issues that made it difficult to access *activista* roles: a lack of information; their own education level; and the influence of gatekeepers and external decision makers.

Comments from volunteers, *activistas*, pastors and organisational staff suggest that the selection of *activistas* is quite a closed process which makes it difficult to gain access to these opportunities. There is no standardised process for applications, and the decisions around these selections are outside the control of the individual volunteer. This is compounded by low education levels which make it difficult to apply for an *activista* position: "It is difficult to make an application as an *activista* – we do not know how to and we are not able to write sometimes. It is the decision of the donor and the organisation how they look for *activistas*" (Group 1 volunteers).

The *activistas* involved in the inquiry were often selected on the recommendation of the pastors, who "looked to see who was serious and genuine and then were recommended to be the *activistas*" (Pastor 2). Church leaders may often make selections based on their views regarding an individual's degree of motivation and the degree of acceptance they have in the community. This may be useful and facilitate the selection of volunteers with a genuine desire to volunteer in their community.

However, externally controlled criteria (i.e. from donors) may also affect who is eligible to be an *activista*. This may be problematic if it leads to the altruism and commitment of existing volunteers being overlooked. One volunteer describes the effect this had:

"When we started we had no incentive in [the organisation], the situation changed when [the organisation] started to get donors with specific programmes. Instead of using the volunteers that were there already and were working in the field, they employed new people and paid them. It was the donors' recommendation. They wanted people who were more qualified. It wasn't [the organisation's] decision it was the donor. The question is why did they not invest in training the existing volunteers? The donors brought new people and this was a mistake. Until now the volunteers still worry about this... It is like people command me. Because the donors do not invest in building the capacity of the volunteers other educated people come from outside and direct us and we feel out of control and we remain in poverty"
Community volunteer

Donors often have their own demands regarding how health programmes are run and who can implement them. However, without having an awareness of the existing volunteering context, volunteers' may feel devalued, and, importantly, their skills and experience may be overlooked. Volunteers felt that donors should invest in the volunteers already providing services and working in the community instead of bringing in 'new people'.

This highlights the issue that those with a higher level of education are given preference to carry out donor-led volunteer programmes (as shown in the *Volunteer vulnerability* chapter). The salience of the association of non-subsidised volunteering with low-education levels is illustrated by the views of a member of the volunteer organisation's staff, who stated: "You pay according to the level of education" (Organisational staff, D1). This suggests that only people with low education are motivated to work as volunteers without a subsidy or opportunities for training, something that those with higher levels of education would not do.

Volunteer vulnerability

These barriers make it more difficult for some volunteers, particularly those with low educational levels, to access *activista* roles and the associated benefits. This leads to increased competition and feelings of inequality between individuals who are and are not able to access these opportunities. This may leave the volunteer feeling disempowered or demotivated. More significantly there are implications for the overall vulnerability of these volunteers.

As discussed in *Community needs and non-programmatic volunteer responses* section, volunteers often draw on their own resources to address issues regarding access to food, transport and education, because these are not tackled directly by programmatic approaches and there is often not the time or the means to wait for resources to come through from elsewhere. However, these volunteers often come from the same poor communities as those they are assisting. They themselves are experiencing poor economic conditions which may be exacerbated by their volunteering because of the additional costs, both in terms of time and money, that volunteering involves. This has implications for their own and their families' livelihood and wellbeing:

"They (donors, NGOs, government) have to be careful because the volunteer could be made vulnerable themselves by the act of volunteering because they have to go out to help others but no one is there to help them. Time spent by the volunteer means that they are away from their own home which means it can fall into vulnerability"
Volunteer group leader

"sometimes when a volunteer is out working the family is at home asking, 'Where is the bread?'"
Volunteer group leader

"When an organisation says we want to do a project with, for example, orphaned and vulnerable children, we want to give them books and a bag etc, they should also be evaluating if the volunteer needs these things too because they have children. They are also vulnerable"
Volunteer group leader

Considering that these volunteers often have a low level of education, and are less likely to have opportunities to access the monetary and training incentives, there are real issues concerning the vulnerable position of volunteers, and the lack of recognition for those least able to raise their voice. It is easy to understand the sentiment presented previously that "everyone is fighting to be an *activista*" (Organisational staff, D1)

Conclusion

Volunteers' access to opportunities may be based on externally set criteria and the decisions of a few key people. This can lead to discrepancies in the opportunities and benefits available to community members who wish to serve their communities, and may lead to some volunteers feeling disempowered and demotivated in the long term. It may also lead to resentment of those who are able to access opportunities that are associated with a subsidy or increased training.

This takes on greater significance considering the additional time and resource costs that may be placed on volunteers who are themselves from poor communities and have limited voice and access to the benefits which may go some way to ameliorate this burden. The structure of volunteering could be revised to ensure fairer access to opportunities and greater recognition of volunteers. There are also wider questions about whether the informal responses of volunteers to needs which are not directly addressed by programmatic approaches could be better supported, recognised and responded to by state- and donor-led programming.

Implications

- A lack of open and transparent recruitment mechanisms for *activista* roles and strict selection criteria mean opportunities for community members to access volunteer and *activista* roles are limited.
- If donor resources were targeted at developing the capacity of community volunteers, this might increase their feelings of empowerment and enable individuals to access the benefits that can be associated with volunteering.
- A lack of open and transparent recruitment mechanisms for volunteer and *activista* roles and unclear selection criteria mean opportunities for community members to access volunteer and *activista* roles may be restricted.

Sustainability

The long-term nature of volunteering, its potential to increase volunteer vulnerability and the different motivations of volunteers raise questions about the sustainability of volunteering efforts. As shown, some participants felt that volunteers and *activistas* either do not volunteer, or volunteer less frequently, when project money is unavailable. There are differing opinions on this issue. However, whether the long-term success of a volunteer-based approach depends on funding to continue to motivate volunteers is worth consideration. Currently the MOH depends on donors to meet obligations to provide volunteer subsidies. If a volunteer-based approach to meeting community needs only works to full capacity if there is a funding stream, this makes the sustainability of the system reliant on the continued support of donors. This section explores factors that affect volunteer motivation, including subsidies and the demands on volunteers' own time and financial resources, and raises questions about the implications this has for the sustainability of the volunteer-based provision of HBC.

The most recent national HIV/AIDS strategic plan acknowledged that sustainability, in the context of a reliance on donors, is a challenge: "[there is] heavy dependence by national and international partners on the provision of home based care by civil society organizations, without clear sustainability mechanisms" (Republic of Mozambique Council of Ministers, 2010–14, p. 57).

However, during this inquiry, volunteers expressed that their motivations were not reliant on monetary incentives or compensation:

"we do it because they are our neighbours"
Activista

"We feel something in our hearts"
Group 1 and 2 volunteers

"Volunteers do also want some money for working but we work anyway without this"
Group 1 volunteer

These views suggest that the sustainability of volunteer activity is based more on altruistic values and the personal connections that the volunteer feels towards others, rather than the subsidies associated with donor-resourced volunteerism. Such non-monetary motivations suggest that the volunteer system is sustainable.

However, considering that volunteers often rely on their own limited resources when addressing community needs, it is questionable how far these personal motivations will be able to sustain volunteering. The fact that volunteers are giving to community members from their own resource pool highlights that their motivations for volunteering don't seem to be led by potential opportunities for donor-funded subsidies. But even if these more altruistic motives suggest that volunteers are committed to serving their communities in the long term, in reality the resources that the volunteers have to use to help people in the community may limit the amount of support they are actually able to give. Therefore, despite their good intentions, volunteers may be unable to sustain their efforts.

For example, if a volunteer has limited resources themselves, how long can they continue to draw on these in order to supplement the needs of the community in which they volunteer? The following quote from a community member gaining support from volunteers demonstrates this point succinctly; "how can the volunteer have strength when they themselves do not have food in their stomach?" (Grandparent-headed household).

Conclusion

Relying on volunteers' altruistic values and connections with their communities may be insufficient to sustain a volunteer-based approach. In the long term, pressures on the personal resources of volunteers (including their time and their emotional and financial resources) may limit their ability to sustain their efforts. This raises the issue of whether donor-resourced volunteer initiatives should include an element of investment in strengthening and supporting these non-programmatic, informal solutions to addressing community needs, as opposed to offering subsidies for short project durations. The organisation participating in the inquiry began to recognise this issue and has delivered income generation training, and training on how to make cheap and healthy food from their own *machamba*. In this way the organisation is attempting to address some of the vulnerability issues experienced by volunteers. There are challenges in developing this approach; for example, the organisation lacks start-up capital to develop these income generation projects. If donors or other funding stakeholders can invest in this type of initiative, this could help in recognising the needs of community volunteers and contribute to a more sustainable approach.

Implications

- The ways in which community level volunteering can be made more sustainable should be considered by volunteer resource providers.
- There is a presumption that the work of the community volunteer is sustainable because of the personal and altruistic motivations that drive the volunteer. This ignores the fact that the limited resources of the volunteer may limit their ability to continue to volunteer in the long term.
- There is a risk that rather than complementing existing services, volunteers are filling a large health service gap and providing a disincentive for the government to identify longer-term, sustainable solutions.

4. Reflections on process

The cost of travel to this location was high and there was a degree of political unrest making it difficult to travel overland towards the end of the second year of the research. This impacted on the accessibility to this area and the length of time spent there. It would have been preferable to begin an action phase with some of the groups participating in the inquiry. On the final visit, some of the groups asked if there was anything that could be done to help them get the message to donors or programme implementers in terms of drawing attention to the issues of food and transport for the sick. This would have been an excellent opportunity to try to create some joint action for the volunteers to change part of the system in which they are working. Budget can really impact on the ability to travel to research locations in Mozambique as the cost of transport and accommodation is very high.

Due to the distance of the researcher from the inquiry locations, the group coordinator/ pastor working at the organisation was the main contact in the area and took responsibility for contacting and recruiting participants. Although this was done in a collaborative manner, this is consequently a non-randomised sample of people and this should be taken into account when reading this report.

Furthermore, during the accompaniment visits to individuals supported in the community, the *activistas* and volunteers who provide them with support were present. This may have limited the openness of respondents. However, responses appeared to be genuine and the volunteers and *activistas* did not try to overtly influence the conversation in any way. It was also useful for local language translation purposes.

5. Conclusions

Community health volunteers are filling a large health service gap through MOH- and donor-funded programmes. They have a multifaceted role in addressing health needs and attending to related community issues such as the needs of orphaned and vulnerable children and grandparent-headed households. The impacts of this type of volunteering are felt greatly by those they support in the community. This study shows that they are addressing felt community poverty health needs at the community level through programmatic responses.

In addition to addressing community health needs that fall within the parameters of programmatic responses, volunteers are meeting self-identified community poverty needs related to food and transportation for sick people in their localities. They often do this by drawing on their own limited personal resources. In addition, relationships and social networks at the community level are important in enabling volunteers to respond to these self-identified health poverty needs. The volunteers' social networks give them first-hand knowledge of community needs and allow them to play an important role in linking with key individuals in the community such as the *Secretario do Bairro*. Stakeholders such as the SDB can be important in mobilising necessary resources and facilitating access to formal services. Trust plays an important role in these social networks. It is of particular importance that volunteers are trusted by community members because this allows them to play an important bridging role between individuals affected by HIV/AIDS and formal services.

Valuing Volunteering Mozambique found that there are key differences in the roles of different community health volunteers, the terminology used to describe them and the benefits and opportunities in terms of subsidies and training associated with the roles. *Activistas* were found to have a higher educational level, more access to training and stipends and more accountability to their organisation in terms of reporting and adhering to set working hours. The volunteer tended to have a lower educational level, less access to training and stipends, yet more autonomy to decide working hours with fewer reporting obligations to the organisation. When *Valuing Volunteering Mozambique* spoke to the individuals supported by the volunteers and *activistas* in the community, they did not perceive a great deal of difference in the activities performed by either. Most people were unaware that there is a difference between the two types of volunteer roles. Recipients of both volunteer and *activista* services stated that they receive support that they regard as highly valuable and even life-saving.

Although recipients of volunteer service did not consider there to be differences in the quality of services delivered, there was evidence that the discrepancies between the benefits associated with the two roles led to feelings of inequality and animosity between the volunteer and *activista*. This may have implications for the motivation of volunteers in the long term, and could lead to volunteering being perceived as a source of '(low-)paid employment', dependent on individuals' education level, and with differing possibilities for training and financial 'reward'. With no standardisation of stipend levels, and some donors even offering stipends equivalent to a minimum wage, the term *activista* risks becoming more associated with paid employment than with voluntary service.

The decision-making power and voice of the volunteers within the programmatic environment in which they are operating was found to be low. The ability of volunteers to gain access to benefits such as training and subsidies is often in the hands of external decision-makers or key influential individuals in the organisation or community. Volunteers are usually unable to input into programme design, and there are few mechanisms in place to ensure that their local level knowledge and expertise is utilised. This is significant given that many volunteers use their own resources to address needs that fall outside the parameters of donor and government interventions. Volunteers expressed that they would like to make changes in this area in order to ensure their knowledge of community needs is recognised and incorporated into programming approaches.

Discrepancies in the opportunities and benefits available to community members who wish to serve their communities were evident. This was partly due to the relatively closed selection processes, and the specific criteria outlined by donors, which made accessing *activista* positions difficult, particularly for those with low formal education levels. This may lead to some volunteers feeling disempowered and demotivated in the long term. It may also lead to resentment of those who are able to access opportunities that are associated with a subsidy or increased training.

The inability of some volunteers to access opportunities associated with benefits such as training and stipends takes on greater significance when considering the additional time and resource costs that may be placed on volunteers who are themselves from poor communities. There is a risk that the volunteers with least ability to raise their voice and have their contribution recognised are the most vulnerable and the most likely to have their limited resources further reduced by engaging in volunteering in the long term. While the structure of volunteering could be revised to ensure greater access to opportunities and greater recognition of volunteers, there are also wider questions about whether the informal responses of volunteers to needs which are not directly addressed by programmatic approaches could be better supported, recognised and responded to by the state- and donor-led programming.

Volunteer-based approaches to meeting community health needs are presumed to be sustainable because of their foundation in the altruistic values of individuals and strong community bonds between different community members. While *Valuing Volunteering Mozambique* found strong evidence of this, the study also revealed that volunteers' limited resource base, which is often relied upon when addressing community needs, may make it difficult for individuals to sustain their volunteering efforts in the long term, despite their good intentions.

Implications for the VSO theory of change

As mentioned earlier, VSO's primary link to the partner organisation involved in this inquiry has been through international volunteers. Whilst it was not the focus of this inquiry to look at the international volunteer role within this process, the findings from this inquiry signpost some useful learning as to the role potential future international volunteers could play in supporting the partner organisation. VSO's Global Theory of Change (VSO International, 2014) outlines one of its primary objectives as "the promotion of community level volunteering which leads to active citizenship, working with local organisations to support people within communities to act individually and collectively to shape their own development".

This *Valuing Volunteering Mozambique* study has found that volunteers often lack power and voice within the programmes they are mobilised to volunteer for. In order to develop local volunteer organisations' ability to promote community-led volunteering in a participatory way that leads to sustainable change, VSO could look at ways in which to better integrate the activities of international volunteers and community volunteers. For example, this inquiry found that volunteers have a lack of voice and input into programme design and implementation. This may prevent the volunteer from expressing their perceptions of the problems, their views about the solutions required to meet community needs and the challenges they face in doing so, i.e. having to rely upon their own limited resources or volunteer stipends to support these needs. VSO should consider opening up the space for volunteers to share important local knowledge, which could be incorporated or supported in the programmatic approaches.

This inquiry also shows that the process of selection and access to volunteer opportunities is not always inclusive. Decisions as to who has access to support, such as training and stipends, is based on criteria that are often set by external decision-makers (e.g. donors) and based on the perceptions of a few key members of the community or organisation. In order to create an inclusive environment that promotes sustainability, it may be advisable to think about standardised application and selection criteria, and greater investment in the capacity of volunteers.

Promotion of community level volunteering is a key feature of the VSO theory of change. However, a greater understanding of the conditions and context in which these activities are being carried out is vital to ensure the empowerment of local volunteers and the effectiveness and sustainability of volunteering endeavours. Furthermore, VSO and other volunteer resource providers need to increase their understanding of the non-programmatic, informal ways in which volunteers are responding to some very basic poverty needs at the community level and ensure that volunteers are not made more vulnerable in attempting to address these.

6. Implications

Community health volunteer roles

- Volunteers are facilitating access to formal health services, providing practical home support, identifying community needs, helping to support orphaned and vulnerable children and providing emotional support and advice to families.

Volunteer impact

- A significant part of the response to the HIV epidemic in Mozambique is being addressed by volunteers. Volunteers are responding in a variety of different ways and taking on a range of roles to try to meet community needs.

Community needs and non-programmatic volunteer responses

- There is a degree of competition in accessing some of the benefits that are attached to *activista* roles, leading to feelings of inequality and the perception of volunteering as a source of low-paid employment for those with little education.
- If volunteers are from outside the community, it may be difficult to develop, nurture, and capitalise on, the strong relationships which are so important in meeting community needs.
- Inclusion of the *Secretario do Bairro* in community volunteer responses is a vital element to consider when planning programmatic responses to community needs.
- External support for community volunteering might be better directed at addressing how to better facilitate volunteers in responding to their own self-identified issues.
- There might be a need for a combination of larger programmatic volunteer-related activities and additional support for non-programmatic volunteer responses.

Factors affecting the motivation, wellbeing and effectiveness of volunteers and *activistas*

- Volunteer and *activista* support is greatly valued irrespective of the terminology used to represent them and does not appear to be affecting the impacts of the volunteers' work at the community level.
- Volunteer resource providers should remain aware that *activista* roles may give individuals greater access to benefits and opportunities than volunteer roles. Organisations should aim to have a standardised application procedure. Rules regarding educational levels for volunteers should be clearly stipulated, or, alternatively, additional training should be provided for volunteers with low educational levels to enable them to access *activista* roles.
- There is a need to clearly define the circumstances in which volunteering becomes a form of low-paid employment. There should be a better understanding of how, why and when community volunteers perceive volunteering as a form of low-paid employment, and not as voluntary activity which is assisted by the provision of a stipend.

Power of the volunteer in programmatic approach: decision making and voice

- If decisions regarding the focus of volunteer activities and access to volunteer opportunities are decided from outside the community (i.e. by organisations, donors or government services) the extent to which interventions meet community needs may be limited.
- Volunteers require a means to amplify their voice within programmatic approaches.
- If donor resources were targeted at community volunteer capacity development, it would enable volunteers to more effectively address community needs and improve the sustainability of volunteer activities, with volunteers feeling more motivated and empowered to tackle issues in their communities.
- Volunteers and *activistas* need training mechanisms to advocate and lobby government to provide what they are entitled to by law.
- There should be a greater emphasis on participatory approaches within programmes to ensure volunteers' voice is included in identifying and defining the focal areas for volunteer action.

Volunteer vulnerability

- A lack of open and transparent recruitment mechanisms for volunteer and *activista* roles and unclear selection criteria mean opportunities for community members to access volunteer and *activista* roles may be restricted.
- There is a need to empower volunteers within programmatic volunteer systems. This might include: standardised application processes; clear selection criteria; and investment in the education, skills and capacity of the individual volunteer.
- Stipends could be standardised to prevent animosity and competition between individuals who wish to engage in voluntary activity. Alternatively, selection criteria for different stipend levels could be made explicit and application procedures made easier for all to access.
- Where volunteer resource providers are implementing projects, there should be a mitigation strategy to prevent an increase in the vulnerability of individual volunteers. This would ensure that the potential negative effects that volunteering has on the volunteer are recognised and steps taken to avoid these.

Sustainability

- The ways in which community level volunteering can be made more sustainable should be considered by volunteer resource providers.
- There is a presumption that the work of the community volunteer is sustainable. This is often reliant on the personal motivations and altruistic values which drive the volunteer. However, given that many volunteers have to draw on their own personal resources when engaging in voluntary activity, questions are raised about the long-term sustainability of the approach.
- There is a risk that rather than complementing existing services, volunteers are filling a large health service gap, providing a disincentive for the government to identify longer-term, sustainable solutions.

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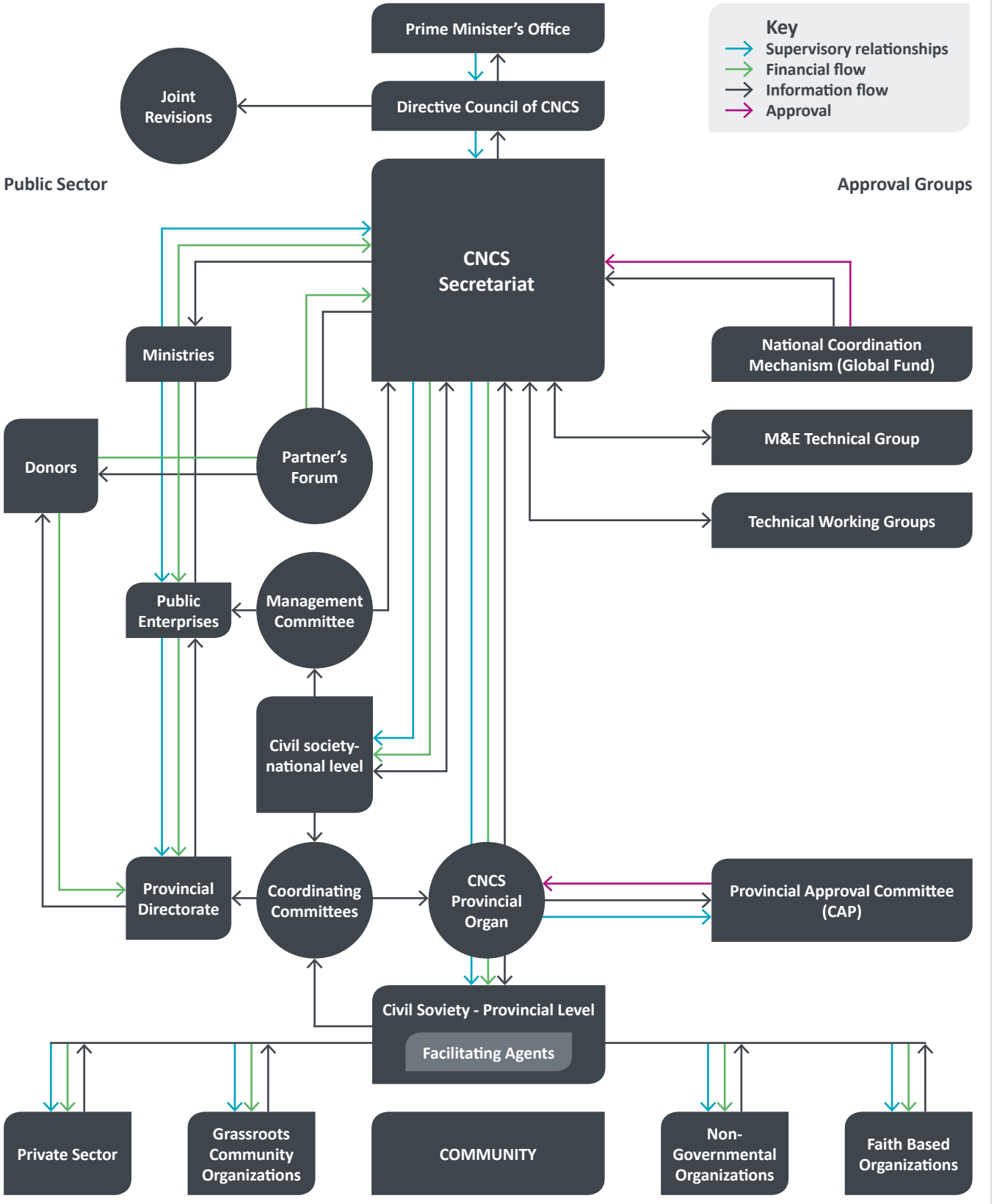
8. Appendix

National Strategy HIV and AIDS Response Plan, 2010–14.

Structure for the co-ordination of the response to HIV/AIDS in Mozambique

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Valuing Volunteering was a two year (2012 – 2014) global action research project, conducted by VSO and the Institute of Development Studies (IDS) to understand how, where and when volunteering affects poverty and contributes to sustainable development. This case study is part of a series of inquiries conducted in the Philippines, Kenya, Mozambique and Nepal which explore the role of volunteering across different development contexts and systems. Using Participatory Systemic Action Research it asks local partners, communities and volunteers to reflect on how and where volunteering can contribute to positive, sustainable change.

For more information about the global *Valuing Volunteering* study please contact: enquiry@vso.org.uk

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