‘Government don't know me and if I stop, they won't know’: A qualitative study on the lived experiences of volunteer health workers in the Nigerian health system and their implications for the sustainable development goals

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Abstract

Background: Volunteer health workers play an important, but poorly understood role in the Nigerian health system. We report a study of their lived experiences, enabling us to understand their motivations, the nature of their work, and their relationships with formally employed health workers in Primary Healthcare Centres (PHCs) in Nigeria, the role of institutional incentives, and the implications for attaining the health-related sustainable development goals (SDGs) targets.

Methods: The study used ethnographic observation of PHCs in Enugu State, supplemented with in-depth in- terviews with volunteers, formally employed health workers and health managers. The analysis employed a combination of narrative and reflexive thematic approaches.

Findings: The lived experiences of most volunteers unfold in four stages as they move into and out of their volunteering status. The first stage signifies hope, arising from the ease with which they are accepted and integrated into the PHC space. The anger stage emerges when volunteers confront the marked disparity in their treatment compared to formal staff, despite their substantial contributions to healthcare. Then, the bargaining stage sets in, where they strive for recognition and respect by pursuing formal employment and advocating for fair treatment and improved stipends. A positive response, such as improved stipends, can reignite hope among volunteers. If not, most volunteers transition to the acceptance stage – the acknowledgement that their status may never be formalised, prompting many to lose hope and disengage.

Conclusion: There should be a clear policy on recruitment, compensation, and protection of volunteers in the health systems, to enhance the contribution they can make to the achievement of the health-related SDG targets.

Keywords

(formal) healthcare workers, lived experiences, primary health centres, SDGs, volunteers

Highlights

High unemployment in healthcare creates demand for volunteers.

Volunteering evolves through stages of hope, anger, bargaining and acceptance.

Volunteers are poorly treated, thus causing career uncertainty.

The health and well-being of volunteers need to be safeguarded.

Introduction

Health facilities in sub-Saharan Africa often rely on volunteer workers to tackle staff shortages.1 This reliance has sparked extensive debate about their contributions to healthcare delivery, their motivations, the incentives acting on them, and how they are governed.2–4 Generally, volunteering represents a form of prosocial engagement wherein individuals actively and willingly seek opportunities or are beckoned at to render services or provide assistance to systems, and in some cases, individuals.5 Volunteering has been defined as dedicating one's time, energy, skills, experiences, and resources to support systems and individuals without necessarily expecting re- wards that are commensurate with the services they offer.6 A twist to volunteering is that persons could volunteer for non-tangible self-benefits (enhancement of skill, building relationships, etc.), or tangible self-benefits (route to employment, little stipend to sort basic economic challenges, etc.).7 Thus, volunteering could provide some sort of benefit to the volunteer, as well as the recipients of the volunteer's services. Unfortunately, despite the immense benefits of volunteering, in some contexts, health sector inclusive, it has provided grounds for exploitation.8,9

Most research on this topic has focused on people volunteering for specific health programmes or in- terventions.[10,11] However, this excludes the many volunteers who deliver a substantial proportion of care, alongside regularly employed health workers, in mainstream services in many Low- and Middle-Income Countries (LMICs). These individuals can see volunteering as an opportunity to integrate themselves into the formal health structure, thereby maintaining their professional status and identity and sense

of social worth.[12] For many vol- unteers, the final destination is not formal employment so there is a need to scrutinise their entry into and exit from the volunteering process.

One particular gap is an understanding of how the experiences of volunteer health workers evolve over time and are shaped by institutional incentives. This requires attention, particularly given recurring reports that these volunteers are being exploited,[1] coupled with concerns about the absence of clear pathways that would enable them to transition into formal employment and thus contribute to achievement of the health-related Sustainable Development Goals (SDGs),[13] whose progress is being constrained by persisting shortages of health workers, especially in Primary Health Care (PHC).

Nigeria has a large health workforce training capacity (and one of the largest stocks of health workers) in Africa, but still has substantial shortages of formally employed staff in its health facilities in many parts of the country.[14,15] This is, in part due to the critical shortage of healthcare professionals. The World Health Organization (WHO) reports a doctor-patient ratio of approximately 4 doctors per 10,000 population in Nigeria, significantly below the WHO's recommended minimum of 23 doctors per 10,000.[16] There are also fewer nurses than needed, with a nurse-patient ratio of approximately 1.5 nurses per 1000 population, well below WHO's recommendation of at least 2.5.[17] This shortage of health workers hampers the ability to provide adequate and timely healthcare services, particularly in busy and hard to reach healthcare facilities. The health worker crisis in

Nigeria is further compounded by maldistribution and emigration of health workers.[15,18,19]

The implications are that many Primary Health Centres (PHCs) in Nigeria depend on volunteers to complement the formal staff. According to the Nigerian Strategic Health Plan, volunteer health workers are people engaged by different health programmes to provide community-based health services, and without explicitly defined in- centives.[20] In the context of our study, volunteer health workers include unemployed health professionals informally engaged, with no uniform remuneration packages and protection. The largest share of these volunteers are community health extension workers (CHEWs) who have been awarded a diploma following completion of a three to 4-year training programme. They are similar to Community Health Workers (CHWs), in that they are drawn from the communities they serve and share the same ethnicity, language, and background[21] but CHEWS undergo more extensive training to enable them to provide maternal and child health care, immunizations, and family planning.[22]

It is important to understand their roles in these facilities, documenting their lived experiences,[23] as this in- formation could offer insights into ways to improve staffing in the Nigerian health system and beyond. These lived experiences encompass the personal, subjective, and often multifaceted aspects of their professional journey, including the challenges and rewards they encounter throughout their careers as health sector volunteers.

It is against this backdrop that this study seeks to examine the lived experiences of volunteer health workers in Nigerian PHCs and explore their implications for the attainment of SDG goals 3 (Good Health and Wellbeing)

and 8 (Decent Work and Economic Growth). They offer untapped potential to strengthen the health workforce in PHC in Nigeria as they have the requisite training and experience needed to fill some important gaps.

Methods

Study design

We conducted a qualitative study using ethnography and phenomenology. It involved participant observation of selected facilities and local government headquarters within Enugu State, in south east, Nigeria (Figure 1). This was supplemented by in-depth interviews with volunteer health workers, formal staff and their health managers.

Figure 1: Map of Nigeria

Sampling and site selection

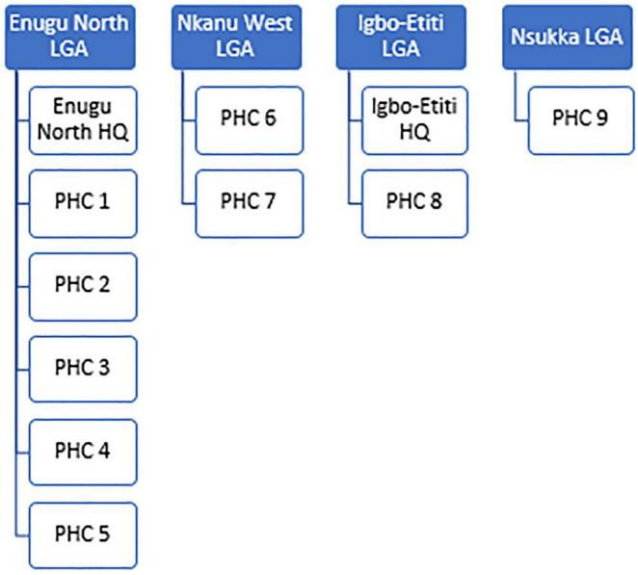
Data collection was planned to take place in nine PHCs located in four of the 17 local government areas in Enugu (Enugu North, Nkanu West, Igbo-Etiti and Nsukka) (Figure 2). However, ultimately, only six could be included because of logistic constraints imposed by distance and transport limitations. In Enugu North, the headquarter (HQ) was selected along with five facilities whose names have been removed to retain confidentially, as required in our ethics approval. In Nkanu West, two health facilities were selected. In Igbo-Etiti, the headquarters and one PHC were selected and in Nsukka, only one health facility was selected. It is important to note that sites were selected in part on the basis of reports of staff shortages and of absenteeism that we believed would increase the likelihood that volunteers would be used.[24,25] Sites were also selected to represent urban (typically busy) and rural (less busy) areas of the State. Selection of sites was contingent upon obtaining approval from the Officer-in-Charge (a health worker responsible for overseeing the administration of a PHC facility) and the Head, responsible for all the PHCs in a local government area. This meant that more facilities were observed in Enugu North where approvals were more readily granted. Such approvals were a condition of ethical approval, as well as being good research practice.[26]

Participants and data collection

This was part of a larger study on health workers and their behaviours that undermine and/or enhance account- ability in primary healthcare. The data collection lasted for 5 months, from December 2020 to April 2021. Four researchers, all trained in participant observation and notetaking, immersed

themselves in the daily life of the facilities. The observation period was organised into two phases. The first involved a 2-week period of unstructuredobservation which informed the development of the observation guide. This was followed by a 3-month period of structured observation. In this phase, field workers examined the lived experiences of volunteers and how these may have been shaped by institutional structures.

Throughout the 8 weeks of participant observation, the research team held weekly meetings to discuss emerging findings, address unanswered questions, and plan activities for the upcoming week. These meetings provided a platform for reflecting on the everyday practices of health workers in general and volunteers in particular. By the end of the observation phase, 35 interviews had been conducted with three groups: volunteers, formally employed staff, and health managers. The interviews were conducted in



English.

Data analysis

Extensive field notes were documented during and after observation sessions, while interviews were audio- recorded and transcribed verbatim. The data, including field notes and transcripts, were imported into NVivo software for analysis. The analyses were based on the combination of narrative analyses and reflexive thematic analysis. This was done by the four researchers who conducted observations. Narrative analysis is a family of methods that analyse the stories that people tell.[27] The stories shared by people serves as windows to their personal experiences, and how this is shaped by the social world.[28] The reflexive thematic analysis was proposed by Braun et al.,[29] and it involves identification, analysis, and interpretation of patterns of meaning inherent in quali- tative data. The combination of methods involves the identification of a series of central narratives from the data, investigating both their structural elements and the thematic links that connect them. This strategy helped us analyse the lived experiences of volunteers, and the broader socioeconomic factors that impact their experience. It has also been used to study the mental health of people seeking asylum in the United Kingdom.[30]

Codes were developed collaboratively within the author team, and after multiple rounds of sorting and organising, these codes were synthesised into overarching themes, a process iteratively refined through discussions within the research team. Two distinct overarching themes emerged from the data included: Emergence of vol- unteers in PHCs and stages of volunteering.

Research Findings

Sociodemographic of participants

There were 35 in-depth interviews (Table 1), broken down as follows: 2 health managers, 16 formally employed staff (Officer-In-Charge, Assistant OIC, CHEW, Health Education, Nurse, Medical doctor), and 17 volunteers (CHEW, JCHEW, Health Assistant). The participants who disclosed their age encompass a range of ages from 24 to 53, and only two are males.

Emergence of volunteers in PHCs

The emergence of volunteer health workers in PHCs is traced to the high unemployment rate and the local gov- ernment's unwillingness to hire formally trained health professionals. In Enugu State, an official recruitment ex- ercise has not been conducted for more than a decade, with authorities attributing the lack of recruitment to budgetary constraints. This has left most PHCs understaffed. To make up for this, PHCs rely on the services of health workers who have the necessary qualifications but are not in formal employment. For example,

> *When I graduated in 2010, I didn't see work, I went to different facilities even private hospitals. So, I had to beg someone, my relative, a woman that I need a health centre where I can stay and work. So, she told x the OIC, to help me secure volunteer work at the health centre so I could attach myself to keep the knowledge fresh. Likewise, others too. They begged her to stay at the health centre and volunteer their services (Volunteer, CHEW, PHC 2).*

However, their recruitment is informal, mostly at the discretion of the Officer-In-Charge – the administrative heads of each PHC, who determines whether they need extra hands and have capacity to manage the volunteer. However, it is expected that they inform the head of department, who may verify their qualifications. Based on our observations, all informally recruited staff are called volunteers as a way to distinguish them from staff recruited through the formal process. When accepted, volunteers may work under the supervision of fully employed staff before gradually gaining independence as their skills are progressively recognized. The following quote is illustrative:

> *Our certificates were checked, and qualification was looked into. And when we started newly, we were placed under the fully employed staff so we could understudy them, before we were left to work without supervision. Then I was under a midwife, Reproductive Officer focal person. Then after 2 years, they saw that we can do it and have the skills to work. Then we were allowed to work alone because we could do it well. Even when they go for training, they usually allow us to work.*
>
> *(Volunteer, CHEW, PHC 5).*

Stages of volunteering

Hope

The ease with which volunteers are initially accepted and integrated into the PHCs creates a sense of hope for most of them. This is especially marked given that most have experienced prolonged periods when they engaged un-

successfully in a search for jobs following graduation from health schools. Being accepted as a volunteer not only provides a sense of purpose for many but also offers stability and opportunities for personal and professional growth. Many see their status as temporary, providing a ladder to reach the status of formally employed staff in due course. The following quote illustrates this:

> *Yes, we always hope so. We hope that by God's grace when they want to start recruitment in the system, they will start with us. We were also told by people that we would be considered first… Thus, [it] gives us the motivation and hope to keep working hard*
>
> *(Volunteer, CHEW, 25, PHC 1, female).*

Table 1 Characteristics of participants.

s/n	Status	Category	Location	Age	Sex
1	Health manager	Head of department	Enugu state	ND	Female
2	Health manager	LIO	Enugu state	ND	Female
3	Formal staff	OIC	PHC 1	52	Female
4	Formal staff	CHEW	PHC 1	51	Female
5	Volunteer	CHEW	PHC 1	22	Female
6	Volunteer	CHEW	PHC 1	25	Female
7	Formal staff	Assistant OIC	PHC 2	ND	Female
8	Volunteer	CHEW	PHC 2	ND	Female

9	Volunteer	CHEW	PHC 3	ND	Female
10	Formal staff	OIC	PHC 3	ND	Female
11	Volunteer	CHEW	PHC 3	ND	Female
12	Formal staff	Assistant OIC	PHC 4	45	Female
13	Formal staff	OIC	PHC 4	53	Female
14	Formal staff	CHEW	PHC 4	51	Female
15	Volunteer	CHEW	PHC 4	30	Female
16	Volunteer	CHEW	PHC 5	37	Female
17	Formal staff	OIC	PHC 6	52	Female
18	Volunteer	CHEW	PHC 6	24	Female
19	Volunteer	JCHEW	PHC 6	24	Female
20	Volunteer	Health assistant	PHC 6	32	Female
21	Volunteer	Health assistant	PHC 6	ND	Female
22	Formal staff	CHEW	PHC 6	38	Female
23	Volunteer	CHEW	PHC 7	35	Female
24	Formal staff	CHEW	PHC 7	41	Female
25	Volunteer	CHEW	PHC 7	28	Female
26	Formal staff	CHEW	PHC 7	ND	Female
27	Volunteer	CHEW	PHC 8	40	Male
28	Formal staff	OIC	PHC 8	44	Female
29	Formal staff	CHEW	PHC 8	48	Female
30	Formal staff	Health education	PHC 9	39	Female

31	Formal staff	Nurse	PHC 9	52	Female
32	Formal staff	OIC	PHC 9	38	Female
33	Volunteer	Health assistant	PHC 9	ND	Female
34	Volunteer	Medical doctor	PHC 9	38	Male
35	Volunteer	CHEW	PHC 9	ND	Female

Abbreviation: ND, Not Disclose

Volunteers are easily integrated into the PHCs, looking like formally employed staff and giving them with a sense of belonging. During the observations, it often took weeks for researchers to be able to differentiate between volunteers and formally employed staff, a fact noted by the CHEWs themselves for example, *"I got the job at [the] first time of asking; Like now, many people including you will think that I am a full staff or even the matron [of the health facility] but I am not"* (Volunteer, CHEW, PHC 9, Female).

The easy acceptance of volunteers can be attributed to the significant staff shortages in many PHCs, perpetuating the demand for health workers. Trained professionals, like CHEWs, are seldom recruited by the state and local government. Meanwhile, existing staff members leave when they reach retirement age, while new fa- cilities are established, necessitating additional personnel. In this context, volunteers exist as quick fix:

> *They had only three health Centres when I started, but now, we have 16 health Centres which will soon be 20 in numbers… I haven't employed anyone since I came, so many people have retired and there is no replacement. We work with volunteers since we don't have enough workers.*

(Health manager, HOD, Female).

The speed at which volunteers are recruited relates in part to the lack of bureaucratic processes. All the volunteers we interviewed approached the OICs in person, or through a friend of family member network, and discuss their desire to volunteer in the public health facility. This provides the opportunity for the OICs to dictate the terms of their work (hours, remuneration and tasks). Therefore, the HODs may not be aware of the conditions or terms in place. For example,

> *Yes, HOD does know about volunteers working in a specific health facility but the agreement regarding their stipends doesn't concern the HOD. The HOD only wants to know the number of volunteers a facility has*
>
> *(Volunteer, CHEW, 22, PHC 1, female).*
>
> *They do, the HOD of health is aware just like I pointed out. When the former HOD came to our facility, I was hiding because I was still new, it was my matron (OIC) who told me to go and greet him so that he would know me*
>
> *(Volunteer, CHEW, 22, PHC 1, female).*

Anger

Among many of the volunteers that we met, the initial hope for stable, interesting, and financially rewarding work which often stems from the ease of acceptance and integration as a health worker, quickly transforms into

frus- tration and anger, driven by a sense of being overloaded with work while poorly compensated. Like other staff, the OICs enter the volunteer worker's name into the roaster of the facility. The roster contains information such as who is at duty, the duty, date, and time of resumption. Over time, the duties can be changed as desired by the OICs.

> *Hmm, we do have rosters. Some of them stay in anti-natal, immunisation, family planning, but after some months they will change. Then you go down, other people will come up. So that's how we rotate it. They usually go to another department to support while others come and work here. Also, to acquire other skills too*
>
> *(Formal staff, assistant OIC, PHC 2).*

Duties are shared between permanent staff and volunteers. Permanent staff can, however, afford to break rules within health centres, often with few consequences. In particular, they can choose to be absent from duty because as permanent staff, the bureaucratic procedure for sanctions is not adequately enforced. In contrast, the volunteers cannot be absent without permission from OICs. Their appointment is informal and through the OIC who also has the power to terminate their positions at will. With this greater control, the OIC is better able to coerce them to perform certain tasks, including those outside the purview of the health facility (i.e., running errands for them). When regular staff are absent from duty, which is frequent, their assigned tasks rest on the shoulders of the volunteers; all of the health facilities that were observed relied on volunteer labour to open on time and function

effectively. Moreover, volunteers are repeatedly reminded that they do not have a stake in the health facility and as such cannot afford to conduct themselves poorly. This is illustrated with the following quotes:

> *You caution the person (volunteer). If the person repeats it again, you caution the person and tell her you may dismiss her if the person does not take correction. But if it is [a] normal staff, they will be cautioned. After the caution, you can issue a written warning. If the staff continue doing what she's doing, then you go and report to the HOD*
>
> *(Formal staff, CHEW, PHC 3).*
>
> *This section on MCH is only volunteers that runs it. All our effort is to make sure that the work at the centre is done. I know how long I stood today, doing my work. Most staff don't care because they know that by month end, they will receive an alert whether they work or not. We volunteers can't do that because we are under the OIC, we have to work well so as to please the person, so she will be happy*
>
> *(Volunteer, CHEW, PHC 2).*

In addition to being held to higher standards, they are expected to demonstrate professionalism and proficiency at all times when dealing with clients. Many volunteers believe that this is a condition to retain their volunteer status. But this also led to a situation we often observed whereby patients preferred to be attended by volunteers. Most patients cannot distinguish between volunteers and formal staff because they wear the same

uniform, but they are well informed about who is regular at the health centre and who has history of attending well to patients. The following quotes are illustrative:

> *You know, volunteer will bring out his or her mind, knowing fully well that this is the only area she will get paid. So, she has to bring out herself in any good thing that she sees, to make that thing to b… put in order, because if she did not do it well, she won't get paid. But the staff, whether doing it well or not doing… she will receive her salary*
>
> *(Volunteer, CHEW, PHC 3).*
>
> *You know in this health centre, there are volunteers and two workers (formally employed staff) from government… Sometimes, they will not even call you that they will not come to work today. You will come you'll not see anybody. You will just see only volunteers. Then you work with them. So that is it*
>
> *(Formal staff, CHEW, PHC 3).*

For these reasons, OICs often expressed a preference for working with volunteers. In contrast to complaints about the formal staff, who were often said to lack seriousness and commitment to duty, volunteers were described as highly dedicated. For example,

> *The OIC prefers to work with volunteers because the fully employed health workers (staff) are not really serious towards work. She always says that volunteers are the ones that do the major job. Some of the staff are less concerned, they are sure that at the end of the month,*

they will be paid. Vol- unteers always take permission from their supervisors if they are not able to come to work

(Volunteers, CHEW, PHC 2).

It is not a problem. I even prefer the volunteers than permanent staff because they will do all the work they are told to do and even do more. But the permanent staffs will say they are staff and you are staff but only that you are the OIC. So, I prefer the Adhoc staff. I don't have problem managing them. If I want something to be done, I will ask the volunteer workers and they will do it perfectly

(Formal staff, 38, OIC, PHC 9).

Poor and disproportionate compensation

Despite the substantial contributions to the functioning of the health facilities, many volunteers reported the absence of a clear payment system. This is another source of anger in the volunteering process. It is important to note that most volunteers were informed that there would be little or no compensation at the onset of volunteering. Despite this, some volunteers report being "promised into," suggesting a spectrum of assurances or expectations about compensation. The stipends that volunteers reported receiving in the six health centres that we observed ranged from 3000 Naira to 15,000 Naira per month, far below the national minimum wage of 30,000 (€31; US$34) Naira per month. Payment varies across facilities. For illustration:

When I started newly, the OIC told me that she was not going to pay me anything and I accepted that. So, when she started giving me 3000 Naira per month as stipend, I gladly accepted it. I won't start being angry, although I don't know the nature of her agreement with other volunteers. This is my agreement when I started work

(Volunteers, CHEW, PHC 2).

These volunteers work together every day. At the end of the month, our OIC will give them some stipends for their transport. I don't know, but I know their payment is not general. But I know she used to give some of them 8,000 – 10000 Naira per month. Between 15000 and 10000 Naira

(Formal staff, assistant OIC, PHC 2).

Whatever the payment, volunteers express acceptance and gratitude to the OIC knowing that they are in no position to dictate terms while also nurturing anger and resentment over their treatment. Anger gradually sets in due to unmet expectations, coupled with the workload they shoulder. For example,

If this is how to get a job then it is tedious and after you get it, it will be boring. How can you serve for more than 12 years without pay and considering the suffering involved? It is tedious and when you finally get it, no amount of money paid to you will make you feel satisfied considering the prolonged years of working for free

(Volunteer CHEW, PHC 9, female).

The stipends provided to the volunteers are raised from informal payments from clients (i.e. payment for immunisation which is actually free). This is illegal and in most cases, health managers are in the know and take no action. The revenue generated in this way is also used to settle other demands (i.e., payment for electricity bills) in the health facilities. However, it was also discovered that formal staff benefit more from these proceeds than the volunteers, serving as another source of anger. The salaried staff rationalise this disproportionate sharing of illegal proceeds by arguing that if there are consequences, it is usually they who would suffer. For example

> *You know immunisation is free, the little money they get is used for buying some items like the cotton wool and for paying the volunteers. What we do is that we tell them openly that immu- nisation is free*
>
> *(Health manager, LIO, Female).*
>
> *There was a point last year that government said we should not collect anything at all. So, our OIC called a meeting and told them, see the situation they said we should not collect anything at all it means that the volunteers will go because she will not use her salary to pay them. That one may lead to termination of appointment. But as time goes on, we still continued with the way we use to collect the #50, #100, that's why they are still with us. But if they say we should not collect at all that would lead to their termination*
>
> *(Formal staff, assistant OIC, PHC 2).*

Truly they are justified but the other way round if the staff want to share some illegal proceed and there is a problem along the line it is the permanent staff that will be held accountable and not the ad hoc (volunteer) so that is the reason why most times the permanent staff opt not to share things equally with the ad hoc staff

(Formal staff, 39, PHC 9).

Bargaining

The emotional toll on volunteers becomes evident over time, as t hey experience a sense of dissatisfaction about not being entitled to certain benefits and the perception of unacknowledged efforts. They express a desire for recognition comparable to formally employed staff, bargaining for equal treatment and acknowledgement from both their colleagues and the government. This recognition, they hoped would be obtained through the formal- isation of their appointment by the local government. Often, the government reacts by asking them to submit their CVs to be considered for employment but this rarely leads to a positive outcome. This is because the employment process is marred by patronage, whereby individuals with connections to influential people, such as high-ranking civil servants, politicians, and government officials, nominate their preferred candidates. Consequently, selection for formal employment tends to be covert, and influenced by personal affiliations rather than merit-based. This leaves the volunteers without connection in despair. For illustration:

It's the same in every facility. We were told [that] it is from the volunteers that employment will start whenever there is open vacancy. That was in 2008, before my graduation. Since then, I have not heard of any employment. Sometimes we are asked to write down our names for possible employment but at the end, there is no positive result

(Volunteer, CHEW, PHC 2).

Some of them knows the person on top, but you know these days, you try and try and try, no employment. Some of them know the people on top that's why they got the job without advert

(Formal staff, OIC, PHC 8).

Nothing has changed since then, it's painful that you see people you graduated with and even your juniors who are now employed. That's to tell you that employment is going on secretly and it's very annoying

(Volunteer, CHEW, PHC 1).

With little opportunity for formal employment, some initiated a process of bargaining for increased stipends from their OICs. They cited the socioeconomic situation of the country and the challenges of continuing to work with little or no compensation. For example,

I don't know because even the 15,000 Naira they are paying didn't come easily, they have been paying me 10,000 Naira until I pleaded with the OIC to increase it because it became too small to take care of

my basic needs. If they can be paying me 30,000 or 35,000 Naira, it will be considered (Volunteer, CHEW, PHC 4).

The response of OICs to these requests can significantly impact the volunteers' subsequent actions. A positive response may instil a sense of hope, while a negative response could trigger anger, shaping the volunteers' subsequent decisions.

Acceptance

The lack of recognition and benefits leaves an impression of frustration, as most volunteers feel that their efforts and contributions are unnoticed by their managers. The feeling of not being regarded as a formal employee, despite their contributions, fosters an unsettling ambiguity about their place within the health facilities. As volunteers navigate their daily responsibilities, a sense of demoralisation sets in. The emotional toll of feeling undervalued gradually erodes the enthusiasm that once fuelled their work. The workplace, instead of being a source of hope and professional growth, transforms into a testing ground for resilience. For illustration:

You know they are not fully employed staff. It makes them feel somehow as if they are working for us. They are working, we are being paid, you know they are not full staff. That's what they feel, some of them o. Some of them feel they are the main people working and they are not being paid. At times you will see their commitment is not full because they are not paying them

(Formal staff, assistant OIC, PHC 4).

I feel bad because you are not entitled to anything and you do everything just to make them happy like coming to work early to clean the facility. If I were a health worker (staff), I won't be doing that, I only do it because I have no option

(Volunteer, CHEW, PHC 4).

At this stage, most volunteers shared the concern that they may remain in perpetual volunteering without ever transitioning to fully employed status. The fear of working hard without job security emerges as a common worry. This is a strong basis for fear and is further buttressed by the fact that only a few volunteers eventually make it into formal employment, through networks with powerful persons. Additionally, there is also the shared concern about the insecurity in volunteering, including the lack of benefits.

Yes, maybe when the OIC comes she now access maybe watching at the person handwork or see maybe the handwork is not erm or maybe the manner of approach, she uses with patients she can now tell the person you can stop for now, I don't need you for now when I need you, I will call. So, no need of telling the person stop coming again, she can even tell the person that no incoming money for the facility to keep up with the payment (Volunteer, CHEW, PHC 5).

Something that didn't come from the top or head is not usually recognized. There are a lot of things you are not privileged to. You are not privileged to bonuses, promotion and the rest. It might just be after a while your contract can even be terminated. They are not under the labour law.

(Volunteer, Medical Doctor, 38, PHC 9).

To quit or not quit

Eventually, most of the volunteers who do not receive improved treatment tend to disengage through unannounced absence from duty or by informing the OICs. Many seek formal employment elsewhere while some completely abandon their practice for business. What is also important to note is the sense of freedom or independence, as they believe they can choose to stop volunteering without facing consequences, given the perceived lack of visibility and recognition by the government. For illustration:

> *When my second was recruited, there was a man working here as a volunteer, the man later left, another man was recruited who stayed for 2 years and left to start a business. The man later left, another man was recruited who stayed for 2 years and left to start a business*
>
> *(Volunteer, CHEW, 28, PHC 7).*
>
> *Nobody will query me because I am just volunteering myself to work for the government. The gov- ernment don't know me and if I stop, they won't know unless I am a full-time staff*
>
> *(Volunteer, CHEW, PHC 9).*

However, some volunteers may continue because they are accruing other benefits from the health facilities. This could be use of the space for business or nurturing a specific goal, including perfecting skills to start a private practice. For example,:

Some quitted but I am still around because I have my aim which is to perfect the act of child delivery, child circumcision and drug administration to patients so that it won't be a difficult thing when I decide to have my own health facility and also in case they want to recruit, they will want to take us since we have been here for years considering our suffering

(Volunteer, CHEW, PHC 9).

Well, I engage myself in something else, I do my little business outside. I deal on male clothing

(Volunteer, CHEW, PHC 6).

Discussion

The narratives shared by healthcare volunteers offer a comprehensive insight into their experiences within the context of their roles and how their perceptions of being in these roles evolve over time. Through the exploration of their stories, we have revealed the intricate dynamics of volunteerism, the prevailing perceptions regarding employment prospects, and the challenges of seeking to continue their professional journey in acutely under- resourced healthcare system. Consequently, four stages of the experience of volunteering in PHCs emerged (Figure 3) showing the phases that most volunteers pass through.

A major finding is the profound reliance on volunteer health worker in health facilities facing persistent staff shortages. These volunteers, predominantly trained as CHEWS, constitute the backbone of the workforce in these

healthcare settings. This narrative consistently underscores the invaluable role volunteers play in addressing critical gaps in the healthcare workforce. Other studies have similarly shown that volunteers make critical contributions to the health systems of LMIC.[3,31] In this study, their role was seen as essential to bridge the gap created by unemployment of formal staff. In essence, these narratives not only shed light on the personal journeys of healthcare volunteers but also illuminate the broader issue of corruption and patronage system affecting the recruitment of staff. Consequently, it calls for the re-examination of the recruitment process in PHCs.

The findings also show that the recruitment of volunteers is mostly handled by the Officer-in-Charge and not local government officials. This informal recruitment process could be through direct interaction between volun- teers and the Officer-in-Charge. While it highlights flexibility in the system, it also creates a sense of hope in the volunteers that their status would soon elevate to formally employed staff. But the hierarchical oversight structure in the recruitment of volunteers, where the head of department is informed but compensation details remain outside their purview, reveals a potential disconnect. The Primary Healthcare Under One Roof policy, which provides the strategic direction of PHC in Nigeria, requires the head of department and the local government health authority to fulfil an oversight function.[32] Consequently, their lack of involvement in the compensation of volunteers may create room for exploitation.

We showed that compensation is a significant challenge for healthcare volunteers, because of the absence of a fixed salary and reliance on informal payments. A recent study has also shown that health workers justify these

informal payments as ‘small’ and necessary to sustain activities in the PHCs.[33] In this study, the variable stipends that volunteers received are influenced by the Officer-in-Charge's discretion and the amount generated from informal payments by the facility. Volunteers' dedication and loyalty to the officer-in-charge become a determining factor in their compensation, and this system often reflects the financial realities of the health facility. But it also buttresses the disconnect between contributions and compensation, and serves as a reason for the anger that volunteers describe.

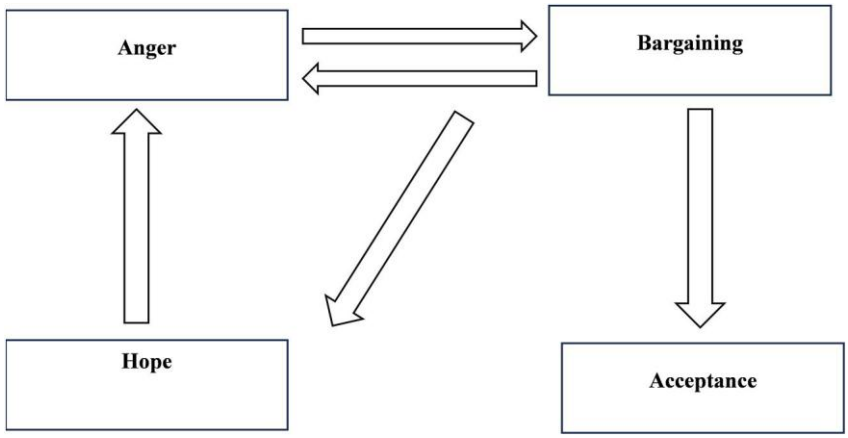


FIGURE 3 The four stages/process of volunteering in PHCs.

The emotional toll on volunteers, stemming from their perceived undervaluation and the disparity between their status and those of formally employed staff, is an important finding. Despite their commitment and contributions to public health, volunteers grapple with feelings of frustration and

the continuous search for recognition and appreciation. The hope for future employment opportunities serves as a double-edged sword, motivating volunteers to persist despite challenges but also contributing to potential disillusionment if expectations are not met. This also validates previous studies showing that volunteering may be connected to the search for identity and the opportunity to be connected to institutions that can contribute to their personal growth and development.[12] Volunteers express hope for future employment opportunities, often encouraged by occasional requests for their names and credentials by the local government. This is the bargaining stage where they believe that some- thing positive could occur. However, most reported that they have been disappointed as this promise did not materialise. In a study in Sierra Leone, volunteer nurses were similarly promised jobs during the Ebola crises only to be later denied by the government.[11] In this study, some volunteers even go to the length of asking for improved pay from the Officer-in-Charge, highlighting prevailing socioeconomic challenges and the hardships encountered in managing the stipends promised to them. As demonstrated in another study, acceding to this request may offer hope, further boosting the commitment of volunteers.[34] However, not acceding to this may mark the end of their volunteering.

On the whole, concerns about job insecurity, non-recognition, and potential exploitation create a sense of vulnerability among volunteers. The patronage system, where influential connections play a role in formal employment, raises concerns about fairness and transparency. The narratives suggest that personal affiliations may outweigh merit-based considerations, leaving volunteers without influential connections feeling disenfranchised. Studies

emerging from west Africa also corroborate that health facilities operate as a patronage system where politically connected persons gain employment and are protected when they break the law.[25,35] In this study, the fear of remaining in perpetual volunteer status without transitioning to formal employment emerges as a prevalent worry among volunteers. At this stage, most volunteers accept that they may never gain employment and as such, quit or look for opportunities elsewhere.

Implications for the attainment of key health system goals

The volunteering experience in PHCs in Nigeria could have significant implications for mental health and the safety and security of workplace environment. Excessive workload created by the absence of colleagues can lead to chronic stress and burnout. Likewise, the constant pressure to meet responsibilities without appropriate re- wards and precariousness can result in emotional exhaustion and a sense of being overwhelmed. The Centre for Disease Control[36] reported that poor mental health and negative working conditions are increasing among health workers compared to any other group. This study suggests that this situation might be particularly dire for volunteer health workers who experience consistent negative work experience due to their status as volunteers. This calls attention to the need to consider the mental health of volunteers who are engaged as health providers in PHCs.

The lack of security in the volunteering process and the absence of clear pathways for rewarding and retaining volunteers are causes for concern. However, volunteers can help alleviate workforce and skills shortages, thereby strengthening PHCs in Nigeria. Volunteers acquire new skills and

accumulate professional experiences, making them indispensable to the Nigerian health system. Yet, the government's attitude toward volunteers, including promises of employment that often go unfulfilled, lead to unmet aspirations and can be a source of frustration for many volunteers. The national policy on volunteerism in Nigeria emphasises the need to protect and reasonably compensate volunteers.[13] Neglecting this policy means that many volunteers continue to experience insecurity in their volunteering process, impeding efforts to achieve the SDGs by 2030.

It is important for the government to have an effective tracking system on the availability of different cadres of human resources for health in the health system for monitoring entry, performance and exit of volunteers from PHCs. As recommended by the Lancet Nigeria Commission “Further, human resources for health tracking and data management systems should be set up at state ministries of health and linked to all training institutions and service delivery points, including the private sector, to facilitate human resources for health planning (p. 1179)."[15] Poli- cymakers should also devise strategies to compensate and retain volunteers, especially those who have distin- guished themselves in practice.

Limitations

While volunteering is widespread in health facilities in Nigeria, there is a lack of evidence and this study sought to provide in-depth initial analysis based on qualitative fieldwork – caution is needed in generalising the findings of this study. The complex nature of Nigeria's multiethnic and religious landscape calls for further research in other parts of the country. Additionally, health workers, including volunteers, may have different

experiences in other PHC facilities where management structures and processes differ. This complexity underscores the need for further studies to gain a comprehensive understanding of the dynamics at play.

Conclusion

The findings highlight the complex and multifaceted nature of healthcare volunteerism in the context of PHCs. The engagement of volunteer health workers offer promise to expand coverage and meet the SDGs however there are major concerns with how they work. The volunteers' experiences reflect a delicate balance between dedication to public health service, the struggle for financial survival, and the hope for eventual formal employment. Addressing these challenges may require a re-evaluation of the recruitment and compensation processes, as well as efforts to bridge the gap between volunteers and fully employed staff in terms of recognition and appreciation within health facilities.

AUTHOR CONTRIBUTIONS

Aloysius Odii, Eleanor Hutchinson, Obinna Onwujekwe, Pamela Adaobi Ogbozor, Prince Agwu, Charles T. Orjiakor and Dina Babalanova participated in the conceptualisation and design; Aloysius Odii, Pamela Adaobi Ogbozor, Prince Agwu, and Charles T. Orjiakor collected and analysed the data; Aloysius Odii prepared the original draft; Eleanor Hutchinson, Obinna Onwujekwe, Pamela Adaobi Ogbozor, Prince Agwu, Charles T. Orjiakor, Dina Baba- lanova, Martin McKee, review and edit the manuscript; Eleanor Hutchinson, Dina Babalanova, Obinna Onwujekwe and

Martin McKee administrated the project and funding. All authors approved the submitted version.

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Ethics statement

Ethical approval was obtained from Health Research Ethics Committee of London School of Hygiene & Tropical Medicine (LSHTM ref: 14 540–1) and University of Nigeria Teaching Hospital Ituku-Ozalla, Nigeria (NHREC/05/01/ 2008B-FWA00002458-IRB00002323). The consent to be observed was obtained from the health workers, including volunteers in the selected health facilities. Also, written consent form was signed by the interview par- ticipants, having read through the purposes of the research and the benefits and risks of participating.

References

1. Kasteng F, Settumba S, Källander K, Vassall A, the inSCALE Study Group. Valuing the work of unpaid community health workers and exploring the incentives to volunteering in rural Africa. *Health Policy Plan*. 2016;31(2):205-216. https://doi.org/10.1093/heapol/czv042

2. Fracchia M, Molina-Millán T, Vicente PC. Motivating volunteer health workers in an African capital city. *J Dev Econ*. 2023;163:103096. https://doi.org/10.1016/j.jdeveco.2023.103096
3. Laleman G, Kegels G, Marchal B, Van der Roost D, Bogaert I, Van Damme W. The contribution of international health volunteers to the health workforce in sub-Saharan Africa. *Hum Resour Health*. 2007;5(1):19. https://doi.org/10.1186/ 1478-4491-5-19
4. Takasugi T, Lee ACK. Why do community health workers volunteer? A qualitative study in Kenya. *Public Health*. 2012;126(10):839-845. https://doi.org/10.1016/j.puhe.2012.06.005
5. Omoto AM, Packard CD, Ballew MT. Personality and volunteerism. In: *The Wiley Encyclopedia of Personality and In- dividual Differences*. John Wiley & Sons, Ltd; 2020:447-451. https://doi.org/10.1002/9781119547181.ch339
6. Zakaria WZW, Jaafar JR. Exploring the lived experiences in formal volunteering among people with mental illnesses (PWMI) in Selangor. 2021;9.
7. Haski-Leventhal D, Paull M, Young S, et al. The multidimensional benefits of university student volunteering: psy- chological contract, expectations, and outcomes. *Nonprofit Volunt Sect Q*. 2020;49(1):113-133. https://doi.org/10. 1177/0899764019863108
8. Ward P. The worth of their work: the (In)visible value of refugee volunteers in the transnational humanitarian aid sector. *Work Employ Soc*. 2022;36(5):928-944. https://doi.org/10.1177/09500170221082481
9. Lawton RN, Gramatki I, Watt W, Fujiwara D. Does volunteering make us happier, or are happier people more likely to volunteer? Addressing the problem of reverse causality when estimating the wellbeing impacts of

volunteering. *J Happiness Stud*. 2021;22(2):599-624. https://doi.org/10.1007/s10902-020-00242-8

10. Domaradzki J. 'Who else if not we'. Medical students' perception and experiences with volunteering during the COVID-19 crisis in poznan, Poland. *Int J Environ Res Public Health*. 2022;19(4):2314. https://doi.org/10.3390/ ijerph19042314
11. Park SJ. They overworked us. *Med Anthropol Theory*. 2017;4(3). https://doi.org/10.17157/mat.4.3.462
12. Prince RJ. Seeking incorporation? Voluntary labor and the ambiguities of work, identity, and social value in contemporary Kenya. *Afr Stud Rev*. 2015;58(2):85-109. https://doi.org/10.1017/asr.2015.39
13. Federal Republic of Nigeria. National Policy on Inclusive Volunteerism for Nigeria; 2020. https://knowledge.unv.org/ sites/default/files/2021-06/DRAFT%20National%20Policy%20on%20Inclusive%20Volunteerism%20for%20Nigeria%20and%20its%20Plan%20of%20Action_.pdf
14. Adeloye D, David RA, Olaogun AA, et al. Health workforce and governance: the crisis in Nigeria. *Hum Resour Health*. 2017;15(1):32. https://doi.org/10.1186/s12960-017-0205-4
15. Abubakar I, Dalglish SL, Angell B, et al. The Lancet Nigeria Commission: investing in health and the future of the nation. *Lancet Lond Engl*. 2022;399(10330):1155-1200.

https://doi.org/10.1016/S0140-6736(21)02488-0

16. Onah CK, Azuogu BN, Ochie CN, et al. Physician emigration from Nigeria and the associated factors: the implications to safeguarding the Nigeria health system. *Hum Resour Health*. 2022;20(1):85. https://doi.org/10.1186/s12960-022- 00788-z
17. Uchendu C, Windle R, Blake H. Perceived facilitators and barriers to Nigerian nurses' engagement in health promoting behaviors: a socio-ecological model approach. *Int J Environ Res Public Health*. 2020;17(4):1314. https://doi.org/10. 3390/ijerph17041314
18. Adetayo JO. A study of factors influencing brain drain among medical personnel in Nigeria. *Niger J Health Biomed Sci*. 2010;9(1). https://doi.org/10.4314/njhbs.v9i1.60969
19. Lawal L, Lawal AO, Amosu OP, et al. The COVID-19 pandemic and health workforce brain drain in Nigeria. *Int J Equity Health*. 2022;21(1):174. https://doi.org/10.1186/s12939-022-01789-z
20. Federal Government of Nigeria. Second National Strategic Health Development Plan (2018 - 2022); 2018.
21. Schaaf M, Warthin C, Freedman L, Topp SM. The community health worker as service extender, cultural broker and social change agent: a critical interpretive synthesis of roles, intent and accountability. *BMJ Glob Health*. 2020;5(6): e002296. https://doi.org/10.1136/bmjgh-2020-002296
22. McCollum R, Otiso L, Mireku M, et al. Exploring perceptions of community health policy in Kenya and identifying implications for policy change. *Health Policy Plan*. 2016;31(1):10-20. https://doi.org/10.1093/heapol/czv007

23. Hutchinson E, Kiwanuka S, Muhindo R, et al. The paradoxical surplus of health workers in Africa: the need for research and policy engagement. *Int J Health Plann Manage*. 2024. https://doi.org/10.1002/hpm.3745
24. Obodoechi DN, Onwujekwe O, McKee M, et al. Health worker absenteeism in selected health facilities in Enugu state: do internal and external supervision matter? *Front Public Health*. 2021;9. https://doi.org/10.3389/fpubh.2021.752932
25. Odii A, Onwujekwe O, Hutchinson E, et al. Absenteeism in primary health centres in Nigeria: leveraging power, politics and kinship. *BMJ Glob Health*. 2022;7(12):e010542. https://doi.org/10.1136/bmjgh-2022-010542
26. Cypress BS. Rigor or reliability and validity in qualitative research: perspectives, strategies, reconceptualization, and recommendations. *Dimens Crit Care Nurs*. 2017;36(4):253-263. https://doi.org/10.1097/DCC.0000000000000253
27. Riessman CK. Narrative Methods for the Human Sciences. Sage Publications; 2008.
28. Jewett R, Kerr G, Tamminen K. University sport retirement and athlete mental health: a narrative analysis. *Qual Res Sport Exerc Health*. 2019;11(3):416-433. https://doi.org/10.1080/2159676X.2018.1506497
29. Braun V, Clarke V. Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. *Couns Psychother Res*. 2020;21(1):37-47. https://doi.org/10. 1002/capr.12360
30. Jannesari S, Molyneaux E, Lawrence V. What affects the mental health of people seeking asylum in the UK? A narrative analysis of migration stories. *Qual Res Psychol*. 2022;19(2):295-315. https://doi.org/10.1080/14780887.2019.1581311

31. Rajaa S, Sahu SK, Thulasingam M. Assessment of Community Health Volunteers contribution and factors affecting their health care service delivery in selected urban wards of Puducherry – a mixed-methods operational research study. *Clin Epidemiol Glob Health*. 2022;17:101135. https://doi.org/10.1016/j.cegh.2022.101135
32. National Primary Health Care Development Agency. Implementation Guidelines for Primary Health Care under One Roof (PHCUOR); 2018. https://ngfrepository.org.ng:8443/jspui/bitstream/123456789/3275/1/IMPLEMENTATION% 20GUIDELINES%20FOR%20PHCOUR.pdf
33. Ogbozor PA, Hutchinson E, Goodman C, McKee M, Onwujekwe O, Balabanova D. The nature, drivers and equity consequences of informal payments for maternal and child health care in primary health centres in Enugu, Nigeria. *Health Policy Plan*. 2023;38(suppl 2):ii62-ii71. https://doi.org/10.1093/heapol/czad048
34. Kweku M, Manu E, Amu H, et al. Volunteer responsibilities, motivations and challenges in implementation of the community-based health planning and services (CHPS) initiative in Ghana: qualitative evidence from two systems learning districts of the CHPSþ project. *BMC Health Serv Res*. 2020;20(1):482. https://doi.org/10.1186/s12913-020- 05348-6
35. Onwujekwe O, Agwu P, Orjiakor C, et al. Corruption in Anglophone West Africa health systems: a systematic review of its different variants and the factors that sustain them. *Health Policy Plan*. 2019;34(7):529-543. https://doi.org/10. 1093/heapol/czz070
36. CDC. Health Worker Mental Health Crisis. Centers for Disease Control and Prevention; 2023. Accessed 29 November 2023. https://www.cdc.gov/vitalsigns/health-worker-mental-health/index.html