EXTERNAL MONETARY INCENTIVE POLICIES FOR COMMUNITY VOLUNTEERS

ANALYSIS REPORT OF A MULTI-COUNTRY STUDY
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AFRICAN PROGRAMME FOR ONCHOCERCIASIS CONTROL
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## Abbreviations

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<tr>
<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
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<td>CDD</td>
<td>community-directed distributor</td>
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<td>CDTI</td>
<td>community-directed treatment with ivermectin</td>
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<td>CV</td>
<td>Community Volunteers</td>
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<td>EMI</td>
<td>External Monetary Incentives</td>
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<td>EPI</td>
<td>Expanded Programme for Immunisation</td>
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<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>ITN</td>
<td>insecticide-treated net</td>
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<tr>
<td>LGA</td>
<td>Local government authority</td>
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<td>MoA</td>
<td>Ministry of Agriculture</td>
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<td>MoEnv</td>
<td>Ministry of Environment</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>MoW</td>
<td>Ministry of Water</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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This report presents the findings of the first phase of a multi-country study carried out for the African Programme for Onchocerciasis Control (APOC) on the issue of external monetary incentives (EMI) provided to community volunteers. The main objective of the study was to document policies on these external monetary incentives by different health programmes, the determinants of these policies and to what extent they overlap at the implementation level. Four countries and ten sites were included in the study: Nigeria (6 sites), Cameroon (2 sites), Uganda (1 site) and Ethiopia (1 site). A qualitative approach was adopted, as data was collected with checklists and document reviews.

The results show that the use of community volunteers for service delivery is common in the health, water, agricultural and environmental sectors. All but one of the sixteen ministries visited at the national level engage community volunteers in their activities, with as many as 68 health programmes using volunteers at the federal level in Nigeria. Cameroon reports 12 health programmes using community volunteers, Uganda 49 and Ethiopia 58.

There is limited guidance from government regarding external monetary incentives, with a few notable exceptions. Six out of fifteen ministries studied, reported having a general policy on EMI for community volunteers. The ministries of Agriculture and Water seem to have the most grip on matters, whereas only one Ministry of Health (Cameroon) in the study and one Ministry of Environment (Nigeria) has a general policy on EMI. Where such a policy exists, it tends to prescribe the provision of EMI. The Ethiopian Ministry of Water (MoW) is the only ministry in the study to have a general policy to not give EMI. This lack of guidance goes a long way in explaining the lack of harmonisation on the issue. Moreover, where a general policy exists it tends to be rather generic, without specific parameters for standardisation.

Most health programmes have a policy/practice of giving external monetary incentives. Only the national data of Nigeria and Uganda contradict this, with less than half of programmes that use community volunteers, having a policy/practice to give EMI. At sub-national level, the reality is that programmes with a policy/practice to give EMI are by far the majority (approximately four out of five).

The two major reasons reported for giving EMI are to motivate volunteers and to facilitate service delivery. The main reason not to give EMI is to ensure sustainability.

Cash incentives are the most common types of external monetary incentives (excluding low cost in-kind incentives like T-shirts, caps, refreshments, etc). Transport allowances, stipends and per diems are typical forms of EMI and they often represent a sizeable income, especially when compared to GDP per capita. The average monetary value of EMI varies per site (from US$ 20 to US$ 310 per volunteer per year) and per health issue (from US$ 10 to US$ 290 per volunteer per year). TB/Leprosy, Reproductive health, STI/HIV/AIDS, Malaria, Nutrition and Immunisation are the health issues providing the highest EMI. These also happen to be the issues receiving the largest donor funds. Donors play a significant role in setting these EMI. Their role is mostly indirect, through the provision of funds. Yet, some donors...
appear to be influencing policies more directly by actually convincing programme managers to have a certain policy or by making it a funding condition.

**Current geographical overlap is high**, with an average of 10 programmes overlapping per district/LGA. And this number is only likely to increase. The financial cost of these EMI to the health systems is considerable.

The occurrence of using the same community volunteers between programmes is highly variable. Where it is done, it could have the positive effect of alleviating some issues, especially if programmes that share volunteers also have a concomitant joint policy on EMI. However, this is not yet the case and where sharing is common, providing programme-specific EMI remains equally common. All in all, coordination and mostly harmonisation are very limited. Where reported, harmonisation remains incomplete, as is the case in Cameroon, where programmes continue to provide their own incentives funded out of their own baskets.

The study suggests that there is a need to formulate a general policy at the national level to guide the implementation of the widespread practice of giving EMI to community volunteers. The current fragmentation of incentive packages is neither cost-effectiveness nor a fine example of coordination in the health sector. A phase II study would enable us to verify the situation at the operational level and understand the dynamics triggered by these external monetary incentives.
1. INTRODUCTION

1.1 Rationale for the study

The health services in developing countries are often unable to cope with high demand for health care delivery, thus the increasing dependence on community involvement and the use of volunteers to help provide these services. The organisations involved in community-based programmes, determine the degree and type of community involvement. The community-directed treatment with ivermectin (CDTI) is a strategy in which communities are responsible for managing and implementing their own programme, selection of community-directed distributors (CDDs) and deciding the type of incentives (monetary and non-monetary) to provide to volunteers. CDTI promotes active community participation and decision-making as a means of improving access to the drug and promoting a sense of responsibility, ownership and sustainability (Amazigo et al. 2002). The CDDs are involved in census, distribution, record keeping and management of side effects. Many are motivated not by monetary incentives but by recognition, self-esteem and skills acquired. Eighty two percent (82%) of CDDs are involved in additional health and development activities in their communities. Some are reported to be involved in as many as six additional activities (Homeida et al. 2002; Okeibunor et al. 2004). The main activities they were involved in were the Expanded Programme on Immunisation (EPI), community development projects, water and sanitation and agriculture (Okeibunor et al. 2004).

Other externally funded control programmes such as EPI, Vitamin A distribution and family planning provide volunteers with external monetary incentives (EMI). In EPI, the polio eradication programme uses the campaign strategy to improve vaccination coverage and thus pays incentives. CDDs involved in EPI were more motivated for EPI activities than for CDTI and other activities they were involved in. This might create problems for volunteers in community-based programmes where incentives are not provided (Amazigo et al. 2002). Also, CDTI technical project reports from various countries have attributed CDD attrition to monetary incentives provided by other programmes (Okeibunor et al. 2004).

A case study of incentives in the Mali health system reported a dissonant situation in which each programme implemented its own external incentive policy. There was a lack of coordination and a considerable dependence on external funds in most of the 14 health programmes supported by various partners (MoH, NGOs and UNICEF) in the country (Remme 2005). According to the study, incentives could therefore affect volunteerism, effectiveness of community involvement, coverage and sustainability. Cameroon has an incentive policy in which volunteers involved in the distribution of Mectizan® are paid by government. There is however a dearth of information on incentive policies and practices in other countries. To understand the extent of the incentive problem in Nigeria, APOC and National Programme on Immunisation agreed to a joint research study. The idea was later extended to include other APOC countries, namely Cameroon, Ethiopia and Uganda.
This multi-country study set out to document the policies of external monetary incentives for community volunteers by different health programmes, the determinants of these policies and to what extent they overlap at the implementation level, in the first phase. Based on the outcome of Phase I study, a second phase study is expected to be carried out to determine the practices and perceptions at the community level with respect to external monetary incentives. The outcome of these studies could inform policies and practices on incentives for community-based programmes.

1.2 Operational definitions

Community Health Volunteers: Members of the community who are engaged to perform or offer to perform services at their own free will with or without monetary or in kind incentives.

Donors are institutions that voluntarily support funding and may or may not be involved in direct provision of services.

External Monetary Incentives: rewards/remunerations given to volunteers on ad hoc or regular basis by health and other programs in the form of cash or in-kind (such as bicycles, motorcycles, radios, ITNs and others) to motivate effort and encourage volunteers to improve and sustain their performance in the community.

Health Issue: disease or health concern used to categorise programmes in the MoH, such as Onchocerciasis Control, Schistosomiasis Control, Nutrition, Reproductive Health, etc.

Health Programme: projects or activities organised by MoH, NGOs and other institutions to provide preventive, curative, promotive or rehabilitative health services to the community through community volunteers. They include health and health related services provided, supervised and regulated by the MoH of a given country and tend to fall under one of the health issues.

National/General Incentives Policies: formal statements of policy developed by government that guides the decisions and actions pertaining to provision of incentives to community volunteers.

Non-Government Organisations (NGOs) are non-profit organisations that are involved in provision, promotion or supporting the provision of services to the community that are not part of government bureaucracy, political parties or business community.

Programme Incentives Policies: formal statements (written and non-written) of policy developed and endorsed at health programmes level (MoH, NGOs, other institutions) that guide the decisions and actions pertaining to provision of incentives to community volunteers.

Programme Overlap: health programmes are said to overlap when their intervention areas coincide geographically at district (LGA) level. By district, we mean the next administrative level after the sub-national one (i.e. National – Regional/Provincial – District).
1.3 Research questions

- What are the policies of different health programmes relating to external monetary incentives for community volunteers?
- What are the determinants of policies of different health programmes relating to external monetary incentives for community volunteers?
- Where do the policies of different health programmes relating to external monetary incentives for community volunteers overlap at the implementation level?
2. STUDY OBJECTIVES

2.1 Main objective

To document the policies on external monetary incentives for community volunteers by different health programmes, the determinants of these policies and to what extent they overlap at the implementation level.

2.2 Specific objectives

- To document any general policy at the national level (states/provinces) on external monetary incentives for community volunteers in the health, HIV/AIDS, agriculture and water sectors.
- To document the external monetary incentive policies of the different health programmes for community volunteers, including the type, monetary value and frequency of the incentive provided, as well as the involvement of communities in setting these incentives.
- To determine the rationale for the above policies and the role of donors in influencing these policies.
- To determine the current and potential/future overlap of these health programmes in the different districts/LGAs.
- To determine whether programmes have policies on using volunteers selected for other health programmes and how they deal with incentives in such cases.
- To document any coordination/harmonisation of incentive policies and practices among different health programmes at national and state/provincial levels.
- To compare external monetary incentive policies in different countries (existence; range; and uniformity of donors’ and programmes’ policies).
3. METHODOLOGY

3.1 Protocol development workshop
(25-27 July, APOC, Ouagadougou)

APOC organised a protocol development workshop on incentives for 10 participants from Nigeria, Cameroon, Ethiopia and Uganda. Six of the participants came from Nigeria including two representatives from the National Immunisation Programme. Other countries had one representative each.

3.2 Study design

This is a two-phased multi-country study that is cross-sectional in design. The first phase concentrated on documenting the existing external monetary incentive policies for the different community-based programmes using community volunteers in five APOC-selected countries, namely; Cameroon, Ethiopia, Nigeria and Uganda. The first phase employed a qualitative approach, using checklists and document reviews.

Phase II will be an in-depth study on how incentives policies have been translated into practice and the perceptions of these incentives by various key players, including the community volunteers.

3.3 Study sites

The first study level was the national (or federal) level. Data was collected at this level in order to sketch the general situation, which was then supplemented by sub-national study sites. A total of 10 study sites were involved in the study. Six of these were from Nigeria, one selected from each geopolitical zone. Cameroon had 2 sites, one in the Anglophone and the other from the Francophone province. Ethiopia and Uganda each had one site.

Selection of sites:

- **Cameroon:** 1 province per language zone (2). North West Province (Cameroon Anglophone) and Far North Province (Cameroon Francophone) were chosen based on the results of overlap at the national level (the province with the most overlapping programmes).

- **Ethiopia:** Oromia state was chosen based on the results of overlap at the national level (the region with the most overlapping programmes).

- **Nigeria:** 1 state per geopolitical zone (6). The states were chosen based on the results of overlap at the federal level (the state with the most overlapping programmes). Bauchi State in North East, Kano State in North West, Plateau State in North Central, Anambra State in South East, Lagos State in South West and Cross River State in South South.
• **Uganda**: The district is the sub-national entity. Hoima District was chosen based on the results of overlap at the national level (the region with the most overlapping programmes).

### 3.4 Research teams

Each study site had a principal investigator (PI), one co-investigator and two research assistants. Preference was given to those who had research experience. They were trained in data collection techniques and familiarised with the objectives of this study.

### 3.5 Pre-testing of data collection instruments

The checklist and the document review guide was pre-tested before its use for data collection. The pre-test facilitated the fine-tuning of the instruments to ensure the logical flow of questions and clarity, as well as the feasibility of the proposed methodology, data collection techniques and sources of information.

### 3.6 Advocacy/Pre-field visits

APOC formally informed the MoH of the study countries and requested their cooperation, as well as that of other relevant ministries and government agencies at national and state/provincial levels.

The study commenced with consultations between country research teams and relevant staff of ministries of participating countries. The consultations aimed at explaining the significance of this study to key stakeholders in the relevant ministries and solicit their support.

### 3.7 Sources of information

In this first phase of the study, information was collected from the national and state/province levels. At the national level, responsible staff of Ministries of Health, Agriculture, Water, Environment, government agencies, national and international NGOs and donors (if implementers) were consulted about the existing policies, their rationale as well as the modalities of these policies. However, it should be noted that some community-based programmes did not have national offices and hence there was a need to get information about them from the state/provincial level.

Overall, the first step was for the country research teams to compile the list of all community-based programmes in the three ministries (Health, Agriculture, Water and Environment). This was followed by identifying all the different NGOs, both national and international, either involved or supporting these programmes. The key staff in these different organisations was then consulted to share their policies regarding the issues of external monetary incentives to volunteers. In addition, a review of all relevant programme documents was done.
3.8 Data collection

3.8.1 Instruments

Checklists (see Annex 1 and 2): two checklists were used to gather information related to the specific objectives of the study, at the national and state/sub-national levels. They captured the availability and provision of policies.

Document review guide (see Annexe 3): A document review guide was used for the content analysis of the relevant documents, such as policy documents, MoUs, technical reports, work plans, minutes and other materials.

3.8.2 Data collection technique

Using the checklists, each PI and co-investigator collected data from all relevant sources identified in a face-to-face interaction and examination of supporting documents. Data was first collected at the national level and then at sub-national level.

3.9 Data processing and analysis

Following data collection, all the checklists were first cleaned and open-ended responses coded. Data was then entered using Epi Info and later exported to the SPSS programme for the multi-country analysis. Logical checks and frequency runs were made on variables to further the accuracy and consistency of the data and identify any outliers before data analysis. Despite these efforts, much of the data is largely inconsistent due to different interpretations and missing data. Frequency tables, descriptive statistics, graphs and charts have been used to present the key findings and trends.

A Data Analysis Workshop was organised by APOC in Abuja (3-6 July 2007) and attended by 9 participants from Nigeria (5), Cameroon (1), Ethiopia (1), Uganda (1) and an additional facilitator. Data was cleaned, merged and analysed by the participants.

3.10 Quality control measures

Quality control is important to ensure the quality of the data. In this particular study, we tried to achieve this through the following;

• Pre-testing of the instruments.
• Recruitment of research assistants with research experience.
• Training the research assistants in data collection techniques.
• Editing of the completed checklists after each successive fieldwork to ensure that the accurate response had been properly recorded.
• The research assistants were supervised by the principal investigator, throughout the entire data collection period.
• The research teams kept field diaries to record study activities.
• Research teams kept track of refusals and non-response.
3.11 Ethical considerations

The broad and specific objectives of the study as well as the procedures for data collection were disclosed to the institutions/organisations to be studied. Only institutions/organisations that voluntarily agreed to participate in the research were studied.

The study collected information on incentive policies that is publicly available (in principle) and thus not confidential. Each research team sought government clearance for collecting, analysing and reporting this information.

3.12 Organisation of fieldwork

In conducting the fieldwork, the following steps were to be undertaken:

1. At National, Sub-National level, teams visited appropriate ministries (Health, Agriculture, Water and Environment) for the list of health, water, agricultural and environmental programmes using community volunteers. Checklist 1 was applied (see Annex Instrument 1).

Also teams visited government agencies for a list of their programmes using community volunteers (Checklist 1 was not applied to these informants).

The instruction for each visit was to:
   a. Obtain administrative clearance.
   b. Obtain list of programmes with community volunteers.

2. The above list (1b) was used to visit all health programmes/agencies using community volunteers and Checklist 2 was applied (see Annex Instrument 2) to each of these programmes.

3. Teams obtained from each programme, the list of its major partners in implementation: UN agencies, national and International NGOs.

4. Teams obtained from each programme, the list of its major financial partners (donors).

5. Checklist 2 was applied to the programme managers in National NGOs, International NGOs and UN agencies using community volunteers.

6. The document review guide was applied (see Annex Instrument 3) to all policy-related documents obtained.

3.13 Study limitations

- The sub-national study areas were purposively chosen in order to capture the maximum number of programmes at the state/provincial level. The results may therefore be somewhat skewed and not entirely representative.

- The choice of only one sub-national region/province per country, one state per geopolitical zone (Nigeria) and one province per language zone (Cameroon) means that the study is not exhaustive. Indeed, this selection may have excluded sites (states/provinces/regions) with other community-based programmes of interest.
• There may have been gaps in the steps to follow to determine which programmes use community volunteers, as the informants might not have known all the programmes concerned (especially non-governmental).

• Although the focus of the study is on health programmes using community volunteers, a tentative was made to document which Agriculture, Water and Environment programmes also use community volunteers. The biased decision to include these three sectors was based on publications on other development activities in which CDDs were involved (Okeibunor et al. 2004) and on the experience of the participants. Since it was not considered to be feasible to visit all government ministries and agencies that might use community volunteers, this decision was made to confine the study to health, with some insight into the Agriculture, Water and Environment sectors. Nevertheless, this bias and confinement are limitations in terms of comprehensiveness.

There are a number of instances in which the data is inaccurate or incomplete, and where it was not possible to further clean it:

- A number of respondents reported having a policy/practice on EMI (Instrument 2, question 1 = Yes), yet they did not answer all the following questions (or their answers were not properly recorded). This is especially the case in the later questions concerning community involvement, policy on sharing volunteers and coordination/harmonisation.

- The lists of all community-based programmes per sector were not compiled in Nigeria and Uganda.

- Non-implementing donors were also interviewed in some sites, while these were not to be included in the study. This data has been removed from the dataset in as far as possible.

- Non-health programmes were included in some sites, while they were not supposed to be. Where possible, they have been removed. Yet in the cases of Ethiopia and Uganda, some might have not been detected. Also in the Nigeria South East data, water programmes have been included under health programmes.

• Teams interpreted a number of definitions differently, making it hard to ascertain the comparability of the data.

- Programme policy on EMI was interpreted as a documented policy in some cases and as a soft policy evidenced by practice, in other cases. We have cleaned the data to fit the latter definition for the policy on EMI. However, the policy on community involvement, sharing volunteers and joint EMI might still reflect these different interpretations.

- Health programme was often confused with the term defined in this study as ‘health issue’. During the Data analysis workshop in Abuja, the participants agreed on the definition and cleaned their data accordingly. The data should now reflect health programme as defined in 1.2.

- Geographical overlap was not understood uniformly across sites, especially future/potential overlap. Although this was also clarified during the workshop in Abuja, the definition of future/potential overlap is sometimes based on programmes’ predictions, rather than a hypothetical overlap, as defined in 1.2.
• National and sub-national data are not clearly distinguished in the cases of Uganda and Ethiopia. Uganda’s data on the monetary value of EMI includes both national data and the sub-national data of Hoima district. Ethiopia’s national data coincides by and large with the sub-national data as the Ethiopian site (Oromia) is the state with the capital city and federal institutions.

• The South West team was not represented at the Data analysis workshop in Abuja, meaning that a number of points that were discussed and clarified then, might not be reflected in this site’s data. Moreover, this data was not merged with the rest of the data and is therefore not entirely comparable. Note that where results for South West are reported, they were compiled by the team itself and not based on an SPSS analysis of the merged data. Hence their computation might vary from that of the other sites.

• Different sections of the report refer to different sample sizes per site. Some sample sizes (N) refer to the total number of programmes using community volunteers, while others represent the total number of programmes with a policy on EMI. The monetary value data does not fit the latter because some programmes are found to have different types of volunteers who receive different incentive packages. The case of North West illustrates this case well, as there are 32 programmes using community volunteers, 30 with a policy on EMI and 37 with monetary value. Several programmes in the monetary value table have 2 or 3 different types of volunteers.

• In the Cameroonian data, the sample sizes of the monetary value data are larger than the rest of the data, with Cameroon’s Anglophone site reporting 9 programmes in most datasets, but 23 programmes in the monetary value dataset. Cameroon’s Francophone site reports 15 in the former and 22 in the latter. This appears to mirror once again the different interpretations of ‘health programme’.
4. Results

4.1 Reliance on community volunteers

In each country, policy-makers in four ministries were interviewed: Ministry of Health, Ministry of Agriculture, Ministry of Water and Ministry of Environment. The choice of these four ministries was based on previous research on CDDs, which found that the latter tended to be involved in health projects, as well as agricultural, water & sanitation and environmental projects (Okeibunor et al 2004). All ministries reported the use of community volunteers in one or more of their programmes, except the Federal Ministry of Water in Nigeria (see Table 1).

In Cameroon, 15 programmes in each language zone were reported by governmental policy-makers to be using community volunteers for service delivery at the national level. In Ethiopia, it was 60 programmes. In Nigeria and Uganda, 68 and 29 health programmes respectively used community volunteers at the national level. These are conservative numbers as it is likely that many more programmes use community volunteers, but were not reported by the national policy-makers, especially non-governmental programmes. Also, for Nigeria and Uganda, we do not have a list of programmes that use community volunteers in the other non-health sectors.

Note that it is questionable how ‘programme’ was understood by the respondents, as some may have interpreted ‘programme’ as strictly governmental and thematic. 1

Nevertheless, it is clear that there is a widespread demand on the services of community volunteers across sectors and across countries.

4.2 General policy on external monetary incentives for community volunteers

Even though all these programmes engage community volunteers, not all sectors have formulated a national policy that is generally applicable (see Table 1).

Cameroon’s MoH is the only MoH in the study to have a policy concerning the provision of external monetary incentives to community volunteers, which states that such incentives should be given if found necessary in order to increase coverage. In fact, Cameroon’s MoA and MoW also have a general policy to provide EMI if found necessary by the programme, and the MoW goes on to prescribe specifically the provision of a stipend and a sales revenue margin for water delivery. The Federal MoA in Nigeria also prescribes the provision of incentives in the form of technical support, especially transportation allowances.

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1 Please refer to the definition of health programme in section 1.2. Health programme refers to all projects implemented by the MoH, NGOs, UN agencies or any other implementing agency, and is distinct from the so-called ‘health issue’.
The MoW in Ethiopia has a general policy not to give EMI to community volunteers. Interestingly, this is the only ministry in the study that has a policy, which is not to provide EMI. All the others that have a policy dealing with this issue, stipulate that incentives should be given or at least given if necessary.

The Nigerian federal MoEnv is the only MoEnv in the study to have a general policy on EMI, prescribing that the latter should be extended for transportation and lunch in order to compensate for volunteers’ time.

Table 1: Use of community volunteers* and existence of policy on EMI per sector

<table>
<thead>
<tr>
<th>Ministry of Health</th>
<th>Ministry of Agriculture</th>
<th>Ministry of Water</th>
<th>Ministry of Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nigeria</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>No policy (0/2)</td>
<td>Policy to Give (1/3)</td>
<td>n.a.</td>
<td>Policy to Give (1/2)</td>
</tr>
<tr>
<td>Cameroon</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Policy to Give (4/5)</td>
<td>Policy to Give (3/7)</td>
<td>Policy to Give (1/2)</td>
<td>No policy (0/3)</td>
</tr>
<tr>
<td>Ethiopia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>No policy (0/4)</td>
<td>No policy (0/3)</td>
<td>Policy to not give (1/1)</td>
<td>No policy (0/2)</td>
</tr>
<tr>
<td>Uganda</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>No policy (0/2)</td>
<td>No policy (0/6)</td>
<td>No policy (0/1)</td>
<td>No policy (0/1)</td>
</tr>
</tbody>
</table>

* Use of community volunteers is represented by a tick.

**NB.** The numbers between parentheses represent the number of departments that have the indicated policy over the total number of departments using community volunteers in the specific ministry.

At state level, only three sites found a general policy on EMI: the two Cameroonian sites and Nigeria’s North West site. The Cameroonian anglophone and francophone provincial departments of health have a policy, which is the same as its national level counterpart, namely to provide EMI if necessary. North West also prescribes that EMI should be provided. All other sub-national level data reflect the absence of a guiding policy from the government, when it comes to EMI.
4.3 Policy on external monetary incentives among programmes at national level

As stated in the operational definitions (see 1.2), a policy on EMI has been defined for the purpose of this study as any formal statement (both written and non-written) of policy developed and endorsed at health programme level that guides the decisions and actions pertaining to the provision of external monetary incentives to community volunteers. The data suggests that this term was interpreted differently in different sites, as some understood policy as requiring a formal document, while others considered practice to be a sufficient indication of the existence of a non-written policy. For practical reasons, when a respondent reported a practice of giving incentives, the respective programme was assumed to have a policy on EMI. Hence, this reflects more adequately the practice vis-a-vis EMI, rather than a hard policy. This also means that programmes that report not having a policy actually have a no-give practice.

Figure 1: Existence of policy on EMI and policy prescription at national level
Contrarily to the ministries, most programmes consulted in this study reported a policy on EMI (see Figures 1 and 3). Indeed, an average of 71% of all health programmes investigated at the national level and about 85% of the health programmes studied at the sub-national level, have a policy on the provision of EMI to the community volunteers that work for their programme. Cameroon is a particular case, where all programmes interviewed reported having a policy, both at the federal level and in the anglophone and francophone sites. Nigeria at the national level reveals relatively less programmes with an actual policy (only 47%), or put differently, more programmes with a practice of not giving external monetary incentives.

4.4 Policy on external monetary incentives among programmes at sub-national level

When comparing Nigeria’s federal data (in Figure 1) to the aggregate sub-national data (Figure 2), we note distinctly more programmes with a policy to give incentives and distinctly less with a no-give policy or practice. Uganda’s national data also

Figure 2: Existence of policy on EMI and policy prescription at sub-national level per country
diverges markedly from the sub-national data, with much more programmes having a policy/practice to give incentives in Hoima district (92%) as opposed to 50% at the national level. This probably reflects a discrepancy between theory and practice, as it appears that the closer we come to the operational level, the more evidence there is of a practice of providing EMI to community volunteers.

Figure 3: Existence of policy on EMI and policy prescription at sub-national level per site

We can observe in the above figures that where a policy exists, it generally prescribes that EMI should be given by the programme. The case of Ethiopia reports several programmes with a policy to give EMI if necessary. In practice, this tends to mean that incentives are given. Few programmes have an explicit policy not to give EMI. Nigeria has relatively more programmes reporting such a no-give policy, whereas none of the Cameroonian health programmes do. Cameroon’s programmes do not even have a no-give practice. At the national level, Uganda also reports a considerable no-give policy, whereas the sub-national data indicates that there is either a policy to give or no policy at all.
A few interesting observations were made concerning policies of certain agencies, which operate several programmes. For example, in South South, WHO has a policy to provide incentives for community volunteers in the Immunisation programme, but a policy not to give incentives in the Malaria programme.

4.5 Types of external incentives and their monetary value

4.5.1 Comparison across Study sites

Each programme provided the types and monetary values of external incentives it gives to community volunteers. Table 2 summarises the frequency with which different types of incentives are provided per study site. It appears that 68% of all programmes using community volunteers, include cash in their incentive package, with Uganda and Nigeria’s North West site reporting 89%. Nigeria’s South South has the least programmes rewarding volunteers with cash (only 31%). With a frequency of 47%, transport allowance is the most popular form of cash incentive, followed by stipends (25%) and per diems (22%). Sales revenue on the other hand, is only included in 8% of programmes’ incentive package.

Table 2: Types and frequency per study site of cash incentive provided (in % of programmes using CV)

<table>
<thead>
<tr>
<th>Sites</th>
<th>Transport allowance</th>
<th>Stipend</th>
<th>Per diem</th>
<th>Sales revenue</th>
<th>Any cash</th>
<th>No cash</th>
<th>Total programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>30</td>
<td>25</td>
<td>11</td>
<td>23</td>
<td>71</td>
<td>29</td>
<td>100</td>
</tr>
<tr>
<td>North West</td>
<td>76</td>
<td>32</td>
<td>24</td>
<td>3</td>
<td>89</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>South East</td>
<td>27</td>
<td>35</td>
<td>12</td>
<td>12</td>
<td>65</td>
<td>35</td>
<td>100</td>
</tr>
<tr>
<td>South South</td>
<td>25</td>
<td>13</td>
<td>0</td>
<td>0</td>
<td>31</td>
<td>69</td>
<td>100</td>
</tr>
<tr>
<td>Cameroon A</td>
<td>43</td>
<td>36</td>
<td>27</td>
<td>5</td>
<td>50</td>
<td>50</td>
<td>100</td>
</tr>
<tr>
<td>Cameroon F</td>
<td>48</td>
<td>39</td>
<td>35</td>
<td>9</td>
<td>57</td>
<td>43</td>
<td>100</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>45</td>
<td>23</td>
<td>34</td>
<td>4</td>
<td>72</td>
<td>28</td>
<td>100</td>
</tr>
<tr>
<td>Uganda</td>
<td>89</td>
<td>4</td>
<td>33</td>
<td>4</td>
<td>89</td>
<td>11</td>
<td>100</td>
</tr>
<tr>
<td>Average</td>
<td>47</td>
<td>25</td>
<td>22</td>
<td>8</td>
<td>68</td>
<td>34</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 3: Types and frequency per study site of in-kind incentive provided (in % of programmes using CV)

<table>
<thead>
<tr>
<th>Sites</th>
<th>Bicycle</th>
<th>Motorcycle</th>
<th>Radio</th>
<th>ITN</th>
<th>Any In-kind</th>
<th>No In-kind</th>
<th>Total programme</th>
<th>Both cash and In-kind</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>11</td>
<td>89</td>
<td>100</td>
<td>11</td>
</tr>
<tr>
<td>North West</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>5</td>
<td>16</td>
<td>84</td>
<td>100</td>
<td>16</td>
</tr>
<tr>
<td>South East</td>
<td>19</td>
<td>4</td>
<td>4</td>
<td>12</td>
<td>27</td>
<td>73</td>
<td>100</td>
<td>15</td>
</tr>
<tr>
<td>South South</td>
<td>19</td>
<td>6</td>
<td>25</td>
<td>0</td>
<td>44</td>
<td>56</td>
<td>100</td>
<td>19</td>
</tr>
<tr>
<td>Cameroon A</td>
<td>14</td>
<td>5</td>
<td>5</td>
<td>0</td>
<td>23</td>
<td>77</td>
<td>100</td>
<td>23</td>
</tr>
<tr>
<td>Cameroon F</td>
<td>26</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>35</td>
<td>65</td>
<td>100</td>
<td>35</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>11</td>
<td>89</td>
<td>100</td>
<td>100</td>
<td>9</td>
</tr>
<tr>
<td>Uganda</td>
<td>50</td>
<td>0</td>
<td>4</td>
<td>11</td>
<td>50</td>
<td>50</td>
<td>100</td>
<td>46</td>
</tr>
<tr>
<td>Average</td>
<td>15</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>23</td>
<td>77</td>
<td>100</td>
<td>19</td>
</tr>
</tbody>
</table>
In-kind incentives are less recurrent, with 23% of programmes using volunteers providing them. Note that we have not included in-kind incentives like T-shirts, caps, cloths, bags, etc, for the purpose of comparability, while these are actually very often distributed to volunteers, as has been reported in most of the study sites. In North West for example, these low cost items (refreshments, lunch, condoms, kits and feeding) accounted for 72% of in-kind incentives. However, we focus on four types of in-kind incentives, of which bicycles come out far ahead as the most popular form of in-kind incentive (15%), with up to 50% of programmes providing them in the Uganda site. Also, about 1 in 5 health programmes studied, give both cash and in-kind incentives to their volunteers.

Figure 4: Average cash incentives per volunteer per year per project site (in US$)

Figures 4 and 5 (on next page) illustrate the total average monetary value of these external incentives volunteer per year and per study site, as well as their sub-components. Both Cameroonian sites emerge at the top with the highest average values of cash and in-kind incentives. Only Nigeria's North West site competes with an equally high average cash value and a slightly inferior in-kind monetary value. Stipends contribute the most to the total cash a volunteer receives on average per year in Cameroon and in Nigeria's North West site, followed by the value of transport allowances. In terms of in-kind incentives, motorcycles are of the highest average monetary value, followed quite closely by bicycles. Radios and ITNs clearly only add marginally to incentive packages that include a means of transportation (motorcycle or bicycle).
Figure 5: Average in-kind incentives per volunteer per year per project site (in US$)

Figure 6: Average total incentives per volunteer per year per project site (in US$)
As depicted in Figure 6, the average monetary value of EMI for a volunteer range from about US$ 20 to US$ 310² per year, while the average GDP per capita ranges from US$ 114 (Ethiopia) to US$ 897 (Cameroon)³. Cash incentives represent by far the greatest share of these EMI.

4.5.2 Comparison across Health issues

In addition to comparing the monetary values of EMI across sites, we have compiled the data according to so-called health issues. Figure 7 presents these results, clearly demonstrating that TB/Leprosy, Reproductive Health, STI/HIV/AIDS and Malaria programmes provide the most costly incentive packages to volunteers, peaking at an average monetary value of US$ 290 per volunteer per year. The helminthic programmes have the smallest incentive packages, worth between US$ 10 and US$ 20 per volunteer per year. Immunisation and Nutrition are in between these two groups, with about US$ 110 per volunteer per year. Again, stipends are the greatest source of monetary value to volunteers, followed closely by per diems and transport allowances.

Figure 7: Average monetary value per volunteer per year (in US$)

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² Based on the average exchange rate in 2006 for US$ 1 = 522.82 Cameroonian CFA Francs; 9.02 Ethiopian Birr; 132.44 Nigerian Naira; 1,846.83 Ugandan Shilling.

The outlying TB/Leprosy bar is in fact slightly deceiving as there are only 7 such programmes in the study sample, with 3 providing very high cash incentives and 4 giving nothing at all. The two Cameroonian sites and Nigeria’s North West site lift up this average as the value of their EMI are respectively US$ 637, US$644 and US$ 483 per volunteer per year. The other 4 TB/Leprosy programmes are in Ethiopia (2) and Uganda (2) and they pull the average down as none give any EMI, except one of Uganda’s programmes with a small US$ 13 per volunteer per year.

However, for the other leading paying categories, the sample size is between 14 and 65 programmes. It is hardly surprising that these issues come out so high, given that they are also the ones receiving the most international attention and donor funding.

4.6 Community involvement in setting external monetary incentives

Each programme that had a policy/practice on EMI was asked whether and how it involves communities in setting the external monetary incentive packages of the community volunteers. As illustrated in Figure 8 most programmes do not consult communities when setting EMI, this highest percentage of programmes involving communities being slightly under 50% in Nigeria’s North East and North West sites as well as in francophone Cameroon. Uganda’s site on the other hand, does not report a single programme involving the community in setting EMI.

Figure 8: Community involvement in setting EMI
The most common manner in which communities are involved, if they are at all, is through consultations with community representatives. The degree of this involvement is unclear and would be more appropriate to gauge at the community level in a Phase 2 study.

The study results reveal that one of the main reasons for not involving communities in setting EMI was that this did not fall under donor policy. In fact, between 50% and 60% of programmes in Nigeria’s South West and South South sites, as well as Cameroon’s anglophone site did not involve communities at all in setting EMI because it was not their donor’s policy. This demonstrates the influence donors have in these matters.

4.7 Rationale for EMI Policies

The principal reasons given by programmes for providing external monetary incentives to community volunteers were motivation and facilitation (see Table 4). There is a widespread belief that EMI stimulate, motivate and encourage community volunteers. Providing them is therefore a way to curb attrition, enhance performance, increase coverage and thus achieve programme targets. However, there is little documented evidence of this correlation and it remains a prevalent assumption.

The main reason for not giving EMI is the fear that external incentives create dependency and thus hamper the sustainability of a programme (see Table 5).

### Table 4: Rationale for giving EMI (in frequency of responses)

<table>
<thead>
<tr>
<th>Reasons for giving Incentives</th>
<th>Ethiopia</th>
<th>Uganda</th>
<th>NIGERIA North West</th>
<th>NIGERIA North East</th>
<th>NIGERIA South East</th>
<th>NIGERIA South South</th>
<th>NIGERIA Southwest</th>
<th>NIGERIA North Central Cameroon</th>
<th>CAMEROON A</th>
<th>Cameroon F</th>
<th>All Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivate/encourage/attract/appreciate volunteers</td>
<td>23</td>
<td>14</td>
<td>25</td>
<td>21</td>
<td>16</td>
<td>5</td>
<td>7</td>
<td>16</td>
<td>7</td>
<td>11</td>
<td>145</td>
</tr>
<tr>
<td>Facilitate service delivery</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>3</td>
<td>14</td>
<td>13</td>
<td>21</td>
<td>102</td>
</tr>
<tr>
<td>Compensate time and out-of-pocket costs of CVs</td>
<td>9</td>
<td>0</td>
<td>14</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>32</td>
</tr>
<tr>
<td>Ownership/comm. Empowerment</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Consideration of volunteers’ socio-economic conditions</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Others pay</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Directives from the centre</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Reduce cost of service</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Table 5: Rationale for not giving EMI in frequency of responses

<table>
<thead>
<tr>
<th>Reasons for NOT giving Incentives</th>
<th>Ethiopia</th>
<th>Uganda</th>
<th>NIGERIA North West</th>
<th>NIGERIA North East</th>
<th>NIGERIA South East</th>
<th>NIGERIA South-South</th>
<th>NIGERIA Northwest</th>
<th>NIGERIA North Central</th>
<th>CAMEROON A</th>
<th>CAMEROON F</th>
<th>All Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure sustainability</td>
<td>4</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>To not create dependency</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

### 4.8 The Role of donors

As noted above, donors\(^4\) appear to play a role in the existence, modalities and implementation of EMI. Each programme with a policy/practice with respect to EMI was asked what specific role their financial donor(s) exercised in the determination of the policy. This question provided four possible responses, which were not mutually exclusive, namely whether the donor(s) played an indirect role by providing the funding for the EMI given; whether the donor(s) convinced programme managers to implement a certain policy; whether the donor(s) made a certain EMI policy a funding condition and finally an open response, labeled “Other”. The results reported under the ‘other’ category included many cases in which donors did not play any role in the determination of the particular EMI policy, or even discouraged the provision of incentives and encouraged community participation.

The findings reveal a great indirect role played by donors in that they provide the funding that covers the costs of the EMI in up to 87% of the programmes in Nigeria’s North West site. In this particular site it is evident that donors would only have an indirect role since it is the state's policy that EMI should be given. Still, the most recurrent response is the provision of funds in all the sites. It is only in Nigeria’s North Central site that this response is at par with the much more direct involvement of making an EMI policy a funding condition (both reported by 42% of programmes with an EMI policy).

It is noteworthy that more direct forms of donor involvement are quite frequent with up to 50% of programmes in South South and 44% in Cameroon’s anglophone site having been convinced by donors to adopt a certain EMI policy. However, Uganda’s site reports no direct involvement of donors.\(^5\)

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\(^4\) Note that in Uganda the key donors supporting community-based programmes include: USAID, UNICEF, WHO, ADB, the EU and DFID. In Nigeria’s South East site UNICEF and WHO top the list as most recurrent financial donors. This pattern is rather consistent across sites, with UNICEF, WHO, EU and USAID coming out as major financial donors.

\(^5\) It ought to be noted that the dataset contains a lot of missing data on this question. Nigeria North East, North Central, Ethiopia and Uganda’s site data do not even add up to 100% on this question (even though it was a question in which several answers could be given).
It deserves to be noted that the dataset contains a lot of missing data on this question, which explains why Nigeria North East, North Central, Ethiopia and Uganda’s site data do not even add up to 100% on this question (even though it is a question in which several answers could be given).

4.9 Geographic overlap

In order to gauge the extent of the overlap of different incentive packages, we have calculated the average number of programmes (using community volunteers) per district/LGA in every site. There are on average 10 health programmes overlapping per district/LGA. By multiplying this number by the average monetary value of external monetary incentives per site, we get a simulation of the average current cost of volunteers per community (US$ 2,340), assuming that every programme has two volunteers per community. These figures give us a slight idea of the financial burden on the health system of providing EMI. If we take into account that Nigeria has a total of 774 LGAs and Ethiopia a total of 556 districts (woredas) this figures become all the more significant. For the sake of illustration, let’s take the example of Nigeria a step further. It is estimated that there are approximately 100 communities per LGA in Nigeria. This would mean that if health programmes were to be active in all the communities in the LGAs they operate, the cost to the LGA would be on average US$ 2,340*100 = US$234,000. Now if we consider Nigeria’s 774 LGAs, the total cost to the Nigerian health system would be a striking US$ 181,116,000. This is all the more remarkable when compared to the total government expenditure on health in 2004 of US $ 900,900,000.

Table 6: Geographic overlap of programmes per district/LGA and corresponding average cost per community

<table>
<thead>
<tr>
<th></th>
<th>Average incentives (US$)</th>
<th>Current overlapping programmes</th>
<th>Average current cost per community (in US$)</th>
<th>Potential overlapping programmes</th>
<th>Average potential cost per community (in US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North East</td>
<td>37</td>
<td>15</td>
<td>1,110</td>
<td>15</td>
<td>1,110</td>
</tr>
<tr>
<td>North West</td>
<td>251</td>
<td>14</td>
<td>7,028</td>
<td>20</td>
<td>10,040</td>
</tr>
<tr>
<td>North Central</td>
<td>-</td>
<td>9</td>
<td>-</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>South East</td>
<td>19</td>
<td>9</td>
<td>342</td>
<td>13</td>
<td>494</td>
</tr>
<tr>
<td>South West</td>
<td>-</td>
<td>12</td>
<td>-</td>
<td>14</td>
<td>-</td>
</tr>
<tr>
<td>South South</td>
<td>32</td>
<td>5</td>
<td>320</td>
<td>6</td>
<td>384</td>
</tr>
<tr>
<td>Cameroon A</td>
<td>159</td>
<td>8</td>
<td>2,544</td>
<td>12</td>
<td>3,816</td>
</tr>
<tr>
<td>Cameroon F</td>
<td>283</td>
<td>8</td>
<td>4,528</td>
<td>13</td>
<td>7,358</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>124</td>
<td>9</td>
<td>2,232</td>
<td>14</td>
<td>3,472</td>
</tr>
<tr>
<td>Uganda</td>
<td>34</td>
<td>11</td>
<td>748</td>
<td>14</td>
<td>952</td>
</tr>
<tr>
<td>Average</td>
<td>117</td>
<td>10</td>
<td>2,340</td>
<td>13</td>
<td>3,042</td>
</tr>
</tbody>
</table>

6 This number is based on the average of the six Nigerian sites in this study.
The future or potential overlap refers to the optimal spread of programmes if programmes would have no constraints and simply operate in every district/LGA that they are needed. In other words, general health programmes that should be implemented across the board, such as Reproductive Health, Nutrition and HIV/AIDS would be in every district/LGA, whereas area-specific programmes, such as Onchocerciasis or Guinea worm, would be in all the districts/LGAs, which are endemic. The average potential overlap is 13 programmes, ranging from 6 to 20. However, it appears that ‘potential overlap’ was not interpreted uniformly across sites. The average potential cost stands at US$ 1,701 per district.

Nigeria’s South South site has the least overlap and North East has the most. Without these two outliers, the overall overlap is very consistent across sites, ranging from 8 to 12 for current overlap and 11-15 for future overlap.

4.10 Sharing Volunteers

The study reveals that the advantages of using community volunteers from other (established) programmes (here referred to as ‘sharing’), in terms of cost-effectiveness and maintaining community ownership, are widely appreciated by programme managers. In some sites, however, the policy is still in its infancy, whereas in others it has become common practice.

The national data suggests quite some inter-country difference in sharing policy. Indeed, Nigeria and Cameroon report a high occurrence of sharing, while the practice does not appear to be quite as common in Ethiopia and Uganda. Where there is a policy to share, we note a lot of variation on the existence of a joint policy on EMI. In Ethiopia, not a single programme sharing volunteers has a joint policy on EMI. In Uganda, only about 1 out 5 has a concomitant policy on EMI. In Nigeria and Cameroon on the other hand, half or slightly more, have a joint EMI policy.

At sub-national level, we again observe much variation in policies (see Figure 9). The case of Uganda’s site reveals inaccurate data, since no programmes have been reported to have a policy to share volunteers, yet 17% of these have a policy on EMI when sharing. This is evidently inconsistent.

In South East, South South and Ethiopia’s site, none of the programmes have a joint EMI policy when sharing community volunteers, even though 15-40% do use the same volunteers as other programmes.

North West has the second highest incidence of sharing, just below Cameroon Anglophone, and the highest incidence of coordination when sharing. This is probably due to the existence of the ‘Association of Kano NGOs and implementers’, which serves as an effective coordinating mechanism and of which most programmes are members. In North West it was noted that the Immunisation programmes used volunteers of other programmes the most, and was closely followed by Reproductive Health/Safe Motherhood, IMCI, Malaria and HIV/AIDS. It is reassuring that the leading payers are the ones sharing volunteers, as this can minimise fragmentation of incentive packages. Since volunteers are getting high incentives from these programmes, this may partly compensate for the low or inexistent EMI from other programmes they are working
with. The reasons given for sharing volunteers were cost-effectiveness, motivation and expanding coverage, sustainability, the integration into Primary Health Care, the effective use of available human resources, promoting ownership and community participation.

**Figure 9:** Existence of a Policy on Sharing volunteers and on EMI when sharing (Sub-National level)

![Graph showing the existence of policies](image)

4.11 Coordination/Harmonisation

In order to determine whether there is any coordination or harmonisation between programmes on the issue of EMI, programmes were asked whether they had discussed the issue with other programmes and then whether they had harmonised their policies with others. National data suggests that few programmes have harmonised policies, with Cameroon coming out high with 50% of programmes having harmonised. However, this appears to be a case of pseudo-harmonisation, as incentives still come out of different baskets and with different labels. In Ethiopia and Uganda the levels of coordination are negligible and harmonisation is entirely inexistent at the national level.
At the sub-national level (see Figure 10), Nigeria seems to have less coordination and harmonisation than reported at the federal level. In the Nigerian sites, 0-47% of programmes with a policy on EMI, have discussed the issue with other programmes. None have harmonised in South East, and less than 20% harmonised in the four other Nigerian sites. Again, North West is an outlier and the only site that coincides with the federal data.

In Uganda, the programmes that had made attempts to discuss the issue were mainly those involved in vector control and included Malaria, Onchocerciasis, Bilharzia, Lymphatic Filariasis and Sleeping Sickness.

In most sites, there is limited coordination (less than half of the time) and even less harmonisation to speak of. A few efforts are noticeable in North West and Cameroon (especially in the Anglophone site).

Note that the low percentages also reflect a large amount of missing values, as many respondents did not answer this question.

Figure 10: Coordination and Harmonisation between programmes of EMI (Sub-national level)
5. MAIN CONCLUSIONS

Despite certain study limitations, a number of clear messages emerge from the study results:

- **The use of community volunteers for service delivery is common.** All but one ministry visited was making use of the services of community volunteers, with as many as 68 programmes using volunteers at the federal level in Nigeria and this only in the health sector. Water, Agriculture and Environment are also engaging community volunteers.

- **There is limited guidance from government regarding external monetary incentives,** with a few notable exceptions. Six out of fifteen ministries studied, reported having a general policy on EMI for community volunteers. The ministries of Agriculture and Water seemed to have the most grip on matters, whereas only one MoH in the study and one MoEnv had a general policy on EMI. Where such a policy exists, it tends to prescribe the provision of EMI. The Ethiopian MoW is the only ministry in the study to have a general policy to not give EMI. This lack of guidance goes a long way in explaining the lack of harmonisation on this issue. Moreover, where a general policy exists it tends to be very generic, without specific parameters for standardisation.

- **Most programmes have a policy/practice of giving external monetary incentives.** Only the national data of Nigeria and Uganda contradict this, with less than half of programmes using community volunteers having a policy/practice to give EMI. At sub-national level, the reality is that programmes with a policy/practice to give EMI are by far in majority.

- **The two major reasons for giving EMI are to motivate volunteers and to facilitate service delivery.** The main reason not to give EMI is to ensure sustainability. These policy-guiding assumptions appear to reflect programme managers’ perceptions.

- **Cash incentives are the most common types of external monetary incentives.** Transport allowances, stipends and per diems are typical forms of EMI and they often represent a sizeable form of income, especially when compared to GDP per capita.

- **The average monetary value of EMI varies per site** (from US$ 20 to US$ 310 per volunteer per year) **and per health issue** (from US$ 10 to US$ 290 per volunteer per year).

- **TB/Leprosy, Reproductive health, STI/HIV/AIDS, Malaria, Nutrition and Immunisation are the health issues providing the highest EMI.** These also happen to be the issues receiving the largest donor funds.

- **Donors play a significant role in setting these EMI.** Their role is mostly indirect, through the provision of funds. Yet, some donors influence policies more directly by actually convincing programme managers to have a certain policy or by making it a funding condition.
• **Current geographical overlap is high**, with about 10 programmes using community volunteers overlapping per district/LGA. And this number is only likely to increase.

• **The occurrence of sharing community volunteers among programmes is highly variable.** Where it is done, it could have the positive effect of alleviating some issues, especially if programmes that share volunteers also have a joint policy on EMI. However, this is not yet the case and where sharing is common, providing programme-specific EMI remains equally common.

• **Coordination and especially harmonisation are very limited.** Where reported, harmonisation remains incomplete as is the case in Cameroon, where programmes continue to provide their own incentives funded out of their own baskets.

Although the issue at stake is very country-specific, the main recommendation that can be made is the need to formulate a general policy at the national level to guide the implementation of the widespread practice of giving EMI to community volunteers. Indeed, a framework is needed to coordinate and harmonise incentive policies and packages, while taking into account programme-specific needs, types of services required, time-frames as well as resources available. Labels should be removed from incentive packages and if community volunteers are to be given EMI at all, these should at least be under a general health label. The next challenge will be to harmonise with the other sectors concerned (water, agriculture, environment).

Cost-effectiveness is the key reason to work towards harmonisation. If a programme is incurring costs for EMI, while it is using community volunteers which are also receiving EMI from other programmes, it would be more cost-effective to put resources in a common basket and give joint EMI.

A second phase of this study is required to ascertain the outcome of this first study at the community level. It is necessary to determine whether these policies are reflected in practice, to verify the extent of community involvement in setting policies and the degree of real harmonisation. The perceptions of volunteers and other stakeholders vis-a-vis this issue of motivation and incentives is another key dimension that is missing in our analysis.
ACKNOWLEDGEMENTS

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- Ministries/Agencies (Health, Water, Agriculture, Others) for the collaboration in the implementation of the study

- Health programmes/Implementing agencies at national, state/provincial levels for their support and collaboration during the study

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ANNEXES
INTRODUCTION 1: 
Checklist for Policy-makers

Respondent:

- Appropriate technocrat at the MoH, MoW, MoA and other relevant government agency at the national level
- Equivalent of Director of public health (state/provincial level)

Instruction:

i) Fill in checklist
ii) Obtain a list of programmes using community volunteers

Identification of Project site:

..........................................................................................................................
(1=Northeast, 2=Northwest, 3=North Central, 4=Southeast, 5=Southwest, 6=South South, 7=Cameroon A, 8=Cameroon F, 9=Ethiopia, 10=Uganda)

Ministry/Agency # (1=Health, 2=Water, 3=Agriculture, 4=Other):

Name of Respondent:

Position:

Introduction: This study sets out to document external monetary incentive policies provided by different community-based programmes to community volunteers. We have defined external monetary incentives as financial and material incentives provided by a party external to the community. Any form of cash coming from outside the community is seen as an external monetary incentive (such as per diem, travel allowance, stipend, sales revenue, etc). In-kind incentives which can be attributed a significant monetary value are also included, such as bicycles, motorcycles, radios, ITNs, etc.

The study is an inventory of policies, for which personal opinions from key informants are not solicited. The questions are seeking to determine whether governments have a general written or non-written policy on external monetary incentives for community volunteers.

List of (health, HIV/AIDS, agricultural and water) programmes using community volunteers:

..........................................................................................................................
..........................................................................................................................
..........................................................................................................................
..........................................................................................................................
..........................................................................................................................
Task 1. Document (if any) general policy at the national level (states/province) on external monetary incentives for community volunteers in the health, HIV/AIDS, agriculture and water sectors.

1. Is there a general policy on external monetary incentives for community volunteers at the national level that applies to all community volunteers, irrespective of the programme they are assisting (this includes an explicit policy to not give external monetary incentives)?

   - Yes (go on to question 2)
   - No (go on to question 5)
   - Don’t know (ask for who else can provide this information, stop and start the checklist again with this other resource person)

2. If yes, when was it formulated? .................................................................

3. By whom was this policy formulated/initiated? ...........................................

4. What does it prescribe relating to external monetary incentives? ..................

   ..................................................................................................................
   ..................................................................................................................
   ..................................................................................................................
   ..................................................................................................................

(Please ask for evidence of policy availability and provisions. For e.g. MoU, minutes of meeting, official letters, reports...).

5. If not, is a policy being formulated?

   - Yes (please ask for evidence of policy being formulated, e.g. MoU, minutes of meeting, official letters, reports...)
   - No (stop here)
   - Don’t know (ask for who else can provide this information, stop and start the checklist again with this other resource person)
INSTRUMENT 2: checklist for health programme manager

Respondent:
- Head of health programme at national level (MOH, NGOs, and agencies)
- Head of health programme at state/provincial level (MOH, NGOs, agencies)

Instruction:
i) Fill in checklist
ii) Obtain a list of the programme’s donors
iii) Obtain a list of implementing International NGOs using community volunteers, known to the programme or partnering with the programme.
iv) Obtain a list of implementing National NGOs using community volunteers, known to the programme or partnering with the programme.

Identification of Project site: .................................................................
(1=Northeast, 2=Northwest, 3=North Central, 4=Southeast, 5=Southwest, 6=South South, 7=Cameroon A, 8=Cameroon F, 9=Ethiopia, 10=Uganda)

Location (1=National, 2=State/province) ...................................................

Name of Health Programme/Implementing agency: ..........................................

Name of Respondent: ..................................................................................

Position: ..................................................................................................

Introduction: This study sets out to document external monetary incentive policies provided by different community-based programmes to community volunteers. We have defined external monetary incentives as financial and material incentives provided by a party external to the community. Any form of cash provided to the volunteer from outside the community is seen as an external monetary incentive (such as per diem, travel allowance, stipend, sales revenue, etc). In-kind incentives which can be attributed a significant monetary value are also included, such as bicycles, motorcycles, radios, ITNs, etc. By community volunteer, we refer to an individual from the community, providing services to his/her own community with or without remuneration.

The study is an inventory of policies, for which personal opinions from key informants are not solicited. The questions are seeking to determine whether programmes using community volunteers have policies (both written and non-written) on providing external monetary incentives and if so, what these policies stipulate. The explicit policy to not provide external monetary incentives is also included as a policy (e.g. CDTI).
List of programme’s financial donor(s):
........................................................................................................................................
........................................................................................................................................

List of partner/known implementing International NGOs using community volunteers:
........................................................................................................................................
........................................................................................................................................

Task 2. Document the external monetary incentive policies of the health programme for community volunteers, including the type, monetary value and frequency of the incentive provided.

1. Does your programme have a policy on whether to give or to not give external monetary incentive to volunteers?
   - Yes (go on to question 3)
   - No (go on to question 2)
   - Don’t know (ask for who else can provide this information, stop and start the checklist again with this other resource person)

2. If No, is a policy being formulated/in process?
   - Yes (please ask for evidence of policy being formulated, e.g. MoU, minutes of meeting, official letters, reports, etc. and stop)
   - No (stop here)
   - Don’t know (ask for who else can provide this information, stop and ask this question to the other informant)

3. If yes, when was it formulated? ..........................................................................................................................

4. By whom was this policy formulated/initiated? ..................................................................................................

5. What does it prescribe?
   - External monetary incentives should be given
   - External monetary incentives should not be given
   - External monetary incentives can be given if found necessary
   - Any other (specify)

(Please ask for evidence of policy provisions. For e.g. policy documents, pronouncements, MoU, minutes of meeting, technical or financial reports, budgets, etc.).
6. Type, Value and Frequency of external monetary incentives per volunteer

<table>
<thead>
<tr>
<th>Type of external monetary incentives</th>
<th>Frequency of incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash incentive</strong></td>
<td></td>
</tr>
<tr>
<td>Yes =1 No = 0</td>
<td></td>
</tr>
<tr>
<td>Amount/number</td>
<td></td>
</tr>
<tr>
<td>Monetary value</td>
<td></td>
</tr>
<tr>
<td>Every time they work</td>
<td></td>
</tr>
<tr>
<td>Once per project life</td>
<td></td>
</tr>
<tr>
<td>Monthly</td>
<td></td>
</tr>
<tr>
<td>Annually</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Transport</td>
<td></td>
</tr>
<tr>
<td>Stipend</td>
<td></td>
</tr>
<tr>
<td>Sustenance/Per diem</td>
<td></td>
</tr>
<tr>
<td>Sales revenue</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
<tr>
<td>In Kind Incentive</td>
<td></td>
</tr>
<tr>
<td>Bicycles</td>
<td></td>
</tr>
<tr>
<td>Motorcycles</td>
<td></td>
</tr>
<tr>
<td>Radio</td>
<td></td>
</tr>
<tr>
<td>ITNs</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

7. Does the policy stipulate that communities are to be involved in setting these external monetary incentives?
   - Yes (go to question 8)
   - No (go to question 9)
   - Don’t know (ask for who else can provide this information, stop and ask this question again to the other resource person)

   *(Please ask for evidence of this policy. For e.g. policy documents, pronouncements, MoU, minutes of meeting, technical or financial reports, budgets, etc.)*

8. If yes, how are they to be involved in setting external monetary incentives?
   - Representatives consulted
   - Representatives signed the MOU
   - Any other (specify)
9. If not, why are they not to be involved in setting external monetary incentives?

- Not our donor’s policy
- Any other reason (specify)

**Task 3. Determine the rationale for the above policies and the role of donors in influencing these policies.**

10. What are the reasons for having the above external monetary incentive policy?

........................................................................................................................
........................................................................................................................
........................................................................................................................
........................................................................................................................
........................................................................................................................

(Please ask for evidence of policy stating the reasons for providing incentives. For e.g. policy documents, guidelines, pronouncements, MoU, minutes of meeting, technical and/or financial reports, budgets, etc.).

11. How have donors played a role in the programme’s policy on external monetary incentives?

- Convincing programme managers that external monetary incentives are necessary to address certain concerns
- Funding conditions
- Provide the funds for the incentives
- Other (specify)

(Please ask for evidence of this donor role. For e.g. policy documents, pronouncements, MoU, minutes of meeting, technical or financial reports, budgets, etc.).

**Task 4. Determine the current and potential/future geographical overlap of these health programmes in the different districts/LGAs**

(Definition of district: administrative area below the sub-national (region, province) level: Nation-Region/Province – District. In the case of Nigeria, we are referring to LGAs.)

12. In which districts/LGAs does your health programme currently operate with community volunteers? (List Districts)

........................................................................................................................
........................................................................................................................
........................................................................................................................
13. In which districts/LGAs should your health programme operate in the long run with volunteers (endemic districts, need for your programme)?

(Also refer to endemicity maps and nature of disease/health issue)

Task 5: To determine whether programmes have policies on using volunteers selected from other health programmes and how they deal with incentives in such cases.

14. Do you have a policy on sharing community volunteers involved in other health programmes? By this I mean, does your programme have a policy to use community volunteers that have already been selected through other health programmes, or a policy to share the volunteers selected for your programme with other health programmes?

☐ Yes (go on to question 15)

☐ No (stop and go on to task 6)

☐ Don’t know (ask for who else can provide this information, stop and start this task of the checklist again with this other resource person)

15. If yes, what does the policy prescribe?

(Please ask for evidence of policy availability and provisions e.g. policy documents, guidelines, pronouncements, MoU, minutes of meeting, official letters, technical reports, etc.).

16. Which programme(s) are you sharing health volunteers with?
(List the programmes involved)

(Please ask for evidence of policy availability and provisions e.g. policy documents, guidelines, pronouncements, MoU, minutes of meeting, official letters, technical reports, etc.).
17. Who was involved in formulating the policy guideline?

........................................................................................................................
........................................................................................................................
........................................................................................................................

18. What is the rationale for having or not having the policy?

........................................................................................................................
........................................................................................................................
........................................................................................................................
........................................................................................................................

19. Do you have a policy dealing with external monetary incentives for health volunteers shared with other programmes?

- Yes (go on to question 20)
- No (stop and go on to task 6)
- Don't know ___ (Ask for who else can provide this information, stop and start this task of the checklist again with this other resource person)

20. If yes, what does the policy prescribe?

........................................................................................................................
........................................................................................................................
........................................................................................................................
........................................................................................................................
........................................................................................................................

(Please ask for evidence of policy provisions. For e.g. policy documents, guidelines, pronouncements, MoU, minutes of meeting, official letters, technical and/or financial reports, etc.).

21. a. How would you describe the proportion of the incentives contributed by your programme?

- More than the other programme(s)
- Less than the other programme(s)
- Equal contribution

b. If yes, how would you describe the type of the incentives contributed by each programme concerned?

- Cash (amount per volunteer)
- In kind (value per volunteer)
22. Has your programme discussed your external monetary incentive policies with other health programmes?
   - Yes (go on to question 23)
   - No (stop here)
   - Don’t know (ask for who else can provide this information, stop and start this task of the checklist again with this other resource person)

23. If yes, with which health programmes?

........................................................................................................................
........................................................................................................................
........................................................................................................................

(Please ask for evidence of these discussions. For e.g. minutes of meeting, official letters, etc.).

24. Has your programme harmonised its external monetary incentive policy with other health programmes?
   - Yes (go on to question 25)
   - No (stop here)
   - Don’t know (ask for who else can provide this information, stop and start this task of the checklist again with this other resource person)

25. If yes, with whom (which health programme(s))? 

........................................................................................................................
........................................................................................................................
........................................................................................................................

26. How have the programmes harmonised these policies?
   - Joint planning of incentives
   - Joint training incentives (per diems, travel allowances)
   - Joint incentive package (cash, in kind)
   - Other arrangements (specify)

(Please ask for evidence of policy on harmonisation. For e.g. policy documents, guidelines, pronouncements, MoU, minutes of meeting, official letters, technical and/or financial reports, etc.).
**INSTRUMENT 3: Document Review Guide**

**Identification of Project site:** ..............................................................
(1=Northeast, 2=Northwest, 3=North Central, 4=Southeast, 5=Southwest, 6=South South, 7=Cameroon A, 8=Cameroon F, 9=Ethiopia, 10=Uganda)

**Name of Ministry/Implementing partner/Health Programme:** ..........................
........................................................................................................................

**Location** (1=National, 2=State/province) ............................................................

**Issues to be reviewed in the documents for specific objectives 1 to 6:**

1.a Availability of (documented and/or implemented) policy on external incentives for community volunteers
1.b If so, what does the policy prescribe?

2.a Availability of health programme policy
2.b Types of incentives
2.c Monetary value
2.d Frequency
2.e Involvement of communities in determining/setting external incentives

3.a Reasons for external incentive policy
3.b Influence from donor agency

4.a Current number of programmes per district/LGA
4.b Potential/future number of programmes per district/LGA

5.a Availability of policy to on sharing volunteers
5.b Provisions of such a policy
5.c Who was involved in the formulation of this policy?
5.d Rationale for this policy
5.e Availability of policy to deal with issue of incentives in such cases
5.f Provisions of such a policy (each programmes contribution)

6.a Existence of dialogue with other programmes on coordination/harmonisation of incentive policies
6.b Programmes involved in this dialogue
6.c Existence of policy for harmonisation with other health programmes on incentives
6.d Programmes involved in this harmonised policy
6.e Provisions for harmonisation