

Searching for
**COMMON GROUND
ON INCENTIVE
PACKAGES**

for Community Workers and
Volunteers in Zambia



National HIV/AIDS/STI/TB Council

**SEARCHING FOR
COMMON GROUND ON INCENTIVE PACKAGES
FOR COMMUNITY WORKERS AND VOLUNTEERS
IN ZAMBIA**

A Review
OF ISSUES AND RECOMMENDATIONS

July 2009

A Report by

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IN ZAMBIA

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DISCLAIMER

It should be noted that the views expressed in this report are those of the authors, and do not necessarily represent the views of the National HIV/AIDS, STI, TB Council, the STARZ Programme, or DFID.

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ACRONYMS AND ABBREVIATIONS

ACCs	Area Coordinating Committees
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CBDAs	Community Based Distribution Agents
CBoH	Central Board of Health
CBOs	Community Based Organisations
CDE	Classified Daily Employees
CHAZ	Churches Health Association of Zambia
CHEP	Copperbelt Health Education
CHW	Community Health Worker
CIDRZ	Centers for Infectious Disease Research in Zambia
CRS	Catholic Relief Services
CWACs	Community Welfare Assistance Committees
DAPP	Development Aid from People to People
DHMT	District Health Management Team
DOTS	Directly Observed Therapy
FBOs	Faith Based Organisations
FGD	Focus Group Discussions
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
HBC	Home Based Care
HEPs	High Energy Protein Supplement
HIV	Human Immuno-deficiency Virus
HNC	Health Neighbourhood Committees
HRH	Human Resources for Health
IGA	Income Generating Activity
ITN	Insecticide Treated Net
KCTT	Kara Counselling & Training Trust
M & E	Monitoring and Evaluation
MCDSS	Ministry of Community Development & Social Services
MDG	Millennium Development Goals
MoH	Ministry of Health
NAC	National AIDS Council
NGOs	Non-Governmental Organisations
NZP+	Network of Zambian People living with HIV
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHIV	People (person) Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PWAS	Public Welfare Assistance Scheme
SCT	Social Cash Transfer
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
tTBA	trained Traditional Birth Attendants
TTR	Treat, Train, and Retain
UNZA	University of Zambia
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organisation
ZNAN	Zambia National AIDS Network
ZPCT	Zambia Prevention & Care Partnership



EXPLANATORY NOTES AND DEFINITIONS OF TERMS USED IN THE REPORT

Volunteer

The Oxford English Dictionary defines “volunteer” as:

1. A person who freely offers to do something.
2. A person who works for an organisation without being paid.
3. A person who freely enrolls for military service rather than being conscripted.

Incentive

1. A motive or incitement, especially to action
2. A payment or concession to stimulate greater output by workers

Community Worker

A person who offers hers/his services in the community usually on a voluntary basis (without anticipation of being paid).

Stipend

Fixed periodic payment or allowance in kind, usually of a short term nature

Salary

Fixed payment made periodically to a person as compensation for regular work

Allowance

A limited amount of money for a specific activity and/or item of expenditure such as transport or food allowances.

Monetary Incentive

Cash payments made to volunteers, either as salary or as allowances.

Non-monetary incentive

Goods and services provided to volunteers in-kind as opposed to cash payments and/or cash allowances.

Intangible incentive

Incentives that cannot be quantified in monetary terms - e.g. satisfaction with being a volunteer; recognition by the community; sense of personal achievement and/or altruism.



EXECUTIVE SUMMARY

Zambia is at the epicentre of the HIV and AIDS pandemic, with an adult prevalence rate of 14.3% in a population of 12 million. Currently there are an estimated 1.2 million people living with HIV (PLHIV) and approximately 350,000 needing treatment and care at present. Most of the burden of care is borne by the public health services, itself beset with chronic human resource shortages, inadequate funding and an unsuitable infrastructure. This situation is made worse by the inequitable distribution of health services in favour of urban areas.

Such an adverse set of circumstances is further exacerbated by a world-wide shortage of approximately 4 million health workers, with poorer, emergent nations faring much worse than well-established western economies. A major outcome of this global shortage has been a net pull of trained health workers from poorer nations – mainly those in Sub-Saharan Africa – to industrialised health systems.

In Zambia, this state of affairs has inevitably resulted in the unplanned and informal shifting of the burden of care from the inadequate service provision offered in the formal health service sector to one which is community-based. As this shift was ad-hoc, it did not have prerequisite policy guidance. Hence there was no accompanying delegation of authority, resources, and other forms of systemic/systematic support. In other words, practice preceded policy development.

Within communities, the bulk of service-provision is currently provided by non-health cadres commonly called, among other terms, 'Community Volunteers'. Volunteers receive some form of training plus a variety of incentive packages depending on geographical location, funding agency and type of training received. Generally speaking, these volunteers are not working within any formal human resource framework or establishment.

In spite of the Government's recognition of the contribution of informal and non-health volunteers, who in 2003 were reported by the MoH to have provided 31% of HIV and AIDS services, the Government has not yet addressed issues of recruitment, training and geographical distribution of this critical health cadre adequately or systematically.

However, the MoH does acknowledge in its 2006-health report that: 'it is predictable that the national HIV and AIDS targets will be impossible to achieve without radical measures to ensure that adequate staffing resources are available. Production, training, and retention of community health workers has not kept pace with health sector needs, both quantitatively and qualitatively, especially in addressing the increasing disease burden as a result of HIV and AIDS and in catering for evolving and expanding health worker roles, as well as new forms of service provision particularly those related to ART'.

The MoH estimates that the number of health and non-health community agents needed to deliver a minimum package of HIV and AIDS services in the health sector is 74,813 in 2009 and 75,071 in 2010 (MOH, 2006). The current number of active community health workers, including fTBAs, is approximately 10,000. Thus, the gap in numbers of community workers needed is around 65,000 for 2009 alone.

The question of whether community workers should be “volunteers” or paid in some form remains controversial worldwide. However, WHO has stated that *‘There exists virtually no evidence that volunteerism can be sustained for long periods: as a rule, community health workers are poor and expect and require an income’*. Therefore, in general, many programmes in the Africa region, and in Zambia particularly, use a combination of non-monetary and monetary incentives to motivate their community workers.

This study reviews experiences and lessons learnt regarding monetary and non-monetary incentives for community workers within the sub-region, and other parts of the world, as well as in Zambia. It includes indicative costings and recommendations for further policy and development with regard to the effective recruitment, training and deployment of community workers in Zambia. Given the current shortfall in the numbers of community workers needed, this is an enormous challenge and underscores the importance and timeliness of this study.

Rapid field assessments, including key informant interviews and focus group discussions, were carried out in Lusaka, Ndola, Mazabuka and Chongwe, targeting policy makers, programme managers, community workers and volunteers.

These assessments and reviews showed that there is a great deal of variation in the incentive packages offered in the public sector (MOH, MCDSS) and the non-governmental sector. These include the provision of multiple incentives - a varying combination of both monetary and non-monetary benefits - or single incentives, which are either monetary or non-monetary.

Such disparities are further exacerbated by externally funded, donor-supported projects where volunteers tend to be given higher monetary incentives than in locally funded projects. In some cases, community workers can be offered a variety of incentive packages, even when they are working for the same programme or organisation.

Focus group discussions with volunteers revealed that they would primarily seek monetary incentives when and where available. Volunteers were also overwhelmingly in favour of regular agreed incentives, disbursed monthly. However, there was an acceptance that there could be difficulties in offering them a monthly “salary”, so it was suggested that a combination of a fixed amount of money, together with goods in-kind (such as food rations) is preferable. It was categorically stated that, whilst non-monetary incentives are appreciated, these alone are insufficient to cover family needs such as education, funeral expenses; moreover, food is not an easily convertible medium of exchange to help cover such outgoings.

Strong recommendations to develop guidelines for volunteer incentives have been made before and there is interest from all stakeholders to standardize and harmonize the system of utilizing the services of volunteers, in line with the Paris Declaration on Aid Effectiveness and the Doha Agreement.

This report suggests that, in the current Zambian context, complete standardization of incentive packages across the board is not feasible and/or enforceable, especially since the national response to HIV is multisectoral. Nevertheless, the authors acknowledge that it should be possible to identify some “common ground” for providing incentive packages to community workers and volunteers. To this end, the authors have drawn on current practice in Zambia to present a number of options for incentive packages based on monetary, non-monetary and combined approaches. A methodology for costing these options is also presented. This methodology is intended to assist those involved in programme design and administration to make informed choices and provide incentive packages within a transparent framework.

Finally, this report makes a number of recommendations to government and non-governmental agencies to help move this initiative forward and establish some common ground for incentive packages. It is suggested that a CHW Programme Development and Implementation Committee be established. This committee could be housed within the MOH and/or NAC to plan, budget, and implement a large- scale CHW recruitment, training and retention programme, including incentive packages.

Other recommendations are divided between short term, medium term, and long- term initiatives and include:

Short term

- Establishment of a multisectoral stakeholder forum for further consultation, consensus building and possible joint planning and funding of community workers programmes;
- Formulation of national volunteer guidelines;
- Formulation of national Task-Shifting guidelines
- Harmonization of terminology of community workers/volunteers;
- Formulation of National Incentive Guidelines - minimum package of monetary and non-monetary – based on the cost of living
- Establishment of a National Training Package e.g. Training and accreditation schemes (including issues of qualifications; standards; development of linked training modules; definition of skill sets required; establishment of “career paths”; frequency of refresher courses; national registration system- basic training for all volunteers as community workers (CW), then builds on depending on particular needs of area, e.g. CW – Malaria, CW – Counsellor, etc.
- Streamlining different methodologies for disbursing incentives in rural and urban areas (e.g. Swift cash, commodity vouchers).

Medium Term

- Development of database of volunteers:
 - Organisations utilizing services of volunteers
 - Volunteer skills mix available
- Conversion of volunteers to recommended grades of community health workers

Long Term

- Formulation of regulatory (registration and accreditation) mechanism for volunteers
- Review of the suitability of an independent mechanism of institutionalizing volunteer services within Government. There are inadequate systems to support an incentive system, hence a unit to deal with this, possibly within Ministry of Community Development and Social Services needs to be considered.



BACKGROUND AND CONTEXT

Introduction and Problem Statement

Zambia is at the epi-centre of the HIV and AIDS pandemic, with an adult prevalence rate of 14.3% in a population of 12 million people, resulting in over 1.2 million people living with HIV (PLHIV) and approximately 350,000 needing treatment and care now. Most of the burden of this care is borne by the public health services. Moreover, despite the best efforts of Government and its cooperating partners, the public health system faces a host of challenges, the major of these being:

1. Chronic human resources shortage
2. Inadequate financial base
3. Inadequate and sometimes obsolete infrastructure
4. Inequitable distribution of health services in favour of urban areas

To make the situation worse, a large number of trained health workers have sought better employment opportunities outside the country, drawn by the acute shortage of health workers worldwide, resulting in a net migration of workers from emergent to established economies. An internal 'brain drain' to the private health sector has further depleted the ranks of public sector health workers. In addition, HIV itself has not spared this sector either, further reducing their numbers (MoH, 2005a).

Involvement of community workers/volunteers in service delivery

In order to cope with the burgeoning additional demands posed by the pandemic on an already inadequate health system, a mechanism to reduce this burden was required. Out of necessity, the burden was shifted from tertiary facilities to secondary, primary and, eventually, to communities. However, the shift of responsibility for the care of patients to lower level facilities and cadres took place without a corresponding delegation of resources, skills and structured authority.

The most visible outcome of this shift can be seen in the proliferation of a variety of community and home-based care service models, most primarily dealing with palliative care. These services are usually provided as either home-based care or through hospices, with the scope of such services further broadened by the advent of anti-retroviral therapy (ART). The bulk of the work and services within communities is, therefore, supplied by non-health cadres. These cadres go by a variety of titles but are more commonly referred to as 'community volunteers'. Such volunteers receive varying degrees of health and palliative training, together with a variety of incentive packages dependent upon geographical location, funding agency, type of training received, involvement in ART and related factors.

Government's recognition of community workers/volunteers

As already noted, in spite of Government recognition of the contribution of informal and non-health volunteers, who in 2003 were reported by the MoH to have provided 31% of HIV & AIDS services, it has not addressed issues of recruitment, training, and distribution of this critical cadre adequately or systematically.

The 2006-2010 Human Resource for Health Strategic Plan partially addresses this matter by advocating the use of multi-skilled health workers, e.g., community health nurses, who are mobilised with a shorter training timeframe in order to help increase staffing levels. These cadres are selected from the local community and may include existing Classified Daily Employees (CDEs), who are actually volunteers, but listed on the Government payroll, though not necessarily restricted to working for them. However, as this cadre is also envisaged as staffing rural districts, such an approach could raise concerns about the quality of services for rural populations to be provided.

Further, although the plan mentions 'non-formal' health workers as a cadre that deserves further investigation in the pursuit of filling service delivery gaps in the health sector, it does not include them in the proposed establishment of health workers, nor in its budget.

Such a cadre is, none-the-less, seen as part of the estimated staff required for ART delivery, especially in relation to the American President's Emergency Plan For AIDS Relief (PEPFAR) .

It should be stressed, however, that such volunteers are not covered in any of the major strategy or training outputs contained within current PEPFAR plans, nor are they formally recognised by, or budgeted for, within the current health establishment. Yet at the same time, they provide a large proportion of very critical service provision in the prevention, treatment, care, support and mitigation of HIV and AIDS.

The concept of volunteerism

In discussing incentive packages for Community Workers, there is general acknowledgement that volunteerism as experienced in industrialised countries and the developing world, especially in Africa, is of a fundamentally different nature (*CHAZ, 2008*). In the former, people generally take up voluntary work because they have time and skills to offer, volunteering for a few hours of charitable work each week, while having a secure social and economic base. As they derive altruistic satisfaction from volunteering, they do not expect any payment for their services.

Conversely, in Zambia, as in other emerging economies, the cost of volunteering is quite high because the majority of volunteers are poor women who are already burdened with their own family responsibilities and survival, and need financial and allied goods-in-kind assistance themselves.

Given such considerations, the use of the blanket term 'volunteer' for many of the non-formal health workers in the Zambian context, is a misnomer and should therefore be reviewed. There needs to be a recognition that the majority of such 'volunteers' themselves reside in the lowest income bracket and/or are unemployed: they 'volunteer' their time and labour in the hope that they may get some form of remuneration for the services they provide. In such circumstance, the motivation exhibited does not strictly adhere to the definition of a volunteer as generally accepted in industrialised countries.

Paid or unpaid voluntary work

Two major and largely unresolved issues need to be considered in here:

First, the question of whether community health workers should be conceptualised as volunteers (in its strictest sense of volunteerism as outlined above), or be paid in some form or other for their work and contributions, remains largely unresolved worldwide. However, according to WHO: 'There exists virtually no evidence that volunteerism can be sustained for long periods: as a rule, community health workers are poor and expect and require an income'.

An ideal and sought for situation in such contexts posits community workers spending only a small amount of time on their voluntary duties, leaving time for other, livelihood gaining, activities. In reality, however, demands for their services by the equally poor communities in which they live often requires full-time engagement, leaving them with little time or opportunity to pursue for their own livelihood activities.

Second, the majority of community workers, especially in African countries such as Zambia, are themselves poor and expect/need some form of compensation which would go towards meeting basic needs such as food, health and shelter. Consequently, many programmes in Zambia, as elsewhere, use a combination of non-monetary and monetary incentives for their community workers, with some offering only one of these, depending on the underlying philosophy of volunteerism driving a particular organisation.



TERMS OF REFERENCE AND METHODOLOGY

At the request of NAC, a team of consultants recruited by STARZ carried out a rapid assessment of incentive packages for community workers in Zambia. The main purpose of the study was to review experiences and lessons learnt regarding monetary and non-monetary incentives for community HIV and AIDS workers in Zambia; to develop and cost incentive options; and to provide evidence-based recommendations for further policy and Programme development. Although the focus of the assignment was on community workers in the field of HIV and AIDS, implications and linkages for other sectors/line ministries such as MoH and Community Development and Social Services were also considered. Detailed terms of reference are presented at appendix A.

Rapid assessment methodology

The rapid assessment had three main components. i) Literature review of relevant Zambian documents and incentive policies, practices and guidelines from the sub-region and beyond (Malawi, Tanzania, Mozambique, Ethiopia, South Africa, and China), ii) Key informant interviews with management in MoH, key HIV and AIDS implementing agencies, civil society, community-based managers and other relevant stakeholders, iii) Focus Group Discussions with community based volunteers.

Before carrying out the assessment, the team identified key target groups and developed questionnaires, interview and focus group discussion tools as appropriate to each one of them. The groups comprised of policy makers, Programme managers, officials from MOH and MCDSS, major civil society organisations, and community health workers. The field surveys were conducted in two urban and two rural districts i.e., Ndola and Lusaka for the urban sample, while the rural districts were Chikankata and Chongwe. The team used convenient sampling to select the districts based on ease of access to Lusaka and time constraints.

Data collection

Both qualitative data through key informant interviews and secondary data using literature review were collected. Primary data was collected from ten comparators –civil society and Government ministries for the costing component of the assignment. During the whole assessment process, the team was particularly interested to gain each group representatives' unique perspectives on monetary and non-monetary incentive packages in particular and on volunteerism in Zambia in general. The assessment tools developed for each group are presented at appendix C, D, and E.

Stakeholders' workshop

A one-day stakeholder workshop provided an opportunity to carry out a facilitated consultation, through which the consultant team, NAC and representatives from relevant INGOs, NGOs, FBOs and Government:

- Deliberated on the team's important assessment findings
- Made concrete suggestions on the recommendations developed by the consultants and,
- Identified challenges and opportunities for implementing the proposed incentive strategy and made suggestions for effective engagement and provision of incentives to community workers.



LITERATURE REVIEW

Human resources shortages in the health sector

According to WHO, the world faces a serious human resource shortage of approximately 4 million health workers, with poorer, emergent nations faring much worse than well-established western economies. This situation has resulted in a net pull of trained health workers from poorer nations – mostly sub-Saharan African – to industrialised health systems. While the disproportionately high impact of HIV in these countries has increased workloads, a global resource shortage has reduced the available workforce who can effectively respond to the epidemic.

Arguably, the agreement reached by WHO member nations to work towards universal access targets to comprehensive prevention, treatment, care and support by 2010, has compounded this situation, placing additional workloads on already inadequate health systems and human resource capabilities.

To implement effectively such a strategy, as well as meet the Millennium Development Goals (MDGs), it was necessary, as already described, to task-shift certain aspects of health services to community-based and patient-centred models of care and treatment of chronic diseases, including HIV-related illnesses (WHO, 2006a; WHO, 2006b; WHO, 2006c; WHO, 2008a; WHO, 2008b). As noted above, this task-shifting was not adequately supported by relevant policy development or health systems implementation. In consequence, practice preceded policy.

Task-Shifting

Although the term 'task-shifting' might appear novel, its concept and practice is well-established. For example, China task-shifted the delivery of its basic health care services by introducing a new cadre of health workers and prevention staff in villages. It took varying periods of time – three months, six months and up to a year - to qualify as 'barefoot doctors' (more recently now referred to as 'village doctors' WHO, 2002), dependent upon the level of instruction and abilities required. This movement had a significant influence on the Alma-Ata Declaration which introduced the concept of Community Health Worker (CHW) to a wider audience, describing the CHW as a pillar of primary health care (WHO, 1978).

It should also be noted that the practice of task-shifting is not only observable among emergent nations but is found in America and Europe, especially since the advent of HIV in the 80's (See for example: Ncama, 2005 and Spier and Edwards, 1990).

In sub-Saharan Africa, however, task-shifting was an ad-hoc response to an immediate and pressing problem and rarely adequately planned for, though identifiable models of service provision did emerge.

WHO (2006b, 2006c) emphasises the fact that while task-shifting may ultimately save resources, it needs substantial expenditure, especially in its initial stages, most of these costs being associated with training and retention of community volunteers. Emphasis is also placed on the fact that task-shifting is not meant to provide lower quality health services, but rather to improve the numbers and skills of health workers available, with sufficient checks and balances to protect both the client and health worker against any potential decline.

Task-shifting is thus viewed as a critical methodology in meeting successfully the goals of Universal Access to Prevention, Care, Treatment and Support interventions, through expanding the pool of trained human resources available (See for example: WHO, 1978; US Committee on a National Strategy for AIDS (1986), Ncama (2005); Uys (2001) and others).

Treat, Train and Retain (TTR)

TTR is a concept established by WHO, which emphasises the fact that for task-shifting to succeed, all cadres of health workers should have access to specially adapted HIV health services to suit their particular needs. In other words, prompt and adequate access to HIV prevention and treatment regimes for task-shift health workers is viewed as a primary contributory factor in both the ongoing retention of staff and in the continuity of their service and support roles.

Activities undertaken by community workers/volunteers

Community volunteers undertake a variety of activities, but the activities mainly relating to HIV are home visiting (including household chores, escorting to clinic, access to food, etc), and comprehensive home-based care, which may include some or all of the components of palliative care. These activities are anchored in a formal service provision structure that may be stand-alone, community-based, linked to a facility, or a comprehensive hospice service (Russell & Schneider, 2000; Malawi MoH, 2003; CRS, 2006).

Caregivers interviewed said that they do not only give physical support, but emotional as well, and, in such respects, their inability to attend to the economic and nutritional needs of their clients is a great concern, as is the often asymmetrical nature of relationships with professional health staff. Research elsewhere concurs with these sentiments, likewise viewing the primary motivations of caregivers being that of making a difference to those they support, and the appreciation so derived, both personal and public (See, for example, on caregivers in South Africa: Uys (2001, 2003).

The motivation and retention of community health workers is thus also affected by community perceptions of both their personal (age, gender, ethnicity, economic status, etc.) and communal status. Too much work, excessive information demands, and long distances to be covered can all be de-motivating factors.

Monetary and Non-monetary Incentives for community workers

Monetary incentives

A review of available literature suggests that money as an incentive is easier to administer, and programmes which provide monetary incentives experience lower attrition rates. Money's major attraction is that it is an incentive that is easy to disburse, while holding volunteers accountable to standardisation, and quality of service, as well as providing a variety of punitive measures if contractual commitments or outputs are not met (Phillips, 1999; Gray and Ciroma, 1987). Regular monetary incentives, allied to the symbolic power of a regular job in areas where such jobs are not easily available, can also greatly enhance status and thus personal and community perceptions of 'worth'. However, salary comparisons with formal health workers can help to undermine such claims and perceptions and help create or exacerbate already problematic relationships. In such respects, in their review of how incentives affect motivation, Basics II (2001) showed that as monetary incentives are directly comparable, volunteers start to comparing themselves with salaried employees especially where they are doing the same or similar work.

In addition, monetary incentives may not be sustainable and thus become a de-motivating factor if not regular maintained. In all respects, it is critical that a careful choice of incentive terms are offered, with timescale or duration known in advance, and with monetary incentives possibly tied to other, non-monetary perks such as transport allowances or are performance based on agreed criteria (Basics II 2001). Augustine and Pipp (1986) demonstrate that indirect payments, like increasing access to money through micro- financing, are also potential motivating factors.

A further consideration is that of workers invariably seeking higher pay for the same amount of work, over time. Therefore, if monetary incentives are not regularly revised upwards, performance levels decrease while attrition increases (Green, 1996; Wubrieh, 1999; Chevalier, 1993; Menda, 2008 unpublished; CHAZ, 2008).

Non-monetary incentives

Non-monetary/payments in kind such as food, agricultural inputs, etc., are difficult to quantify and thus reduce the effectiveness of comparisons made with salaried employees. Items that allow the volunteers to do their work better, such as HBC kits and bicycles appear to be good incentives. Supervision, recognition, identification tags, personal growth and training (including refresher courses), community relations, have all been cited as other forms of non-monetary incentives which are appreciated by community workers.

Pros and cons of monetary and non-monetary incentives

There are pros and cons to the use of either monetary or non-monetary incentives discussed in many of the reports reviewed during this assignment including BASICS II (2001).

Monetary incentives

Pros:

- Majority of community workers/volunteers are poor people trying to support their own families
- Cash incentives increase retention of community workers/volunteers in the programmes
- Cash allowances can be used for other needs such as educational, funeral and medical support

Cons:

- The money might not be enough
- May not be paid regularly
- May stop altogether
- May cause problems among different cadres of volunteers between those who are paid and those not paid
- May cause migration of volunteers from low paying programmes to other s offering more

Non-monetary incentives

Pros:

- Relatively small and inexpensive items such as chitenges, identification badges, T-shirts that nonetheless, provide community workers with a sense of pride in their work and increase their status in the community.
- Training increases volunteers' chances of getting jobs in other related s
- Work experience increases volunteers' chances of gaining employment in other related s
- Volunteer feel that they are part of the health care system through supportive supervision and training

Cons:

- Volunteers might need cash allowances for other family expenses such as educational, funeral and/or medical support
- Disparities in the types of non-monetary incentives between different s and organisations might be a discouraging factor for Volunteer
- Arbitrary frequency with which non-monetary incentives are provided to different cadres of volunteers
- Life span of the material incentives not taken into account-one might have an item given to them at the beginning of their voluntary work and not repeated long after the item's life span is over
- Lack of a standardized set of options, or coordinated incentive system in the country even for the same such as HBC.

Table 1 overleaf is adapted from BASICS II, (2001) is an illustration of incentives and disincentives that affect community workers' motivation and performance:

Table 1: Community Health Workers Incentives and Disincentives

	Incentives	Disincentives
Monetary factors that motivate individual CHWs	<ul style="list-style-type: none"> ▪ Satisfactory remuneration/ Material Incentives/Financial Incentives ▪ Possibility of future paid employment 	<ul style="list-style-type: none"> ▪ Inconsistent remuneration ▪ Change in tangible incentives ▪ Inequitable distribution of incentives among different types of community workers
Non-monetary factors that motivate individual CHWs	<ul style="list-style-type: none"> ▪ Community recognition and respect of CHW work ▪ Acquisition of valued skills ▪ Personal growth and development ▪ Accomplishment ▪ Peer Support ▪ CHW associations ▪ Identification (badge, shirt) and job aids ▪ Status within community ▪ Preferential treatment ▪ Flexible and minimal hours clear role 	<ul style="list-style-type: none"> ▪ Person not from community ▪ Inadequate refresher training ▪ Inadequate supervision ▪ Excessive demands/time constraints ▪ Lack of respect from health facility staff
Community-level factors that motivate individual CHWs	<ul style="list-style-type: none"> ▪ Community involvement in CHW selection ▪ Community organisations that support CHW work ▪ Community involvement in CHW work ▪ Community information systems 	<ul style="list-style-type: none"> ▪ Inappropriate selection of CHWs ▪ Lack of community involvement in CHW selection, training, and support
Factors that motivate communities to support and sustain CHWs	<ul style="list-style-type: none"> ▪ Witnessing visible changes ▪ Contribution to community empowerment ▪ CHW associations ▪ Successful referrals to health facilities 	<ul style="list-style-type: none"> ▪ Unclear role and expectations (preventive versus curative care) ▪ Inappropriate CHW behaviour ▪ Needs of the community not taken into account
Factors that motivate MOH staff to support and sustain CHWs	<ul style="list-style-type: none"> ▪ Policies/legislation that support CHWs ▪ Witnessing visible changes ▪ Funding for supervisory activities from Government and/or community 	<ul style="list-style-type: none"> ▪ Inadequate staff and supplies

Source: BASICS II (2001)

Examples of Incentive Packages Offered to Community Workers in Selected Countries

Experiences on incentive packages for community workers range from a systematic structured use of community health workers -"Community-Based Distribution Agents (CDAs)" working in family planning services in Tanzania, to the famous recruitment, training and distribution of "Barefoot Doctors" now referred to as "Village Doctors" in China. The selection of these four countries as examples is based on their unique volunteer Programmes and incentive packages that they offer to their community workers. They also serve as good practices and lessons learnt for Zambia to consider in its planning and development of an effective incentive system; and to avoid some of the mistakes made in the implementation of some of these programmes.

China

The systematic and countrywide organisation, implementation, and funding of the “village doctor” programme is one of China’s largest and most extensive health delivery schemes. They have, however, encountered difficulties related to incentives that are provided to the village doctors. In a paper presented in Australia by Jackson and his colleagues in 2008, they stated “irrational prescribing practices often led to serious consequences....” They found malpractices in all the 30 villages surveyed, e.g. about 28% of all patients visited were prescribed five or more different kinds of drugs (*one common definition of poly-pharmacy*), the highest number was 15 drugs for a single patient visit”. The Chinese Government is reviewing the health insurance scheme in order to improve the health service delivery system and the village doctor is one of the major channels of that service delivery system.

Incentives for ‘Village Doctors’ in China

Those range from allocation of pieces of land to the village doctors in some parts of China; to allowing them to charge a small user fee for their services and to sell drugs that they prescribe to their patients. The latter has created problems in that there is a tendency for a majority of village doctors to over prescribe on tests and medicines-in one case 15 different types of drugs prescribed for a single patient visit. (Jackson et al, 2008)

Tanzania

In Tanzania, some Programmes pay salaries to Community Distribution Agents (CDAs). An evaluation of two Programmes that paid CDAs (*Janowitz et al, 2000*) showed that the programme that paid agents the highest annual compensation (US\$398) also had the highest costs per agent (\$701), but also had the highest number of visits per agent (425).

On the other hand, the programme that had the lowest annual payments per agent (\$33) also had high costs per agent (\$558), but that its agents produced fewer visits (105). Simulations showed that an increase in the amount spent on agent remuneration reduces costs per visit, because the number of agent visits increases, thereby spreading out supervision and training costs over a larger number of visits.

The authors concluded that, ‘the challenge for a CBD Programme seeking to reduce their costs is to determine which cost components to decrease [in order] to minimize any reduction in visits. For example, those programmes that spends little on compensation might improve their performance by spending more on compensation but less on training or supervision’.

Mozambique

According to Save the Children (an international Non Profit Organisation operating in Mozambique), the Ministry of Health in Mozambique has stated that HBC volunteers should be paid 60% of the minimum salary. However, due to budgetary limitations, it had been difficult for some organisations to meet this requirement. A further problematic is that as HBC initiatives are primarily implemented on a time-limited project basis, long term sustainability is therefore extremely difficult to realise. When a project ends, so does the required 60% minimal salary to the volunteers required by the state.

Save the Children’s Pool Fund Concept in Mozambique

Save the Children in Mozambique (SCiMOZ), is piloting another kind of incentive model in Zambézia province. Each volunteer is given 50,000 Mt (30% of the minimal salary). Half of that amount is allocated to a POOL FUND. HBC volunteers contributing to the POOL FUND then agree on a certain economically viable initiative. Outputs of the initiative are then distributed to contributing HBC volunteers. Such an approach might be better able to contribute to the sustainability of incentives packages provided to HBC volunteers. HBC volunteers are trained using the guidelines from the Ministry of Health. Bicycles and t-shirts are additional incentives provided. When volunteers travel to participate in coordination meetings and/or go on exchange visits, SCiMOZ meets the related costs.

Ethiopia

In a system established in Ethiopia’s Gumer District, each household contributed one *birr* (US\$0.15) a year to support the community health agents (CHAs) and traditional birth attendants (TBAs). This contribution was apparently enough to cover a modest stipend for all trained CHAs and TBAs, and the attrition rate of these agents fell from 85 percent a year to zero (*Wubneh 1999*).



FINDINGS FROM THE RAPID ASSESSMENT

Current situation and existing policies

The following section is based upon finding from relevant programmes, policy documents, and reports from Zambia together with the findings of the fieldwork commissioned with this report.

Being at the epi-centre of the HIV pandemic, the Zambian HIV and AIDS response has seen the rise of numerous local and international actors, (bilaterals, multi-laterals, NGOs, FBOs, CBOs universities/research institutions, etc), each bringing with them, as already noted, their own particular organisational cultures, values and incentives.

Such a heterogeneity of approach is further complicated by a global shortage of health workers, which, as we have also noted, is estimated by WHO at some four million, with the largest shortfall being in sub-Saharan Africa. For example, 95% of PLHIV live in poor countries, almost two thirds of them in sub-Sahara Africa, which only has 3% of the global health work force and 1% of global health expenditure (WHO, 2008).

The following table illustrates the problem:

Table 2: Human Resource Crisis - health care personnel (doctors and nurses) per 100,000 population.

Cadre	South Africa	Botswana	Ghana	Zambia	Tanzania	Malawi	USA	UK
Doctors	69.2	28.7	9.0	6.9	2.3	1.1	230	256
Nurses	388.0	241.0	64.0	113	36.6	25.5	1212	937

Source: *The World Health Report – Working together for Health*, Geneva, World Health Organisation, 2006; <http://www.who.int/whr/2006/en>

In Zambia, such human resource shortfalls can be observed in the fact that more than 50% of rural health centers have only one qualified health worker. Indeed, such human resource shortages are notably worse in rural areas than urban. For example, Lusaka has a doctor population ratio of 1:6,247 compared to Northern Province's ratio of 1:65,763 (MoH, 2006)

HIV and AIDS has worsened such shortfalls by increasing the workload while reducing trained workforce numbers via the pandemic.

Table 3: Numbers of Staff by Cadre and staff/population ratios in the Public Sector (2005)

Staff Category	Current Staff Levels	Current Staff: Pop Ratios
Doctors	646	17,589
Nurses	6,096	1,864
Mid Wives	2,273	4,999
Clinical Officers	1,161	9,787
Pharmacists	24	473,450
Pharmacy Tech	84	135,271
Lab. Scientists	25	454,512
Lab. Technologists	100	113,628
Lab. Technician	292	38,914
EHO	53	214,393
EH Technologist	32	355,088
EH Technicians	718	15,826
Dental Surgeon	14	811,629
Dental Technologist	40	284,070
Dental Therapist	2	5,681,402
Physiotherapist Deg.	0	-
Physiotherapist Dip.	86	132,126
Radiologists	3	3,787,601
Radiographers	139	81,747
Paramedics	320	35,509
Nutritionist	65	174,812
Support Staff	11,003	1,033
Total	23,176	490

Source: Ministry of Health MoHHRIS database 2004/2005

The Ministry of Health recognises this critical human resource shortage faced by the health delivery system and formulated the Ministry of Health's Human Resources Strategic Plan 2006 – 2010.

"The health sector is facing a major human resource crisis and there are shortages of health workers at every service delivery level. The health sector recognizes that human resources are critical in the provision of quality health care and that to address the current crisis it is essential that it *"ensures an adequate and equitable distribution of appropriately skilled and motivated health workers providing quality services"*.

A number of factors have been cited as contributing to such shortages. These include:

- Inadequate conditions of service (pay, allowances and incentives)
- Poor working conditions (facilities, supplies and equipment)
- Weak human resource management systems
- Inadequate education and training systems"

In consequence, the Ministry of Health's Human Resources Strategic Plan 2006 – 2010, aims to 'ensure an adequate and equitable distribution of appropriately motivated, skilled and equitably distributed health workers providing quality services'.

However, the Plan hardly addresses the issue of volunteers, dealing instead mainly with formal employees. Neither the planned establishment proposed nor concomitant budgets put forward in the Plan recognise community-based agents or allied incentive packages. Volunteers are not formally recognised as part of any establishment and consequently not covered in any of the various sector budgets.

Similarly, the hiring, training and retention of volunteers is not adequately covered by policy guidelines to help guide and inform policy. The Plan simply alludes to the fact that both monetary and non-monetary incentives will be pursued (MoH, 2006), without further elaboration, though senior MoH officials indicate that a formal policy on volunteers is being formulated.

The advent of Home Based Care in Zambia

Given the somewhat myopic outlook of the Ministry of Health's Human Resources Strategic Plan 2006 – 2010, towards volunteers, it must be reiterated that Zambia, as part of the early response to chronic care in the presence of the burgeoning HIV and AIDS crisis, was one of the pioneers of home based care in the Region. The process was spearheaded by faith-based organisations which saw service to humanity as a requirement of faith, together with civil society organisations (e.g., CHAZ secretariat, Chichetekelo, Lusaka Arch-Diocese, Chikankata, etc).

Volunteer systems in Zambia

According to WHO, task-shifting to health workers with a shorter training period and fewer qualifications demanded is supposed to be implemented when appropriate and feasible service standards and guarantees for health worker, client and the overall implementing system are in place (WHO, 2008).

With such apriori conditions and standards currently still not being adequately addressed in Zambia, the net result, as noted earlier, has been a plethora of un-regulated partners and stakeholders coming into being, who cover the whole spectrum of the HIV response from prevention, treatment, care and support to impact mitigation.

Currently, there are varieties of organisations that hire volunteers. They can be classified in three broad groups:

1. Government/public health facilities
2. Faith-based organisations
3. Other None-Governmental Organisations (both local and international).

These categories influence policy framework and practices that are associated with volunteers in the absence of national policy guidance on incentives.

Policies on incentive packages

Most public owned facilities do not have a policy that informs incentive packages for volunteers. In practice, there are no formally institutionalised incentives, but certain 'gifts in kind' are periodically made available to them.

Such an approach depends largely on the availability of gifts from donors or funding organisations as these institutions do not routinely or systematically budget for them. In such contexts, a mix of incentives is usually offered to volunteers with, more recently, monetary incentives being provided if volunteers take on work that requires the delivery of specified outputs within a given timeframe. A percentage of monetary incentives can take the form of a 'transport allowance', usually a fixed monthly amount that often does not reflect actual travel costs. Similarly, innovative Health Neighbourhood Committees (HNC) in urban areas provide 'transport allowances' and other incentives drawn from a 10% levy of user-fees.

The organisations frequently cited in these respect were Zambia Prevention and Care Partnership (ZPCT) and the Centers for Infectious Disease Research in Zambia (CIDRZ).

Selective remuneration of volunteers

Rapid assessment findings showed that in some instances allowances are not given directly to all volunteers in a programme, but rather to those specifically trained by the funding organisation to meet a particular mandate.

A typical example of such a situation may be observed in a programme with volunteers working in the community to provide counselling, IEC materials distribution, palliative care, VCT and treatment adherence support. However, with the priority programme interest of the funding partners being centred upon ART adherence figures, only trained ART adherence supporters would, in consequence, receive direct monetary remuneration. Untrained volunteers whose work nevertheless still had a direct bearing on ART uptake numbers and care, were not so remunerated. Similar practices were found in hospices that remunerated volunteers taking on the role of nursing care, while those in the communities whose work directly accounts for the bulk of hospice clients were not remunerated.

Such selective remuneration of 'volunteers' within the same organisation, doing similar, inter-related and often inter-dependent work, can, and often does, cause disharmony, disunity and de-motivation within the ranks of such workers, especially if it appears based solely on the type of incentive approach adopted by the agency and not as a reflection on what the volunteers actually do.

With FBOs, there is a generally observed tendency to oppose monetary incentives. However, attitudes can range from disapproval of all forms (monetary and non-monetary) of incentives, to a more general acceptance of providing gifts in kind. It should be noted that recently some FBOs have adopted monetary incentives as well as employing a mix of various other options available to them.

Lack of clear policy guidelines

Lack of clarity and policy guidance on volunteers can also affect relationships with formal employees. Volunteers' contend that they carry most of the workload, yet the health system seems not to 'appreciate' their work. Indeed it was claimed, and observed, that sometimes they carry more weight and responsibility than trained and remunerated formal health workers.

Lack of standardization of incentive packages

Such a lack of coordination and standardisation is not necessarily confined to incentives, but to the selection and hiring and training of volunteers, activities carried out, reporting systems, and career progression. As no standard criteria exists, organisations have formulated their own in-house volunteer guidelines, for example, CHAZ, Care International, International AIDS Alliance and so on.

Despite such differences, the majority of volunteers in the country look for ways to maximize their incentives. Volunteers may be hired by a variety of organisations, usually playing similar roles, in the hope of maximizing the take-home 'pay'.

Survey findings from rapid assessment in the field

The findings noted in the previous section were augmented by rapid field assessments consisting of focus group discussions with volunteers; key informant interviews of policy makers and implementers in both Public Service (MOH, MCDSS); and some major non-Governmental organisations (NGOs) and faith-based organisations (FBOs) that utilize volunteers.

Focus Group Discussion Participants

The volunteers were drawn from:

1. Ministry of Health
 - i. Chongwe DHMT
 - ii. Ndola DHMT
2. NGOs (local and international)
 - i. CRS
 - ii. Hope Humana - DAPP

3. FBOs (local and international)
 - i. Circle of Hope
 - ii. Young Women's Christian Association
 - iii. Chikankata Mission Hospital

Policy level participants

Policy level interviews were conducted with:

1. The Ministry of Health
2. The Ministry of Community Development and Social Services
3. USAID
4. Churches Health Association of Zambia
5. World Vision Zambia
6. ZNAN
7. International AIDS Alliance

Implementers Participants

The following implementers were interviewed:

- | | |
|-----------------|--------------------------------|
| 1. Ndola DHMT | 6. NZP+ |
| 2. CRS | 7. Hope Humana – DAPP |
| 3. CARE | 8. Chichetekelo Hospice |
| 4. KCTT | 9. Chikankata Mission Hospital |
| 5. Chongwe DHMT | |

Monetary incentive packages offered to volunteers

As shown in Table 4, monetary incentives and cash allowances differ from one organisation to another, from place to place and from programme to programme. Amounts paid to community workers range from ZMK20, 000 to ZMK400, 000 per month depending on the organisation and , whether they work in the Public Sector or in NGOs/CBOs, whether the programme supports ART adherence, and whether it is funded externally or internally. On the other hand, the number and range of non-monetary incentives that are provided by various organisations particularly NGOS/ FBOs shows a much more consistent pattern as is shown in Table 5 below.

Table 4: Types of monetary –cash allowances offered to Volunteers by selected Organisations

Organisation	Salary -amount	Training/ workshop Allowance	Transport	Food allowance	IGAS	Other allowances	Frequency
AIDS Alliance	K240,000 (\$50)						Per month
CIDRZ							
1 st category	K380,000						Per month
2 nd category	K160,000						Per month
3 rd category	K100-150,000						Per month
CARE		K12,500		K20,000 K40,000			per capita during training sessions
MCDSS-Kalomo	K100,000				K650,000 K850,000	IGA fund /grp Seed fund/grp	Per report Once off Once-off
MCDSS-Chipata		K20,000 per volunteer during training	K100,000 bicycle maintenance allowance	K10,000 in training workshops			per volunteer during training sessions
Catholic Archdioceses						K500,000 funeral allowance	Per funeral
ZPCT			K100, 000 transport refund				

The data in Table 4 is indicative of the disparities in money and cash allowances offered as incentives to volunteers by different organisations in Zambia, such that it is actually impossible to find comparators for the baseline when dealing with monetary incentives. This underscores the need for some form of standardized options for monetary/cash allowances and other incentive packages in the country.

Non-monetary/In-kind Incentives

The disparities between different organisations in relation to in-kind incentive packages is smaller than monetary incentives, rendering it much easier to establish a basic incentive package which might address the needs of a variety of organisations.

Recommended package options are based on a survey of the following NGOs/FBOs operating in Zambia: International AIDS Alliance, CARE International (CARE), Kara Counselling and Training Trust (KCTT), Catholic Archdiocese of Lusaka, Catholic Relief Services (CRS) and its s; Zambia National AIDS Network (ZNAN), The Salvation Army, Hope Humana, World Vision Zambia, Network of Zambian People Living with HIV (NZIP+), Chichetekelo Hospice, and Churches Health Association of Zambia (CHAZ). All these organisations have established volunteers and can therefore inform policy development in the recruitment, training and retention of community workers/volunteers in the country.

Table5: Non-monetary incentives commonly provided to volunteers

Organisation	Non-monetary Incentives																			
	TS	B	S	U	C	K	R	TR	BL	MM	MS	IGA	FS	ES	EM	ID	Cert	Bag	FI	FP
AIDS Alliance		y						y												
CARE	y			y	Y															
KCTT	y	y	y	y	Y	Y	y	y												y
Catholic Arch-Diocese		y			Y	Y			y	Y	y					y		y	y	
AIDS Relief	y	y	y	y	Y			y									y			
CRS		y				Y		y												
ZNAN								y												
SUCCESS	y	y	y	y	Y															
RAPIDS	y	y	y	y	Y		y													
CHAZ		y				Y		y			y	y	y	y		y				

TS - T-shirts

U - Umbrellas

R - Raincoats

TR - Training

CERT- Certificates

FI - Farm inputs

FP – Food packs

B - Bicycles

C - Chitenges

K - Kits (HBC/testing)

BL - Blankets

MM - Maize meal

FS - Funeral support

S - Shoes/Boots

EM - Employment

ES - Education support

ID - Identification

MS - Medical Support

IGA - Income Generating Activity

Figure 1: Graphic Representation of non-monetary Incentives Provided by NGOs and FBOs

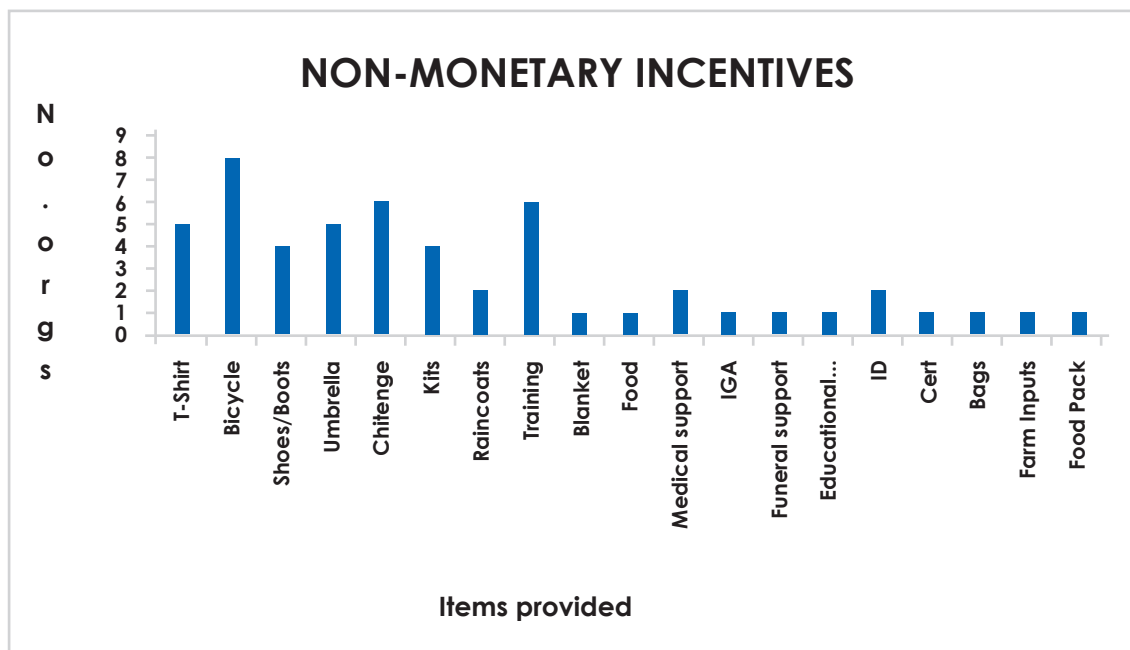


Figure 1 above shows that bicycles are the most popular non-monetary incentive provided to volunteers in organisations interviewed. Bicycles are closely followed by training and chitenges, T-shirts and umbrellas, HBC kits and shoes/boots, medical support/Identification badges, and raincoats.

Findings from Focus Group Discussions

During the FGDs conducted in Lusaka, Chikankata, Chongwe and Ndola districts, it was found that most of the pros and cons in the literature discussed above apply in the Zambian context as well. For instance, most of the volunteers are poor and in need of assistance and can all testify to the erratic nature of compensating community workers. Some volunteers were given an incentive at the beginning of their work two or three years ago, and are still working as volunteers with the hope of getting more benefits or a paid job in another programme or organisation. Some programmes pay different cadres of volunteers different salaries, as already noted. For example, CIDRZ pays volunteers involved in intensive VCT K20, 000 per day and those in PMTCT K100, 000 – K150, 000 per month (MCDSS, 2008). In addition, lack of a standardized model of incentive packages and refresher courses were further cited as major constraints facing volunteers in Zambia.

Additional Notes on Volunteers in Public Services

The Ministry of Health (MOH) and the Ministry of Community Development and Social Services (MCDSS) have the largest number of community workers in the health and social service sectors in the country.

Ministry of Community Development and Social Services

MCDSS runs the Public Welfare Assistance Scheme (PWAS) that was set up to provide social protection to vulnerable households in the informal sector. Within the PWAS scheme is the Social Cash Transfer Scheme, whose main objective is to assist the most destitute and incapacitated households in society meet their basic needs, particularly health, education, food and shelter. According to a 2008 report from MCDSS, the SCT was introduced in 2003 and piloted in Kalomo district then introduced to four others: Chipata, Katete, Monze and Kazungula, with assistance from CARE International, DFID, GTZ, the World Bank and other cooperating partners in social protection.

'The PWAS at grass root level uses a community based approach through community volunteer structures, that is, the Areas Coordinating Committees (ACCs) and the Community Welfare Assistance Committees (CWACs) to target 10% of the most incapacitated households countrywide as well as monitor the operations of the scheme such as witnessing the payment of cash to beneficiaries, counselling beneficiaries when they have difficulties related to use of cash transfers and reporting' (MDCSS, 2008).

The programme has established 5,506 Community Welfare Assistance Committees (CWAC) countrywide. There are 10 volunteer committee members per CWAC for 55, 060 volunteers serving in the programme, making it the largest formal and structured volunteer programme in the country. Each committee member works part-time for 3 full days per month.

Non-monetary Incentives offered to volunteers in PWAS

The management structure of the SCTs in PWAS is very well developed and organised. However, there does not seem to be a systematic or clearly defined package of incentives for committee members in CWACs or ACCs.

Not only are there disparities between different cadres of volunteers within the same , but disparities between districts as well. According to the MCDSS 2008 report, one CWAC of ten members received one bicycle as did the ACCs in Chipata district, whereas in Kalomo district, some CWAC and ACC members had received T-shirts in addition to bicycles in 2006. The volunteers cited no other non-monetary incentives.

Monetary Incentives offered to volunteers in PWAS

Monetary incentives were just as problematic as the non-monetary incentives. According to the same account, *'Liona CWAC was the only SCT volunteer group in the study from Chipata who reported that they had received some monetary incentives before from the programme . Although the other CWAC and ACC visited reported that there had been no monetary incentives, a check with the DSWO revealed that the had paid the volunteers K20, 000 and K10, 000 for transport and lunch respectively during training for targeting. This was a once off occurrence. The DSWO further reported that the had provided K100, 000 to each CWAC and ACC for maintenance of the bicycles between 2006 and 2007 – a once off payment.....whereas, in Kalomo district, almost all SCT volunteer committees visited indicated that they had received some monetary incentives at one time or the other. These incentives have already been alluded to and refer to the performance based trial monetary incentives. Between 2003 and 2006, 6 ACCs and 36 CWACs were rewarded with K650, 000 and K850, 000 IGA seed funds respectively. The amounts were linked to cost of farming inputs for one hectare of land. However, because the committees submitted their project/ business proposals late (according to the DWSO), the funding was made when the planting season was over. The volunteer groups there had to redirect the funds into other ventures.'*

The point of quoting the MCDSS's SCT evaluation report is to illustrate not only the disparities, but the uncoordinated manner in which both monetary and non-monetary incentives are distributed/allocated to volunteers in the same programme, plus the disparities in incentive packages among districts that are implementing the same programme.

Ministry of Health

The Ministry has a large number of active community health workers and an equally large number of patients attended to by these CHWs annually. The CHWs are chosen by their communities and trained by the MOH in basic curative skills. The following table indicates the distribution of CHWs in the nine provinces and number of patients they attended to in 2006:

According to the MOH, the number of CHWs decreased from 4,954 to 4,480 (approx. 10%) between 2005 and 2006. This might be due to several factors that could include conditions of service and/or type of incentive packages that CHWs receive from the MOH. It would appear from the statistics in Table 6 below, that the number of patients attended to by each CHW during 2006, was highest in Eastern, and followed by Northern, then Central Provinces.

These figures are indicative of the burden of care for community workers in those provinces that need to be taken into account when putting together an incentive package that is fair to all community workers in the Public service.

Table 6: Table Showing Number of active CHWs and patients attended (2006)

Province	No. of Active CHWs	Patients attended to by CHWs	
		No. of patients	No. of Patients per CHW
Central	579	454,650	785
Copperbelt	299	182,399	610
Eastern	644	643,330	999
Luapula	388	293,608	762
Lusaka	369	137,378	373
Northern	820	745,625	910
N/Western	324	312,404	109
Southern	804	643,111	330
Western	577	488,702	488
Zambia	4,480	3,903,207	460 average

Source: The 2006 Annual Health Statistical Bulletin



DISCUSSION OF THE FINDINGS

Motivation for becoming a volunteer

The findings from the survey showed a variety of reasons why individuals became volunteers. The main one being out of compassion for their community and a sense of duty to the community especially for those who had themselves benefited from the services of other volunteers.

Characteristics of volunteers

Generally, volunteers are female over 35 years old and tend to have a religious motivation. Younger volunteers, especially males, have a higher attrition rate as they are looking for a paying job and only end up as volunteers due to inadequate job opportunities.

Though it was clearly understood that the work would be free, there was an underlying expectation of some return for services rendered. It was universally agreed that not only do men find it difficult to work without pay but generally seek other remunerated work elsewhere at the earliest opportunity; They also tend to influence their wives' perception of 'voluntary work'. Thus, undermining the concept of pure "volunteerism", especially since one of the main reasons for attrition is moving onto gainful employment.

Reasons for the existence of volunteers

In agreement with authorities on task-shifting, the findings show that there is a human resource shortage that has been exacerbated by HIV and natural increase in population, resulting in increased workload for formal health workers. The extra-workload was taken over by the community not out of deliberate design, but by necessity. Therefore, practice preceded policy and there is little guidance to support the activities.

Incentive packages

The findings of the rapid assessment revealed great variation in incentive packages offered to volunteers. There are s that offer multiple incentives-a combination of both monetary and non-monetary benefits; others offer either monetary or non-monetary incentives but not both. There are also differences in incentive packages between Government schemes and projects that are implemented by NGOs and FBOs. However, these disparities are not peculiar to Zambia, many countries in the region have similar experiences (BASICS II, 2001); they also tend to be exacerbated in donor driven projects where volunteers are not only compensated differently, but tend to have higher monetary incentives than those operating in locally funded projects/s. There is general agreement on the desirability of incentives, even in a where the philosophical basis is one of pure volunteerism, only the managers ascribed to this point of view. The volunteers themselves would rather have some form of payment for their services.

Rationale for incentives

Monetary incentives

The payment was generally viewed in terms of a regular periodic set standard (monetary or non-monetary). There was a general view that authorities would be unwilling to pay a living wage, so the consensus was to mix money with commodities, mostly a defined food basket with other items that included a bicycle, a care kit and some form of identity. Various authorities pointed out that purely monetary incentives lead to comparisons with the formal sector employees, and may result in unsustainable demands for increases as well as industrial action.

Whereas monetary incentives are easier to administer, they may bring in a sense of being in formal employment and there is a fear, which has been realised in some cases, of volunteers asking for gratuity, terminal benefits, funeral grants, etc. Some volunteers even broached the issue of organised unions. Moreover, money is rarely enough and there would be need to periodically, review the monetary incentives and revise it upwards in line with other cadres in the formal sector. Since money is quantifiable, it makes it easier to compare and contrast with formal sector employees who, according to volunteers, do less work for regular and higher pay.

Non-monetary incentives

On the other hand, incentives in-kind such as food packages, identity labels, e.g., nametags and T-shirts; items to facilitate work such as bicycles and kits, etc, while they are not as easily quantifiable and therefore do not lend themselves well to comparison, they pose a nightmare in their acquisition, distribution and targeting to appropriate recipients. There is need to source the items, store and transport them. At the user-end, there may be further storage requirements before actual distribution. Bicycles would illustrate this better. In organisations where the bicycles are owned by the organisation and not individual volunteers, there are added maintenance and repair logistical arrangements to deal with.

Therefore, in order to maximize the use of the incentive system without disadvantaging the volunteers, the organisation, as well as the smooth running of the , it is important that organisations be given options to choose from depending on their financial and organisational capacities.

Tools of the trade as incentives

Tools of the trade and facilitatory items such as bicycles were also seen as incentives. However, volunteers preferred individual to communal usage of bicycles, more so in systems where volunteers were allowed to keep the bicycles in their homes and use them for personal errands. In such cases, bicycles reverted to the volunteer after two years of service, a fact that ensured that the bicycles were well looked after. Where an incentive is regarded as a payment to induce or motivate greater output, volunteers generally viewed commodities or materials necessary to do their work, and thus provide better services to their clients, as such incentives. However, volunteers unanimously called for the re-imburement of costs incurred by them while doing their work. Provision of microfinance schemes, for personal and small entrepreneurial activities, were also viewed as an important incentive.

“Why did they have to tell us that they will pay us? We have been working for free all along. They should just have left us alone”

“We have been working for free and then they come and promise what they cannot deliver”

Intangible Incentives

Motivation was not affected only by tangible goods. Although communities did not remunerate the volunteers in any way because of a generally challenged economy, and the misconception that volunteers are paid by the state, their gratitude was very much appreciated by the cadres. Almost all valued that they were called “doctors” and “nurses” in the community. The gratitude of the community was also an added incentive. Success in their work provides a big incentive, e.g. seeing a defaulter back on ART and doing well; seeing a client who was terminally ill back at work, and so on.

Rural/urban divide and its effect on incentives

Rural participants tended to add farming implements to their preferred incentive package, while their urban colleagues preferred money. The other interesting finding was that in some instances the provision of school exercise books was also viewed as an incentive.

Volunteers in Lusaka have more opportunities for remunerated work and access to refresher training, than those on the Copperbelt, while those in rural areas far fewer such opportunities available to them. One of the most striking differences between urban and rural was that rural volunteers bemoaned the fact that they had no time to tend to their subsistence farming due to their voluntary work. There was also the perception in rural areas that urban volunteers were more likely to receive better remuneration than their rural counterparts.

Effects of education and experience on incentives

Most programmes did not emphasise the need for formal education, but where records are required to be kept (testing and counselling, dispensing of medicines, etc.), some level of literacy is required. In most donor-funded programmes, higher literacy levels attracted higher allowances. Another area which attracted allowances, especially from PEPFAR-funded programmes, was the ART component. Other volunteers working within the same programme, but on other aspects of HIV, were not as well remunerated. ART services also attract more training, hence more opportunities for training allowances, workshop allowances, and certification.

While experience was valued, it did not seem to attract remunerations, other than for those volunteers engaged at Chichetekelo Hospice, where earlier recruits got K100, 000 while their latter colleagues received K60, 000 per month. The factors that affected remuneration were the type of work a volunteer did (hospice work and ART adherence) and the organisation that trained the volunteer (especially CIDRZ and ZPCT), while experience did not have a big role in determining the beneficiaries of monetary incentives.

Incentives as de-motivating factors

Erratic incentives, as pointed out in the literature posed a very serious disincentive. Most volunteers who work for no pay are negatively impacted by promises of incentives that are never fulfilled. However, the greatest de-motivating factor was the selective payment of some volunteers within one while others remained unpaid. Discussion of this fact was the only example when volunteers showed disunity and broke up into two camps that were diametrically opposed, with threats of eventual industrial action and possibly quitting their voluntary work. This issue requires immediate attention by all those organisations that recruit volunteers.

“I’m a breadwinner. My children expect me to put food on the table at the end of the day”

Thus, there was general discontent from those volunteers who did not get any remuneration at all, as is reflected in some of the sentiments expressed during focus group discussions.

Logistics of disbursing incentives

Commodities required tendering procedures, procurement, storage, distribution and disbursement. This does not only need transport costs, security arrangements, allowances for involved members of staff and wear and tear on vehicles, but has resulted in some organisations increasing their ware-housing space, a non-core function. The purchase, storage and distribution of incentives can therefore all pose administrative challenges and increased programme costs. Disbursement of money can also pose major challenges, especially in rural areas, where banking services may not be as widespread and require physical transportation to a disbursement point, a situation that can add extra costs as well as security problems to a programme.

“When they call us nurse or doctor, we feel so nice and wish that we could make it come true, but anyway, what type of doctor is it who cannot afford to send their children to school?”

Working hours

Almost all volunteers worked more hours than agreed, but the general activities they did tended to be the same. Outside of the physical activities done, spending time and praying with the clients was reported to be highly valued. Authorities emphasise the need to delineate the exact and specific activities to be done by non-health cadres for task-shifting to succeed, and it was clear that the volunteers knew exactly what they did.

These extra hours of work may have contributed to the belief by volunteers that they carry a significant amount of the workload, a view validated by the literature review. Despite carrying this workload, there is a feeling of animosity due to a perception that their contribution is both undervalued and abused, especially since it receives little or no remuneration. This view is further strengthened by the fact that during working hours, very few volunteers –even those working in health facilities – are invited to tea during the tea-breaks by the formal employees.

Rationale for standardization and harmonization of incentive packages

Advantages and Disadvantages

Standardisation assumes an agreed standard and the capacity, ability and willingness to conform to such a standard. The advantages of standards is that they allow for uniformity, but their-in lies one of their greater weaknesses – stifling of individuality and gradual onset of rigidity and resistance to change. Therefore, organisations should periodically review their standards' acceptability, cost-effectiveness, feasibility, responsiveness and relevancy to the problem at hand.

Standardisation also allows comparison of services for resources spent. Replicating services in other areas is easier and cheaper as there is no expenditure on devising new ideas and trying them out. It allows the use of similar or same training facilities and resource people. It is also one of the initial steps in assuring the quality of services offered. Further, standardisation allows organisations to plan better as they do not have to formulate and try out new methods of doing things. In addition, it reduces migration of volunteers from one to another and protects the interest of the volunteers, as they will at least get the minimum return for services rendered.

Standardisation of incentive packages in the Zambian Context

In the current Zambian context, standardization of incentive packages across the board is not feasible and/or enforceable, especially since the national response to HIV is multi-sectoral and multi-disciplinary. The recommended strategy is to develop national guidelines for a more harmonized approach across all sectors and all disciplines.



INCENTIVE PACKAGE OPTIONS

This section outlines monetary and non-monetary incentive package options for community workers/volunteers as well as a training component that are deemed crucial to each proposed strategy.

Based on the findings of the RA, literature reviews and interviews with programme managers and volunteers during the FGDs, the following three incentive options are proposed including a minimum package and a training component:

1. Only monetary
2. Only non-monetary/in-kind package
3. A combination of monetary and non-monetary package

Incentive options

Only Monetary

Due to the large disparities in salary/cash allowances paid to volunteers by different organisations in the country, a baseline/minimum salary of **K350, 000** per month per volunteer is proposed. This figure takes into account the average salary of the comparators in table 4 above, and the JRTC and CSO estimated cost of a monthly basic needs basket per family of six.

Pros and cons of monetary incentives

As enumerated above, there are pros and cons to the use of monetary incentives discussed in many of the reports reviewed during this assignment, the critical one being that, most volunteers are unemployed, are poor and need support themselves, before they can offer any services in their communities free of charge. Therefore, if the proposed strategy is going to work, it is necessary to deal with the cons of monetary incentives first. For instance, once an organisation has agreed upon a specific amount for the monetary incentives, this amount should be paid regularly (ideally on a monthly basis), and should be the same amount for all the volunteers working in the same programmes.

Only in-kind incentive options

As illustrated in Table 7, the first five preferred items on the list of non-monetary incentives (A) are: Bicycles; Training; Chitenge; T-shirt; and a Care Kit – depending on the programme/disease prevention they are involved in e.g., malaria, HBC, tTBA).

Table 7: Minimum and extended list of in-kind incentive options

A. Minimum to facilitate CHWs' work	B. Optional Extended list of items & Support	C. Minimum + Extended list A + B
1. Bicycle	6. Umbrella	1. Bicycle
2. Training	7. Raincoat	2. Training
3. Chitenge	8. Boots/shoes	3. Chitenge
4. T-Shirt	9. Identification badge	4. T-shirt
5. HBC Kit	10. Carrier bag	5. HBC Kit
	<i>Other forms of support</i>	6. Umbrella
	11. Medical support	7. Raincoat
	12. Food package	8. Boots/shoes
	13. Farm inputs	9. Identification badge
	14. Educational support	10. Carrier bag
		11. Medical support
		12. Food package
		13. Farm inputs
		14. Educational support

These items are the most popular provided by many organisations in Zambia for their volunteers. In addition, volunteers in FGDs frequently mentioned them as items of choice. HBC kits are a necessary tool for many community workers/volunteers working in the field of HIV and AIDS and are provided by almost all organisations implementing HBC Programmes in the country.

Thus, for the non-monetary incentives, we propose that at a minimum, items in group (A) are provided and selected items from (B) left to the discretion of each organisation.

Pros and cons of non-monetary/in-kind incentives

As already discussed, major considerations here are:

- The arbitrary frequency with which non-monetary incentives are provided to different cadres of CWs/volunteers;
- Life span of the material incentives not taken into account;
- Lack of a standardised, non-monetary incentive system even when addressing the same programmes issues, for example HBC.
- Consistency in the provision of non-monetary packages is very important, as is attention to the lifespan of the items given to Volunteers;
- Non-monetary incentives are only meaningful if they are replaced once they come to an end of their lifespan, so each item provided should have some measure of its probably life span; this would also make costing and time projections easier to factor into programme budgets.

A combination of monetary and non-monetary incentive package

A minimum cash allowance of **K200, 000** per month is suggested to be paid to each CHW plus **(A)**: The list in **A** is the minimum incentive package that facilitates the work of community workers and volunteers and organisations should provide it as a minimum incentive package to every volunteer.

Once again, the choice of what combinations of monetary and non-monetary incentives to offer volunteers is for the discretion of each organisation. What the team is suggesting is a combined minimum of non-monetary items and a monetary amount that can suffice to motivate community workers and cater for their basic needs.

Minimum package

A. Minimum to facilitate Volunteers' work

1. Bicycle
2. Training
3. Chitenge
4. T-Shirt
5. HBC Kit

This strategy also advocates for the provision of a minimum incentive package to facilitate the work of CHWs/volunteers, this has to be applied across the board in order to motivate community workers/volunteers to continue working as volunteers and to do the best work possible. This is the list of items in category A. Training, means of transport such as bicycles and care kits-HBC/ malaria/tTBA etc. are essential for facilitating the work of community workers and in addition, they serve as incentives for the volunteers.

Proposed training Programme for CHWs for the HIV and AIDS Programme scale-up

Training is a very powerful non-monetary incentive cited by almost all the volunteers interviewed during FGDs and from literature review, hence, the addition of a specific training component in this strategy. As discussed above, the Government needs to train about 7,200 community workers per province and distributed to districts according to their staff needs and HIV and AIDS disease burden. Thus, a broad based initial training Programme for community agents comprising CHWs and tTBAs is proposed and this would cover the following subjects/topics:

Basic training content for all CHWs

1. Understanding of job description (based on a clear understanding of the long term vision for CHWs as an integrated human resource in the health system)
2. Definition of commonly used terms
3. Filling of forms (designed for purposes of record keeping, data collection, referral etc.)
4. Topics:
 - a. Psychosocial counseling skills
 - i) interpersonal communication (verbal and non-verbal-greet, ask, talk, hear, explain, review)
 - ii) Focus
 - iii) Probing
 - b. Community awareness or information dissemination
 - i) Techniques
 - ii) Principles
 - c. Technical information
 - HIV and AIDS transmission
 - Prevention methods
 - Disease progression
 - Identification of OIs
 - Benefit of treatment
 - Information on PMTCT (transmission, benefits, exclusive breastfeeding/feeding, options etc.)
 - Addressing stigma
 - Counselling and Testing
 - Nutrition basics
 - Prevention of TB, malaria
 - Health education
 - Hygiene
 - Adherence counselling (DOTS, ART)
 - Basic palliate care
 - Child health
 - Water & sanitation (water borne diseases)

Specialized Training

After the initial training of 1-6 months, CHWs should be given special training in specific areas such as counselling; adherence; TB; ART; Malaria; and thereafter their titles would change to reflect their area of specialization: e.g.:

CHW-Counsellor
CHW-Malaria

CHW-Adherence
CHW-HIV

CHW-ART
CHW-HBC

This suggestion would help identify community workers who have done both the broad based and specialized training and would be easier to allocate non-monetary incentives such as kits accordingly.

TOT Programme

In order to reduce training costs, Government would need to budget for:

- a) TOT at provincial, district, and community levels
- b) Utilise their own tutors to train TOTs and community health workers
- c) Use their own facilities free of charge during training sessions instead of hotels or conference centers
- d) At nation level select two trainees per province for the national level TOT
These two will then select two trainees per district for the district level TOT
These two will select two trainees from each community for the community level TOT

A) Recognition of Community Health Workers/Volunteers

- Community Health Workers be recognised and honoured on Volunteers Day, which is held by United Nations organisations-UNV and the ILO.
- Organisations encouraged to provide "long service" awards to volunteers who have served in Programmes for at least five continuous years, and to present awards marking subsequent five year intervals of service
- CHWs be provided with stationery for correspondence and communication purposes every year
- CHWs awarded certificates of practice after serving continuously for one year
- CHWs be registered and accredited to an appropriate authority e.g., Ministry of Health.

B) Work advancement

When positions open up in HIV and AIDS related Programmes e.g., home based care, before they start recruiting externally, organisations should first consider for employment trained CHWs with relevant qualifications for work at community level.



METHODOLOGY FOR CALCULATING THE COST OF THE INCENTIVE PACKAGES

Simplified costing methodology

The most useful and simplest methodology given the disparities in incentive packages offered by different organisations in the country is to annualize the cost of both the monetary and non-monetary incentives, as well as the output variables. World Bank, PHRplus project, Abt Associates etc. and other organisations and researchers, commonly use this methodology to calculate the cost of intangibles in community based Programmes and/or settings.

Steps in the costing exercise

Cost of monetary incentives

We take annualized cash payments/allowances paid directly to community workers/volunteers

Cost of in-kind/non -monetary contributions

We establish the current “*replacement cost*” of each item on the list obtained from various organisations:-

- Bicycles
- Blankets
- T-shirts/uniforms
- Carrier bags
- Shoes/boots
- Chitenges
- Home Based Care Kits
- Umbrellas
- Raincoats
- Millie-meal
- Medical support
- Funeral support
- Educational support
- Income Generating Activities
- Employment
- Training

Estimated life span of the item/Duration of support

We then estimate the useful life span of each item based on interviews with community workers/volunteers and Programme managers, e.g.:

Item	Life span/duration of support
• Carrier bags	1 year
• Shoes/boots	1 year
• Chitenges/uniforms/T-shirts	1 year
• Home Based Care Kits	2 years
• Bicycle	5 years
• All support contributions	once off/annually

Equipment

If there is equipment involved e.g. computers, boats etc. we would calculate what the Programme could have earned if it had invested the funds used to purchase the equipment, or the "opportunity cost of capital". We assume for instance, that funds conservatively invested would have earned 3% interest per annum for the organisation, thus we take 3% of the value of the equipment as the annual cost.

Cost of training the community workers/volunteers

We calculate the cost of initial/refreshing training sessions annualized over a two-year period, depending on number of training sessions that take place. It is however, difficult to determine the useful life of the initial training sessions, which should be equal to the number of years that community workers/volunteers are expected to work in the Programme. Thus, we annualized the training costs over a two year period which is the estimated number of years that a community worker or volunteer in most of the organisations interviewed, is expected to stay in their position in that particular organisation.

Cost of supervisors for community workers/volunteers

We calculate the cost of paying supervisors such as salaries, benefits and travel costs. In this regard, we determine the number of hours that the supervisors spent during the year on that supervisory role as a percentage of their overall work load and remuneration package.

Vehicles

Operating costs for vehicles include the cost of fuel, maintenance, repair, insurance and licenses. However, we are inclined to leave this cost item out, since use of vehicles is typically shared among community workers/volunteers and other Programme activities. If necessary, we could use the Programme manager's costs – proportion of time vehicles are used for community work.

Output variables

This relates to the number of hours or visits per year that the community workers spend, divided by the number of active community workers/volunteers in the same period. This provides a good estimate of the average annual number of visits/hours spent in communities per community worker (number of workers adjusted to account for those who didn't work for the whole year or those who dropped out or received their initial training during and not at the beginning of the year).



APPLICATION OF THE COSTING METHODOLOGY TO THE INCENTIVE PACKAGES OBTAINING IN ZAMBIA

Cost of monetary incentives

This was calculated by taking cash payments, such as salaries, transport, food, workshop allowances paid directly to community workers/volunteers per year.

Cost of in-kind/non-monetary incentives

In order to arrive at the replacement cost of the items listed below, we conducted a market survey in Kamwala – a retail shopping centre where most of the low-medium income, informal sector sub-population of Lusaka (the capital city of Zambia) do most of their shopping.

Table 8: Estimated replacement costs of the items

Item	Unit of measure	Current Price/replacement cost
Bicycle	Each	K400,000
Chitenge	Per meter	K5,000
T-shirt	Each	K12, 000
HBC Kit *	Each	K560, 000
Raincoat	Each	K35, 000
Boots	Per pair	K72, 000
Shoes (regular)	Per pair	K115, 000
Canvas shoes (women)	Per pair	K27, 400
Canvas shoes (men)	Per pair	K53, 000
Identification badge	Each	K10, 000 (un- laminated)
Carrier bags	Each	K35, 000 (medium size canvas bags)
Blankets	Each	K45, 000
Umbrella	Each	K12, 000
Food package		
Maize meal (breakfast)	Per 25 kg bag	K45, 000
(roller meal)	Per 25 Kg	K36, 000
Kapenta	Per 90 kg bag	K750, 000
Beans	Per 90 kg bag	K400, 000
Cooking oil	Per 750 gms	K8, 000
Sugar	Per 2 kg	K8, 000
Salt	Per 500gms	K2, 000
Farm inputs		
- Fertilizer	Per 50 kg	K50,000-k300,000(at the moment K50,000 under FSP)
- Seeds-maize seed	Per 25 kg	K100, 000

We surveyed at least four shops offering the same product in order to arrive at the average replacement/unit cost of each of the items listed below for Lusaka. These are current prices, thus if we were to project those in the future, we would add about 1-5% to the cost to take account of likely increases in the annual inflation rate.

Secondly, we estimated the useful life span of each item based on interviews with community workers, volunteers, and managers. This provided us with annualized estimates of the cost of each item, incentive payments as well as other support.

Cost of HBC Kits

The cost of one HBC Kit (**K560, 000**) is based on an estimated national average cost used by the CRAIDS project, a component of the World Bank supported HIV & AIDS from 2003 to 2008. This particular HBC kit was developed after consultations with key stakeholders including MOH and contains the following items:

Table 9: Contents of HBC kit

1. PVC washable Plastic apron	8. A5 note book
2. Medium sized water proof bag	9. Pen
3. Small wash basin	10. Hand torch
4. 100 gms medicated soap	11. Surgical scissors
5. 500 gms Vaseline	12. Latex gloves
6. Hand towels	13. Panadol
7. Foldable umbrella	14. ORS – 5 sachets

Source: (World Bank –CRAIDS Implementation Status, 2003-2008)

Cost of training community workers

This is the cost of initial/refresher training sessions annualized over a two-year period, depending on the frequency of the training. It is however, difficult to determine the useful life of the initial training sessions, which should be equal to the number of years that community workers/ volunteers are expected to work in the . Thus, we annualized the training costs over a two year period which is the estimated number of years that a community worker or volunteer in most organisations, is expected to stay in their position in that particular organisation before moving on.

Comparators for the training costs

For estimating the training costs, we utilized estimates from training s for community workers that were provided by AIDS Alliance, AIDS Relief, Dakana

Table 10: Organisations, training emphasis and approximate costs

HBC Project in Kabwe and IDA/STARZ. These four organisations /programmes have detailed costings of their community workers' training between 2007 and 2008 which could form a core group of comparators as well as a baseline for current projections on training costs. The latter would include participants' transportation, food, accommodation, tutors' fees and meal allowances.

Organisation	Training Activity	Approx. Cost per trainee	Annualized cost per CW/2
AIDS Alliance		K1, 480, 680	K740, 340
AIDS Relief		K986, 666	K493, 333
Dakana HBC project	Psychosocial Counsellors	K608, 166	K304, 083
	Home Care Givers	K476, 340	K238, 170
IDA/STARZ	Psychosocial Counsellors	K537, 910	K268, 955
	Treatment supporters	K943, 510	K471, 755
	Training in ART	K435, 267	K217, 634
Average training costs per community worker		K781, 220	K390, 610

Administration costs

In costing the non-monetary incentives, we left out administrative costs that might include: Rent; office supplies; telephone; audit; contingencies etc. These would have to be factored into the total cost of hiring and supervising community workers. The cost of procurement, storage, and distribution of the incentive packages themselves should also be factored into the total cost. These total costs will vary between different organisations, between rural and urban areas, and between different sources of funding and sources of supply, including the cost of individual incentive items themselves.

Due to these differences, incentive packages need to be tailored to the circumstances and/or environment in which the community workers operate. For instance, agricultural inputs might be more appropriate as incentives for volunteers in rural and remote areas of the country, whereas, commodity vouchers for food might be better for the urban community workers.

Indicative costing

The team wishes to emphasise that all the costing in this report are indicative. Their purpose is to illustrate how to plan and budget adequately for community workers' incentive packages using annualised unit costs.



COSTING OF PROPOSED OVERALL STRATEGY FOR GOVERNMENT

Assumptions

In making calculations we have assumed that administrative costs will be absorbed within the MOH to cut down on the cost of scaling-up the HIV and AIDS response at community level throughout the country. All estimates are subject to change, depending on how the Government might wish to proceed, including deciding which costs might be absorbed more easily by the MOH within its own structure and resource base.

These figures are indicative, being provided to assist decision makers plan for, and calculate, the cost of increasing the number of community workers in the country and the type of incentive options they might use.

The figures provide the annual unit costs of a proposed package for 65,000 newly trained CHWs. This number could be varied depending on the financial resources that Government is able to commit to this programme. The figure of 65,000 could also be spread over a number of years. For example, a target set of 5,000 new recruits per year would see the target figure realised within 13 years. Thus, the annual budget to recruit, train and distribute community workers can be divided by thirteen.

Only Monetary incentives

We have used our suggested baseline/minimum salary of **K350, 000** per month as proposed in the strategy.

Cons and pros of monetary or non-monetary incentives have been discussed above. However, non-monetary incentives by themselves cannot cater for other financial needs such as medical/ educational and/or funeral support and some cash transfers to voluntary workers would be necessary.

Non-Monetary incentives

The methodology used to calculate the unit cost of each item found above:

<i>Minimum package</i>	<i>Annual cost</i>
1. Bicycle	K80, 000
2. Chitenge	K10, 000
3. T-shirt	K12, 000
4. HBC Kit	K280,000

1. **Total annualized unit cost per CHW = K382, 000 per annum if all the items listed are included in the package for a total of K382, 000 x 65,000 CHWs**

Total cost K24, 830, 000,000

Breakdown of estimated costs for 65,000 CHWs

- Bicycles only => $65,000 \times K80, 000 = K5, 200, 000,000$
- Chitenge only => $65,000 \times K10, 000 = K650, 000,000$
- T-Shirt only => $65,000 \times K12, 000 = K780, 000,000$
- HBC kit only => $65,000 \times K280, 000 = K18, 200, 000,000$

2. **Estimated 75 days training spread over 3 months for 65,000 CHWs 75 x at a proposed K14,000 per day x 65, 000**

Total cost K68, 250, 000, 000

3. **Monetary/Salary only => CHW unit cost K350, 000 x 12 = K4, 200, 000 x 65,000 per annum**

Total cost K273, 000, 000, 000

Advantage of using unit costs

As mentioned above the usefulness of calculating unit costs of the incentive packages, means that one can plan for any number of community workers from one extra community worker to thousands. Yet such an approach also allows budgets be set utilising a number of options to suit a variety of situations.



RECOMMENDATIONS AND CONCLUSION

This review of incentive packages for community workers, presented in this report clearly shows that, there is no one single package, rather a variety of incentive packages obtaining in the country, offered by various organisations-INGOs; NGOs; FBOs and Government schemes such as PWAS in the ministry of community development and social services. That multiple incentives-a combination of monetary and in-kind incentives are the most preferred by the majority of community workers interviewed.

Monetary incentives can increase retention of community workers, because the majority of volunteers are poor people trying to support their families. However, as discussed above monetary incentives also bring their own problems, including causing discontent among those who are not paid. While non-monetary incentives alone cannot cater for other needs that need cash, such as medical, educational or funerals expenses.

At policy level, there appeared to be consensus in the stakeholders' meeting that across the board standardization of incentive packages, in the current Zambian context would not be feasible or even desirable, because the principles discussed in this report extend beyond health to other social service sectors. Development of a set of guidelines would be more appropriate that would:

- provide a reference point for further stakeholder dialogue and consensus building
- Provide operating procedures for hiring, training and deployment of volunteers in the country.
- provide a basis for negotiation, target- setting and costing

As way forward, the team's recommendation for Government would include firstly, the establishment of a CHW Programme Development and Implementation Committee. This committee could be housed within the MOH and/or NAC to plan, budget, and implement a large- scale CHW recruitment, training and retention Programme, including incentive packages.

Other recommendations are divided between short term, medium term, and long - term initiatives and include:

Short term

- Establishment of a multi-sectoral stakeholder forum for further consultation, consensus building and possible joint planning and funding of community workers Programmes;
- Formulation of national volunteer guidelines;
- Formulation of national Task-Shifting guidelines
- Harmonization of terminology of community workers/volunteers;
- Formulation of National Incentive Guidelines - minimum package of monetary and non-monetary – based on the cost of living
- Establishment of a National Training Package e.g. Training and accreditation schemes (including issues of qualifications; standards; development of linked training modules; definition of skill sets required; establishment of "career paths"; frequency of refresher courses; national registration system- basic training for all volunteers as community workers (CW), then builds on depending on particular needs of area, e.g. CW – Malaria, CW – Counsellor, etc.
- Streamlining different methodologies of disbursing incentives for rural and urban areas (e.g. Swift cash, commodity vouchers-giving community workers commodity vouchers) would cut down on the transaction costs of paying them salaries directly or buying their incentive items).

Medium Term

- Development of database of volunteers:
 - Organisations utilizing services of volunteers
 - Volunteer skills mix available
- Conversion of volunteers to recommended grades of community health workers

Long Term

- Formulation of regulatory (registration and accreditation) mechanism for volunteers
- Review of the suitability of an independent mechanism of institutionalizing volunteer services within Government. There are inadequate systems to support an incentive system, hence a unit to deal with this, possibly within Ministry of Community Development and Social Services needs to be considered.

Conclusion

While most of the volunteers seemed resigned to receiving fewer incentives than they believe their work is worth, almost all preferred a regular standardised multiple package combining both monetary and non-monetary incentives. The team acknowledges the fact that, it would not be appropriate to recommend one standard incentive package, but to establish a set of standardised incentive options for organisations to choose from based on the capacity to meet the standard and organisational philosophy and principles about voluntarism.

The standard package options should be formulated with the participation of all stakeholders, especially relevant line ministries, donors, implementing partners, volunteers, PLHIV and others. If “task-shifting” to community workers and volunteers is to be considered, there is need to carefully consider the design of the task-shifting package and agree on both the activities and type of cadres of community health workers who might perform such tasks. The type of training required at each level operational is also a factor that should be taken into account. Effective coordination of implementers and activities is essential to achieve this.



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APPENDICES

Appendix A: Terms of Reference

Purpose of the assignment

The purpose of the assignment is to review experiences and lessons learnt regarding monetary and non-monetary incentives for community HIV&AIDS workers in Zambia. The assignment will include a rapid costing of options and development of recommendations for further policy and development. Although the focus of the assignment is on community workers operating in the field of HIV&AIDS, implications and linkages for other sectors/line ministries (such as health) will also be considered.

To achieve this, two consultants (a team leader and an economist), will

- a) Attend a briefing session with the NAC Civil Society Adviser and the Director of PMSR.
- b) Undertake an extensive literature review on community HIV&AIDS workers to identify relevant issues, lessons learnt and experience from Zambia, as well as other countries in the region (especially South Africa) and elsewhere.
- c) Complete a rapid assessment to: i) map the range of community workers deployed in the field of HIV&AIDS in Zambia; ii) document current practice with regards voluntarism, stipends and non-monetary incentives; iii) identify the strengths, weaknesses, opportunities, threats (SWOT) and lessons learnt from current practice; iv) collect preliminary data to support the costing of options for the way forward. This rapid assessment is likely to include key informant interviews with selected sector representatives, policy makers, planners and senior managers, as well as interviews with a sample of key practitioners at the community level (such as PACAs, DACAs, community workers and professional service providers (such as health and social workers, teachers etc). Key informant interviews might also be supplemented by email communication and distribution of questionnaires.
- d) Prepare a draft outline based on the findings of Tasks b) and c) above. Include options for the way forward on monetary/non-monetary schemes for community workers, as well as the methodology that will be used to cost the options. Submit the outline report to the Civil Society Adviser and Director PMSR for review.
- e) Once the draft outline and options/recommendations have been approved, complete a rapid costing of each option in accordance with the agreed methodology (for example, the estimated annual cost per capita/nationally of standardised stipends (including administration) for all community workers deployed in the field of health and HIV/AIDS).
- f) Complete a draft report that expands on the agreed outline, options, estimated costs and recommendations.
- g) Present the draft report to a meeting of key stakeholders and make any further revisions required.
- h) Submit the final report in hard copy and electronic formats.
- i) Prepare a short Task Completion Report (1-2 pages) that describes tasks completed, challenges encountered and recommendations for future assignments of this nature.

Appendix B: Schedule of Activities and Interviews

			Output
Briefing session with the Civil Society Adviser and Director PMSR.	11 Nov 08	Consultant time Civil Society Adviser time TORs Briefing Notes	Dated schedule of activities
Literature Review meeting with Dr Terri Collins and Director PMSR	18 – 23 Nov 08	Dated schedule of activities	Agreed schedule of activities and assessment methodology Letter from NAC to MoH seeking authority to conduct research
Literature review		<p>Volunteer Incentive documents from</p> <ol style="list-style-type: none"> MoH <u>Ndeke House</u> Dr Albert Mwango Mrs. Anna Mupinde Mrs. Grace Mumba Tembo <u>Lusaka DHMT</u> HBC coordinator USG – PEPFAR coordinator Ministry of Social Services and Community Development - Public Welfare Assistance Scheme (PWAS) GFATM Principle recipients (Ministry of Finance and National Planning, Zambia National AIDS Network; Churches Health Association of Zambia) Major implementing partners – Catholic Dioceses; CRS; DAPP; Red Cross; NZP+, Care International, World Vision Zambia UNZA HIV&AIDS Response – Anita Menon, Dept of Psychology, UNZA Kara Counseling Trust Contact Salvation Army HQ or Chikankata to send documentation if any, or phone conversation, on community volunteers <p>Incentive literatures from the sub-region, including South Africa</p>	List of incentive options practiced in Zambia and the region
Development and pre-testing of tools	23 – 26 Nov 08	incentive options practiced in Zambia and the region	Rapid assessment tools
Meeting with Dr Terri Collins	24 Nov 08	Rapid assessment tools	
Rapid assessment, including one site visit	27 Nov – 10 Dec 08 Lusaka 27 – 28 Nov 08	<p>Rapid assessment tools; Motor vehicle; Soft drinks for FGD participants; Dictaphone appointments with:</p> <p>Headquarters Level – key informant interviews</p> <ol style="list-style-type: none"> MoH Director Public Health and Research with ART and HBC coordinators (Dr. Mukonka, Dr Mwango and Mrs. Anna Mupinde) Director Human Resources – Mrs. Kapihya PEPFAR Coordinator (American Embassy) Principle Recipients CHAZ; ZNAN; MoFNP (Mr. Scott Tembo – at NAC) NGOs World Vision, DAPP, NZP+, CRS; Kara Counseling Ministry of Social Welfare and Community Development – Community Welfare Assistance Committee Ministry of Agriculture – Extension workers Archdiocese of Lusaka Zambia Youth Council – Mr. Beck Banda (contact details from NAC) Lusaka PACA and DACA Zambia Agency for People with Disabilities <p>Get comprehensive list of community radio stations from One World Africa (in Roma – Ms Jere)</p> <p>Field Staff</p> <ol style="list-style-type: none"> SWAAZ YWCA CRS community s Bwafwano Home-Based Care 	Rapid assessment data from totality of community services spectrum

Rapid assessment, including one site visit	2 Dec 08	2 FGDs with 12 – 15 community volunteers Key informant community volunteers Traditional Birth Attendants Community Leaders Local leaders (traditional and elected) Community media	Rapid assessment data from totality of community services spectrum
	3 Dec 08	Chikankata Mission Hospital - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives)	
	4 – 8 Dec 08	Chongwe DHMT - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives) Visit to Ndola Ndola DHMT - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives) Diocese of Ndola - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives) DAPP - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives) Copperbelt Health Education (CHEP) - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives) Chichetekelo HBC (Ndola – contact through Ndola DHMT) - Key informant interview with HBC coordinator and site managers - 2 FGD with community volunteers (one group of paid volunteers; second group with other incentives)	
Meeting with Dr Terri Collins and Director PMSR	4 Dec 08	Literature review outcomes; tentative list of options	Consensus on way forward
Preparation of draft outline with options	10 – 22 Dec 08	Rapid assessment data from totality of community services spectrum	Draft out line with incentive options
Revisions to draft outline	22 Dec 08 – 12 Jan 09	STARZ time Review by various partners	Final draft outline
Costing of options	12 – 19 Jan 09	Final draft report	Costed incentive options
Meeting with Dr Terri Collins and Director PMSR	12 Jan 09	Costed Options	Consensus on costed options
Preparation of comprehensive draft report	19 – 23 Jan 09	Costed incentive options Comments from reviewers	Final Draft Report
Meeting with Dr Terri Collins and Director PMSR	23 Jan 09	Final Draft Report	Report revised and approved for presentation
Presentation to stakeholders	26 Jan 09	Final Draft Report Venue List of invitees Copies of report LCD Projector Stationery	Comments for consensus on final report
Final revisions	26 – 29 Jan 09	Comments for consensus on final report	Final Report
Preparation of Task Completion report	30 - 31 Jan 09		Task completion report and final Rapid Assessment Report ready for printing and dissemination
Meeting with Dr Terri Collins and Director PMSR	30 Jan 09	Final Report	

Appendix C: Examples of Various Home-Based Care Kits

Type of HBC Kit	Kit Contents
Client kit	<ul style="list-style-type: none"> • 1 bottle of Vaseline • 1 bottle of Jik • 1 ten kg bag of High Energy Protein Supplement (HEPS) per month when available and if the client is eligible • A packet of multivitamins • A packet of Panado • 1 box of gloves (100 per month) • 1 tablet of soap • Mosquito treated bed net (ITN) • 3 sachets of Oral Rehydration Salts (ORS)
Care giver kit	<ul style="list-style-type: none"> • Rubber gloves • Hand towel • Durable bag • Plastic apron • Adult disposable napkins/usable napkins • 90-100g antiseptic soap • One bottle Jik • 100gms Vaseline • Plastic mattress cover (when available) • Torch and batteries • Gauze swabs • Cotton wool • Crepe bandage • Basic drugs <ul style="list-style-type: none"> ○ 60 tablets multivitamins ○ 36 tablets Panado or Aspirin tablets 500mg ○ Anti-diarrhoea medicine ○ Antacids (magnesium triscilicate) ○ Gentian violet • Soap holder and 1 hand towel • 1 bottle of chlorine for treating water (disinfecting or chlorinating drinking) • 4 sachets of ORS • A packet of cooking soda/ash • Razor blade • Rub on • Care giver's diary (note book) • Pens/pencils • Referrals forms • Clients register and assessment card • Pair of scissors • Gallipots/receivers
Caregivers tools for work/incentives	<ul style="list-style-type: none"> • Bicycle • Chitenge • Umbrellas • Clothes • Shoes • Bags • Pens • T-Shirts • Clothes

Source: Adapted from MoH, CBoH and CARE (2005)

Appendix D: Framework for Analyzing and Costing Incentive Packages for Community Workers Operating in the Field of HIV and AIDS, as Basis for Policy Recommendations

Existing situation/baseline	Issues to be considered
1. Existing demand/need for community workers	<p>type of existing community workers for HIV related Programmes</p> <p>a mapping of the range of community workers deployed in the field of HIV in Zambia and location</p> <p>nature of health staff shortages at community level/supply of human resources – gaps/deficit that is currently filled by community workers</p> <p>target population-PLWHIV/others</p> <p>nature of services that are currently being provided-HBC Prevention/treatment/care & support/impact mitigation/others?</p> <p>frequency of service provision/hourly/weekly/monthly/yearly</p> <p>time frame of services provided</p>
2. Selection criteria for community workers	<p>gender, age, education, experience</p> <p>community or institutional recruitment</p> <p>training of community workers for what Purpose?</p> <p>retention of community workers</p> <p>average duration of community worker's participation in Programme</p>
3. Incentive/benefit packages monetary/non-monetary	<p>current practices with regard to voluntarism/stipends/ incentives-SWOT</p> <p>cash allowance, service provision or combination/multiple incentives</p> <p>maximum and minimum benefits</p> <p>medicines and supplies</p> <p>food provision</p> <p>transport-e.g. bicycles, chitenges, T-shirts etc.</p> <p>other in-kind provisions</p> <p>dis/satisfaction with conditions of service/motivation of community – voluntary workers</p>
4. Programme operation	<p>Government-run or private/NGO/FBOs/CBOs</p> <p>responsibility for service delivery</p> <p>coordination of activities of community workers</p> <p>supervision of community workers</p> <p>quality assurance of services provided by community workers</p> <p>coverage/percent of population in need of service</p> <p>locations/disease categories and target populations</p>
5. Cost	<p>costs of services provided by community workers</p> <p>hourly/weekly/monthly costs</p> <p>ratio of paid to unpaid workers/volunteers</p> <p>training costs for community workers</p> <p>medicines and supplies</p> <p>transport</p> <p>food supplements</p>
6. Financing	<p>govt./community contribution to the cost of the community Programme</p> <p>in-kind funding of costs by community/govt./institution.</p>
Costing options	Issues to be considered for a standardized incentive package
1. Human resource needs for HIV & AIDS	<p>anticipated no. of PLWHIV in the country & geographic distribution</p> <p>current supply/shortage of trained health workers & need for community workers to augment cadre of health workers in the country</p>
2. Scaling up human resources to meet increased demand	<p>level of and scale of activities that can be considered for "Task-shifting"</p>

Source: Adapted from WHO-Community Home-Based Care in Resource-Limited Settings, 2002.

Appendix E: Policy Level Key Informant Questionnaire on Community/Volunteer Workers

Name of organisation:
Designation of Respondent:

Name of Respondent:
Date:

Thank you for agreeing to take part in this rapid assessment on volunteers and volunteerism.

We will use the data so generated only for the purposes of supporting the formulation of recommendations to govern incentive packages for various community-based volunteers that work in HIV&AIDS.

Thank you.

1. How does your organisation define a community/volunteer worker?
2. What specific name do you call such cadres in your organisation?
3. Do you know of any other names used by other organisations to describe similar workers?
4. Does age, sex and education level affect the type of incentives volunteers are ready to work for? Explain
5. What type of type training do you recommend for volunteers?
6. Where are they trained?
In-house:
Training institution (name):
Other (name):
7. Does qualification (including type of training as a volunteer) affect incentive package offered to volunteer? Give examples:
8. What is the average cost that you budget for the training of a volunteer?
9. What type of services/activities do the community workers/volunteers provide? (please list)
10. Is the training adequate to cover the services/activities they carry out? Explain.
11. Do you have policy guidelines for incentives in your organisation? (Get a copy):
12. How where these guidelines developed? (Where they locally developed; did community volunteers participate in the process?; based on national documents/standards (specify); or based on parent organisation policy)
13. How would you recommend that incentive guidelines are developed?
14. Do you have authority to change your incentive packages to conform to national standards if that was available? Explain
15. Do all volunteers doing similar work in the organisation get the same or similar incentives? Explain:
16. What type of incentive does your organisation offer – specify? Give reasons for your organisations' choice

Monetary (amount/period):
Non-monetary:
Other:

Reason:

17. Do you know of other incentive packages from similar organisations? List them:
- | | | |
|----------|--------------|-------|
| Monetary | Non Monetary | Other |
|----------|--------------|-------|
18. What are your views about standardising incentives for volunteers? What would you prefer – every organisation has own incentive package, one standardized option for all or a package of limited options for implementers to choose from? Give reasons for your answer?
19. If it were agreed that standardization was the better option, who are the key players you think should take part in the process?
20. What obstacles would you foresee in the standardization? Give reasons why
21. How would you overcome these obstacles?
22. Do you consider the incentive package that you offer to volunteers satisfactory/adequate? Explain
23. How are these incentives disbursed?
Explain the process
Amount of time required
Staff required - is there staff dedicated to do this?
What are the challenges associated with the disbursement?
What are the lessons learnt?
Do you have a budget (collect copy):
24. What incentives (monetary and non-monetary) would your organisation regard as affordable for effectively organizing community/volunteer workers?
25. What incentives (monetary and non-monetary) would your organisation regard as ideal for effectively organizing community/volunteer workers?

Any other information you wish to give me about your community workers/volunteer Programme?

Thank you very much for your time.

Appendix F: Programme Level Key Informant Questionnaire

Name of organisation:
Designation of Respondent:

Name of Respondent:
Date:

Thank you for agreeing to take part in this rapid assessment on volunteers and volunteerism.

We will use the data so generated only for the purposes of supporting the formulation of recommendations to govern incentive packages for various community-based volunteers that work in HIV&AIDS.

Thank you.

1. How does your organisation define a community/volunteer worker?
2. What do you call such cadres in your organisation?
3. Do you know of any other names used by other organisations to describe similar workers?
4. State the predominant age, sex and education level (range) of your volunteers?
5. Does age, sex and education level affect the type of incentives volunteers are ready to work for? Explain
6. How are they recruited?
7. How are they selected? 1 community [] 2 by organisation []
8. What is the range of their qualifications?
Non-literate-----
Primary education-----
Secondary education-----
Tertiary education-training colleges/universities-----
9. What type of type training do they receive?
10. Where are they trained?
In-house:
Training institution (name):
Other (name):
11. How long is the training? Is there certification?
12. How much does it cost to train the volunteers?
13. What subjects are covered during the training Programme?
14. Does qualification (including type of training as a volunteer) affect incentive package offered to volunteer? Give examples:
15. What type of services/activities do the community workers/volunteers provide? (please list)
16. Is the training adequate to cover the services/activities they carry out? Explain.
17. What is the workload?
Hours per day:
Days per week:
Days in an average month:
18. What is the main reason for attrition of volunteers?

19. On average, what is the farthest distance a volunteer may travel to see a client? How do they usually cover the distance?
20. Do you have policy guidelines for incentives in your organisation? (Get a copy):
21. How were these guidelines developed? (Were they locally developed; did community volunteers participate in the process?; based on national documents/standards (specify); or based on parent organisation policy)
22. Do you have authority to change your incentive packages to conform to national standards if that was available? Explain
23. Do all volunteers doing similar work in the organisation get the same or similar incentives? Explain:
24. What type of incentive does your organisation offer – specify? Give reasons for your organisations' choice
 - Monetary (amount/period):
 - Non-monetary:
 - Other:
 - Reason:
25. Do you know of other incentive packages from similar organisations? List them:

Monetary	Non Monetary	Other
----------	--------------	-------
26. What are your views about standardising incentives for volunteers?
27. What would you prefer – every organisation has own incentive package, one standardized option for all or a package of limited options for implementers to choose from? Give reasons for your answer.
28. If it were agreed that standardization was the better option, who are the key players you think should take part in the process?
29. What obstacles would you foresee in the standardization? Give reasons why
30. How would you overcome these obstacles?
31. Do you consider the incentive package that you offer to volunteers satisfactory/adequate? Explain
32. How are these incentives disbursed?
 - Explain the process
 - Amount of time required
 - Staff required - is there staff dedicated to do this?
 - What are the challenges associated with the disbursement?
 - What are the lessons learnt?
 - Do you have a budget (collect copy):
33. What incentives (monetary and non-monetary) would your organisation regard as affordable for effectively organizing community/volunteer workers?
34. What incentives (monetary and non-monetary) would your organisation regard as ideal for effectively organizing community/volunteer workers?

Any other information you wish to give me about your community workers/volunteer Programme?

Thank you very much for your time.

Appendix G: Focus Group Discussion Guide for Volunteers

Name of Group:

Date:

Venue:

Thank you for agreeing to share with us your experiences as volunteers. We will use the information only for the purposes of supporting the formulation of recommendations to govern incentive packages for various community-based volunteers that work in HIV&AIDS.

Thank you.

1. Reasons for becoming volunteers
Selection of volunteers; training; official title; other titles for community volunteers; motivation to work; other organisations worked for and reason for leaving, etc
2. Reasons for the existence of community volunteers
HR shortages; cheaper workforce; magnitude of problem
3. Work and responsibilities of volunteers
Actual activities; workload – hours per day and days per week; how long will they stay as volunteers and why? What is next career move?
4. Returns for work done
What is received for work done – money or payment in kind; community appreciation; what is most important and reasons why; satisfaction levels with current package and why; ideal package and reasons why
5. Any other thoughts? Questions?



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