Diagnostic Evaluation of Community-based Worker System in South Africa

National Evaluation Plan Report

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This report has been independently prepared by Southern Hemisphere. The Evaluation Steering Committee oversaw the operation of the evaluation, and commented on and approved the reports. The committee comprised Ms Kgaugelo Moshia-Molebatsi (DPME), Ms Desiree Jason (DSD), Ms Dibolelo Ababio (DSD), Mr Mbulaheni Mulaudzi (DSD), Mr Boipelo Matladi (DSD), Ms Lesego Mogami (DSD), Mr Edwin Molebale (COGTA), Ms Mary Maake (COGTA), Ms Noxolo Madela (National Treasury), Mr Rhulani Manganye (DPSA), Mr Muchuchi Donald Nghonyama (SACSSP), Mr Sidwell Mokgothu (DSD), Mr Theresho Mokgahla (DPME) and Mr Garfield Whitebooi (DAFF).

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This was a mixed-method evaluation combining a literature review, semi-structured qualitative interviews and focus groups, and a document review. The evaluation took place between January 2018 and February 2019.

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Abbreviations

BCEA	Basic Condition of Employment Act
CASP	Comprehensive Agriculture Support Programme
CBIMS	Community-based Intervention Management System
CBO	Community-based Organisations
CBW	Community-based worker
CCG	Community Care Giver
CCW	Community Care Worker
CDP	Community Development Practitioner
CDW	Community Development Worker
CDWP	Community Development Workers Programme
CHW	Community Health Workers
COGTA	Cooperative Governance and Traditional Affairs
CWD	Children with Disabilities
CWP	Community Work Programme
CYCW	Child and Youth Care Worker
DAFF	Department of Agriculture, Forestry and Fisheries
DALY	Disability-adjusted life-years
DHIS	District Health Information System
DOH	Department of Health
DPME	Department of Planning, Monitoring and Evaluation
DPSA	Department of Public Service and Administration
DPW	Department of Public Works
DSD	Department of Social Development
ECD	Early childhood development
EPRE	Estimates of provincial revenue and expenditure
EPWP	Expanded Public Works Programme
ESC	Evaluation Steering Committee
FS	Free State
GBV	Gender Based Violence
GDP	Gross domestic product
HBC	Home-based carers
HCBC	Home- and Community-based Care
HPCSA	Health Professionals Council South Africa
HWSETA	Health and Welfare Sector Education and Training Authority
ISRDP	Integrated Sustainable Rural Development Programme
KZN	Kwa-Zulu Natal
MCH	Mother and Child Health
M&E	Monitoring and Evaluation
MTEF	Medium term expenditure framework
NACCW	National Association of Child Care Workers
NGO	Non-Governmental Organisation
NPO	Non-profit organisation
NQF	National Qualifications Framework
ODI	Overseas Development Institute
OotP	Office of the Premier

OSS	Operation Sukuma Sakhe
OVC	Orphaned and Vulnerable Children
OVCY	Orphaned and Vulnerable Children and Youth
OVS	Operation Vuka Sisente
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
QCTO	Quality Council for Trades and Occupations
RAO	Rural Animation Officer
SA	South Africa
SACSSP	South African Council of Social Service Professionals
SAQA	South African Qualifications Authority
SP	Social Protection
SSI	Semi-structured interviews
TB	Tuberculosis
TOR	Terms of Reference
UFE	Utilisation-focused evaluation
UIF	Unemployment Insurance Fund
UNICEF	United Nations Children’s Emergency Fund
USAID	United States Agency for International Development
VHW	Village Health Worker
WBOT	Ward-Based Outreach Team
WBPHCOT	Ward-based Primary Healthcare Outreach Teams

Glossary

Community-based workers: For this study it refers to women and men who are generally community-based and selected from the community in which they live. They work in a particular ward or village (that is, within a specific, small geographical area). They are lay or non-professional workers that have qualifications up to NQF Level 4. They visit households and/or work at or from a community-based centre or as part of an outreach team. They provide community-based services, ideally under the supervision of a para-professional or professional in their related field, directly to community members, and/or linkages / access to other services. In this way, the CBW extends the reach of service delivery.

Coordination: For this study, it refers to different stakeholders in policy, programming and delivery processes working together (conducting joint activities) with the aim of improving health and social development outcomes. It can be dined as the alignment and harmonisation of all stakeholder activities (at the programme and administration level) in a coherent and holistic way to reach clearly identified and shared objectives (at the policy level). A vertical link (vertical coordination) is also required between the policy and operational levels (Chames & Davies, 2017).

Diagnostic evaluation: To ascertain the current situation prior to an intervention and to inform intervention design (DPME, 2014).

Harmonisation: Working on complementary areas to allow various plans to work together for the achievement of an overall strategic objective. (SIMPLA, n.d)**.** Practically, it adjusts differences and inconsistencies among different measurements, methods, procedures, schedules, specifications, or systems to make them uniform or mutually compatible. (Business Dictionary, 2019)

Household Profile: Information collected on households about their socio-economic situation.

Integration: The coordination of working arrangements where multiple departments or public sector organisations are involved in delivering a public service or programme (Morse, 2013).

Policy integration: Management of cross-cutting issues in policy-making; management responsibility within a single department or sector. For policies to be qualified as ‘integrated’ there needs to be comprehensiveness, aggregation, and consistency (Meijers and Stead, 2004).

Rationalising: Reorganizing a process or system to make it more logical and consistent; making a company, process, or industry more efficient, usually removing additional personnel or equipment (Oxford, 2019).

Policy Summary

Diagnostic evaluation of community-based worker system in South Africa

The Department of Planning, Monitoring and Evaluation (DPME) commissioned this diagnostic evaluation to assess the use of community-based workers (CBWs) by the South African government to improve the effectiveness and efficiency of CBWs in programme delivery. The evaluation followed a participatory and utilisation-focused approach, employing mixed research methods with a strong focus on secondary data sources, supplemented by qualitative tools.

The overall finding of the diagnostic review is that workforce strengthening and planning is mainly what is needed to improve CBW use. There are many types of CBWs within the Department of Social Development (DSD) and one in the Department of Health (DOH), yet there are few in other government departments that meet the definition of a CBW. Hence, the focus of the improvement should be in the social and health sectors. CBWs are a critical component of ensuring that services reach the most marginalised and vulnerable people in society when and where they need them. CBWs who currently occupy the murky space between volunteer and employee also deserve decent working conditions and career opportunities, which in turn will improve quality. The poor application of the Basic Conditions of Employment Act, 75 of 1997 (BCEA) to CBWs and the use of the Extended Public Works Programme (EPWP) (which by its nature is temporary work) to fund CBWs are threats to this.

Rationalising the cadres of CBWs to three main types (community caregivers – CCGs), community health workers (CHWs), child and youth care workers (CYCWs), with various specialisations such as in disability or the aged will enable career development (including training, supervision and promotion). CHWs and CYCS already have professional pathways; it is the CCGs that need attention. The recent adoption of the DSD Policy on Social Service Practitioners (2016) will enable this. There are no other policy gaps.

The coordination of work among these cadres is also critical, and here the Community Development Practitioners (who are professionals and hence not CBWs) play a role, as well as initiatives such as Sukuma Sake and Ward Based Outreach Teams.

CBWs are employed by government or through transfers to NPOs. The flaws in the available information on budgets and expenditure seriously limits the extent to which the scale, effectiveness and efficiency of CBWs can be assessed. Better data will enable the assessment of this. The preventative role of many CBW services should also be considered when assessing value for money.

Recommendations

R1. The South African government must work to improve data on the scale, scope and distribution of CBWs, relative to the need for services.

R2. Existing legislation and policy should be implemented before crafting new policies – with a focus on labour legislation, transfer payments to NPOs and social service workforce policy.

R3. Strong coordination mechanisms are critical for effective and efficient implementation of CBWs, rather than increased standardisation and rationalisation of cadres.

R4. EPWP workers should not be viewed as a cadre of CBWs, but rather that EPWP should be viewed as a funding stream for CBW programmes.

R5. The CBW workforce must be recognised by government for the critical role it plays. As such, the CBW workforce must have decent working conditions, reasonable remuneration, training and development opportunities and be well managed.

R6. To measure value for money of CBWs, DSD should undertake an investment case study for CCGs and CYCWs, as the DOH did for CHWs.

R7. The frameworks for monitoring and evaluation of programmes using CBWs should be reviewed to include standardised indicators about the access and quality of CBWs, but also to be able to monitor the successful implementation of programmes.

R8. A new policy framework needs to be developed to cover CBWs employed to support government programmes in health and social services. The Policy Framework should ensure that the CBWs are able to provide quality services and that they have decent working conditions.

Executive summary

Diagnostic evaluation of community-based worker system in South Africa

Introduction

The Department of Planning, Monitoring and Evaluation (DPME) commissioned this diagnostic evaluation to assess the use of community-based workers (CBWs) by the South African government, to improve the effectiveness and efficiency of CBWs in programme delivery. The evaluation followed a participatory and utilisation-focused approach, employing mixed research methods, with a strong focus on secondary data sources, supplemented by qualitative tools. The evaluation took place between February 2018 and February 2019.

Key evaluation findings

The evaluation starts with defining which CBWs the diagnostic evaluation covers and their role in service delivery. It then analyses the various system elements to identify what is in place regarding CBWS and what the strengths and challenges are.

What is the scale, scope and distribution of government supported CBWs?

The main CBW groups are located within the health and social sectors. The primary function of these CBWs is to provide some services directly to families, households or communities, and to link individuals or families to services.

The community health workers (CHWs) are the main CBWs within the sphere of the Department of Health (DOH), while there are a number of cadres in Department of Social Development (DSD) programmes, the main ones being community care givers (CCGs) and learner and auxiliary child and youth care workers (CYCWs). Community development workers (CDWs) and community development practitioners (CDPs) are part of the CBW system and can play an important role in the coordination of CBWs at local level, but are not considered CBWs as they do not meet all the criteria for a CBW as described below[1].

A CBW:

- is generally **community based and selected from the community** in which he/she lives. They work in a particular ward or village (that is, within a specific, small geographical area)
- is a **lay or non-professional worker that has qualifications up to NQF Level 4**.
- **visits households and/or works at or from a community-based centre or as part of an outreach team**).
- provides **community-based services, ideally under the supervision of a para-professional or professional in their related field, directly to community members, and/or linkages / access to other services**. In this way, the CBW extends the reach of service delivery.

[1] EPWP is viewed as a funding stream, and not as a type of CBW because most of the categories of workers in the EPWP social sector also exist outside of the EPWP, thus they are not a cadre on their own.

Evaluation question 1.2: What are the job descriptions and duties of CBWs at household and community level, and evaluation question 3.4: Is there duplication among them?

A review of documents and primary data collection was unable to determine the scale and distribution of government supported CBWs. In terms of their scope of work, the review of job descriptions and analysis of primary data confirms that CBWs provide or facilitate access to a wide range of health and social services targeted at the individual, household and community level. Many of the functions performed by CBWs are preventative or provide early intervention, and hence protect families and individuals from falling further into poverty, or into curative or rehabilitation systems, which are more difficult and costly to address.

There is disagreement as to whether there is duplication and overlap in CBW models, but an analysis of the roles and functions of the main CBW cadres shows that while there is room for alignment, there is not much duplication. The evaluation highlights that duplication of services should only be perceived as a challenge if a household received duplication of the same services. There is little evidence to suggest that this is a wide-scale problem, and conversely any attempt to rationalise services could result in gaps in services at the household level.

What are the respective roles of sector departments and centre of government departments (COGTA and DPSA) in regulation and implementation of CBW models?

In general, the role of the various departments and tiers of government in relation to the employment and use of CBWs is clear and unproblematic. The only real concern is the CDW programme, which was developed by the Department of Public Service and Administration (DPSA). It was supposed to have been handed over to the Department of Local Government and Traditional Affairs (CoGTA) for implementation, but it has not taken it over. Workers are employed by provincial government but located at and accountable to local government. This is not optimal and needs the special attention of both departments, and the DSD. There is some overlap between the role and function of CDPs, and there could be scope for integrating the CDWs into the CDP programme.

How do CBWs interface with other institutional and service delivery initiatives such as departmental and provincial service delivery improvement interventions? (1.7)

What, if any, regulatory frameworks and institutional mechanisms are in place to support CBWs (professional regulatory requirements, continuous training and development, supervision), and are they working well (1.5)

What is the requirement, job grade and income levels of different CBWs? (1.3)

CBWs play a key role in a number of departmental implementation strategies with certain service delivery models. The DOH has integrated CHWs into Ward Based Outreach Teams (WBOTs) which are part of the Primary Health Care Service Delivery model. KwaZulu-Natal is implementing a provincial integrated service delivery model called Operation Sukma Sake (OSS), which also coordinates services at a local level.

There are numerous policies and legislation, employment statutes, guidelines and norms and standards that are relevant to CBWs. There are no glaring legislative or policy gaps, although inconsistent adherence and implementation is a challenge. The solution is the correct implementation of what exists, such as the Basic Conditions of Employment Act, 75 of 1997 (BCEA), rather than new legislation or policy.

There are no overarching professional regulatory requirements for CBWs because they are not a single cadre or workforce; however, there are requirements governing certain categories

of CBWs and CYCWs. Policy directives are clear about the importance of training and skills development for the various groups of CBWs and the need to link it to career progression.

Evidence from the literature and document review found that CBW supervision is a crucial factor for good quality service provision. There is evidence that various CBW programmes have supervisory structures in place, but challenges remain.

Evaluation question 1.8: How well integrated are the CBWs within their respective professional practices?

CHWs and CYCWs have the opportunity to register with their professional councils (the Health Professions Council of South Africa and the South African Council for Social Service Professions, respectively), but CCGs and other cadres do not. The evaluation has identified the need for career incentives and professional development opportunities for CBWs to improve effectiveness and efficiency.

Is the use of community-based workers improving access to services and local democratic governance? (effectiveness) (2)

Are CBWs providing quality services to communities and households (2.1)

What challenges are experienced by CBWs that erodes their ability to provide services? (2.2)

This evaluation confirmed the essential role CBWs play in ensuring that the most vulnerable and marginalised people can access services in their communities. They are positioned to build trust and challenge norms preventing people from using services; they are essential in facilitating the utilisation of services. However, they also face many challenges and barriers hindering their ability to implement services in communities and households. Many of these relate to conditions of employment and remuneration, training and development and career progression.

Is there value for money in using CBWs? *Evaluation question 3.1: Is the provision of services through CBWs cost-effective and does it improve access to services?*

Flaws in the available information on budgets and expenditures seriously limit the extent to which CBWs' effectiveness and efficiency can be assessed.

Allocation of funding for CBWs shows that the jobs are not well funded; they are lower paid, relative to other sectors even within the EPWP. Challenges of poor administration of the NPO transfers for government supported programmes and inequality in pay within and among programmes and provinces are significant. Respondents noted that the delivery of services through NPOs was much cheaper than delivery through government officials, mainly reflecting lower compensation.

How have different departments using CBWs monitored and evaluated the models? *Evaluation question 4: How have different departments using CBW monitored and evaluated the models?*

Primary data shows that despite the availability of M&E frameworks, one of the biggest challenges is inadequate capacity to implement at the local level and this affects overall reporting at different levels of accountability. Hence, the quality of data is questionable, and the non-standardisation of indicators across programmes that specifically speak to the scale, scope and quality of the CBW workforce makes aggregation across cadres difficult.

Regarding evaluation, CBW models are under-evaluated despite their importance. Although a number of evaluations have taken place, their focus is more commonly on the service provided and beneficiaries rather than the CBWs and CBW models themselves.

To what extent is there potential to rationalise, coordinate and develop common norms and standards across government for CBWs? *Evaluation question 5: What are the legislative labour relations, professional, political and financial considerations? (5.1) Is the CBW model sustainable? (5.2)*

There is no single CBW workforce but rather a range of categories of CBWs that operate under different sector departments, mainly in the health and social sectors – where this evaluation has also focused.

There have been previous attempts at rationalising CBWs in the sense of introducing standardisation. Though success has been limited. One of the more successful attempts, in the form of standardisation, was the national roll-out of the Isibindi Programme.

The evaluation team questions a call for rationalisation across the different types of CBWs for several reasons.

First, the fact that the different categories work at community level does not constitute a sufficient basis for rationalisation. Second, any attempt to rationalise across the different types of CBW when there are still enormous differences among CBWs within a single type is almost certainly doomed to failure. Third, the differences in the nature of the work done by the different categories would make standardisation difficult, if not impossible. Fourth, in areas where there is standardisation, the regulations are often ignored. Before introducing further policies and regulations, government needs to ensure the existing ones are complied with.

An area that calls for rationalisation and standardisation as well as improvement, is the way in which government funds NPOs and manages the service level agreements and transfers.

Another issue on which clarity is needed is the relationship between the EPWP and CBWs. For the most part the CBWs covered by this evaluation perform tasks and deliver services that are needed on an ongoing basis. Their work relates to what should be ongoing government programmes rather than time-delimited projects. In these cases, use of the EPWP is questionable as EPWP employment is meant to be time-delimited and EPWP funding is provided for 12 months maximum at a time.

In summary, the evaluation team supports some standardisation, but this should happen within and for particular types of CBWs rather than across the ‘CBW system’ because there is not and should not be a single ‘CBW system’. This, for example, would mean ensuring that norms and standards for community-based care are adhered to and that the BCEA is implemented in a standardised way across all cadres of CBWs and across all provinces.

National officials might argue that they do not have the power to impose particular approaches on provinces. However, provinces have relative not absolute autonomy, and the legislation and policy in respect of health and social development exists primarily at a national level. The 10x10s and similar structures embody the cooperative governance approach which is meant to underlie the relationship among the three spheres. In addition, there is evidence in respect of other sectors – in particular education – where national has coordinated provinces in implementing standard practices. This evidence suggests that it is possible if the political will exists and the service area is considered sufficiently important.

Constitutionally, local government has minimal responsibilities in respect of social services. The fact that CBWs work locally does not mean they become a municipal responsibility. Instead, local implementation of service delivery within social development and health can be seen as taking the district level structures that already exist within these sectors to a lower level. Keeping responsibility with these two sectors does not rule out engagement with municipalities. The important point is that the responsibility and accountability for the services remains firmly with the province. This is especially important given the poor state and capacity of many municipalities in the poorest areas – precisely the areas where CBWs are most needed.

As part of administrative coordination, there needs to be greater clarity on the different types of CBW with a standardised term for each of the CBWs – and then to have some basic minimum standards within each type. There is also a need for roles and responsibilities clarification among the various stakeholders within each type of CBW in each sector.

Regarding **legislation**, considerations should mainly pertain to ensuring compliance with existing legislation. Linked to this is **labour relations** where considerations should be that CBWs who are employed should receive a minimum wage or stipend of R3 500 unless the CBWs are on the EPWP, where they would receive a smaller standardised amount. The evaluation recommends, however, that the EPWP is only used as a vehicle to employ CBWs who are receiving training, and that they should graduate from the EPWP as soon as they are qualified.

In the area of **professionalisation**, it does not make sense to standardise when there are at least two distinct professional areas in which CBWs work. Official bodies responsible for these professional areas should be tasked with putting whatever is needed in place for these lower-skilled, para-professional workers.

In the area of **financial** considerations, it must be emphasised, that since the CBWs are an essential part of government's service delivery mechanisms, if they are not sustainable, neither are government services – they are inextricably linked.

Finally, it could be suggested to also have some standardisation of indicators to ensure standardisation of M&E and improved analysis of the situation of CBWs across government departments and provinces.

Conclusions

The main focus for improving the effectiveness and efficiency of the use of CBWs in the delivery of government services, should be on improving conditions of work and skills development. Implementation of the suite of labour laws that already exist to protect workers will go a long way to solving many of the problems identified in this evaluation. There is some potential to rationalise cadres within the DSD (for example HCBC, VEP and disability assistants could all become CCGs or CYCWs depending on their orientation); there is no sense in rationalising across sectors. The CDPs could play an important role in coordinating CBW activities at a local level, but as professionals they are not CBWs themselves. It is not possible to accurately assess the value for money of CBWs since the data to do so does not exist, and any attempt to do so in the future must take into account the cost of not having CBWs who play a critical role in the prevention and early intervention of trauma and poverty.

Recommendations

The evaluation makes the following key recommendations.

R1. The South African government should work to improve data on the scale, scope and distribution of CBWs, relative to the need for services.

R2. Existing legislation and policy should be implemented before crafting new policies – with a focus on labour legislation, transfer payments to NPOs, and social service workforce policy.

R3. Strong coordination mechanisms are critical for effective and efficient implementation of CBWs, rather than increased standardisation and rationalisation of cadres.

R4. EPWP workers should not be viewed as a cadre of CBWs, but rather that the EPWP should be viewed as a funding stream for CBW programmes.

R5. The CBW workforce must be recognised by Government for the critical role it plays. As such, the CBW workforce must have decent working conditions, reasonable remuneration, training and development opportunities, and be well managed.

R6. To measure value for money of CBWs, the DSD should undertake an investment case study for CCGs and CYCWs, as the DOH did for CHWs.

R7. The frameworks for monitoring and evaluation of programmes using CBWs should be reviewed to include standardised indicators about the access and quality of CBWs, but also to be able to monitor the successful implementation of programmes.

R8. A new policy framework needs to be developed to cover CBWs employed to support government programmes in health and social services. The Policy Framework should ensure that the CBWs are able to provide quality services and that they have decent working conditions.

Full Report

Diagnostic Evaluation of Community-based Worker System in South Africa

1 Introduction

1.1. Introduction to CBW, Its History and Development

International developments

Community based workers (CBW) are frequently defined as women and men who operate (work) within local communities where they live or with which they are familiar. They offer a wide range of services, depending on the needs of the community and they acquire the necessary skills through dedicated training. The services may be focused on households, individuals, groups or take the form of community-wide interventions (Pallas *et al.* 2013; Mokoena & Moeti, 2017).

The term 'community' – in the term CBW – refers to the geographic location of the work done by the people. It also describes the type of service offered by the CBW. For example, the Community Development Workers (CDW) attend to the 'development' (the empowerment of socially excluded individuals and communities) of communities, the Community Health Workers (CHWs) attend to the basic health needs within communities and Community Caregivers (CCG) offer either home-based care, rehabilitation care, youth care or care related to a specific pandemic such as HIV and Aids, particularly in the case of South Africa.

The history of community-based work globally can be traced back to the first CHWs who were trained in China in the 1930s. Illiterate farmers were trained to record births and deaths, vaccinate against smallpox and other diseases, give first aid and health education talks, and help communities keep their wells clean (Perry, 2013). They later became known as the Barefoot Doctors whose numbers grew to one million and served a rural population of 800 million in China by 1972. The Barefoot Doctor model was adopted by many countries in the developing world as a way to serve the needs of rural and poor populations. In Africa and elsewhere, the Village Health Worker (VHW) operated as a health care provider, an advocate for the community, an agent of social change, and functioned as a community mouthpiece (Lehmann & Sanders, 2007). The modern western medical model of trained physicians was unable to serve the needs of the most vulnerable and this necessitated the need for community participation and the decentralisation of services that included the provision of services by CBWs.

The international Alma Ata conference on public health in 1978 identified CHWs as one of the cornerstones of comprehensive Primary Health Care. Numerous CHW programmes emerged as a result, including the Brazil National healthcare programme (Lehmann & Sanders, 2007); the Female Community Health Volunteer programme in Bangladesh/ Nepal in 1988 (Kamaraj & Swechhya, 2014); the Lady Health Worker Programme in Pakistan (Zhu et al, 2014) and the National Health Sector Development Programme in Ethiopia. It is therefore in the health sector that CBWs were initially utilised on a large-scale.

However, during 1980s the global economic recession affected everyone but particularly the economies of developing countries. CHW programmes were the first to fall victim to new economic stringencies and most large-scale, national programmes collapsed (Lehmann & Sanders, 2007). Many large-scale programmes had suffered from a number of conceptual and implementation problems such as unrealistic expectations, poor initial planning, problems of sustainability and the difficulties of maintaining quality. Other problems encountered included inadequate training and supervision, and insufficient remuneration. The selection and training of individuals were also marred by political interference resulting in less suitable people becoming involved in-service delivery. In addition, the governance systems in many parts of the world, Africa in particular, during this period were marked by the introduction of democratic governance and decentralisation policies. NGOs and faith-based organisations, however, continued to invest mostly in small, community-based health care. A study by the Khanya-African Institute (ODI, 2007) found that community-based services offer the potential to reach many more people within the limited financial resources available to African governments. The HIV and Aids pandemic added significant pressure to the health and welfare responsibilities of governments and the study suggested that communities should be utilised to influence services to meet their own, locally-specific needs, and to monitor the performance of delivery agents.

Internationally, and in South Africa, the use of CBWs was considered important for the government's attempts to expand access to social services more generally. The government's roles as 'provider' and change agent has been significantly changed by structural adjustment policies enforced on African countries in the 1980s and 1990s (ODI, 2000). States were encouraged to play a more facilitating role and public servants had to develop the facilitation skills necessary to benefit the projects and clients. The inadequate supply of social service professionals necessitated the expansion of Human Resource capacity through the employment of other categories of social service personnel, such as CHWs or extension workers, social development workers and volunteers. This approach incorporated two key purposes (agendas). The first was a service-oriented agenda of extension of preventive and curative services while the second was a transformative agenda concerned with engagement of communities in the process of taking responsibility for their health, and addressing the environmental, social and cultural factors that produce ill health, including inequity and deep poverty. The decentralisation of services was based on principles of social justice, equity, community participation, prevention and multi-sectoral collaboration. It intended to bring the services as close as possible to the people using appropriate technology and available human resources such as CBWs. The underlying logic of the CBW system, according to the Overseas Development Institute, was that programmes delivered utilising CBWs would reach more people in a cost-effective manner and be more culturally appropriate than traditional models of service delivery (ODI, 2007).

CBW in South Africa

In the 1970s, CHW programmes were initiated by NGOs to address the intentionally inequitably distributed health services during the apartheid era. They were viewed as an innovative, responsive, comprehensive and empowering resource for health care providers and communities. These CBWs went by different names: village health workers, health workers, first aid workers and/or development workers. The CHW programmes in South Africa flourished in the 1980s due to strong support from international donors. Community

development ***as collective action*** was an integral component of the liberation struggle and implemented by non-government and Community-based Organisations.

Immediately post 1994, the new South African government committed to the Primary Health Care (PHC) approach being staffed mainly by doctors and nurses. This saw CHWs side-lined, resulting in many CHW programme initiatives collapsing. This picture soon changed. South Africa experienced a large increase in CHW activity in response to the HIV epidemic and the overburdened public health system in the late 1990s and early 2000s. The increase was due to government attention, international financial support and volunteers at community level. A cadre of disease-focused CHWs emerged employed, particularly for HIV, Aids and tuberculosis (TB) care treatment and support.

Community development in democratic South Africa was also institutionalised in the Department of Social Development (DSD) through the White Paper for Social Welfare of 1997. It had a key challenge to overcome the legacy of colonialism and apartheid which was characterised mainly by the racially segregated settlement patterns and the unequal distribution of resources. In 1999, unemployment and resulting poverty were identified as the most significant threats to South Africa's new democracy. Community development is defined in the Toolkit for Community Development Practitioners as *"… building active and sustainable communities based on social justice and mutual respect. It seeks to change power structures in order to remove the barriers that prevent poor people and vulnerable individuals, such as women and children, from participating in issues that affect their lives and development*." (DSD, 2009).

The governing party, the African National Congress (ANC), resolved to establish an Expanded Public Works Programme (EPWP) to provide infrastructure and basic social and municipal services through labour-intensive methods to maximise job creation and skills development. Phase I of the EPWP was from 2004–2009, and covered infrastructure, environment and culture, and social and economic sectors. The EPWP was extended in 2010 to include non-profit organisations (NPOs) and the CWP to include incentives for different spheres and sectors, for example an expansion incentive was provided through the schedule 5 Social Sector EPWP Integrated Grant to provincial Social Sector departments to expand their ECD and home community-based care (HCBC) programmes delivered through NGOs in line with an agreed business plan and set service standards. Although the EPWP was established as a temporary job-creation programme, in reality, a wage subsidy was provided to volunteers in NPOs who already create work for poor communities and had programmes/projects that were primarily funded by other donors (Department of Public Works, 2014). Hence the EPWP funded the employment of a range of CBWs. The Expanded Public Works Programme was also used for skills development; for example the ECD Programme (EPWP-ECD) supported the Department of Basic Education (DBE), Department of Higher Education and Training and the DSD to pursue the training of more than 80 000 ECD practitioners and Grade R teachers at levels 4 and 5 for the period from 2009/10 to 2013/14.

Another large-scale government programme – the Home and Community-based Care (HCBC) Programme, was initiated in 2001, following the first Southern African Regional Community Home-based Care Conference which was held from 5–8 March 2001 in Gaborone, Botswana. It was here that community home-based care (or later HCBC) was first used as a term and proposed as the best strategic approach for dealing with the effects of the HIV/Aids epidemic. The DSD has been one of the lead departments and the CCGs, supported by a variety of DSD

funded HCBC organisations, have been the key providers of the programme (Friedman et al, 2014).

Most programmes in the social sector are carried out by NPOs on behalf of government. This work generally requires that the NPO assume responsibilities such as stipend payment, training, site visits to NPOs and attending related meetings. Government – usually in the form of provincial departments – may provide transfer payments to assist with the costs, but, as the NAWONGO case and judgment confirmed, these payments generally take the form of subsidies, i.e. they do not cover even the core costs of implementation. Many CHW programmes in South Africa started out having multiple external funders and most are still, at least partially, funded by donors. NPOs in South Africa that employ CHWs and CCGs have become reliant on government funding to support community activities although government rarely covers the full cost of programmes, such as supervision. The late payment of stipends – which very often reflects late transfers from government to the NPOs concerned – and low quality or inappropriate training provided affect the quality of the services provided by CBWs. CBWs are subjected to negative employment experiences and poor working conditions (HSRC, 2008). They are often as vulnerable as the families that they are intended to help. Some volunteers receive stipends, but these also vary considerably between sectors and depending on who is employing CBWs.

To address these concerns, there has been an increased emphasis on the professionalisation of CBWs in more recent years, one example being the professionalisation of Child and Youth Care Workers (CYCW) through the roll-out of the Isibindi Programme which was launched in South Africa in the mid-2000s by the National Association of Child Care Workers (NACCW), supported by the DSD and other donors. It was absorbed in 2018 into the child protection programme under the DSD's Orphan and Vulnerable Children (OVC) Directorate and is now called the Community Based Prevention and Early Intervention Service for Orphaned and Vulnerable Children Programme. Hence, on the other side of the employment spectrum, the development of professional qualifications and regulatory frameworks for the recruitment, training and employment of CBWs have enabled some people to get access to accredited training and obtain accredited qualifications within the National Qualifications Framework (NQF) which improve their employability over the longer term. CDWs, CHWs, CYCWs, caregivers and other types of CBWs now have articulated job descriptions. The extent to which this training leads to employment or more regular employment is contested in the literature, especially when workers have been recruited and paid through the CWP and other parts of the EPWP.

It is clear that there is no one CBW workforce, but due to the historical development of the CBW system in South Africa, it remains largely uncoordinated with limited career growth opportunities for community-based workers. Their place within the public administration is also not clearly articulated. These and other factors have motivated this diagnostic evaluation.

2 Problems identified for the diagnostic evaluation

The terms of reference (TOR) for the diagnostic evaluation indicate a lack of consolidated information on the cadre of volunteers/ workers collectively referred to as CBWs. This includes how many there are, where they are working, what they are doing and how they operate. There is an assumption of duplication of services at household level due to overlapping job

descriptions and poor coordination. Furthermore, there is a lack of comprehensive knowledge of what methods and tools CBWs use, and where these may possibly overlap.

In essence, the CBW system has emerged organically over time in response to various Government and donor agendas, and societal needs. There is little consolidated information to aid decision makers in their attempt to improve the system. All of this poses a conundrum for government as it wishes to have a model for CBWs which services communities adequately and provides career growth opportunities to those employed. The purpose of this diagnostic evaluation is to help unpack all the concerns and suggest possible ways forward.

Table 1 unpacks the evaluation questions in the TOR relative to the problems intended to be addressed. It also indicates where in the report these problems are addressed.

Table 1 Evaluation question and problem statement

Evaluation question	Problems as listed (or embedded) in the TOR or in the problem analysis workshop	Where is it addressed in the report
1. What is the scale, scope and distribution of government supported CBWs?	Government does not know how many CBWs there are, what they are doing and where are they operating.	Section 4.1–4.3 and 4.5.5
	There is overlap and duplication of services to household.	Sections 4.1–4.4; 4.5.3; 4.5.5
1.1 How have different departments, provinces and municipalities defined CBWs?	There are different definitions for CBWs.	Sections 4.1–4.4
1.2 What is the requirements, job grade and income levels of different CBWs?	There are inequitable employment conditions with different job scale and remuneration. There is no uniform application of the Basic Condition of Employment Act. There are in general no clear minimum entry requirements. There is no clear career pathway and development.	Section 4.1-4.4 and 4.5.5
1.3 What are the job descriptions and duties of CBWs at household and community level?	Different CBWs have different job descriptions and there is a lack of knowledge of what they are.	Section 4.1–4.4
1.4 What methods and tools do CBWs use in their work in communities and households?	There is lack of a comprehensive knowledge of what methods and tools are used by the CBWs.	Section 4.2
1.5 What, if any, institutional mechanisms are in place to support CBWs (professional regulatory requirements, continuous development training, supervision, funding)	There is limited continuous skills development and limited supervision of CBWs. The funding or timeous transfer to the NGOs is erratic. The funding stream of CBWs is multiple. There is lack of	Section 4.5.4 and 4.5.5

Evaluation question	Problems as listed (or embedded) in the TOR or in the problem analysis workshop	Where is it addressed in the report
and are these mechanisms working well?	sufficient accountability mechanism.	
1.6 What are the respective roles of sector departments (national, provincial and municipal) and centre of government departments (COGTA and DPSA) in regulation and implementation of the CBW models?	There is lack of administrative and management capacity to coordinate and implement CBW programmes. There can be a mismatch between departments responsible for implementing the CBW programmes and those who carry these out. There are insufficient roles and responsibility clarification between the different departments but also vertically between national, provincial and local government pertaining to CBWs. The various departments work in silos.	Section 4.1–4.4; 4.5.3 and 4.5.5
1.7 How do the CBWs interface with other institutional mechanism and service delivery initiatives such as departmental and provincial service delivery improvement interventions?	There is no agreed service delivery model. There is insufficient knowledge of whether CBW is interfacing with other institutional mechanism and service delivery initiatives.	Section 4.5.3
1.8 How well integrated are the CBWs within their respective professional practice?	There is no clear career pathway for the CBWs. There is an assumption that many CBWs are 'floating' outside the professional practice they belong to.	Section 4.5.5
2. Is the use of CBWs improving access to services and local democratic governance?	While it assumed that use of CBWs improves access to services and local democratic governance, there is insufficient knowledge about whether that is the case. There is poor programme planning by the departments. Lack of core package of services.	Section 4.6.1
2.1 Are the CBWs providing quality services to the communities and households?	As CBWs are part of the service delivery system of Government and are working with the most vulnerable members of society, it is critical that the services they provide are of good quality. It could be a challenge that because CBWs are less qualified, they provide insufficient quality services to the community and households. There are also questions about the effectiveness of supervision and mentoring for CBWs.	Section 4.6.2

Evaluation question	Problems as listed (or embedded) in the TOR or in the problem analysis workshop	Where is it addressed in the report
2.2 What challenges are experienced by CBWs that erode their ability to provide services?	There are inequitable employment conditions. CBWs are not provided proper safety equipment and they are not supervised sufficiently.	Section 4.6.2 and 4.5.5
3. Is there value for money in using CBWs for service delivery and expansion?	It is assumed that there is value for money in using CBWs for service delivery and expansion, but it is unknown whether this is the case. There are multiple funding sources with different objectives.	Section 4.5.4
3.1 Is the provision of services through the CBW cost effective and does it improve access to services?	It is assumed that the provision of services through the CBW is cost effective, but it is unknown whether this is the case. There are few investment cases. The EPWP is time bound.	Section 4.5.4
3.2 Is there economic efficiency in government employed CBW compared to those employed by NGOs?	There is no overview about the economic efficiency in government employed CBW compared to those employed by NGOs	Section 4.5.4
3.3 Is the way departments are using CBWs efficient?	There is under-funding of CBWs. There is insufficient knowledge of whether CBWs are used efficiently.	Section 4.5.4
3.4 To what extent is there duplication and overlap in government supported CBW models	It is assumed that there is duplication and overlap of services in government supported CBW models.	Section 4.1–4.4; 4.5.3; 4.5.4
4. How have different departments using CBWs monitored and evaluated their programmes or CBW models?	There is insufficient information about the M&E of the programmes that CBWs are involved in and of the CBW models. There is limited information about what the indicators are and there are multiple and fragmented M&E systems.	Section 4.5.6
5. To what extent is there potential to rationalise, coordinate and develop common norms and standards across government for CBWs?	The various CBW cadres are governed by different norms and standards relative to their respective service areas and programmes. There is no consolidated information on what these are which could help to devise systems for improved coordination across government for CBWs.	Section 5.1
5.1 What are the legislative, labour relations, professional,	There is no overview of the legislative, labour relations,	Section 5.1

Evaluation question	Problems as listed (or embedded) in the TOR or in the problem analysis workshop	Where is it addressed in the report
political and financial considerations?	professional, political and financial considerations for rationalisation, coordination and development of common norms and standards.	
5.2 Is the CBW model sustainable?	The sustainability of the system is important because a high turn-over of CBWs results in inefficiencies and insatiability in the system, which is not good for government, the NGOs or the beneficiaries.	Sections 4.5.4; 4.5.5; 5.1

3 Evaluation objectives, approach and methods

Evaluation purpose and objectives

The Department of Planning, Monitoring and Evaluation (DPME) commissioned this diagnostic evaluation to provide information regarding CBW systems used by the South African government.

The purpose of a diagnostic evaluation is to conduct research to ascertain the "… current situation prior to an intervention and to inform intervention design" (DPME, 2014). Hence, the purpose of this evaluation was to gather infomation regarding the current situation of government supported CBW systems and services in South Africa, including key successes and challenges in the implementation of CBW programmes. This information was used to assess the potential - as well as options - for system rationalisation, with a view to improving the implementation, effectiveness and efficiency of community-based work in the country.

Key evaluation questions

The following key evaluation questions, taken from the TOR, provided the overarching framework for the diagnostic evaluation:

- What is the scale, scope and distribution of government supported CBWs?
- Is the use of CBWs improving access to services and local democratic governance?
- Is there value for money in using CBWs for service delivery and expansion?
- How have different departments using CBWs monitored and evaluated their programmes or CBW models?
- To what extent is there potential to rationalise, coordinate and develop common norms and standards across government for CBWs?

3.1 Evaluation methodology

The following section of the report describes the evaluation approach, process and research methods used. A summary of the final sample for primary data collection is also included.

3.2 Evaluation approach

This diagnostic evaluation followed a participatory and utilisation-focused approach.

The utilisation-focused evaluation (UFE) approach is based on the principle that the intended primary users of evaluation outputs should play a key role in making decisions about the evaluation process. This is intended to ensure that evaluation outputs are relevant to their needs and will enhance the likely utilisation of evaluation findings for evidence-based decision-making and future changes for improvement.[2] In addition, adopting a participatory approach helps to build cooperation as well as the capacity of stakeholders participating in the study.

In keeping with the approaches outlined above, the DPME convened an Evaluation Steering Committee (ESC), including stakeholders from National Treasury, the DSD, the Department of Cooperative Governance and Traditional Affairs (COGTA), the Department of Public Service and Administration (DPSA) and the DPME. This committee participated in planning the evaluation and in shaping the evaluation process and questions. Members of the committee were also invited to assist in formulating evaluation outcomes and recommendations via a feedback workshop, which was hosted on the 23 January 2019.

3.3 Evaluation methods

Mixed research methods were used for the diagnostic evaluation. These included a document and literature review, workshops and primary data collection via focus group discussions and semi-structured interviews.

As noted in the TOR[3] and agreed upon during the pre-inception meeting (outlined below), the evaluation focused on secondary data sources, including published and grey literature, government documents and online resources. Thus, limited primary data collection was required, and the TOR only identified interviews pertaining to evaluation question 1, although the evaluation team did expand the scope of the interview questions (See evaluation framework in Annexure 2).

3.4 Evaluation Process

The section below outlines the main steps in the evaluation process.

Inception meeting and workshop

A face-to-face, pre-inception meeting took place in early December 2017, led by the DPME. The objectives of this meeting were to provide background, history and context to community-based work and to the diagnostic evaluation, to clarify evaluation objectives and to discuss the evaluation methodology. Southern Hemisphere then submitted a draft inception report and revised proposal to the DPME in preparation for a follow-up inception workshop, which was held on 23 January 2018 with the ESC. Southern Hemisphere prepared a final inception report and submitted it to the DPME on 06 February 2018.

2 Source: Utilisation-focussed evaluation; https://www.betterevaluation.org/en/plan/approach/utilization_focused_evaluation. Accessed 09 January 2019.

3 The TOR notes that the evaluation questions can be best responded to through a mixed method approach, including document review, literature review and some primary data collection (page 4).

Literature review

An extensive review was conducted of grey and published South African and international literature covering CBW models and their implementation. Key documents from South African government departments were also included in the review.

The systems approach was adopted as a framework for the literature review. The systemic elements included in the literature review framework are noted below:

- Programmes and services
- Legislative framework and policies
- CBW workforce, including issues of employment and professional development
- Efficiency and finances
- Management and coordination
- Monitoring and evaluation (M&E).

An annotated bibliography of the literature to be reviewed was provided to the DPME prior to the inception meeting noted above, while the literature analysis framework was presented during the inception workshop with the ESC. A draft literature review report was presented to the DPME for review and comment prior to its finalisation.

Instrument design

Ten instruments were designed for primary data collection, which are attached as Annexure 4.

Instrument design was informed by the literature review as well as the discussions at the inception meeting and inception workshop. All instruments were approved by the ESC prior to fieldwork.

Primary data collection, including sample

A non-probability purposive sampling design was utilised to select respondents. A purposive sampling design emphasises an in-depth understanding of a particular set of issues or conditions and thus leads to the selection of information-rich cases (or individuals) for study purposes. Such stakeholders were identified with the support of the DPME and DSD. A snowball sampling technique was then used to identify additional stakeholders for inclusion in the study.

In terms of the geographic sample utilised for the diagnostic evaluation, it was proposed that the provinces of KwaZulu-Natal, Gauteng, Eastern Cape, Limpopo and Free State be included in the study primarily due to their adoption of ward-based models aimed at coordinating service delivery, including Sukuma Sake and other models.

Data collection among national level government stakeholders commenced in September 2018 and continued to mid-December 2018. Fieldwork in the sampled provinces took place over the course of November and early December 2018. In total, 46 semi-structured interviews and 10 focus group discussions were conducted. All the sampled National Departments were interviewed.

An overview of the final sample achieved is provided below; the detailed sample is in Annexure 3.

Table 2 Final sample achieved for the diagnostic evaluation of CBW systems

Level	Stakeholders	Data collection method	Number of interviews/Focus group discussions (FGDs) conducted
National	National government department stakeholders; experts, professional bodies / associations	Semi-structured interviews (SSIs)	15
Provincial departments	CBW manager/supervisor or coordinator	SSIs	6
Local government (Municipalities)	CBW manager/supervisor or coordinator	SSIs	9
NPOs implementing CBW models funded by Government	CBW manager/supervisor or coordinator	SSIs	14
Community-based Workers	CBWs operating within each of the sampled provincial departments above4. CBWs implementing through NPOs	FGDs	10
Community-based Workers	CBWs operating within each of the sampled provincial departments above[5]. CBWs implementing through NPOs	SSIs	2
Total number of SSIs conducted: 46 **Total number of FGDs conducted: 10**			

Limitations and mitigations

Gaining approval for government departments to participate in the study – at both national and provincial level – was a key challenge, as was securing the participation of identified stakeholders. The DPME assisted with the required government-to-government protocols, which facilitated access to some degree. However, many government stakeholders were not available to participate in the study for various reasons. Some of the contacted participants were not available for interviews within fieldwork timeframes due to work constraints, travel or illness. Furthermore, a number of the stakeholders who were contacted to request their participation in the evaluation never responded to emails or calls or were unavailable at the time of the scheduled interview, despite prior confirmation. In addition, the fieldworkers noted that the end of year period was a difficult time to go into field given that many of the possible respondents were engaged in strategic planning meetings, workshops or community-based campaigns.

4 CBWs from the different departments could be mixed in one group.
5 CBWs from the different departments could be mixed in one group.

As a result of the abovementioned challenges, no interviews were conducted with provincial level government stakeholders in the KwaZulu-Natal (KZN) and Limpopo provinces. This resulted in data gaps; for example, no provincial level insights regarding the Sukuma Sakhe model in KZN could be obtained. Similarly, no input was received from Limpopo provincial level government stakeholders regarding best practice examples of coordination of service delivery in that province.

Despite these challenges, a substantial amount of good quality data was gathered for evaluation purposes. A number of documents were also obtained by the fieldwork team during primary data collection. These were reviewed during the data analysis phase of the study and provided valuable additional information. Unfortunately, a number of key documents, requested by the evaluation team, were not received, including national DSD's NPO reports and the audit of the social workforce.

The fieldwork team experienced good levels of cooperation among the CBWs who were approached to participate in the FGDs – and with local government and NPO stakeholders.

Ethics

The standards for evaluation in government provide ethical guidelines which were followed by this evaluation.

The following ethical standards were adhered to in this study:

- All participants were fully informed of the evaluation process, its aims and objectives and how the gathered information would be utilised.
- All participants were informed that their participation was voluntary – and of their right to withdraw from the study at any time.
- Verbal consent for participation in the study was acquired at the beginning of each interview where these were conducted telephonically. Participants in face-to-face interviews and FGDs were required to sign a consent form.
- All study participants were assured of anonymity.
- The confidentiality of information was communicated to all of the participants and was maintained throughout the data capture, coding, analysis and report writing process.
- Based on the advice from the Evaluation Steering Committee Chairperson (DPME) and following the Standards for Evaluation in Government (DPME, 2014), it was deemed not necessary to gain ethical clearance for this study.

On the advice of the ESC, the rationale for this instruction is that the sample did not include respondents aged 18 years and below nor did it include members of vulnerable groups.

Capacity development element

The problem analysis workshop, attended by a wide range of stakeholders, was the main vehicle for capacity development in this evaluation; that is, it included both inputs (pedagogic) and workshop elements.

4 Key findings

In this main body of the report, the key findings are discussed. These are drawn from the various data sources outlined above, including a literature and document review. The first section defines what a CBW is and develops a framework for identifying who the CBWs are that the evaluation will cover. The following sections cover the system elements related to the CBW system and analyse this information on related to the cadres of CBWs selected for inclusion. Service delivery outcomes of CBWs are also discussed, followed by a look at the sustainability of the CBW model.

4.1 Definitions and description of various types of workers who work in communities, and associated programmes

Evaluation questions

This section responds to the following evaluation questions:

- *Evaluation question 1.1: How have different departments, provinces and municipalities defined CBWs?*
- *Evaluation question 1.2: What are the job descriptions and duties of CBW at household and community level?*
- *Evaluation question 1.3: What is the requirement, job grade and income levels of different CBWs?*
- *Evaluation question 1.4: What methods and tools do CBWs use in their work in communities and households?*

In this first section of the findings, we develop a framework to decide which cadres of volunteers can be considered to be CBWs. The first step to achieve this was to develop a definition for a CBW in the South African context.

The TOR mentions a range of different workers employed by government and NPOs to work in communities. Hence, the diagnostic evaluation reviews each of these types of workers, and some others that have been identified in the process, to identify typologies of various types of CBWs to decide if they meet the definition of a CBW. Typologies of various workers have been identified to help refine the definition and the inclusion / exclusion criteria. The section concludes by arguing which workers might be considered to be CBWs for the purposes of this diagnostic evaluation – and why. These cadres are focused on for the remaining report sections.

4.1.1 Definition of CBW

A CBW should meet all of the criteria below:

- Is generally **community-based and selected from the community** in which they live. They work in a particular ward or village (that is, within a specific, small geographical area).
- Is a **lay or non-professional worker that has qualifications up to NQF Level 4**.

- **Visits households and/or works at or from a community-based centre or as part of an outreach team**).
- Provides **community-based services, ideally under the supervision of a para-professional or professional in their related field, directly to community members, and/or linkages / access to other services**. In this way, the CBW extends the reach of service delivery.

CBWs are not:

- Retired workers who decide to volunteer in the community; people who volunteer on an ad hoc basis through faith-based or other avenues.
- Necessarily paid, some are volunteers who may not always receive a stipend for their work.

4.1.2 Overview of CBWs and CBW programmes in South Africa

South Africa has a variety of programmes that support work at a community level or for communities, primarily in the health and social sectors. The main types of workers identified in the process of the evaluation that could be considered CBWs are the following:

1. Community health workers (CHWs)
2. Community caregivers (CCGs) (we also noted CBWs for the VEP programme and disability assistants – and we are treating them in the category of community caregivers)
3. Auxiliary Child and Youth Care Workers (CYCWs)
4. Community Development Workers (CDWs)
5. Community Development Practitioners (CDPs)
6. Agriculture Extension Workers (AEWs)
7. Auxiliary Social Workers (ASWs)
8. Volunteer Food Handlers (VFHs).

Within groups such as CCGs and CHWs, a number of sub-groupings with various titles, roles and areas of primary focus or specialisation were identified. For example, the cadre referred to as CCGs includes sub-groupings with a primary focus on home-based care provision, while other sub-groupings focus on service delivery to the elderly, to people with disabilities (personal assistants and respite care service providers) or to victims of abuse. The picture is further complicated by terms, such as CHW or CCG, being used and understood in different ways by different stakeholders and in different contexts.

It is likely that there are other cadres of volunteers within various DSD programmes, but they do not appear in the official documents reviewed. It is argued that if they meet the criteria identified below in section 4.4 then they can fall under the category CCG.

The EPWP is not considered a type of CBW, but rather a funding stream[6] for various types of workers, including some CBWs. The EPWP includes many types of CBW workers as well as workers who are not CBWs. For many, if not all the CBW categories covered by EPWP funding, there are other CBWs who are funded through other sources who are doing exactly the same

6 It is a less than ideal funding stream for reasons explained in section 4.5.4

work. To give a concrete example, some provinces used the EPWP to fund transfers to NPOs that employ Isibindi CYCWs, while the same provinces and others used the equitable share or other sources of funding for transfers to NPOs that employ Isibindi CYCWs. Regardless of the funding source, all the Isibindi CYCWs had the same job description, scope and standard of practice. Further, the CYCWs in a particular site might in one period be funded with EPWP funds and in another period with equitable share funding. Hence, the EPWP is regarded as a funding stream rather than a category of CYCW.

Table 3 below provides an overview of the main programmes and workers relevant to the CBW system in South Africa. It includes the name of the government programme, the type of worker associated with the programme, key policy and legislative frameworks underpinning each programme and the relevant government department/s.[7] The table is followed by a definition and description of the roles and responsibilities of each of the listed workers, as well as the tools they may utilise; for example, for tasks such as community profiling.

7 An expanded version of this table, including roles, responsibilities, compensation, professional development, and supervision of the various CBW groupings, can be found attached as Annexure 5. Please note that the table provides an overview to support more detailed discussion of each of these elements in the report sections that follow.

Table 3 Overview of programmes relevant to the CBW system in South Africa

Type of CBW	Description	Name of programme/s	Estimated number[8]	Department	Key policy and legislative frameworks (including drafts)
CHWs	The Ward-Based Primary Healthcare Outreach Teams Policy Framework and Strategy (2018/19–2023/24), provides the following definition of a CHW: *Refers to any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial well-being and provide ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.* The category CHW includes lay health counsellors / workers, voluntary counselling and testing counsellors, community care	National Community Health Worker Programme (2004); social sector programme on the EPWP Re-engineering Primary Health Care Programme (rPHC)	Estimates range from 45 000 to 70 000 across SA (primary data, doc review)	DOH; policy maker, funder	Community Health Worker Policy Framework (2004, revised 2008) South Africa National Policy Framework for Home and Community-based Care and Support Programme (July 2010)[9] Ward-Based Primary Healthcare Outreach Teams Policy Framework and Strategy (2018/19–2023/24)

8 Estimated numbers are provided as there is limited, up-to-date data available on the number of CBWs within each cadre. In addition, such data would be required from both government and from all non-governmental organisations, supported by government. The use of varying terms and definitions for each of the groupings noted above also means that numbers provided on what may be presented as the same cadre may not correlate.
9 This policy framework was compiled as a revision of the Community Health Worker Policy Framework (2004).

Type of CBW	Description	Name of programme/s	Estimated number[8]	Department	Key policy and legislative frameworks (including drafts)
	workers, treatment adherence (e.g. Directly Observed Treatment – DOT) supporters, Nompilo, and (youth) peer educators.				
CCGs	CCGs are sometimes viewed as one of the main sub-categories within the concept of CHWs. The terms CCG and CHW are even used interchangeably in KZN. (Primary data) The South African National Policy Framework for Home and Community-based Care and Support Programme (DSD and DOH, July 2010) provides the following definition of CCGs: "*The Community Caregiver is the first line of support between the community and various health and social development services. He/she plays a vital role in supporting and empowering community members to make informed choices about their health and psychosocial well-being and provides ongoing care and support to individuals and families who are*	HCBC programme; social sector programme on the EPWP	49 042 (Literature review)	DSD and DOH – mandated by Cabinet in the 1999–2000 financial year to jointly oversee and implement the HCBC Programme by pooling resources. In DSD, CCGs fall under the HIV/Aids Directorate	National Policy Framework for Home- and Community-based Care and Support Programme (DSD and DOH, July 2010); Draft Joint Community Care Worker Management Policy Framework (2009)[10]

10 Previously referred to as the Community Caregiver Framework for Home Community-based Care. Note, this was never adopted or implemented. See section on coordination.

Type of CBW	Description	Name of programme/s	Estimated number[8]	Department	Key policy and legislative frameworks (including drafts)
	vulnerable due to chronic illness and indigent living circumstances". CCGs are also referred to as home-based carers and health promoters.				
CCG (disability)	A CCG that focuses on service provision for people with disabilities (PWD) is defined in DSD's Revised Policy on Residential Facilities for PWD (draft 1, October 2018, page 128) as *Any person who, in relation to persons with disabilities, takes responsibility for meeting the "basic" daily needs of, or is in substantial contact with, persons with such disabilities.* The revised policy also defines the concept of "care" as referring to *holistically providing for people's physical, psychological and spiritual needs where they are unable to provide these for themselves. Care is an approach that improves quality of life through prevention and relief of suffering by means of early identification, assessment and treatment. In the case of children with disabilities, care includes providing, within available means, a suitable place to live; living conditions that promote well-being, financial support and the other*	HCBC programme	Respite care service providers – no data Residential facility caregivers (449) and volunteers (791) (DSD Audit of Residential Facilities for PWD; 2013) Personal assistants – no data	Department of Social Development (DSD): Directorate Services to People with Disabilities; funder, policy maker	White Paper on the Rights of Persons with Disabilities (2015) Framework on Respite Care Services to Families of Children with Disabilities (2016) Revised Policy on Residential Facilities for PWD (draft 1, October 2018)

Type of CBW	Description	Name of programme/s	Estimated number[8]	Department	Key policy and legislative frameworks (including drafts)
	measures reflected in the Children's Act, 38 of 2005. Various cadres within this sub-category of CCG are noted including – but not limited to – respite care service providers, residential facility caregivers and volunteers, and personal assistants.				
CYCWs	A CYCW refers to a person who works in the life space of children and adolescents with both normal and special development needs to promote and facilitate their optimum development. (Jamieson, L; 2013)	Isibindi Programme (now Community Based Prevention and Early Intervention Service for Orphaned and Vulnerable Children Programme) absorbed in 2018 into child protection programme under the OVC Directorate, DSD	Approximately 7 000 (employed on Isibindi sites; primary data)	Department of Social Development (DSD); funder, policy maker	Children's Act (2005) Social Service Professions Act, 110 of 1978 (amended) DSD Policy for Social Service Practitioners (adopted by MINMAC 2017 and is currently being costed).
CDWs	CDWs are also referred to as participatory change agents and are defined as community-based resource persons who collaborate with other cadres to help fellow community members progressively meet their needs, achieve goals,	Community Development Workers Programme (CDWP)	3239 (Media statement issued 07 November 2018; http://www.cogta.gov.za)	DPSA and Ministry of Provincial and Local Government are jointly responsible for strategic direction and coordination at national level (national	Public Service Act (1994) Draft Policy: CDW Programme, Discussion Document (20 August 2009)

Type of CBW	Description	Name of programme/s	Estimated number[8]	Department	Key policy and legislative frameworks (including drafts)
	realize their aspirations and maintain well-being. The general job purpose for CDWs as part of the Community Development Workers Programme (CDWP) was redefined in 2010 as having to liaise, coordinate, mobilise, inform and assist communities with access to services provided by government. (DPSA, 2010)			CDW Task Team), while the Department of COGTA provides overall programme management support and funding. The CDW Programme is implemented at provincial level, while CDWs are employed in the Office of the Premier (Free State and North West), while others are employed in the Provincial Departments of COGTA	
CDPs	A CDP is defined as *a paid person qualified in and applying all the theories and principles of community development practice.* In the Toolkit for CDPs (2009: 10), a CDP is defined as *…a person who facilitates activities that enable households and communities to manage their own development in order to achieve sustainable livelihoods.*	Integrated Sustainable Rural Development Programme (ISRDP) Urban Renewal Programme (URP)	No data	DSD, Directorate of Community Mobilisation; funder, policy maker	Community Development Practice Policy (2017) Community Development Norms and Standards (2017)

Type of CBW	Description	Name of programme/s	Estimated number[8]	Department	Key policy and legislative frameworks (including drafts)
AEWs	AEWs provide a mentoring service to farmers to ensure the commercial viability of emerging farmers from a household food security level to commercial level.	Generally work under the Comprehensive Agriculture Support Programme (CASP) Department of Agriculture, Forestry and Fisheries (DAFF)	2210 (as of 2007)	DAFF; funder; policy maker	Natural Scientific Professions Act 27 of 2003 (came into effect in 2007)
ASWs	ASWs are assistants to social workers and provide support services under the supervision and guidance of a social worker.	HCBC Programme; Isibindi; Isolabantwana and Asibavikele programmes	No data	(DSD); funder, policy maker	HCBC Programme; Isibindi; Isolabantwana and Asibavikele programmes
VFHs	VFHs are community members that assist with the preparation and serving of meals at primary and secondary schools classified as quintile 1–3.	National School Nutrition Programme	58 990 (primary data); National School Nutrition Programme Grant reports 55 168 (no date indicated)	Department of Basic Education (DBE); funder, policy maker	National Guidelines for the Implementation, Monitoring and Reporting on the National School Feeding Programme (Draft 5, 6 July 2010)

4.2 Descriptions of types of workers considered in the evaluation, roles and responsibilities, and methods and tools

In this section, the possible cadres of CBWs are explored to determine a definition of CBW (in section 4.4), and also to unpack the specific unique characteristics and similarities between CBWs.

Community health workers

As noted in the literature review, CHW is an umbrella term used for a heterogeneous group of health workers, their scope of practice ranging from implementing biomedical interventions to acting as community agents for social change (HST, 2011). The Ward Based Primary Healthcare Outreach Teams Policy Framework and Strategy (2018/19–2023/24), provides the following definition of a CHW:

> *Refers to any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial well-being and provide ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.*

Based on the literature review as well as input obtained during primary data collection, the category CHW includes lay health counsellors / workers, voluntary counselling and testing counsellors, community care workers, treatment adherence (e.g. Directly Observed Treatment – DOT) supporters, Nompilo, (youth) peer educators, TB defaulter tracers, high transmission area workers, hospice workers and mentors.

Most CHWs are affiliated with Community-based Organisations that are central to the implementation of PHC in district health services in South Africa. In the delivery of PHC, CHWs are commonly identified as critical because of their capacity to work closely with vulnerable communities and individuals, and to address problems arising from limitations in the number of trained health workers available and able to work at this level (Nxumalo, Goudge & Manderson, 2016).

As per the summary of a CHW's job description, members of this cadre are responsible for a number of tasks at individual, household and community level. These include health screening/ health assessments; referrals; the provision of pre- and post-natal care, adherence and treatment support; distribution of medicines; counselling; health promotion; and community education and mobilisation around health-related issues.

Because CHWs meet the criteria for CBWs, they are included in the definition of CBW in this study.

Community caregivers

The South African National Policy Framework for Home and Community-based Care and Support Programme (DSD & DOH, July 2010) provides the following definition of CCGs:

> *The Community Caregiver is the first line of support between the community and various health and social development services. He/she plays a vital role in supporting and empowering community members to make informed choices about their health*

> *and psychosocial well-being and provides ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.*

CCGs are also referred to as home-based carers and health promoters. As per the summary of the job description of a CCG, members of this cadre are responsible for a number of tasks at individual, household and community level. These include needs assessments; referrals; the provision of material support, home-based care and treatment support and counselling; community education, mobilisation and community profiling; plus the provision of support for income generation activities, such as food gardens.

As noted in the literature review, there was an attempt to consolidate the work of CHWs in the DOH and CCGs in DSD, into a joint Community Care Worker Management Policy Framework to facilitate the collaboration of the different departments (DOH & DSD, 2009). The framework document coins the term *Community Care Worker* (CCW) and indicates that this category encompasses and replaces CHWs and CCGs. The CCW refers to "… *any worker, albeit a volunteer worker, who delivers services under the auspices of Home Community-Based Care and Support programmes both in support of health and social development programmes*." This policy framework is, however, a draft document. Furthermore, the term CHW is clearly used in the Ward Based Primary Healthcare Outreach Teams Policy Framework and Strategy noted above and CCGs are centrally located in the National Policy Framework for Home- and Community-based Care and Support Programme (DSD and DOH, July 2010). Hence, it seems as if the attempt to consolidate CHWs and CCGs has not been successful.

Because CCGs meet the criteria for CBWs, they are included in the study.

Community caregivers: Disability

A CCG that focuses on service provision for people with disabilities (PWD) is defined in the DSD's Revised Policy on Residential Facilities for PWD (draft 1, October 2018, page 128) as "Any person who, in relation to persons with disabilities (PWD), takes responsibility for meeting the 'basic' daily needs of, or is in substantial contact with, persons with such disabilities." The revised policy also defines the concept of "care" (in relation to PWD) as referring to holistically providing for people's physical, psychological and spiritual needs where they are unable to provide these for themselves. It notes that "*Care is an approach that improves quality of life through prevention and relief of suffering by means of early identification, assessment and treatment. In the case of children with disabilities, care includes providing, within available means, a suitable place to live; living conditions that promote well-being, financial support and the other measures reflected in the Children's Act, 38 of 2005*."

Various cadres within this sub-category of CCG are noted including – but not limited to – respite care service providers, residential facility caregivers and volunteers, and personal assistants. Variations in tasks were noted among these groupings. For example, respite care service providers offer individualised, flexible, family-centred, temporary relief to families caring for PWD or for children with disabilities (CWD). Respite services can be offered within the home or via a facility. The home-based care model includes providing the family with guidance and assistance on daily routines and care for the CWD as well as his / her siblings with the aim of preventing neglect or isolation. (Framework on Respite Care Services to Families of Children with Disabilities; 2016) Personal assistants provide a range of services designed to assist PWD with their daily activities, with the aim of increasing levels of independence and control. Such assistants include – inter alia – personal aides, guides, lip-speakers, whisper interpreters,

South African sign language interpreters, note-takers, interpreters for deaf-blind persons, and sexual and intimacy assistants. CCGs who offer facility-based services for PWD assist with daily living activities such as personal hygiene; feeding; dressing and grooming; mobilisation, turning and pressure care; incontinence management; and safety needs.

Child and youth care workers

A CYCW refers to a person who works in the life space of children and adolescents with both normal and special development needs to promote and facilitate their optimum development. (Jamieson, 2013).

According to South Africa's NACCW[11], the CYCW provides a range of care services to children and youth within their homes. For example, they help the family with basic household chores and provide education about general hygiene, gardening, health, nutrition, and household care. The CYCW also facilitates the transfer of knowledge and skills on issues such as HIV/Aids awareness, testing and management, safety, nutrition and educational assistance. They teach basic life skills and provide support services, specifically to child headed and parentless families. Support services include assessment and referral of children and families to relevant service providers; assistance with child / social protection administration requirements, such as applying for birth certificates; and the provision of counselling where required.

The DSD (together with the support of donors such as USAID and UNICEF) supported the roll-out and scale up of the Isibindi Programme that was designed and developed by the NACCW, to demonstrate the role of community and child and youth workers. It was absorbed in 2018 into child protection programme under the OVC Directorate, DSD.

CYCWs also provide facility-based care and supervision to children and youth via the Isibindi Safe Parks model.

Because aux-CYCWs meet the criteria for CBWs, they are included as CBWs in the study.

CDWs

The CDWP is driven at the national sphere by the DPSA and COGTA. CDWs are considered civil servants with particularly close links to local communities. The main role of CDWs is to work with government departments to help bridge the gap between government and communities. As such, CDWs have to improve community access to government services and strengthen integration and coordination between different government line services (Van Rooyen, 2007).

A CDW in South Africa is defined as a *community-based resource person who collaborates with other colleagues to help fellow community members progressively meet their needs, achieve goals, realise their aspirations and maintain well-being*. The general job purpose for CDWs (launched in 2004) was redefined in 2010 as having to liaise, coordinate, mobilise, inform and assist communities with access to services provided by government. The programme identified four areas that provided the context for this job purpose, namely; promoting food security; supporting early childhood development; participating in HIV/Aids campaigns; and contributing towards the promotion of social protection (DPSA, 2010).

11 Source: Isibindi Programme, see http://www.naccw.org.za/isibindi; accessed 07 January 2019.

The CDW cadre operates at ward level and is responsible for a number of tasks including community profiling and needs assessments – and the sharing of assessment and profiling findings with relevant government service providers; community education regarding available services and how to access them; facilitation of coordination of interdepartmental programmes and community work teams; assisting communities with the development of proposals for inclusion in integrated development plans; and monitoring and reporting of community level interventions – and any outcomes achieved.

The CDW Handbook (2007) includes a profiling tool for CDW community profiling purposes. This indicates that profiling conducted by this cadre collects information regarding:

- Community demographics (number of community members living in the covered area, disaggregated by gender and age – under 18 / over 65 years of age; percentage of adults unemployed, disaggregated by gender)
- Community facilities (schools, clinics, sports facilities, community halls, crèches)
- Community programmes (example, EPWP) and informal sector activities
- Geographic layout of the community and distances to key sites such as police stations, post office, clinics, hospitals, banks, shops, courts, etc
- Common forms of employment / types of work performed by men and women in the community, challenges experienced and rates of payment
- Water and fuel sources, plus forms of sanitation (toilets)
- Types of housing and public transport found in the community
- Community challenges, in terms of health, crime and violence, social and family problems
- Levels of access to services.

CDP

The CDPs are part of the ISRDP and the URP in the DSD. The Toolkit for CDPs (2009: 10), defines a CDP as *a person who facilitates activities that enable households and communities to manage their own development in order to achieve sustainable livelihoods.*

Guided by the sustainable development approach, the CDP is required to be a change agent within communities, offering advice on contextual education, training and capacity building; facilitating services and learning among groups for overall improvement in local well-being factors in communities; building capacity to develop socially inclusive communities; carryinig out monitoring and evaluation of implementation, as well as giving feedback to the community and other relevant stakeholders (DSD, 2017). Other tasks include community mapping to identify patterns of resource use and settlement patterns; community-based planning and the identification of livelihood opportunities; and the facilitation of stakeholder liaison, network formation and collaboration among key community stakeholders to support development according to identified priorities.

The Toolkit for CDPs in South Africa (DSD, 2009) provides clear guidelines for CDP management of community and key stakeholder interactions. It also describes the Participatory Learning for Action methods and tools that the CDP may utilise when facilitating community-led analysis and planning for development. The Norms and Standards for

Community Development (2017) stipulate the CDPs should be guided by the community development approaches and should implement one or all of the following approaches Asset Based Community Development Approach; The Household or family Based Approach; The Social Transformation Systems Approach; Dialogical Approach.

CDPs are also responsible for conducting community and household profiling. The community profiling tool included in the Toolkit for CDPs in South Africa (DSD, 2009) includes similar categories to that noted above for the CDW, namely:

- Community history
- Community structure and demographics (number of households; number of community members disaggregated by gender and age; social, economic, ethnic and cultural groups living in the community)
- Livelihoods, including community members involved in livelihood activities (disaggregated by gender, age, socio-economic group); timing and location of livelihood activities
- Local organisations and associations
- Economic and business activities
- Natural resources, including their location and use
- Community challenges, in terms of health, abuse, unemployment, domestic violence
- Availability and levels of access to services.

The household profiling exercise provides information regarding the following:

- Household demographics
- Asset ownership and capability patterns and levels of the household
- Shocks and stresses affecting the livelihood of the household
- An understanding of how existing policies, institutions and processes enhance or hinder livelihoods
- How households in the community are obtaining their livelihoods, including available opportunities.

Because CDPs are not working at the individual and household level, they are not considered CBWs, but they could play a critical role in the coordination of CBWs in local communities.

AEWs

The DAFF employs extension workers to provide information and advisory services that are needed by farmers and other actors in the agrifood systems and rural development. Extension workers are drawn from areas where they live so that they can communicate more effectively with local farmers who need assistance. Their skills include technical knowledge, facilitation, brokering, coaching of different actors to improve market access, dealing with changing patterns of risk and protecting the environment. Extension is an integral component in ensuring efficient service delivery of the government programmes aimed at alleviating poverty, improving livelihoods and a sustained environment (DAFF, 2011; Makapela, 2015).

Affiliated to the use of AEWs is the Rural Animation Officer (RAO) Initiative. This initiative was developed in the Free State province to enhance the provision of farmer support via RAOs (Carnegie, 2001). RAOs formed part of the DOA client support service team and were meant to work as assistants to extension officers and to facilitate linkages between the community and the DOA. However, evidence indicates that the RAO initiative was abandoned in most parts of the Free State due to issues of incompetence. There is no cadre of CBW in Agriculture.

ASWs

In response to the need for social workers to manage their caseloads, ASWs were introduced as assistants to social workers. "The SACSSP then developed a training programme and took responsibility for training ASWs since the early 1990s," (DSD, 2016, page 77). As per the South African Council for Social Service Professions (SACSSP) website[12], the Regulations in the Service Professions Act, 1978 (as amended) defines social auxiliary work as *an Act or activity practised by a Social Auxiliary Worker under the guidance and control of the Social Worker and as a supporting service to a Social Worker to achieve the aims of social work*. This implies that ASWs are assistants to social workers and that they provide support services under the supervision and guidance of a social worker.

According to the Policy for Social Service Practitioners (DSD, December 2016) ASWs assist in providing social services and support to individuals, families, groups and communities. These services include but are not limited to life skills development; recreational needs; facilitation of non-therapeutic (educational and support groups) groups; facilitating participatory development in communities to address common socio-economic needs and to promote social justice; and collecting and collating data to inform social services interventions.

Because ASWs are predominantly supporting social workers, they are also not considered to be CBWs.

VFHs

VFHs are community members that assist with the preparation and serving of meals at primary and secondary schools as part of the DBE's National School Nutrition Programme. VFHs are required to prepare and serve one–two meals per day, five days a week, on school premises. Meals are to be prepared according to guidelines provided by National DBE and noted in the National School Nutrition Programme Grant (NSNP) (n.d.) and NSNP Implementation Guidelines (2010). VFHs are also responsible for collecting and washing dishes, cleaning the kitchen and storeroom, and stock taking.

Cooking utensils are provided by the DBE as is the budget for food purchases. VFHs are also, where possible, provided with protection clothing such as aprons.

According to the definition below, VFS are not CBWs.

Comparison of functions of community workers and community-based workers

The table below compares the functions of the various types of community workers, including CBWs, according to three levels of intervention – individual level, household level and community level. There seems to be more activity among them at community than at individual level, and a close reading of the table shows that while they may have similar functions, their focal areas are different. For example, while both CCGs and CHWs may run support groups,

12 South African Council for Social Service Professions; see www.sacssp.co.za/Professionals/download/18 (Accessed 29 January 2019)

the focus of these groups will differ. There are few specific tasks that are duplicated, the main one being treatment adherence support.

Table 4 shows that CCGs, CHWs and CYCWs are most active at the individual and household level, while CDPs and CDWs are most active at community level. What is also evident from the table is that the main focus of CBWs' work is preventive or early intervention work, helping to support people and communities to avoid crisis.

Table 4: Comparison of CBW functions targeted at the individual level (based on policy documents, toolkits and job descriptions)13

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24, ECD Policy)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
Counselling			☑ • Individual and group therapy • Bereavement • Stress • Conflict • Crisis • Abuse	☑ • Basic/lay counselling • Including trauma debriefing • Bereavement support • Support groups	☑ • Family planning counselling		☑ • Psychosocial support to child and youth headed households
Material support				☑ • Meals • Food supplements • Food baskets • Clothing • Uniforms		☑ *No further information*	

13 If there is no text in the block, it is because there was no detail provided in the documents reviewed for this evaluation.

Functions	**CDW** (CDW Handbook, CDW Job Advert)	**CDP** (CDP Toolkit, 2009)	**CYCW** (NACCW)	**CCG** (Policy Framework, 2010)	**CHW** (Policy Framework and Strategy 2018/19-2013/24, ECD Policy)	**Auxiliary Social Worker** (SACSSP Info Brochure)	**CCW** (Draft Policy Framework 2009)
Treatment support			☑ • Directly observed therapy	☑ • Directly observed therapy • TB • ARVs • Defaulter tracing	☑ • Adherence support • Defaulter tracing • Distribution of medication		
Capacity building			☑ • Life skills • Budgeting • HIV/AIDS • Hygiene	☑ • Life skills • Budgeting • Parenting skills			☑ ▪ *No further information*
Support groups					☑ • Pregnant women • Mothers of infants and young children		

Functions	CDW (CDW handbook, CDW job advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy framework and strategy 2018/19-2013/24, ECD policy)	Auxiliary social worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
Health assessment			☑ • Health screening • Developmental assessment • Children and families		☑ • Health screening and assessment		

Table 5: Comparison of CBW functions targeted at the household level (based on policy documents, toolkits and job descriptions)

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy framework and strategy 2018/19–2013/24, ECD policy, review WBPHCOT)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
Needs assessment			☑ • Children • Families	☑ • Including early identification of child-headed households			
Referrals to appropriate services			☑ • Screening and referral processes – health, trauma, education, food insecurity	☑ • No further information identified	☑ • Identification of pregnant women • Pre- and post-natal care • Referrals based on identified health risks		☑ • No further information identified
Material support		☑ • Food and nutrition security		☑ • No further information identified	☑ • Food and nutritional support for		☑ • Food parcels • Clothing

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy framework and strategy 2018/19–2013/24, ECD policy, review WBPHCOT)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
					pregnant women and young children at risk		
Poverty alleviation			☑ • Capacity building • Support with establishing food gardens	☑ • Support with establishing food gardens			
Household profiling		☑ • Household assets • Household demographics • Household vulnerability					
Domestic services			☑ • Cooking • Cleaning		☑ • No further information		☑ • Washing

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy framework and strategy 2018/19–2013/24, ECD policy, review WBPHCOT)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
			• Hygiene				• Feeding children • Cooking
Support groups					☑ ▪ *Pregnant women* ▪ *Mothers of infants and young children*		
Service access support			☑ • Birth certificate application assistance • Assistance with accessing social grants				☑ Ensure attainment of vital documentation (e.g birth / death certificates, ID)

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy framework and strategy 2018/19–2013/24, ECD policy, review WBPHCOT)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
Health assessment					☑ • Health screening and assessment		

Table 6: Comparison of CBW functions targeted at the community level (based on policy documents, toolkits and job descriptions)

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24, ECD Policy 2015)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
Support groups				☑ • No further information identified	☑ • Pregnant women • Mothers of infants and young children		☑ E.g. • HIV/AIDS • Youth headed households • Older persons
Community Profiling	☑ • Mapping community services	☑ • Mapping community services • Patterns of resource use • Settlement patterns		☑ • Mapping community services			☑ • Mapping community services
Stakeholder liaison/ networks/ collaboration	☑ • To help community members	☑ • Ward committees • CBOs • CDWs		☑ • NGOs • Government	☑ • Work with other government sectors to promote and		☑ • Facilitate health and social worker

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24, ECD Policy 2015)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
	access services • To help community members determine what services are available	• Community-based stakeholders		• Traditional / community leaders	undertake collaborative community-based interventions e.g. ECD and geriatric care		household access
Community mobilisation	☑ • Service delivery and policy (Integrated Development Plans) • Participatory democracy	☑ • Manage community resources to support priorities		☑ • No further information identified			☑ • To determine and take responsibility for their own health and social needs
Advocacy	☑ • Service delivery and policy (Integrated						☑ • Health and social well-being

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24, ECD Policy 2015)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
	Development Plans)						
Community education (IEC)	☑ • Provide information regarding accessing services • Inform what services are available • HIV/AIDS education			☑ • No further information identified	☑ • Health promotion programmes	☑ • Educating communities on how to access and use available resources	☑ • Health and wellness skills training • Health promotion programmes • Succession planning
Income generating activities	☑ • Community projects	☑ • Community-based planning • Identification of livelihood opportunities		☑ • No further information identified			

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24, ECD Policy 2015)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
Conflict resolution		☑					
Child protection			☑ • Safe parks • Recreational and cultural activities • Provision of child and youth basic and developmental care	☑ • Homework supervision • Recreational activities • Youth/holiday programmes		☑ • After care services	
Needs assessment	☑					☑ • Data collection and processing	
Health Assessment					☑		

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24, ECD Policy 2015)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
					• No further information identified		

Table 7: Comparison of CBW functions targeted at the facility level (based on policy documents, toolkits and job descriptions)

Functions	CDW (CDW Handbook, CDW Job Advert)	CDP (CDP Toolkit, 2009)	CYCW (NACCW)	CCG (Policy Framework, 2010)	CHW (Policy Framework and Strategy 2018/19–2013/24)	Auxiliary Social Worker (SACSSP Info Brochure)	CCW (Draft Policy Framework 2009)
M&E	☑ • *No further information*	☑ • Assess progress of interventions being implemented • Hold service providers accountable					
Coordination	☑ • Interdepartmental programmes • Community work teams • Communication of community needs to relevant stakeholders						

Capacity building		☑ • Institutional capacity building					

4.3 Requirement, job grade and income levels of different CBWs

The literature review for this evaluation revealed that there is a great deal of diversity in CBW employment arrangements. It goes on to note that, "The sector relies heavily on unpaid workers or volunteers, but also includes CBWs who…earn salaries." This assertion was confirmed in the course of primary data collection and during the review of additional documents. CBWs may be volunteers but a number of the CBWs that participated in FGDs reported receiving a stipend or some form of compensation for their work. The amounts received varied considerably within and across cadres as illustrated by the examples that follow in the section below.

- An Eastern Cape DOH official reported that CHWs employed with EPWP funding worked for 18 hours per week (that is, six hours per day for three days). These CHWs were contracted for one year at a time and earned a stipend of R3 000 per month. The official noted that the CHWs were included on the PERSAL system but were not entitled to any benefits. However, according to Resolution 1, 2018: Agreement on the Standardisation of Remuneration for CHWs in the DOH (Public Health and Social Development Sectoral Bargaining Council)[14], CHWs with a Grade 12 are entitled to payment of R3 500 per month, while provincial Heads of Department (HODs) are responsible for their recruitment and for the provision of all necessary tools required for CHWs to do their work
- Within the DSD's Community Development Programme in the Eastern Cape, community mobilisers or change agents are recruited to conduct household profiling in their wards. These CBWs receive a stipend of R2 000 per month and are contracted for a year. A Free State NPO respondent reported that the organisation's volunteers received a stipend of R1 000 per month from the DSD, while a respondent from a government-funded Gauteng NPO reported a stipend level of R1 936 per month. This was justified on the basis that the CBWs employed by the organisation worked from 08h00 to 14h00 each day
- The VHFs, while classified as volunteers by the DBE, receive an honorarium of R1 188 per month. This cadre works five days per week, from 05h00 to 11h30. Should additional work be required, for example, food preparation during school camps or for school-related weekend events, the school principal is responsible for paying the VHF an additional sum of money. VHFs are registered by the DBE for UIF and are contracted for a two-year period
- CDWs have public servant status with the benefit of permanent employment and potential earnings of R200 000 per annum. AEWs are also reported as being salaried employees

The DPSA Circular 10 (01 April 2018), *OSD for Social Services Professions,* notes the following cadres' job grades and income levels:

Table 8 Personnel noted on PERSAL tables 260 and 261 (01 April 2018)

14 See http://www.phsdsbc.org.za/agreements/RESOLUTION%201%20OF%202018%20-%20AGREEMENT%20ON%20THE%20STANDARDISATION%20OF%20REMUNERATION%20FOR%20COMMUNITY%20HEALTH%20%20WORKERS%20IN%20THE%20DEPARTMENT%20OF%20HEALTH.pdf; accessed 31 January 2019.

Worker type	Grades	Income range
Auxiliary Social Worker	Grades 1, 2 and 3	Full time: R139 563–R249 831
Assistant Community Development Practitioner	Grades 1, 2 and 3	Full time: R132 729–R237 597
Community Development Practitioner	Grades 1, 2 and 3	Full time: R204 951–R409 137
Child and Youth Care Worker	Grades 1 and 2	Full time: R132 729–R176 796

As indicated by the examples provided above, there is a considerable variation in remuneration and working arrangements among CBWs. Similar findings emerged regarding job requirements amongst the CBW cadres noted in Table 3. For example, the NSNP Implementation Guidelines (2010) indicate that VHFs must be unemployed members of the community below the age of 65 years. No qualifications are required other than an ability to cook. It was noted in the course of primary data collection that many VFHs do not have formal schooling and thus may not be able to read or write. Given that they are recruited from the community in which the school is located, many of the VFHs are learner parents or grandparents. In contrast, the Ward-Based Primary Healthcare Outreach Teams Policy Framework and Strategy (2018/19–2023/24) notes that going forward, the entry requirement for CHWs will be grade 12. Similarly, the minimum qualification for employment as a CDW is located at Grade 12 or NQF level 4.

In contrast, the Community Care Worker Management Policy Framework (draft version 6, 2009) notes that CCWs must be at least 18 years of age but that level of schooling may not be used as an entry requirement other than to determine what training may be provided. For CBWs considered as professionals, such as CDPs, a higher education qualification is generally required, while for auxiliary CYCWs and ASWs, registration with the professional body, the SACSSP, is stipulated.

Table 9 below presents a typology of CBWs according to their job requirements.

Table 9 Job requirements

Status	Job requirements	Type of worker
Unqualified	Grade 10–12	CHW, VFH leader
Basic qualification	NQF 3–4	CYCW (learner); CDW[15]; ASW16
Para-professional	NQF 5; must be registered with a professional body	CYCW (auxiliary)
Professionals	NQF 6 +	CDP

15 The Draft Policy: Community Development Workers (CDW) Programme, Discussion Document (20 August 2009, page 23), notes that *"On successful completion of the learnership, the CDW is awarded a Further Education and Training Certificate in Development Practice (FCDP) at NQF level 4."*
16 The ASW is required to register with the SACSSP.

4.4 Which cadres can be considered Community-based Workers?

The core characteristics of a CBW emerged from the overview provided above. These are summarised below and provide the basis for the formulation of a definition of CBW, which will be used for the purposes of this study.

A CBW must meet all of the following criteria

Table 10 Criteria for selecting CBWs and which categories of workers meet this criteria

Criteria	CDP	CDW	AEW	VFH	CCG	CHW	CYCW
Is generally community-based and selected from the community in which they live. They work in a particular ward or village (that is, within a specific, small geographical area).	×	×		✓	✓	✓	✓
Lay or non-professional worker that has qualifications up to NQF Level 4 (may include auxiliary worker up to NQF level 4).	×	×	×	✓	✓	✓	✓
Visits households and/or works at or from a community-based centre or as part of an outreach team.	×	×	×	×	✓	✓	✓
Provides community-based services, ideally under the supervision of a para-professional or professional in their related field, directly to community members, and/or linkages / access to other services. In this way, the CBW extends the reach of service delivery.	×	×	×	×	✓	✓	✓

In sum, a CBW must meet all of the criteria as follows:

- Is generally **community-based and selected from the community** in which they live. They work in a particular ward or village (that is, within a specific, small geographical area).
    - *This means that CDPs, who are often deployed in communities where they do not reside, do not fall within the definition of CBW adopted for this study.*
- Is a **lay or non-professional worker that has qualifications up to NQF Level 4.**
    - *This means that professionals such as CDPs, AEWs and CDWs should be excluded from the definition of CBW adopted for this study.*

- **Visits households and/or works at or from a community-based centre or as part of an outreach team**).
    - *This means that CBWs such as CHWs, CCGs and CYCWs should be included in the definition of CBW adopted for this study.*
- Provides **community-based services, ideally under the supervision of a para-professional or professional in their related field, directly to community members, and/or linkages / access to other services**. In this way, the CBW extends the reach of service delivery.
    - *This means that CBWs such as CHWs, CCGs and CYCWs should be included in the definition of CBW adopted for this study.*
    - *CBWs who focus on the promotion of democracy and democratic liaison, such as CDPs and CDWs, are excluded from the definition of CBW for this study as they provide information (from government to community and vice versa), but not a direct service to community members.*
    - *VFHs do not provide services directly to the community as they operate within a school. Therefore, it is proposed that this cadre be excluded from the study as well.*
- Can be **paid by government directly, or by NPOs via transfer agreements or other means**.

CBWs are not:

Retired workers who decide to volunteer in the community; people who volunteer on an ad hoc basis through faith based or other avenues.

Lastly, for defining the boundaries of a CBW system, it is useful to think of two primary groups of CBWs; that is, those who are **central to health and social services** (core CBWs) and those who are part of allied systems. For example, we view CDWs and CDPs as facilitating agents, whose role it is to interface between the department and the CBWs. Hence, CDWs and CDPs are not CBWs as such, but rather play a facilitating or supporting role in the deployment of CBWs.

Based on the above key characteristics of a CBW and the distinction between core and allied systems, the diagram below indicates which categories of CBW are included in this evaluation – and which are excluded. Those listed in the left circle are perceived as being central to community-based service delivery; that is, they are viewed as being the core or primary groupings of CBWs, plus they meet all of the criteria noted above. Those on the right are viewed as allied or support role players, while the CBW cadres in the centre circle do not meet all of the specified CBW criteria.

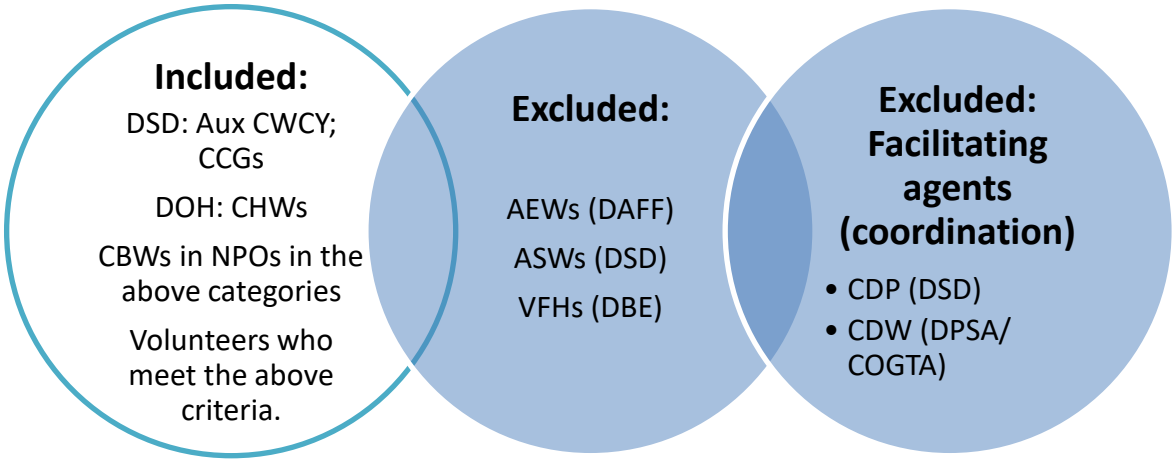

Figure 1 Final selection of CBWs for inclusion in the diagnostic evaluation

Key point summary

- A number of CBW cadres operate within South Africa. Each of the departments deploying or funding CBWs has defined their particular cadre in a specific way, plus allocated that group a specific set of tasks or scope of work.
- Although there are many different terms for various CBWs depending on their sub-programme (e.g. disability assistants or community rehabilitation workers), they can be defined under the broader category of community caregivers.
- CBWs provide or facilitate access to a wide range of services at individual, household and community level, and one of their key functions is to connect the most vulnerable to relevant services, thus extending the reach of services to those who need them most and facilitating the uptake of these services.
- Some groups have tools and specific approaches or methodologies to frame their community-based interventions and are highly regulated and integrated with their respective professional councils (such as CYCWs), but others are not.
- While there may be some overlap in the services provided, such as household profiling, evidence of the distribution and 'saturation' of CBWs suggests that they are not distributed evenly or rationally around the country on the basis of need, and hence it is unlikely that there is much duplication. This is discussed further in the section on workforce, scale of CBWs.
- In terms of job requirements, job grades and income levels of different CBWs, there is a wide variation across and within the different cadres. This issue is explored further in the report sections below, which address the systemic elements of funding, budgets and workforce.

4.5 System elements in place to support community-based workers

In this section, the evaluation explores the existing situation, strengths and challenges of the CBW system according to the key system elements related to the regulatory framework; political will and leadership, coordination and management, financing and budgets, the CBW

workforce and monitoring and evaluation. It then discusses the service delivery outcomes that are achieved through the use of CBWs and how these are affected by the implementation of the other system elements. Lastly, the question of the sustainability of CBWs is discussed.

4.5.1 Policy, legislation and norms and standards

This section provides an overview of the policy, legislation, norms and standards that are in place to support CBW as well as gaps in policy, legislation, norms and standards.

There are existing overarching policies and legislation that provide the foundation for the rights of all citizens, the plan for national development and the structures and systems for where CBWs can be located. These policies include:

- The Constitution of the Republic of South Africa, 1996
- The National Development Plan Vision 2030
- The White Paper on Local Government, 1998.

Additionally, the South African labour legislation framework, which guides the labour regulations of all persons forming part of the public service, including the CBW programme, includes:

- Basic Conditions of Employment Act, 1997
- Skills Development Act, 1998
- Public Service Amendment Act, 2007
- Basic Conditions of Employment Act, 1997: Ministerial Determination 4: Expanded Public Works Programme (2012).

There is no single overall comprehensive legislation pertaining to CBWs and the various departments have different policies and regulatory frameworks for their CBWs. Table 11 lists the various policies, guidelines, and regulations that govern the implementation of the different CBW models.

Table 11 Community-based worker legislation, guidelines, norms and standards

Community-based worker type	Legislation, guidelines, norms and standards
CHW	• Provincial Guidelines for the Implementation of the three streams of PHC Re-Engineering (2011) • Ward-Based PHC Outreach Teams: Implementation Toolkit (2011) • National Department of Health: Strategic Plan 2015–2020 • Staffing Norms for Primary Health Care in the Context of PHC Re-Engineering (2012) • National Department of Health: Policy Framework and Strategy for Ward Based Primary Health Care Outreach Teams (2018/19–2023/24)
CYCW	• White Paper for Social Welfare (1997) • Generic Norms and Standards for Social Welfare Services: Towards Improved Social Services (2013) • Norms, Standards and Practice Guidelines for the Children's Act (2010) • Policy on Social Service Practitioners (2016)

Community-based worker type	Legislation, guidelines, norms and standards
EPWP[17]	• Basic Conditions of Employment Act, 1997: Ministerial Determination 4: Expanded Public Works Programme (2012) • Code of Good Practice for EPWP • Expanded Public Works Programme: Consolidated Programme Overview and Logical Framework (Version 6 – June 2014) • EPWP Phase II: Training Framework (2012)
HCBC	• Staffing Norms for Primary Health Care in the Context of PHC Re-Engineering (2012) • National Guidelines on Home-Based Care and Community-Base Care (2011) • Policy on Social Service Practitioners (2016)

Gaps in the policy/legislative frameworks landscape

There are many policy/legislative/guidelines norms and standards in play. Some are in draft form, some have recently been revised and others are currently being revised. Sector departments have developed policy frameworks and implemented different models of CBWs to encourage community participation and to improve access to services. The 1997 White paper for Social Welfare was the first government policy to propose transformation of social services to communities. CBWs were proposed as a model that could be cost-effective and efficient to expand services to poorly serviced communities. While the employment of CDWs was governed by the Public Service Act, giving them public servant status, CBWs were contracted either directly by a government department or employed via NPOs who were supported through the DSD funding. A 2017 policy document defines a CDP as a paid person qualified in and applying all the theories and principles of community development practice whereas a community practitioner is defined as a person employed to deliver services to a community by utilising a community development approach (DSD, 2017). The DOH generated policies and regulations for CHWs, and the EPWP used CBWs for different purposes.

The national DOH defined an overall model and roles for the CHWs in the Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) (DOH, 2017) and issued a set of implementation guidelines. However, the detailed design, funding and implementation of the WBPHCOT strategy were left to provinces. Provinces have proceeded to adopt and adapt the strategy and as a result, implementation has been highly uneven across the country. Only 42% of the required estimated total of 7 800 WBPHCOT teams were in place and submitting information by March 2017 (Schneider et al, 2018). Health care workers in WBPHCOTs have mostly been recruited from the pool of existing lay health workers in communities, who are then trained and entered into new organisational and contractual relationships with local health systems. The wide range of background (educational, experiential and training) and competencies among health care workers has resulted in a cadre of workers with varied skill levels, literacy levels and capacities.

The confusion at implementation level has resulted in discrepancies in the duration of basic training, different ways to measure performance, various models of supervision and general

[17] These are included although they are not considered a CBW but a funding stream

lack of standardisation according to respondents interviewed.[18] CHWs have also been remunerated differently, for example, some received basic salaries from the DOH while those who engaged by the DSD did not get basic salaries but were reimbursed for travel expenses. According to the respondents in this evaluation, there is a lack of professional recognition for the work of CBWs and senior and middle management do not understand CBWs' critical functions. One respondent stated that CBWs suffer because they are not adequately covered by current legislation.

> *"There is a gap – CBWs are not included in the policies – they are taken as volunteers and even labour relations issues are not taken into consideration, e.g. injury while on duty – this is not covered." (SSI_Local government).*

There are national guidelines for the joint policy for HCBC workers but there is also much confusion. Policy and legislative frameworks are either not clear or poorly understood and there is a problem with implementation, according to respondents interviewed. They pointed out that some community-based care organisations are not funded by the DOH or DSD and they work in communities without adequate supervision and monitoring. Currently, there is no legislation that binds the health department to regulate how the CBWs operate. CBWs further expressed the need for systems and standards to regulate community-based health workers, even in those located in Community-based Organisations (CBOs).

The EPWP benefits from detailed frameworks and implementation and infrastructure guidelines (as listed above) which provide strategies for effective implementation. The Employment Conditions Commission under the Department of Labour advises the Minister of Labour who makes the determination, and the minimum wage is increased annually. This provides basic conditions of employment and minimum wages for persons employed as part of the EPWP. Some are of the opinion that the Ministerial Determination undermines the Basic Conditions of Employment Act and allows for remuneration disparities between EPWP workers and those doing similar work outside of the EPWP. The Minimum Wage Act which came into effect at the start of 2019 explicitly provides for a substantially lower minimum wage for EPWP workers than for other workers – with the EPWP rate at only 55% of the standard minimum wage. CBWs engaged in the EPWP are in the system much longer than anticipated and this has implications for the labour relations provisions.

The DSD and DOH have provided handbooks or guidelines for HCBCs. Policies or guidelines which outline the roles and responsibility of CCGs are missing. An attempt to outline these were made with the Community Care Worker Policy Management Framework (2009) but this was never implemented. National representatives within the DSD agreed that there were gaps but indicated that it is developing policies that will regulate CCGs' working conditions and clearly define their role within the DSD. It is also developing a supervision framework for all social service professionals. The idea is to create alignment and to improve conditions in terms of services – particularly to children. The NACCW developed a full set of documentation on Isibindi in the course of the five-year national roll-out. The main document, which was issued as an official DSD document in the first year, was entitled, *Isibindi Minimum Standards and Practice Guidelines for the Replication and Implementation of the Isibindi Model*. The guidelines were refined and updated towards the end of the roll-out incorporating lessons learned over the five years. This model was handed over to DSD in 2018 and is now a

18 This is described in detail in chapter 5.5.5 on workforce.

programme called Community Prevention and Early Intervention Services for Orphaned and Vulnerable Children.

Currently CCGs fall under community work practice and CHWs under health work interventions, which results in a challenge when workers in the EPWP perform functions that span both community work and health work practices. The move to review the White Paper for Social Welfare and to adopt and cost the Policy on Social Service Practitioners that will be inclusive of all kinds of practitioners i.e. social workers, CDPs and CDWs and CYCWs, is a welcome one. While this is considered positive, a respondent expressed a need for harmonisation of frameworks at implementation level – at HOD level as this is where the discrepancies creep in. One also expressed ambivalence about harmonisation;

> *"Harmonisation of policy, yes and no. For high level there needs to be policy that helps with how the CBWs relate with one another and can work with one another at local level. But policy must not be prescriptive but stipulate roles and interaction between stakeholders." (SSI_Provincial Government)*

Key point summary

- Numerous policies and legislation provide the foundation for the rights of citizens and employment statutes in South Africa.
- Various existing frameworks, guidelines and norms and standards are in use to regulate specific models of CBWs, but there is no single overall comprehensive legislation pertaining to CBWs.
- Some policies have remained in draft form for extended periods and other frameworks and guidelines speak to specific types of CBWs and have been developed by different national departments.
- The gaps identified in the policy framework space include poor implementation strategies, and a lack of monitoring and evaluation of the strategies employed. The existing policy and legislative frameworks are either not clear or poorly understood and there is a problem with implementation.
- The White Paper for Social Welfare is current being reviewed and the Policy on Social Service Practitioners is envisaged to include regulations for social workers, CDPs and CDWs and CYCWs.

4.5.2 Leadership and political will

This section provides an analysis of the leadership and political will pertaining to CBWs.

Leadership and political will is necessary to ensure the successful implementation of the CBW system and the overwhelming majority of respondents (NPOs and government officials) believe that this political will is in place.

The overwhelming majority of respondents believe that there is the political will to improve the conditions and effectiveness of CBWs. The most frequently mentioned *drivers* of political will are job creation and service delivery improvement. However, there is hesitancy to increase the public service workforce and salary bill.

> *"Yes there is political will – it is driven by the mandate to strengthen the health care system, alleviate poverty and job creation. Hence the ward-based recruitment (of CBWs)." (SSI_Local Government)*

On the other hand, one respondent noted that the continuity of various CBW programmes is shaped by political or personal interests. Thus, when a lead person who supports the programme leaves the department, it loses momentum.

The need to improve service delivery is another driver of political will. Respondents frequently noted that government departments, and in particular the DOH, would not be able to achieve their targets without CBW support. They are referred to as 'the eyes and ears of the community'; they have insight into the needs of the community members and are the key for service delivery.

Many respondents highlighted that, despite strong political will, weak programme implementation and limited allocation of resources remain a persistent challenge. These issues are explored further in the sections below.

Additionally, one respondent noted that, while there is evidence of political will, politics at local level sometimes negatively affect the CBW system:

> *"Yes there is political will…however it is often diluted at the local government level because of political party competition…CBWs can be hijacked for party political reasons and agendas." (SSI_Local government)*

Another two respondents confirmed that recruiting CCGs is the responsibility of the wards and sometimes local politicians manipulate the recruitment system to further their own political agendas. As one provincial stakeholder pointed out: *"Once politics is too involved, people lose focus on what needs to be done on the ground level." (SSI_Provincial Government)*

Key point summary

- There is political will to support the CBW system, although politics at local level sometimes negatively affect the CBW system, for example, when local leaders ensure that those whom they know as family, politically or in some other way are prioritised for jobs.

4.5.3 Coordination and management

This section provides an analysis of coordination and management of CBWs. It starts with outlining the relevant evaluation questions related to coordination and management before providing the findings on the evaluation questions.

The evaluation questions addressed in this section are:

- *Evaluation question 1.6: What are the respective roles of sector departments (national, provincial and municipal) and centre of government departments (COGTA and DPSA)[19] in regulation and implementation of the CBW models?*
- *Evaluation question 1.7: How do CBW interface with other institutional mechanisms and service delivery initiatives such as departmental and provincial service delivery improvement interventions? What are the strengths and challenges in coordination with these other initiatives?*
- *Evaluation question 3.4: To what extent is there duplication and overlap in government supported CBW models?*

The coordination model depicted below, which has been adapted from social protection (Chames & Davies, 2017), could assist in looking at the different possible layers of coordination. The foundation of coordinating CBWs rests on policies, strategies and norms and standards. Financial resources also underpin CBW coordination. The services provided by CBWs can be considered the pillars, namely health and social services. Effective coordination of CBW services can promote universal access to basic services to reach the system goal of 'Improve health and social development outcomes'.

Coordination can happen both horizontally and vertically. The horizontal level can be divided into policy level, programme level and administrative level.

The need to have an overall policy coherence across government should be discussed. It includes strategic vision, policy and legal frameworks to establish guiding principles to support inter-sectoral coordination.

Horizontal coordination at programme level aims to improve the design of programmes, to identify and maximise synergies, and strengthen linkages between programmes in different sectors.

Horizontal coordination at the administrative level aims to improve efficiency in delivery and enhance quality of services from the perspective of users, and reduce duplications and transaction costs. The focus is on the 'nuts and bolts' that facilitate the core business processes of the service programmes. This level includes beneficiary identification and enrolment, MIS, referral systems etc.

Vertical coordination aims to ensure consistency, responsiveness to local context and accountability in programme implementation. Coordination is considered to be 'vertical' when it takes place among the different spheres and tiers of government (national, provincial, local and district).

19 It is noted that Department of Public Works (for EPWP) and Department of Labour (for labour legislation) are not mentioned in this evaluation question in the TOR.

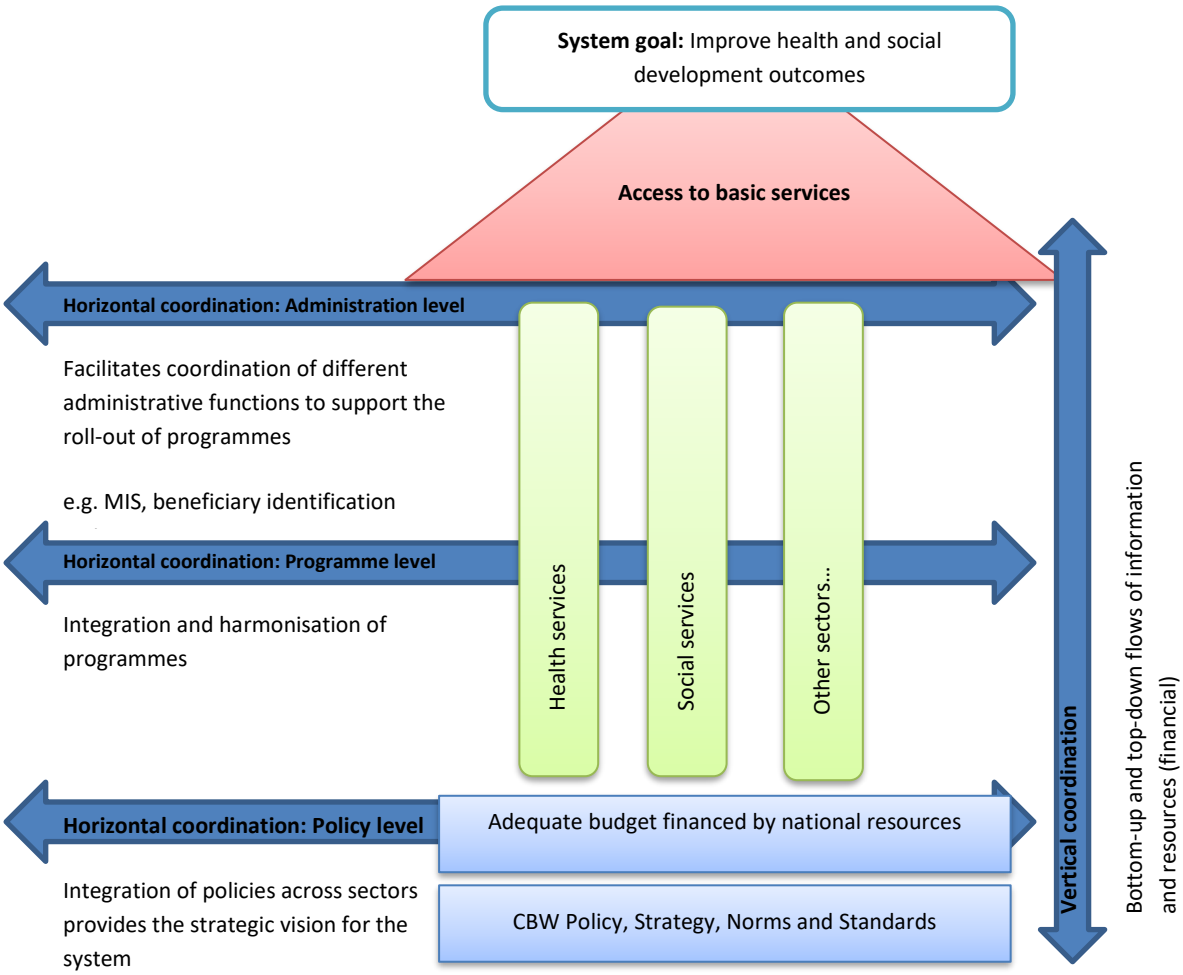

Figure 2 CBW Coordination diagram

What are the respective roles of sector departments (national, provincial and municipal) and centre of government departments (COGTA and DPSA) in regulating and implementing the CBW models?

In general, the inter-relationship between national, provincial and local government is regulated in the Intergovernmental Relations Act, 13 of 2005. This Act serves to establish a framework for the national government, provincial governments and local governments to promote and facilitate intergovernmental relations; to provide for mechanisms and procedures to facilitate the settlement of intergovernmental disputes; and to provide for matters connected therewith. As raised in the National Treasury 2014 review: "*National government's role is to formulate policy and develop norms and standards; provinces and municipalities are mainly responsible for implementation. In practice the lines of responsibility and accountability are often blurred. These challenges can be overcome through institutional frameworks that allow for greater coordination".*

Regarding CBWs, the national departments are responsible for policy and regulative developments and norms and standards, while provincial departments are responsible for the implementation, supervision and M&E of the implementation of CBW models. Local government is responsible for implementing some of the CBW models like the CDPs.

Although the CDWs under the auspices of the DPSA and COGTA are excluded from the CBW definition in this evaluation, they are listed here for the **purpose of coordination** among these departments and the DSD and DOH. The CDWs have to improve community

access to government services and strengthen integration and coordination among different government line services (Van Rooyen, 2007).

Table 12 indicates the department involved, the key policy and legislative frameworks and the name of the CBW programme.

Table 12 Overview of departments involved with CBWs

Department	Key policy and legislative frameworks	Name of programme/s
DOH	• Community Health Care Workers Policy Framework (2004, revised 2008) • Policy Framework and Strategy Ward-based Primary Healthcare Outreach Teams (WBPHCOT) (2018/19–2023/24)	• National Community Health Worker Programme (2004); integrated into the Social Sector EPWP • Re-engineering Primary Health Care Programme (rPHC)
DSD and DOH	• Draft National Policy Framework for Home- and Community-based Care and Support • Draft Joint Community Care Worker Management Policy Framework (2009), not implemented • Draft Policy Framework on Management of Community Caregivers (2018) DOH only • Draft Policy Framework on Management of Community Caregivers (2019) DSD only	• Home- and Community-based Care Programme (HCBC) – social sector programme on the EPWP
DSD	• Children's Act (2005), Social Service Professions Policy and Act No 110 of 1978	• Isibindi Programme, absorbed in 2018 into child protection programme under OVC Directorate, DSD
DPSA, COGTA and Local Government	• Public Service Act (1994)	• Community Development Workers Programme (CDWP)
DSD, Directorate of Community Mobilisation	• Community Development Practice Policy (2017)	• Integrated Sustainable Rural Development Programme (ISRDP); Urban Renewal Programme (URP)

What is evident is that some programmes (such as the HCBC and CDW programmes) have different departments working together. For example, DSD and DOH were mandated by Cabinet in 2009 to jointly oversee the HCBC Programme, and the DPSA and COGTA work together on the CDW Programme. The Draft National Policy Framework for Home- and Community-based Care and Support; draft Joint CCW Management Policy Framework (2009), was also an attempt to integrate the work with CBWs by the two departments but it has not been adopted. This shows an attempt by departments to work together, even if not successful.

The CDW programme is coordinated jointly by the DPSA which is responsible for the workplace environment, job description, and acts that govern the workplace, while COGTA is responsible for the day-to-day running of the programme, and the scope of work that cascades

down to provinces and municipalities. Originally, the DPSA was overall responsible for the establishing the CDW Programme (incubation phase), which was meant to have been handed over to COGTA when operational, but this transition never took place. Hence the DPSA still coordinates the programme, while it is employed by COGTA and responsible to local government. There are a number of challenges with this arrangement, particularly over accountability and coordination; the departments have to work together closely to ensure that their goals and strategies are aligned. Currently all CDWs are employed by COGTA provincially, except in the Free State and North West provinces where they fall under the Office of the Premier. When asking the respondents what role the DPSA has played to strengthen the use of CBWs and improve service delivery by departments, it came out strongly that the DPSA is not visible (or relevant at community level). Of the 30 respondents who answered the question, only five were aware of its role or had worked with it before.

Strengths and challenges of the coordination of CBWs

From a vertical coordination point of view, there was uncertainty as to whether the 10x10 meetings are taking place for health and social services sectors. The 10x10 meetings bring together the National Treasury, HODs and finance heads of the nine provincial and related national department (National Treasury, 2018). These meetings would be one of the forums in which such coordination could be discussed. It would require the national officials who oversee the services provided by a category of CBWs to bring together those heading provision of this service in the nine provinces to plan, implement and monitor the process.

Regarding horizontal programmatic coordination, strengths that have been highlighted in terms of coordination include the working relationships that NPOs have with government departments (reported by 3 NPOs), despite the many challenges noted in other parts of this report related to the government-NPO partnership / service provider arrangements. Another strength was the number of coordinating forums or networks (reported by nine respondents). District level coordination was highlighted by one respondent as a strength.

Eight respondents felt that coordination at government level was insufficient and a challenge to providing required services. The respondents were from NPOs (4), national government (2), and one from each local government and CBWs. The challenge is in both vertical and horizontal coordination. Lack of commitment was reported by five respondents while non-functioning forums or too many forums were also highlighted.

Description, strengths, challenges and lessons learned of coordination between the DSD and DOH on HCBC

HCBC was mainly conceived to address the HIV/Aids crisis in the 1990s. The national DOH and DSD were mandated by Cabinet in 2009 to take responsibility jointly for the implementation of the country's HCBC and support programme.

There was an attempt to consolidate the work of CHWs in the DOH and CCGs in DSD into a joint draft CCW Management Policy Framework to facilitate the collaboration of the different departments (Republic of South Africa, 2009). The framework document coins the term Community Care Worker and says that it encompasses and replaces CHWs and CCGs. The Community Care Worker refers to "…any worker, albeit a volunteer worker, who delivers services under the auspices of Home Community-Based Care and Support programmes both in support of health and social development programmes." This policy framework is, however, a draft document, and it is clear from the analysis of the regulatory framework that the term Community Health Worker is clearly used in the PHC Re-engineering documents, which came

out after 2009; CCGs are centrally located in the HCBC 2010 programme. Hence, it seems as if this attempt to consolidate the two types of CBWs was unsuccessful. The evaluation explored the reasons why this policy was not accepted, and the reasons provided were speculative and non-conclusive. Nevertheless, it includes some useful ideas which are shared below.

The 2009 Draft Community Care Worker Policy Management Framework specified the roles of both the DSD and DOH with regards to manging and coordinating CBWs. However, from respondents, it seems that there were challenges with regards to the DSD's and DOH's different needs in terms of CBWs and currently, nationally, the DOH is playing a lead role in implementing HCBC. Provincially, similar challenges emerged. One provincial respondent argued that the challenge was that the DSD and the DOH both had their own policies on CBWs and each department has different needs; one was about physical caring and the other psychosocial support and it was difficult to marry the two (Provincial DSD).

It could contribute towards rationalisation and ultimately effectiveness and efficiency if the two departments were able to coordinate better around this programme by at least revisiting the roles outlined in the draft policy and revising them accordingly. In the meantime, both the DOH and the DSD have developed or are developing a Policy Management Framework for each of their cadres.

Local stakeholders that CBWs interact with and their roles

The CBWs in 10 FGDs were asked who the local stakeholders they interact with are. The answers indicated that they interact with a number of local stakeholders. The most common stakeholder they interact with is SAPS (7); this was for issues such as stock theft or Gender Based Violence (GBV). Other stakeholders with whom interaction was frequently referred to included youth structures or other NGOs (4) or clinics (4). Additionally, SASSA, DOH, ECD Centres and communities or community centres were each highlighted in three FGDs. There were also a number of respondents who mentioned other stakeholders such as the DSD or social workers. Interacting with CDWs was only mentioned by one FGD consisting of CHWs.

However, what is evident is that CBWs have significant interaction with officials of different government departments to help provide necessary services such as documentation or health care.

According to five respondents, rivalry between CBWs was a significant challenge. These respondents allege that a number of CBWs fight over houses in order to meet their targets (particularly in areas with low population numbers).[20] Aside from rivalry and competition among CBWs, rivalry is linked to duplication and can negatively affect those receiving services. However, one expert, who does not believe there is duplication or rivalry, argued that if any duplication were to occur it would be in urban areas.

> *"We do not have sufficient numbers in any of the categories that we have identified to see a competition over families… we haven't even touched rural areas properly." (SSI_Expert)*

How do CBWs interface with other institutional mechanisms and service delivery initiatives such as departmental and provincial service delivery improvement

[20] For example with PEPFAR funding, which usually has very high targets for service delivery – and in the previous funding cycle was working in hard to reach areas, with smaller population sizes.

interventions? What are the strengths and challenges in coordinating with these other initiatives?

CBW models are generally coordinated by various departments cascading from national to provincial level. KZN has pioneered a ward-level collaborator model called Operation Sukuma Sakhe (OSS), which addresses the inter-functional coordination of CBWs. It is an attempt to integrate and coordinate CBWs' work and is based on the principle of cooperative governance and effective service delivery and is an example of working across programmes.

The model was highlighted by two respondents as being particularly successful. Additionally, in January 2014, it received the Health Innovator's Review Award from the Inclusive Health Innovation Initiative. The same year, at the launch of a publication celebrating OSS Best Practices, UNAIDS endorsed OSS as a powerful programme with wide reach into needy communities around the province (KwaZulu-Natal Province, 2015).

OSS focuses on community partnership, behaviour change, economic activities and environmental care. It shifts the government's traditional vertical approach of service delivery towards cross-functional teams that consist of employees from different departments. The teams work with stakeholders from civil society, business and communities and identify community and household needs within wards. They then deliver integrated, transversal services monitoring and providing feedback to the communities. OSS is led by all 11 members of the Provincial Executive Council and their heads of departments. They are champions of specific district municipalities where they provide leadership; their role is to lead a team of all departments and ensure that integrated services are delivered to communities. If there are challenges, these teams interact with the communities to solve them or escalate issues where necessary. A key part of the OSS structure and process are the War Rooms.

War Rooms are generally in churches, community halls, schools, clinics, and other government buildings. These War Rooms are a space to hold community meetings where local governance, Task Team members and fieldworkers gather to plan for and report on household needs and intervention strategies. In addition, they store documentation relating to household needs, notices and minutes of meetings and service delivery reports. As can be seen from the figure below, both the CDPs and the CDWs have a coordinating role among the stakeholders represented in the War Rooms and the CBWs (in this case the CCGs).

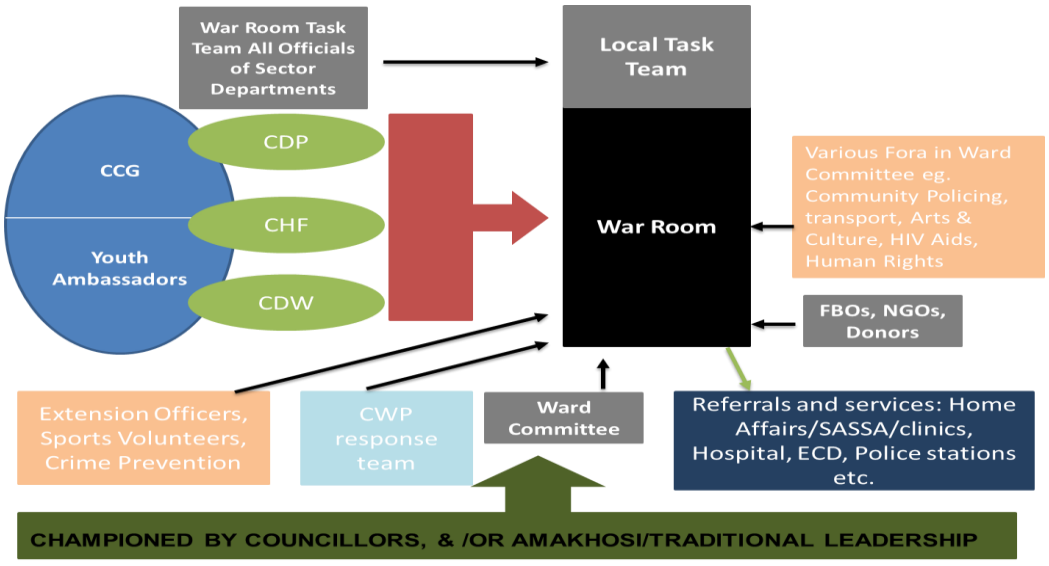

Figure 3 The OSS War Room

Figure 3 above (adapted from the OSS Service Delivery Model Dialogue in 2018) depicts the War Room. The War Rooms have been highlighted by two respondents in interviews as a strength in coordination.

Figure 4 below is from the OSS Review (2015) and depicts the OSS Structures at different levels.

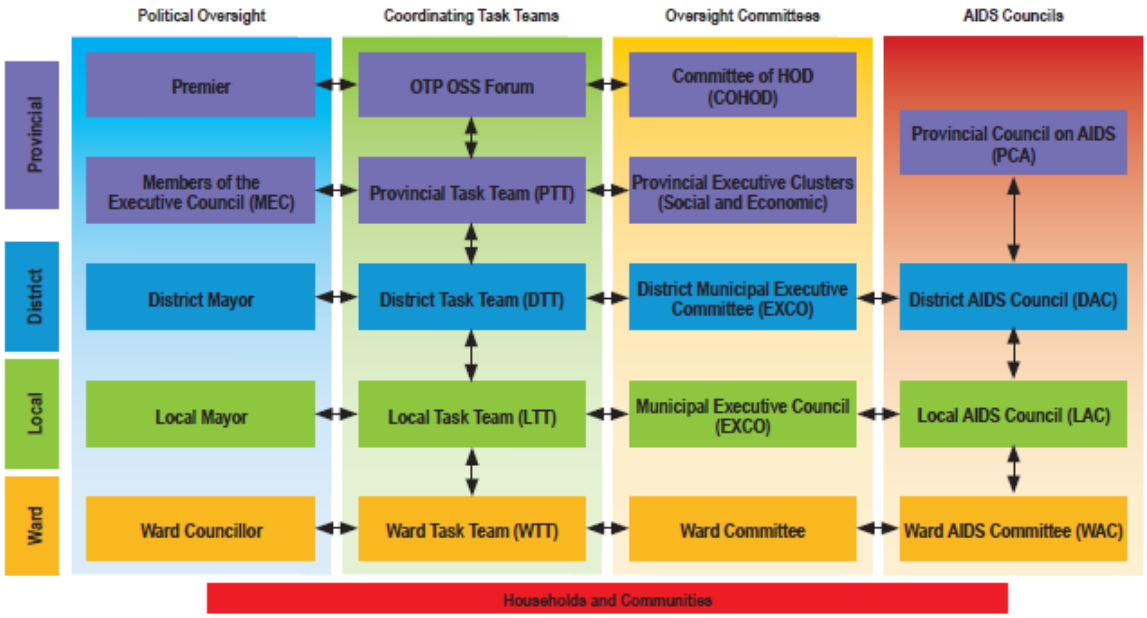

Figure 4 OSS Structures at different levels

According to the KZN Provincial government (2012), each of the Task Teams is made up of government departments, community leaders, civil society including social partners and community fieldworkers. Fieldworkers include one CDW, two Agricultural Extension Officers, two Sports and Recreation Coordinators, and two Social Crime Prevention Volunteers per War Room and one CCG per 60 households in each ward.

Communication within the governance and leadership structure of OSS is multi-dimensional; and vertical as well as horizontal. Critically, it depends on reciprocal communication with households and communities, which makes communities the centre of development. Through War Rooms, communities have the opportunity to make their voices heard and plan for integrated service delivery, together with government (Province of Kwazulu-Natal, 2015). The War Rooms also include Traditional Leaders (Amakhosi). Within the model, there are four main stakeholders serving community beneficiaries; local, provincial and national government; community leaders; civil society organisations (CSOs) and community fieldworkers

The four main processes of the integrated service delivery model are:

1. Household needs identification
2. Appropriate services identification
3. Service delivery
4. Closure of the referral once service provided (Ndlovu & Msweli, 2016).

The process is described in Figure 5 below, taken from the 2012 OSS Guidelines for Coordination document on page 29 (KwaZulu-Natal, 2012). As with Figure 4, PTT are Provincial task teams, DTTs are the District task teams, LTTs are Local task teams, WTT are Ward task teams.

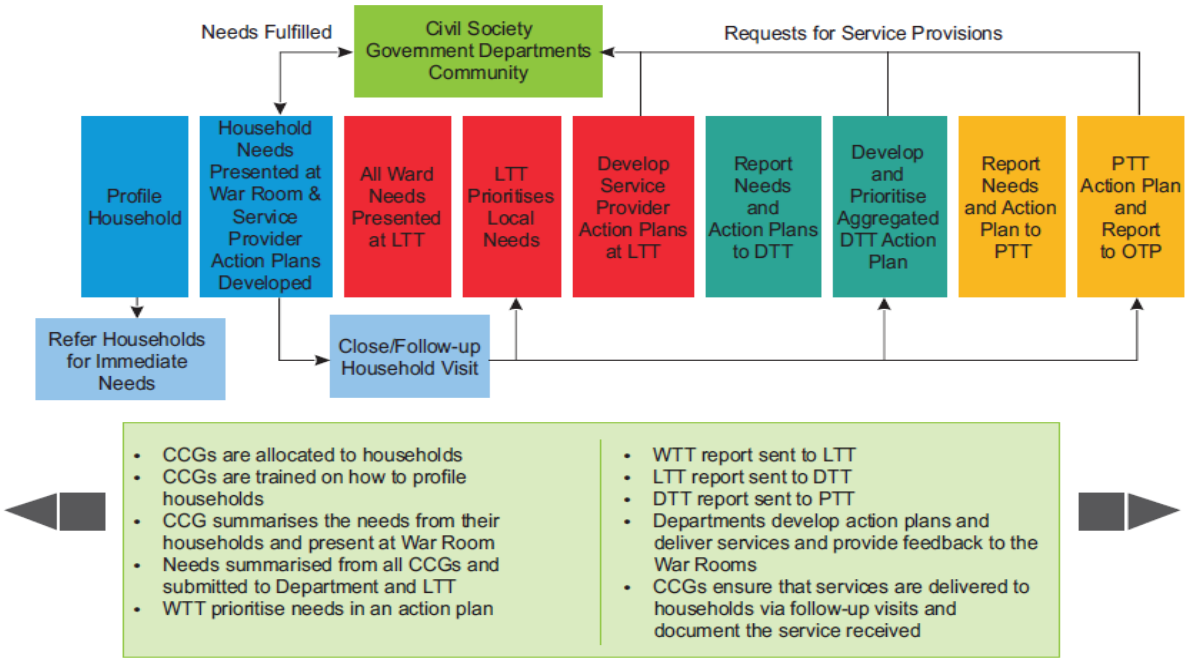

Figure 5 OSS process

As the diagram shows, CCGs are a vital part of implementation. They interact with directly with the community and provide the information necessary for effective service delivery. They are able to effectively provide the services needed through the War Rooms

According to the OSS Handbook (2015, p. 12), the programme aims to coordinate service delivery by mobilising community partnerships with the private sector, NPOs, CBOs and government (Ndlovu & Msweli, 2016). Services provided include immediate essential services[21] such as food parcels, grants, temporary shelter, basic municipal services, behavioural change campaigns and access to healthcare. Additionally, medium-term services,[22] including skills development, job creation and enterprise development, and long-term services,[23] such as infrastructure development and some municipal services, are also provided.

The impact assessment of the HCBC Support Programme has used this model as a basis to develop a more active citizen engagement model based on the OSS War Room concept. The evaluation report notes that the critical conceptual difference in this approach and the current model is that there is more emphasis on encouraging greater accountability of NPOs to the community. However, one could also question government's accountability to the community.

[21] Provided within 90 days.
[22] Provided within 180 days.
[23] Provided within a year or more.

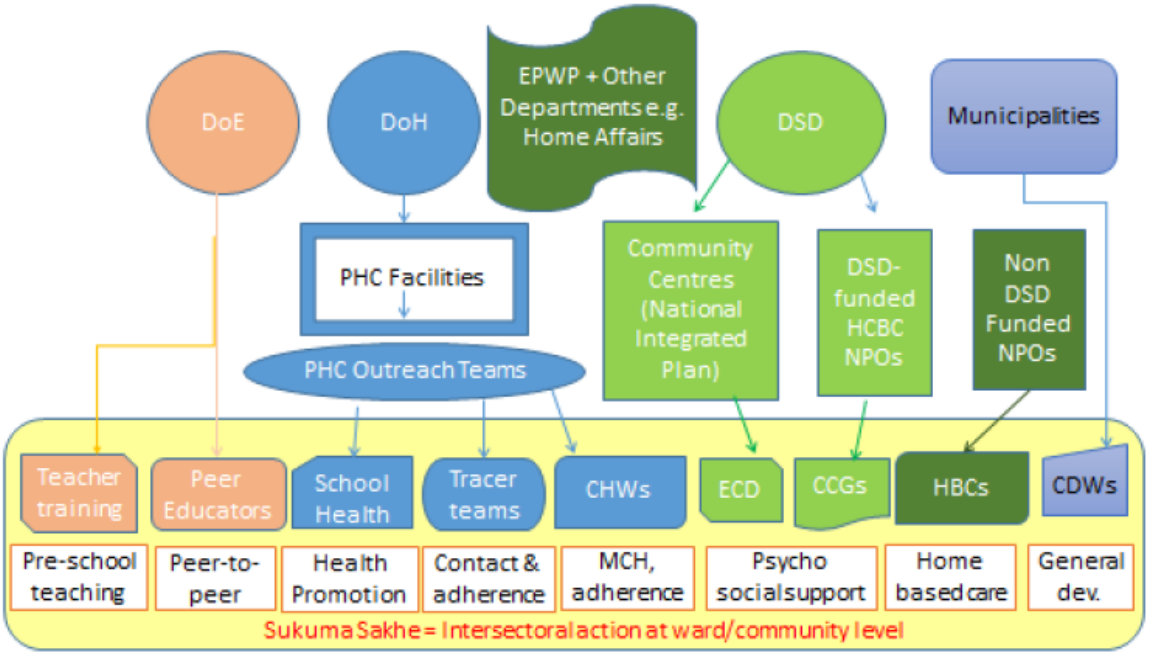

Figure 6 The War Room concept – a schematic representation of a more active citizen engagement model

Source: Friedman, I et al, 2014

Another model being implemented in South Africa, though focused on health care, is the Ward-Based Outreach Team (WBOT) approach.

In 2011, inspired by the success of the Brazilian model, the South African government formulated a PHC Re-modelling. The strategy prioritised four 'streams', one of which was the WBOT. The model and roles of stakeholders involved were defined by the DOH, which also issued implementing guidelines. However, provinces are in charge of designing funding and implementing the strategy. Thus different provinces have adopted, adapted and implanted the strategy at different paces (Gray et al, 2018).

According to the DOH strategy, each municipal electoral ward should deploy WBOTs (on average one team per 1 500 households). The roles of the teams are to strengthen health prevention and promotion and identify and support vulnerable individuals and families. Each team should ideally comprise a professional nurse and five to six CHWs, as well as a health promoter and an environmental health practitioner. Each team is linked to a health facility and serves households in the catchment area of that facility. Each facility could have several WBOTs linked to it (Asegaai, Raegon & Schneider, 2018). WBOTs also provide referral networks to ensure integrated services. WBOTs work with government departments, FBOs and other NGOs.

Strengths and challenges of the coordination of CBWs with other institutional mechanism and service delivery initiatives

A number of aspects of OSS have been highlighted as strengths. These include integrated development planning and institutional arrangements and linkages, including linking departmental operational plans with OSS, having plans and programmes with clear

performance indicators, outputs and outcomes and leadership (KZN Office of the Premier, 2012). Other factors include; inclusive community structures and arrangement linkages. Additionally, the integration of operational plans with government department plans, establishing and training task teams at all levels, establishing a permanent War Room, allocating cadres to conduct household profiling to identify needs and moving away from working in silos have been highlighted as programme successes (Kwa-Zulu Natal, 2018).

A report from 2015 found roughly 9250 fieldworkers (CCGs) had been appointed by government departments to work with War Rooms (KZN Province, 2015). CBWs thus play a key role in OSS.

> *"CCGs are like the soldiers who make Sukuma Sakhe to be active because they are the ones who interact directly with the community and come with challenges that need to be addressed in the community so if it was not for CCGs Sukuma Sakhe would not be operating as good as it is. So CCGs are the backbone of Sukuma Sakhe." (SSI_LG)*

However, despite the positive aspects of OSS, not all War Rooms are functioning; a 2015 presentation by Ngwenya at Moses Mabida Stadium highlighted that out of 822 War Rooms that had been established in the programme, only 391 were functional (Ngwenya, 2015). An assessment of War Room functionality was undertaken in August 2018 by the KwaZulu-Natal Legislature. It assessed War Room composition, frequency of meetings and participation by stakeholders; cases dealt with and turnaround, data management; follow up, report processing, feedback to communities; and overall percentage of functional OSS War Room interventions (KwaZulu-Natal Legislature, n.d). However, it was not possible to find the results of this assessment. In addition, the 2018 Growth and Development Plan included indicators concerning War Rooms and set a target of 80% functional War Rooms by 2020 (KZN OotP, 2018).

There are other changes related to the functionality of War Rooms. In order for them to work well, good information flow is key. However, research in 2012 found disjuncture in information flows caused mainly by lack of access to computers, emails and cell phones, specially to structures such as War Rooms. Further, poor understanding of OSS by local structures and political infighting create additional challenges. There are also challenges caused by ongoing lack of financial resources for operational and transport costs, associated with the fact that OSS has no funding of its own and participating agencies do not always cover transport and other staff costs. Another significant challenge is non-attendance of all key stakeholders (KZN OotP, 2012).

The OSS War Room model was adapted in Mpumalanga in 2015 under the name Operation Vuka Sisente (OVS). However, it has not yet been properly evaluated. Nevertheless, there were significant challenges with establishing War Rooms in the province (de Villiers, 2015), and the 2016 Municipal budget was slightly underspent as a result of delays with OVS (Mpumalanga OotP, 2015).

A number of studies on WBOTs have been undertaken and many positives have been found.

Data from the North West Province found that health facilities with WBOTs had significantly greater improvements in family planning, measles vaccination coverage and reduced cases of severe diarrhoea. In Gauteng, patients with hypertension receiving home delivery of medication and follow-ups had higher levels of blood pressure control (Gray et al, 2018). However, there are significant challenges with the implementation of the WBOT system.

A study in two peri-urban communities in KwaZulu-Natal found that the while WBOTs were necessary, their coordination was inadequate (White et al, 2017). A 2018 review found that although the strategy has been favourably received, implementation has been slow, unequal and that coverage is low (Gray et al, 2018). This ties in with White et al (2017), who found that only 42% of the teams submitted data to the DHIS – anecdotally it has been suggested that a number of teams are incomplete. Other significant challenges include those relating to policy conceptualisation by implementing staff and team composition (particularly with leadership, team composition and size). Working conditions, information and data and education, training and career pathing were also highlighted as challenges to implementation. Finally, functional authority and jurisdiction were highlighted as a significant challenge that negatively impact practical and organisational culture management (Jinabhai et al, 2015).

Finally, one could also question why is there a need for these ward-based approaches when they should be implementing a case management approach at a local level and whether this is supposed to substitute for poor case management. It should be added that UNICEF and the DSD are currently working on strengthening integrated case management and USAID is conducting research to clarify the role of the community care giver.

To what extent is there duplication and overlap in government supported CBW models?

Some of the literature suggests significant duplication of roles and responsibilities of the various departments involved in CBW programmes. Peters et al. (2017) argue that there appears to be a lack of consensus on the roles and responsibilities of various departments and municipalities, which results in poor coordination, insufficient or incorrect reporting, and wastage of limited resources and duplication of efforts. In addition, at community level, many CBWs are reported to be doing similar work with the same households. The greatest challenge is to synchronise their roles and functions to avoid conflict and duplication (DCoG, 2015). However, in the interviews conducted for this evaluation, four respondents agreed there was duplication, while an equal number disagreed.

A recommendation suggested by respondents to combat duplication has been more meetings and forums to help coordination. However, there are already numerous forums and one respondent highlighted that a number of current forums are not functional and that not all departments are committed to attending the forums. Hence there is disagreement as to whether there is duplication and overlap in CBW models. However, in unpacking the term ‘duplication’, it should be stressed that duplication of services should only be perceived as a challenge if a household received duplication of the same services.

The adoption of the Policy for Social Service Practitioners (2016) does a great job of outlining the roles and responsibilities of the various types of workers, but it is silent on coordination of the various social service practitioners. Since the various cadres of CBWs have emerged in response to the social needs in the communities, their work even within the realm of the DSD, can be uncoordinated. Hence, there is potential to coordinate household visits better by the cadre of CBWs within each department. For example, a household visit where a child with disabilities live could be coordinated between the learner / auxilary CYCW and the CCG (e.g. a respite care service provider).

Key point summary

- CBWs play a key role in a number of departmental implementation strategies and both DSD and DOH have their CBW models that they are coordinating. There have

been attempts by departments to work together, though unsuccessful, most likely due to them serving different needs.

- Certain service delivery models, such as WBOTs or OSS rely heavily on CBWs and have received significant praise by respondents in the evaluation for the effectiveness of their work and coordination – where they work well. However, they still face certain challenges in terms of implementation, making particularly administrative coordination, better implementation strategies and M&E of these strategies even more vital.
- The CDPs and the CDWs have a coordinating role among the stakeholders represented in the War Rooms and the CCGs.
- There should be better coordination within programmes before attempts to coordinate across programmes take place.
- There is disagreement over duplication and overlap in CBW models. However, in unpacking the term 'duplication', it should be stressed that duplication of services should only be perceived as a challenge if a household received duplication of the same services. Coordination at the local level can assist with duplication if it exists, rather than opting for rationalisation of services.

4.5.4 Funding and value for money

In this section, the diagnostic evaluation addresses a number of evaluation questions as shown below.

Evaluation question 3: Is there value for money in using CBWs? (Efficiency)

Evaluation question 3.1: Is the provision of services through the CBW cost-effective and does it improve access to services?

Evaluation question 3.2: Is there economic efficiency in government employed CBW compared to those employed by NGOs?

Evaluation question 3.3: Is the way departments are using CBW efficient?

Financial flows and budgets

The TOR requires answers to several questions related to whether the current CBW system and/or CBWs in themselves deliver value for money. To attempt an answer to these questions, one first need to understand the nature of the government financial flows and budgets relates to CBWs. This sub-section therefore provides this background.

There are two main government sources of funding for CBWs, namely provincial budgets and EPWP funding. The two are often seen as separate flows. In reality, however, there is substantial overlap in that a large proportion of the relevant EPWP funds are channelled through provincial budgets in the form of a conditional grant – the Social Sector EPWP Incentive Grant.[24] Adding the EPWP and provincial budget amounts together would thus represent double-counting.

[24] Some EPWP funding is also channelled through national and municipal budgets but these are less likely to be for CBWs.

Some provincial expenditure on CBWs is not funded by the EPWP grant. Identifying which provincial expenditures are and are not funded by EPWP revenue is, however, not always easy. Provincial budgets report EPWP funding as revenue, but often do not link this revenue explicitly to specific expenditures. Further, in theory at least, provinces can use revenue from other sources for EPWP projects. Thus the term EPWP does not necessarily mean that the funding source is the conditional grant.

There also seems to be confusion among government officials as to how and for what EPWP funding can be used. A Gauteng official who was interviewed said that EPWP was a "completely different programme" to the WBOT[25] programme. However, the 2016/17 Annexure F of the EPWP report for the third quarter includes some CHW projects. For example, the Eastern Cape DOH reports CHW projects in Alfred Nzo, Amatole, Buffalo City, Chris Hani, Joe Gqabi, Nelson Mandela Metro, OR Tambo and Sarah Baartman. Other provinces report funding of a relatively large number of (community-based) home-based care projects. Unfortunately, Annexure F is not available on the EPWP website for subsequent periods.

Given these complications, we discuss the two sources (EPWP and provincial expenditures) separately below. We start with the EPWP funds because the CBW funding is generally easier to identify in the EPWP reports than in the provincial budgets.

EPWP

The EPWP website describes "home community-based care" as involving "provision of basic health services needs by formal or informal caregivers employed in EPWP projects to people in their own homes or home-based care that the community can access closer to their homes."[26] Allocations in respect of HCBC are found in both provincial DSD (for mitigation of impact of ill health) and provincial DOH (for the more medical/health aspects). Initially, the DOH workers were often referred to simply as home-based carers (HBC), but terminology has shifted over time.

When social sector EPWP was introduced, the focus within health was explicitly on HBC while the focus within DSD was on ECD. Over time, the scope of social sector EPWP broadened to encompass a larger number of types of workers, making it more difficult to monitor flows for HBC/HCBC in particular.

The EPWP website provides detailed downloadable quarterly reports on all projects reported to them by national, provincial and local government, the CWP, as well as the relatively small number of projects managed by NPOs. In December 2018, the latest report available on the website was for the second quarter of 2018/19, covering April to September 2018 (DPW, 2018).

Table 13 shows the relative size of the different EPWP sectors in terms of number of projects, rand and work opportunities created. The social sector accounts for 37% of the projects, 20% of work opportunities and only 13% of the rand. This pattern is explained by the much smaller average allocation per project – R3.4 million per social sector project as against R18.6 million in the infrastructure sector of the EPWP. Infrastructure also has a much higher average allocation per work opportunity than the social sector – R350 000 against R90 000 – despite infrastructure projects tending to be of shorter duration. The social sector also has the highest percentage of jobs going to women – 83% against an overall average of 71% (and 58% for

[25] The full name is Ward-based Primary Health Care Outreach Teams (WBPHCOTs).

26 "provision of …. needs" seems incorrect, but is a phrase commonly used in South Africa.

infrastructure). These comparisons bear testimony to the cost-effectiveness (understood as "cheapness") and job-creating potential of the EPWP social sector, but also to the possibility of worker exploitation if this involves services government is obliged to provide.

Table 13 EPWP allocations by sector, 2018/19

Sector	Projects	Rand (millions)	Work opportunities
Infrastructure	4 091	76 235	216 250
Environment and Culture	2 509	11 930	127 148
Social	4 194	14 255	156 099
Non-state: NPOs	359	694	600 72
Non-state: CWP	225	9 658	218 748
Total	11378	112 763	778 317

Source: Quarterly Report, Annexure A

For national government, the quarterly report shows a social sector allocation only from the Department of Public Works (DPW). The project is for community safety (and thus not CBWs), the amount is less than R1 million and only 44 job opportunities were provided.

Annexure C1 of the quarterly report, which shows provincial department projects, is more relevant for our purposes. Unfortunately, the table shows the province and department but does not describe the type of work done by workers. Table 14 therefore includes all allocations for provincial departments of health and social development – whether funded through the social sector incentive grant or other funds – as other departments are unlikely to provide for CBWs as defined in this report. However, some of the health and social development projects do not involve CBWs. If all were CBWs, there would be 127 947 EPWP-funded CBWs.

The allocations by these two departments account for 78% of all social sector projects, 77% of funds allocated by provinces to the social sector and 64% of work opportunities in the social sector. The final column shows the daily minimum wage on the projects ranging from R97.91 to R230.77. The minimum wage is higher for health than for social development across all provinces except KwaZulu-Natal.

Table 14 EPWP allocations by provincial health and social development departments by province and department, 2018/19

Sector	Projects	Allocated (R'000)	Work opportunities	Minimum daily wage
EC – Health	8	182 160	4 711	230.77
EC – Social Development	1 146	595 190	3 525	98.28
FS – Health	11	3 740 028	2 291	108.60
FS – Social Development	30	133 915	6 297	98.80
GP – Health	17	432 898	9 873	114.48
GP – Social Development	288	144 602	5 647	88.00
KZN – Health	10	482 712	7 092	97.51
KZN – Social Development	15	1 641 019	11 904	130.38
LP – Health	22	255 954	8 693	132.59

Sector	Projects	Allocated (R'000)	Work opportunities	Minimum daily wage
LP – Social Development	46	58 059	2 129	91.86
MP – Health	219	125 083	4 273	101.29
MP – Social Development	248	87 958	2 151	89.71
NC – Health	11	62 727	1 611	124.54
NC – Social Development	73	78 219	1 660	94.32
NW – Health	312	262 941	5 906	110.24
NW – Social Development	44	16 360	594	94.59
WC – Health	14	188 297	2 745	138.20
WC – Social Development	58	41 538	1 199	114.50
Sub-total Health & DSD	2572	8 529 659	82 301	
Total Social Sector	**3 285**	**11 138 270**	**127 947**	
Health & Social Devt as % total	78%	77%	64%	

Source: Quarterly Report, Annexure C1

Annexure E3 provides the breakdown of provincial support for social sector EPWP by type of programme. Unfortunately, this annexure does not include disaggregation by province or even department, and Annexure F – which lists all provincial projects – is not available on the website for 2018/19. However, Table 15, extracted from Annexure E3, reveals that HCBC – the only programme that is likely to involve CBWs as defined in this report – accounts for 36% of the projects, 43% of the total allocation and 40% of the work opportunities. HCBC also has the second lowest minimum daily wage. This table suggests about 51 000 CBWs funded through EPWP across the nine provinces.

Table 15 EPWP allocations by provincial health and social development departments by EPWP sub-sector, 2018/2019

Programme	Projects	Allocation (R million)	Work opportunities	Minimum daily wage
Community Safety	203	928	5 081	112.62
ECD	1 158	1 095	21 856	97.59
Expansion (NEW) [ECD]	375	2 291	18 546	110.16
Home Community-based Care	***1 187***	***4760***	***51 088***	***101.22***
Mass Participation	17	44	1 025	126.76
National Nutrition	345	2 019	30 351	107.31
Total Social Sector	**3 285**	**11 138**	**127 947**	**102.44**
HCBC as % of total	36%	43%	40%	

Annexure G1 shows 28 108 social sector job opportunities across the municipalities in the country. None of these is likely to involve CBWs.

Estimates of provincial revenue and expenditure

As noted above, where provinces use EPWP grants from national government for funding CBW programmes, the money is channelled to the provincial department and is thus reflected in its budget. It should be clearly reflected on the revenue side. Although it will also be included in the expenditure estimates, the *Estimates of provincial revenue and expenditure* (EPRE) do not always show clearly where and how it is used. This information may, however, be indicated in the narrative. The narrative may also include other information about CBW programmes, including performance against indicators. In addition, the EPRE will include allocations for CBWs made from non-EPWP revenue. However, it is often not clear whether and how much funding goes for CBWs as the allocations are disaggregated only to the sub-programme level. This sub-section explores what can be found in the EPRE documents despite these challenges.

Table 15 below shows the total allocations per province to the four sub-programmes – two in Health and two in Social Development – that are most likely to include allocations for CBWs. The amounts shown are the "baskets" within which CBW allocations may be found. The majority of the funds in the different sub-programmes is likely to be spent on other goods and services. In particular, the HIV/Aids sub-programme within Health includes allocations for South Africa's massive anti-retroviral programme. In the community-based services sub-programme within Health, for at least some of the provinces, the allocation includes funding for chronic medication delivered through a community-based system.

The final column in the table represents funds that are specifically allocated for CBWs, in that they represent transfers to NPOs implementing the Isibindi Programme. Only four of the provincial budgets specify the amounts for these transfers although other provinces probably also have such transfers. A further complication is that at least one province – North West – records the Isibindi transfer under the HIV & Aids sub-programme rather than the community-based sub-programme where National Treasury specifies it should be. The Western Cape almost certainly has some allocations for CBWs within Social Development but does not allocate any funds at all for the two sub-programmes where one would expect to find CBWs.

Table 16 Allocations to relevant sub-programmes in provincial health and social develpoment budgets (R'000)

	Health		Social Development		
Province	HIV/Aids	Community-based services	HIV & AIDS	Community-based services for children	Includes: Isibindi transfers
EC	2 098 633	551 266	133 845	43 946	24 182
FS	1 227 425	406 747	36 351	10 678	
GT	4 465 616	1 984 289	378 012	488 205	
KZ	5 677 225	419 637	234 953	122 688	31 045
LM	1 600 516	253 963	187 604	138 559	
MP	1 903 549	18 526	54 120	37 517	
NC	561 649	0	25 849	17 895	9 099
NW	1 338 145	9 149	76 380	1 574	22 458
WC	222 491	1 613 225	0	0	

	Health		Social Development		
Province	HIV/Aids	Community-based services	HIV & AIDS	Community-based services for children	Includes: Isibindi transfers
Total	**19 095 249**	**5 256 802**	**1 127 114**	**861 062**	

The table reveals that within Health in all provinces except the Western Cape, the amount allocated to HIV/Aids is far larger than the amount allocated to community-based services. Within Social Development, Gauteng is the only province that allocates more to community-based services for children than to HIV and Aids. It is ironic that it is the two most urban and wealthy provinces that appear to prioritise community-based services.

Within Health, the WBOTs specifically require employment of CHWs. The WBOTS system was launched in South Africa in 2012, but the roll-out has been patchy. A recent Medical Research Council study (Daviaud et al, 2017) of the programme in two better-performing districts found that these provinces spent less than 4% of their PHC budgets on WBOTs. The 2018 national government budget documents suggest that there is some recognition of the need to accelerate the roll-out of CHWs within the health system. In particular, a new component – for community outreach service – was specified for the Comprehensive HIV, Aids, TB and community outreach services conditional grant and is intended for funding of CHWs.

The funds in this grant, as for other conditional grants, are ring-fenced, i.e. they may be used by provinces only in respect of HIV, Aids, TB, community outreach services and malaria; with the latter added in 2018 (National Treasury, 2018). In three provinces – Eastern Cape, KwaZulu-Natal and Limpopo – the conditional grant accounts for the full amount of the HIV/Aids sub-programme within Health, i.e. the province does not add any funds from its equitable share revenue. The new component does not involve allocation of additional funds from National Treasury. Instead the amounts specified for the new component indicate how much of the existing allocations are ring-fenced for expenditure on CHWs. Further, provinces will be required to report on the number of CHWs receiving stipends through this component. For the nine provinces combined, the amounts specified for the new component are R1.4 billion for 2018/19 and R1.5 billion for each of 2019/20 and 2020/21 (National Treasury, 2018). The breakdown across the provinces for 2018/19 is shown below.

Table 17 Allocations for Community Outreach Services within the Comprehensive HIV, Aids, TB and community outreach services conditional grant, 2018/29 (R'000)

Province	Allocation
Eastern Cape	93 066
Free State	46 119
Gauteng	216 998
KwaZulu-Natal	262 426
Limpopo	292 075
Mpumalanga	153 858
Northern Cape	70 960
North West	167 729

Province	Allocation
Western Cape	96 769

Source: Division of Revenue Act, 2018

Within provincial DSD budgets, allocations for CBWs are most likely to be found in the HIV, Aids and community-based care sub-programmes. The first of these falls in the Social Welfare programme, and the second in the Children and Families programme. The second sub-programme was established in 2015/16 and was intended as funding for drop-in centres and Isibindi. As noted elsewhere, Isibindi by definition provides services primarily through CBWs. While the Isibindi roll-out was in progress (April 2013 to March 2018) transfers to NPO implementing partners should have accounted for a large proportion of the allocations. However, the allocations often also included allocations to NACCW for mentoring and training of CBWs, alongside allocations of varying size to drop-in centres.

Across the provinces, the following information is provided in the DSD narratives in respect of HIV and Aids. In many, if not all, cases the narrative seems to span both the sub-programmes identified above.

- The Eastern Cape reported utilisation of the EPWP conditional grant to reach 44 678 beneficiaries through social and behaviour change programmes ("You Only Live Once" or YOLO) in 2017/18. For 2018/19, it reports that it will continue to fund HCBC projects, implying that this was also done in 2017/18. The indicators section envisages creation of 680 EPWP work opportunities in HCBC in each of the three years of the medium-term expenditure framework (MTEF).
- Gauteng reported creation of 6 927 work opportunities in HCBC by the end of the third quarter of 2017/18 against a target of 8 393. These opportunities will be created using EPWP funding. Gauteng also refers to Isibindi under this sub-programme (although it should be reported under the Community-based Care sub-programme). It may be that the 6 927 work opportunities referred to are at least partly within Isibindi.
- KwaZulu-Natal reported funding of 230 HCBC organisations in respect of social behaviour change and psychosocial support. It refers to phasing in the HCBC Re-Engineering Model, which focuses on prevention and awareness to avoid new infections, especially among teenagers. This may qualify as CBW work although it may not involve many home visits. KwaZulu-Natal also reports establishment of six community care centres, with support from national DSD and the German Development Bank. These centres will be used to implement HCBC and social behaviour change programmes. The province reported use of the Social Sector EPWP Incentive Grant ("which varies over the years") to pay stipends to CCGs who were previously employed by NPOs. For 2018/19, R13 490 million is allocated for this purpose.
- Limpopo reported provision of psychosocial support to 19 824 people, especially children, affected by HIV and Aids. Again, this may be a reference to Isibindi. Limpopo's HIV and Aids allocation includes R2.5 million to procure school uniforms for poor and vulnerable children and R8.7 million for food parcels for vulnerable families, thus reducing the share of the budget available for CBWs.
- Mpumalanga reported funding 87 organisations to provide HIV "prevention, care and support" services. For 2018/19, the province envisages reaching 7 426 people with

psychosocial support services and 12 252 through social and behaviour change programmes.

- The Northern Cape envisages providing psychosocial support services to 2 490 children through HCBC organisations. Like Mpumalanga, it does not specify how many CBWs will provide the services.
- The North West reported use of the EPWP Incentive grant to fund 534 work opportunities in HCBC, prevention and drop-in centre programmes in 2017/18. It further refers to creation of "additional job opportunities for unemployed youth" across 12 Isibindi sites through the partnership with the NACCW. It notes transfer payments to HCBC and drop-in centres.

The Free State and Western Cape allocate funding to the sub-programme/s but have no narrative.

Within Health, the most relevant sub-programmes are HIV and Aids and community-based services, both of which are within the District Health programme. The second of these sub-programmes is described as "rendering a community-based health services at non-health facilities in respect of home-based care, abuse victims, mental and chronic care, school health, etc".

Five provinces add relevant narrative, as follows:

- The Free State recorded an allocation of R5.25 million for supply and delivery of home-based care kits for government employed CHWs. It reported that R12.05 million of an EPWP grant would be used for transfers (to NPOs) under the community-based services programmes but did not specify what services and/or workers would be funded. It further reported plans to train CHWs under the Health Science and Training budget programme.
- Gauteng reported that the number of WBOTs "that provide preventive care and collect information" would increase from 719 to 780 by 2020/21. It noted that CHWs are directly employed, rather than through transfers to NPOs.[27] It also noted training of CHWs (and nurses) under the Health Sciences and Training programme.
- KwaZulu-Natal reported that R262.4 million of its Comprehensive HIV, Aids and TB Grant is ring-fenced for the new community outreach services component in 2018/19, with a further R281.2 million in each of the two subsequent years. However, the province reported that the amount received as its EPWP incentive grant is – at R24.2 million – "significantly" less than the R47.1 million received in 2017/18. The decrease is, in part, attributed to poor reporting and illustrates the danger of volatile funding flows associated with use of EPWP. The province noted that community caregivers (CCGs) are now, as in Gauteng, on the government payroll rather than paid through NPOs.
- The Northern Cape recorded transfers of R84.6 million under the HIV/Aids Home-Based Care Project.
- The North West reported appointment of 6 877 CHWs, of whom 2 406 work in WBOTs. It noted that the roll-out of WBOTS had stalled in 2017/18 due to the

[27] However, as seen below, a contractor manages the payments.

difficulty in recruiting professional nurses to serve on the teams. Training of WBOTs was also halted due to “budgetary constraints” but was due to resume.

Is there value for money in using CBW?

The three evaluation questions can be seen as speaking to the standard three Es of budget making, namely economy, efficiency and effectiveness. They can also be interpreted as speaking to the fourth E introduced by economists concerned with social justice, namely equity.

- Economy assesses the translation of finances into inputs, and – in crude terms – asks whether inputs are acquired cheaply. In our case, the main inputs are CBWs.
- Efficiency assesses the translation of inputs into outputs. In our case, a key output is beneficiaries served.
- Effectiveness assesses the extent to which outputs contribute to the desired outcomes or impact. In our case, the most important outcome is improved health and well-being (social protection).
- Equity is a consideration across all of the other three Es. The evaluation questions are implicitly asking about equity when asking about improved access to services.

The flaws in the available information on budgets and expenditures seriously limits the extent to which we can assess any of the three Es. There are also serious deficiencies in data related to inputs (e.g. how many CBWs employed), cost of inputs (e.g. remuneration), outputs (see discussion of target and performance data below) and outcomes. The evaluation exercise did, however, provide some indications that are discussed further below.

Ideally, an assessment of the value for money of CBWs should go beyond assessing the value of the direct services provided to considering the costs and damage that these services prevent. This added value arises because CBWs’ work is focused at the primary and/or preventive level rather than at the more expensive secondary and tertiary level that is required when health and social problems are not attended to early. So, for example, the costs involved in having a CHW ensure that children are vaccinated avoid the larger financial and other costs that would occur if the diseases concerned were not controlled. Similarly, the costs involved in having a CYCW identify instances of potential abuse in the family before they become serious avoids the costs and trauma that could well result if these were not identified and addressed immediately and instead resulted in the need for institutionalisation of the child, imprisonment of the perpetrator, medical and psychological treatment for those affected, and/or a host of other developments requiring intensive and expense interventions. The paragraphs below do not assess the value of these avoided costs and trauma, but they remain one of the most compelling reasons for investing in CBWs.

Evaluation question 3.1: Is the provision of services through CBW cost-effective and does it improve access to services?

Use of EPWP for funding of CBWs reduces costs, including in the way described above of avoiding the need for more expensive interventions. However, the cost-effectiveness of EPWP funding is reduced by the volatility from year to year, and the low pay and delays in payment caused by delays in departments signing contracts and paying transfers to NPOs, and resultant delays in payment of CBWs, can lead to attrition and demotivation.

Access to services is improved because CBWs take services to beneficiaries rather than vice-versa, and – because of the nature of the service – one CBW typically reaches more beneficiaries than other workers.

A recent investment case prepared by the Medical Research Council for CHWs (Davidaud et al, 2018) explores the costs and benefits for the health system, the economy and society of the CHWs operating within WBOTs. It does this by comparing the impact of the current system without WBOTs with the current system with CHWs added. In so doing, it partially answers the three questions posed in the evaluation but also goes beyond them.

The investment case was prepared to support government officials motivating for budgetary allocations for CHWs – motivation that resulted in the conditional grant component for CHWs. The study draws on international studies documenting the "impressive impacts" of use of CHWs in mother and child programmes, HIV and Aids and TB programmes as well as chronic diseases and palliative care. The impact relates to better prevention, improved case-finding, improved adherence and control or cure rates, and more effective palliative care. It does so by estimating the number of deaths and disability-adjusted life-years (DALYs) averted and the cost of an additional DALY averted over a 10-year period and assessing whether CHWs are cost-effective or even cost-saving. It also looks at the benefits for the economy and society in terms of increased employment and productivity. While the findings are very positive, the report emphasises that the programme must be properly resourced if it is to achieve the hoped-for benefits.

The study assumes that CHWs were paid the equivalent of R2 500 per month in 2017. This and all prices are expressed in 2017 rands. The cost per DALY averted is assessed against the 2017 gross domestic product (GDP) per capita of R78 254 per annum in 2017. While, as noted above, as from 1 April 2019, CHWs should be paid R3 500 per month, the results would almost certainly remain positive even with this increase.

Over the 10-year period:

- Mother and child health interventions were found to translate into 34 800 additional lives saved and more than 1 million DALYs averted. If CHWs spend 19% of their time on Mother and Child Health (MCH), the cost per DALY averted is R15 228.
- For HIV and Aids, the cumulative number of deaths averted was 96 923, while DALYs averted number a million. There is a saving, rather than cost, per DALY averted of R22 150.
- For tuberculosis, an estimated 60 642 additional deaths were averted and more than 1 million DALYs. There is again a saving, rather than cost, per DALY averted – in this case, R2 518 per DALY.
- For hypertension, 6 588 deaths and 14 266 DALYs were averted at a cost per DALY of R88 809. While this is higher than GDP per capita, it is less than three times the GDP per capita that the World Health Organisation uses as the cut-off for assessing cost-effectiveness.
- For diabetes, 1 195 112 DALYs were averted, with the cost per DALY averted at R5 461.
- CHW interventions in respect of palliative care would save R30 billion when compared with management in hospitals.

Evaluation question 3.2: Is there economic efficiency in government employed CBW compared to those employed by NGOs?

Interviewees generally focused on this aspect when asked about value for money. The interviewees noted, in particular, that delivery of services through NPOs was much cheaper than delivery through government officials. This reflects lower compensation and limited if any benefits for management and support staff as well as CBWs within NPOs when compared to government officials.

Unfortunately, it is not possible to present reliable quantitative information on this aspect due to the unavailability of exact budget allocations for CBWs (discussed above), the remuneration differences across and within provinces (which means that, even with budget allocations, one cannot calculate the number of workers employed), and the paucity of performance information. This budget and output (performance) information is needed to assess economic efficiency.

All provinces are required to report against a minimum set of non-financial (performance) indicators in respect of each budget sub-programme. Within the DSD, two indicators are available for Community-based care for children: (a) number of children accessing drop-in centres, and (b) number of children accessing services through the Isibindi Model. For HIV and Aids, there is one indicator – the number of beneficiaries receiving psychosocial services. Unfortunately, the latest available report on the DPME website is for the fourth quarter of 2015/16, i.e. the end of the third year of the five-year national roll-out of Isibindi.

Table 18 below shows the targets for 2015/16 and actual delivery reported against these three indicators for the fourth quarter. The table reveals a very mixed picture. For some provinces, there is no information at all, either for both or one of the indicators. In most cases, the targets and delivery for drop-in centres are lower than for Isibindi; this is not the case for Limpopo. The size of the targets is puzzling. For example, Limpopo's targets and delivery are far higher than for the Eastern Cape despite the latter having a larger population and similar levels of poverty. The North West has delivery for Isibindi that is 220 times the target. Some provinces have the same target for the year as a whole as for each quarter, implying ongoing services to the same individuals. Others, in contrast, have a target for the year that is about four times the quarterly target. This suggests either double-counting or that different beneficiaries are serviced in each quarter. The approach adopted by a particular province sometimes differs across provinces. These puzzling features suggest that there are serious problems either in the planning and implementation processes, or on the data side. The numbers are not useful for examining value for money although they do show that there is often a large difference between the target and actual delivery, with instances of both over- and under-performance (or under- and over-ambition in target-setting).

Table 18 Targets and delivery in terms of children reached through community-based DSD services, 2015/6

	Drop-in centres		Isibindi		HIV & Aids	
	Target	Actual	Target	Actual	Target	Actual
EC	453	570	7 323	6 093	26 553	14 019
FS	5871	2 743	1 860	2 720	7 530	5 755
GT			8 829	13 495	50 521	63 867
KZN	8 633	13 208	30 347	33 884	39 558	10 096

LM	41 700	44 414		11 434	10 900	4 058
MP	8 444	9 700	12 150		8 500	
NC						
NW	94	76 000	133	29 279	100 135	25 447
WC						

Source: Department of Social Development, Provincial fourth quarter performance report, 2015/16

Evaluation question 3.3: Is the way departments are using CBWs efficient?

On the health side, none of the performance indicators reported to DPME give beneficiary numbers that can be readily linked to CBWs. Again, this frustrates attempts at assessing economic efficiency.

KPMG's evaluation of Isibindi's implementation (KPMG, 2016) was conducted during the fourth year of the five-year roll-out. The evaluation is not explicitly an investment case or value for money study. The sections on funding and financial arrangements do, nevertheless, highlight important lessons for government in respect of CBW programmes if the programmes are to achieve their full potential. KPMG's report can thus be seen as partially responding to this evaluation question. For example, the report notes the importance of avoiding fluctuations in and uncertainty about funding, as well as the need to ensure timely payments to NPOs that employ CBWs so as to allow them to make timely payment of remuneration.

The report notes that the funding allocated to implement Isibindi was noticeably less than the cost estimates drawn up prior to the roll-out. The shortfall in government funding, in particular, increased from 61% in year 1 to 78% in year 3. Further, the relevant DSD officials did not seem to understand the funding modality (which included additions to the provincial equitable share) and amounts. One result of under-funding was the CYCWs continued to receive a stipend after they had completed the Further Education and Training Certificate, despite prior agreement that they would then qualify for a proper salary.

KPMG found that three provinces had utilised EPWP funding for Isibindi while a further three had plans to do so. However, it cautioned against this practice for cost items such as stipends and multi-year training given that EPWP is allocated on an annual basis and might therefore not be available in succeeding years.

The KPMG report thus suggests that the various ways in which government generally (under) funds these programmes undermines efficiency and effectiveness.

In sum, due to data inadequacy it is not possible to directly answer questions about value for money and effectiveness and efficiency based on administrative data. However, research suggests that there can be impressive health and welfare impacts from the use of CBWs, yet this is undermined by under-funding and poor implementation and administration of programmes.

Key point summary

- The flaws in the available information on budgets and expenditures seriously limits the extent to which the effectiveness and efficiency of CBWs can be assessed.
- The services provided by CBWs play a critical preventive role in avoiding further poverty or trauma. Hence, an assessment of value for money of CBWs should go

beyond assessing the value of the direct services provided by them to considering the costs and damage these services prevent.

- Access to services is improved because CBWs take services to beneficiaries rather than vice-versa, and – because of the nature of the service – one CBW typically reaches more beneficiaries than other workers.
- The investment case for CHWs that resulted in the conditional grant component for CHWs documented "impressive impacts" of use of CHWs in mother and child programmes, HIV and Aids and TB programmes as well as chronic diseases and palliative care.
- There are two main government sources of funding for CBWs, namely provincial budgets and EPWP funding. The two are often seen as separate flows but there is substantial overlap in that a large proportion of the relevant EPWP funds are channelled through provincial budgets in the form of a conditional grant – the Social Sector EPWP Incentive Grant.[28] Adding the EPWP and provincial budget amounts together would thus represent double-counting.
- The analysis of the funding to social services in the EPWP, and the allocation of funding for CBWs shows that the jobs are not well funded and lower paid (and the majority are being done by women), relative to other sectors (e.g. infrastructure). The comparisons bear testimony to the cost-effectiveness (understood as "cheapness") and job-creating potential of EPWP social sector, but also to the possibility of worker and gender exploitation if this involves services that government is obliged to provide.
- In terms of EPWP spending, allocations by the Departments of Health and Social Development account for 78% of all social sector projects, 77% of funds allocated by provinces to the social sector, and 64% of work opportunities in the social sector. The daily minimum wage on the projects ranges from R97.91 to R230.77. The minimum wage is higher for health than for social development across all provinces except KwaZulu-Natal. (EPWP Quarterly Report 2018/2019, Annexure C1)
- The EPWP provincial reports suggest that HCBCs (the only type of worker likely to be defined at a CBW in terms of this report), accounts for 36% of the projects, 43% of the total allocation, and 40% of the work opportunities. HCBC also has the second lowest minimum daily wage. This table suggests a total of about 51 000 CBWs funded through EPWP across the nine provinces.
- In terms of provincial revenue and expenditure, the allocations for CBWs are opaque and allocations are inconsistent across provinces, and not always in line with Treasury requirements, making it difficult to estimate expenditure on CBWs from provincial budgets.
- The analysis of the funding to social services in the EPWP and the allocation of funding for CBWs shows that the jobs are not well funded and they are lower paid, relative to other sectors (e.g. infrastructure), or that some provinces do not allocate any money to CBWs beyond their conditional grants.
- Within provincial DSD budgets, allocations for CBWs are most likely to be found in the HIV and Aids and community-based care sub-programmes. The first of these falls

[28] Some EPWP funding is also channelled through national and municipal budgets but these are less likely to be for CBWs.

in the Social Welfare programme, and the second in the Children and Families programme.

- Within Health, the WBOTs specifically require employment of CHWs. The WBOTS system was launched in South Africa in 2012, but the roll-out has been patchy. A recent Medical Research Council study (Daviaud et al, 2017) of the programme in two better-performing districts found that these provinces spent less than 4% of their PHC budgets on WBOTs. The recent 2019 budget speech allocated R1bn for CHWs.
- Use of EPWP for funding of CBWs reduces costs but the cost-effectiveness of EPWP funding is reduced by the poor administration of stipends and the low pay, both of which cause demotivation and dissatisfaction.
- The poor administration of the NPO transfers for government supported programmes also contributes to this, as does inequality in pay within and among programmes and provinces. Interviewees generally focused on this aspect when asked about value for money.
- Respondents noted that the delivery of services through NPOs was cheaper than delivery through government officials, mainly reflecting lower compensation for wages for CBWs, supervisors and managers when compared to government officials.

4.5.5 Work force

This section looks at the workforce related elements of the CBW system in order to address the evaluation questions in the box below.

- *Evaluation question 1: What is the scale, scope and distribution of government supported CBW?*
- *Evaluation question 1.5: What, if any, institutional mechanisms are in place to support community-based workers (professional regulatory requirements, continuous development training, supervision, funding) and are these mechanisms working well?*
- *Evaluation question 1.8: How well integrated are the CBWs within their respective professional practice?*

Scale of CBW

The evidence presented below confirms that it is extremely difficult to obtain a broad overview of the scale of the CBW workforce because of the limited data available.

One might assume that the approximate number of CBWs funded by government could be calculated from the budget allocations. Unfortunately, for several reasons, this is not possible: (a) we do not know what proportion of the sub-programme budgets listed above are for CBW programmes; (b) the funding allocated for CBW programmes often includes other elements such as management and administrative overheads, training costs, amongst others; (c) payment per CBW differs across programmes and provinces; and (d) the amounts for CBW stipends may be recorded in different economic categories (NPO funding; goods and services; or compensation of employees). The situation is further complicated by the hours being worked by CBWs on different programmes differing, as well as the number of months per year for which the programme operates. All these factors add to the difficulty of estimating the number of government-funded CBWs.

National Treasury reported that it estimated there were between 60 000 and 70 000 CHWs in the country but said that the DOH's estimate was around 45 000 (this could be due to different reporting dates, so we can assume the number ranges between 45 000 and 70 000).

In terms of CYCWs, in December 2015, the one national and nine provincial DSDs employed 3 818 CYCWs (DSD, 2016). The 3 818 CYCWs accounted for 11% of the total DSD workforce. This number included those with job title "Isibindi worker" within KwaZulu-Natal's EPWP employees. This is not, however, a reliable measure of the number of CYCWs funded by government and who fit our definition of CBWs. Firstly, many of the 3 818 probably worked in institutions such as child and youth care centres rather than in the "community". Secondly, the number includes 1 777 Isibindi workers in KwaZulu-Natal as the province had these workers on the PERSAL system at that point despite their working in NPOs. It does not, however, include Isibindi workers subsidised by government in other provinces as they were not on the PERSAL system.

Distribution of CBW

The desktop and literature review found no available data on provincial distribution of CHWs and CCGs. However, according to a recent article from the Health Systems Review (Schneider et al, 2018) which reviews the implementation of community-based outreach teams, National Health Insurance (NHI) pilot districts have received support with the roll-out WBPHCOTs, but "… *implementation has been highly uneven across the country. By March 2017, there were 3 275 WBPHCOTs submitting information through the national DHIS, 42% of the estimated total of 7 800 teams required. Anecdotal evidence suggests that many teams are incompletely staffed*." (p. 61).

Further, the Isibindi Programme's data provides insight into the distribution of CYCWs across the provinces.

Table 19 shows the number of CYCWs reported to have been trained or in training by the end of the third year of the national Isibindi roll-out in March 2016. The heading to the table in the source report is "Creation of decent jobs and career paths for 10 000 community child and youth care workers mainly in rural areas", highlighting the explicit attempt to reach rural – and underserved – areas. The fact that the CYCWs are employed in groups of about 20–25 by several hundred different community-based organisation facilitates greater reach than would be possible if the CYCWs were concentrated in fewer locations.

The provincial target distribution for the Isibindi roll-out was based in large part on the distribution of maternal orphans suggested by analysis of birth (of children) and death (of mothers) data from the Department of Home Affairs. The fact that the actual distribution does not match the target distribution raises concerns in respect of Eastern Cape, in particular, as this very poor province has only 2% of the trainees against its target of 14%.

Table 19 5-year targets and 3-year achievement in respect of training of child and youth care workers through Isibindi roll-out, March 2016

	Target	% of total	Achieved	% of total
Eastern Cape	1425	14%	152	2%
Free State	650	6%	429	6%
Gauteng	1925	19%	1011	15%
KwaZulu-Natal	2825	28%	2368	34%

	Target	% of total	Achieved	% of total
Limpopo	825	8%	738	11%
Mpumalanga	925	9%	703	10%
Northern Cape	125	1%	218	3%
North West	800[29]	8%	943	14%
Western Cape	525	5%	336	5%
Total	**10025**	**100%**	**6922**	**100%**

Source: Department of Social Development. June 2017. Status Report on the National Roll-out of Community-based Child and Youth Care Services through the Isibindi Model. Pretoria.

At the start of the roll-out, there were already more than 60 Isibindi sites. These sites employed CYCWs who were already qualified and continued to be employed. In that sense, the 6 922 shown in the table is an under-count of the number of CYCWs employed on the Isibindi Programme.

In the interviews for this report, national DSD reported approximately 7 000 CYCWs employed at Isibindi sites around the country. The fact that this number is very similar to the number of CYCWs receiving training by the end of the third year of the roll-out is probably an indication of the extent to which some provinces have cut back on support for the programme in the last year or two.

Similar information in respect of the distribution of other CBW cadres was not found during this evaluation. However, the conditional grant for provincial health departments since 2018/19 including a component explicitly intended for stipends for CHWs indicates CHWs in all provinces. Given that the WBOT system provides for CHWs to be linked to district teams, one can assume that the CHWs are distributed around the provinces rather than confined to a few highly urbanised areas.

What is missing is an analysis of the distribution of CBWs according to need – this is much needed study that should be conducted by DSD to assist with welfare planning and resource allocation. The provincial profiles that should be completed for the Children's Act could be a good starting point for this at least for the Children's sector.

Scope of CBW

The scope of CBW refers to their scope of work including CBW roles, responsibilities and job descriptions. This is dealt with in Tables 4–7 in section 4.2. In summary, CBWs provide or facilitate access to a wide range of services targeted at the different levels of the system including individual, household and community level. A further observation is that there is limited duplication in terms of job descriptions and duties that would warrant radical rationalisation of groups of CBWs, at any level.

Recruitment and selection

Evidence from the literature review indicates that standardised recruitment and selection of workers is central to the success of CBW programmes. More specifically, Caldes et al (2004)

[29] The source has North West target at 1200, but this is out of line with the target distribution shown in the table, and also results in a total substantially above the overall target of 10 000.

suggest that the recruitment and selection of CBWs must include the following two elements: 1) a clear set of criteria and 2) a fair and transparent process to minimise patronage and abuse. In this regard, this section discusses the strengths and challenges of recruitment, selection and retention of CBWs in community-based programmes.

Findings from the literature review indicate that different government departments and NPOs have different methods of recruitment and selection. The various methods employed include community-driven processes of recruitment, recruitment based on set criteria (e.g. education), and voluntary participation. For instance, the WBPHCOT Policy Framework and Strategy (2017) states that CHWs should be selected by a committee that includes health facility committee representatives, outreach team leaders, operation managers and representatives from NPOs where necessary (Schneider et al, 2018). The policy also specifies matric is the minimum educational requirement for CHWs in WBPHCOTs.

However, it is important to note that although some programmes list matric as the minimum requirement, this criterion is not standardised across all CBW programmes. For example, some of the community worker qualifications fall within NQF Levels 1 to 3, which are lower than the matric equivalent NQF Level 4[30]. For example, some of the DOH registered CHW qualifications include; a) CCW set at NQF Level 1 and b) Community Health/Development Support Worker at NQF Level 3. More details on these qualifications is provided in the section on career development below.

Primary data confirms there is no standardised qualification requirement for CBWs providing different services for government and NPOs. For some programmes, criteria for selection are based on nomination by community members, experience working with similar programmes, and demonstrated passion for community-based work.

The primary data collection reveals recruitment by government departments and NPOs may be done via advertisements on various platforms. The majority of respondents indicated that CBW positions are often advertised in newspapers and suitable candidates are shortlisted for interviews. For example, one respondent notes *that "the procedures of recruitment and selection are fair, community is involved, and interviews are held to select CBWs."* (SSI_DSD_Prov)

However, some interview respondents argued that the challenge with advertising CBW jobs is that few people respond to the advertisements and this affects the extent to which they have a pool of eligible candidates to select from. Low remuneration of CBWs was cited as the main cause for the low response rates. As one respondent states, "*when we advertise CBW positions for the programme people in the community don't respond because they know that the stipend is low."* (SSI_NPO)

Furthermore, primary data shows that using educational criteria as a minimum recruitment requirement also contributes to fewer people applying for CBW positions, and unfortunately those who do qualify are less likely to be interested given the low stipends. The following quote supports this argument:

> *"Since the minimum education level for CBWs to be employed is grade 12 and most youth in the community don't finish school, most become excluded from becoming CBWs." (SSI_NPO)*

30 It is not clear if these qualifications have been implemented.

The need for community involvement in the selection and recruitment of CBWs is widely expressed in this evaluation's literature and findings. This is justified on the basis that community members have good knowledge of who would be most suitable for the CBW position and should have the right to select the people who will serve them (Ludwick et al, 2013). Many advantages come with the active involvement of community members in recruitment processes and these include increased appreciation and support of CBWs by community members, enhanced understanding of CBW's roles and responsibilities, and reduced inappropriate demands and frustrations (Bhattacharyya et al, 2001). Indeed, the evaluation findings confirm that community involvement increases the likelihood of community support for the programme.

However, it should be noted that although community involvement in recruitment processes is preferred, it also comes with its own challenges. First, it has been argued by some respondents that it can lead to conflict over allocation of tasks among the community and nepotism by those who have the decision-making power. Second, relying on the community to nominate CBW candidates without stipulated selection criterion also results in the recruitment of people who lack the aptitude to deliver and report on the services provided. Third, there is the underlying vexed question of who can be seen as truly representing the community given that every community is made up of diverse people with diverse needs and interests. The following quotation substantiates this argument.

> *"Recruitment has to do with the need out there – there is so much unemployment – people put forward a name of people for training, but not taking into consideration their ability to implement the training. So we designed a slip where participants had to answer why you are here – and we got some very odd responses which indicated that there was no proper selection process prior to people attending the training. In small towns it is mostly somebody who is unemployed and we can use the two extra hands, and there is someone they know in the organisation and they have been volunteering already but there is no proper selection process." (SSI_Professional)*

The primary data also suggests that recruiting replacement CBWs who leave the programmes is slow and in the worst-case scenario, replacements are never found. This increases the workload on the remaining CBWs and affects programme performance. This is substantiated in the following quote:

> *"Sometimes DOH take a long to replace someone; it can go up to even 8 months. Currently we are short of four staff members and we have been waiting for new staff from DOH since April 2018 and they cannot recruit and we are failing to meet their monthly targets." (SSI_NPO)*

Conditions of employment

The evidence from a review of government documents reveals that, despite different departments having independently developed programmes, there are some clear directives in place regarding employment arrangements and working conditions for CBWs on state-funded programmes. The most notable of these include:

- The Ministerial Determination for Expanded Public Works Programmes issued in terms of the Basic Conditions of Employment Act, 1997 which contains the standard terms and conditions for workers employed in elementary (semi- and unskilled) occupations on an EPWP. The CWP is part of the EPWP and thus is covered by this

determination. The minimum wage in the determination is increased on an annual basis.

- The Norms and Standards for the Community Work Programme, 2016.
- Norms and Standards for Social Service Professionals as contained in the Policy for Social Service Practitioners, revised December 2016, DSD which are relevant for CCGs.
- The National Minimum Wage Act, 2018, which stipulates that the national minimum wage is R20 for each hour worked for workers other than those in agriculture, domestic work and the EPWP. Workers employed on an EPWP are entitled to a minimum wage of R11 per hour. The minimum for EPWP is in line with the minimum wage specified in the Ministerial Determination cited above.
- The draft CCW Management policy framework (2009) which sets out the employment conditions for CCWs employed within state-funded HCBC organisations. It states that "The minimum requirements of this policy framework are based on the Basic Conditions of Employment Act. Several minimum requirements in the policy framework will exceed the requirements of the Act." (DOH & DSD, 2010, p. 49)

This policy framework has not been adopted, but we have evidence that the DSD was still engaging with it in 2017.

Numerous policies and legislation provide the foundation for the rights of citizens and employment statutes in South Africa. CBWs, even the volunteers as long as they received some compensation, are governed by the labour regulatory framework including the Basic Conditions of Employment Act (BCEA, 75 of 1997) and various Ministerial Determinations governing working conditions and wage levels.

The definition of Employee in the BCEA covers volunteers who receive remuneration as follows:

'employee' means – any person, excluding an independent contractor, who works for another person or for the State and who receives, or is entitled to receive, any remuneration; and

any other person who in any manner assists in carrying on or conducting the business of an emloyer, (and 'employed' and 'employment' have a corresponding meaning). (Worklaw, website)

This excludes unpaid volunteers, but by definition, includes paid volunteers. There are a number of areas in the BCEA that do not apply to people who work for less than 24 hours a month for an employer. The literature suggests that most CBWs work for more than this, and hence, would be considered employees.

It thus appears that many of the CBW workforce challenges would be addressed if they were recognised as the employees they are, and treated accordingly.

Norms and standards

Besides the abovementioned policy directives, no overarching norms and standards are in place to guide employment of CBWs.

When asked whether these should be developed across all government departments and NPOs, the overwhelming majority of respondents responded positively. The main argument provided here is that, *without* standardisation of a number of aspects of the CBW system, the

problem of inequitable employment conditions (different contracting arrangements, job scale, remuneration etc) will persist. Evidence of these problems is presented below.

On the other hand, key experts were very cautious about developing one common set of norms and standards for a diverse set of cadres. They warned against making top down policy statements that are unlikely to be supported by practice on the ground.

One expert has rejected the notion of viewing the CBWs as part of one system and argues that they are in fact part of various systems – for example, the child protection system or the PHC system, and that it is only appropriate to have norms and standards at sector level.

Employment arrangements

A key finding of the literature review was that **CBW employment arrangements are not standardised across departments or sectors**. This is because sector departments and NPOs implement different models each with different employment arrangements and conditions for their respective CBWs. On the one hand, this is pragmatic as the needs of the beneficiary may differ from sector to sector – for example a CYCW may have to work in the evenings when children are out of school and not in the mornings. On the other hand, it has been criticised for creating inequality and uncertainty amongst CBWs. This assumes that there is a single system as there are few who would argue that, for example, nurses and social workers should fall under a single set of norms and standards.

What is more concerning than lack of standardisation across departments or sectors is where there is lack of standardisation within a specific programme or cadre. Where this happens, workers performing similar tasks and delivering what should be the same services are treated differently. This more clearly reflects a situation of unjustified inequality.

Many CBWs are employed by NPOs or CBOs and presumably the conditions of employment stipulated in the work contract differ across these organisations. It was also noted that the poor Human Resource (HR) capacity of some NPOs results in poor management of basic conditions of employment as one respondent explains:

> *"If a funder is funding a community-based organisation to run a programme then the funder does not get involved in minimum wage, contract etc. The organisation needs to take over this activity, but the CBO project managers do not have the capacity to do this, so the minimum wage or basic conditions of employment are very poorly managed. So it makes it difficult to keep CHWs." (SSI_Professional Organisation)*

CBW respondents confirmed that the basic conditions of employment are not being applied uniformly across the system and reported instances of no overtime pay or recognition of weekend work[31], no access to the Unemployment Insurance Fund (UIF), no workers compensation or any other benefits. This is despite those CBW programmes funded by EPWP and CWP being protected by the conditions of employment as contained in the Ministerial Determination and CWP norms and standards. This highlights how challenging it is on the ground to get basic compliance with accepted and relatively long-standing legislation.

In another example, the model of CHWs employed by the NPOs that are working in close cooperation with public health structures creates the potential for misunderstanding and

[31] EPWP determination does not provide explicitly for overtime pay and requires that every worker has two days off each week.

tension because CHWs are unsure to whom they are responsible – the employing NPO, public health service staff or local community members (Clarke, Dicks & Lewin, 2008).

The literature notes that these different employment arrangements have the potential for conflict and there is evidence of this from the primary data collection. For example, CBWs highlighted the *"different expectations from the DOH and NPOs"* as a challenge they are facing. In some provinces (KZN and GP) CHWs went on strike resulting in their being directly employed by the DOH rather than NPOs. This is positive in that it has led to more formalised employment arrangements and improved compensation. However, it has been argued by one expert that government-employed CHWs could become distanced from the communities as they are no longer rooted in communities and tend to become more facility oriented. However, this depends largely on the CHW supervisor and their orientation to the WBOT which focuses primarily on outreach work in the community.

Finally, the temporary nature of much CBW employment was frequently mentioned by respondents as a challenge for CBWs employed by both NPOs and government – either because of EPWP, which is short-term employment, or that they are hired on a contract basis.

> *"The CBW sector is not secure, the contract is for a year and the stipend is paid for nine months." (SSI_NPO)*

This finding is supported by the literature review which highlights the precarious nature of being employed as a CBW. For example, van der Westhuizen (2007) found that the short-term nature of the EPWP work opportunities cancelled out any potential benefits for the poor.

Poor working conditions

The primary data collection gave some insight into CBWs' working conditions.

The CBW focus group respondents asserted that they acquire a number of benefits through their work including stipends and in-kind benefits, access to training, access to free health care and special status in the community. However, the overwhelming theme that emerged was that CBWs face extremely tough working conditions. Those most frequently mentioned included walking far distances on foot in extreme weather conditions; issues of personal safety due to high levels of crime and violence (women are at particular risk here); risk of contracting communicable diseases such as HIV or TB; long working hours and weekend work[32]; lack of support from community members and community leaders; and the emotionally draining nature of the work which leads to burnout.

A further factor is that they are generally from the community they serve and often deal with the same barriers as their clients which impacts on their ability to provide or meet the community's needs (Nxumalo et al, 2016).

Gender

There is also a gender dimension to the challenge of poor conditions of work and remuneration. Generally, women are more likely than men to be unemployed or in informal jobs, while performing the bulk of unpaid care work in households (Stats SA 2013). The higher female unemployment rate, together with the gender targets for some programmes such as the EPWP, and the fact that many of the jobs are in the broad care sector that is stereotypically

[32] This is despite the EPWP Ministerial Determination placing a restriction of 40 hours per week except for security guards

seen as women's work, results in a predominance of women among CBWs. The result is implicit gender discrimination if the work concerned is not decent work and adequately remunerated. (Parenzee & Budlender, 2016)

Furthermore, poor working conditions are compounded by the inadequate resources, a factor frequently mentioned during the primary data collection. As one respondent stated:

> *"Methods are good on paper and difficult to implement due to unavailability of resources." (FGD_CBWs)*

Many programmes are also under-resourced in terms of transport, equipment and communication technologies, which affects the quality of the service and the number of beneficiaries that CBWs can reach (both poor quality and low reach negatively affect value for money) (Kardan et al, 2017; Bhutta et al, 2010; Moetlo et al, 2011).)

In a study in the Eastern Cape, when CHW respondents were asked if they had all the necessary equipment to fulfil their duties, 99% responded "no" (Austin-Evelyn, 2017). The challenges are further affected by poor community infrastructure and location as rural and isolated communities provide extra resource challenges for the CHW (Haines, 2007; Naimoli et al, 2015). Many CHWs have reported using their own limited resources to assist with transport or food for beneficiaries, which further adds to the economic strain of the worker. CCGs have highlighted similar resource challenges required to perform their work, including a lack of transportation and care kits (Friedman et al, 2010).

The primary data reveals that sometimes resources or tools are available but are not distributed to CBWs in time resulting in repeated household visits and further strain on resources:

> *"Sometimes we don't get stationary and tools on time…this requires us to go back to clients twice to get the client's signatures – this is daunting and affects our work and sometimes our stipends because we do not get paid when we have not submitted everything." (FGD_CBWs)*

Poor management of resources at district level was highlighted as the main contributing factor here as well as the location of some communities which are in remote areas and long distances from suppliers and with no proper delivery system in place.

These findings confirm the problem statement that CBWs are not provided with proper safety equipment.

Remuneration

The literature and document review confirmed the problem of inequitable remuneration for CBWs. The **stipend amount for CBWs is not standardised, varies considerably across departments and NPOs, and is dependent on the particular programme, roles and responsibilities**. The fact that the remuneration is so often referred to as a "stipend" rather than a "wage" or "salary" provides implicit evidence of the low levels of pay.

Although the government Personnel and Salary system (PERSAL) provides standardised salary scales for government employees on salary levels 1–12,[33] the only CBW occupation

[33] DPSA, "Salary scales, with translation keys, for employees on salary levels 1 to 12 and those employees covered by Occupation Specific Dispensations (OSDs), 1 April 2018"

included on the PERSAL system are CYCWs (level 1 to level 5)[34]. However, even these positions are not held by community-based CYCWs (most of whom are, strictly speaking, auxiliary CYCWs). Instead, the PERSAL-based CYCWs work in institutions such as child and youth care centres.

There is no provision for CHWs in the PERSAL salary scales. A recent agreement in the Public Health and Social Development Sectoral Bargaining Council represents an interim (12-month) arrangement that provides for standardisation of the remuneration for CHWs in the DOH (Resolution 1 of 2018). However, the standardisation is on the basis of "non-service remuneration" of R3 500 per month. While this is in line with the Minimum Wage Act that came into effect in January 2019, the "non-service" seems to indicate that the CHWs will not be part of the public service and thus, among others, not be entitled to the medical aid, pension and other benefits that public servants have.[35] The specified wage is also below level 1 of the public service salary scale. The agreement does not indicate what is envisaged when the 12-month period to which it applies comes to an end in June 2019.

Van Pletzen and McGregor, (2013) highlighted that a challenge in the PHC sector is the huge provincial discrepancies on what "ward-based" CHWs are paid, who pays them, the kind of work benefits they get and how many households they need to cover. This same problem was highlighted in relation to CBWs affiliated to DSD during the primary data collection:

> *"The biggest challenge is on how to compensate CBWs because there is no determination from DSD for stipend amount for CBWs – they get varying stipend amounts from different programmes that we are providing for DSD." (SSI_NPO)*

The interim agreement is specifically targeted at CHWs working within the WBOTs so should address this challenge. However, it does not address the inconsistency in remuneration across other programmes confirmed as problematic by respondents during the primary data collection:

> *"Another challenge is that we pay according to the Ministerial Determination but our counterparts from health are implementing the minimum wage which is higher than the Ministerial Determination so they may be doing the same work…this causes discontent amongst the CCGs." (SSI_National DSD)*

Further, the same DSD official reported that although they had adopted the (EPWP) Ministerial Determination as the basis for stipends, the amount eventually paid to CBWs depended on provincial finances. An official from the HIV and Aids Chief Directorate similarly reported that they used the Ministerial Determination to calculate payments. In contrast, at least initially, when the Isibindi roll-out started, the agreement was that CYCWs who were being trained would receive a stipend (i.e. the EPWP amount), but that once qualified, they would receive a proper salary. This did not happen other than in Gauteng and Western Cape. Various studies of the Isibindi roll-out revealed further differences in compensation across provinces.

Even among programmes and projects funded through the EPWP, many struggle to pay minimum wages because of the problems with programme funding/transfers to NPOs by departments (DPME and DSD, 2016).

[34] CDPs and Social Auxiliary Workers are also included in the PERSAL but are not considered to be CBWs for this study because they are not community oriented.

35 PHSDSBC, Resolution 1 of 2018: Agreement on the standardisation of remuneration for community health workers in the Department of health.

In addition, the minimum wage of EPWP has been criticised as being too low, providing too little income for households to move above the poverty line (Gafane, 2011). There are costs for individuals in accessing the EPWP programme, for example, such as transport costs (McCord, 2012). Further, personal costs include opportunity costs of potential income from other livelihood activities, informal family responsibilities which have to be neglected, and potentially having to decide between household welfare benefits and individual EPWP work (McCord, 2012). Additionally, in the case of the CWP alongside other programmes reliant on government transfers to NPOs, inconsistent payment or late payment removes all benefits of having regular and predictable income, which is a crucial component of a social protection programme (Lomofsky, Davies & Burns, 2015).

Similarly, the mid-term review of the Isibindi Programme (2016) found that the quality and effectiveness of the Isibindi Programme was compromised by the inconsistencies and uncertainties in ensuring that contracts with implementing partners were signed on time, and that CYCW stipends and related expenses were paid. The review team recommended an urgent review of the working conditions and job satisfaction of CYCWs.

According to one expert, this is a consistent problem across all NPOs funded by the DSD (and probably Health). It was reported on in the report of the Ministerial Committee into the Review of Welfare White Paper and formed the core of Proposal 11 of the 16 proposals put forward by the Committee and subsequently formally adopted and agreed to by Cabinet in mid-2016. Proposal 11, to "Accelerate NPO funding reform process", described the problem as follows:

> *NPOs deliver a substantial proportion of social development services across most service areas. Their service delivery assists government in fulfilling its commitments. There is, however, widespread acknowledgement that the current funding arrangements for NPOs are inadequate in many respects, including the amount of funding, disparities across and within provinces, and inefficient processes…. There are, however, as yet no fixed plans or dates for addressing the problems. In the meantime many NPOs are struggling to continue delivering services, some are closing, some retrenching staff, some cutting back on service areas. All of these actions reduce the already inadequate services available in terms of need….*

The proposed actions were to:

- Put in place immediate measures to address inefficiencies such as late payment;
- Require that all provincial DSD and their sub-units comply with approved and efficient measures and monitor that they do so;
- Accelerate the project and allow for phased introduction of reforms, with a first substantial phase to be implemented in 2017/18 financial year at the latest.

The proposal was in line with the National Development Plan, which calls explicitly for "a review of funding for NPOs". However, while government has commissioned work and developed processes and the like for regularising the system, there has been little if any implementation to date.

Meanwhile, unsurprisingly, there is evidence from CBW respondents in the primary data collection that those CBWs working for NPOs have more challenges associated with lower stipends and irregular payments than those employed by government. According to interview respondents, **inadequate funding of NPO programmes was the main cause for low stipends and delays in payments.** Stipends paid by government tend to be higher, which

makes it difficult for NPOs to retain CBWs and in most instances they have to depend on unpaid volunteers.

> *"There is high turnover due to lack of stipends and incentives since there's an expectation in the community for some sort of stipend for the work of CBWs. Retention is a challenge; because there's no stipend people leave the programme as quickly as they find a paying job." (SSI_NPO)*

> *"We were paying the organisation to pay the CHWs – so they don't always pay them regularly, and then you find high turnover. One has to cover both administration and project management costs and facilitation – if you only pay the CBO for wages, then how are they supposed to manage the CBOs and fund their own administration." (SSI_NPO)*

The methods of payment also vary across sectors and provinces. In provinces such as the Eastern Cape, some CHWs are on the government payroll (PERSAL), some are paid by NPOs with government or donor funding, and others are voluntary workers (meaning that they do not receive income for services provided). In the Western Cape Province, the government subsidises the payment of CHWs through NPOs who then take the responsibility of supervision (HST, 2011). The diversity of who pays and the amounts paid have already been presented in sections 4.1–4.3 of this report.

The coming into effect of the Minimum Wage Act in January 2019 adds to the challenges – and also to the extent to which legislation is likely to be flouted in respect of many CBWs.

The report[36] of the expert panel constituted to advice on the level and other aspects of a proposed national minimum wage during the process of developing this legislation, recognised the challenges that would arise for the NPOs operating in the care sector and those they employed. Unfortunately, the Panel did not come up with a solution to the fact that the current subsidies provided by government to NPOs would not allow for the payment of the minimum wages to NPO workers (including CBWs). The panel wrote as follows:

> *The Panel is very concerned about the impact of a national minimum wage at a level of R3 500 on the sector. In essence, government needs to ensure that this sector is adequately funded in line with its constitutional and legal obligations. The Panel believes that it is imperative that this matter be fully investigated and that appropriate measures are instituted during the adjustment process outlined below.*

In subsequent phases of deliberation on the National Minimum Wage, a concerned group of people associated with NPOs advocated through various channels for a task team to be established to look into this matter. The Department of Labour duly formed a government committee of concerned departments to discuss the matter, but no further report or solution was offered other than informal suggestions that NPOs should regard the EPWP minimum as applying to them. This is problematic on various counts, including that the Act does not state this explicitly and, in fact, the social parties agreed that there should be no exemptions beyond those explicitly provided in the Act; that many NPOs are funded by government using non-EPWP funds; and that the transfers received by many NPOs are insufficient to pay stipends even at the EPWP minimum level. Another suggestion was that NPOs should apply for exemption from the National Minimum Wage. The problems here include (a) that the

36 A National Minimum Wage for South Africa: Recommendation on Policy and Implementation: National Minimum Wage Panel Report to the Deputy President. 2017.

application process is quite cumbersome, and would have to be applied for annually by each affected NPO, presenting a burden on both the NPOs concerned and those responsible for adjudicating applications for exemptions from tens of thousands of NPOs; (b) that those who are exempt are still subject to a minimum wage, but set at 80% of the minimum rather than the full minimum, and it is not clear that NPOs can afford this on current transfers; and (c) the exemptions were not envisaged as available for any employers on an ongoing measure, but instead as an interim arrangement.

Retention rates

Secondary data demonstrates that high attrition rates are a major hindrance to the success of CBW programmes. According to Bhattacharyya et al (2001), internationally attrition rates for CHWs range from 3.2% to 77%, with higher rates generally associated with volunteers. Many factors have been identified as contributing to high attrition rates in CBW programmes, most of which have been discussed above. These include low stipends, lack of job security, work overload, inadequate resources and lack of support from community members (Bhattacharyya, 2001; Chatio & Akweongo, 2017; Ludwick et al, 2013). In this regard, a study by Chatio & Akweongo (2017) indicates that remuneration, provision of transport and logistics, and community level factors such as respect and support for CBWs by community members influence their retention and the sustainability of their activities. Other factors include inclusive community-driven selection processes, recruitment of CBWs who are passionate about the work and have a sense of social responsibility, and regular training and supervision. Chatio and Akweongo (2017) also suggest educating community members on the concept of voluntarism and the sacrifices that CBWs make to ensure effective service delivery.

Findings from the interviews conducted for this evaluation also confirm the attrition-related factors listed above. When asked what makes CBWs leave their jobs, the most cited reason was, *"low stipends and the need for better work opportunities".* This confirms the initial problem statement that due to CBWs being underpaid, they will not stay in their programme if they get better work opportunities elsewhere. Other factors influencing retention are delayed payments and a lack of standardised stipends for CBWs doing the same work, especially for those working for NPOs, and lack of psychosocial support.

There is no data on attrition rates of CBWs in South Africa.

The complex nature of the job exposes CBWs to traumatic experiences within the homes they serve which eventually takes a toll on their mental and psychological well-being.

> *"The job comes with serious occupational challenges, like emotional and psychological problems. The lack of psychological support can lead one to leave-we don't have any such support that's why you find CYCW committing suicide." (SSI_CBW)*

> *"The pressure sometimes can be too much because we come across very sad things, people take a burden to you, dealing with 36 families coming with different challenges and problems as a young person yourself this can be too much to bear. The community can feel and respond from a point of saying that you are invading their space and lives, and this causes CBWs to face rejection, judgement and to be called names by the community." (SSI_CBW)*

Failure to retain CBWs poses a lot of challenges for programme implementers. Discussions in the literature demonstrate that low retention results in increased programme costs due to the need for continuous recruitment and training of new CBWs. According to Bhattacharyya et al

(2001) a problem with low retention is that considerable investment is made in each CHW and programme costs for recruitment, selection and training increase with high attrition rates. One interview respondent also confirms this as he notes, *"CBWs leave the programmes as soon as there's no stipend. You have to continuously train and work with new people and it is difficult to recruit and train because of funding challenges."* (SSI_NPO) This is a major challenge given that most programmes are already underfunded and cannot bear the extra recruitment and training costs. The section below provides more detail on this.

Professional development, training, mentoring and supervision

Table 20 below presents the various professional, regulatory or coordinating bodies relevant to CBWs operating across sectors.

Table 20 Professional regulatory bodies for CBWs

Professional Body/ Association	Established	Purpose
Health Professionals Council South Africa (HPCSA)	1974 in current form	All individuals who practise any of the health care professions incorporated in the scope of the HPCSA are obliged by the Health Professions Act, 56 of 1974 to register with the Council.
South African Council of Social Service Professionals (SACSSP)	1998	The SACSSP/ Council) is a statutory body established in terms of section 2 of the Social Service Professions Act, 110 of 1978 (the Act). Council has two professional boards under its auspices: the Professional Board for Social Work and the Professional Board for Child and Youth Care Work.
Hospice Palliative Care Association of South Africa (HPCA)	1987	A membership organisation for South African hospices which has "established national and provincial Palliative Care development structures aimed specifically and purposefully at support and capacity building of member hospices and more recently of partner organisations in terms of the provision of quality palliative care."
National Health Care Professional Association		Provide support for, represent, and safeguard the interests of all health care workers and professionals (whether private or public).
National Association of Child Care Workers (NACCW)	1975	NPO that provides the professional training and infrastructure to promote healthy child and youth development and improve standards of care and treatment for orphaned, vulnerable and at-risk children and youth in family, community and residential group care settings.

A review of government documents found that **no overarching professional regulatory requirements for CBWs in general, which reinforces the argument that they are not a single cadre or workforce.** However, there are requirements governing categories of CBWs. For example, CYCWs are required to register with the SACSSP's Professional Board for Child and Youth Care Work from the time they start training; and CBWs involved in working with children are required by the Children's Act to meet specific requirements such as being vetted

against the Child Protection Register. Similarly, people working with older persons must meet the requirements of the Older Persons Act.

During the primary data collection, respondents were asked their opinion on professionalisation and career incentives of CBWs in the various sectors. Most respondents confirm that CBWs are not recognised as professionals despite the fact that many do the work of professionals. As one respondent explains:

> *"CBWs have no professional status although they do most of the work and have diverse roles such as health promotion, psychosocial support to the community – they are the foot soldiers." (SSI_NPO)*

As this quote suggests, they are not receiving the recognition or remuneration they deserve and, as mentioned previously, this is a key contributor to attrition. Primary data shows that CBWs were most likely to leave because they felt that their work is undervalued (associated with low pay) and hence not recognised as a formal profession in South Africa despite the amount of work they put into delivering services to the communities.

> *"Lack of recognition of CYCW by giving a professional status even though they work as hard even more than professionals like nurse, but are paid very lowly stipend, there's not enough financial support this leads to families asking you to consider other work because you're working but you can't support your family." (SSI_CBW)*

> *"CYCW work very hard in the community, yet this work and service in not yet recognised in South Africa…CYCW need to be recognised as serious service." (SSI_CBW)*

Further, the mid-term review of the Isibindi Programme (2016) found that, as a result of the collaborative initiative of the NACCW and the DSD, significant progress has been made in establishing child and youth care work as a profession registered through the SACSSP.

Skills development, career development and progression

A review of the government documents found that policy directives are clear about the importance of training and skills development and some documents provide very specific guidance on the shape it should take.

However, there was agreement among respondents that there is a need to professionalise the CBW system **because there are currently no clear career pathways for CBWs.**

Here it is argued here that the word 'professional' and 'professional practice' does not have to mean *having a degree* but rather having a 'unique scope of practice and body of knowledge' such as substance abuse or HIV/Aids. As one respondent noted:

> *"We have a lot of talented people as community care workers…why don't we design a programme to train them that follows the recognised path within social service professionals." (SSI_Professional bodies)*

However, it is critical that this training and career pathing be coupled with a plan for sustainable deployment into various sectors such as the child care sector in line with the Children's Act and Health Care Act. In other words it should be aligned with workforce planning so that it becomes *'career-driven workforce development*' where the workforce is built while servicing the community at the same time. This has not been the case in South Africa thus far.

Some ideas for workforce development include training CBWs in basic skills such as identification and referral, case management and ethical guidelines that can be used irrespective of their specific roles.

This idea is elaborated in the Draft Community Care Worker Policy Management Framework (2009) which proposes that a new framework for skills development be established, in part, to establish a common and quality skills base for both health and social development services as well as to deal with some of the challenges currently inherent in the system. As such, the goals for the new skills development framework are to:

- establish the minimum skills for employment and delivery of quality services
- be affordable, especially given the high turnover rate
- create a single yet flexible platform for training of CCWs which can allow mobility within HCBC
- allow direct access to skills programmes that are specific to the job and workplace
- align to the requirements of South African Qualifications Authority (SAQA) for accredited learning but not be bound by its hierarchical qualifications structure
- allow opportunities to gain a qualification to be educationally rather than occupationally directed, that is, promote education-oriented qualifications to promote further development opportunities.

Given these goals, the skills development framework is not based on qualifications but rather applied skills programmes. The proposal is for CBWs to have a minimum skill set irrespective of their service area, and then they can have opportunities for specialisation. This can be seen as an overlapping of the minimum skills required, and specific workplace skills required for service delivery subject to local needs and provincial service delivery models. Figure 7 below illustrates this understanding.

Figure 7 Overlapping minimum skill requirements and applied skills programme

A further important aspect of this framework is that the pursuit of qualifications is not viewed as the primary purpose of this training framework. This approach is motivated in part by the actual need for workplace competencies and questions the perception that qualifications are

better. This is particularly the case with CHWs where the existing qualifications are not effectively opening up other job opportunities. As a result, the pursuit of a qualification will be housed within this policy framework's further development and exit strategies where the support of qualifications is viewed as supporting a CCW's broader life goals. Figure 8 illustrates this understanding.

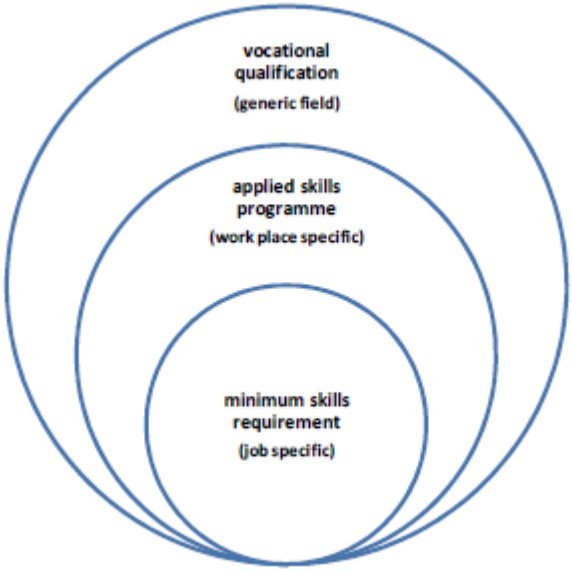

Figure 8 Articulation into a qualification

However, the notion of exit strategies is questionable and should rather be replaced with career pathing for CBWs. Career incentives should be used to recruit and motivate CBWs.

Further, the argument that the CCW training and development should not be bound by the SAQA qualifications framework is not without contention. A number of experts interviewed for this study argue that accredited training linked to the NQF is critical for career progression because it allows CBWs to progress along a career path. According to one expert, there are many training courses registered for CBWs, but they are not structured or articulated so that the CBW can progress along a career path leading to higher paid work:

> *"We would want to see the Community Caregiver have a career path similar to aux social workers – but at the moment training that can be accessed is all over the show. There is a variety of NQF Level courses that have been registered that community caregivers could take; but for majority, their access to training is on the job type training. We have tried to structure this, but it is very difficult as you are not dealing with a para-professional, you are dealing with community-based workers." (SSI_Expert)*

What is clear from the review of relevant literature is that there is no standardised approach to training, but that what is preferable is a mix of short courses, on the job training and NQF accredited courses (including recognition of prior learning and workplace-based learning such as learnerships). However, the courses should clearly articulate with one another. There is a precedent for this. The training programme for the WBPHCOT strategy combines both short courses and NQF Level courses. One of the early steps taken in the implementation of the WBPHCOT strategy was to set up short-course training in phases, followed by the development of a national qualification through the Quality Council for Trades and Occupations

(QCTO), the regulatory body for work-based learning and apprenticeships. The training is currently divided into three phases, consisting of 10-day short courses followed by practicums. Phase one (initiated in 2012) covers orientation on the structure and functioning of the health system and the WBPHCOT, plus orientation on HIV and Aids, TB, and maternal, child and women's health and nutrition. The second phase (initiated in 2014) expands to cover the topics of non-communicable diseases and social support. The third phase (initiated in 2015) is the one-year NQF Level 3 Health Promoter qualification, (Schneider et al, 2018).

The National Policy Framework for the HCBC Programme (2010) states that HCBC organisations need to attend to the capacity needs of community caregivers. This should entail the development of an overall Staff Capacity Plan, which, among others, should include:

- training based on registered unit standards and aligned with a minimum skills set that includes the Recognition of Prior Learning process
- regular supervision of community caregivers
- a database of accredited service providers and courses offered.

The HCBC Programme requires a four-pronged approach to build capacity, underpinned by the relevant legislatives frameworks, including the Basic Conditions of Service Act, the Skills Development Act, the Labour Relations Act and the NQF. Guided by this approach, capacity building should include:

- profiling and screening prospective learners to determine and assess their training needs
- exposing experienced workers to the Recognition of Prior Learning process
- providing advanced learners with additional skills to prepare them for specialist levels of training
- implementing a retention and exit strategy for community caregivers.

On a broader level, the DOH has registered three community worker qualifications in terms of NQF, creating the possibility of career pathways for CHWs as mid-level health workers (Ogunmefun et al, 2011). These qualifications have provided benchmarks for skills assessment as well as opportunities for career progression for CHWs. Three levels of qualifications for CHWs have been registered with the SAQA. The CHW qualification entails (1) the Community Care Worker qualification at NQF Level 1; (2) the Community Health/Development support worker qualification at NQF Level 3 (mentioned above); and (3) the Community Health Worker/Auxiliary Social Worker qualification at NQF Level 4. It is not clear if these are being implemented. The National Certificate for Community Health Work (SAQA QUAL ID 64749) is registered at a level 2 and is valid until 2023.

The Hospice Association of South Africa has also developed a 59-day training course for home-based care workers. Although not accredited by SAQA, this programme has provided a standardised form of training which has greatly accelerated the provision of quality community-based palliative care, often under the supervision of hospices (Friedman, 2005). The content of the training is important as well as the duration of the training. Community members tend to distrust CHWs who had attended very short training programmes as they may lack legitimacy (Thomson, 2016).

DSD uses a 4-tier funding model for NPOs that includes capacity building for CBWs. The strength of this model is that the NPOs can select the training that CBWs require and they are

required to identify accredited service providers to provide the training. NPOs employing CBWs report that they give CBWs access to modular training such as: community-based carer's certificate, community facilitation course, mentoring and coaching certificate, counselling and behaviour modification, and personal information training.

Similarly, the Draft Community Care Worker Policy Management Framework (2009) talks to the interrelatedness of learning and career paths. It specifies that learning and skills development, as well as further development and exit strategies, should be viewed as interrelated and supporting each other. It states that although these strategies are promoting the CCWs own life goals, there is also a need to actively promote the opportunities within the sector. The interrelatedness of the learning, further development and exit strategies to the various career paths associated with them is shown in Figure 9.

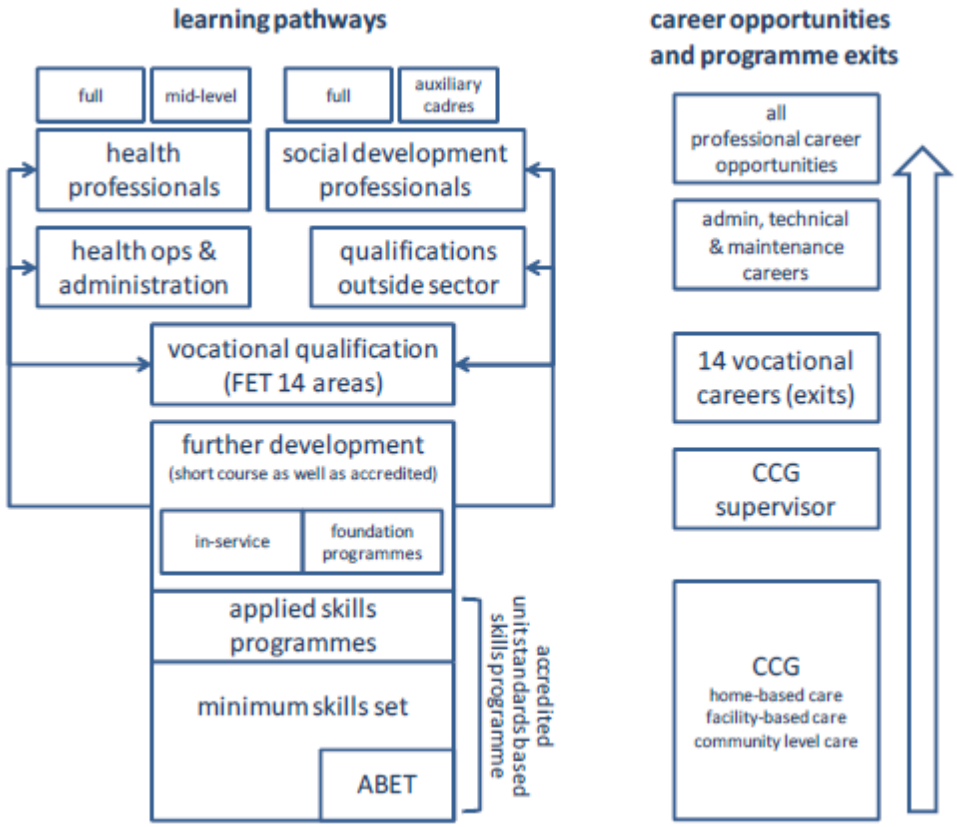

Figure 9 Further development, exit strategies and their associated career paths

However, despite these developments, and the fact that decentralised training systems have been established at district and even sub-district level in a number of provinces, through in-house regional training centres, a system of career progression in community-based services is still to be established, (Schneider et al, 2018).

Workforce planning

Another important point is that training cadres should not be done in isolation of the ability to absorb them into the workforce, and for this, workforce planning is necessary.

Luka (2005) pointed out that not all recruits into the HCBC and ECD social sector EPWP programmes were able to get full-time jobs after training. Those who were already employed by NPOs or CBOs were trained on the job and did not reduce the unemployment numbers but

only increased the number of skilled workers. However, having the required skills, essentially obtained through the EPWP programme, allowed these individuals to compete for positions that became available. McCord (2009) maintains that those workers who manage to access employment opportunities after their periods in the EPWP represent the displacement of one set of low-skilled workers by another. It is a repositioning of workers in the labour market rather than a net increase in employment.

USAID, through Pact as the implementing agent, has been implementing the Government Capacity Building and Support Programme which is funded by President's Emergency Plan for Aids Relief (PEPFAR). The aim of the programme is to support the DSD to improve service delivery to OVC and vulnerable youth, with a focus on workforce strengthening as one key system elements. The programme has worked with the DSD to produce a social workforce strengthening programme practitioners policy.

The DOH's development of Staffing Norms for Primary Health Care in the context of PHC Re-engineering (2012) is a step in the right direction here as it developed staffing norms for each component of PHC services, including CHWs. These norms are used to compare with actual staff availability in the public sector to inform short- and medium-term planning and deployment as well as planning for training requirements. The same exercise could be replicated for other sectors.

Strengths and challenges with training and skills development for CBWs

During the primary data collection, most CBW focus group respondents from both NPOs and government departments confirmed that they had attended some form of training. This training ranged from being more structured and formal such as the accredited CYCW certificate; towards less formal, non-accredited, on the job training. Training service providers vary and include professional bodies (which may or may not be accredited training providers), NPOs, accredited service providers, the DOH or the DSD.

The majority of respondents confirmed that the qualification and training for CBWs is *relevant* to what they are doing at the community level. Other strengths identified include good quality training and the existence of accredited training for some areas.

Although policy directives and training opportunities for CBWs are in place, a review of literature and government evaluations shows that the implementation of training has not always been successful. Some of the findings are presented below.

A DSD (2014) study found that CCGs were often not adequately equipped to respond effectively to vulnerable persons during circumstances such as bereavement and sexual abuse.

The implementation evaluation of the CWP (DPME, 2015) found that the way that training is being implemented also requires a change of strategy. Firstly, the budget analysis raises a puzzle of high training expenditures in the face of apparently low levels of training. Regarding implementation, more than half the participants (55%) reported that they do not receive the relevant training to do their jobs well, and this same theme emerges from the site managers about themselves and their teams.

Similarly, the implementation evaluation of the EPWP in the Social Sector (DPME, 2015) found that the Sector provided less training than it intended to, with most provinces reporting less than half of the targeted number of training opportunities. Contributing factors included constrained human resources to plan the training; small equitable share budgets for training coupled with an inability to access the training funded through the National Skills Fund; the low

skill levels of participants and the scarcity of accredited trainers in some programmes. Training was generally in line with the skills participants needed for their work, although shorter training opportunities (skills programmes and short courses) were often deemed relevant but insufficient on their own. The training data available at a national level focuses on the number of training opportunities provided, potentially masking important implementation failures such as high dropout rates, and not indicating the quality and appropriateness of training. It is concerning that most national departments are unaware of how many EPWP-SS participants in their provincial programmes have the minimum training required for their work.

In the mid-term review of the Isibindi Programme (2016), what came out clearly from the interviews and FGDs was the need that CYCWs had for ongoing professional development over and above the support CYCWs. Many indicated their need for specialised training in areas that would strengthen their capacity to manage specific community challenges. It was thus recommended that continual capacity improvement and support for CYCWs be provided.

A national appraisal of WBOTs (2015) found that the organisation and timing of available training is inadequate, particularly the need for CHWs to complete Phase 1 before they begin to go out into the community; the slow pace of progression through the phases; the absence, shortages or delays in materials; unconducive learning spaces; and a lack of budgeting and generally poor planning. While central to successful performance, systems of induction and in-service and continuing education remain ad hoc and poorly connected to the basic training (Jinabhai, 2015).

The respondents raised a number of specific challenges related to training:

First, it was noted that training across the various CBW programmes is not structured or standardised as there is no overarching qualification framework for CBWs, while some question whether this is even desirable or feasible. In addition, not all CBW training is accredited – it does not have NQF credits – making it difficult for CBWs to further their studies. In addition, accredited training is often expensive.

Second, although training is available, many CBWs said it was *insufficient* with limited opportunities for follow up and refresher training which is critical in specialised areas such as HIV/Aids where new knowledge and information is constantly emerging. It was also highlighted that there were some gaps in availability of certain training topics with the most frequently mentioned being facilitation skills, community dialogue skills, computer literacy and report writing; and training packages are often outdated – one respondent reported that training modules had not changed for more than 10 years. Furthermore, there are few or no service providers offering training in certain outlying areas. With regards to location of training, the literature review found it is preferable for training to take place in the community rather than in health facilities (or central locations) to provide hands-on experience in the work environment of the CHW/ CBW, (Cesar, 2005; Haynes et al, 2011; Zachariah et al, 2009). This is supported in the primary data collection where some CBW respondents said that they travel long distances to attend training with no travel allowances provided. In response to this, it was highlighted that training should take place in CBWs local reality which is also less costly since the only payment is for the trainer to travel:

> *"You should train them in their local reality and move only the trainer. We have had to sit with HWSETA and explain that you cannot develop rural people unless we take the training to them…." (SSI_Professional body)*

Thus it is critical to develop more models that will allow training to go into rural areas and develop a paradigm of building more capacity in outlying areas. The Isibindi roll-out performed very well in this, taking training to all the outlying areas and getting venues in all of them accredited by the HWSETA. Among others, this decreases costs because only the facilitators have travel and accommodation costs. It also facilitates participation for learners with family responsibilities.

Another concern is that sometimes DSD officials force NPOs to contract a service provider of its (DSD's) choice because of the relationship it has with them, regardless of the qualification in the specific area of training. The low literacy levels of some CBWs make it difficult to access training opportunities.

Third, there is limited budget allocation for training from the DSD grant for NPOs – it tends to be the smallest portion of the funding received.

Finally, it was noted that there is poor management of training interventions including poor communication about the training opportunities; location of training, times etc.; and late arrival of certificates.

In addition, a review of literature found that adequate *practical* training had not been effectively provided to all CHWs and this has negatively affected their motivation, morale and job satisfaction and ultimately the potential impact of the CHW programme (Cesar, 2005; Haynes et al, 2011; Zachariah et al, 2009). It is assumed that this applies to other CBW cadres.

Strengths and challenges of the mentoring and supervision of the CBWs

Supervision refers to the monitoring, assessment, mentoring and support needed by CBWs to provide optimum services. CBWs work with human subjects and there are ethical considerations. CHWs and CCGs also need psychosocial support as they have to cope with the painful situations of their beneficiaries (Ntobeng, 2016).

The literature and document review found that the various CBW programmes have supervisory structures in place, but that supervision is taking place to varying degrees. Some of these findings are presented below.

The mid-term review of the Isibindi Programme (2016) provides evidence of a well-structured mentorship model that could be replicated. Mentorship is provided to oversee the work of CYCWs and NACCW has put in place a comprehensive system for providing mentorship to the CYCWs on a regular basis – usually one week on site every month. The mentors are themselves supported and supervised by Mentor Supervisors. A 2015 Formative Evaluation identified the quality of mentorship as a crucial factor underlying quality service provision. In qualitative interviews, CYCWs spoke about the extensive support they received from their mentors as well as the value of that support for their care practice.

Haines et al (2007) discuss the guidelines for supervision of CHWs and suggest that two key supervisory activities be included: supervision should 'ensure a two-way flow of information' and the supervisor must 'act as a role model'. They recognise that supervision becomes more challenging when programmes scale up, particularly in rural communities where supervisors may provide the only point of contact with the formal health system. The continued quality of service provision by CHWs depends on good quality supervision and the provision of other forms of support, such as supplies. Only good supervision, together with adequate material support, will enable CHWs to function (Hermann et al, 2009).

The PHC Re-engineering Model Structure (since 2010) – including the CHWs, the WBOT Leader and the Health Facility district management – depends on a sound supervision system that is in touch with the pulse of the community-based health model. The services are to be provided in close association with facility-based health services, other sectors and government departments, CBOs and NPOs providing community-based services (White, Govender & Lister, 2017). The careful and supportive supervision of CHWs is essential. However, in their assessment of the Ward-based PHC outreach teams, Schneider et al (2018) found that insufficient supervision has been a persistent challenge for WBPHCOTs due to under-resourced, overstretched or absent outreach team leaders.

The primary data collection revealed that the quality of supervision and mentoring of CBWs is variable across the different programmes.

While all of the NPO CBWs confirmed that they receive good quality supervision and support, the government-employed CBWs gave mixed responses. For example, in support of the Schneider et al (2018) study above, DOH CHWs are supervised by facility-based staff who do no outreach work thus making it difficult for them to monitor and oversee the CHW work at household level.

Despite the positive feedback from CBWs about NPO supervision, both NPO respondents and the literature note challenges with supervision. The most frequently noted challenge with supervision and support is insufficient funding to provide adequate support. Provincial governments have reduced their funding to NPOs, partly to directly employ CBWs. In addition, government has limited capacity to monitor the work of the CBWs on the ground.

> *"For years we used the vendor-based system to pay CBWs but now they are being paid by the department – they are taken on as department employees on short-term contracts. This happened after they accused us of outsourcing…they will be moved to the PERSAL system to be 100% employees of the department. the CBWs who work at the NPOs are recruited by the department but allocated to the NPOs, now the challenge is they report to the NPOs but they have no direct influence over them because they are not employees", (SSI_Provincial Government)*

Even when NPOs are paid to hire CBWs, this is a wage – cost only, and frequently excludes sufficient funding for supervision (Lehmann & Sanders, 2007). The frequent contact required to support CHWs can effectively generate supervision costs that represent 40% of the cost of one CHW (which could also be a factor of CBWs' low pay). However, not only has the cost been overlooked, often the need for supervision has been either overlooked or underestimated, or not adequately planned for. Also, who the supervisors should be and what their tasks are arer often ill-defined (Lehman & Sanders, 2007).

Key point summary

- The evaluation was not able to determine the scale and distribution of government supported CBW as it was not possible to calculate this from budget allocations, and there are contradictory estimates from various departments. However, it is clear that there are not enough to reach all the areas of need.
- In terms of their scope of work, the review of job descriptions and analysis of primary data confirm that CBWs provide or facilitate access to a wide range of health and social services targeted at the individual, household and community level. The limited duplication of their duties suggests that rationalisation of CBWs is *not* warranted.

- Overall, it is evident that there are many challenges with the conditions of work for CBW workers in South Africa. There are many regulations governing CBW wages, including minimum wage and Ministerial Determinations, but CBWs are not being adequately remunerated, stipends within programmes are not standardised resulting in inequitable remuneration within the different programmes, and further, causing confusion and conflict among the CBWs and between CBWs and their employers. One of the key challenges is that they are seen as 'volunteers' not employees, however the majority are receiving a stipend, which means that they are considered employees under the BCEA and should be treated as such, both by Government and the NGOs that employ them.
- The poor administration of government funding to NPOs further fuels this already complex problem.
- Regarding the integration of CBWs within their professional practice, not all cadres of CBWs are linked to a professional stream with associated skills development and career progression. There are no overarching professional regulatory requirements for CBWs because they not a single cadre or workforce, however; there are requirements governing certain categories of CBWs – CYCWs are required to register with the SACSSP and CHWs are integrated into the Health Professions Council, but there is no professional body for CCGs – the other main cadre of CBWs within DSD.
- Training, development, mentoring and supervision are critical for the success of the CBW system, and policy directives are clear about the importance of training and skills development.
- There are a number of training opportunities, both formal and informal, in the sector, but access to training, articulation between courses and funding for training are key problems, among others. Training in rural areas remains a challenge, but systems set up for the roll-out of Isibindi that encouraged training in communities should continue to be used.
- Supervision is crucial for good quality service provision; supervisory structures are in place but vary in quality and reach. The transfer of wage costs only to NPOs affects the ability of NPOs to supervise adequately, although the data suggests that supervision in the CSO sector is still better than supervision of government-employed CBWs. The well-structured supervision demonstrated in the model of the Isibindi Programme is an example of good practice which could be replicated. However, quality of supervision becomes more challenging as programmes scale up.
- The quality of supervision and mentoring of CBWs across the various programmes is not always adequate to build or support their professional growth and development. These lack of career incentives are a barrier to recruiting appropriate CBWs and becomes demoralising for those who are working as CBWs.
- There is thus a need to professionalise the CBW system. Standardisation of learning and skills development for CBWs is a good starting point with recognition of the interrelatedness of learning and career paths. Workforce development must come together with funding for implementation of programmes and workforce planning. This will result in building the workforce while servicing the community at the same time. If people are trained without employment prospects, it could contribute to increasing the pool of skilled unemployed or under-employed people.

4.5.6 Monitoring and Evaluation of the CBW Models

This section answers the following evaluation question:

- *Evaluation question 4: How have different departments using CBW monitored and evaluated the models?*

The section begins with a review of government documents outlining the indicators associated which work conducted by CBWs. The information was extracted from government Annual Performance Plans (APPs) and reports for the period 2016-2019. The second part provides an overview of evaluations that have been done of programmes using CBWs in South Africa.

Indicators

The table below presents a summary of the findings from the review of government documents to highlight what performance information is available about CBWs in South Africa.

Table 21 Review of DSD performance indicators for various programmes

Programme	Sub-Programme	Type of CBW	Non-Financial Performance Indicators
Social welfare services	Old People's Programme	CCGs	Number of older persons accessing community-based care and support services
	Services to the Persons with Disabilities	CCGs/ Personal Assistants	Number of persons with disabilities in DSD funded community-based day care programmes. Number of people accessing DSD funded NPO specialised support services
	HIV/Aids	CCGs	Number of food parcels and daily meals issued by HCBC organisations Number of vulnerable households receiving psychosocial support services Number of children and adults receiving antiretroviral and supported Number of beneficiaries receiving psychosocial support services from HCBC organisations
Child and family care support services	Community-Based Care Services for children	CYCWs	Number of Child and Youth Care Worker trainees who received and completed training through the Isibindi Model. Number of children accessing services through the Isibindi Model Number of NPOs capacitated to implement prevention, early intervention and protection services through Isibindi Model
Restorative services	Victim Empowerment Programme	CCGs	Number of victims of crime and violence accessing services from funded Victim Empowerment Programme service centres
	Substance Abuse,	CCGs	Number of service users who accessed community-based treatment services

Programme	Sub-Programme	Type of CBW	Non-Financial Performance Indicators
	Prevention and Rehabilitation		Percentage of funded substance abuse community-based services

As demonstrated in the table above, the DSD has various indicators for the different community-based programmes within the department that are contained in the Department's Annual Performance Plans. The DSD is required to report on these performance indicators to DPME/National Treasury. As can be seen from the indicators, there is little standardisation among them about where services are provided (community or facility based) and by whom. There are also no specific indicators about the number of CBWs used to deliver these services. This makes it difficult to speak about the scale and scope of CBWs, and the value for money of CBWs, as highlighted previously in the report.

Further, the indicators are all output related (quantitative), and specific attention is placed on output data such as the number of beneficiaries receiving various services as well as NPOs supported by the DSD. There was no mention of outcome indicators in the documents reviewed. This can be considered as one of the major weaknesses of the CBW monitoring system given the importance of routine outcome monitoring in assessing programme effectiveness. Furthermore, outcome monitoring is also important because it provides valuable sources of information through which government spending decisions can be made.

Another weakness with the monitoring system is that with the exception of the Isibindi Model, very few programmes track indicators associated with CBWs directly. Most programmes focused on collecting data on the number of people receiving community-based services. In addition to tracking the number of children accessing its services, the Isibindi Model also collects monitoring data on the number of CBWs that had received and completed training. This may be important for all CBW programmes as it gives a clear indication of how many CBWs in the system have received adequate training to deliver services. It would also be interesting to have an indicator that tracks the overall number of CBWs employed in the system, although even this this may be challenging given that they are employed by different stakeholders including NPOs.

Monitoring systems

The **Community-Based Intervention Monitoring System** (CBIMS) was developed by the DSD for use by CBOs to capture services delivered by CBOs at beneficiary level. It has been rolled out since 2015 in South Africa and is managed under the Welfare Services, HIV and Aids programme. CBIMS is being rolled out and the DSD 2016 Annual Report notes that 230 officials were trained on CBIMS data quality management; and training for CBOs on CBIMS is also reported on in both the 2016 and 2017 annual reports (603 and 403 CBOs were trained each year, respectively).

The **District Health Information System** (DHIS) was introduced in South Africa in 1996 and was extended to the entire country by 2001.The system's purpose is to collect aggregated routine data from all public health facilities to support decentralised decision-making and health service management. The DHIS should allow health care workers to analyse their levels of service provision, predict service needs and assess performance in meeting health service targets (Garrib et al, 2008).

The **CHW Registration Database** was created by DoH to monitor the number for of CHWs who are part of WBOTS and funded by government.

Although useful and moving in the right direction for evidence-informed decision-making and budgeting, implementation and data quality of these systems remains a challenge as described in the challenges section below.

Evaluation

When it comes to evaluation, CBW models are under-evaluated despite their importance. Although a number of evaluations have taken place, their focus was more commonly on the service provided and beneficiaries rather than the CBWs and CBW models themselves.

Table 22 provides a list of evaluations done on various CBWs by in the past 10 years[37] (as such, it excludes a 2005 CDW evaluation), with those initiated or funded by government highlighted.

Table 22 Evaluations on CBWs

Category of CBW	Evaluation	Key Findings
CHW	Ogunmefun C, Madale R, Matse M, Jassat W, Mampe T, Tlamama F and Masuku M. **An Audit of Community Health Workers in the Districts of the North West Province.** Health Systems Trust; Durban, 2011	The audit confirms the challenges that cited in the literature since implementation of the programme. These include gaps in the training, remuneration challenges, fragmented roles, and transport problems.
	Ndou T, van Zyl G, Hlahane S, Goudge J. 2013, **A rapid assessment of a Community Health Worker pilot programme to improve the management of hypertension and diabetes in Emfuleni sub-district of Gauteng Province, South Africa, Global Health Action,** 24;6:19228. doi: 10.3402/gha.v6i0.19228.	The role of CHWs in the management of hypertension should be given greater consideration, with larger studies being conducted to provide more robust evidence. Adequate training, supervision, and operational support will be required to ensure success of any CHW programme.
HCBC	Moetlo, GJ, Pengpid, S & Peltzer, K. 2011. **An evaluation of the implementation of integrated community home-based care services in Vhembe district, South Africa.** Indian journal of palliative care, vol. 17, no. 2 pp.137.	Community home-based caregivers are largely able to implement home-based care services but need more support (training, financial, career structure, and health system) to improve their services.
WBOT	Jinabhai CC, Marcus TS, Chaponda A. 2015. **Rapid appraisal of Ward Based Outreach Teams.** University of Pretoria & University of Fort Hare; Pretoria	The report presents data on a rapid appraisal of the Ward Based Outreach Team (WBOT) model in National Health Insurance (NHI) pilot sites in seven provinces three years into the process of implementation and

37 Google was used to locate evaluations, by searching the type of CBW (e.g. CHW) both in full and abbreviated, followed by each 'evaluation', 'appraisal', and 'assessment'. 'South Africa' was also included in the search bar and the first 5 pages of results were considered as after this results were no longer relevant.

Category of CBW	Evaluation	Key Findings
		takes best practice examples into consideration
CCG	van Pletzen, E and MacGregor, H. 2013. **Multi country research on community caregivers: the backbone of accessible care and support - South Africa report.** The Caregivers Action Network	At the time the research was finalised it was still too early to comment implementation and its implications for CHBC in the country
CYCW	Mott Macdonald. 2016. **Mid-Term Review of the Isibindi Program, Final Report**	The MTR summarises and evaluates the successes, challenges and gaps of Isibindi within the parameters of national and provincial child protection legislation, OVCY policies, strategies and programmatic interventions. The qualitative evidence gathered indicates that Isibindi services make a difference in the lives of those OVCY who receive them, and may have a multiplier effect within the household and across the community.
	Kvalsig, Taylor. 2015. **Isibindi Programme Effects of Service Delivery and Community Capacity to Care for Orphans and Vulnerable Children in South Africa, A Formative Evaluation 2015**	The Isibindi Model is appropriately targeted at a highly vulnerable population and training and mentorship underpin a fully realised model of community and home-based community development. Nevertheless, there are significant challenges with regards to support and resource provision.
CWP	Lomofsky, Dena, Davies, Nana and Burns, Justine. 2015. **Implementation evaluation of the Community Work Programme. DPME and DCOG.**	CWP is a relevant strategy to reduce extreme poverty by providing an income floor to the poorest and most marginalised. However, it is not universal and can only do this for the participants it reaches, which falls short of its target.
	Thuthong Training and Development, 2011. A Qualitative Evaluation of the Community Work Programme Umthwalume CWP.	Beneficiaries are pleased with the quality of services provided through the CWP programme, such as home-based care, cleaning of crèches and teachers assistants etc.
EPWP	Economic Policy Research Institute (EPRI). 2015. **Implementation Evaluation of EPWP in the Social Sector: Phase Two (2009/10 – 2013/14)'. DPME and DSD**	The evaluation found growth in the number of participants and programmes in EPWP-SS which is encouraging as it represents the growing buy in of social sector programmes into the EPWP mandate. There are, however, a number of implementation issues, many of which are related to ineffective coordination and institutional arrangements; resource constraints and inappropriate allocation of existing resources; lack of senior management

Category of CBW	Evaluation	Key Findings
		involvement; weak internal communication; and monitoring and evaluation.

Table 23 Dissertations on CBWs

CBW Category	Dissertation	Finding
EPWP	Sithole TCN. 2010. **An evaluation of the Expanded Public Works Programme in poverty alleviation in Inanda, Ntuzuma and Kwamashu.** A dissertation submitted in partial fulfilment of the requirements for the degree of Master of Public Administration, Faculty of Management Studies, UKZN.	The programme seems to have a positive impact in the communities mainly because of the knowledge and skills that the beneficiaries gained. The issue of job creation is still a major challenge in terms of addressing poverty.
	Mohapi, 2013. **An evaluation of the sustainability of the social sector of the Expanded Public Works Programme to empower women, youth and the disabled,** Thesis (DPhil), University of Pretoria, 2013.	The 2% target of persons with disabilities as participants in the programme was not reached; no persons with disabilities were registered as beneficiaries of the HCBC and ECD.
HCBC	Moshi, C. 2017. **Evaluation of community home-based care programmes in the Capricorn District Municipality**, Thesis presented in partial fulfilment for the degree of Master of Management (in the field of Public Sector Monitoring and Evaluation) to the Faculty of Commerce, Law and Management, University of the Witwatersrand	The service provided by the programme has improved the lives of many patients and remains important to community well-being, there are however, a number of challenges threaten its sustainability. The thesis concludes that the programme requires the full support of the DOH or the programme could collapse which could lead to a national disaster in the health care system.
	Morton. 2012. **A critical assessment of the quality of community home-based care, NMMU School of Governmental and Social Science**, Thesis Presented in fulfilment of DPhil	Volunteer home-based caregivers are critical role players in South Africa's health care and it is important that the care and treatment provided to patients is of a high quality. The study unpacked issues related to quality such as poverty, unemployment, stipends, food insecurity and the related

CBW Category	Dissertation	Finding
		problems of poor living conditions. However, it did receive some organisational support.
WBOT	Whyte, 2015. **Implementation of the Ward Based Primary Health Care Outreach Teams in the Ekurhuleni Health District: A process Evaluation,** submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfillment of the requirements for the degree of Master of Medicine in the branch of Community Health	There were sufficient numbers of CHWs in WBOTs although they lacked sufficient knowledge and resources to conduct household visits. CHWs adhered to the guidelines regarding the follow up of maternal clients however, a significantly smaller proportion of unimmunised children were appropriately followed up. Challenges identified included: lack of supervision, limited resources and poor knowledge.

It is clear that not many relevant evaluations have taken place, and none for CDWs, CDPs or AEOs in the past 10 years. Further, even for those where evaluations have taken place, few categories of CBW have more than one evaluation in the period. These include CHWs, CYCWs, and CWPs. There have been a number of dissertations evaluating CBWs, particularly the EPWP. Many of the evaluations highlight that despite the importance of CBWs and the positive work they are able to do in communities, there are a number of implementation challenges. However, it is difficult to ascertain the quality of services provided by the CBWs.

Description, strengths and challenges of monitoring and evaluation by departments and NGOs using CBWs

Several benefits of M&E in CBW programmes have been cited in literature and these include improved recruitment and selection, training, programme implementation and impact. Primary data collected for this evaluation also shows that M&E helps implementers of CBW programmes to a) monitor programme performance against planned activities, b) provide information that can be used for programme improvement and future planning (learning), c) reduce programme costs and maximise programme impact, and d) facilitate future funding. When asked about the outcomes of the M&E system in their organisation, one respondent expressed that, *"the system enables us to track progress against targets and measure programme performance and to have a record of performance to access funding"* (SSI_NPO). Another respondent also reiterated, *"through the M&E system we are able to report on statistics and generate reports for DSD and funders. We are then able to see where we have worked well in the programmes."* (SSI_NPO)

Evidence from the primary data also demonstrates that M&E is used to hold implementers of CBW programmes accountable. According to one of the interview respondents, the centralised CBIMS ensures there is a formal line of accountability when it comes to reporting and provinces who do not comply can be followed up. This also ensures a timely response to challenges faced in reporting.

> *"We have a monitoring and evaluation system within DSD where we obtain all the information, it is called Community Based Intervention Management System, and all the CBOs report into this, so we are able to gather information, so if the province is not reporting, we are able to track and identify challenges." (SSI_National DSD)*

Despite the merits of M&E in assessing community-based interventions, findings from the literature review reveal that it has not been prioritised and there is a dearth of rigorous evaluation in the field. Reasons for the shortage of evaluations are varied and include the temporary nature of the programmes, the difficulty of defining the evaluation objective, and the difficulty of collecting data. Primary evidence from this study shows that evaluations are not conducted regularly and few CBW programmes have undergone some form of evaluation. Out of 23 respondents who responded to the question on whether their programmes had been evaluated, only nine gave an affirmative response. It was also evident that most of the evaluations conducted were done internally without engaging external consultants. Friedman (2002) argues that many of these evaluations reach a limited audience.

CBWs in the focus groups conducted for this evaluation shared that they collect various types of information including demographic information of programme beneficiaries, attendance records, number of household visits and people reached, number of materials distributed and number of beneficiary referrals. The frequency of data collection ranges from daily to weekly for most CBWs in our sample, and this information is collated into monthly, quarterly or annual reports submitted to different stakeholders. Despite this progress, the interviews confirm that the data collected is not always reliable and sufficient, and this often affects accurate reporting for both government departments and NPOs using CBWs. Interview respondents cited inadequate staff and low literacy levels of CBWs as the most common reasons for poor quality data:

> *"The literacy level is a problem, some CBWs left school at grade 7 and they sometimes cannot read the data they collect." (SSI_DOH_Prov)*

As indicated in the secondary data, despite efforts to build checks into the reporting process, the quality of data collected by CBWs is poor and marred by inconsistencies between information entered in data collection tools and the narrative descriptions provided by the same informants. One interview respondent explained that, *"The challenge is the literacy level, it takes time to understand what the CBWs write on the tools, they call them and ask for clarification of what happened and they explain in their language."* (SSI_DOH_Prov) Another respondent substantiated this by stating, *"They are good in verbal reporting which does not help the office as they concentrate on written reports."* (SSI_NPO)

Another issue raised in literature is that M&E systems should not only focus on collating statistics as is the case with most CBW programmes. It is argued that counting numbers may not give the necessary detail needed to improve the effectiveness of implementation. According to Bhattacharyya et al (2010) programmes that may not understand why their CHWs drop out may be well served by monitoring some of the most important factors that affect CHWs' motivation and desire to stay in the job. Interview respondents also expressed the same sentiments arguing that too much focus on quantitative data collection may hinder the collection of useful information regarding programme performance.

Finally, the secondary data reveals that use of the paper-based M&E system in CBW programmes is time-consuming and compromises the reliability and accuracy of data. Consolidating reports from CBO level to district, provincial and national levels is a lengthy process characterised by errors and inaccurate data entries. The DSD (2007) acknowledged that the paper-based system creates an opportunity for error and does not allow data verification. The challenge with this is that decisions and planning are then made based on inaccurate data. Efforts by the DSD to roll-out CBIMS to all community-based services in the

different provinces can be perceived as a good starting point for improved data quality. The effectiveness of this roll-out is yet to be seen.

In spite of the abovementioned challenges, M&E is increasingly viewed as an important management tool through which community-based programmes can track progress, make necessary adjustments and ultimately improve the quality and reach of the services for targeted communities.

Key point summary

- Different departments have M&E policy and frameworks in place to assess CBW models; however, implementation in terms of accurate data collection remains a challenge.
- There is need to ensure the effective implementation of M&E policies at the local level. Adequate M&E and data entry training should also be provided to deal with issues of data transfer accuracy.
- The indicators are not comprehensive or standardised enough to provide a full picture of what is going on in the sector, or to allow comparisons between programmes on aspects such as reach, distribution and value for money. Of course, this level of information is critical for any policy or management decision-making.

4.6 Service delivery outcomes

This section of the report reports on a) whether CBWs provide quality services to communities and households; b) whether CBWs improve access to democratic governance, and c) the challenges and barriers for the services CBWs deliver. Hence this section of the report answers the evaluation questions in the box below.

- *Evaluation question 2: Is the use of CBWs improving access to services and local democratic governance?*
- *Evaluation question 2.1: Are CBWs providing quality services to communities and households?*
- *Evaluation question 2.2: What challenges are experienced by CBWs that erode their ability to provide services?*

Why CBWs have been part of the system of service delivery

The history of CBWs and their development was addressed in section 1.1 Introduction to CBW, its history and development. Essentially, CBWs involvement in service delivery has been two-fold. First, through programmes such as CWP, individuals (CBWs) are absorbed into the labour market and are provided with opportunities to actively participate in society (Lomofsky, Davies & Burns, 2015). Second, the underlying logic of the CBW system is that programmes delivered utilising CBWs would reach more people in a cost-effective manner and be more culturally appropriate than traditional models of service delivery (ODI, 2000).

What specific role do they play in the service delivery system?

Both the literature and results from the SSIs and FGDs emphasise that CBWs provide social, health and empowerment services (to name a few) to vulnerable and hard-to-reach communities. For instance, these communities can be located far from government and/or NPO services and endemic poverty prevents individuals from accessing transport required to access institution-based services (Chappell & Lorenzo, 2012). Thus, while the services may be focused on households, individuals, groups or community-wide interventions, CBWs are employed through facilitating agents linked to a government department or an NGO to improve access to services, provide culturally appropriate services and opportunities and to be a liaison between communities and institutional structures (Chappell & Lorenzo, 2012; Nxumalo, 2013; ODI, 2000). More specifically, the ODI study of the CBW phenomenon in four African countries identified the following roles CBWs play:

- Acting as a conduit for information and technologies
- Being a bridge/link person between the community and service providers/facilitating agent
- Mobilising the community into groups for learning activities including behaviour change interventions or awareness raising campaigns
- Providing advice and training for community members and providing follow up support
- Working on their own activities and providing demonstrations from their households
- Animating the community by providing energy and enthusiasm for development activities and maintaining the momentum to pursue them. (ODI, 2007: 2)

Findings from the SSIs and FGDs indicate that another role can be added to these roles identified by the ODI:

- CBWs identify community needs (SSIs and FGDs).

4.6.1 Use of CBWs to improve access to services and local democratic governance

This section of the report deals with the evaluation question: Is the use of CBWs improving access to services and local democratic governance?

Improving access to local democratic governance

It is primarily the role of CDWs and CDPs to successfully link communities to local government decision-making, but these workers have not been included in the definition of CBWs in this evaluation, for reasons described in section 4.4.

However, the respondents indicated that CBWs have been found to assist in bringing government closer to the people by gathering information about community needs via community forums and communicating community needs at ward level; there are however reports of animosity between ward councillors and CBWs suggesting political complications with the CDW effort. Other respondents note that some CBWs, such as CHWs, are not invited to attend community and government meetings and can therefore not bring communities closer to democratic governance.

To answer the second part of evaluation question 2, it is necessary to review the evidence for whether CBWs are effective in increasing access to services.

Improving access to services

Overall, CBWs are effective in increasing access to services, as is evidenced by their ability to a) access hard-to-reach and vulnerable communities; b) build trust and relationships with communities; c) identify community members in need of health and/or social services, and d) effectively link communities to formal services. Evidence for each point is provided below.

CBWs can access hard-to-reach and vulnerable communities

While reflecting on the strengths of the CBW system, most participants of the SSIs and FGDs indicated that because CBWs across provinces and cadres are members of the communities they serve, they are well positioned to access hard-to-reach and vulnerable communities. Thus, CHWs serve as an essential link between government health services and vulnerable communities (Sips et al, 2014).

CBWs deliver effective services due to trust and relationship-building competencies

Further, the evidence suggests that having accessed communities, CBWs can build trust with community members who previously, "could not open up to anyone, and are very secretive" (SSI_Government). The international experience of CBW systems mirrors the finding that CBWs can foster trust with cautious community members:

> *"CBWs are members of the community so they are readily accepted by the community… those in the communities also tend to trust one of their own – if a stranger, unless you come up with something really impressive, you won't be easily accepted or trusted in the community. Also, as a professional, you have to know the entry points" (SSI_Expert).*

Respondents explain that this process of trust-building between CBWs and community members is due to CBWs having pre-existing relationships with community members, knowledge of community dynamics, and the ability to communicate in the beneficiaries' home language given that CBWs live in the communities themselves.

> *"CBWs are members of the community, the live in the same community, understand community dynamics and have a language advantage." (SSI_Local Government)*

A key contributor to building this trust is that CBWs are relatable and can therefore "*market their services effectively"* (SSI_Local Government). A South African study found similar results; CBWs (Community Rehabilitation Workers) enabled effective community-based rehabilitation for persons with disabilities because of their psychosocial competencies (being relatable and able to build trust and relationships) (Chappell & Johannsmeier, 2012). In the case of persons with disabilities, the researchers noted that the way in which services are delivered and communities are accessed is an important enabler for (or barrier to) effective service delivery. Thus, the process of trust-building is essential.

Identifying community members in need of health and social services

A previous evaluation of the Isibindi Programme found that CYCWs have been effective in identifying orphans and vulnerable children and youth OVCY in poor wards in South Africa in need of social services (Mott MacDonald, 2016). Similarly, the SSI conducted for this evaluation found that CHWs in particular are instrumental in identifying individuals in need of medical care. Thus CHWs serve as an essential link between government health services and vulnerable communities (Sips et al, 2014). The role of CHWs in providing services to people

living with HIV/Aids (PLWHA) was perceived by respondents of the SSIs and FGDs as a key strength of the CBW service delivery system. This is supported by the wider literature where CHWs and other CBWs are also positioned to challenge social norms and stigmas associated with PLWHA and poor treatment adherence (Perry, Zulliger, & Rogers, 2014; Mwai et al, 2013).

Improving access to services through linkage to formal care

The literature further indicates that having accessed communities and identified those in need of services, the linkage or referral services CBWs deliver can be effective when CBWs have good working relationships with other para-professionals[38] as well as professionals (Mott MacDonald, 2016). For instance, from the SSIs and FGDs, it is clear that some CHWs in the Eastern Cape and Limpopo regions have good relationships with nurses, physiotherapists and social workers. Thus CBWs are able to screen and identify individuals and link them to further care when required. In so doing, CBW-implemented services are effective in increasing government's reach of social and health-related services. Other CBWs within South Africa report successfully linking community members to other government and community-based services, such as support groups.

In sum, CBWs increase access to services due to their unique positionality to a) access hard-to-reach communities; b) identify community needs as well as individuals in need of care/services, and c) refer/link such individuals to systems of formal care such as clinics (and in so doing improving access to care).

Moreover**,** according to stakeholder responses from two different NPOs as well as government stakeholders, the beneficiaries CBWs serve would, in many instances, not be serviced if it were not for CBWs. Similar findings emerge from the literature (Mott MacDonald, 2016). The literature indicates that without CBWs, vulnerable communities would – at the very least – be underserviced and services would be less available to these populations (Ataguba et al, 2012; Mott MacDonald, 2016; Western Cape Government, 2014).

4.6.2 Quality of CBW services

Evaluation question 2.1 asks: "are CBWs providing quality services to communities and households?" The evidence pertaining to this evaluation question is addressed in this section**.**

The quality of CBW services is difficult to assess and remains debatable. There are several reasons contributing to this quality debate, the most pertinent include that CBWs vary significantly in their mandates, competencies, training, supervision and in the specific services they deliver. Assessment of these services is thus complex (see section 4.5.5).

From the available evidence, it is clear that on the one hand, across the globe, CBWs such as CHWs have become recognised and valuable members of the health delivery system that have a profound impact on the health and well-being of community members (Bhutta et al, 2010; Maes et al*,* 2014; Naimoli et al*,* 2015; Omgunmefun et al, 2011). For instance, task-shifting[39]

[38] Note that certain CBWs working with the Isibindi programme are para-professionals themselves.

[39] In cases where there is a shortage of professionals (doctors, physiotherapists, nurses and social workers etc.), CBWs perform certain tasks traditionally carried out by professionals (such as providing rudimentary medical treatment) thus sharing the burden of care and allowing professionals to focus on more technical tasks that CBWs are not trained to do. This is referred to as task-shifting. Task-shifting thus enables more people to access services, as well as upskilling CBWs by increasing their scope of work (Ataguba et al, 2012).

to CHWs has been found to be cost-effective and reaches otherwise underserviced populations; they have also been critical in improving the quality of lives of PLWHA. In a South African study, CRWs deliver quality services, as evidenced by their beneficiaries (persons with disabilities) reporting positive outcomes – such as increased independence in activities of daily living; increased social integration and mobility – which were directly linked to the perception that the CRWs delivered quality services (Chappell & Johannsmeier, 2009). Similarly, an evaluation of the Isibindi Programme found that OVCY benefited profoundly from CBWs, and that without CBWs, this population would be worse off (Mott MacDonald, 2016). Refer to section 4.5.4 for a detailed discussion on CBWs and value for money.

It is worth noting that in the above examples, quality is defined differently and is dependent on the type of service, the context and the perceptions of service recipients. Thus some researchers argue although CBWs can deliver services, the *quality* of services is compromised when delivered by CBWs due to their comparatively lower levels of formal training (compared to professions) (Ataguba et al, 2012; Clark, 2015; Dawad & Jobson, 2011). Other researchers argue that if adequately supervised, and if adequately resourced, CBWs can deliver quality services (Hermann et al, 2009; WHO, 2007). Supervision, however, varies among cadres of CBWs (SSIs, FGDs). A document review of key instruments (norms and standards, policies and legislation pertaining to CBWs) reveals gaps that need to be addressed to ensure these documents are useful and accessible to CBWs. See section 4.5.1 for a detailed analysis on these guiding legislations and policies.

Another factor influencing the quality of services delivered by CBWs is that, due to a lack of funding, some NPOs use the EPWP to employ CBWs. On the one hand, this is considered to be an '*innovative*' solution to social employment, however, it is clear that the implications of using the EPWP to employ CBWs as it currently stands can compromise quality of services, and can be contradictory where there is an ongoing need for CBWs' services (SSI_Expert). For instance, some NPOs report that CBWs employed through the EPWP work on rotation schedules, resulting in frequent changes in staff. One SSI stakeholder notes that: *"This means the quality of services is not constant and consistent when new people come on board" (SSI_NPO).* Even though rotation is common in social services when people need 24-hour services, it can become problematic when handover is not well managed, and if a new set of people is brought in every six months losing those who had previously been trained and gained experience.

Other stakeholders note that NPOs' authority is undermined because they (NPOs) do not pay CBWs – thus NPOs cannot stipulate working hours of CBWs resulting in the NPOs' reach and quality of service provision being compromised. Moreover, funding provision from the EPWP is, according to SSI respondents, unpredictable and unreliable. This results in difficulties for NPOs who are reliant on this funding.

According to the FGDs and SSIs, one of the challenges to the CBW services is that of accountability. The current model of government employing some types of CBWs (such as CHWs in KZN) in certain provinces has occurred partially in an effort to improve accountability of CBWs to ensure effective service delivery. However, as discussed in section 4.5.5, the fragmented state of these accountability measures is insufficient to ensure that CBWs are held accountable to the communities for the services they provide.

The SSIs and FGDs indicate that there are other barriers to providing effective services because the overall management, coordination and supervision of programmes differs from province to province, depending on the development cluster and the involvement of different national departments.

Thus, with no standard measurement of quality and a healthy debate on the topic as seen in the literature, it remains uncertain whether all CBWs deliver quality services to communities and households. It is, however, clear that without CBWs, many services would not be delivered at all. The conclusion from this finding is that improving the quality of CBW services is a high priority area.

Challenges of the services provided by CBWs and barriers eroding CBWs ability to deliver services

Evaluation question 2.2 asks "What reported challenges are experienced by CBWs that erodes their ability to provide services?" This section of the report documents the relevant evidence pertaining to this question (drawing mainly on SSIs and FGDs).

Challenges and barriers CBWs face personally eroding their abilities to provide services to communities

This evaluation confirms what was found in the literature review, namely that the various CBW programmes encounter numerous challenges and barriers. These are discussed below.

The literature indicates that CHWs – and indeed other CBWs – are generally from the community they serve and therefore they often deal with the same barriers as their clients which impacts on their abilities to provide or meet the community's needs (Nxumalo et al, 2016). For instance, according to the FGDs with CBWs, one of the most frequently mentioned barriers CBWs face personally is **safety and security** due to operating in high-crime areas. Specifically, CBWs report fearing drug merchants and addicts. Another respondent stated that there are "no-go zones" where CBWs simply cannot access communities without compromising their own safety.

Another barrier CBWs share with their beneficiaries is income **poverty**. This, coupled with minimal resources such as a small or no travel allowance, means CBWs sometimes travel long distances on foot to get access to vulnerable communities. Limited resources also can result in **unsafe working conditions**. For instance, in a FGDs, CBWs report not having safety equipment (such as medical masks) to prevent the transmission of TB when working with patients with TB. Lacking resources such as protective clothing, stationary or **demonstration aids for educational purposes** was also reported. It should be noted that in some provinces, certain CBWs such as CHWs report having sufficient resources and medical supplies. However, the fact that this has been found to be a 'significant' barrier to effective service delivery in the evaluation of the Isibindi Programme, a 'more strategic approach to resource allocation' is required (Mott MacDonald, 2016 p.40). One expert respondent described the problem as follows:

> *"The lack of resources for the CBWs is completely endemic in the sector – this is the cancer of the sector that robs government of the money that it invests when it employs the practitioner. That practitioner is not used efficiently and effectively because they do not have the tools of the trade that they need to implement." (SSI_Expert)*

As discussed earlier, partnerships between CBWs and para-professionals/professionals are enablers for quality services. The FGDs reveal that in some instances, CBWs feel these **partnerships are lacking**, and that there can be animosity between CBWs and these partners. During the FGDs, the CBWs reported **feeling that their work is undervalued** and unappreciated by some community members and partners, such as nurses. This contrasts somewhat with findings from a previous evaluation of the CWP, where CWs indicated that they

feel appreciated for the work they do within their communities (Lomofsky, Davies & Burns, 2015). However, literature has indicated that **poor understanding of roles and responsibilities among CBWs and their partners** (e.g. para-professionals and professionals) limits the degree to which CBWs can fulfil their mandate and thus hinders service delivery (Chappell & Johannsmeier, 2012; Mott MacDonald, 2016). CBWs also partner with teachers and parents when CBWs offer services to children, according to the FGDs, a lack of cooperation from teachers and parents can be barrier to service delivery.

There are huge discrepancies among provinces in what "ward-based" CHWs are paid, who pays them, the kind of work benefits they get and how many households they need to cover (Van Pletzen & McGregor, 2013). Similarly, in the FGDs, CBWs report that they are **poorly incentivised** for their work and there are discrepancies between stipends between various departments and NPO service providers (see Table 15 for discrepancies in remuneration and section 4.5.4 on conditions of employment). Other barriers faced by CBWs are the **social norms, attitudes and beliefs** prevalent in the South African context. The fear of being stigmatised (in the case of PLWHA or persons with other stigmatised health conditions) contributes to a defaulting behaviour and poor treatment adherence. CBWs report **low participation** in their projects in some regions. This low uptake of services is due to social and political divides within communities. Another reason for low participation is poor communication of the role of CBWs and their projects. Lastly, CBWs report having too many community members to service which is exacerbated by long distances or poor road conditions that make it difficult to reach people in a reasonable time frame.

In sum, CBWs report multiple challenges eroding their ability to provide services to communities and households. There are significant structural and institutional barriers, such as issues of coordination, management, supervision and accountability – these relate to the CBW system of service delivery. Additionally, there are barriers CBWs face personally such as community norms and standards, lack of resources, unsafe working conditions and poor incentives.

Key point summary

- CBWs increase access to services due to their unique positionality to a) access hard-to-reach communities; b) identify community needs as well as individuals in need of care/services and c) refer/link such individuals to systems of formal care such as clinics (in so doing improving access to care).
- The quality of CBW services is difficult to assess and remains debatable. With no standard measurement of quality and a healthy debate on the topic as seen in the literature, it remains uncertain whether all CBWs deliver quality services to communities and households. It is, however, clear that without CBWs, many services would not be delivered at all. Hence, improving the quality of CBW services is a high priority.
- CBWs report multiple challenges eroding their ability to provide services to communities and households. There are significant structural and institutional barriers, such as issues of coordination, management, supervision and accountability – these relate to the CBW system of service delivery. Additionally, there are barriers CBWs face personally such as community norms and standards, lack of resources, unsafe working conditions and poor incentives.

4.7 Whether the CBW model is sustainable

This section reports on the sustainability of the CBW model. It first looks at what sustainability means. Thereafter it looks at CBWs as a model of sustainable service delivery and whether the CBW model is sustainable, before concluding. It answers the following question in the TOR:

Evaluation question 5.2: Is the CBW model sustainable?

This evaluation question can also be considered in the inverse, are government services sustainable without CBWs? Both angles are discussed below.

Sustainability can be seen as having the finances, capacity and HR to continue providing services to beneficiaries. Globally, for over 50 years, low-paid or voluntary CBWs have been a popular strategy to increase access to services to underserved populations in a cost-effective way. CBWs are assumed to be more sustainable because of their lower costs as well as their connection with (and accountability to) local communities (Boesten, 2005; ODI, 2007).

The importance of long-term sustainability of CBWs was highlighted by two respondents who work for NPOs. Both felt that without the support of CBWs, government departments would not have the capacity to meet the needs of the country's population – particularly in the health sector, and even then, the demand/need is not met.

Various issues could potentially negatively impact the sustainability of the CBW model. One factor that seriously impacts the sustainability of the service, also related to cost-effectiveness, is the high turnover of CBWs in the system[40] due to the volunteer model (insecure working conditions and poor remuneration), and lack of access to career paths and opportunities. In addition, inequitable conditions of employment could demotivate specific workforce members. If the CBW workforce was more sustained, then the whole system would be more sustainable.

From the respondents and literature reviewed, it appears as though the CBW model is potentially sustainable for a number of reasons. A key reason emphasised in both the literature review and in the interviews was the importance of political will in ensuring sustainability – it would ensure the funding and systems required. According to a 2005 HSRC Assessment report, the continued sustainability and funding of the CDW programme is dependent on continuous endorsement at a political level and most interview respondents feel that political will should be sustained. The section on Leadership and Political Will (4.5.2) discusses it in more detail. The emphasis on political will and political leadership was shared by a respondent from a national directorate. Three government respondents argued that there was political support for the system.

> *"The fact that we are implementing as a government indicates that there is political support for it, if there wasn't political support we could have stopped implementing." (SSI_National Government)*

However, another felt that political will varied among Members of the Executive Council who have differing priorities and political will itself may not be sustained.

Clearly NPOs play a critical role in the delivery of social services in South Africa – but it is increasingly unsustainable for NPOs to manage and supervise CBWs with low management fees (Peter et al, 2017).

40 As seen in section 4.2.5

For NPOs and government respondents, funding was a significant focus and indeed is a key focus of sustainability. Many CHW programmes in South Africa started out having multiple external funders and some are still, at least partially, funded by donors but most donor funding is time-bound. CHW programmes can thus be thrown into crisis at the conclusion of an external grant. Governments may attempt to retain the CHWs for some time, but the programmes are not sustainable without the financing for financial incentives for CBWs (such as stipends, wages or compensation) or other and further training (UNICEF, 2014). According to respondents, five NPO workers felt funding from government would be continued, while two were unsure. For government stakeholders, three provincial department stakeholders felt funding would be continued (from DSD, DOH and OotP) while one was unsure (DOH).

The sustainability of CBWs is thus vital for the country to extend the reach of services to the most vulnerable and marginalised people. What is key is political will, funding and involving all stakeholders such as NPOs. Improved monitoring may help with political will as it could show how effective CBWs are. Additionally, planning for sustainability is important. Most respondents felt that there was political will and that government would continue to provide funding for CBWs. CBWs are cheaper than the alternatives in terms of service delivery; if CBWs are not sustainable then such services are simply unsustainable. According to ODI (2007), the cost of CBWs could potentially be offset to some extent by savings elsewhere, such as reduced hospital admissions. Further, the benefit:cost ratios were expected to increase with the improvement of livelihoods as a result of CBW work. Additionally, as shown in the value for money section (section 4.5.4) of the report, research done by the Medical Research Council found significant cost savings in HIV & Aids, TB and palliative care in addition to the number of people that would benefit. There is thus potential for sustainability going forward and a belief in its importance.

Other recommendations for sustainability in the literature include the development of a strategy to ensure the overall sustainability of the programmes in terms of resources allocated, including financial, human and capacity resources (DSD, 2014). Interviews suggest that there is a sustainability plan for the DSD OVC Directorate and that while the directorate can sustain a small-scale programme, it needs to be expanded to meet national needs. Isibindi is an interesting case. It is a successful programme that is highly regarded abroad and being replicated by others. However, as one respondent from a professional body noted, although the programme was 18 years old with evidence that it is successful, they are coming up with a new package of services and redesigning Isibindi.

Further, it is recommended that CBW programmes be embedded in the Integrated Development Plans at municipal level and that the framework in which funds are made available for the delivery of training be streamlined to reach the providers and learners on time and without obstacles (HSRC, 2005). It is also important to note that different projects have different sustainability challenges. For example, with regards to Togomelo, one professional body member highlighted that a challenge was donor funding not being used strategically to ensure training is sustainable.

Additionally, improved monitoring was highlighted by two respondents as being able to improve investment return and ensure that CBWs are adding value. This will help indicate to government whether CBWs are value for money, which could ensure more political buy-in.

Key point summary

- The CBW models are sustainable if they have continual political endorsement. The CBW models are cost-effective and without the support of CBWs, government

departments would not have the capacity to meet the needs of the country's population.

- High turnover of CBWs, due to insecure working conditions, poor remuneration and lack of access to career paths and opportunities affects the sustainability of the CBW workforce. If the CBW workforce was more sustained, then the whole system would be more sustainable. Other factors affecting sustainability are the low management fees allocated to NPOs to manage and supervise CBWs and multiple and time-bound funders of CHWs.

5 Conclusions and recommendations

5.1 Conclusion

The purpose of the diagnostic evaluation is "to assess the use of CBWs by government (either employed by government or in government supported programmes) to streamline, strengthen implementation and improve effectiveness and efficiency." (TOR, DPME).

What is the scale, scope and distribution of government supported CBWs?

How can CBWs be defined (1.1); what are the job descriptions and duties of CBW at household and community level (1.2); what methods and tools do they use in their work in communities and households (1.4).

To begin answering this question, the evaluation sought to identify a **definition of CBWs**. Following investigation into the various CBW policies, programmes and cadres, it is clear the main groups of CBWs are located within the DOH and DSD, and the programmes supported by these departments. The primary function of these CBWs is to provide some services directly to families, households or communities, and to link individuals or families to services – essentially to extend government services into communities. While there are many volunteers within the government system, they do not fulfil the roles described above. So, for example, while there are volunteers in education, such as in the School Nutrition Programme, they are not CBWs in that they are not linking individuals or families to services or enabling government to extend services into communities; they are bolstering facility-based services.

Definition of CBW in this evaluation

The evaluation has defined CBWs as those who are selected from and work in the communities in which they live; are non-professional workers but who may have a qualification up to NQF level 4; work at individual, household and community level, or as part of outreach teams; provide community-based services directly to community members or provide linkages to other services. Their primary aim is to extend the reach, access and uptake of services by the most vulnerable members of society. CBWs should ideally work under the supervision of a para-professional or professional in their related field. They can be employed directly by government or NGOs on government or donor supported programmes, although this evaluation is focused on those who are working in government supported programmes. EPWP and CWP are considered as funding streams for CBWs, rather than a type of CBW on their own.

The CHWs are the main CBW within the sphere of the DOH, while there are a number of cadres in DSD programmes, the main ones being CCGs (which includes HCBC, VEP and disability assistants for example) and learner and auxiliary CYCWs. Although CDWs and CDPs are part of the CBW system, they are not considered CBWs as they do not primarily engage people at the individual and household level, and CDPs are professionals. They are considered facilitating agents who play a role in coordination, mobilisation and liaison at community level, and between communities and government.

Hence, the scope for harmonisation, rationalisation and coordination being considered is within or between the DOH and DSD.

What are the job descriptions and duties of CBWs at household and community level, and is there duplication?

A review of documents and primary data collection was unable to determine the **scale and distribution** of government supported CBWs as it was not possible to calculate this from budget allocations and there are contradictory estimates from various departments. In terms of their **scope of work**, the review of **job descriptions** and analysis of primary data confirm that CBWs provide or facilitate access to a wide range of health and social services targeted at the individual, household and community level. These services are often preventative and prevent those already at risk from further trauma and illness.

Some groups have tools and specific approaches or methodologies to frame their community-based interventions, such as CYCWs who work specifically in the life space of the child. However, there is limited data to indicate to what extent the same applies to the other cadres and sub-groupings of CBWs.

There is disagreement as to whether there is duplication and overlap in CBW models. However, in unpacking the term ‘duplication’, it should be stressed that duplication of services should only be perceived as a challenge if a household received duplication of the same services. While there is a measure of overlap in the services provided on paper, such as household profiling, the data from the FGD, SSI and document review on the scale of CBWs suggests that a community may not necessarily have both a CHW and a CCG, for example. Furthermore, while they may both be conducting assessments, CHWs conduct health assessments, while a CYCW would focus on assessing child and social protection requirements. There is little evidence to suggest that this is a wide-scale problem, and conversely any attempt to rationalise services could result in gaps in services at the household level.

What are the respective roles of sector departments and centre of Government Departments (COGTA and DPSA) in regulation and implementation of CBW models?

In general, national departments are responsible for policy and regulative developments, while provincial departments are responsible for the implementation, supervision and M&E of the implementation of CBW models, including funding (unless they receive a conditional grant). Provinces have relative, not absolute, autonomy, and the legislation and policy in respect of health and social development exists primarily at national level.

The real concerns about the roles of departments is in relation to the CDW programme, which was developed by the DPSA but was supposed to be handed over to COGTA, which for various reasons has not taken it over, and where the workers are employed by provincial government, but are located at and accountable to local government. This is not an optimal situation and needs the special attention of the people directly involved from both departments

(and potentially the DSD, as the CDPs are very closely related to the CDWs and there could be potential for rationalisation in this regard).

How do CBWs interface with other institutional and service delivery initiatives such as departmental and provincial service delivery improvement interventions? (1.7)

What, if any, regulatory frameworks and institutional mechanisms are in place to support CBWs (professional regulatory requirements, continuous training and development, supervision), and are they working well? (1.5)

What is the requirement, job grade and income levels of different CBWs? (1.3)

CBWs play a key role in a number of departmental implementation strategies and both the DSD and the DOH have their CBW models they coordinate. There have been attempts by departments to work together (also at the instruction of Cabinet), though these were not successful most likely since they serve different needs. Certain service delivery models, such as WBOTs or OSS, rely heavily on CBWs and have received significant praise by respondents in the evaluation of the effectiveness of their work and coordination. However, they still face certain challenges in terms of implementation, making particularly administrative coordination, better implementation strategies and M&E of these strategies even more vital.

Numerous policies and legislation provide the foundation for the rights of citizens and employment statutes in South Africa. CBWs, even the volunteers so long as they receive some compensation, are governed by the labour regulatory framework including the BCEA and various Ministerial Determinations governing working conditions and wage levels. The conclusion is that implementing the BCEA should go a long way to solving many of the problems faced by the CBW workforce.

The EPWP worker is not a type of CBW – rather it is recognised as a funding stream for CBWSs. The use of EPWP as a funding stream to pay for CBWs is not ideal as it provides precarious and temporary work opportunities. EPWP is useful to support those who are trainees or learners on the path to becoming CBWs, and who can thus exit EPWP with a qualification.

Various programmes stipulate guidelines for recruitment and norms and standards that cover working conditions and practices. Inconsistent adherence to these regulations and guidelines causes problems of inappropriate recruitment of CBWs, inadequate remuneration, inequality and dissatisfaction amongst the CBW workers, both in government and in the NPO sector. This also results in confusion and conflict among the CBWs and between CBWs and their employers. The inadequate and late payment of funding to NPOs further fuels this already complex problem. The solution to these problems is the correct implementation of what exists, including the implementation of the Policy for Social Service Practitioners, rather than more new legislation or policy.

CBWs can be recruited from grade 10, and typically go up to NQF level 4, although some may argue that para-professionals should not be considered CBWs.

There are no overarching professional regulatory requirements for CBWs because they are not a single cadre or workforce; however, there are requirements governing certain categories of CBWs. The only two cadres who currently require registration are CHWs (with the HPCSA), and CYCWs (with the SACSSP).

The White Paper for Social Welfare is currently being reviewed and a Policy for Social Service Practitioners includes regulations for social workers, CDPs and CDWs and CYCWs, with an

emphasis of training and development. This is obviously a key document that addresses many of the concerns raised in this evaluation, at least within the Social Development field.

Policy directives are clear about the importance of training and skills development for the various groups of CBWs and the need to link it to career progression. Evidence from literature confirms that there is no standardised approach to training but that it should be a mix of short courses, on the job training and NQF courses. A review of the policies (draft and final) from the DOH, DSD and the NPO sector is that this approach is being followed and there are mechanisms in place to facilitate the training of CBWs; but there is still much work to be done to improve the articulation of training in terms of career pathing, access to training (particularly in rural areas) and quality of training.

In terms of CBW supervision, evidence from the literature and document review found that this is a crucial factor for good quality service provision. There is evidence that various CBW programmes have supervisory structures in place, but supervision is taking place to varying degrees. The limited funding allocation to NPOs for supervision has had a negative impact on the quality of CBW supervision. The well-structured supervision model of the Isibindi Programme is an example of good practice which could be replicated. However, quality of supervision becomes more challenging as programmes scale up.

Evaluation question 1.8: How well integrated are the CBWs within their respective professional practice?

Regarding the integration of CBWs within their professional practice, the evaluation found that some categories of CBWs are not being sufficiently integrated within their respective professional practice. The main reasons for this are that there are no clearly articulated career paths for the professionalisation for all cadres of CBWs; not all cadres of CBWs are linked to a professional stream with associated skills development and career progression; and finally, the quality of supervision and mentoring of CBWs across the various programmes is not always adequate to build or support their professional growth and development.

The evaluation has identified the need for career incentives and professional development opportunities for CBWs.

Is the use of community-based workers improving access to services and local democratic governance? (Effectiveness) (2)

Are CBWs providing quality services to communities and households? (2.1)

What challenges are experienced by CBWs that erodes their ability to provide services? (2.2)

It is worth noting that this evaluation confirmed the essential role CBWs play in accessing communities (through penetrating hard-to-reach communities, building trust with communities, identifying those in need of services and linking communities to institution-based care). While the quality of CBW services has not yet been established given the lack of measureable indicators and standards, there is evidence of positive impacts of CBW-related services in communities. CBW models are under-evaluated despite their importance. Although a number of evaluations have taken place, their focus is more commonly on the service provided and beneficiaries rather than specifically on the CBWs' role in the provision of these services, and even so, it is difficult to ascertain the quality of services provided by CBWs.

CBWs face many challenges and barriers hindering their ability to implement services in communities and households, the most prominent barriers are threats to safety, income poverty, unsafe working conditions because of limited resources (e.g. safety equipment), a lack of demonstration aids and poor partnerships between CBWs and professionals.

Overall, CBWs work in unsafe working conditions and battle poverty themselves. These factors along with poor incentives (including career incentives) mean there is a high turnover that ultimately interferes with the ability to deliver services.

CBWs work because of how uniquely they are positioned to BUILD TRUST with communities, and challenge social norms in communities that prevent people from utilising services. Access alone is not enough – CBWs are essential in facilitating UTILISATION of services. Considering this, people need to be incentivised to work in the communities in which they live. CBWs should not be undervalued because this results in high turnover, which causes inefficiency and inconsistency of service delivery.

Is there value for money in using CBWs? (3); *Evaluation question 3.1: Is the provision of services through CBW cost-effective and does it improve access to services?*

The flaws in the available information on budgets and expenditures seriously limits the extent to which the effectiveness and efficiency of CBWs can be assessed. The report explains key problems related to double-counting between EPWP and provincial grants and found that provincial revenue and expenditure allocations for CBWs are opaque with many inconsistencies in allocations across provinces and with treasury requirements. This makes it difficult to estimate expenditure on CBWs from provincial budgets. There are two compelling arguments for funding CBWs. First, their largely preventive function prevents further trauma and illness – which are costlier to address (the costs of which have not been considered for this study but are considered in the prevention and early intervention literature). Second, CBWs take services to the people, where they need them the most, and there is compelling evidence of positive impacts in numerous evaluations and investment cases, both globally and locally.

Despite the importance of CBWs in the service delivery model of government, and evidence of tremendous impact, the analysis of the funding to social services in the EPWP, and the allocation of funding for CBWs shows that the jobs are not well funded and are lower paid, relative to other sectors (e.g. infrastructure), or that some provinces do not allocate any money to CBWs beyond their conditional grants. Use of EPWP for funding of CBWs reduces costs, but the cost-effectiveness of EPWP funding is reduced by the poor administration of stipends and the low pay, which cause demotivation and dissatisfaction. The poor administration of the NPO transfers for government supported programmes also contributes to this, as does inequality in pay within and between programmes and provinces. Interviewees generally focused on this aspect when asked about value for money. Respondents noted that the delivery of services through NPOs was much cheaper than delivery through government officials, mainly reflecting lower compensation for wages for CBWs, supervisors and managers compared to government officials. Hence, all the challenges noted above regarding effectiveness of the CBWs and around the CBW workforce, inhibit but do not discount their value for Government.

How have different departments using CBW monitored and evaluated the models? (4)

Based on the evaluation findings, it can be concluded that different departments have M&E frameworks put in place to assess CBW models. What remains questionable, however, is their adequacy in capturing the basic necessary data. The document review revealed that performance indicators largely focus on output indicators such as the number of beneficiaries reached with little or no attention to outcome performance indicators. In addition to this, there are few or no indicators related to CBWs specifically. Primary data also shows that despite the availability of M&E frameworks, one of the biggest challenges is inadequate capacity to implement at the local level and this affects overall reporting at different levels of accountability.

To what is there potential to rationalise, coordinate and develop common norms and standards across government for CBWs (5)

What are the legislative labour relations, professional, political and financial considerations? (5.1)

Is the CBW model sustainable? (5.2)

The evaluation team wants to emphasise that there is no single CBW workforce but instead a range of categories of CBWs that operate under the auspices of different sector departments. This diagnostic evaluation focused on the health and social sector CBWs. Even with this narrower scope, there is a range of categories or cadres of CBWs.

There have been previous attempts to rationalise CBWs in the sense of introducing standardisation. The first point to note here is that these attempts have generally focused on one or two specific types of CBWs rather than CBWs as a whole. The second point to note is that while these attempts have sometimes resulted in policy documents, these policy documents have sometimes remained at the draft stage rather than being formally adopted. Further, even if adopted, there has been limited success in implementing them.

One of the more successful attempts at rationalisation in the form of standardisation was the national roll-out of the Isibindi Programme. However, even here, with the national DSD as the overall lead for the roll-out and a single organisation (NACCW) supporting the process, developing detailed **standardised processes and procedures** and employing the mentor team, provinces sometimes chose to deviate from the prescribed norms and standards. The fact that provinces were funding much of the roll-out presented a challenge for attempts to enforce standardisation. That said, it is worth noting that other national departments – and in particular the DBE – have to a large extent been able to enforce standardisation within the public school system despite provincial departments funding this service and constitutional provision for some provincial autonomy.

Most respondents and experts said there was a need to rationalise the CBW systems. However, asking whether someone supports “rationalisation” or “integration” is essentially a leading question, in that “rationalisation” and “integration” are seen as positive attributes that one should always support.

The evaluation team *questions* a call for rationalisation across the different types of CBWs for several reasons.

First, the fact that the different categories work at the community level does not constitute a sufficient basis for rationalisation. If we do not aim to rationalise or standardise the system for nurses, teachers, and social workers who work in institutions, why would we want to do this for different cadres who work in the community but in different sectors and on different tasks.

Second, any attempt to rationalise across the different types of CBW when there are still enormous differences between CBWs within a single type is almost certainly doomed to failure. Similarly, attempts to rationalise across sectors or departments when a sector or department has not rationalised within its own sphere seems over-ambitious.

Third, the differences in the nature of the work done by the different categories would make standardisation difficult, if not impossible. For example, on a simple issue such as hours of work, while community based CYCWs might need to work flexible hours so as to be available at times of the day when children are not in school and family members are available for family interventions, a CBW providing palliative care to an older or ill person could have more standardised hours.

Fourth, in areas where there is standardisation – such as aspects covered by the BCEA – the regulations are often ignored. Before introducing further policies and regulations, government needs to ensure that the existing ones are complied with.

An area that does call for rationalisation and standardisation as well as improvement, is the way in which government funds NPOs and manages the service level agreements and transfers. Recommendation 11 in the report of the Ministerial Committee on the Review of the Welfare White Paper dealt with this issue, and all the Committee's recommendations were adopted by Cabinet. Substantial work has already been done in this area with support from National Treasury. However, the reforms have not yet been implemented.

Another issue on which clarity is needed is the relationship between EPWP and CBWs. For the most part, the CBWs covered by this evaluation are performing tasks and delivering services that will be needed on an ongoing basis. Their work relates to what should be ongoing government programmes rather than time-delimited projects. In these cases, use of the EPWP is questionable as EPWP employment is meant to be time-delimited and EPWP funding is provided for only 12 months maximum at a time. The confusion between EPWP and CBWs, and sometimes conflation of the two in discussions, almost certainly encourages calls for rationalisation in the sense of "sorting out the confusion". As this report stated above, EPWP needs to be understood as a funding stream rather than a programme. Ideally, it should be recognised as a less than ideal funding stream for most CBW programmes.

In summary, the evaluation team supports some standardisation, but this should happen within and for particular types of CBWs rather than across the "CBW system" – because there is not, and should not be, a single "CBW system".

In terms of **coordination**, action is needed both within and across sectors. Within sectors, coordination is needed to effect the rationalisation and standardisation of processes and procedures. This would require the national officials who oversee the services provided by a category of CBWs to bring together those heading provision of this service in the nine provinces to plan, implement and monitor the process of planning and implementation. On the finance side, the 10x10 meetings that bring together the HODs and finance heads of the nine provincial and related national department would be one of the forums in which such coordination could be discussed.

National officials might argue that they do not have the power to impose particular approaches on provinces. However, provinces have relative not absolute autonomy, and the legislation and policy in respect of health and social development exists primarily at a national level. The 10x10s and similar structures embody the cooperative governance approach which is meant to underlie the relationship between the three spheres. And there is evidence in respect of other sectors – in particular education – where national has coordinated provinces in implementing standard practices. This evidence suggests that this is possible if the political will exists and the service area is considered sufficiently important.

Constitutionally, local government has minimal responsibilities in respect of social services. The fact that CBWs work locally does not mean that they become a municipal responsibility. Instead, local implementation of service delivery within social development and health can be seen as taking the district level structures which already exist within these sectors to a lower level. Keeping responsibility with these two sectors does not rule out engagement with municipalities. The important point is that the responsibility and accountability for the services remains firmly with the province. This is especially important given the poor state and capacity

of many municipalities in the poorest areas, which are precisely the areas in which CBWs are most needed.

As part of administrative coordination, there needs to be greater clarity on the different types of – and standardised term for each of the CBWs and then to have some basic minimum standards within each type. There is also a need for roles and responsibilities clarification between the various stakeholders within each type of CBWs in each sector.

In the area of **legislation**, considerations should mainly pertain to ensuring compliance with existing legislation, e.g. the BCEA (see above). Linked to this is **labour relations** where considerations should be that CBWs who are employed should receive a minimum wage or stipend of R3 500 unless the CBWs are on the EPWP when they would receive a smaller standardised amount. Hence, with regards to stipends, there are no other labour relations options unless the CBW is working for free. These minimum stipends should be enforced.

In the area of **professionalisation**, it does not make sense to standardise when there are at least two – and possibly more – distinct professional areas in which CBWs work, i.e. health and child and youth care work. There are also official bodies in place which are responsible for these professional areas and they should be tasked with putting whatever is needed in place for these lower-skilled para-professional workers. Within each sector, consideration should be on including career incentives and professionalisation of CBWs with credit-linked training and opportunities for further training, qualification and development of CBWs to create career development pathways linked to workforce planning. Any work to improve employability should be grounded in sound research (DPME, 2015). Likewise, a comprehensive, supportive supervision framework for all categories of CBWs in that sector to include regular in-service training and development is of critical importance.

In the area of **financial** considerations, it should be emphasised that CBWs to a large extent deliver specific services that would otherwise not be delivered and that it is more cost-effective to use CBWs than if the services were to be delivered by professionals. However, there is currently not enough budget allocated to the CBWs, and measures to address inefficiencies such as late payment to NPOs should be implemented. These inefficiencies negatively influence the sustainability of the CBW workforce. It must, however, be emphasised, that since the CBWs are an essential part of the service delivery mechanisms of government, if they are not sustainable, neither are government services – they are inextricably linked.

Finally, it could be suggested to also have some standardisation of indicators to ensure standardisation of M&E and improved analysis of the situation of CBWs across government departments and provinces.

5.2 Recommendations

Following from the conclusions above, the evaluation makes the following recommendations.

R1. The evaluation recommends that the South African Government work to improve data on the scale, scope and distribution of CBWs, relative to the need for services

R1.1 The evaluation has found no available data on the scale and distribution of CBWs. To address this, government Departments implementing CBW programmes (DSD, DOH) should develop standardised indicators to capture to measure the scale, scope and distribution of CBWs according to area of need.

R1.2 A standardised definition of CBW in line with that developed for this evaluation should be developed and implemented across all government and government supported programmes.

R2. The evaluation recommends that existing legislation and policy be implemented before crafting new policies, with a particular focus on the following:

R2.1 Manage and monitor the implementation of the recommendations of the Ministerial Committee on the Review of the Welfare White Paper, particularly Recommendation 11 that deals with funding of NPOs, and all recommendations of the Committee that were adopted by Cabinet. Substantial work has already been done in this area with support from National Treasury.

R2.2 Implement the Policy for Social Service Practitioners which is of utmost important to help standardise cadres within the sector.

R2.3 Develop strategies to ensure that the labour legislative framework is adhered to for all CBWs, those in government and NPOs. This may include more inspectors for the health and social sector, and all capacity building to help NPOs and CBOs implement labour laws.

R2.4 Ensure provinces do not deviate from Ministerial Determinations for wages and conditions of employment.

R3. The evaluation recommends strong coordination mechanisms to ensure effective and efficient implementation of CBWs, with a minimal amount of standardisation and rationalisation of cadres.

3.1 National Treasury and provincial social sector departments should ensure that there is strengthened coordination **within** sectors in terms of vertical coordination, e.g. ensuring 10x10 meetings are functional, are taking place and have the full attendance of the national and provincial DSD and DOH.

R3.2 The DSD should incorporate all the cadres who are not CYCWs or on the social work or CDWP streams, as CCGs. Hence, the DSD should only have two cadres of CBWs: CYCWs and CCGs (or CCWs as proposed in the 2009 Community Care Worker Management Policy Framework). They can all be on a career path to join the social work, CDP or CYCW streams for professionalisation; and potentially also the CHW stream – crossing over to the Health Professions.

3.3 National and provincial DSD and DOH together with relevant stakeholders from the NPOs should also strengthen administrative coordination **within** and **across** sectors. As part of administrative coordination, there needs to be greater clarity on the different types – and a standardised term for each – of the CBWs and then to have some basic minimum standards within each type. There is also a need for roles and responsibilities clarification among the various stakeholders within each type of CBWs in each sector. The base of the roles and responsibility clarification should be the draft Community Care Worker Management Policy Framework's as well as the Policy for Social Service Practitioners.

3.4 The evaluation recommends that CDWs and CDPs play a coordinating role of CBWs in local areas and link CBWs to government if necessary. Since COGTA has not taken over the CDW programme as intended, it could be considered that DPSA CDWs are absorbed into the DSD CDW programme – hence rationalising these two cadres and doing away with the CDW programme.

R4. It is recommended that the EPWP workers should not be viewed as a cadre of CBWs, but rather that EPWP should be viewed as a funding stream for CBW programmes.

4.1 The EPWP should be recognised only as a funding stream for most CBW programmes, and EPWP workers should not be considered a cadre of CBWs in themselves. Rather the work they do in the EPWP should be aligned to one of the programmes of the sector departments.

4.2 It is recommended that the ongoing use of EPWP to pay for CBWs salaries be seriously re-considered; since EPWP is supposed to be time-limited, it is not ideal for providing a service that is ongoing. Hence, the evaluation recommends that EPWP funding be used for training of CBWs only, so that trainees can learn on the job and have an income while doing so. They should then graduate onto the minimum wage according to their career progression.

R5. The CBW workforce must be recognised by government for the critical role it plays in ensuring that critical government services reach the marginalised and vulnerable people in our society. As such, the CBW workforce must have decent working conditions, reasonable remuneration, training and development opportunities and be well managed. In order to achieve this, the evaluation recommends the following:

5.1 Government Departments implementing CBW programmes (DSD, DOH) must ensure that sector specific norms and standards are in place for all cadres of CBWs that are relevant to the particular CBW programmes. There are various norms and standards in place covering certain cadres and covering some aspects. They should be reviewed to see that they cover the following aspects, among others:

- Recruitment and selection including vetting of CBWs who are working with vulnerable groups
- Remuneration and job grades
- Training, skills development and career pathing
- Supervision and mentoring
- Monitoring and evaluation
- Coordination and service integration
- Service delivery.

5.2 Recruitment criteria must be transparent, fairly implemented with community involvement. Career incentives should be used as part of recruitment drives.

5.3 Efforts are made to standardise remuneration within each cadre of CBW between those in the government and NPO sectors, applying the basic minimum wage.

5.4 The DSD and DOH should develop sound strategies for improvement of employability of CHWs and DSD CBWs (CCGs). This should include career incentives and professionalisation of CBWs with credit-linked training and opportunities for further training, qualification and development to create career development pathways which are linked to workforce planning. Any work to improve employability should be grounded in sound research (DPME, 2015). The Isibindi Programme achieved this for CYCWs, and the same can be achieved for all the other CBWs who, we are suggesting, could fall under the category of CCGs or CCWs.

5.5 With regards to training and development of CBWs, the DSD and DOH should further develop the skills training framework for CHWs and DSD CBWs (CCGs) as introduced in the

CCW Management Policy Framework (2009) to include an induction package and then identify a list of training based on community needs.

5.6 DSD and DOH should develop a comprehensive, supportive supervision framework for all categories of CBWs that includes regular in-service training and development.

5.7 All recruitment and training of CBWs should be in conjunction with the identification of the need for their services and in accordance with funding for their employment. If people are trained without employment prospects, it could contribute to increasing the pool of skilled unemployed or under-employed people.

5.8 There needs to be improved funding of CBWs to improve quality and reach of workforce, both within government and to NPOs who are implementing programmes or services on behalf of government or funded by government. Training for CBWs must come together with funding for implementation of programmes, which includes funding for decent wages, mentoring, supervision and management as NPOs should not be expected to bear these costs if they are implementing programmes on behalf of government. This will also result in building the workforce while servicing the community at the same time.

5.9 To strengthen coordination and service integration, ensure that good case management and referral systems are in place at a local level. CDPs could play a role in coordinating CBWs at a local level.

R6. To measure CBWs' value for money, the DSD should undertake an investment case study for CCGs and CYCWs as the DOH did for CHWs

6.1 A value for money exercise for CCGs and CYCWs should consider the critical role that they play in the prevention and early intervention of social problems, hence avoiding further trauma and costly response interventions.

6.2 To answer questions about the value for money in the use of CBWs, standardised, good quality data is needed. Standardised indicators across government are necessary to answer questions about the scale and distribution (access) and quality of CBWs. Hence, government could design a project specifically to design and test CBW indicators and measures. It could be a test project, implemented in a few districts of one province, where standardised indicators are developed, integrated with existing data collection systems, and good data quality control and validation processes. Lessons from this can inform the roll-out of the new indicators.

R7. The frameworks for monitoring and evaluation of programmes using CBWs should be reviewed to include standardised indicators about the access and quality of CBWs (as mentioned above), but also to be able to monitor the successful implementation of programmes. In order to achieve this we recommend the following:

7.1 All government implementation programmes that use CBWs should follow the protocol for design of implementation programmes in Government (see draft guideline 2.2.3 of DPME, and appropriate training courses have been developed by the DPME – https://evaluations.dpme.gov.za/images/gallery/Guideline%202.2.3%20Implementation%20%20Programmes%2013%2007%2030.pdf). This will facilitate that these programmes to be well conceptualised with a theory of change, be well planned, have monitoring and evaluation frameworks built into them and have complete activity based budgets and risk-assessments (among other things).

7.2 Regular monitoring and evaluation need to occur – it is recommended that all programmes collect data and conduct periodic evaluations that will allow for in-depth analysis of the quality of services offered by each CBW cadre.

7.3 To ensure effective implementation of M&E policies at the local level, CBWs should receive adequate M&E and data entry training and ongoing support for this. This is important as it would help resolve issues of data quality and accuracy. Particular attention in any implementation programme should be paid to establishing data collection systems, with data quality assurance.

7.4 The DSD should continue to support the roll-out and improvement of CBIMs and conduct a data quality assessment of CBIMS with a view to supporting the improvement of data entry and quality.

7.5 It should also develop outcome indicators that can be monitored at the local level to avoid a situation where only data on output and activity indicators is collected. This is important as it gives an indication of whether or not government investment in these programmes is yielding positive results.

R8: It is recommended that a new policy framework needs to be developed to cover CBWs employed to support government programmes in health and social services. The Policy Framework should ensure that the CBWs are able to provide quality services and that they have decent working conditions. Hence, the Policy Framework should cover the following:

1. Recognition that it is important that CBWs provide quality services in communities and put the needs of communities first.
2. That all programmes using CBWs have implementation and outcomes evaluations every 5–10 years to learn lessons for improvement.
3. The programmes should be designed according to guideline 2.2.3 (design of development programmes in Government Departments).
4. Recognition that there is not one CBW workforce, but that it is made up of many cadres with different roles and responsibilities that are governed by the various government programmes in which they are located.
5. A good definition of CBW based on the one identified for this evaluation.
6. Recognition that it is not one workforce, but that each cadre of CBW works under a specific programme and should be governed by the programme design, and the norms and standards of each programme.
7. Recognition of the important role that these workers play in ensuring that the most vulnerable and marginalised in society have access to and take up government services.
8. That the policy intention is to ensure that this cadre of workers be protected by the labour legislative framework and have decent working conditions, including adherence to a standardised minimum wage across cadres and across the country (appropriate to their level of qualification and hours of work).
9. That each sector department ensure that it has policies to govern all the CBWs in its systems, including those employed by NPOs.

10. That the cadre of CBWs employed by government fits into a programme with proper supervision and management arrangements and funding.
11. That all CBWs are governed by norms and standards, and ethical practices relevant for their respective professions and programmes.
12. The policy must recognise that CBWs employed by NPOs are affected by the efficiency of the transfers of funding to NPOs; and that transfers must be on time and accurate.
13. That CBWs are recruited in a fair and transparent way, according to the stipulated requirements, and they are recruited using career incentives (i.e. they should want to progress along a career path to becoming a qualified worker).
14. That career paths exist for each cadre, with appropriate training and development up to professional level.
15. That each cadre is linked to a professional body so that they can register and be bound by professional ethics.
16. That the EPWP be viewed as temporary funding for those CBWs who want to develop their skills and not as a vehicle for employment of CBWs.
17. That indicators are developed that can provide a good picture of the size, distribution (reach) and quality of the workforce.
18. That workforce planning be conducted according to need, and that training opportunities are linked to workforce planning.

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Annexure 2: Evaluation Framework

See separate word document

Annexure 3: Detailed methodology and sample

See separate word document

Annexure 4: Data collection instruments

See separate word document

Annexure 5: Overview of government supported CBW programmes

See separate word document

Annexure 6: Literature review

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Annexure 7: Diagnostic workshop report

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