Experiences with community-based worker systems in Kenya, Lesotho, South Africa and Uganda: final report of the four-country CBW project

Khanya-African Institute for Community-Driven Development

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The report is available from www.khanya-aicdd.org

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Glossary

ADP	Area Development Programme
AHITI	Animal Health Industry and Training Institute, Kenya
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress, South Africa
ASAL	Arid and semi-arid lands, Kenya
ASGISA	Accelerated and Shared Growth Initiative of South Africa
ATICC	AIDS Training, Information and Counselling Centre, South Africa
BMU	Beach management units (Uganda, Kenya)
BUCODO	Budongo Community Development Organisation, Uganda
BUSTIHA	Bulo STI/AIDS awareness group, Uganda
CAHW	Community animal health worker, Kenya
CBMIS	Community-based management information system, Uganda
CBO	Community-based organisation
CBW	Community-based worker
CDS	Centre for Development Support (University of the Free State), South Africa
CDW	Community Development Worker
CHW	Community Health Worker
CLAS	Comites Locales de Administracion de Salud - (Local Committees for Health Administration), Peru
CMIP	Consolidated Municipal Infrastructure Programme, South Africa
DFID	Department for International Development, UK
DoA	Department of Agriculture
DoH	Department of Health
DoHSD	Department of Housing and Social Development, South Africa
DOHSW	Department of Health and Social Welfare, South Africa
DOTS	Direct Observation Therapy Short-course
dplg	Department of Provincial and Local Government, South Africa
dpsa	Department of Public Service and Administration, South Africa
DSD	Department of Social Development, South Africa
DTEEA	Department of Tourism, Economic and Environmental Affairs, South Africa
DVS	Department of Veterinary Services, Kenya
DWAF	Department of Water Affairs and Forestry, South Africa
ECD	Early Childhood Development, South Africa
EPWP	Expanded Public Works Programme, South Africa
EU	European Union
EW	Extension worker
FA	Facilitating Agent
FBO	Faith–based organisation
GEAR	Growth, Employment, and Redistribution strategy, South Africa
GTM	Greater Tzaneen Municipality, South Africa
HASA	Hospice Association of South Africa
HBC	Home-based care
HIV	Human Immunodeficiency Virus
IBAR	African Union Inter-African Bureau of Animal Resources, Kenya
IDP	Integrated Development Plan (South Africa)
IFMD	Indigenous Forest Management Directorate, Uganda
IMCI	Integrated Management of Childhood Illnesses
JIDDECO	Jinja Diocesan Development Coordinating Organisation, Uganda
KICOSHEP	Kibera Community Self-help Programme, Kenya
LC	Local council, Uganda
LDA	Limpopo Department of Agriculture, South Africa

M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MEC	Member of the Executive Council, South Africa
MGLSD	Ministry of Gender, Labour and Social Development, Uganda
MLG	Ministry of Local Government, Lesotho
MoACLR	Ministry of Agriculture, Cooperatives and Land Reclamation, Lesotho
MSA	Municipal Structures Act /Municipal Systems Act, South Africa
NAADS	National Agricultural Advisory Services, Uganda
NASCOP	National AIDS/STD Control Programme, Kenya
NDA	National Development Agency, South Africa
NGO	Non-governmental organisation
NPO	Non-profit organisation
NR	Natural resources
ORUDE	Organisation for Rural Development, Uganda
OVC	Orphans and vulnerable children
PEA	Participatory extension approaches, South Africa
PEAP	Poverty Eradication Action Plan, Uganda
PFM	Participatory Forest Management
PHC	Primary Health Care
PLWHA	People living with HIV+AIDs
PMA	Plan for the Modernization of Agriculture, Uganda
PMTCT	Prevention of mother to child transmission
PRS	Poverty reduction strategy, Lesotho
PSIRP	Public sector improvement and reform programme, Lesotho
PTA	Parent Teachers Association
PW	Public works
RDP	Reconstruction and Development Programme, South Africa
RFSA	Rapid Food Security Assessment
RSDA	Rural Self-help Development Association, Lesotho
SDIP	Social Development Sector Strategic Investment Plan, Uganda
SMMEs	Small, medium and micro-enterprises
SP	Service provider
SSIP	Social Sector Investment Plan, Uganda)=
SSRLs	Institutional Support for Sustainable Rural Livelihoods
STD	Sexually transmitted diseases
STI	Sexually-transmitted infection
TB	Tuberculosis
TNFSP	Thaba 'Nchu Food Security Programme, South Africa
UFS	University of the Free State
VCT	Voluntary counselling and testing
WASDA	Wajir South Development Association, Kenya
WHO	World Health Organisation
WVSA	World Vision South Africa

EXECUTIVE SUMMARY

1 Introduction

1.1 Community-based services offer the potential to reach many more people within the limited financial resources available to African governments, to respond to widespread need as in the situation of HIV and AIDS, and to significantly improve people's quality of life. In addition, community-based services represent an opportunity for communities to influence services to meet their own, locally-specific needs, and to monitor the performance of delivery agents.

In recognition of the potential of community-based services, Khanya-African Institute for Community-Driven Development (Khanya-aicdd) has been managing a 4-country action-research project involving Kenya, Lesotho, South Africa and Uganda to see how community-based worker (CBW) systems can be used to widen access to services and empower communities in the process.

1.2 CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task, supported and supervised by a facilitating agent (FA) which may be either a non-governmental organisation (NGO) or government entity. The CBW may play some of the following roles:

- being a conduit for information and technologies (and sometimes inputs);
- being a bridge/link person between the community and service providers/facilitating agent;
- mobilising the community into groups for learning activities;
- training community members and doing follow-up;
- working on their own activities and providing demonstrations from their own farm or household;
- animating the community by providing energy and enthusiasm for development activities and maintaining the momentum to pursue them.

1.3 The community-based worker project **purpose** was that organisations in South Africa, Uganda, Lesotho and Kenya have adapted and implemented a community-based worker system for service provision in the NR/HIV sectors, and policy makers and practitioners in the region have increased awareness of the use of CBW models for pro-poor service delivery.

The main **activities** of the 4-country action-research project involved:

- a review of CBW systems and programmes within each country and identification of good practice;
- a study tour to Peru;
- distilling best practice across the four countries and developing guidelines to implement such a system;
- supporting pilot projects which incorporated these learnings about 'best practice';
- evaluation of these pilot projects;
- the development of refined guidelines for community-based worker projects, based on this experience;
- a workshop for policy-makers and practitioners to debate potential impacts and adoption of these on policy in the four countries.

The project started in January 2004 and concluded in September 2007.

1.4 This report is a synthesis of the final country reports produced by the four countries that participated in this project. Chapter 1 explains the project's rationale and process. Chapter 2 gives contextual background. Chapter 3 presents the case study reviews and findings on selection procedures, financing, training, roles and responsibilities, support and supervision, accountability, coordination and linkages to other stakeholders. Chapter 4 presents the pilot projects and chapter 5 findings as to impact and cost-effectiveness. Chapter 6 examines the implications for policy and legislation. In addition to this report, recommendations that emerged from the project have been captured in a set of Guidelines for practitioners for implementing a CBW system.

2 Government policies, systems and structures in service delivery

2.1 The public sector has traditionally been the major service provider in **Kenya**. The recent poverty reduction strategy has given the private sector more of a role and supports the concept of community participation. Other policies have recommended community-based workers such as the National Agricultural Extension Policy, which recommended the use of community animal health workers (CAHWs) in the provision of extension services in arid and semi-arid lands (ASALs). Through the Economic Recovery Strategy, the government committed itself to improved service delivery in the health sector by setting up special health care programmes for people living with HIV and AIDS (PLWHA). Community health workers in home-based care form part of the strategy for responding to the epidemic.

2.2 The Poverty Reduction Strategy (PRS) of **Lesotho** focuses Government resources on activities that will have the most impact on reducing poverty. The PRS has three interconnected goals: (i) to create jobs through the establishment of an environment that facilitates private sector-led economic growth; (ii) to empower the poor and the vulnerable and improve their access to health care and education; and (iii) to deepen democracy and improve public sector performance. The social welfare strategic plan 2005-2010 and the primary health care strategy involve training additional village health workers and introducing incentives for them, establishing training for traditional healers to complement health delivery and emphasising health education to prevent disease transmission.[i] Lesotho held its first local government elections on the 30th April 2005 and 139 local authorities (community councils) were created. Lesotho has therefore taken important steps in decentralisation of power by devolution, giving communities more control of their own development.

2.3 **South Africa** sees the delivery of basic services as a central task in poverty reduction. Government departments have a responsibility to deliver services but personnel in government departments are sometimes so thinly spread as to render the service ineffectual and there are serious backlogs in many departments. Recently there has been a move to more demand-driven approaches with projects identified by communities themselves. The Local Government White Paper of 1998 and subsequent Municipal Systems and Structures Acts made the legislative transition towards developmental local government, with a focus on local government committed to working with citizens and community groups to find sustainable ways to meet their social, economic, and material needs.

2.4 One of the main goals of **Uganda's** Poverty Eradication Action Plan (PEAP, 2000[ii]) is to increase the ability of the poor to raise income and improve their quality of life. The main policy that targets service delivery to rural communities is the decentralization policy, officially launched in 1992, which involves substantial transfers of political, financial and planning responsibilities from the central government to local councils. The main objectives of the

i http://www.lesotho.gov.ls/articles/2005/chapter_8.pdf
ii Draft PEAP (2000)

Plan for the Modernization of Agriculture (PMA - 1987 and 2001) is to increase the incomes of poor subsistence farmers through increased productivity and increased share of marketed produce, to encourage agro-processing and promote environmentally friendly technologies. The National Agricultural Advisory Services (NAADS) has revitalised agricultural extension services through the use of community-based farmer to farmer extension.

The community mobilisation and empowerment programme includes a range of activities directed at empowering communities such as functional adult literacy initiatives; the community-based management information system (CBMIS), adolescent reproductive health, farmer empowerment and information and library services. Community-based systems have undergone tremendous growth in the last two decades and have emerged as a key service delivery mechanism in almost all sectors. Improvements in service delivery have been remarkable in key rural based sectors such as education, health, water and sanitation, infrastructure, and more recently, agriculture.

2.5 Of the four countries, Uganda has gone furthest in terms of decentralisation, and implementation of community-based worker systems is now widespread in both the health and natural resource sectors. In South Africa, community-based workers are being deployed in a range of sectors notably HIV and health-related, but, with the exception of the health sector, the scale is small and the policy environment and coordination of these, is undeveloped. The relevant services are provided essentially by provincial governments, and in some cases by NGOs, FBOs and CBOs. Government has decided to mainstream funding of stipends in the HIV and AIDS and health sectors. In Lesotho, community-based services have struggled in terms of continuity of funding but community-based worker programmes exist in adult education, agriculture and health, and are now being considered at the highest levels of government, as a result of this project. Kenya still retains a highly centralised service delivery system. In recent years, Kenya's health department has looked to community-based health workers to manage the large numbers of people affected by HIV and AIDS. Private sector CBWs have emerged in the animal health sector (community animal health workers) which is perhaps the most advanced in Africa, but they are viewed by government as a temporary, emergency measure. The creation of a cadre of community health workers, offering home-based care and other services in response to HIV and AIDS, has happened across all countries.

3 A review of community-based worker systems in Kenya, Lesotho, South Africa and Uganda

3.1 The Kenyan **case studies** reviewed were: a home-based care programme for people living with HIV/AIDS (PLWHA), a community-based contraceptive distribution programme, HIV/AIDS education and counselling for the deaf, two community-based animal health programmes, programmes to disseminate livestock marketing information, and a community-based farmer organisation for the improvement of livestock farming.

In Lesotho the case studies were: a paralegal association, a community health worker programme, community-based contraceptive distribution and a sexual health and rights promotion project.

The South African case studies were a participatory extension programme using farmer facilitators, a community sanitation committee programme, two home-based care programmes and a hospice palliative care programme.

In Ugandan, the case studies were: forestry sector programmes promoting tree planting, bee-keeping and charcoal production; an integrated health, nutrition, food security and

agriculture project, a micro-finance project, a home-based care project and a fisheries' management and rights project.

3.2 The organisations differed along a continuum in terms of how far the facilitating agent controlled the **selection** of CBWs and how far they involved or empowered the community in this process. Similar criteria were generally used in selection though organisations differed in respect of the importance attributed to literacy. All organisations felt that involving the community in selecting CBWs is vital for the project to be truly community-owned. During planning of the proposed programme, extensive dialogue with local leaders, local structures and other stakeholders was felt to be essential to success of the CBW system.

3.3 Programmes may be **funded** by government but with donor financing supporting the programme, funded solely by donors or a 'user pays' model. Recognising that donor funding eventually dries up, some organisations are trying to raise income within its constituency to at least give the volunteers a small income even if it is insufficient to sustain the whole programme. True volunteer programmes can only demand 4-8 hours of a person's time, so that the CBWs have time to earn their livelihood, although in many places volunteers are working up to 40 hours a week, severely impacting on their ability to earn a livelihood. Ideally, where people are working more than 4-8 hours a stipend should be provided as the volunteers have no other source of income. Most implementing partners felt that scaling up would require programmes becoming part of mainstream government–funded delivery because of the costs involved. It was felt that the stipend remuneration should be uniform across programmes within the same country. It is easier to demand high standards from CBWs if stipends are offered. However, it puts additional fund–raising and administrative pressure on the organisation and some governments may not be able to afford widespread provision of stipends. The micro-finance promoters in Uganda were paid a stipend but were also able to charge clients for some services such as support with accessing HIV project grants. In the Kenyan animal health worker projects, the livestock owners paid for the drugs and treatment advice that they received from the community animal health workers. Communities also contribute in offering meeting places, food, labour, cash or through fund-raising events.

3.4 Quality of **training** is one of the most important determinants of programme quality and impact. All organisations offered initial training to their CBWs and ongoing training on a regular basis and the partners agreed that this is essential to any programme. External evaluators in all countries called for more uniformity in training and clarity on the roles and responsibilities of CBWs. It is recommended that FAs using outside training agencies need to carefully monitor the training offered and its integration into practice. There is a risk of CBWS being overloaded, over expectation on what they can provide or exploited. Training is a very strong motivating factor for CBWs who value the skills they receive and who see this as a logical progression to future opportunities.

3.5 All action-research study agreed on the need for post-training **supervision and support**. Most partner organisations involved had systems in place whereby full-time staff would meet CBWs on a regular basis to provide support and supervision. CBWs working with people with HIV and AIDS need counselling and support from skilled health professionals because of the severe emotional strain engendered. Group bonding helps with motivation, supervision is essential for systematic documentation of activities and impact.

3.6 **Accountability** to the FA was accepted and systems well established, but accountability to communities is limited, except in the CAHW model where users choose to pay for their service. Uganda has appropriate local council (LC) structures, which are mandated to oversee service delivery.

3.7 Committees are needed to **co-ordinate** programmes at local level and to avoid overlapping roles and competition between service providers. In the health sector, coordination between the CBW programmes and the formal health service is well established. In the animal health sector in Kenya, the principle of supervision of CAHWs by professional veterinarians is also established. A thorough stakeholder analysis is needed before any programme is implemented in order to avoid duplication and possible conflict with already existing organisations, and to work out ways of working that are complementary and mutually beneficial. FAs are usually responsible for creating and maintaining links with donors to maintain funding of the programme's activities. This is a challenging role. Organisations have to work together with the government, central agencies or through coordinating forums to create more coherent and consistent CBW systems and to further recognition and acceptance .

4 The pilot projects: implementation from January 2005 to March 2007

4.1 Five CBW service delivery models were identified by partners at the first 4-country workshop held in September 2004. They are:

- 4-8 hours per week unpaid volunteers
- 20 (exceptionally up to 40) hours per week unpaid volunteers
- 20-30 hours per week. paid a stipend (SA)
- 40 hours per week paid
- Paid by user

4.2 Guidelines for pilots implementing a CBW system were developed – to further explore these models. Pilots were selected based on their flexibility, potential for scaling up, monitoring processes in place at the time, financial viability of the partner organisation and agreement to participate in an evaluation process to reflect on changes and impact of such an initiative.

4.3 Representatives from the four countries also participated in a study tour to Peru. The delegation gained an in-depth understanding of the nature of Peruvian community-based worker projects and explored comparisons with those in their own countries.

4.4 The **Kenyan** pilot projects were ABC Kisumu, a sexual and reproductive health and rights project promoting behaviour change and communication; WASDA, a community animal health worker project in the arid and semi –arid lands and KICOSHEP-Kibera, a health services NGO. The **South African** pilot projects Golang Batchaa and CHoiCe, offering home-based care and other health services, Kodumela, an area development programme offering health and social services, and Thaba 'Nchu Food Security Programme and Ramalema Environmental Pollution Prevention Project, in the natural resources sector. The **Ugandan** pilot projects were BUCODO, which is primarily an agro-forestry programme, the NAADS farmer extension programme, BUSTIHA and Kamwokya health education and home-based care programmes and Rukungiri Functional Literacy Resource Centre, an adult education and community development programme.

5 Impact and cost-effectiveness

5.1 Most of the pilot projects underwent an evaluation sometime in 2006. The main objectives were to establish impact and cost-effectiveness. The hypothesis was that well-run CBW programmes would reach more people in a cost-effective manner and be more culturally appropriate and sustainable than traditional models of service delivery.

5.2 In the health sector, interviews with beneficiaries and statistical data provided strong evidence of impact. Examples given were increased understanding of health, disease, nutrition and hygiene and increased adherence to treatment resulting in improved health outcomes. Beneficiaries reported significant psychosocial support. A reduction in stigma against PLWHA and changes in attitudes towards women was reported by ABC-Kisumu. Some health care organisations also had statistics confirming extensive social support such as distribution of food parcels, supporting orphans and vulnerable children (OVCs) and alerting the relevant authorities about vulnerable members of the community. Kodumela ADP was involved in food gardens and psychosocial support to OVCs. KICOSHEP-Kenya also runs a primary school for 450 children.

In the NR sector, there was little statistical data forthcoming from projects. However adoption of new technologies, replanting of trees, income from sales of seedlings, fruits and honey, improved livestock management, improved soil conservation, greater understanding of land use rights were all reported benefits. The NAADS farmer extension programme in Uganda is being rolled out on a large scale, which suggests that it is working effectively. A pilot project in South Africa had limited impact but poor conceptualisation of the project and management problems seem to have been the cause rather than the CBW model itself. Criticisms from NR projects suggested that CBWs are not always sufficiently knowledgeable and equipped to pass on information to others adequately.

CAHWs in Kenya are providing a valuable service in the arid and semi-arid lands which would otherwise have no veterinary services. Ramalema Environmental Prevention Project has had an impact in terms of cleaning its environment and raising awareness of pollution among the youth from the evidence of stakeholders but unfortunately did not log activities systematically or collect photographic evidence.

5.3 In terms of impact on the CBWs themselves, the CBWs reported many benefits from their work such as satisfaction in being of service to their community, increased knowledge, skills and confidence, greater status in their community; increased income (for those who received stipends) and gifts inkind such as tools or farming inputs. The negatives were loss of economic opportunities because of their commitments as CBWs, personal risk, emotional strain, feelings of being exploited and concerns that their community commitments were causing their family to suffer.

5.4 In terms of impact on the service providers, health CBW programmes are strongly integrated with the formal health services. The formal health services view them very positively and appear to see them as effective and essential partners reaching deeply into the community, following up on patients, conveying important health messages and freeing the formal services up to concentrate on work which previously they did not have time for. Nurses in the South African evaluation stated that there needed to be clearer specification of the roles of CBWs in government policy and recognition that staff had to be assigned to supervise CBWs.

In the NR sector, CBWs are integral to extension services in Uganda. The Kenyan Veterinary Services accept that CAHWs are the only way to provide a service to ASALs but they do have concerns. The Department of Agriculture in South Africa is experimenting with CBW projects in some areas but has not yet fully explored their potential. Lesotho is exploring implementation of a national system of community livestock workers, learning from the Kenyan experience, to support small livestock and create a response system in case of an avian flu epidemic, so there is clearly a positive response there. The NGOs supporting CAHWs in Kenya have faced the challenge of the legal uncertainty around the position of CAHWs and the fact that some of the CAHWs have struggled with the cash flow of their businesses.

5.5 Cost-effectiveness calculations in the health sector, comparing the cost of home-based care treatment to the cost of treatment at a primary health care clinic, or comparing the cost of employing a CBW to work in HIV/AIDs advocacy and behavioural change to the salary of a social worker (in Kenya), indicates that the CBW service will cost less than one-third of the conventional service. Of course, the comparison is limited in that the roles of the service providers in each case are not identical.

In the NR sector, the evaluations did not have sufficient data to compare the CBW programmes to conventional models. However, a cost-effectiveness study that Khanya carried out in Lesotho in 2002 indicates that CBW programmes can be run very cost-effectively. The estimated total cost per participant with significant impact in the TEAM project (CARE Lesotho's Training for Environment and Management Project), was $298 compared to $989 for a conventional system. Transport availability and distances which CBWs have to cover on foot or by bicycle to see clients were identified as a challenge in the NR sector. The Ugandan strategy of gathering farmers at demonstration sites is a model to be explored further.

6 Implications for policy and legislation and conclusion

6.1 Community-based and para-professional services offer the opportunity of bridging the gap between professional services and the general community by devolving aspects of services to lesser trained personnel who can be trained more cheaply and quickly and are paid less and so there can be many more of them. The study indicates many benefits in using such models of delivery including cost-effectiveness. However, if the model is to be applied widely, national governments need to develop policy and legislation to support the development and scaling up of this method of service delivery.

Up-scaling will require greater standardisation of training outcomes, standards of delivery, conditions of service and remuneration. In addition, funding would have to be provided from government while delivery could be through a wide variety of implementing agents. It is recognised that a lot of work needs to be done for this to happen and that the national and international stakeholder meetings that were part of this action-research have contributed to this body of work.

6.2 There was a general consensus that training should now be according to agreed outcomes and curricula should be more standardized. Accreditation would also come to the fore and certification that CBWs have achieved minimum standards. Stipends, if agreed to, would also lead to more careful monitoring of delivery which would increase supervisory costs. There would be tighter definition of the roles of CBWs and more formal recruitment processes, work contracts and benefits. In effect, a new cadre of community-based service providers with labels such as community forestry workers or home-based carers, would be created. These would be supported by para-professionals such as animal health technicians or medical clinicians. Career-pathing would be a reasonable expectation of CBWs.

6.3 Funding at scale will have to come from government, in partnership with external funders where governments cannot afford to pay without assistance. The cost to the government of paying the CBWs could be offset to some extent by savings elsewhere e.g. in hospital admissions or better health from improved livelihoods. The 'user pays' model also needs to be explored more as well as models where the organisation has income-generation activities alongside service activities with the profit from the former funding the latter.

6.4 Friedman (2005: 186) suggest the use of credits as a reward for voluntary work. The idea is that CBWs could be allocated points for hours worked which could be accumulated and used, for example, to "pay" for further studies.

6.5 Key policy changes and, in some cases, changes in legislation are needed to upscale. Urgent change is required in Kenya where CAHWs are not recognised in law. The lowest cadre of personnel qualified to offer animal health services in Kenya is an animal health technician. It seems unlikely that there will be enough trained technicians in the near future so it is important for the government to regularise the position of the CAHWs and the service providers who support them.

Friedman (2005) notes that, in the health sector at least, there is a serious problem with the proliferation of many types of health ancillary workers without any overarching system. Policy development is therefore needed both within sectors and also across sectors, for instance, to create coordination between health and social services.

A professional body and specific legislation is needed to regulate and advocate for CBWs within their different spheres of work so that they know their rights and responsibilities and are protected from exploitation.

6.6 The learning and recommendations that emerged from this project have been worked into comprehensive guidelines for CBW systems that can be accessed on www.khanya-aicdd.org. The project has brought together policy makers, government departments and implementing agencies in rich and beneficial dialogue. It is hoped that the stakeholder groups which have worked so hard within the project will find resources to continue their work so that the goal of increased access, within Africa, to quality services responsive to the community, will be achieved.

PART A INTRODUCTION

1 Introduction

1.1 The community-based worker project

In order to achieve the Millenium Development Goals (MDGs) there is a need to improve models and methods for effective delivery of services at scale for poor people. This represents a significant challenge to policy-makers and programme designers, governments and NGOs involved in service delivery. The challenge is to reach many more people within the limited financial resources available, to respond to widespread need as in the situation of HIV and AIDS, and to offer services that significantly improve people's quality of life. Community-based services offer the potential of achieving the above and an opportunity for communities to influence services to meet their locally-specific needs and to monitor the performance of delivery agents.

In recognition of the potential of community-based services, Khanya-African Institute for Community-Driven Development (Khanya-aicdd) has been managing a 4-country action-research project involving Kenya, Lesotho, South Africa and Uganda to see how community-based worker (CBW) systems can be used to widen access to services and empower communities in the process. *The project purpose was that organisations in South Africa, Uganda, Lesotho and Kenya have adapted and implemented a community-based worker system for service provision in the NR/HIV sectors, and policy makers and practitioners in the region have increased awareness of the use of CBW models for pro-poor service delivery.*

1.2 The CBW system

The model below shows the key components of the system: the **community**/informal institutions such as farmer groups or a community administrative unit through which people organise to act collectively; a **CBW**; a **facilitating agent** (FA) supporting the CBW; and other **service providers**. **Government**, national institutions and the international community help to provide an enabling environment, funding and opportunities for strengthening capacity. These are all key stakeholders who need to be involved at all stages in the process for the CBW system to work effectively.

CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task, supported and supervised by a facilitating agent (FA) which may be either a non-governmental organisation (NGO) or government entity. CBWs are usually in some way accountable to the community or a specific group within the community they serve and the faciliating agent they are affiliated to. They usually receive some form of incentive non-monetary incentives, in most cases their costs are covered when they attend meetings and training events, and in some cases they receive a fee or a stipend for the service they render. The CBW may play some of the following roles:

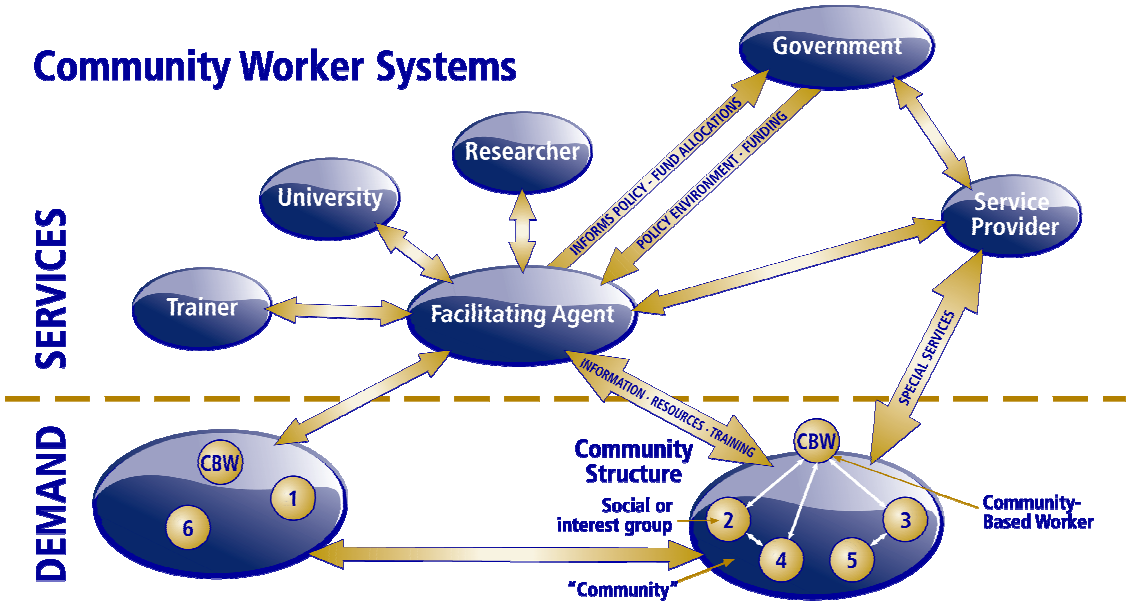
- being a conduit for information and technologies (and sometimes inputs);
- being a bridge/link person between the community and service providers/facilitating agent;
- mobilising the community for learning activities and people into groups;
- training community members and doing follow-up;
- working on their own activities and providing demonstrations from their own farm or household;

- animating the community by providing energy and enthusiasm for development activities and maintaining the momentum to pursue them.

The **FA** can be from government or the non-government sector. The FA supports and mentors the CBW and other service providers (SPs). FAs might provide funding for the work undertaken by the CBW, give information, support in training and provide technical supervision. Their work may inform government policy and they may act as instigators of collective action and intermediaries between people and public service providers.

Government and donors provide the enabling environment, develop/create policies and training guidelines and may fund the system. They may also participate in linking policy with practice and sometimes government may be an implementer, e.g. in health, agriculture and social development.

Figure 1: The CBW system



1.3 Project outputs, activities and time line

The 4-country project started in January 2004 and ended in September 2007. The intended outputs were:

1. Good practice in CBW systems documented and shared;
2. Common framework for CBW models developed, with suggestions for good practice in different sectors;
3. Pilots for community-based worker systems designed and implemented, or existing practice modified;
4. Results of pilots mainstreamed into CBW implementation in at least two partner countries;
5. Information on CBW systems and policy implications widely disseminated and debated in southern and eastern Africa.

The main activities included:

- a review of CBW systems and programmes and identification of good practice to be tested and piloted within each country;
- a study tour to Peru to learn from a fifth country implementing such a system;
- distilling best practice across the four countries and developing guidelines;
- supporting pilot projects which incorporated these learnings about 'best practice';
- evaluation of these pilot projects;
- the development of refined guidelines for community-based worker projects, based on this experience;
- workshop for policy-makers and practitioners to debate potential impacts on policy and mainstreaming of the system.

The initial stages of the 4-country CBW project involved scoping visits to identify partner countries and possible partners who were using CBWs or interested in the use of CBWs as a model for pro-poor service delivery. These included a mix of policy-makers and practitioners (often NGOs or government services). Steering committees were established in each country to manage the national process and to maintain the links between policy-makers and implementing practitioners.

Research was undertaken in each country to review current experience and lessons and provide a situational analysis of CBW systems in that country. These were presented at national workshops during 2004 attended by a range of practitioners and policy makers. The broad aim of these workshops were to share current CBW approaches in the country and explore partner understanding of the mechanisms and structures of the systems that were in use at the time of project initiatition.

Subsequently all four countries came together in a workshop from 20-23 September 2004 in South Africa to share their findings. and to draw out models of good practice for implementation. A small group of representatives from each partner country then met again in January 2005 to discuss each model in depth and agree the core elements to pilot in their respective countries. Guidelines for implementing each model were developed and partners identified in-country implementing partners to test one or two of the models. These were piloted during the period 2005 and 2006.

From 16-29 October 2005 12 delegates from the four countries travelled to Peru to find out about CBW systems, comparing their own experience that of a fifth country, an in another continent. This also provided an opportunity to involve strategic partners, such as Lesotho's Deputy Minister for Justice, who was to be very influential in later developments in Lesotho. The second 4-country workshop was held from 1-3 November 2005 in South Africa. Participants were joined by the delegates who took part in the Peru study tour, and who enriched the sharing of experiences. This workshop also included a field visit to CBW projects in Limpopo province.

During the last six months of the initial project period, evaluations were conducted of the CBW pilots, which were shared in in-country national workshops. Each national workshop also established a vision and a task team with terms of reference and activities to take forward the process. A third 4-country workshop was held in Uganda in April 2007. DFID agreed to extend the project for a further six months to September 2007, to allow for development of Guidelines for good practice and a workshop of policy-makers in September to explore the implications of CBW systems for policy.

1.4 Objective and structure of the report

This report is a synthesis of the final country reports produced by the four countries who participated in this project and synthesises the experiences and the findings. The report is in three parts:

Part A gives the background to the CBW project and explains the process of the 4-country action-research project and its objectives.

Part B gives background information on the policies, practices, and mechanisms that formed the context of service delivery and provision at the time when the CBW project began in 2004. It focuses on mechanisms for pro-poor delivery and the extent to which community-based worker systems were known and being used in each country.

Part C looks at what happened during the actual project**.** Chapter 3 presents the case studies from the four countries that were reviewed at the beginning of the project. It presents findings on a range of elements of the system including selection procedures, financing, training, roles and responsibilities, support and supervision, accountability, coordination and linkages to other stakeholders. Chapter 4 explains the models and the pilot projects. Chapter 5 presents the findings of the evaluations regarding impact and cost-effectiveness. Chapter 6 presents an analysis of, policy and legislative issues that emerged from the research and the conclusion.

PART B THE SITUATION PRIOR TO THIS PROJECT

2 Government policies, systems and structures in service delivery in 2004

This section of the report gives a short contextual background for each country. It examines how the policy and legislative environment in each country in 2004 impacted on community-based worker approaches to service delivery and how widely such approaches had already been adopted in each country.

2.1 National policies and strategies for service provision in Kenya

After independence in Kenya, the public sector was seen as the major service provider. However, inadequate resourcing of the public sector led to fewer skilled personnel, poor working conditions and low staff morale. Also, top-down centralised approaches have led to lack of ownership of interventions and therefore lack of effectiveness.

Since 2000, other market players have emerged. Through the Economic Recovery Strategy (2003-2007), the Strategy for Revitalising Agriculture, launched in 2004, the National Agricultural Extension Policy and the Poverty Reduction Strategy Papers of 2004, sector-wide public reforms have been taking place that have given the private sector a larger role and are in support of the concept of community participation.

The Kenyan Government has committed itself to strengthening the community-based animal health approach to address development of arid and semi-arid areas (ASALs). Important policy documents in the animal health sector include the Livestock Development Policy which advocated for improved participation of the community in provision of livestock extension, services and the Strategy for Revitalising Agriculture and the National Agricultural Extension Policy which recommended the use of community animal health workers (CAHWs) in the provision of extension services in ASALs.

Prior to 1986, the Department of Veterinary Services (DVS) provided free or highly subsidized services. In 1986 policy changes brought more private sector participation in the delivery of veterinary services giving rise to a division in service delivery, with the government undertaking public good services and the private sector undertaking private good service delivery.

Through the Economic Recovery Strategy, the Government committed itself to improved service delivery in the health sector by setting up special health care programmes for people living with HIV and AIDS (PLWHA). It incorporated an HIV and AIDS component into school and community training curricula and strengthening the health sector response to HIV and AIDS by forming AIDS Control Committees at constituency levels.

The Government Sessional Paper No. 4 of 1997 on HIV/AIDS, outlined the government's policy and provided broad guidelines for all organisations involved in HIV/AIDS work on how best to address critical issues over the next 15 years and beyond. In addition, the paper outlined strategic interventions and an appropriate organisational structure for effective implementation of programme activities. It also identified the policy issues that were needed in order to operationalise such an ambitious strategic plan. Since then a number of policy guidelines and publications have been produced, through the National AIDS/STD Control Programme (NASCOP), including programmatic standards and requirements for service delivery for health service personnel, a training curriculum for community health workers in home-based care and national voluntary counselling and testing guidelines.

2.2 National policies and strategies for service provision in Lesotho

In Lesotho, 58% of the total population of 2.2m live below the poverty line[3]. Unemployment has increased with the retrenchment of thousands of workers from the mines in South Africa[4]. The mountainous terrain and pastoralist tendencies of the population make it difficult for the government to deliver services.

The Constitution of Lesotho 1993, section 106 (1) provides for the establishment of structures that will enable public participation in the development process. In line with the Constitutional obligation, His Majesty, King Letsie III, called on Government to maximize public participation in planning and implementation of development programmes. These calls laid the foundation for Lesotho's Vision 2020 and the national Poverty Reduction Strategy (PRS). The PRS has three interconnected goals: (i) to create jobs through the establishment of an environment that facilitates private sector-led economic growth; (ii) empower the poor and the vulnerable and improve their access to health care and education; and (iii) deepen democracy and improve public sector performance.

The research that went into the PRS indicated a high level of dissatisfaction with service delivery. The success of the PRS process will lie in the transformation of government management and the development of service delivery capacity. The public sector improvement and reform programme (PSIRP) aims to improve public financial management and the ability to monitor progress, particularly with respect to how much of the social spending improves the lives of poor communities.

Between the 1970s and the 1990s, Lesotho had an effective primary health care system. During this period, life expectancy grew and infant mortality declined but these trends have reversed in recent years. However, the social welfare strategic plan 2005-2010 and the primary health care strategy are intent on improving the situation. As the health services are overwhelmed by the HIV/AIDS pandemic, part of the strategy involves training additional village health workers and introducing incentives for them, establishing training for traditional healers to complement health delivery, and emphasising health education to prevent disease transmission[5].

Lesotho held its first local government elections on the 30th April 2005. This event was a major move towards institutionalising grassroots democracy by involving the local population with their own development. 139 local authorities were created and follow a 'Westminster' single-member constituency model. The key objective of this intervention, as envisaged by the government, is to bring services closer to the people and the key objectives of the local councils are for them to take control of all district affairs and to form links with the central government (MLG, 2007).

[3] http://www.undp.org.ls/millennium/default.php
[4] The numbers of migrant mineworkers from Lesotho fell from 61,424 at the end of 2003 to 56,353 at the end of 2004. http://www.undp.org.ls/millennium/default.php
[5] http://www.lesotho.gov.ls/articles/2005/chapter_8.pdf

2.3 National policies and strategies for service provision in South Africa

South Africa's post-apartheid economic policy has delivered reasonable levels of economic growth (currently around 5%), but has struggled to create jobs, reduce poverty and deliver adequate services for the majority of those previously disenfranchised. There is an increasing income inequality between urban elites and inner city, peri-urban and rural poor.

The Reconstruction and Development Programme (RDP) of 1994 stressed the need for national government to be closer to the people it serves. It emphasised building the economy and developing human resources through a people-centred, rights-based mobilisation of communities. In 1996 the RDP was largely replaced by the Growth, Employment and Redistribution (GEAR) policy. GEAR emphasised economic growth and macroeconomic stability. GEAR's premise was that sustained and increased growth required a competitive, outward-oriented economy but it also called for a "strengthening of redistributive efforts and improved service delivery through, for example, reprioritising spending to historically disadvantaged communities and focusing welfare spending on assistance to the poor rather than institutionally based services" (Khanya, SA CBW in-country review report, 2004: 16). However, the emphasis was on welfare spending in the context of greater fiscal discipline, improvements in efficiency, more rigorous cost recovery and the need for financial sustainability. There was an increase in social security spending via a range of different grants and pensions, also spending on development and job creation.

In 1997, the Ministry of Health tabled the White Paper on the Transformation of the Health System in South Africa. The aim was to introduce a strong shift towards universal and free access to comprehensive health care, and to shift resources from tertiary services in urban settings into primary health care and rural settings.

In 1998, the Local Government White Paper made the legislative transition towards the notion of a developmental local government, suggesting a focus on local government committed to working with citizens and community groups to find sustainable ways to meet their social, economic, and material needs. The Municipal Systems Act (2000) emphasised the importance of participation, with wards defined as the local constituency for representation, participation and consultation in planning and for service delivery.

The delivery of basic services is a central task in poverty reduction. Government departments have a responsibility to deliver these services but personnel in government departments can be so thinly spread as to render the service ineffectual. For example, in 2005, Botshabelo in the Free State had only one agricultural extension officer serving around 200,000 people" (Khanya, Report of 4-Country CBW Workshop, 2005: 16). The design of service provision in South Africa has left serious backlogs in various other departments, including housing, social welfare and health.

Mechanisms for service provision vary across and within sectors. In principle, if not always in practice, local government transformation has adopted many of the practices associated with transformation in local government worldwide, aimed at enhancing the legitimacy, effectiveness and efficiency of municipal service delivery. Entrepreneurship, facilitative partnerships, sustainable local development programmes, service delivery partnerships, internal trading entities, municipal business enterprises and companies, and local economic development partnerships, are just a number of potential arrangements and instruments either available or already adopted.

The R7 billion Consolidated Municipal Infrastructure Programme (CMIP) is one example of a state-led programme. The programme has been highly successful in providing significant

infrastructure in support of service delivery to underserved people. However an evaluation of this programme suggested that since municipalities rather than communities were the instigators of CMIP projects, there has been a failure in communities taking ownership of assets. The recommendation was the beginning of a move towards more demand-driven approaches for the programme, with projects identified by communities themselves. The failure of the Batho Pele "people must come first" campaign also led to a recommendation to move more towards a notion of democratic rather than good governance.

The concept of CBWs has been recognised in the HIV/AIDS and health sectors, where home-based carers and DOTS workers are mainstream. There has been a positive move, since1999, with the development of formal training of a large number of home based caregivers to assist and support families caring for the sick and frail aged in the community, as hospitals, hospices and similar institutions have become increasing overburdened, and unable to cope. A national CHW Policy Framework has since been drafted and was released in early 2004. The framework was developed by national Department of Health (DoH), in consultation with other departments, the provinces, municipalities, NGOs, academic institutions, other civil society structures, the Health and Welfare Sector Education Training Authority (HWSETA) and the South African Qualification Authority (SAQA) **6**. An overview of the CHW Policy Frammework is in annex 3.

2.4 National policies and strategies for service provision in Uganda

Uganda was in the past characterized by strong community mobilisation institutions but the political turmoil in Uganda during the 1970s and early 1980s led to the degeneration of public and private institutions, and most community-based initiatives became non-functional. Since 1986 the Government has supported a recovery programme and when the Poverty Eradication Action Plan (PEAP, 2000[7]) came in, community mobilisation again became a public sector priority. The PEAP is the guiding framework for eradicating mass poverty in Uganda and adopts a multi-sectoral approach. The PEAP has the following main goals:

1. Creating a framework for rapid economic growth and structural transformation;
2. Ensuring good governance and security;
3. Directly increasing the ability of the poor to raise incomes; and
4. Directly increasing the quality of life of the poor.

A number of policies and strategies have been formulated aimed at improving rural service delivery. These include the Social Sector Investment Plan (SSIP), which emphasises harmonised interaction of community- based services; the Government-NGO partnership that emphasises the role of NGOs in supporting the public sector to respond to the needs of the community; and the National Agricultural Advisory Services (NAADS) which focuses on empowerment of communities to demand and control the delivery of agricultural advisory services.

The main policy that targets service delivery to rural communities is the decentralisation policy, officially launched in 1992 and enshrined in the 1995 Constitution, leading to the enactment of the Local Governments Act of 1997. The decentralisation process involves substantial transfers of political, financial and planning responsibilities from the central government to local councils. This empowers the local governments (districts, sub-counties

[6] http://www.hst.org.za/uploads/files/sahr05_chapter13.pdf

[7] Draft PEAP (2000)

and urban authorities) to take increasing responsibility for the delivery of services and promotes participation of local people in decision-making.

The Plan for the Modernization of Agriculture (PMA, 1987 and 2001) is a multi-sector initiative to increase the incomes of small- holder farmers in an integrated way. Its main objectives are to increase the incomes of poor subsistence farmers through increased productivity and increased share of marketed produce, to encourage agro-processing and promote environmentally friendly technologies.

The Ministry of Gender, Labour and Social Development (MGLSD), is the coordinating agency for the Social Development Sector Strategic Investment Plan (SDIP) of 2004. The strategic objectives of the SDIP include:

1. To empower communities to appreciate, access, participate in, manage and demand accountability in public and community-based initiatives;
2. To protect vulnerable persons from deprivation and livelihood risks;
3. To create an enabling environment for increasing employment opportunities and productivity for improved livelihoods and social security for all, especially the poor and vulnerable;
4. To ensure that issues of inequality and exclusion in access to services across all sectors and at all levels are addressed.

Government is committed to continue supporting the empowerment of organisations and ensuring their active participation in the development process. Government is mainly interested in ensuring that public resources are used in building the capacity of the private sector and civil society, in involving them in public sector activities and in contracting them as service providers in the delivery of services.

The community mobilisation and empowerment programme includes a range of activities directed at empowering communities such as functional adult literacy initiatives; the community-based management information system (CBMIS); adolescent reproductive health; farmer empowerment and information and library services. Community Development Workers (CDWs) are being revitalised to facilitate community planning, group formation, home improvement campaigns, civic education, mobilisation of functional adult literacy learners and establishment of classes, monitoring activities and information dissemination on government programmes. Community-based systems have undergone tremendous growth in the last two decades and have emerged as a key service delivery mechanism in almost all sectors. Improvements in service delivery have been remarkable in key sectors important in rural areas such as education, health, water and sanitation, infrastructure, and more recently, agriculture.

2.5 Emerging issues around national contexts in the four countries in 2004

2.5.1 Context

Of the four countries, Uganda has gone furthest in terms of decentralisation and implementation of community-based worker systems. At the start of this project, community-based workers in Uganda were already widely recognised in law and accepted in practice in natural resource management, in farmer to farmer extension services and in preventative and health care programmes. In South Africa in 2004, community-based workers were used in a range of sectors: land reform, community-based resource management, statistical services, food security, paralegal services, urban rangers working in environmental health and auxiliary social workers. However, apart from the health sector where home-based

carers are widely used, the programmes are rather experimental and small scale and the potential contribution of CBWs as a systemic approach to service delivery had not been recognised. In Lesotho, before a professional public service emerged, services already provided by the community were traditional birth attendants, circumcision school tutors, traditional healers, etc. Village health workers were part of service delivery from the 1970s and were very effective. Currently, these community services as well as programmes in agriculture and adult education continue on a small scale alongside the public service though some have ended due to discontinuation of donor funding. Donor funding has prioritised HIV/AIDS so the majority of current CBW programmes are in the health sector working to effect behavioural change and offering home-based care. Kenya still retains a highly centralised service delivery system. Kenya's health department in recent years has also looked to community-based health workers to manage the large numbers of people affected by HIV and AIDS through national policies, strategies, curriculum, training materials and detailed resource materials that were planned centrally. Otherwise it appears that CBWs are not widely accepted. CBWs have emerged in the animal health sector but they are seen as a temporary, emergency measure and are without legislative backing.

In 2004 the four countries showed quite a variation in terms of maturity of local government institutions and policy development in relation to community-based workers. A comparison of governance structures in the four countries is provided in the following sections.

2.5.2 Uganda

Most development functions have been decentralized to local government levels. The Decentralised Policy was introduced in 1992 and gazetted as the Local Government Statute in 1993. The policy empowers local governments with responsibilities for the allocation of public resources, for participatory planning, budgeting and investment management.

Table 2.5.2: Levels of governance in Uganda

	Political	Administrative	Traditional
Centre (26 million people)	National government	National ministries performing policy roles only	Strong kingdoms at sub-national level, eg Buganda, with prime minister and ministers
LC5 District (56)	Elected local government	Locally appointed technical staff in most disciplines	
LC4 County	Constituency		King representatives
LC3 Sub-county (1000+)	Elected local government	Sub-county Chief. Technical staff posted at this level – powers increasing.	Clan heads
LC2 Parish	Parish Council and dev. committee	Parish Chief	
LC1 Village	Village council and development committee	Village chief	

2.5.3 South Africa

Decision-making has been devolved to provinces who provide many services. There is an increasing role of local government in service provision at the municipal and at ward levels.

Table 2.5.3: Level of governance in South Africa

Level of Government	Political	Admin	Traditional
Centre (43 million people)	National government	National Departments, some with national competence eg Land Affairs.	
Provincial (9) Metros (6)	Provincial governments Metros (A) can generate revenue	Most development services managed from this level Can't generate revenue although legislation is pending to permit this	King in some areas (eg of Zulus)
District Municipalities – 47 (B)	Elected council	Technical staff and some technical functions eg health. Produce Integrated Development Plan (IDP) Can generate revenue	
Local Municipalities 231 Category (C)	Elected council with technical staff	Technical staff and some technical functions. Produce IDP Generate significant revenue, mainly through electricity, water and rates	Chiefs powerful in some rural areas, especially former bantustans
Wards (7-100 per municipality)	Councillor and Ward committees	Local staff may operate at this level but not linked to ward structure. Wards very weak.	Headmen in some rural areas

2.5.4 Kenya

Kenya has a highly centralised system but a strong provincial administration system. Government is structured into a central national structure, provincial, district, division, location and sub-locational administration.

Table 2.5.4 Levels of governance in Kenya

Level of Government	Political	Admin	Traditional
Centre (30 + million people)	National government	National Ministries very strong with staff down to Divisional level	
Provinces (8)	Appointed provincial commissioners	Provincial administrations headed by provincial commissioner (responsible for districts, locations and sub-locations) Technical staff of various Ministries	

Level of Government	Political	Admin	Traditional
District (71) (approx 400 000 on average)	County council – Very limited powers eg roads, markets, sanitation Raise taxes. Produce district development plan	Admin head is district commissioner and ex-officio of Council – coordinates technical staff of various Ministries, members of District Development Committee (inc MPs) chaired by DC Districts have significant power and own budget Coordinate NGOs – who work mainly at district level. Can generate revenue	Some places still strong eg Njuri Nceke in Mt Kenya Region, Adakar in Turkana, Kokuro in Pokot, Yaa in Gabbra
Division (approx 3-10 per district)	Constituency with MP approx at division level, sometimes more than one division	Headed by district officer with technical staff Divisional development committee and the MP is a member	
Location	Councillors members of locational development committee	Principal administrator is a chief Frontline staff eg extension staff, AHA	
Sublocation		Headed by subchief	Headmen and elders
Villages		Village representative reports to subchief	Opinion leaders

2.5.5 Lesotho

Lesotho has a centralised national system, some de-concentration to districts, strong traditional authority. The 2005 election decentralised development implementation to the districts and created a community of councils.

Table 2.5.5: Levels of governance in Lesotho

Level of Government	Political	Admin	Traditional
Centre (2.2 million people)		National Ministries very strong with staff down to local level	King of the Basotho
District (10) (approx 270 000 on average, less in mountains)	District councils	Deconcentrated staff of national Ministries Incipient district development committee Some move to devolution	Principal chief (and senators) with advisory council – powerful, especially over land
Community councils	Community councils	Administrative staff of community council Local staff of national Ministries	
Villages		Village development committee	Area chief for 4/5 villages Headmen

PART C WHAT HAPPENED DURING THE CBW PROJECT

3 A review of CBW systems in Kenya, Lesotho, South Africa and Uganda

In the first phase of the CBW project, a number of case studies from the HIV/AIDS and NR sectors were reviewed during national stakeholder workshops to capture current experiences in each country. These findings were then compared and discussed at a 4-country workshop that was held in November 2004. More detail on the case studies can be found in each country's review report (see list of these in annex 2), or in final country report of 2007[8]. This section of the synthesis report lists the case studies from each country and presents what was learnt about CBW systems in terms of the following elements: recruitment and selection of CBWS; financing of programmes; training, roles and responsibilities; support and supervision; accountability and linkages. To avoid repetition, findings on impact and cost–effectiveness from the case studies are discussed in section 4 along with findings from the evaluations of the pilot projects which focussed on these issues.

3.1 The Case Studies

Tables 3.1.1 to 3.1.5 show the different case studies which were examined to develop the initial ideas around good practice. This also draws on some previous case studies used for a cost-effectiveness study in Lesotho.

Table 3.1.1: Case studies from Kenya

Facilitating agent	Name of the programme/ implementing agent	Services provided by CBWs
Kenya Ministry of Health National AIDS and STI control programme (NASCOP)	Home–based care programme for people living with AIDS	Home nursing care, counselling, ensuring compliance with ARV therapy; educating family care –givers on how to care for the patient and how to protect themselves; referral of cases to clinics and hospitals.
Kenya National Coordinating Agency for Population and Development	Community-based contraceptive distribution	Information, education and counselling on all aspects of family planning, distribution of contraceptive materials and referrals for clinical attention where necessary.
Kenya National Deaf HIV/AIDS Education Programme	Deaf community–based organisations	Information on HIV/AIDS, education & counselling, interpreting, linking to government institutions and services and community mobilisation for the deaf on HIV/AIDS.
Kenya Department of Veterinary Services	Community-based animal health workers	Diagnosis and treatment of common diseases, reporting occurrence of livestock diseases, promotion of good livestock management practices.
Kenya Livestock Marketing Council	Livestock Marketing Associations	Dissemination of livestock marketing information, sensitisation and mobilisation of communities with the aim of improving the marketing skills of pastoralists.
Heifer Project International Kenya	Community-based farmer organisations	Pass on technical and business skills to farmers so that they can make a living through livestock.

[8] The 2004 in-country reviews can be found at www.khanya-aicdd.org See Khanya 2004 Kenya CBW in-country review report; Uganda CBW in-country review report, and so on.

Facilitating agent	Name of the programme/ implementing agent	Services provided by CBWs
(HPI/K)		HPI/K provides start –up animals.
PAVES private pastoral veterinary practice	Community-based animal health technicians and community-based animal health workers linked to PAVES	Provide technical assistance with livestock management, sell veterinary products, provide referrals for serious illnesses, monitor disease outbreaks.

Table 3.1.2: Case studies from Lesotho in this CBW project

Facilitating agent	Name of the programme / implementing agent	Services provided by CBWs
Federation of Women Lawyers	District paralegal associations	Education of communities about different aspects of the law; legal services
Ministry of Health and Social Welfare	Community Health Worker Programme	Management of minor ailments; supervision of treatment, health education, family planning, ante and post natal care, health data collection, referrals.
Lesotho Planned Parenthood Association	Community-based contraceptive distribution	Information, education and counselling on all aspects of family planning, distribution of contraceptive materials and referrals for clinical attention.
CARE Lesotho's Sexual Health and Rights Promotion Project (SHARP)	5 strategies: peer education; capacity building of service providers; establishment of community resource centres; home-based care.	Comprehensive home-based care and support for PLWHA; education about HIV/AIDS.

Table 3.1.3: Examples of the use of Community-based Workers in Lesotho - a cost-effectiveness study in 2003 (Khanya, 2003)

Agency	Worker	Voluntary	Paid
Ministry of Health	Village health workers (VHW)	X	
MoACLR	Nutrition and extension assistants. Proposed Multidisciplinary Facilitators		X
Local Government	Interim Community Councils	X (elected)	
CARE	Farmer Extension Facilitators, marketing representatives Home-based CARE workers	X (elected) X (elected) X	
GROW	Host Farmers	X	
LAPCA	Community support groups	X	
Machobane Foundation	Tutor farmers	X	
RSDA	Community animators Tutor farmers/leader farmers	 X	X
World Vision	Community facilitators		X
Teba (rural development section)	Field workers who are contact people for technical support people		X

Table 3.1.4: Case studies from South Africa

Facilitating agent	Name of the programme / implementing agent	Services provided by CBWs
Department of Agriculture, Limpopo Province	Participatory Extension Approaches using farmer facilitators	Training of fellow farmers in soil and water conservation, soil fertility management, livestock and small-scale seed production.
Mvula Trust (water supply NGO)	Community sanitation committees	Collect data on sanitation-related diseases; compile a sanitation profile of the community; identify a target community for an intervention projects
CHoiCe Trust	Home –based health care	Counselling, education, physical care, cleaning and food preparation, family support and guidance.
Golang Batchaa	Home –based health care	Home-based care, health education and counselling in homes and in primary health care clinics
Hospice Palliative Care	Naledi, Smithfield, St Thomas and Ladybrand Hospices and St Nicholas Children's Hospice	Provide basic nursing care in the home and in the centres, train families on care, infection control and nutrition and provide bereavement support.

Table 3.1.5: Case studies from Uganda

Facilitating agent	Name of the programme/ implementing agent	Services provided by CBWs
The Government of Uganda Forest Sector Umbrella Programme	Community –based agro-forestry organisations	Assist with information dissemination relating to bee-keeping, agro-forestry, fruit trees, woodlot trees and charcoal production, depending on the interest of the CBO.
Jinja Diocesan Development Coordinating Organisation (JIDDECO)	Partner implementing community-based organisations	Help communities plan and develop integrated health, nutrition, food security and sustainable agriculture projects.
Organisation for Rural Development (ORUDE)	Rural community groups interested in accessing micro-finance	Assist the groups to save, to access loans from formal lending institutions and to develop action plans to access community HIV/AIDS initiative grants.
Concern Worldwide International NGO	Branches of Concern in five districts in Uganda working through community-based organisations	Practical patient care services, counselling, information on HIV/AIDS, nutrition, support to care-givers in the home; other volunteers assist the bereaved regarding their legal rights.
Uganda Fish and Fisheries Conservation Association	Community-based fisheries-related organisations	Help community members know their rights, participate in management and decision making, keep fisheries related data and improve their livelihoods

3.2 Recruitment and selection of CBWs

The process of selecting CBWs was not specific to particular countries but there were differences between organisations across the four countries. The main difference was the extent to which the facilitating agent controlled the process and the extent to which the facilitating agent involved other stakeholders and the community in the selection process. Some facilitating agents relied on local leaders or staff of local organisations to recommend people they thought would be suitable candidates to be trained as CBWS. These were then interviewed by the FA.

ORUDE said that they specifically targeted and recruited those members of the community who asked many questions and expressed interest in the programme during their introductory meetings. Other organisations facilitated a process whereby the community drew up selection criteria and chose their CBWs. In some cases, the community chose the CBWs, while in others, the community could put forward names but the FA reserved the right to make the final selection.

In terms of drawing up selection criteria, many criteria were recognised as important by all organisations and communities. These were attributes such as trustworthiness and personal integrity, leadership qualities, ability to express oneself in public and zeal for the work. Other criteria, one of which was being able to read and write, were seen as essential by some organisations but not by others.

Although organisations differed in their practice, a strong consensus emerged from the national and international meetings as to best practice. All organisations felt that widespread ownership was essential to success, and that selection of CBWs by the FA through consultation with only a few local leaders would risk nepotism and reduce ownership of the project by the wider community. The correct process is to use existing community structures including traditional leaders, local councils and community-based organisations. Also, any government departments or organisations with relevant expertise need to be consulted and included. After consultation with these stakeholder organisations community meetings should be held in the target community to explain the purpose of the project while giving the community an opportunity to voice their opinion. Then selection criteria should be developed with the community. However, the FA needs to raise awareness in the community of criteria crucial to success such as relevant farming experience[9], or criteria that reflect the FA's core values such as the need for gender balance in the selection process. There should be extensive dialogue with the community involving them in planning the whole intervention. The process needs careful facilitation to make sure that there is representative participation and that everybody's voice is heard. The consensus was that while this process takes time, commitment and patience on the part of the FA, it is necessary if the programme is to be truly community-driven and hence sustainable.

The community selecting the CBW was also perceived as a motivating factor for commitment and good performance on the part of the CBW since the CBW has seen that the community has vested its trust in him/her at a public meeting.

[9] In one of the pilot programmes in South Africa, the evaluation commended the ownership by the community engendered by the selection process but felt that the need for the CBW to have farming experience was not properly explained and led to poor choices.

3.3 Financing of CBW programmes

There are two key issues here – the first is how service delivery programmes using CBWs are to be funded and secondly, the issue of whether CBWS should be paid.

Service delivery, even where a large proportion of people are working voluntarily, costs money. All programmes spent money on running initial training programmes and continued refresher training for the CBWs as well as on supervision, reporting, and all other associated costs of running an organisation. Some CBW programmes are run by government departments with government budgets, such as the Department of Agriculture case study in Limpopo, in South Africa. In some cases, the programme is government-funded but with outside donor support, as with the Forest Sector programme in Uganda. In other cases, the programme is managed by an NGO and wholly donor-funded. Legitimate concerns were raised around the sustainability of donor-funded programmes as funding is usually for a limited time span. The general consensus by partners in the project was that greater advocacy is needed to convince government departments of the advantages of community-based service delivery so that it becomes part of mainstream government-funded delivery.

A long debated question at national and international meetings was the reward or the incentives that CBWs should receive in return for their work. All programmes offered some **non-financial incentives** such as:

- initial and ongoing training opportunities;
- networking opportunities;
- items of clothing such as t shirts, caps or uniforms;
- diaries;
- bicycles to assist with transport;
- farming inputs and tools;
- Christmas gifts.

Some organisations motivated their staff by regularly finding ways to indicate appreciation of their work. For instance, CHoiCe's CBWs had, at different times, received shoes, bibles, calculators, splash-proof jackets, skirts and shirts.

Lesotho, at one stage, had a policy of free medical treatment for community health workers as an incentive, but it did not work in practice because there was no clarity as what this meant e.g. did it extend to free operations? Also some health facilities in Lesotho are for profit and they complained that the policy had never been communicated to them. It is clear therefore that such ideas, while having potential, cannot be implemented without careful consultation and the agreement of a clear policy backed up by adequate legislation.

Stipends[10] were more commonly offered in South Africa[11] than in the other three participating countries, especially for home-based care programmes. People's perspectives on this question are affected by their views on how societies should be structured. For instance, it has been reported that community members who had worked voluntarily in Mozambique under a socialist system began to demand cash incentives with a move towards capitalism[12]. The NGO Forum of Uganda decided not to pay salaries to CBWs but rather to offer incentives such as t-shirts and bicycles and provide allowances for CBWs

[10] The difference between being paid a stipend and being paid a salary is that in the former case, there is no recognition of an employment relationship.
[11] Friedman (2005:178) estimates that in South Africa approximately one third of Department of Social Development or Health CBWs receive a stipend.
[12] University of the Free State (2005): International lessons in the use of CBW systems.

when they attend trainings. It was felt that free help was part of one's community responsibility and concern was expressed about international NGOs undermining this attitude by offering stipends.

The amount of time spent on the work in question is a factor. Most people would contribute 2-4 hours a week as a volunteer in an organisation without expecting payment but the issue of stipends arises when volunteering detracts significantly from volunteers' opportunities to assure their own livelihoods, or when they are working similar hours to and alongside salaried employees. Another factor is the type of work undertaken. Farmers who agree to pass on technical information learned to other farmers, are being exposed to knowledge that directly benefits their own livelihood whereas a CBW who delivers home-based care is not necessarily furthering his/her own livelihood. And, in fact, among the case studies, farmer CBWs were less likely to be paid a stipend than home-based care CBWs[13].

An example of a true volunteer programme was BULO STI/AIDS Awareness group, a home-based care organisation in Uganda, one of the study's pilot projects. This is one of a consortium of eight CBOs, who between them have over 700 volunteers. The volunteers are given a basic training to enable them to offer informed assistance to PLWHA, working 4-8 hours a week. Not only are these volunteers not paid but they actually pay to become members of the project. The number of volunteers suggests that the people are keen to volunteer. This contrasts with other models exemplified in the case studies that invest heavily in extensive training in the expectation of full-time work and a long-term commitment on the part of the CBW. The conclusion of the action-research study is that for programmes of the latter type there is an increasing expectation that CBWs be remunerated if their livelihoods will not to be compromised.

Concern was also expressed about widely differing stipends being offered for the same work by different organisations which caused resentment among some of those who were not receiving the same financial benefits as their counterparts. Participating partner countries were therefore generally in favour of more uniform financial rewards.

Some participants expressed the view that CBWs should be paid a stipend because the CBWs are poor themselves and because their commitments as CBWs sometimes jeopardise significant economic opportunities such as temporary employment. Another argument put forward, particularly in the health sector, is that most of the volunteers are poor women struggling to survive economically and usually carrying heavy household responsibilities, and the cost of participation in voluntary activities isvery high, not only for themselves but for their families. Some CBWs stated that they used their stipends on costs associated with their work such as transport to reach clients or to buy food for impoverished clients because they know that certain medications cannot be taken on an empty stomach. One CBW commented that her role is to wash patients so she bought soap to take with her because sometimes there was none.

Others argued for stipends on the basis of the higher attrition rate among volunteers than among CBWs paid a stipend, which leads to increased costs in a voluntary system as new workers have to be recruited and trained more frequently. Quotations from CBWs in the South Africa evaluation indicate that the majority of people entered CBW programmes in the hope that it would lead to some remuneration in the future, either because the organisation they work for will become better resourced and afford to pay them, or that the training that they get will give them a greater chance of being employed in the future (see Box 1).

[13] For example, NAADS farmers CBWs are not paid. However, if they are assigned some specific duties by NAADS outside their routine work, they are then paid up to Ug shs 5 000= (about $3) per day.

The CBWs are in fact responding to the market forces that affect employment in general. Where there is high unemployment, people will work as volunteers as it gives them marketable skills and valuable work experience. Stipends will prove more attractive and increase retention of staff but trained CBWs will move to other organisations offering higher stipends if they exist in the area.[14] Home-based care organisations in South Africa found their CBWs being recruited elsewhere as counsellors or government community development workers where they were paid up to three times as much.

Box 1 Comments from CBWs in SA

"We have got the training, but where do we go from here? The training should translate into us getting preference when it comes to jobs."

"I have been in this field for more than six years now and I thought that by now I would be an Assistant Nurse so that other people can see that volunteerism is a beneficial act…."

Others argued for stipends on the grounds that the programme is easier to manage when workers are paid. This argument is backed up by research by Family Health International into community-based distribution projects similar to the ones reviewed in Lesotho and Kenya, which indicated that paid workers perform better than volunteers and that CBD programmes using volunteer workers are more complex to manage as it is harder to supervise volunteers and to maintain service quality.[15] However, these advantages have to be balanced by the additional work required of the organisation. A staff member at ChoiCe commented that the introduction of stipends for their CBWs had ushered in an era of much more stringent supervision which is demanding on management. Obviously there would also be greater administration involved in managing and distributing the funds. Managing money is a large responsibility and it also requires the organisation to have the capacity to prepare funding proposals to maintain the funding[16].

Another way of giving CBWs an income is a '**user pays**' model. ORUDE in Uganda had a "mixed model": they paid their CBWs allowances but in addition the community paid CBWs a fixed fee for assisting them to develop action plans to access government grants for HIV/AIDS projects. The 'user pays' model has been most developed in Kenya in the community animal health programmes in the arid and semi arid lands (ASALs). The Department of Veterinary Services (DVS) has not had the capacity to reach into these areas, which are characterised by vast distances and difficult terrain. People living in these areas are pastoralists who graze animals as a principal source of livelihood as there is insufficient rainfall to grow cereal crops. The DVS has supported NGOs and private veterinarians to train and equip community animal health workers to offer basic animal health care. The CAHWs are herders who move with their community. They are given training to enable diagnosis and treatment of common diseases that affect the community's animals and, in most case, are given starter drug kits at a large discount by the FA. The CAHWS can then run their own business charging clients for their services and for the drugs. The system is deemed to have been successful though the absence of a cash economy and the fact that the pastoralists struggle to survive under difficult conditions for running a business. It was noted that the community was prepared to pay for private good services (direct services to their own animals) but not for public good services such as long-term disease control through programmes such as tetse fly trapping. Availability of credit is important for this model. In the PAVES case study from Kenya, the veterinarian struggled to get credit to set up the system

[14] This is not to diminish the volunteers' genuine desire to serve those in need in their communities. It just reflects the reality that as adults we also have a responsibilities to support ourselves and our dependents.

[15] Family Health International (1999): Motivating community–based workers.

[16] The South African Community Health Workers Policy Framework (2004) states that: 'although voluntarism will continue to be encouraged, volunteers should not be employed more than a few hours a week without remuneration……CHWs will receive a stipend.

and was forced to use his own capital. Later, some pharmaceutical companies started advancing goods on credit.

Finally, some organisations, mindful of the risks of relying on donor support, are looking to assist CBWs with income-generating activities as a way of them supporting themselves. This is the case with Kibera Community Self-help Project (KICOSHEP-K), one of the Kenya pilot projects working in the reproductive health and home-based care sector. The CBWs have been trained in income-generation (IG) skills and given initial monetary support to start IG projects. But the Kenyan partners noted that while the projects might generate some income for CBWs, it is not currently considered a sustainable mode of financing the system.

Partners also reported that communities contribute to CBW programmes through providing meeting places, food, cash, labour or materials or organising community fundraising events to generate money.

3.4 Training, roles and responsibilities

Quality of training is one of the most important determinants of programme quality and impact. All organisations offered initial training to their CBWs and ongoing training on a regular basis and there is agreement that this is essential to any programme.

In some cases, there has been collaboration at a national level to standardise curricula for CBW training. For instance, in Kenya, the government Department of Veterinary Services collaborated with NGOs to develop standards and guidelines for training of community-based animal health workers. In the health and social welfare sectors in South Africa, accredited training is provided in the 59-day home-based care workers developed by the Hospice Association of South Africa (HASA). Friedman (2005:178) comments that *"The HASA 59-day training course for HBC workers…. has provided a standardised form of training, which has greatly accelerated the provision of quality community-based palliative care…. Training is based on a curriculum and materials developed by HASA and approved by the DOH. There is an initial 70 hours of classroom input linked to 160 hours of clinical placement, shared between hospice, primary health care clinics and participating hospitals."* Unit standards and qualifications have also been developed by the South African Qualifications Authority for ancillary and community health workers.

However, participants in the study also complained of inconsistencies in training and in job descriptions for CBWs. For instance, in the health sector it was found that some programmes trained their community-based health workers in curative care, others in health education (prevention) and others in support care activities. Some did not get training in support care because their FA believed the role of the CBWs was preventative. This can lead to confusion for the CBWs and in the eyes of the public. Friedman (2005:178) states that of the more than 60 000 community health related volunteers linked to the Department of Health, *"few of these have had the opportunity to receive standardised training and a variable quality of delivery has been the outcome."*

The consensus emerging from the study was that greater clarity and uniformity is needed on the content and duration of training courses and the tasks that CBWs are expected and allowed to perform.

Flexibility in terms of delivery and methodology was thought to be important to accommodate CBWs' specific needs. For instance, experience within organisations suggested that while taking trainees to a residential training venue away from home was advantageous so trainees were not distracted by other responsibilities, women would then be less likely to

attend. There was general agreement that training should be participatory, active, learner-centred, problem-posing and practical and delivered in circumstances that closely mirror the true situation in the field.

In some organisations, particularly in the natural resources sector, CBWs would receive some generic training and then select a specialist area. For example, Ugandan community forest advisors would all be trained in group dynamics, facilitation, community mobilisation and soil and water conservation and then would choose a specialist area such as fruit trees or bee-keeping. In other cases, CBWs are expected to be generalists. This is understandable especially in dispersed communities. However, the wider the knowledge a CBW is expected to have, the more strain this puts on the FA and the CBWs themselves and could mean a dilution of the quality of the service.

When outside training organisations are used, CBWs can receive duplicated training, training that is too far removed from their existing practices or training with conflicting messages from different organisations. So FAs need to be thoroughly familiar with the range and content of training provided. Training can also be inappropriate or delivered at the wrong level. The FA also needs to provide post-training **technical support** to help the CBWs compare and integrate what has been learnt with their existing knowledge and practices. Indigenous farming knowledge must be respected[17] and theories about causes of HIV and suspicions about medication be brought into the open. While this is known in theory, in the rush to implement projects, the space for this kind of dialogue may not be created. Back-up materials need to be provided, including audio visual material where literacy is an issue, to allow further discussion in follow up sessions.

There was evidence that CBWs found themselves being given too much work and also being asked to take on tasks that were outside the initial conception of their role. There were instances where forestry and animal health workers had been asked to also provide services in the area of HIV/AIDS, conflict resolution and elimination of child labour. CBWs who were originally meant to offer home-based palliative care, sometimes found themselves delivering services in integrated management of childhood illnesses, giving health education talks at clinics, establishing food gardens, looking to the needs of child-headed or grandparent-headed households, getting IDs from Home Affairs, helping people get government grants and delivering food parcels, as captured in the following quote from a CBW from CHoiCe[18]:

'We have turned into social workers because the community consults us on any issue. It ranges from child abuse, IDs, birth certificates, in fact anything related to community life…"

There is a positive side to CBWs having multiple roles. For example, where this demonstrates the demand for local accessible services, and where the FA is acting in response to genuine needs being expressed by the community, as the aim is to create a responsive service rather than a top-down service. However, it is asking a CBW to be very multi-skilled. For instance, a CBW who is good at working on a one-to-one basis with patients may not enjoy giving health education presentations. Another problem arises if a CBW's responsibilities are so extensive or so open-ended that it leads to them working longer hours than originally agreed, or they start to feel they are being exploited. The South African evaluation of Golang Batchaa home-based care project states that CBWs (in Golang Batchaa) are supposed to capacitate relatives and friends of patients to wash the patients

[17] For instance, in the Thaba'Nchu Food Security Project, a Free State pilot project, there was uncertainty whether promoting more productive but more fragile hybrid chickens over local breeds was the right advice to give to farmers. CBWs in the Lesotho Planned Parenthood Association felt ill-equipped to deal with negative cultural attitudes towards contraception.

[18] Khanya (2006: 46)

and perform routine non-CBW tasks. However, the evaluation found that the CBWs were washing patients and cleaning the house and the relatives were becoming dependent on them and seeing it as no longer their responsibility. The challenge therefore appears to be sifting out those genuinely in need because there is no-one else to care for them, from those where the relatives are able but reluctant to do the work. What is clear is that expectations of the community, the FA and the CBWs themselves need to be managed and CBWs have to know when they have the right to say no!

In addition, it is also difficult to monitor performance if a person's job description is ill-defined. This can mean that the CBW does not know what to prioritise, what to report on and loses the satisfaction of 'a job well done'. These factors could be quite significant in retaining CBWs.

No doubt a good CBW training course would give CBWs an understanding of who to refer to for problems that are outside their sphere of interest. However, the relevant professionals are likely to also be thin on the ground and may not have the capacity to respond quickly. The Ministry of Social Development in South Africa announced in September 2007 its intention to train 7000 auxiliary health workers as it recognises that there are not enough social workers. It puts a strain on CBWs if the systems they need to refer to or seek support from are also weak.

An important issue that was raised was that when new CBWs were brought into the projects to replace CBWs who had left, they often received insufficient training in comparison to their co-workers. This leaves the new entrants at a disadvantage and undermines the quality of the programme.

It was very clear from the study that training is a strong motivating factor for CBWs who value the fact that training provides them with specialist skills that enable them to perform a service to their community, and that raises their status in the community. It also increases CBWs' future employment prospects. The quality, regularity and relevance of the training is thought to be critical to CBW retention.

3.5 Support and supervision

All country partners agreed on the need for post training, supervision and support. Within the animal health field, the African Union Inter-African Bureau of Animal Resources (IBAR) indicated that from their experience, technical or communication problems with CAHWs occur within three months after training, and so close supervision was needed in this phase including on-site visits to check on CAHWs' knowledge and skills, with more routine supervision after that period[19].

Most organisations had systems in place whereby full-time staff met CBWs on a weekly or monthly basis to provide support and supervision. The meetings allowed supervisors to receive feedback on the CBWs' work, to collect performance data and provide an opportunity for all to share information and challenges, discuss progress and voice community concerns. In some organisations, CBWs also met regularly on their own, and these meetings were seen as an important component of good practice.

The Kenyan Ministry of Health (ID21, 2007) researched factors that motivated community-based contraceptive distributors and found that supervisors are mentors for the volunteers and provide important psychological support. Group bonding and a sense of belonging

[19] Khanya (2005): International lessons in the use of CBW systems p. 3

among volunteers was also said to be important motivating factors. Those who had stopped CBW work said that they missed the interaction with other volunteers. These are therefore likely to be some of the reasons why regular meetings were considered to be important to programme success.

In terms of support, the study notes that CBWs working with people with HIV and AIDS needed a lot of support and counselling from skilled health professionals because of the severe emotional demands of the work. In recognition of this need, CHOiCe Trust had employed a dedicated counsellor as a service for the CBWs. However, CBWs in many other organisations do not have any such support.

Supervision is critical to support systematic documentation on the functioning of programmes. If programme impact is to be captured, data on tasks carried out has to be fed into the organisation by the CBWs and impact measured in terms of quantity and quality. Good supervision systems can help facilitate this. Participation in the 4-country study was highlighted as having strengthened awareness among participating organisations of the necessity of careful data collection.

3.6 Accountability

Accountability is a process in which two or more actors undertake a given task and have a shared understanding of the goals and responsibilities for effectively fulfilling the task while ensuring regular feedback through mutually agreed channels and procedures. For accountability then to take place, the parties involved must have a shared understanding of what to do and why, for whom and with whom.

The CBW partners perceived accountability as operating at different levels. The CBWs have multiple accountability responsibilities depending on the type of system and service provided. They are accountable to the community who are also the clients and also to the FAs as they provide support and resources to the CBWs. Depending also on the types of linkages the CBWs are also accountable to other stakeholders such as technical line departments or private sector stakeholders.

There was agreement amongst participants that most CBWs felt that they were first and foremost accountable to the FA, which was seen as the 'employer' and provides supervision and incentives. Accountability is achieved by means of contracts which lay down the responsibilities and duties of CBWs in a clear job description and by reporting processes. Poor accountability systems were reported by organisations without contracts or regular reporting systems with their CBWs.

The CBW role is one of building bridges between local service provision systems and the communities they serve. Therefore, researchers agreed that accountability to the community as both beneficiary and manager of their services is very important, but is in most cases not well developed. To achieve this, organisations were encouraged to involve the community in the selection process as described in 3.2.

It was felt that ongoing accountability to the community could be strengthened through the establishment of committees drawn from the community that the FA and CBWs would report to, or by using existing local committees. To enable meaningful accountability communities would have to be properly briefed about what they should expect of the CBWs and trained in straightforward and simple mechanisms for monitoring performance. It was generally agreed that communities will need to be capacitated to take on such roles.

The CHoiCe Trust NGO stated that they reported on the performance of their health CBWs to a local committee so that the community would appreciate how hard they worked. NAADS farmer CBWs in Uganda report to the parish council who also carry out monitoring visits. Uganda has well developed local structures for this purpose as they have a local council system which is responsible for monitoring service delivery. The chair of the council is elected by the community so is a legitimate representative of the people. Kenya has constituency development committees with constituency development funds to spend on local development projects. South Africa has ward committees and also local health committees.

The study participants warned that multiple accountability could be quite taxing on CBWs if different reporting formats and differing ways of structuring and collating statistics were used. CBWs in the health sector may be accountable to the FA, to the health service and to the community. For example CHoiCe's CBWs meet with the nurse in charge of their local clinic and with their CHoiCe's CBW coordinator on a monthly basis. If they had to submit different written reports to each, that would be a considerable administrative burden. Efforts would have to be made to develop one simple reporting format.

3.7 Coordination and linkages to other stakeholders

Committees are needed to coordinate CBW programmes at a local level and to avoid overlapping roles, duplication of effort, competition and contestation of territory. In Uganda, for example, there are village health committees to monitor health programmes at the community level and these have been established in many areas in South Africa.

In the health sector, CBW programmes were strongly integrated with service provision. For example, Golang Batcha works in the Free State Department of Health's clinics, stipends are paid by the Department and the Department also controlled entry into the programme. In other cases services were contracted out to an NGO which operated more independently and from its own premises. But in all cases, CHW programmes worked closely with the local formal health institutions. The CBWs refer their clients to the clinics and hospitals and clinics and hospitals refer clients back to CBWs. CBW programmes will also report on their activities to the formal health services. The University of the Free State (2005: 17) refers to a World Bank report which concludes that *"if CBWs have no clear connection to the existing health system, they are often bypassed by household members who consult providers at the first level of the formal health system"* [20].

In the NR sector, some CBW interventions were a programme of the relevant government department as with NAADS, while in other cases the programme was independently managed and funded, but had strong links with the relevant government departments. In animal health in Kenya it is accepted that even where CAHWs were self-employed they should always be linked to qualified veterinarians who can support and periodically check on the quality of service provided. The CAHWS must also be linked to qualified pharmacists who are the only legally recognised suppliers of drugs in Kenya. Most CAHWs were established through NGO projects such as Farm Africa or Practical Action – East Africa. However, PAVES is an example of a CAHW programme set up by a private veterinarian.

Participants in the CBW project indicated that a thorough stakeholder analysis should take place before any programme is implemented. Two reasons are provided. Firstly, this can avoid duplication and possible conflict with already existing organisations. A CBW from

[20] Khanya (2005): International lessons in the use of CBW systems

CHOiCe was quoted as saying, *"Many NGOs operate here. This creates confusion as we are duplicating services."*

Secondly, exploration with other organisations working in the area can enable organisations to collaborate in a more coherent and integrated manner to complement and mutually benefit each other. This would enable them to deal more comprehensively with the challenges faced in their particular sector or on an interrelated issue (HIV & AIDS), that impacts negatively on the community socio-economic). For example, ABC-Kisumu (one of Kenya's pilots) is working to improve sexual health and has worked closely with the already established beach management units (BMUs) on the beaches of Lake Victoria where both organisations were operating. The beach management units were working to improve the fishing communities' ability to assert their rights and influence policies affecting them. Both organisations felt that their working together had synergistic effects.

Another type of linkage that has to be managed effectively by FAs is to service providers who can offer technical training and back up. Even when outside service providers are used, there is work for the FA to do to manage, monitor and coordinate as explained earlier.

FAs are responsible for creating and maintaining links with donors (government, NGO or private sector) to maintain funding of the programme's activities. The challenges of doing this were documented, such as CBOs' limited capacity to write funding proposals, donors' reluctance to commit to long-term recurrent costs such as salaries, and the sometimes erratic and unreliable nature of government funding. There was a sense that there is a lack of realism on the part of funders about the time it takes for a programme to build partnerships and see results and that their thinking is too short-term.

Communication with other stakeholders is also necessary to achieve acknowledgement of CBWs and understanding of how they play a complementary role to the work of existing service providers. Some of the CBWs interviewed in the evaluations commented that health providers such as nurses felt threatened by them when their programme first began.

Finally, loosely defined roles, disparate levels of training and divergent systems are seen to be creating confusion and hindering adoption of CBW systems. Partner countries in this study emphasised that all organisations have to work together with the government or central agencies or through coordinating forums to create more coherent and consistent systems. The result of this will be that the roles of, for example, a home-based carer, will be known by the general public, and that the place of CBWs within the scheme of service delivery can be widely understood and accepted.

4 The pilot projects: implementation from January 2005 to March 2007

4.1 The five models

At the 4-country workshop, held in September 2004, partner countries shared their findings from their in-country review. Their analysis clustered CBW systems into five types or models in terms of hours worked in a week and type of remuneration. The five models that emerged from the workshop are shown in Table 4.1.

Table 4.1: Main models emerging

Model	Features
4-8 hours per week unpaid volunteers	• Often interest-linked eg church-linked volunteers, scouts/guides, environmental groups, befrienders, cancer support groups • May be professional volunteers eg attorneys/doctors helping in a hospice**;** representational – school board members/ governors/PTAs, community policing forum members, ward committee members, etc. In this model, some expenses are usually paid.
20 (exceptionally up to 40) hours per week unpaid volunteers	Used by many NGOs (eg World Vision Lesotho, Concern Uganda, CARE Lesotho). In this model, travel expenses are paid and meals when the person is being trained.
20-30 hours per week, paid a stipend	eg home-based carers in the health sector and social welfare; MvulaTrust water and sanitation programme; lay counsellors, in South Africa, teaching assistants.
40 hours per week paid	Paid either as salary or commission (eg CHoiCe supervisors in South Africa, fisheries workers in Beach Management Units in Uganda; paralegals, some contraceptive distribution programmes).
Paid by user	Hours variable, (eg Community Animal Health Workers (CAHW) in Kenya; community resource workers in agriculture, Uganda; people assisting with Community Based Planning, Uganda).

A small group of representatives from each partner country met again in January 2005 and worked further on developing guidelines for implementing each model. They also identified implementing partners to test one or two of the models developed. The implementing partners, called the *pilot projects*, agreed to modify their practice to incorporate some of the elements of best practice emerging from the action-research and agreed to an external evaluation. As well as the official final evaluation, peer review exercises also took place in some countries, involving implementing partners and members of the steering committees.

4.2 Guidelines for implementing a CBW system

Pilots were selected based on:

- **Potential for scaling up –** ensuring sustainability and scaling up in the pilots, so that the system that is being tested is not restricted to small-scale operations or isolated islands of excellence;

- **Monitoring process:** For the pilots to be useful, adequate monitoring and learning must be carried out. A learning framework should be used to directly monitor each project and may include:

- CBWs logging time through the use of diaries for example, and client feedback on services received and provided;
- FAs logging support and supervision provided to CBWs;
- Challenges emerging from the revised practices;
- Monitoring visits by steering committees;
- Reporting to other structures in the communities e.g. local government structures, about the pilots.

- **Financing the implementation:** partners in the pilot projects are actively involved in implementing a community-based worker approach and have enough finances (at least one-year funding) to support their work (as the four country project did not fund implementation);

- **Evaluation:** Evaluation of pilot projects should be undertaken by an independent organisation to ensure credibility and should be a formative evaluation on what elements worked, what did not, and what should be modified as a next step in improving practice.

The elements of the model on which pilot projects are based were flexible, but some initial guidelines based on the elements of section 3 were provided for them to adapt their operations. For each pilot there was a variety of common and specific elements. The FA could decide which of these to implement. However, the steering committee in each of the partner countries was informed as to what was being tested in each pilot. These pilot projects formed a peer-review process in each partner country. Regular monitoring visits within the country and across the participating countries were undertaken. Also implementing pilot projects conducted exchanges amongst themselves.

4.3 Incorporation of learnings from the Peru study tour

The study tour to Peru was intended to give participants a wider perspective of related programmes on another continent and inform their understanding of the in-country pilot projects. One good practice example of a community-based worker system identified there was the Local Committees for Health Administration (CLAS). This is a decentralised health service where administration and delivery of primary and preventative health care is shared between communities and government. The model aims to decentralise health management through the promotion of community participation, involvement of NGO expertise and governmental support. Central government, through the Ministry of Health, provides resources and subsidised technical support (doctors and nurses) while local communities administer and manage health projects through local committees using public funds. Over 35 percent of all primary health care (PHC) facilities in Peru are currently administered through this system and over six million Peruvians access primary health care through health centres managed by the CLAS Associations.

From the CBW projects visited, the delegation gained in-depth understanding of the nature of Peruvian community-based worker projects. The projects visited included a community technical assistant programme implemented by CARE Peru in Ayaviri District and focusing on animal health support, and a community animal health worker (kamayoq) project supported by Practical Action (formerly ITDG) in Sicuani District, where indigenous knowledge is nurtured and built into the project.

Many lessons were learnt during the trip and compiled into a report. Notably CBWs in Peru are rarely compensated financially and value their training as an important incentive for participation. The experiences from Peru suggest that volunteer service can be sustained

without financial incentives as long as those providing the service are rewarded with recognition and self-fulfilment.

4.4 The Pilot Projects

Tables 4.4.1-3 show the pilots adopted in Uganda, Kenya and South Africa. No pilots were implemented in Lesotho.

Table 4.4.1: The Kenyan Pilot Projects

Implementing organisation	The work of the CBWs	What was piloted
ABC-Kisumu, a CBO working in poor fishing communities on the beaches of Lake Victoria	• To carry out advocacy, behaviour change and communication activities in relation to sexual and reproductive health and rights. • Community-based Facilitators organise roundtables for community members and government officials to dialogue on advocacy issues.	• Up to 20 hrs unpaid & 20-30 hrs paid model; • More transparent selection processes; • Improved local linkages; • Improved documentation by CBWs; • Expansion of model to more districts and in Tanzania and Uganda.
Wajir South Development Association (WASDA)	Primarily to provide basic veterinary care to fellow pastoralists in their communities but also to encourage dialogue about environmental and water conservation and conflict management.	• Paid by user model; • Improved selection process; • Improved training; • Strengthening linkages to support CAHWs.
– Kibera Community Self-help Programme – (KICOSHEP) Kenya	Provide HIV/AIDS testing, counselling, health services for the debilitated and home-based care for people living with HIV & AIDS (PLWHAs), and nutrition and schooling for orphans and vulnerable children (OVCs)	• Up to 20 hrs unpaid; • 20 hrs paid (testing motivation between the two models); • CBWs paid a stipend for the first time, • Improved accountability to KICOSHEP and to community; • Strengthening linkages with stakeholders

Table 4.4.2: The South African Pilot Projects

Implementing organisation	The work of the CBWs	What was piloted
Phaphamang Community Development Project (NGO)	• Thaba'Nchu Food Security Programme (TNFSP): To improve food security through growing vegetables and rearing chickens and create a small income through marketing of surplus produce. • CBW support a group of 15-20 members within their community through advice and guidance on how to improve their agricultural production – both crops and poultry.	• Programme was set-up to test the 4-8 hrs unpaid modelworks and how it can be improved. • Monitor whether the selection criteria by community can be managed better
Golang Batchaa - an NPO working with the local department of health)	Provide home-based care, tuberculosis palliative care - DOTS; integrated management of childhood illnesses; HIV/AIDS and anti - retroviral treatment, counselling and administration.	20-30 hours a week, paid a stipend.
CHoiCe Trust - an NGO working	Home–based care and health education; tuberculosis palliative care, support to	• 20-30 hrs a week unpaid; • 40 hrs a week paid (coordinators of

Implementing organisation	The work of the CBWs	What was piloted
with the local department of health	PLWHA and orphans and vulnerable children	other volunteers). • Support other emerging HBC CBOs and establishment of ChoiCe's CBWs into CBOs • Improve record keeping through introduction and use of diaries. • Introduce and implement contracts through clear job descriptions.
Kodumela Area Development Programme - World Vision, SA	Home–based care and health education; tuberculosis palliative care, support to PLWHA and orphans and vulnerable children	• 20-30 hours paid a stipend, others not paid; • Work on clear criteria for recruiting new care givers. • Strengthen recording and building relationships with community and community structures through use of diaries • Improved accountability to ward community, councillor and tribal authority to ensure ownership of the process
Ramalema Environmental Pollution Prevention Programme	Cleaning up the environment by collecting refuse, sorting refuse for recycling; overseeing food and animal care; watchdogs for pollution in the area including the rivers.	• 20 – 30 hours a week unpaid • Use of recycled product to produce glass and plates from bottles; • Develop criteria for recruiting and selecting members

Table 4.4.3: The Ugandan Pilot Projects

Implementing organisation	The work of the CBWs	What was piloted
Budongo Community Development Organisation (BUCODO)	Promotion of sustainable rural development through advising on forest resources conservation, population development, human rights and household poverty alleviation. Activities include tree planting, commercial cultivation of medicinal plants, seed collection, apiaries, advice on reproductive health.	• 20 hours a week, unpaid; • Improved documentation of activities and time spent on voluntary activities, • Improved linkages and support with other stakeholders.
NAADS Mbarara (formerly ULAMP)	Helping their fellow farmers to adopt appropriate technologies to improve production	Expected to work 3 hrs a day
Bulo STI/AIDS awareness group (BUSTIHA) Supported by Concern MPIGI	HIV/AIDS practical patient care, nutrition and hygiene advice, counselling, education, herbal remedies for opportunistic infections, monitoring of progress, patient tracking and data collection	• 4-8 hrs a week unpaid; • 20 hours a week by the leaders • Record keeping and monitoring skills refresher courses • More accountability to the community and PLWAs households • Involvement of the affected groups – clients for effective peer support • Revision of the group constitution to specify roles of different stakeholders • Development of a CBW Code of Conduct in the

Implementing organisation	The work of the CBWs	What was piloted
		field and practice
Kamwokya Christian Caring Community	HIV/AIDS practical patient care, nutrition and hygiene advice, counselling, education, treatment of opportunistic infections, monitoring of progress, patient tracking.	• 20-30 hours a week, paid • Piloting a new programme - HIV/AIDS Treatment Support. (HATS). Develop a tool for capturing information to ensure that patients on ART adhere to drug regimens, give reports about drug side-effects and any opportunistic infections, and provide psychosocial support to clients and their caregivers. Also document the social issues affecting the clients and how these impact on adherence. • Clarify roles and responsibilities for volunteers to enhance accountability • Develop a volunteer code of conduct in consultation with the community and volunteers. • Develop commendation criteria and disciplinary practices for volunteers.
Rukungiri Functional Literacy Resource Centre (RFLRC)	Works with Village Based Trainers (VBTs) to assist villages develop village-based development plans in 17 villages of Kanungu and Rukungiri Districts. Activities that have been started include savings and credit schemes, forest guiding for tourists and making and selling handicrafts. Adult literacy programmes are also offered at the centre.	▪ More involvement of FA to enhance training of VBTs i.e. meet at least 75% of training costs. ▪ Support the information sharing strategy up to the village level. ▪ Support the follow -up system from national to sub county level. ▪ Capacity building of the resource centre (O.D in terms of facilities and equipment to manage information and recording). ▪ Collaboration and involvement of with the private sector in the two districts in terms of support and supervision of VBTs

5 Impact and cost-effectiveness

5.1 The evaluations

Most of the above projects underwent an evaluation in 2006. In South Africa the evaluation was undertaken by the Centre for Development Support (CDS) of the University of the Free State, while other countries used individual consultants. The main objectives of the evaluation were to establish whether the CBW system was effective and having an impact on people's livelihoods and whether the CBW system was cost-effective as a form of service delivery. In addition, the evaluations made recommendations in terms of improvements that could be made, benchmarking projects against each other and CBW literature, and also looked at the positioning of each pilot in terms of current government policies and the potential for scaling up.[21]

The hypothesis was that improved approaches to community-based worker (CBW) systems would increase accessibility, sustainability, cost-effectiveness, and cultural effectiveness of the delivery of pro-poor services. The assumptions were as follows:

- **Accessibility**: By deploying local service providers (CBWs), a wider network of services can be set up and more people, especially those marginalised and in remote areas, can be reached;
- **Sustainability**: Sharing and handing over responsibility to the beneficiaries can make them more involved in development planning, and thus help make development interventions and service delivery more sustainable;
- **Cost-effectiveness**: Working with volunteers is a cost-effective way of expanding services, especially in poorly resourced areas;
- **Cultural effectiveness**: The relationship between local providers and beneficiaries might be more equitable in terms of who is served and reach more people who might otherwise be overlooked. Mitigating socio-cultural misunderstandings might improve service delivery.

The rest of this chaper will focus on what was learnt from the evaluation and the study generally about impact, cost-effectiveness and sustainability. Chapter 5 will focus on the broader institutional, policy and advocacy implications, and the potential for upscaling.

5.2 Impact of the pilots on clients

5.2.1 The Health Sector

The evaluations consistently produced evidence from interviews with beneficiaries that home-based care CBWs were having a significant positive influence on their well-being and livelihoods. In most cases the organisations had collated statistical data relating to activities carried out which provided strong evidence of impact.

Examples of activities where clients attested to benefits from CBWs were:

- Being reminded to take their medication;
- Taking correct dosages of medication;
- Being reminded about appointments with health personnel;
- Increased understanding of their illness, the treatment and the prognosis;
- Increased understanding of the importance of adhering to treatment;
- Increased awareness of methods of infection;

[21] The evaluation reports – one for each of the three countries is available at www.khanya-aicdd.org

- Greater knowledge of health, hygiene and nutrition;
- Support with organising transport to health centres;
- Increased confidence to disclose one's status and deal with stigma;
- Psychological support and comfort;
- Reduced fear;
- Support with resuming former activities and returning to work;
- Family members feeling more empowered to care for an affected relative.

ABC Kisumu in Kenya particularly mentioned that group therapy meetings for PLWHA had built the confidence of participants, reduced stigma against PLWHA and increased the number of people seeking VCT services, though there were no statistics reported.

Further evidence of impact came from the health services which were enthusiastic about the contribution of the CBW programmes which are being seen by some as indispensable to the primary health care service. The quote in Box 3 from a service provider at Gombe Hospital in Uganda on BUSTIHA's CBWs sums up the way CBWs can be a very effective health service partner.

Box 3 Staff member at Gombe Hospital's view on CBWs

"CBWs have strengthened adherence. Adherence for our HIV beneficiaries at Gombe Hospital is above 95%. The drop out rate from the clinic is almost not there and the death rate from HIV-related illness has also gone down. This is because we have BUSTIHA volunteers that follow beneficiaries and ensure that they take medication, return for routine check-ups. As people stabilize and live longer they are able to go back to work and take care of their families and plan better for their future and that of their children."

A TB nurse at a clinic in Mangaung, South Africa, also said that their statistics indicated that Golang Batchaa CBWs had improved the treatment outcome in TB patients. CBWs intervention assisted in reducing the TB interruption rate from 19.7% in 2000 to 13.8% in 2002 due to Direct Observation Therapy Short-course (DOTs).

ABC Kisumu had a behavioural change focus rather than care and support for the sick. Their aim was to increase community understanding and encourage action with reference to sexual and reproductive health rights and associated issues such as poverty. They worked through round table discussions and youth peer educators. Indicators of impact included a higher rate of condom use, reduction of unwanted pregnancies and changes in attitudes towards girls and women. While hard statistical evidence was lacking, the evaluation team confidently reported significant changes in community knowledge, attitudes and practices.

Many of the health organisations offered additional social services such as supporting the elderly and children in accessing grants, identifying those in need of food parcels and distributing them, supporting people in the community with income generating projects, and alerting authorities to vulnerable people in the community e.g. child-headed households and the mentally ill. KICOSHEP in Kenya also runs a primary school and Kodumela had a particular focus on identifying orphans and vulnerable children (OVCs) and providing follow-up support to schools to establish food gardens.

The South African evaluation reported that the health NGOs were better at monitoring and reporting on quantity rather than the quality of service provided, in other words, visits were recorded but what happened on visits was not necessarily captured.

5.2.2 The Natural Resources Sector

In the NR sector, evidence of impact was harder to quantify and there was little statistical data forthcoming from projects. There was also greater diversity in the programmes with some working with communities on rights and governance issues relating to the sustainable management of shared resources such as lakes and forests, others assisting with food security and farming on a household basis, while others were working with pastoralists in the ASALs. Ramalema in South Africa was working in environmental health and waste management.

Beneficiaries in Uganda reported on the following benefits from the work of NR sector CBWs:

- Adoption of new technologies e.g. use of fireless cookers, charcoal fridges and fuel-saving stoves, methods to conserve soil and water conservation, improved livestock management and general management skills;
- In forestry communities, achievements were replanting of trees, establishment of tree nurseries and earning income from the sale of seedlings, establishment of apiaries and sales of honey;
- In the forestry sector, Communal Land Associations have been established to manage the community forests and beneficiaries reported developments in user rights.

The use of farmer CBWs to extend the work of extension officers is well developed in Uganda through the National Agricultural Advisory Services (NAADS) programme. Evidence of success is the fact that a programme which started in six districts in 2001 was by 2006 operating in 64 districts and 532 sub-counties. Farmers groups (of approximately 15 farmers) in an area elect someone from among themselves to represent them at the sub-county farmer forum. The sub-county forum members propose from among themselves those whom they want to be trained to be farmer CBWs. The CBWs also have to be accepted by the parish coordinating committees (PCC) which monitor the activities of NAADS staff through field visits. Farmer CBWs are assisted to spread new technologies by having demonstration sites on their land that the other farmers can learn from in a practical way. They are not paid but receive free inputs and information which they are expected to pass on to other farmers. NAADS publications attest to many farmers having increased their productivity through the sharing of technologies and the system appears to be very successful.

A pilot project in South Africa which aimed to increase homestead agricultural production had a weak impact but problems with the conceptualisation of the project, management problems and failure to address key constraints such as lack of access to water could have been the problem here rather than a CBW model itself.

Positive feedback from NR projects included appreciation of CBWs for being accessible – both in physical proximity and language - and for motivating their clients to achieve. Some of the criticisms were:

- CBWs arriving late or not turning up at all, disrupting farmers' work schedules;
- Visits from CBWs that were too short;
- Visits too infrequent;
- CBWs not having adequate information, giving wrong information or omitting to pass on important information;
- CBWs lacking adequate equipment or tools for demonstrations.

The Kenyan WASDA project which trained community animal health workers, reported that they had trained 140 CAHWs of which 80 were still active and 60 had relocated to Somali

and Ethiopia. As the programme deals with pastoralists who are also self-employed, it is hardly surprising that gathering data on the progress of trainees is difficult. However, they estimated that 1050 persons from seven pastoralist associations had benefited from the programme. The benefits were primarily help in the diagnosis and management of common diseases that might affect their animals, and improved access to veterinary drugs. CAHWs have also helped the government with disease surveillance and vaccination programmes. The government is using the CAHWs to help with rapid response in the case of emergencies and CAHWs have played an important role in raising awareness of environmental management issues, responding to water shortages, dealing with stock theft and managing conflict.

Given that the government has failed completely to take services into ASALs and private vets are unwilling to go there as they can find easier and more lucrative work elsewhere, the CBW programmes have filled a serious gap. It appears that while NGOs believe the CAHWs are playing an important role, veterinary professionals have expressed concern about lowering of standards. One concern was that giving medicines to people with only rudimentary training would contribute to the problem of drug abuse and drug residues in livestock products. However, research by Dr C.M.McCorkle in Ghana and Mozambique found that the vast majority of drugs are bought directly by the animal owners who tend not to adhere to drug administration guidelines, often stopping treatment too early or underdosing. In contrast the CAHWs maintained higher standards of treatment, suggesting that CAHWs are more likely to be part of the solution than part of the problem (IDL group, 2003). CAHWs are also more likely to be sourcing their drugs from a reputable supplier as they are supported and monitored by NGOs or vets. Another argument against CAHWs put forward by the Director of Veterinary Services (Kenya) is that there cannot be two standards of service delivery in the same country with some areas being served by professionals and others by non-professionals. However, until such time that the Kenyan government can afford to deploy veterinarians in the ASALs, a less sophisticated service has to be better than none at all.

The impact of Ramalema Environmental Pollution Prevention Project has been a thorough clean-up of its town through the volunteers picking up refuse from the streets. It has also sorted the waste for recycling e.g. separation of bottles and plastic, and has involved itself with the inspection of food hygience and animal care in its area. The community is encouraged to dump waste into Ramalema's system of refuse collection, to earn money for the area (through recycling) and possibly create jobs in the future. Ramalema's staff of volunteers have also given awareness raising talks to the local youth on waste management and taught local schools to reduce air pollution by recycling rather than burning refuse. All stakeholders agreed that this work had been done although Ramalema has unfortunately not paid attention to recording tangible proof in terms of statistics or 'before and after' photographs.

5.3 Impact on the CBWs themselves

The benefits attested to by the CBWs were:

- Empowerment and increased confidence through acquiring new knowledge and skills;
- Personal satisfaction in being of service to their community;
- Increased visibility and status in their community;
- Pride in belonging to a respected organisation;
- Support from fellow CBWs;
- The opportunity to network with others;
- Some income, for those who received a stipend;
- Free inputs and tools and Increased farming capacity for those in the NR sector;

- Small business start up support in the shape of subsidised drug kits for CAHWs;
- Health CBWs had taken HIV tests and had changed their attitudes towards HIV and AIDS.

Negative experiences were:

- Loss of economic opportunities because of their commitments as CBWs;
- Personal risk of assault or abuse as they walk the streets alone and go alone into people's houses;
- Risk of being attacked by dogs;
- Feelings of being exploited by their organisation or by clients;
- High levels of emotional strain on the part of home-based carers dealing all day with the sick and dying and with bereaved relatives including orphaned children;
- Tiredness from walking long distances to visit clients, sometimes in bad weather;
- The risk of contracting disease when working with people with infectious diseases, especially when gloves were lacking;
- Concerns that their families were suffering as a result of the time (and sometimes, resources) they were using to help their clients.

5.4 Impact on service providers

The evaluations suggest that health sector CBWs are viewed very positively by the service providers they are linked to. This implies that their work is indeed seen by the health services as being complementary to rather than competing with the focus of the health service. A Department of Health and Social Development official in South Africa commented that *"the primary health care system could not function without CBW workers"*. Perceived impacts of CBWs included:

- Alerting health and social services to complicated and sensitive issues which may never have come to the attention of clinics, such as domestic violence, substance abuse and child-headed households;
- Support to the health service by providing case management in the community;
- Follow-up on patients in the community;
- Decreased TB patient load for clinicians who are able to *"pay more attention to other important issues which were previously neglected"*;
- Reaching more community members than clinicians alone could reach;
- Spreading important health messages in the community including hygiene, nutrition, reproductive health, HIV & AIDS and TB;
- Changing the attitude and behaviour of some patients, particularly regarding adherence to DOTS dosages;
- Making sure patients turn up for appointments.

The important role of CBWs is expressed by Friedman (2002: 172) who comments that *"various studies have shown that training of many health professionals such as doctors and nurses does not adequately prepare them for work in a community setting….CBHWs have a vital role and to do this, they need to be formally recognised as members of the district health team."*

Some personnel claimed that the relationship between CBWs and clinic staff or nurses was sometimes strained by issues of conflict or jealousy. To better understand this issue, the South African evaluation team organised a focus group with nurses who said that they generally experienced CBWs as very helpful but that government policy was needed concerning CBWs and clarity regarding CBWs' roles in PHC. One factor that nurses interviewed drew attention to was that the existence of the CBW programmes engendered

more work for the health service which had to assign staff to supervise the CBW staff. True costing of a CBW project has to also include, therefore, the cost to the health service of any additional personnel required to work in partnership with the health CBW agency.

In the NR sector, in Uganda, CBW farmers are an integral part of the National Agricultural Advisory Services strategy. In Kenya, the Department of Veterinary Services has, despite their concerns which were discussed earlier, accepted CBWs being used to extend services into geographical areas which the government has failed to service. The Kenyan government has also come to value having a network of CAHWs in the ASALs for mobilising a rapid response in the case of emergencies such as disease, drought or conflict situations.

The Ugandan pilot partners also noted how CBWs can assist the government by providing an efficient entry point into communities. It was reported that when the National Agricultural Advisory Services was formed in 2002, one of its first tasks was to form farmers' groups. The officials found that when they worked in areas where CBWs were operating, it was much easier to form the farmer groups because the CBWs were conversant with the area and its issues and were able to more easily facilitate the bringing together of the farmers.

The agricultural extension officers in the Free State admitted that they did not have the capacity to reach into the trust lands in Thaba'Nchu where the Thaba'Nchu Food Security project offered its services, and so they welcomed the chance to reach into the area through CBWs. Unfortunately, the relationship between the Department of Agriculture and Phaphamang was not established early enough for the CBWs to effectively prevent a lot of chickens in their area of operation dying in their first year of operation from Newcastle's disease. However, this is an example – if a negative one – of the potential for CBWs to quickly respond to a situation and alleviate a crisis. The two facilitators and 15 CBWs could have been quickly trained in the simple procedure to vaccinate the chickens and taken the vaccination material and the know-how into the community.[22]

Service providers in Lesotho are beginning to recognise the value of CBW systems. The country has recently been through a design phase for implementation of a national system of community livestock workers, a parallel project to the CBW project, which drew from the experience of CAHWs in Kenya, and is seeking to ensure that there is both promotional capacity to support small stock in all the villages of Lesotho, as well as a response system to avoid the potential dangers of avian flu and generally livestock production (Khanya-aicdd/MoAFS, 2007).

Problems that faced the NGOs supporting CAHW programmes in Kenya were the legal uncertainty regarding the position of CAHWS (see section 5) and the fact that sometimes the CAHWs exhausted their drug kits and were unable to replace the drugs used. The inability to replace drug stocks has to be attributed to bad business management but the CBWs do work in a harsh, drought-prone environment where there is not an established cash economy and sometimes they were paid in animals which could get sick or be stolen.

[22] Community Forestry Advisors in Uganda's Luweero District also complained that in the three years their project had been operating, they had received no support from local agricultural extension officers with their problems with insects, diseases and all the other challenges that they faced although the extension officers had been tasked to help them. (Khanya; Learning about CBW systems newsletter 6, June 2007).

5.5 Cost effectiveness

The University of the Free State was contracted to look specifically at issues of cost-effectiveness. It was noted that in order to determine whether a project is cost effective or not, a number of relevant factors have to be determinable:

- All the costs attributable to the project operations;
- Quantifiable indicators of significant impact;
- Comparison data from equivalent service providers against which to benchmark the costs.

This evaluation made some comparisons in the health sector and four examples drawn from three countries are given below. In all cases, the researchers noted that the comparison was limited in that the role of an advocate for behavioural change in relation to sexual health, as in ABC-Kisumu's case, is not the same as that of a social worker, and a home-based care worker does not fulfil the same functions as a nurse. In South Africa, costs have been used from CHoiCe Trust because all their costs were included in calculating the cost per hour including administration, marketing, management, training and infrastructure. Golang Batcha's cost per hour was much lower but that is because they piggy-backed on the health service for administration and infrastructure and did not have to pay for these directly, which makes the comparison less realistic in terms of the true costs of running a CBW programme.

Table 5.5 (a) shows the expenditure of the CHoiCe programme over the course of the fiscal year 2005 and table 5.5 (b) quantifies impact.

Table 5.5 (a): Summarised income and expenditure of CHoiCe for 2005 (in Rands)

Activity classification	(1)CBW Expense	(2)Non-CBW expense	(1)CBW Expense	(2)Non-CBW expense	Total Amount
	Apportionment basis		Amounts		
Administration	80%	20%	136,797	34,199	170,996
Caring materials purchased	100%		17,058		17,058
CBO Mentorship		100%		253,050	253,050
CBW expenditure - incentives	100%		78,820		78,820
CBW expenditure - stipends	100%		593,505		593,505
Community outreach expenses	100%		528,585		528,585
Income-generating expenditure - Subcontracting		100%		28,330	28,330
Infrastructure	80%	20%	102,270	25,567	127,837
Management - meeting expenses	80%	20%	77,230	19,308	96,538
Management and Operations - Salaries	80%	20%	754,962	188,741	943,703
Marketing and promotions	80%	20%	30,806	7,701	38,507
Training	60%	40%	688,597	459,065	1,147,662
Travel	80%	20%	16,992	4,248	21,240
Grand Total			**3,025,622**	**1,020,209**	**4,045,831**

Notes:
- CBW Expense - Attributed to the caregivers and their day-to-day activities, including training.
- Non-CBW Expense **-** Attributed to other activities of CHoiCe, e.g. strategic activities, networking, non-CBW training, etc.

Table 5.5 (b): Significant impact indicators for all CBW activities at CHoiCe

PLWAs supported	1,062
Total no. of TB follow-up visits	25,858
Visits Conducted - seriously ill	7,277
Food parcels distribution	1,243
OVCs Served	10,787
No. of OVCs referred (Social 837), Medical (843)	1,680
Hours spent on HBC activities	**102,989**
Hours spent otherwise – non-core time	8,299
Referrals	
• Medical	9,394
• Social Welfare	1,220
• VCT	559
• TB	600
Total Referrals	**11,773**

In 2005 CHoiCe had 228 active volunteers working in 119 villages within the Greater Tzaneen Municipality. With funding from and in partnership with the Provincial Department of Health and Social Development, CHoiCe provided 120 volunteers with stipends for one year.

The table 5.5 (a **)** indicates that it cost CHOiCe R 3 million ($415 000) to run the organisation in 2005. Taking the 102,989 hours spent on home –based care as the defining indicator, if the total cost of running the organisation is divided by 102,989, this gives a total cost per home-based care hour of R19.58. This is approximately 1/3 of the cost of an out-patient visit to a primary health care facility, as worked out using World Health Organisation statistics.

The following table looks at similar cost comparisons for other health sector organisations in Kenya and Uganda**.**

Table 5.5 (c): Cost-effectiveness of different health delivery models in Kenya and Uganda

Pilot	Costs
ABC Kisumu, Kenya	Salary of CBW was 1/3 of the salary of an entry level social worker
KICOSHEP – Kenya	A 20 minute consultation in a primary health care facility costs nine times the cost of a home-based care consultation for the same length of time.
Kamwokya Christian Caring Community (KCCC) in Uganda	Unit cost was 41% of the unit cost of the Adult Infectious Disease Clinic of Makerere University National Referral Hospital.
CHoiCe Trust in South Africa	Cost of one home-based care hour is roughly 1/3 of the cost of a an out-patient visit to a primary health care facility.

In the NR sector, the evaluations in each country were unable to find sufficient or relevant data to conduct a comparison of service delivery costs in CBW programmes compared to conventional systems. However, previous work by Khanya in Lesotho in 2003 compared two CBW models with the current government extension system and with one that the government was proposing to roll out as its decentralised model (the Unified Extension System). These based the figures on estimates of how many farmers the extension system was having an impact on. Tables 5.5 (d) and 5.5 (e) summarise these findings and Annex 3 has more detail on the costings used.

Table 5.5 (d): Comparison of estimated effectiveness of different extension systems in Lesotho (Khanya, 2003)

Factor	TEAM[23]	Macho-bane	Ministry of Ag current – example from Leribe District	Min of Ag proposed model – all districts
No of Extension Workers (EWs)	210	70	20	548
Contact hours per week per EW		3-6	<16	22
No of farmers reached	2310	562	17924	122273
Estimated % of farmers active	45%	53%	8%	15%
Nos of active farmers reached	1040	300	1434	18341
Estimated % of active farmers with significant benefits from extension	50%	40%	30%	40%
No of farmers with significant benefits from extension	520	120	430	7336
No of active farmers per EW	**5.0**	**4.3**	**71.7**	**33.5**
No of farmers with significant benefits per EW	**2.5**	**1.7**	**21.5**	**13.4**

Table 5.5 (e): Summary of cost-effectiveness of the different extension models in Lesotho (adapted from Khanya, 2003)

Factor	TEAM	Machobane	Min of Ag current as in Leribe[24]	Min of Ag fully decentralised
Total Cost (Maluti)	1,085,072	538,287	4,131,086	50,779,751
Total cost per EW	5,167	7,690	206,554	92,664
Total cost per active participant	1,044	1,794	2,881	2,769
Total cost per participant with significant impact	2,088	4,486	9,603	6,922
Estimated total cost $/participant with significant impact	**298**	**641**	**1372**	**989**

Note: this assume $1 = 7 Maluti/Rand

The calculations show that CBW programmes are usually run very economically and so are providing services to the community in a cost–effective way compared to public sector service delivery.

With regard to costs, one of the reasons why CBW projects are run very cheaply is that CBWs work without transport whereas in the formal public service, professional staff are provided government cars[25] or transport allowances. CBWs do all their work of getting around on foot or on bicycles. In the NR sector, provision of bicycles in programmes was common though unfortunately there was no data supplied as to how easy it was for the CBWs to maintain the bicycles and how much they assisted CBWs in their work. This relates to the accessibility of the CBW which does seem to have been an issue in the NR sector given that there were complaints from farmers that they were not seeing CBWs regularly.

[23] TEAM was CARE Lesotho-South Africa's Training for Environment and Management Project. Machobane is a specific type of farming system, developed in Lesotho and spread from farmer to farmer through a system of farmer CBWs. For extension workers (EWs), read conventional extension workers for the Ministry of Agriculture and CBW extension workers for TEAM and Machobane.

[24] Costs for both support included in the above.

[25] Though in many cases staff are grounded or there are restrictions on use of government vehicles as the petrol allowance is exhausted or no budget is allocated.

CBWs also complained that the distances they are expected to cover were too large. This led to a recommendation by some researchers that CBWs should only be expected to work within a limited radius. An alternative is to fund transport but transport may not be easily available in deep rural areas. The Ugandan strategy of having demonstration sites and getting the farmers to come to the CBW is a strategy that should be explored.

6 Implications for policy and legislation and conclusion

6.1 Scaling up of services to all communities

The general consensus emerging from the action-research in the four countries is that Africa is faced with a serious problem in that the general population is hugely underserved by the small number of professionals available in a range of services. In many cases, professionals can pick and choose where they work and so poor, inhospitable or remote areas receive few services, if any.

In a climate of structural adjustment there is no sign that the number of skilled personnel is going to increase. Community-based and para-professional services offer the opportunity of bridging the gap between professional services and the general community by devolving aspects of services to lesser trained personnel who can be trained more cheaply and quickly and are paid less and so there can be many more of them. There is also less risk that once trained they will move to "better pastures". At the same time, they also offer greater community ownership and involvement in service delivery, which is advantageous in unlocking the resources of communities.

The research indicates many benefits associated with the use of CBWs. In general, the cost per client appears to be significantly lower than using conventional government delivery mechanisms (generally less than one third of the cost) and CBW programmes extend into communities in a way that conventional service delivery models are unable to. Therefore there would appear to be an important role for such models in the delivery of basic services. However, if the model is to be applied widely, national governments need to develop policy and legislation to support the development and scaling up of this method of service delivery.

There is a sense that the "project" phase of implementation of such systems has led to a proliferation of small projects with differing training methods, standards and remuneration systems. To take such projects to scale this should now give way to more standardized delivery programmes with nationally recognized training outcomes, standards and agreed conditions of service, and mainstreamed funding, but which can be delivered through a wide variety of facilitating agents, both NGOs, government and the private sector (for example private veterinarians). It is recognised that a lot of work needs to be done for this to happen and that the national and international stakeholder meetings that were part of this action-research have contributed to this body of work.

6.2 Formalisation of systems

There was consensus that training should now be according to agreed outcomes and curricula should be more standardized. Training courses would comprise core modules with additional specialist modules adapted to particular situations. Accreditation would also come to the fore with regulations about who can examine and issue certification that the CBWs have achieved a minimum standard. Stipends, if agreed to, would also lead to more careful monitoring of delivery in terms of quantity e.g. the number of home visits by HBC, and quality – what service was actually delivered. It was acknowledged that this would increase supervisory costs. This would lead to a tighter definition of the roles of the CBWs, which was also felt to be a good thing.

In effect, what would happen is that a new cadre of community-based service providers would be created with new labels e.g. community forestry workers, farmer extensionists, home-based carers, supported by a wide range of CBOs and NGOs as well as government services and the private sector in the business model. These services are likely to employ

para-professionals to provide support, such as nurses, animal health technicians, auxiliary social workers, medical clinicians and soil conservation technicians, who undertake some of the roles of professionals such as doctors, vets, engineers etc.

Some community-based workers will want to progress in terms of their careers, take on more responsibility and have the opportunity to earn more so a great deal of work needs to be done in this area in terms of mapping out the relationships between qualifications and how training credits build up to a qualification. This work is in progress in South Africa in the field of health with levels of basic home care giver, senior home care giver, basic community health worker and 'full' community health worker being defined within the ancillary health worker field[26] but there is still a lot work to be done. Recognition of prior learning for those with years of experience already in the field but without formal qualifications also poses a challenge.

6.3 Funding of the system

The type of formalisation described above will only come about with considerable investment in building of the systems and commitment to fund running costs of programmes. Funding at scale will have to come from government, in partnership with external funders where governments cannot afford to pay without assistance.

It remains to be seen whether governments will be prepared to shift more of their budget to such primary services. However, the cost to the government of paying for CBWs should be offset by savings elsewhere e.g. in hospital admissions, time lost through sick leave, and improvements in the general health of the population, increased food security and rapid response to emergency disease outbreaks in animals[27].

In South Africa, the trend seems to be that government will not employ CBWs directly but will fund civil society organisations who will employ CBWs. This is what has been written into the Community Health Workers Policy Framework and it does seem to be consistent with the intention of providing a more flexible and community responsive service.

An alternative to government or donor funding is a move towards 'user pays' models or even a mixture of the two. The CAHW 'user pays' model in Kenya has been described in this report and seems to have worked on the whole, despite the poverty of the user group (although livestock owners are not usually the poorest). The Lesotho Ministry of Agriculture and Food Security is currently adapting the Kenya model for Lesotho. An initial project was developed as a partnership between the Ministry of Agriculture and Food Security and Khanya-aicdd, and funded by Irish Aid, and a study tour was carried out to Kenya to learn from experience there. A cadre of community livestock workers is proposed, part of a private sector model of CBWs, linked into the Departments of Livestock Services and Field Services, and linked with the private sector drug distribution system. This design has been accepted by the Ministry and Irish Aid is willing to support an implementation phase. It has also been agreed that the Ministry's SANReMP programme operating in the three southern districts of Mohale's Hoek, Mafeteng and Quthing should implement this as a first stage.

Programmes using a private sector model are most valuable when, as in the examples above, they create local employment opportunities and keep the money spent circulating in the community. Another example is a system of eye care that was developed by a charity run by Dr Kassalow, an eye specialist. Dr Kassalow realized that many poor people lost their

[26] Friedman (2005:181)
[27] See section on using NR CBWs in Lesotho to act as a warning system for avian flu.

means of livelihood from simple presbyopia, which meant that they could no longer do fine work such as sewing or woodwork. He therefore set up a system to mass produce cheap and robust reading glasses. Local entrepreneurs were trained to carry out eye tests and sell the glasses. Spectacles made for $1 were sold to the franchise-holders for $2 and the franchise-holder sold them for $3. The clients didn't need to pay for expensive eye tests from qualified opticians.

"*Profitability means sustainability… Western-style training offers higher-quality care in theory – but is too expensive in practice. What poor countries need is lots of people, trained flexibly and quickly, at lower levels of skill, he says. Workers trained in this way are more likely to stay in the villages where they are needed*." (The Economist, 7 July 2000: 60).

Jacob (2007) gives another example concerning the delivery of pit latrines in India, where defecation in the open was found to be responsible for widespread diarrhoea. When the government gave people toilets, they carried on with their usual habits of defecation in the local rivers and used the concrete toilet structures to store grain. Another charity used marketing techniques to convince the people that they *needed* toilets and sold them the toilets, offering a choice of 12 designs. Local people became marketing agents, paid through commissions on their sales, and the toilets were manufactured locally, creating employment. The people are said to take pride in the toilets because they have chosen and paid for them and so they use and maintain them.

In ORUDE, one of the Ugandan case studies in this project, the micro-finance promoters were trained to assist the community to apply for community HIV/AIDS initiatives. The promoter was paid by the community who received the grant and this was said to have brought 'ample paid work to promoters'.

The *kamayoq* programme in Peru is another example where local community farmers are trained to provide technical assistance to fellow farmers whom they charge for the advice provided. *Kamayoqs* are able to identify and treat different animal diseases using both traditional and modern medicines. For example *kamayoqs* have developed a medicine formula using a blend of local herbs that farmers themselves can easily make from locally available plants to develop an affordable and effective treatment for sheep/llama liver fluke. The Kamayoqs are also contracted out and consulted on agro-forest and natural resource management matters for which they charge a fee. A key learning from the model of *kamoyoqs* is that they do not need to rely on outside help to change their livelihoods; there are resources within their own communities where they can earn a little by providing advice, teaching community members how to use traditional medicines and experimenting with the knowledge they have acquired in the *kamayoq* schools[28].

Examining these different models can stimulate creative thinking around how to train local people to deliver demand–driven 'user pays' services that would provide benefits to the community and a small income to the service provider. For instance, could it not be possible for organisations to offer home-based care services on a fee–paying basis but subsidised by government? The client would pay the home-based carer on an hourly basis for services. The home-based carer would take the receipts (signed by the client) to their FA at the end of the month and for every hour worked a percentage would be paid by the FA to make up the HBC's final salary. One advantage of such a system would be that some control and quality monitoring would come from the users as home-based carers offering a poor service would not be re-booked by clients. Community-responsiveness may also increase as clients who are paying for a service may feel they have more right to influence that service. In addition, those home-based carers who worked longer hours would earn more. If the clients got used

[28] For further information on the *kamayoqs* see Peru Study Tour report (July 2006).

to a 'client pays' model, it would be easier for the CBWs to add on small fees for additional services.

Some organisations have developed income-generation projects to assist CBWs with generating an income. However, if the income–generation project is not integral to the project but an add-on, then either the income-generation project risks being neglected and the income remains very small, or if it is successful and brings in a substantial income, it could lead to the CBWs' energy being directed into the income–generating business rather than into the community service they were originally recruited to render.

6.4 Implications for voluntarism, stipends and empowerment

It was said earlier that a distinction must be drawn between volunteer programmes where personnel work a small number of hours and more full-time programmes where it was reasonable to expect a stipend. The consensus was that where stipends are to be offered, these must be standardized through a transparent criteria. Once one enters the realm of paid employees, all aspects of delivery need to be more carefully monitored as the money spent has to be accounted for and therefore the standard of management by organisations would have to improve. If the aim is for mass delivery, this would put a lot of pressure on NGOs as they would have to manage large amounts of money. There would therefore be a great need for organisational development and capacity building for smaller NGOs and CBOs.

Friedman (2005: 186) suggests the use of credits as a reward for voluntary work. The idea is that CBWs are allocated points for hours worked which could be accumulated and used, for example, to "pay" for further studies. This idea has great potential especially with many young people who cannot afford the fees to pay for further education. As with the free health care idea, it is important for the implications and ramifications to be fully explored.

6.5 Key policy changes needed

All of the changes discussed above that are necessary to scale up and formalise CBW systems will only happen with changes in current policy and legislation and government commitment to CBW type approaches. Stakeholder representatives will have to lobby the relevant departments and present their case. The need for changes in legislation is urgent in Kenya in relation to community animal health workers, where much of the system is well developed. While livestock policies and strategies for the revitalization of agriculture recommended the use of CAHWs, the law defines Animal Health Industry and Training Institute (AHITI) certificate holders as the lowest cadre of personnel qualified to offer animal health services anywhere in Kenya including the pastoralist areas. Currently it is illegal for CAHWs to offer services or for qualified vets to support and inspect them. According to the case study presented in Khanya, (2004:25)[29] the Department of Veterinary Services had no intention of changing the legislation because they saw the CAHWs as only a temporary measure to fill a temporary service gap. The recommendation by the DVS was that CAHWs must be supported financially and logistically to receive the AHITI training. The questions raised here are whether finance and support would be forthcoming, whether the entry level requirements of a Form Four school leaving certificate would be waived, whether those who got the higher qualification would still serve the ASALs? In addition, there were questions whether it would be possible to train enough of them as the areas that need to be covered are vast. It is unlikely that AHITI certificate holders will be trained in anything like the numbers needed which suggests that CBWs will continue to be needed and therefore

[29] Khanya (2004) Kenya in-country review report, November 2004

legislation needs to be enacted to get both the veterinarians and the CBWs some recognition in law.

Friedman (2005) notes that in the health sector at least there is a serious problem with the proliferation of many types of health ancillary workers without any overarching coordination system. Some of these are single purpose such as HIV voluntary counselling and testing, family planning advisors or DOTS supervisors. Others such as community health workers are more generic. There therefore appears to be an urgent need for planning and coordination to ensure that health workers are not stepping on each other's toes, that communities are not over-served or under-served and to get the most needed services to the those who need them most and for the whole system to be effectively governed and managed. This is therefore an area where there needs to be policy development both within sectors and also across sectors, for instance, to create coordination between health and social services.

Finally, the University of the Free State, in their evaluation of the CBW systems in SA, noted that no professional body (regulatory or advocacy) exists for the regulation and advocacy of CBWs, markedly increasing the risk that CBWs may be exploited and/or unsure of their rights and responsibilities. As these systems are scaled up, it will be important to have some body recognising CBW interests and rights. Their recommendation was that the relevant departments should investigate founding a governing body, and introducing specific legislation governing CBWs.

6.6 Conclusion

The learning and recommendations that emerged from this four country action-research project have been worked into comprehensive Guidelines for CBW Practitioners which can be accessed on the Khanya-aicdd website - www.khanya-aicdd.org. The purpose of these guidelines is to assist practitioners and implementing partners to run CBW systems more effectively, maximising the impact for clients of the service, empowering communities, empowering the CBWs themselves, and assisting government to ensure that services are provided across the country to enhance livelihoods. The guidelines focus on how to run the CBW system rather than technicalities around HIV/AIDS or natural resources issues. The Guidelines give the benefit of a wealth of experience to anyone developing community-based worker interventions. The project has brought stakeholders from policy makers, government departments, implementing agencies and the grassroots together in a rich and beneficial dialogue. Through peer and external evaluations, participants have critically reflected on their practice and received many ideas on how they can strengthen their operations. They have also achieved a wider perspective on their work by having the opportunity to learn from practitioners in other sectors, in other countries and even on another continent through the study tour to Peru.

In this way, greater consensus about what needs to be done has been achieved and advocacy for CBW systems has been strengthened. It is hoped that the task teams and stakeholders groups established by this project will find the resources to continue their work so that the goal of increased access, within Africa, to quality services managed by and responsive to the community, will be achieved.

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Annex 2 CBW Reports

These reports can be found on the Khanya website: www.khanya-aicdd.org

Publication	Date
Policy Forum workshop report, Maseru, Lesotho, 19-21 Sept	Sept 2007
A report on experience with CBW systems in Kenya, Lesotho, South Africa and Uganda	Sept 2007
Community-based Worker Systems – Guidelines for Practitioners	Sept 2007
Final report on CBW Project in Lesotho	Sept 2007
Final report on CBW Project in South Africa	Aug 2007
Final report on CBW Project in Uganda	Aug 2007
Final report on CBW Project in Kenya	Aug 2007
Evaluation of Community-Based Worker Systems in Uganda	June 2007
Evaluation of Community-Based Worker Systems in Kenya	May 2007
Report of 4-Country CBW Workshop, Entebbe, Uganda 10-13 April	April 2007
Evaluation of Community-Based Worker Systems in South Africa	Feb 2007
CBW National Workshop report Kenya	Jan 2007
CBW National Workshop report, Uganda	Dec 2006
Lesotho CBW Symposium report	Dec 2006
CBW National Workshop report, SA	Nov 2006
Guidelines for Implementation of CBW Pilots	Nov 2005
Peru Study Tour Report on Community-Based Worker Systems	July 2006
4-country CBW workshop report, Johannesburg SA, 01-03 Nov	Nov 2005
4-Country CBW Workshop, Bloemfontein SA, 21-23 Sept	Feb 2005
SA CBW in-country review report	Nov 2004
Kenya CBW in-country review report	Nov 2004
Uganda CBW in-country review report	Nov 2004
Cost effectiveness of Community-Based Worker Systems	Feb 2003
Lesotho Report on Symposium on CBWs, Maseru, 11-14 November	Nov 2002

Annex 3: Detailed costings used in cost-effectiveness study in Lesotho[30]

Cost of Ministry of Agriculture's extension - Leribe District

	No	TOTAL - Excludes capital costs	Note
Reach			
No of Extension workers	328	20	All field workers
No of farmers/h-h reached		17924	Pop of 300 000, h/h size 5.9, 94% own hoes, 37.5% reached (DES, baseline)
% active		8%	Figure for extension success in Wessels (1999)
Nos of active farmers reached		1434	
% of active farmers with sig benefits		30%	
No of farmers with sig benefits		430	
No of active farmers/EW		71.7	
No of farmers with sig benefits/EW		21.5	
Direct extension worker costs			
- EW package (inc support and field)		2,217,285	From DES - all technical and extension staff, subtracting DAO, admin
- costs of travel etc		793,210	From DES
- training		6,810	
- subsistence		110,740	From DES
Sub-total extension workers		*3128045*	
Support costs			
No of support workers (training officers)		151	
- support worker package		0	
- support worker travel (km)		0	
- support worker training		0	
- travel claims		0	
- subsistence		0	
Other support			
Sub-total support workers		*0*	
Overhead cost			
% of overheads to	*100%*		

[30] (Khanya, 2003)

	No	TOTAL - Excludes capital costs	Note
extension			
- salaries of DAO, admin		341,659	Taken from MoACLR 2001a, p 62
- office costs		661,382	Operating costs
Sub-total overhead allocated to extension		*1,003,041*	
Total		4,131,086	
Total/EW		206,554	
Total/active participant		2,881	
Total/participant with sig impact		**9,603**	

Impact of Ministry of Agriculture's extension service

Factor	Situation
Nos of EWs	32 in Leribe
Total nos of h/h covered	47800[31]
Nos of hh participated (%)	17924[32]
Nos active (%) – ie regular participants	1434 based on assumption of 8%
Nos with significant positive impact (%)	430, assuming 30% of active have significant benefit

Cost of extension in CARE's TEAM Project using farmer extension facilitators – example of Morifi village

	No	Unit cost	TEAM	Note
Reach				
No of Extension workers (Ews)			210	
No of farmers reached			2310	Estimate from evaluation - 10/village + FEFs
% active			45%	
Nos of active farmers reached			1039.5	
% of active farmers with significant benefits			60%	Evidence from Morifi
No of farmers with significant benefits			623.7	
No of active farmers/EW			5.0	
No of farmers with significant benefits/EW			3.0	
Direct extension worker costs				
- EW package			0	
- costs of travel etc			0	
- training			367500	2 courses/year
- subsistence			0	
Sub-total extension workers			*367500*	
Support costs				
No of support workers (FLFs)	7			
- support worker package	7	23985	167895	

[31] Assumes population of 300 000, household size of 5.9, 94% own hoes (ie do some agriculture).
[32] 37.5% reached (DES, baseline)

	No	Unit cost	TEAM	Note
- support worker travel (km)	75600	3.8	287280	Visit each EW 6 times a year at 120km visiting 2 per trip
- support worker training	42	135	5670	2 courses/year, 7 people, 3 days per course @R135
- travel claims		1680		R140 per month per FLF
- subsistence	7	1680	11760	
Other support	0.1	186000	18600	10% of marketing and ISF
Trainer of FLFs	1	87000	87000	50% on training of FLFs, 50% on module dev (not inc)
Sub-total support workers			*578205*	
Overhead cost				
% of overheads to extension	*25%*			
- salaries of project manager, admin			39644	Divided by 4 units
- office costs			99724	
Sub-total overhead allocated to extension		*0*	*139367*	
Total			1085072	
Total/EW			5167	
Total/active participant			1044	
Total/participant with sig impact			**1740**	

Factor	Situation
Nos of villages/EWs	30
Total Nos of hh covered	1040
Nos of hh participated (%)	300 (29%)
Nos with significant positive impact (	180 (60 % of 300)

Annex 4 Overview of the Community Health Workers Policy Framework

The rationale for CHWs in South Africa is based on five imperatives:

- The State President's commitment in the State of the Nation Addresses to getting government closer to communities and serving them better
- The need for expanded human resource and skills development using new learning pathways and opportunities for life-long learning.
- The increasing complexity of ill-health and poverty.
- The growing need for health promotion, community and home-based care.
- National commitment to strengthening participation by people and civil society in development.

Broadly the policy states:

- CHWs are defined as community-based generalist promotion, primary health care, health resource networking and coordination.
- CHWs should provide a limited range of services within the scope of their competence.
- They should also, in terms of their engagement with communities and households, determine health needs and facilitate the improvement of services.
- In situations where single-purpose community health workers (such as DOT supporters or VCT counsellors) operate, CHWs should improve the effectiveness of these and simplify life for community members by coordinating these activities.
- CHWs will receive a stipend, but will not be government employees and will be employed through civil society initiatives
- The preferred model is a Government / NGO partnership where Government provides grants to NGOs, which employ the CHWs. This might vary according to local conditions.
- Although voluntarism will continue to be encouraged, volunteers should not be employed more than a few hours a week without remuneration. Volunteers also should not be misled into believing that they will necessarily get paid work.
- A Clinic Committee / Community Health Committee should provide a governance mechanism.
- There should be community participation in the selection and recruitment of CHWs.

The role of the CHW is to:

- Mobilise community members to determine health needs and take responsibility for their own health and access services.
- Act as an advocate to improve health.
- Coordinate the access of other health workers into households and communities in order to ensure effectiveness of services to communities.
- Provide specified primary health care services to community members.
- Provide basic counselling services.
- Disseminate health information.
- Carry out health promotion activities.
- Transfer health and wellness skills to the community.
- Refer to the appropriate agency when faced with a situation outside of their scope of practice.
- Link with other community service agents such as community development workers, agricultural extension officers, youth workers and social work auxiliaries.

Principles in the education and training of CHWs:

- Learning programmes should be based on registered unit standards, taking into account learning needs, knowledge, skills and values required by learners and the context.
- Training providers should be accredited by the relevant sector education and training authorities.
- Learnerships within the relevant sectors, including the NGO and CBO sectors should be established.
- Strong partnerships between the government and civil are important.
- Sustainability and funding of CHW programmes should be based on a

situation analysis and a rigorous monitoring system.
- Training should be undertaken by providers with skills in primary health care, the district health system, community development and education of development practitioners.
- Community representatives should be involved in the recruitment and selection process of CHWs.
- Trainees should be residents of communities in which they will work
- CHWs should have a support system e.g. be part of an NGO/CBO and have access to a referral system.
- Training should be community-based and include a substantial proportion of structured learning time in the community.
- Training should be followed by a period of supervised practical work.
- People from vulnerable groups, such as people with disabilities should be empowered to participate as CHWs.
- In-service education should continue to be provided and the CHWs.

Mentoring and supervision:

- Quality assurance should form an important part of mentoring, supervision, support and monitoring.
- Community involvement, commitment of top management, redress of previous inequality, learner contribution, stakeholder participation and needs-based approaches are key principles.

Logistics of the programme:

- Fully trained generalist CHWs would receive a minimum stipend of R1 000
- In rural areas each CHW would cover from 80 to 100 households, the corresponding number being 100 to 150 households in urban areas.
- The maximum number would be 250 households to ensure that quality is not compromised.
- A geographic information system (GIS) would be developed together with a directory and operational monitoring and evaluation system

Overview taken from: Friedman I (2005) Community Health Workers and Community Caregivers, page 179