



khanya-aicdd
African Institute for Community-Driven Development

Final country report on Community-based Worker systems in South Africa

Khanya-African Institute for Community-Driven Development

March 2007

Khanya-African Institute for Community-Driven
Development
(Khanya – aicdd)

Head office: 16A President Steyn Ave, Westdene,
Bloemfontein, 9301, Free State, South Africa
Tel +27 (0)51 430 0712 Fax +27 (0)51 430 8322

admin@Khanya-aicdd.org

www.Khanya-aicdd.org

Acknowledgements

This report is the culmination of the work of many partners in civil society and government who have shared their experience and experimented with different approaches. All of these partners are working in providing basic services at community level. We acknowledge the very important work they are all doing, and the time and effort they have contributed to make this project a success. This is one step in the scaling up of community-based worker systems in South Africa.

Patrick Mbullu, Project Manager, 30 June 2007

© Community-Based Worker Project, 2007

South African partners and members of the national steering committee

Alfa Mahlako, National Department of Social Development	Alfa.mahlako@socdev.gov.za
Gomba Mashao, Limpopo EPWP	gombam@worpfs.norprov.gov.za
Lerato Matlakala, National EPWP	leratoma@socdev.gov.za
Stephen Mcfarlane, World Vision	Stephen_mcfarlane@wvi.org
Mpogeng Mahlangu, Siyabhabha Trust	mmahlangu@sacbc.org.za
Mpontsheng Kumeke, National Department of Social Development	Kumeke.m@socdev.gov.za
Silas Thakanyane, World Vision Free State	Silas_thakanyane@wvi.org
Fiona McDonald, CHoiCe	fiona.choice@mweb.co.za
Morongoa Mbhalathi, Tzaneen Municipality	Morongoa.mbhalathi@tzaneen.gov.za
Modjadji Letsoalo, Mvula Trust, Limpopo	modjadji@mvulaptb.co.za
Marietta Janse van Rensburg, Mangaung Local Municipality	aticc@civic.mangaung.co.za
Zoli Kampi, Development Bank of Southern Africa	Zolik@dbsa.org
Dr. Dovhani Mmphiswana, Department of Premier Free State	mamphiswa@premier.fs.gov.za
Clr Leonard Makhanya, Mangaung Municipality	Leonard@civic.mangaung.co.za

Project manager:

Patrick Mbullu, Khanya-African Institute for Community-Driven Development, Tel: 051 430 0712 Fax: 051 430 8322 Email: patrick@Khanya-aicdd.org

South African project co-ordinator:

Monene Mamabolo, Khanya-African Institute for Community-Driven Development, Tel: 011 642 5211 Fax: 011 642 6093 Email: monene@Khanya-aicdd.org

This action-research was funded by the Central Research Department of the UK's Department for International Development (DFID). However, the findings, interpretations and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed to DFID, which does not guarantee their accuracy and can accept no responsibility for any consequences of their use.

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

Contents

Acknowledgements	i
Glossary	iv
EXECUTIVE SUMMARY	vi
PART A INTRODUCTION	1
1 Introduction	1
1.1 Background	1
1.2 The community-based worker project	1
1.3 Overall timeline of the project	1
1.4 The CBW system	3
1.5 Why interest in CBW systems?	4
1.6 Community-based worker systems in South Africa	5
1.7 Objective and structure of the report	7
PART B THE SITUATION PRIOR TO THIS PROJECT	8
2 Government policies, systems and structures in service delivery	8
2.1 Context	8
2.2 Policies and national strategy for service provision	8
2.3 The role of the state in service delivery	9
2.4 Evidence of effectiveness in the current system	10
PART C WHAT HAPPENED DURING THE CBW PROJECT	12
3 A review of community-based worker systems in South Africa	12
3.1 Case studies in 2004	12
4 Findings from the case studies reviewed	16
4.1 Focus on CBW Systems	16
4.2 Selection criteria and procedures for CBWs	16
4.3 Financing of CBWs	16
4.4 Training, support, supervision and accountability	17
4.5 Relationships between community structures, roles and linkages	18
4.6 Impacts and sustainability of CBW systems	19
4.7 Summary of lessons and areas for immediate follow-up	19
4.8 How this relates to the legislative and policy environment	20
5 The pilot projects - implementation from January 2005 to March 2007	21
5.1 The five models	21
5.2 Guidelines for implementing a CBW system	21
5.3 Pilots implemented	22
5.4 Incorporation of learnings from the Peru study tour	26
6 Impact and cost-effectiveness of CBWs	28
6.1 Impacts of the pilots on clients	28
6.2 Impact of the pilots on CBWs	31
6.3 Impact of the pilots on other service providers	33
6.4 Changes in the way the pilots worked	33
6.5 Cost-effectiveness of the pilots	33
6.6 Comparison of cost-effectiveness of CBW and conventional systems	37
6.7 Impact of the CBW project on policy and systems	39
PART D LESSONS LEARNT AND RECOMMENDATIONS	41

7	Good practice emerging from the pilots	41
7.1	Revisions to the models.....	41
7.2	Generic good practice emerging.....	41
7.3	Training, support and supervision.....	45
7.4	Linkages of CBWs to other support agencies.....	47
7.5	Accountability.....	47
7.6	Financing the CBW system.....	48
7.7	Specific issues for each of the models in South Africa	51
8	Summary and recommendations	53
8.1	The effectiveness of the CBW pilots.....	53
8.2	Keep it simple	54
8.3	Build strong stakeholder relationships.....	54
8.4	Formalisation and standardisation.....	55
8.5	Improve monitoring and evaluation.....	56
8.6	Government as funder	56
8.7	Role of NGOs and private sector.....	57
8.8	Way forward.....	57
8.9	Action plan for South Africa	58
Annex 1	References	60

Glossary

ADP	Area Development Programme
AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
ASGISA	Accelerated and Shared Growth Initiative South Africa
ATICC	Aids Training, Information and Counselling Centre
BCID	Bradford Centre for International Development
CBO	Community-based organisation
CBW	Community-based worker
CDS	Centre for Development Support
CDW	Community Development Worker
CHW	Community Health Worker
CLAS	<i>Comites Locales de Administracion de Salud (Local Committees for Health Administration)</i>
CMIP	Consolidated Municipal Infrastructure Programme
CPI	Consumer Price Index
DANIDA	Danish International Development Agency
DFID	Department for International Development
DoA	Department of Agriculture
DoH	Department of Health
DoHSD	Department of Health & Social Development
DOTS	Direct Observation Therapy Short-course
dplg	Department of Provincial and Local Government
dpsa	Department of public service and administration
DSD	Department of Social Development
DTEEA	Department of Tourism, Economic and Environmental Affairs
DWAF	Department of Water Affairs and Forestry
ECD	Early Childhood Development
EPWP	Expanded Public Works Programme
EU	European Union
FA	Facilitating Agent
FBO	Faith –based organisation
GEAR	Growth, Employment, and Redistribution strategy
GTM	Greater Tzaneen Municipality
HBC	Home-based care
HIV	Human Immunodeficiency Virus
IDP	Integrated Development Plan
IFMD	Indigenous Forest Management Directorate
IMCI	Integrated Management of Childhood Illnesses
KMD	<i>Kerklike Maatskaplike Diens</i>
LDA	Limpopo Department of Agriculture
M&E	Monitoring and Evaluation
MEC	Member of the Executive Council
MLM	Mangaung Local Municipality
MSA	Municipal Structures Act /Municipal Systems Act
NDA	National Development Agency
NGO	Non-governmental organisation
NPO	Non-profit Organisation
NR	Natural resources
OVC	Orphans and vulnerable children
PEA	Participatory extension approaches
PFM	Participatory forest management
PHC	Primary health care

PMTCT	Prevention of mother to child transmission
PW	Public works
RDP	Reconstruction and Development Programme
RFSA	Rapid Food Security Assessment
SMMEs	Small, medium and micro-enterprises
SP	Service provider
SSRLs	Institutional Support for Sustainable Rural Livelihoods
STI	Sexually Transmitted Infection
TB	Tuberculosis
TNFSP	Thaba 'Nchu Food Security Programme
VCT	Voluntary counselling and testing
WHO	World Health Organisation
WVSA	World Vision South Africa

EXECUTIVE SUMMARY

1 Introduction

1.1 Improving service delivery is a key priority for the South African government to reduce poverty and enable growth.

1.2 Khanya - African Institute for Community Driven Development (Khanya-aicdd) has been managing a four-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 focuses on promoting dispersed, active and locally accountable CBWs, in a range of sectors, addressing services which are widely needed and best delivered at community level.

1.3 The project collaborated with government and civil society organisations at national, provincial and municipal levels. The project reviewed the experiences of a range of organisations implementing service delivery using CBWs. Regional, national and four country workshops were held to share experiences, and five projects operating in Limpopo and the Free State piloted emerging models. Representatives from the four participating countries also went on a study tour to Peru.

1.4 CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task which may best be delivered at community level and supported and supervised by a facilitating agent (FA) which may be either a non-governmental organisation (NGO) or government entity.

1.5 If people's livelihoods are to be improved, there is a need to strengthen micro-macro linkages, both in terms of improving participatory governance and in terms of improving services. The CBW project aims to identify how services can be provided to all villages/communities in a cost-effective and sustainable way.

1.6 South Africa exhibits a variety of CBW approaches, each exhibiting its own unique characteristics, arrangements and objectives. Examples are development practitioners, forestry workers, volunteer social workers, home-based carers and urban rangers.

1.7 This report summarises the development and results of the CBW project, which has been running in South Africa over the past three years from 2004 to 2007. It aims to inform organisations in South Africa of the CBW context and to highlight key lessons learnt by the partners involved in the implementation of the project.

2 Government policies, systems and structures in service delivery

2.1 Despite macroeconomic stabilisation, government policy has failed to substantially reduce poverty or provide adequate services for large numbers of people. CBW systems have risen as one response to the lack of impact in poverty eradication.

2.2 Following the end of apartheid, the Reconstruction and Development Programme (RDP) stressed empowerment and reliance on the energies of communities to realise basic goods and services. However, the Growth, Employment and Redistribution (GEAR) policy, adopted soon after, emphasised greater fiscal discipline and more rigorous cost recovery in service delivery. Policy on Social Development sought to develop human capacity and

self-reliance but Treasury indicated that this would need to happen with limited extra resources.

2.3 Government's response to service delivery backlogs has typically emphasised the central role of the state in financing, providing and regulating services. The state is seen as better placed to respond to the challenges of scale and market failures in ensuring access to services for all groups, regardless of their socio-economic status or geographic location. However, if visible gains are to be made in reducing poverty and inequality across the country, a paradigm shift to improved models and methods for service delivery is needed for greater reach of services to previously disenfranchised community groups.

2.4 Spending on basic services has increased significantly over the past decade. However, the approach has tended to focus on the delivery of physical infrastructure. Policy level support for responsive and interactive service delivery has not translated into reality to date.

3 A review of community-based worker systems in South Africa

3.1 Case studies from six partners implementing work using a variety of community-based worker systems were reviewed. The partners were the Limpopo Province Department of Agriculture's farmer facilitators, CBWs working within the participatory forest management programme of the Department of Water and Forestry in Limpopo, the Mvula Trust community sanitation committees and community-based organisers, CHoiCe Trust providing health care in Tzaneen, in Limpopo, Golang Batcha community-based health workers in Mangaung in the Free State and Hospice Palliative Care in Motheo District in the Free State.

4 Findings from the case studies reviewed

4.1/2 In considering the success factors for CBW systems, evidence suggests that community ownership and project success is enhanced where CBWs are selected from and by communities they serve

4.3 The case studies reviewed suggested that a monthly stipend enhances the sustainability of CBWs' engagements. Where this is not the case, the demands on CBWs can cause high attrition rates over the course of the programme. It is suggested that the feasibility of formalising salary structures be explored.

4.4 Well-developed management structures must be in place if projects are to succeed. Community forums in the natural resources sector should play a strong role. The facilitating and supporting organisations, the CBWs themselves and the community must all receive training.

4.5 There is a need for community engagement at the early stages of conceptualisation and design in order to enhance appropriateness of the model and sustainability of the programme. It is time consuming and costly to build up and establish linkages between institutions. However, the sustainability, reach and outputs of programmes are enhanced by multi-stakeholder collaboration.

4.6 The case studies showed that the CBW model is relevant and applicable across all sectors. CBWs complement the existing services and improve the outreach of such services to those mostly marginalised without convenient access. The case studies reviewed indicate significant impact and sustainability potential of providing services using

a community-based worker model. In the NR sector, for example, programmes are going from strength to strength both within communities and with external collaborators.

4.7 The range of CBW systems in place in South Africa represent an enormous achievement. Governments need to be aware of their potential and consider using such systems in the design of their programmes. A range of issues that need to be further explored was identified such as accredited training courses, how to make CBW systems more cost effective and whether benefits to CBWs are adequate.

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

5.1 Five CBW service delivery models were identified by participants at the first 4-country workshop. 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
- 40 hours per week paid
- Paid by user

In SA, the following organisations were selected to participate as pilot implementing organisations:

- Free State - Thaba Nchu Food Security project (TNFS) established with support from Khanya to test the 4-8 hour model, unpaid; Golang Batcha HBC Project (20-30 hrs, paid a stipend); St. Nicholas Children's Hospice HBC (20 hrs, costs paid),
- Limpopo - Environmental group with Greater Tzaneen Municipality –(20 hrs unpaid), CHOICE Trust HBC (20-30 hrs. paid a stipend and 40 hrs paid a salary; World Vision Kodumela– Food Security and HIV (20 hrs unpaid & 20-30 hrs paid a stipend).

5.2 Guidelines for implementing a CBW system were developed. The principles underpinning these involve flexibility, potential for scaling up, monitoring processes in place, financial viability within the organisation and agreement to participate in an evaluation process.

5.3 The Centre for Development Support, University of the Free State was commissioned to evaluate the five South African pilot projects to determine impact, cost-effectiveness and lessons learnt. The five pilot projects were: Thaba'Nchu Food Security Project in Mangaung, whose goal is improving the food security of its rural beneficiaries; Golang Batcha, an NPO employing CBWs who work alongside professional nurses in the Free State Department of Health extending their reach into the community, CHoiCe Trust in Tzaneen, an NGO providing health care services to rural communities, Kodumela Area Development Programme which assists the rural community where it operates with communal gardens, building school classrooms, purchasing computers for schools and providing health services, and Ramalema Environmental Pollution Prevention Project, an NGO in the Greater Tzaneen Municipality dedicated to creating a clean environment and managing and recycling waste.

5.4 Representatives from the 4 countries who participated in the action research went on a study tour to Peru to learn from a fifth country. 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.

6 Impact and cost-effectiveness of CBWs

6.1 Inadequate record keeping made it difficult to evaluate the impact of TNFSP on its clients, but according to the beneficiaries the impact was minimal. Record keeping was weak in Ramalema, also, but all stakeholders expressed the view that villages where Ramalema was working were cleaner, that Ramalema had raised community awareness about public health and pollution and that they have taken measures to manage waste and recycle. Projects within the health sector also had widespread success going by beneficiaries' assessment. Both patients and family members of patients cited CBWs as indispensable and integral to government health systems because they provided human caring, health awareness, enhanced adherence to critical medicinal dosages, DOTS support and home-based care for bed-ridden patients.

6.2 Retaining CBWs was reported to be difficult in each of the pilot projects because CBWs often choose to take paid employment when the opportunity arises, suggesting that a paid model might be a better practice. CBWs also suffered stress in the face of the poverty and sickness of their clients, from personal risk e.g. of assault and, in some cases, work overload. On the positive side, training, work experience, networking, and the satisfaction of contributing to their community were cited as motivating factors.

6.3 The impact on service providers was that CBWs decreased the load on clinicians trying to meet the extensive needs of the community and extended their reach into communities with a wide range of services. Recommendations by service providers were that the job descriptions of CBWs needed to be clarified and that facilitating agents must have the capacity to supervise CBWs if they are to work effectively. CBWs were also seen as strengthening links between the grassroots and government departments.

6.4 The action-research project offered the opportunity for greater networking and collaboration between participating projects which was deemed to have been very advantageous.

6.5 It was not possible to measure the cost-effectiveness of TNFS and Ramalema due to a lack of relevant data. Cost effectiveness calculations carried out for the health sector pilot organisations indicated a favourable cost per significant impact.

6.6 Comparison of cost-effectiveness of CBW and conventional systems indicated that CBWs can indeed carry out services at a lower cost compared to the cost of employing a primary health care professional nurse and that CBW home visits could be reducing the number of patients needing to be treated as an out-patient or in hospital thereby considerably reducing health service costs.

7 Good practice emerging from the pilots

7.1 Remuneration of CBWS should be considered as one change to the models.

7.2 Community involvement in selecting CBWs should be an essential requirement for any programme using CBWs. Facilitating agents can set specific standards and advise on important criteria. CBWs must have clear job descriptions and not be overburdened.

7.3 Facilitating agents must play a strong managerial role, assist with strategic direction and render technical guidance. Training was deemed to be essential to all projects. Extensive training was offered to all CBWs initially recruited. However, CBWs recruited at later stages did not always get the same training opportunities which is problematic if a steady turn over of CBWs is to be expected.

7.4 Linkages must be created with other stakeholders, creating a synergy of resources and overcoming competition or jealousy.

7.5 Accountability to the community must be built into the project design as well as accountability to the facilitating agent through the use of contracts.

7.6 Some organisations pay CBWs a stipend and some do not. Other incentives were provided such as uniforms, bicycles or diaries. Remuneration builds commitment and viability of projects. The projects varied in terms of financial security. For some the funding scenario was bleak while others have secured government funding which is relatively secure.

7.7 Most CBWs claimed to exceed the hours stipulated in the model description. Travel time was a significant factor as no CBWs have their own transport. Formalisation of systems was proposed, particularly by the health care organisations who argued for nationally agreed contracts, training and stipends, effectively creating a new nursing tier. If CBWs are to work from CBOs as the government is requesting of CHoiCe Trust, there has to be the management capacity to run the organisations, manage the workers, measure outputs and control finances, which is a big challenge.

8 Summary and recommendations

8.1 This study was concerned with the need for public services to reach many more people. It explored whether a CBW model where more basic services are devolved to a much larger number of lesser trained and lower paid workers can answer this need. The study was an action-review process through which policy makers and organisations shared their perspectives, experiences and practice. Overall, the value of the model was supported with considerable evidence that CBWs are giving a good service in a very cost-effective manner.

8.2 CBWs must be given clear job descriptions to avoid overload. Training must not be too extensive and expensive so that organisations can afford to repeat the training for new recruits and be able to offer the training on a large scale.

8.3 Strong stakeholder networks must be built for effective service delivery. Mechanisms must be put in place to ensure that CBWs see themselves as answerable to the community, not just to the FA. FAs need to listen to CBWs' concerns. The role of local and provincial government and government sector departments must also be clarified and agreements put in place as to how they will support delivery. Government must back up the system with appropriate policies and legislation.

8.4 It is critical to formalise and professionalise CBW mechanisms and procedures. There should be standardised recruitment procedures, standardised selection procedures, standardised training, formal contracts and standardised remuneration. The creation of a CBW governing body should be considered that would introduce specific legislation governing CBWs and create national strategic plans regarding the implementation of CBW programmes.

8.5 Every organisation must have a continuous performance reporting mechanism. The information recorded should directly relate to the strategic goals of the organisation and serve as a measurement of performance against such goals. The information should be compiled into regular reports to boards and stakeholder/community organisations.

8.6 The majority of CBW funding should come from the state as CBWs supplement existing state services, such as clinics, agricultural extension work and refuse management. In addition, community support, in the form of voluntary work or direct payment in-kind, should not be underestimated.

8.7 NGOs and the private sector can act as back up support through their expertise and experience in specialist sectors. NGOs can play a major role as implementing organisations. Thirdly, NGOs and the private sector can be a significant source of financial and material support to CBW systems.

8.8 The work captured in this report is being continued through a task team, which was put together at the last national South Africa workshop in November 2006 which is particularly considering the question of how to set up CBW systems to deliver services on a large scale.

8.9 This section gives the detailed action plan for South Africa for 2007.

PART A INTRODUCTION

1 Introduction

1.1 Background

Improving service delivery is a key priority for the South African government to reduce poverty and enable growth. Improved service delivery is identified as one of the key areas in the Accelerated and Shared Growth Initiative South Africa (ASGISA), which aims at an annual six-percent growth rate. In addition, it was the main platform in the local government elections in March, 2006. South Africa also spends a great deal of public funds on public services, and funding has been increasing over the years. Concomitantly, substantial and rapid decentralisation has also taken place. According to recent benefit incidence studies, public spending has become highly pro-poor over the past decade. However, results remain inferior,

Improved models and methods for effective delivery of publicly provided services to the poor represent a significant challenge to many stakeholders, from policy makers and programme designers to government departments involved in service delivery. For underserved individuals and communities, community-based service delivery represents an opportunity to engage actively in meeting their own, locally specific needs and demands, and in monitoring the performance of delivery agents.

1.2 The community-based worker project

To meet this challenge, Khanya - African Institute for Community Driven Development (Khanya-aicdd) has been managing a four-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**. This 4-country project aims to develop revised approaches to the use of CBWs in service delivery in both the HIV/AIDS and natural resources (NR) sectors. 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.

1.3 Overall timeline of the project

The initial stages of the 4-country CBW project involved scoping visits to a number of potential partner countries. The visits culminated in a launch workshop in each country. These brought together practitioners and policy makers implementing work using CBWs or interested in the use of CBWs as a model for pro-poor service delivery. Steering committees to manage the process in-country were established. The purpose of the Steering Committee was to manage a national process for taking forward community-based worker systems as an approach to service delivery and community empowerment, as well as the country's participation in the 4-Country CBW project.

For the project to have the impact intended, and to achieve its purpose and outputs, the role of the Steering Committees was to link with policy makers (macro), implementing practitioners and facilitating partners (micro) levels. Detailed terms of reference with key milestones to be achieved over the project period, were also developed.

In SA, two provinces were chosen to focus the CBW action-learning project - Limpopo and the Free State. Partnerships were established with Provincial Departments of Agriculture, Health and Social Development and with partners – Hospices, Motheo District Municipality, World Vision and the AIDS, Training, Information and Counselling Centre (ATICC) in the two provinces. These became the core members of the steering committee with Khanya acting as secretariat.

The first national workshop was held in July 2004 and a range of practitioners and policy makers participated. The broad aim of this workshop was to share current CBW approaches and explore partner understanding of the present mechanisms and structures of the systems that are in use, in-country. In essence this event introduced the project and the report produced became the situational analysis of current CBW systems in SA.

Following from the in-country review and the national workshop, SA participated with other partner countries at the 4-country workshop, held from 20-23 September 2004, hosted by South Africa. Partners shared their findings and identified common frameworks and models for implementing a CBW system were designed.

A small group of representatives from each partner country met again in January 2005 to discuss each model in depth and agree the core elements to pilot in their countries. Guidelines for implementing each model were developed and partner countries identified implementing partners to test one or two of the models.

From 16– 29 October, 2005, 12 delegates participated in a study tour to Peru. Three of the delegates were from South Africa. The objective of the visit was to understand about CBW systems in Peru, testing emerging thinking from a 5th country on another continent.

The second 4-country workshop was held from 01-03 November, 2005 in Johannesburg, South Africa. Participants were joined by the delegation from the Peru study tour who enriched the sharing of experiences. The workshop enabled partners to share lessons and findings of current approaches they are implementing. It also allowed the partners to review the models they were then piloting. Participants also took part in the making of the CBW DVD, which discusses different dimensions of the work of CBWs. Prior to the actual workshop event, partners participating in the workshop spent a day visiting CBW projects in Limpopo province. The site visit was part of the peer learning process. It enabled partners to discuss and share experiences from their respective countries.

Another significant activity that has informed the in-country process in South Africa was the round table meetings to reflect on the CBW experiences and to share with other key stakeholders in each province. Key local and provincial government officials and practitioners in other fields participated. They included the specific local municipalities – Mangaung and Greater Tzaneen, the Motheo and Mopani districts' officials in Health, Social Development and Welfare, the Expanded Public Works Programme (EPWP), as well as the Department of Environment Affairs and Toursim. In Limpopo, the EPWP has begun supporting a number of CBW partners. These round table meetings also formed the basis for exchange visits between Limpopo and Free State, with government officials from Limpopo attending the Free State round table meeting.

The last 6 months of the initial¹ project period were characterised by an evaluation of the CBW pilots, planning and holding the national CBW workshop in November 2006. The SA national workshop developed a three-year vision. A task team with clear terms of reference and activities was mandated by the workshop to take forward the process. The task team included national and provincial policy makers and implementing agencies.

Ten people from SA participated in the final 4-country workshop, which was held in Uganda from 10-13 April 2007.

In South Africa, the CBW project has operated in partnership with a range of key stakeholders including:

- the Department of Provincial and Local Government (dplg);
- the national Department of Social Development (DSD) through the Expanded Public Works Programme (EPWP) in Limpopo;
- a cluster of provincial and municipal partners in the Free State: the Departments of Health and Agriculture, the AIDS Training, Information and Counselling Centre (ATICC), and the Mangaung Local Municipality (MLM);
- provincial and local partners in Limpopo Province: the Department of Agriculture, Greater Tzaneen Local Municipality, and the Comprehensive Health Care Trust (ChoiCe); and
- national partners: World Vision South Africa (WVSA), Hospice Palliative Care Association of South Africa, and CARE South Africa/Lesotho.

Five implementing partners tested and piloted some of the five models in two provinces (Free State and Limpopo). Two pilots were in the Free State and three in Limpopo. Three of these were in the HIV and AIDS sector and two were in the NR sector.

1.4 The CBW system

The model below shows the key components of the system: the community/ informal institutions by which people organise to act collectively; a CBW; a facilitating agent supporting the CBW; and other service providers.

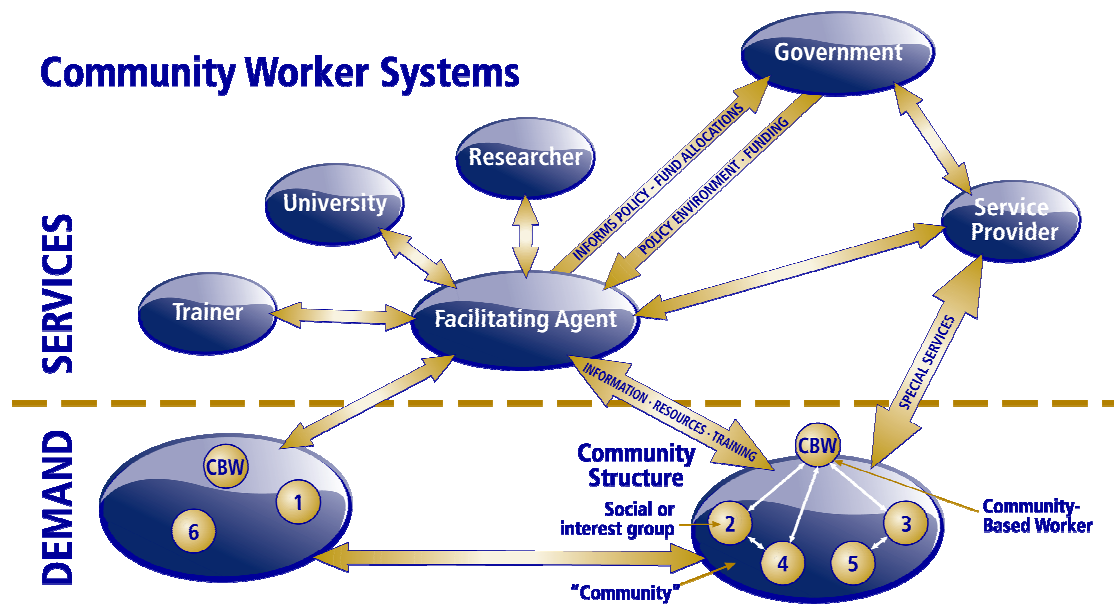
CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task which may best be delivered at community level, supported and supervised by a facilitating agent (FA). CBWs are usually in some way accountable to the community or a specific group within the community they serve and the facilitating agent they are affiliated to. They usually receive some form of incentive (monetary and non-monetary), in most cases their costs are covered, such as travel and food, 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;

¹ This CBW project was initially intended to run from March 2004 through to March 2007, but has been extended to September 2007 to allow the partners to develop guidelines for good practice and present these at a regional workshop, as well as thinking around up-scaling such a system.

- engaging in training activities with the facilitating agent, 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 of development activities.

Figure 1.4 The CBW Model



The FA can be from government or the non-governmental organisation (NGO) 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, national institutions, international community 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. Government and the international community also help in strengthening capacity to address poverty.

These are all key stakeholders who need to be involved at all stages in the process for the CBW system to work effectively.

1.5 Why interest in CBW systems?

The CBW project is informed by earlier research work undertaken by Khanya on Institutional Support for Sustainable Rural Livelihoods (SSRLs) in southern Africa. This work identified that if people’s livelihoods are to be improved, there is a need to strengthen micro-macro linkages, both in terms of improving participatory governance and in terms of

improving services (Khanya, 2001). Six key governance requirements were identified to address poverty. These are grouped under three themes as follows:

Empowered communities (micro)

- **Poor people** active and involved in managing their own development;
- Active and dispersed network of **local service providers** (community-based, private sector or government);

Empowered local government and management of services (meso)

- **At district/local government level**, services managed and coordinated effectively and responsibly and held accountable (*lower meso*);
- **At provincial level**, capacity to provide support and supervision (*upper meso*);

Realigning the centre (macro)

- **centre** providing holistic and strategic direction around poverty, redistribution, and oversight of development;
- **international level** strengthening capacity in-country to address poverty.

The second of these requirements implies the need for a pool of active and locally accountable community workers, who can work in a range of sectors, addressing services which are frequently needed and that can be provided locally. These need to be linked to higher levels of government and NGOs for support. This requirement recognises that service delivery is critical in improving human development, especially in sub-Saharan Africa where poverty levels have continued to rise despite attempts by governments to curb them. In Khanya-aicdd's experience of participatory development, most communities depend on locally provided services, e.g. crèches, traditional birth attendants, farmer extension schools, traditional healers, home-based carers, local spaza shops, etc. There have been programmes using CBWs such as home-based care (HBC), community health workers (CHWs) and paralegals but these have remained as isolated examples and have not been scaled up.

The CBW project aims to bridge such a gap by identifying how such services can be provided to all villages/communities in a cost-effective and sustainable way. It also proposes a paradigm shift from the conventional service delivery model so that all villages/communities can be adequately served. The concept contributes to increasing the coherence and effectiveness of the many ongoing efforts by poor communities to achieve their own development in the communities where they live and work. The question is how can these be made more effective and be scaled up, and what are the requirements for doing so?

1.6 Community-based worker systems in South Africa

The post-apartheid decade in South Africa has heralded a progressive revision and rewriting of public policies and legislation aimed at addressing the requirements of the large and previously marginalised and excluded sections of society.

Changes in the design of government programmes have opened space for the adoption of a range of CBW systems. The result is that South Africa exhibits a variety of CBW approaches, each exhibiting its own unique characteristics, arrangements and objectives.

For example, in the unfolding of land reform policies and programmes, advocacy NGOs have repositioned and restructured themselves to provide support services via full-time CBW-type agents called development practitioners. In the example of the Surplus People

Project (SPP), CBW-type agents assist individuals and community organisations to acquire land or access to commonage land, facilitate the establishment of group committees and provide capacity building and technical training to emerging farmers and commonage committees. They link with responsible officials and support in the accessing of public resources in provincial and local government.

In Limpopo province, a new policy was developed and an innovative participatory programme designed for the management of local indigenous forestry resources. This led to the creation of Participatory Forest Management (PFM) Forums by the Department of Water Affairs and Forestry (DWAFF). Selected community members living adjacent to forests constitute these forums. The members are trained in the identification, planning and establishing of appropriate projects with local communities, with further training provided to selected local people to manage them. The needs identified vary from community to community. Training projects to date include bee-keeping, eco-tourism, the management of hiking trails and bird-watching trips. A central Community Facilitation Fund, supported by DANIDA and DFID, outsources and approves suitable service providers.

World Vision, an international faith-based NGO, has initiated an Area Development Programme (ADP) approach, premised on large-scale needs identification processes, and aimed at addressing a range of poverty, HIV and AIDS, food security and health needs. Local committees nominate a member who is selected and receives comprehensive training from private and public service providers. These workers are then tasked with identifying the poorest of the poor and those who most need ADP assistance. They resource start-up food packages, or other relevant resources, and are responsible for providing support, information and motivation, and in establishing local producer groups.

In the 'Urban Rangers' programme, initiated by the Department of Tourism, Economic and Environmental Affairs (DTEEA) in the Free State, community members largely in the former townships are encouraged to approach the Department to assist them to declare an urban conservancy. All local and municipal stakeholders are assembled to select a conservancy committee, which is then invited to nominate candidates from local wards to work as 'rangers' who receive comprehensive training from environmental officers in the Department. The 'rangers' respond to local environmental health issues identified through the conservancy committee. To date they have undertaken clean-ups of illegal dumping sites, organised urban beautification projects and carried out basic sanitation and hygiene training in their communities.

The *Kerklike Maatskaplike Diens* (KMD) is an NGO of the Dutch Reformed Church with 30 qualified social workers, 13 auxiliary workers and 337 volunteer workers, operating in Bloemfontein, in the Free State. The latter two types of workers are selected from communities. They receive training from the DSD in counselling and in the implementation of new laws and procedures such as those associated with the Child Care Act. The auxiliary social worker becomes the extension of the local KMD office and the volunteers are the direct link to the community and to the system of local state clinics. They network extensively and provide management support to smaller organisations.

These examples sit alongside a range of commitments within government that have sought to enhance pro-poor service delivery. For instance, the recent Ten Year Review initiated by the Policy Co-ordination and Advisory Services in the Office of the President calls for the articulation of a more synchronised national development strategy and planning framework over the next decade. This is in response to the currently dispersed and uncoordinated range of policies and programmes across departments, agencies and different spheres of

government. The Review notes that the "fundamental feature of the South African developmental state must be people oriented and capable of addressing the socio-economic needs of its entire population²" with, among others, an associated call for an imaginative and pro-poor service delivery which builds on poor peoples' economic networks and systems.

1.7 Objective and structure of the report

This report summarises the development and results of the CBW project in South Africa over the past three years. It draws together the experiences of the South Africa partners who have participated in the 4-country CBW systems action-research since February 2004. It aims to inform organisations in South Africa of the CBW context and to highlight key lessons learnt by the partners involved in the implementation of the project.

The report is divided into five parts:

Part A gives the background to the CBW project within the context of social development in South Africa, and explains the process of the 4-country action-research project and its objectives. **Part B** assesses important government policies, practices, and mechanisms that have informed service delivery and provision prior to the inception of the CBW project in 2004. The outcomes of initiatives for pro-poor development and service delivery are highlighted. **Part C** summarises seven case studies of community-based worker systems in the HIV/AIDS and NR sectors reviewed at the beginning of the project. It then goes on to discuss five organisations that piloted the issues that emerged from the 4-country workshop. **Part D** looks at the lessons learnt from the project research questions. **Part E** develops and summarises these issues and points to the implications of the analysis for the future and for policy and legislative environments of African governments to take forward such an approach in their service delivery priorities and planning

2 "Social and Economic Impacts of Government Programmes Since 1994", Synthesis Report, Papers 6.2 and 6.7 of the 'Ten Year Review Research Programme', prepared for the Policy Co-ordination and Advisory Services

PART B THE SITUATION PRIOR TO THIS PROJECT³

2 Government policies, systems and structures in service delivery

2.1 Context

Despite its relative success in terms of macroeconomic stabilisation, South Africa's post-apartheid economic policy has mostly failed to promote sufficient growth, job creation, poverty reduction and adequate service delivery for those previously disenfranchised. This disappointing record has taken place against the backdrop of apartheid's dual legacy of racially embedded inequality and highly segmented factor markets from which poor people are largely excluded. While economic growth is regarded as the motor for sustained development, service delivery is increasingly becoming critical to human development. In many African countries, contemporary growth conditions are characterised by reduced public expenditure and an increasing income inequality that has largely created a social distance between urban elites and inner city, peri-urban and rural poor. Backlogs in the design and delivery of appropriate services match these disparities and require a greater reach and deeper impact if the needs and demands of constituencies are to be met and if visible gains are to be made in reducing poverty levels.

2.2 Policies and national strategy for service provision

A number of policies, strategic national service plans and legislation instruments were developed to reflect the post-apartheid Constitution. The Reconstruction and Development Programme (RDP) of 1994 stressed the need for national government to be closer to the people it serves. "It defines participation within a people-centred, rights-based mobilisation of communities, a people-driven process, with the role of the state not simply delivering goods and services to a passive citizenry, but stressing a growing empowerment and reliance on the energies of communities" (in Hemson (2004), cited in Khanya-aicdd – SA in-country review report, (2004). The RDP programme was published before the democratic elections of 1994 and the African National Congress (ANC) announced its programme of action to resolve the inequalities inherited from the past. The RDP identified five key themes: meeting basic needs; developing human resources; building the economy; democratising state and society; and implementation (Khanya-aicdd, 2005: 4). The RDP was a worthy visionary document, but it failed to provide a clear implementation strategy, and this led to great difficulties in implementation and slow progress on key programmes.

The 1996 macro-economic Growth, Employment and Redistribution (GEAR) policy was another key framework targeting economic growth and job creation in a post-apartheid South Africa. GEAR emphasised economic growth and macroeconomic stability as the building blocks on which redistribution in favour of the poor would be realised. GEAR's premise was that sustained and increased growth required a competitive outward-oriented economy. GEAR 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

³ This section draws heavily on the South Africa in-country review report produced in 2004

institutionally based services” (Khanya-aicdd, 2005⁴) but within the context of greater fiscal discipline, more rigorous cost recovery and the need for financial sustainability.

Over the same period, the 1997 White Paper on Social Development signalled a departure from traditional welfare approaches, towards the provision of services that would lead to higher self-sufficiency and sustainability. The prevailing goal was to create a welfare system that developed human capacity and self-reliance within an enabling socio-economic environment. Again, this was in the context of a Treasury that was arguing for efficiency improvements to resolve the problems of inadequate service delivery, rather than greater resources from the state.

In 1997, the Ministry of Health tabled the White Paper on the Transformation of the Health System in South Africa (Department of Health 1997). The White Paper dealt with the transformation of the health services to reduce the high levels of social inequality in health. The aim was to introduce a strong shift towards universal and free access to comprehensive health care, and shift the disproportionate level of preventable diseases and premature deaths in certain segments of the population (Mdhuli, 2006: 20). The policy document called for reallocation, shifting resources from tertiary services in urban settings to a more comprehensive approach, including rural settings. The White Paper recognised the importance of knowledge, information and evidence by stating that research must be linked and integrated into planning, policies, programmes and implementation.

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 and improve the quality of their lives. The Municipal Structures Act (1998) and the Municipal Systems Act (2000) gave substance to this shift. The former provided for the establishment of ward committees to enhance participatory democracy and women’s participation. A range of provisions in the latter required that local government become the conduit for all forms of public and agency infrastructure and defined the role of communities in planning, service delivery and performance management. Objectives were set for attaining reciprocal rights and duties between councils, administrations and communities. Integrated Development Planning (IDP) was to become the vehicle for the realisation of participation and consultation mandates, with the wards defined as the local constituency for representation, participation and consultation in planning and for service delivery.

2.3 The role of the state in service delivery

The delivery of basic services is a central task in poverty reduction. Access to basic needs such as water, housing, education, healthcare and personal security is a matter of human rights, not a commodity for the world’s elite. However, the service delivery model inherited from apartheid was a state essentially designed to serve the needs of its privileged members, and to control the rest. While government departments have the responsibility to deliver these services in general terms, this may not be a reality at community level. For example, Botshabelo in Free State had only one agricultural extension officer serving around 200,000 small-scale farmers. Clearly, this is a general service and not available widely to specific community members or groups. The design of service provision in South Africa has left serious backlogs in the various departments, including housing, social welfare and health.

⁴ Policy Overview: Community-Driven Development in South Africa, WP 3: BCID

To rectify these backlogs, strategies to improve service delivery have typically emphasised the central role of the state in financing, providing and regulating services. The state bears the legal responsibility to ensure that the fundamental human rights to security, education and healthcare are realised. The state is seen as better placed to respond to the challenges of scale and market failures in ensuring access to services to all groups, regardless of their socio-economic status or geographic location.

2.4 Evidence of effectiveness in the current system

Two predominant thrusts have characterised social services spending over the past decade: an increase in social security spending via a range of different grants and pensions and spending on development and job creation. Recent broad-based estimates indicate 60% of spending on the former.

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. It is one of the largest programmes undertaken by government via the Treasury and the Department of Provincial and Local Government (dplg) in terms of the equitable share allocations in the Division of Revenue Act. The overall aim has been the provision of developmental infrastructure in support of improving the quality of life of low-income households and neighbourhoods and building sustainable communities. Funds enable municipalities to provide at least basic levels of services such as water, roads, storm water drainage and solid waste disposal systems, community lighting, clinics, cemeteries and multi-purpose sports centres, as well as some major linking and bulk infrastructure.

A recent national evaluation of this programme for the dplg found that the aggregate national inputs and outputs reflect an extraordinary achievement. Total allocations by January 2003 were R5.13bn, with 3,859 projects approved at a total value of R7.34bn.

The evaluation found that CMIP had successfully established significant infrastructure in support of service delivery to underserved people, enhancing the integration of previously segregated neighbourhoods, while making considerable inroads into infrastructure and basic service backlogs. However, the same evaluation revealed some significant conceptual limitations. These included an overemphasis on the delivery of physical infrastructure, failure to acknowledge the full human development potential present, and failure to ensure that the programme aligned its products to local needs or embedded itself into local institutions and economies. While the slogan of the CMIP was building communities through infrastructure provision - thus proposing an integral connection between delivery and community development and participation - participation has actually been limited to representation on steering committees, in the IDP process and to employment during construction.

Programme implementers at national level recognise that community development should occur through improvements in the general standards of living that flow from access to

services. However since municipalities rather than communities were the instigators of CMIP projects, the evaluation says that there was failure in communities taking ownership of assets. The recommendation was the beginning of a move to more demand-driven approaches for the programme, with projects identified by communities themselves.

The Ten Year Review also evaluated the effectiveness of the “people must come first”-customer concept embodied in the Batho Pele White Paper. The paper emphasised consultation regarding specific levels of services, equality in access to services, accurate information about the services to be received, and principles of apology, explanation and sufficient remedy in the event of non-delivery.

The results were disappointing, with the “implementation of the policy not accompanied by culture change programmes that address deep underlying issues. Progress made was evaluated as superficial and the true determinants of service improvement not addressed resulting in diminishing returns on future efforts” (in Khanya-aicdd, (2004): 18 – SA in-country Review Report). The review proposed deepening Batho Pele principles with reference to the Canadian Service Delivery Gap model. This model emphasised knowing what citizens and clients expect in terms of public sector services. Also, how they want to be engaged in their priorities for service improvements; measuring progress in closing the service gap using a variety of tools and ensuring accountability for results, etc.

Recommendations were based on incorporating the state values of a people-centeredness on governance, and on a notion of democratic rather than good governance. These emphasised public participation in decision-making, on performance management and accountability, and on the organisational redesign of government regarding appropriate internal and external partnerships with business, industry and CBOs, as well as the adoption of specific approaches to the design of public goods and services.

PART C WHAT HAPPENED DURING THE CBW PROJECT

3 A review of community-based worker systems in South Africa

3.1 Case studies in 2004⁵

3.1.1 Context

In the first phase of the CBW project in South Africa in 2004, case studies from six partners implementing work using a variety of community-based worker systems were reviewed. This section outlines the core characteristics and approach of these organisations at the start of the project.

3.1.2 Participatory Extension Approaches, Department of Agriculture, Limpopo Province

Since 1998, the Limpopo Department of Agriculture (LDoA) has used 'Participatory Extension Approaches' (PEA) to improve service delivery to previously disadvantaged smallholder farmers. Programme objectives included the development of a new approach using participatory methodology to interact with the communities targeted and the development of knowledge and skills amongst extension officers and 'changing the outlook' of such officers toward interacting and learning with the communities under their care. The programme was implemented in two districts involving six different villages in total. It encouraged community-based development in two distinct ways. The first was training agricultural extension officers, which has management, support and evaluation implications for the project. The second was the institutionalization of community-based workers.

The PEA approach uses farmer facilitators as CBWs, nominated by members of their community. Farmer facilitators undergo group training in agricultural issues, with the Department requiring that they have a background in farming and are willing to assist others with the knowledge acquired during the training. For a period of eight to 24 months, the Department's extension officers meet with these farmer facilitators to investigate the impact of the process.

At the time of the study in early 2004, 190 villages were implementing this approach, with an overwhelming majority situated in former homeland areas, involving 261 extension staff. Approximately, 109 farmers were trained as facilitators during 2002/03 period in soil and water conservation, soil fertility management, livestock and small-scale seed production. By the middle of 2004, some 114 farmers had been trained and a further 71 were scheduled to conclude their training by the end of 2004.

3.1.3 Participatory Forest Management Programme, DWAF, Limpopo Province

DWAF's Indigenous Forest Management Directorate (IFMD) initiated the Participatory Forest Management (PFM) programme in 1999. The objective of the programme was to enable communities living in the vicinity of commercial and state forests managed by the Department to make use of the forest to sustain and promote their livelihoods. The

⁵ For full details of these case studies please refer to SA in-country review report (2004).

approach was guided by the White Paper on Sustainable Forest Development in South Africa, which maps out a community forestry approach.

Responsibility for implementing the programme lies with the DWAF individual estate manager. These officials are responsible for approaching communities who live adjacent to DWAF-managed forests to explain the purpose of the project. During the course of this project, all stakeholders within the community are approached, including the traditional leadership in the area, ward councillors of the local municipality in question, and community organisations. Once the purpose of the project is explained, community meetings are called and a Participatory Forest Management Forum elected to interact with the estate manager and the community. The PFM becomes a voluntary CBW system whose role is to act as facilitators between the IFMD and the community. “They are accountable to the community in terms of reporting how the Department has responded to their needs, as well as to the IFMD for continuous needs identification. They also submit monthly progress reports in cases where the Department had organized training courses and projects on account of information supplied by the PFM Forum” (Khanya-aicdd, 2004: 24). The CBWs take part in project management and basic financial skills training to help facilitate this process.

3.1.4 The Mvula Trust: Community Sanitation Committees and Community-based Organisers

The Mvula Trust is a water supply NGO that supports the delivery of water services in rural and peri-urban areas. “Programmes include community management, the establishment of community-based water service providers and support for local authorities creating an enabling environment for sustainability. Mvula Trust projects average a three year lifespan, run alongside sanitation and water supply programmes initiated by the Department of Water Affairs and Forestry (DWAF) and are designed to gain the cooperation and trust of the community concerned.

Prior to initiating any project, Mvula Trust staff consults with key stakeholders in the community, including traditional leaders, the ward councillor and relevant community-based organisations. Ten members are chosen to serve on the water and sanitation committee. They must have lived in the community for the last five years, possess no criminal record and the majority (65%) of them must be women. The selection process is designed to prevent projects from elites capture and to avoid youths and men using the role as a form of employment as opposed to a means of promoting community well-being and sanitary health. These CBWs are responsible for identifying community health needs upon completion of their training. They utilise a needs analysis, derived from visiting clinics, to acquire information on the prevalence of sanitation-related diseases within the community. CBWs also compile a sanitation profile of the community to identify the shortcomings in the sanitation practice of residents, and identify a specific target community for an intervention programme. The role of the CBW is to build a bridge between the Districts Municipality’s efforts at service delivery and the community as a whole and to minimize the down time of schemes –time that people spend without access to water because of technical failures - to a maximum of 48 hours delay.

3.1.5 CHoiCe Trust – Home-based Care in Tzaneen, Limpopo Province

CHoiCe Trust serves a population of 448,000 in the rural areas of Mopani District in Limpopo. There are four health centres and 26 clinics that act as the base for the village projects. At the start of the CBW project in 2004, ChoiCe had 252 community health workers (CHWs) from 102 villages and 50 farms.

The CHWs conduct house-to-house visits to introduce the role of CHoiCe and continue the same pattern while working as a CHW. Identifying the needs of families and children is a priority, with the appropriate care given or referrals made. This gets round the problem of the stigma of HIV as all members of the community are visited and care provided to all, regardless of status. Services include counselling, education, physical care, food preparation, cleaning assistance and family support and guidance. The CHWs have become the extension of the local clinics into the communities. Health professionals refer clients needing on-going care and support to CHWs, who in turn refer patients back to the clinics for further care where necessary. The CHWs are not paid. They go through the 59-day Ancillary Health Worker course, a SETA accredited curriculum, which is run over a two-year period. They also receive incentives, which include record keeping books and stationery, transport fares and support meetings with other trained staff.

3.1.6 Golang Batcha Community-based Workers in Mangaung, Free State Province

Golang Batcha was established in 1998 by ten young people who had just completed high school and had no employment opportunities. Their main focus was to address the deficiency of health care services in the fight against HIV & AIDS and other related diseases, such as Sexually Transmitted Infections (STIs) and Tuberculosis (TB). Once the group was established they found that other young people were also interested in replicating what the initial members had started, in their own local clinics.

In 2004, Golang Batcha had 42 community members rendering health service assistance in seven primary health care clinics around Bloemfontein. The group received initial guidance for its establishment from the Health Division of Mangaung Municipality and registered as a non-profit organisation (NPO).

This network of CBWs serves an estimated population of over 156,748 people (1998 census). The CBWs provide support to professional nurses through a range of activities including basic health education to patients at clinics as well as to groups in the communities served by a particular clinic. The CBWs also provide home-based care (HBC).

3.1.7 Hospice Palliative Care - Care along a Continuum, Motheo District, Free State Province

The Bloemfontein Naledi Hospice was established in 1989 to provide palliative care for those with incurable conditions, as well as support to their families. Other hospices have emerged since - St Nicholas Children's Hospice, Smithfield Hospice, St Thomas Hospice and Ladybrand Hospice. The first volunteer caregivers were trained in 1989 with annual training expanding into all branches. The first employed community caregivers were appointed and trained in 1994.

The St Nicholas Children's Hospice formally separated from Naledi Hospice on 1st April 2004. Naledi focuses on caring for adults while St Nicholas focuses on children with a referral system between the two hospices. The area of service in Mangaung includes Bloemfontein and Botshabelo with most patients (550 children and 320 adults) living in the townships and informal settlement areas. Community caregivers provide care in the six Community Palliative Day Care Centres of St Nicholas according to the standards of the Integrated Community-Home-Based Care model of best practice. They assist with the weekly palliative care clinic and provide care for children made vulnerable and orphaned by HIV/AIDS, as well as working in the children's in-patient unit at Sunflower House. A professional nurse supervises the HBCs.

CBWs also provide basic nursing care in the home, day care centres, and at Sunflower House. This comprises bathing of patients, simple dressings, mobility, hygiene and supervision of medication. St Nicholas CBWs are also trained to supervise anti-retroviral therapy (ART) and prepare and get children drug-ready. Working with the nurses, they supervise pain and symptom management. They also give training in the home on care of patients, infection control, and nutrition, and provide bereavement support. St Nicholas also provides specialist support including Memory Work⁶ under supervision of a social worker and orphan and vulnerable children (OVC) support.

⁶ Memory Work involves the gathering of items by one person for their relatives to remember them by e.g. photos or letters put together by a dying parent as memorabilia for his or her children.

4 Findings from the case studies reviewed

4.1 Focus on CBW Systems

Participation and pro-poor development is both enabled and constrained by individual identities, the actions of community workers and the workings of institutions. The positive aspects of this process can be enhanced through greater understanding of their motivations, institutional processes and improved monitoring techniques (Khanya-aicdd, 2005: 2).

4.2 Selection criteria and procedures for CBWs

It is vital that all key stakeholders participate in the selection of CBWs. Community involvement and participation in all aspects of the CBW programme and especially in establishing the selection criteria and making the final selection - an essential step towards a community-driven development. Community involvement in selection will enhance the communities' ownership of and commitment to the process and so greatly increase the chances of success.

The Mvula Trust case study undertook a participatory exercise prior to initiating their community-led programmes. They first approached existing community structures, including the traditional leadership in the area, the ward councillor connected with the local municipality and a number of other community-based organisations. They also contacted the Departments of Health and Education, since the programme required their expertise. After consulting key stakeholders, a community meeting was held to explain the purpose of the project, while giving the community an opportunity to voice their opinion. Only then were CBWs selected.

4.3 Financing of CBWs

Financing of the CBW system was identified as critical. The question of who pays CBWs is an important one from the point of view of the CBWs' accountability to the community. Ideally, local service provision systems, whether public or private sector, non-governmental, FBO or community-based organisations (CBOs), should mobilise and manage resources and create public facilities and services. The mobilisation of local revenues to finance local initiatives and provision of stipends for CBWs is an important foundation for sustainable community-based service provisions. However, the State should take the ultimate responsibility and donor funding should be viewed as supplementary, for example, for testing innovative ideas.

The case studies reviewed in 2004 suggest that an agreed monthly stipend enhances the sustainability of CBW' engagements. Where this is not the case, the demands on CBWs can cause high attrition rates over the course of the programme and a related loss of social capital. Well-developed selection criteria and procedures that combine local opinion with outside observation must counter the limitations of allowing those with an interest in the salary alone to be absorbed as CBWs.

The range of practices assessed in these case studies suggests that good practice should be informed by overlapping roles and responsibilities for payment, divided between the public, donor and voluntary sectors, where NGOs are major partners. Where roles and responsibilities are not shared, the public recognition of the CBW role needs to be

formalised within each sector and the Government's role in payment should come to the fore. In addition, more refined models for CBWs should include a service fee to beneficiaries and recipients of the service, which while providing for essential resources such as transport, should be used as part contribution to the cost of the CBWs stipend.

Friedman (2004: 170) argues that the feasibility of national or provincial salary structures, standardised according to level of training and years of service should also be considered. There are various options for funding. The best option, given restricted government resources, is to promote public-private partnerships between the provincial Departments of Health and local private or overseas funding organisations who together can achieve more than what is possible from government sources alone.

4.4 Training, support, supervision and accountability

The review established a clear need for well-developed types of management structures to be set in place. Community forums in the natural resources sector should have a strong role in management, meeting regularly, receiving reports, and engaging with stakeholders. Because of the emotional, physical and psychological strain of working with people living with and affected by HIV/AIDS, ongoing support networks and continued training and supervision by more skilled health professionals needs to be put into place to sustain the role of CBWs in this sector. Over time, this should ensure the development of best practice.

The case studies suggest a pattern where CBWs are ultimately accountable to their clients in the community but are in most cases similarly accountable to the facilitating agency such as the district council, or the Department of Agriculture. The downside to this accountability requirement is the demands it places on the CBW, implying multiple accountability and extensive reporting, sometimes in different formats for different bodies.

Training should be developed for three different stakeholder groups. Firstly, those in the public sector supporting or interacting with emerging CBW systems need training in the operation of the CBW model in place. Without this level of understanding, the public support service is likely to be reduced in scope and content. Public officials can sometimes profess a full knowledge and understanding of how communities are constituted and what their requirements and needs are, but this can be contradicted by adopting a professional and social distance from the circumstances of 'the poor'. Therefore, a more intense engagement with the specifics of CBW systems is important. The duration and phasing of such training can be varied, but in essence it needs to be ongoing as the programme elements unfold.

Secondly, CBWs need specific training in both the operation of a CBW programme as well as in the specific tasks, methods and techniques required to perform their role effectively. The latter should be phased with modules for ongoing learning. The training service provider needs to be close to the programme in order to tailor the training to local contexts. There is a potential for CBW training methods and models to be too vague, especially in the NR sector. There is a clear need for a repository of methodologies and content to be developed for a specific CBW systems training, to be stored and replicated nationally and internationally as is partly occurring in the HIV/AIDS sector for CHWs. In the HIV/AIDS sector, accredited training is already provided based on the 59-day Hospice model of home-based care that has now been adopted as a public policy. CBWs would however benefit from a dedicated CBW systems module.

Thirdly, beneficiaries must be trained so that community participants can properly understand what they can expect and what they can contribute in managing the CBW operations. This is occurring in some of the NR case studies, but less so in the HIV/AIDS sector.

In the NR sector established public institutions such as the Agricultural Research Council would be an ideal place for locating a dedicated CBW training, linked to other technical courses on offer. NGOs, CBOs and community forums would be well placed to provide training to beneficiaries especially if they had undergone training in a centralized accredited CBW systems training course. Specific training regarding the operation and desired outcomes of the particular model and programme in place would also be required. Similarly, these organisations could provide the background training to civil servants regarding the specifics of CBW-based programmes.

4.5 Relationships between community structures, roles and linkages

The CBW role is one of bridge building between local service provision systems and the communities they serve. The establishment of programmes, identifying of community needs and resources and setting of goals should be facilitated by CBWs on behalf of the community.

The case studies demonstrate the need for community engagement at the early stages of programme conceptualisation and design in order to enhance the appropriateness of the model and sustainability of the programme. In the HIV/AIDS sector, support and intervention is becoming more critical, therefore all role players – public, private and community - need to come together and debate how to define and drive the most appropriate models for CBWs and for the roles and arrangements between the respective interest groups. It is time consuming and costly to build up and establish linkages between institutions. However, the sustainability, reach and outputs of programmes are enhanced by multi-stakeholder collaboration and by clearly defined roles and linkages for individuals receiving the service, for community representation, and for the public and NGO sectors.

There is potential for conflict in all development programmes and sufficient checks and balances need to exist within the community for different interests to reconcile their differences and work towards achieving common outputs. It is important that all stakeholders view the development process as a bottom-up process with agendas designed to meet the community's needs and not the government's agenda or large NGOs' objectives. Where there is conflict and competition in community-based organisations (CBOs), there is a need to support them through the engagement of well-developed NGOs active in the same field, to mediate and to lobby, and to assist in addressing concerns and differences in a way that can work for all.

The view of stakeholders should be one of partnership. CBWs and the communities they represent should abstain from viewing the government and NGO resources as the answer to poverty, inequality, unemployment and/or AIDS. In contrast, government officials and NGOs should abandon top-down implementation processes. It is important that all stakeholders understand their role in the process, while striving for improved services.

Government should continually refine and implement a deeper range of macro pro-poor policies on a sector-by-sector basis, while engaging, assisting and supporting the design and implementation of appropriate programmes with stakeholders. NGOs can provide more coherence and depth to public policy, bringing their own experiences and practices into this realm, and play a major role in support of CBWs in implementation. Their

experience and innovation can contribute to the ongoing redesign of aspects of CBWs' roles and responsibilities, and provide the necessary back up structures and support.

Private sector roles can range from funding and providing resources to networking, supporting and providing facilities for forums. In the natural resources sector, private sector involvement can include providing appropriate products - in terms of size and sample, price, range and technology. There is also scope for the redesign of their market and service to better receive and to distribute the small volume and potentially lower standard and 'niche' products becoming available from small scale producers. The type and extent of their engagement will vary according to the type of programme.

4.6 Impacts and sustainability of CBW systems

The case studies showed that the CBW model is applicable across the natural resources and HIV/AIDS sectors. It is at the level of the local home or homestead that the CBW is so critical, engaging with the 'farmers', 'patients' and 'community' and articulating their needs and demands. It is in this interface with local communities, covering the identification and support of locally defined needs and opportunities that the model is most effective and provides optimum benefits. The capability of the CBW system is enhanced where systems of public services are currently active and working. CBWs complement the existing services and improve the outreach of such services.

The personal lives of CBWs are also affected by the services they provide. Since becoming volunteers in the health sector, CBWs have a better understanding of the condition, how to prevent transmission, and how to care and support those infected and affected. CBWs are more tolerant of HIV-positive people and recognize that other HIV-related illnesses such as TB can be cured with good health management. (Mhdululi, 2006: 21-22). One could argue that this knowledge and understanding about health improves the quality of life of those actually providing the service to the community. "CBWs reported that, prior to gaining in-depth information about HIV/AIDS, they were ignorant and classified HIV/AIDS as a death sentence. They also reported having perceived HIV-infected people with pity. All that they've learned from their voluntary work is applied in their own personal life" (ibid).

Despite the absence of baseline data surveys, the case studies indicate that services using a community-based worker model have significant impact and sustainability potential. In the NR sector, programmes are going from strength to strength. Direct outputs include reduced downtime of water facilities in water schemes, increased numbers of suitable sanitation systems installed and behaviour change amongst stakeholders. The range of villages serviced is increasing annually, and the number of projects adjacent to indigenous forests growing. The conditions which promote these impacts are essentially institutional, that mixture of arrangements between stakeholders which contributes to ongoing work and the delivery of outputs in a sustainable way. Had baseline surveys been conducted at the outset of each programme, significant impacts and outputs may be clearer.

4.7 Summary of lessons and areas for immediate follow-up

The range of CBW systems in place in South Africa represents an enormous achievement and it appears to be the case that compared to conventional systems, CBW systems can reach more people, provide a more targeted and dedicated service and allow for a very high degree of individual and community participation in decision-making and implementation. Governments need to be aware of these advantages and consider taking them into account in the design of their programmes, if they wish to gain a purchase on

service delivery and maintain political credibility. Furthermore, they need to seriously consider devoting more resources to CBW systems.

Immediate follow-up issues that can be explored include the following:

- development of an accredited CBW system training course located nationally in a public institution;
- a public commitment to replicate and roll out the models and methods of a 'best practice' CBW system;
- support for deepening the engagement of existing CBWs nationally through a central facility which establishes methods for learning, refinement and for replication;
- look at how best to evaluate the gains made in programmes overall, essentially by introducing and undertaking an agreed method of monitoring and evaluation (M+E)
- in the NR sector, measure the impact on beneficiaries and the extra output what use is made of this and how it contributes to livelihoods and asset creation;
- explore the sustainability of beneficiaries' engagement and commitment, looking at how best to promote this more effectively;
- investigate the potential roles of the private sector in the product and output based CBW systems within the NR sector;
- look at what is required to make CBW systems more cost effective including the potential for charges for services rendered;
- look at the potential for providing health benefits packages⁷ as an alternative or a supplement to stipends within the HIV/AIDS sector, also examine benefits to CBWs in general and whether they are adequate;
- is the development and support of consortia the best way forward for small CBOs? What are the alternatives to the model and why?, can CHW/CBWs become more independent /commercial/resourced organisation operating in local neighbourhoods?

4.8 How this relates to the legislative and policy environment

Policy and legislation will need to be amended if the government is to recognise and scale up CBW systems as integral to public methods of services delivery and to institutionalise current practices. Presently, there are large gaps that need addressing if the CBW systems approach is to contribute significantly to addressing pro-poor poverty. The potential for large-scale cost reductions compared to other methods of service delivery is apparent and could be of great benefit, given the social and economic conditions prevailing in Africa. However, such benefits will not be realised if governments continue to focus exclusively on expensive, professionally-based systems which are not able to reach deeply enough into communities to create the required impact.

The next section will look at how such a system can be operationalised. It will examine the five models that emerged from the initial 4-country workshop in 2004 and which partner countries tested in pilots in-country.

⁷ Currently some organisations have arranged health benefits for health CBWs such as volunteers and their families getting priority attention at clinics or health centres in recognition of their contribution.

5 The pilot projects - implementation from January 2005 to March 2007

5.1 The five models

At the 4-country workshop, held in September 2004, in South Africa, partner countries shared their findings from their in-country review. In their analysis, they grouped CBW projects 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 were:

- **4-8 hours per week unpaid volunteers** (interest linked - church-linked volunteers, scouts/guides, environmental groups, befrienders, cancer support groups; professional volunteers e.g. attorneys/doctors helping in a hospice; representational – school board members/ governors/PTAs, community policing forum members, ward committee members, etc). In this model, some travel expenses and meals are usually paid;
- **20 (exceptionally up to 40) hours per week unpaid volunteers**, travel expenses, meals usually paid for (e.g. World Vision Lesotho, Concern Uganda, SHARP Lesotho, Family Support in the Greater Tzaneen Municipality);
- **20-30 hours per week. paid a stipend** (e.g. home-based carers in the health sector and social welfare, Mvula Nelspruit water and sanitation programme; lay counsellors, teaching assistants);
- **40 hours per week paid**, either as salary or commission (e.g. WASDA Community Health Workers in Kenya, CHoiCe supervisors in Limpopo, fisheries workers in Beach Management Units in Uganda; paralegals in the Eastern Cape); and
- **Paid by user** – hours variable, (e.g. Community Animal Health Workers (CAHW) in Kenya; community resource workers in agriculture, Uganda; people assisting with Community Based Planning CBP, Uganda).

A small group of representatives from each partner country met again in January 2005 and worked further on refining the guidelines for implementing each model. They also identified implementing partners to test one or two of the models developed. In SA the following pilots were identified as potential pilots:

- Free State - Thaba Nchu Food Security project (TNFS) established with support from Khanya to test the 4-8 hour model; Golang Batcha HBC Project (20-30 hrs, paid a stipend); St. Nicholas Children's Hospice HBC (20 hrs, costs paid),
- Limpopo - Environmental group with Greater Tzaneen Municipality –(20 hrs unpaid), CHoiCe Trust HBC (20-30 hrs paid a stipend and 40 hrs paid a salary; World Vision – Food Security and HIV (20 hrs unpaid & 20-30 hrs paid a stipend).

5.2 Guidelines for implementing a CBW system

The principles underpinning these guidelines were as follows:

Flexibility: The elements of the model on which pilot projects are based should be flexible. There are a variety of common and specific elements that may be included in any pilot project and it is up to the FA to decide which of these to implement. However, the steering committee should know what is being tested in each pilot.

Potential for scaling up: It is very important to consider issues of sustainability and potential for scaling up in the design of the pilots, so that the system that is being tested

can realistically be applied at scale, and is not restricted to small-scale operations, i.e. 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 e.g. through the use of diaries, activity, learning and client feedback on services received and provided, etc);
- FAs logging support and supervision provided to CBWs;
- Challenges emerging from the revised practices;
- Monitoring visits by Steering Committees to pilot sites;
- Reporting to other structures resident in the communities eg ward committees, about the pilots;
- Peer reviews by other piloting partners and the Steering Committee.

It is very important that government and policy makers are involved in reviewing and monitoring pilots so that they are motivated to act on the lessons learnt. It is also important to make sure that DFID country offices/advisors are continuously briefed about progress.

Financing the implementation: It is assumed that partners in the projects are actively involved in implementing a community-based worker approach and have finances to support their work. One-year funding threshold was agreed upon as a minimum to enable the learning process to be meaningful. Although partners are expected to contribute to the functioning of the CBW system, they may also leverage for funds within their country, either from a particular government department or from in-country or international donors. Being involved in the 4-country project was seen as a great opportunity to attract additional resources to the participating organisations.

Evaluation: Evaluation of 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.

5.3 Pilots implemented

Five projects tested and implemented one or two of the five models during the course of the CBW project in South Africa. Two of the pilot projects were in the natural resources (NR) sector, while three were in the HIV and AIDS (health) sector. The Centre for Development Support at the University of the Free State was commissioned to evaluate the pilot projects to determine:

- the impact and cost-effectiveness of the SA CBW pilots (models selected), including sustainability potential;
- the lessons learnt from the pilots for mainstreaming CBW systems into service delivery, and
- if cost-effective, how to influence policy and practice in supporting such models of service delivery.

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 and served;
- **Sustainability:** sharing and handing over responsibility to the communities and 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 thus reach more people otherwise overlooked. The absence of socio-cultural misunderstandings might improve service delivery.⁸

The profiles of the CBW pilot projects evaluated are as follows :

5.3.1 Thaba Nchu Food Security Project

The Thaba 'Nchu Food Security Programme (TNFSP) is managed by Phaphamang Community Development Projects. TNFSP received funding from the National Development Agency (NDA) to support community-based service delivery and help to improve the productivity of small scale farmers in Ward 41 within Thaba 'Nchu. The project aims at supporting a collection of largely unemployed individuals with prior small-scale crop production experience and/or experience with chickens, assisting them to grow vegetables and fruit and also to produce eggs, primarily to enable food security but also for income generation purposes. The project was planned to span a two year period, starting early 2005. It had three employed staff members with agricultural qualifications. In 2005 (March/April), 15 community volunteers were selected by the communities across Ward 41 as CBWs, to work 5-8 hours a week, without monetary reward. Each CBW was to support a group of 15-20 members within their community through advice and guidance on how to improve their agricultural production – both crops and small-stock livestock. The CBWs formed the main linkage between the beneficiaries of their services in the community groups and the facilitating agent - Phaphamang. Monthly meetings were held between the CBWs and the facilitators to discuss progress, challenges and problems and to gather information regarding production.

Although the project was to implement the 5-8 hour unpaid model, in reality the CBWs spent on average 12 to 15 hours per week supporting the 15-20 members in their group. The 15 CBWs were supported by two paid field facilitators each of whom had just graduated with an agricultural degree. A project manager maintained overall project management responsibility. A board provided strategic and oversight.

Initial training of the CBWs was provided by Khanya-aicdd who also acts as support manager for Phaphamang in terms of administration, documentation, record keeping and as grant holder for NDA. Technical training was conducted by the non-formal unit of the Provincial Department of Agriculture on the basics of vegetable production and the management of chicken layers and broilers. The CBWs also attended a course on permaculture design offered by Food and Trees for Africa. World Vision National undertook

⁸ Adapted from the Bradford Centre for International Development (BCID) - Community-driven development: understanding the interlinkages between individuals, community-based workers and institutions. Khanya-aicdd was partner in this parallel project, also funded by the UK Department for International Development (DFID) – exploring issues in the Water and HIV & AIDS in Tanzania and South Africa.

a Rapid Food Security Assessment (RFSA) of all the communities involved in the project prior to the initiatives being introduced.

Vegetable seeds and/or six pullets and chicken feed (growing mash) was donated to participating beneficiaries to initiate the food security programme, with the CBWs providing technical advice and assistance and problem solving capacity, supported by the two project facilitators. 220 beneficiaries have participated in the egg production component of the project to date. The beneficiaries and CBWs have managed, to produce vegetables for their own use and established egg production systems. Some of them are saving small amounts of money from the sale of the eggs. One group has bought a new clutch (100 1-day-old chicks) from egg sale savings.

5.3.2 Golang Batcha

Golang Batcha, which means “growing youth” or “growing from inside”, renders a comprehensive health service linked to seven primary health care clinics within the Bloemfontein area. Services offered are not confined to HIV-positive people only as this would exacerbate stigma by singling out those who are HIV positive. Golang Batcha is legally established as an NPO and receives guidance from the health division of the Mangaung Local Municipality. They are also supported by the Free State Department of Health. The CBWs provide support to professional nurses including delivering basic health education to clients when they are visiting clinics and health institutions, and outreach work in the communities served by a particular clinic. The CBWs also assist with visits to members of the community who are bedridden and unable to attend clinics, as well as providing home-based palliative care for patients identified by professional nurses.

Of the 42 CBW at the start of this project in 2004, Golang Batcha has only 21 CBWs now. Some CBWs have died of HIV & AIDS related diseases while others have been absorbed into the government Community Development Workers' programme. Golang Batcha forms part of a consortium of home-based care NGOs in the Free State province.

Courses attended include Home-based Care – a 59-day comprehensive course which is now standard across South Africa; Direct Observation Therapy Short-course (DOTS) support; first aid; integrated management of childhood illnesses (IMCI); HIV/AIDS counselling and anti-retroviral treatment counselling and administration. The CBWs have also received debriefing sessions from students studying psychology at the University of the Free State who meet the CBWs on a monthly basis.

Golang Batcha CBWs are expected to work a minimum of 20 hrs per week, four days of the week. In reality, some of them work five days a week and almost eight hours a day. CBWs give health education talks to groups every month and attend to an average of 4-5 TB patients every day, performing Direct Observation Therapy Short-course support (DOTS).

In 2006 Golang Batcha wrote a letter of concern to the Provincial Premier, Mrs Beatrice Marshoff, and the MEC (Member of the Executive Council) for Health, Mr Belot. Discussions with these key policy makers resulted in a public promise to increase the CBWs' stipend to R1 000 from June 2006. This promise materialised and it may be argued that this initiative by Golang Batcha has led into change in national and provincial policy with increased stipends implemented in the whole province and now on the national agenda.

Golang Batcha's carers are accountable to a range of stakeholders: the clinic group leaders in the respective clinics to which CBWs are attached, TB clinical nurses in terms of patients referred, the head of the health directorate in the municipality for data collection

and monthly monitoring, and also to the Free State Department of Health by whom their stipends are paid (or withheld if non-/underperformance is detected).

5.3.3 CHoiCe Trust

CHoiCe (Comprehensive Health Care Trust – HIV/AIDS) was established in 1997 as a non-governmental organisation in response to the identified health problems in the rural areas around the Greater Tzaneen Municipality. CHoiCe is now an umbrella facilitating agent for the provision of health care services to rural communities in the Mopani District in Limpopo. CHoiCe is an accredited health care training provider, and has an agreement with the Department of Health to offer mentoring support to other organisations working with home-based caregivers. The CBWs, which CHoiCe refers to as Community Health Workers, provide home-based care to community members in the rural areas.

During 2004, 232 volunteers were trained in aspects of home-based care. In 2005 CHoiCe had 228 active volunteers working in 119 villages within the Greater Tzaneen Municipality and performed in excess of 147,000 visits to healthy homes giving health talks and supporting families socially, spiritually and emotionally. With funding and partnership with the Department of Health & Social Development, CHoiCe provided 120 volunteers with stipends for one year. This required the introduction of stringent monitoring and evaluation controls.

Caregivers work 20-30 hours per week, while the volunteer coordinators work 30-40 hours per week. This is a challenge because both volunteers and coordinators work flexible hours depending on the needs of clients. Volunteer coordinators are in contact with CHoiCe once a month to follow up on activities and for CHoiCe to provide the support needed. CBWs are accountable to the volunteer coordinators, who in turn, report to CHoiCe's project manager. They are also accountable to their local clinics where they meet with the nurse in charge on a monthly basis.

5.3.4 Kodumela Area Development Programme (ADP)

Kodumela (meaning "work hard") ADP was founded in 2001 with funding from World Vision. Kodumela ADP is operating in the development field assisting five different villages in its immediate vicinity with a communal garden, and assisting schools in building classrooms and fences and purchasing computers. Initially, Kodumela's health services targeted only clients that were HIV-infected and bed-ridden. Currently, however, its services have been expanded with each carer serving roughly 250 households on general health issues. Within Kodumela, there are approximately 30 carers, most of whom are women. All CBWs work 40 hours a week and their work involves providing information and counselling to community members and patients either going for HIV testing or seeking treatment, and supporting the elderly and children to access grants, obtain documents and nutrition, etc.

World Vision Kodumela ADP seeks to procure continuous funding to ensure sustainability of the programme, recruit new carers and update CBWs on policies and changes from the government and in their roles as caregivers. The CBWs are accountable to Kodumela. to their allocated local clinic where they report to the nurses on a regular basis; to their communities and to their ward councillors and tribal authorities.

The CBWs received part of the 59-days home-based care training but very few have completed the course. Referrals are made to the clinic and the hospital and vice versa. Some of the villages only have a mobile clinic. Carers are encouraged to talk to the people while they are waiting to see a health practitioner.

5.3.5 Ramalema Environmental Pollution Prevention Project

Ramalema was founded in 1998 as an NGO. Ramalema's management team consists of four [4] members and it has a staff of approximately 18 volunteers (the CBWs). The project concentrates on land, water, air and sound pollution. There are ongoing 'clean-up' campaigns in the community organised by Ramalema.

CBWs' tasks include cleaning the environment by picking up refuse from the streets, sorting waste for recycling, e.g. separation of bottles and plastic, and the inspection of food premises and animal care in their area. Many of the community members also sort the refuse in their homes and bring glass bottles and paper to the premises where Ramalema has its recycling base. The CBWs were selected when the project was proposed to the villages and people were asked to volunteer. Interviews were conducted by the forum and the selection of the volunteers made. The CBWs work approximately 30 hours a week, and are not remunerated. They have received training from the Department of Labour in terms of management and clerical skills and the volunteers attended an IDASA workshop.

Ramalema claims that their village is one of the cleanest in the Greater Tzaneen Municipality in that there is less litter lying around and the water streams are no longer polluted. Ramalema's vision is that this project should sustain the livelihoods of the local residents with an income in the future.

5.4 Incorporation of learnings from the Peru study tour⁹

Informing an understanding of the pilot projects listed above and notions surrounding CBWs was the study tour to Peru, which was intended to give participants a wider perspective on service delivery using community-based workers from a fifth country. One good practice example of a community based worker system in Peru is the Local Committees for Health Administration (CLAS). This is a decentralised health service where administration and delivery of primary and preventative health care is co-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 and explored comparisons with those in their own countries. The projects visited included a community technical assistant programme implemented by CARE Peru in Ayaviri District, 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. A third project visited was the Condoray Women's Centre for Professional Formation, which trains rural women promoters (CBWs). The majority of these women were illiterate when they joined the programme but have developed reading and writing skills over time. Another organisation visited was KALLPA, an association of NGOs primarily focusing on health issues, which works as a facilitating agent assisting communities to run their own projects and to be dynamic and understand and carry out

⁹ See full report on the study tour to Peru at www.khanya-aicdd.org/cbw/publications

their functions effectively.

The Peru experience also has some implications for SA. For example, the current government initiative on Community Development Workers (CDWs) as intermediaries between government and communities can be scaled up and strengthened to mirror the CLAS model of co-management of resources at the grassroots level. This can be complemented by training of politicians, particularly local councillors to better understand their mandate and link community needs into the IDP plans of local municipalities.

As the South African government continue with its modernisation and reform of services, the discourse of decentralisation will be strengthened by more involvement of organs of civil society informing government planning. This can be supported through community-based planning and participatory budgeting at the local and provincial municipal levels, informed by comprehensive development plans from the ward level.

Many lessons were learnt during the trip and compiled into a report. The study tour gave participants a better opportunity to understand the nature of CBWs as “members of the community who, through own willingness, devote time to community development services in their respective communities” (Khanya-aicdd, 2006:6). They are supported by local and national governments and through private donors and NGOs. This suggests that linking the macro, meso, and micro levels of governance can ensure that CBW work is sustainable in delivering and meeting minimum service delivery standards. 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. Further, FAs and the communities have initiated income generating projects (IGAs) for CBWs to at least earn and meet their basic needs.

6 Impact and cost-effectiveness of CBWs¹⁰

This section draws on the evaluation findings of the community-based worker pilot projects that participated in the study. The independent evaluation was carried out by the Centre for Development Support (CDS) at the University of the Free State. It examines the impact of the pilot projects on clients, on the CBWs themselves and on the service providers whose work was extended and supported by the CBWS. It also analyses the cost-effectiveness of services using community-based workers.

6.1 Impacts of the pilots on clients

Within the natural resources sector, the TNFSP programme reported a rather poor impact on food security for the beneficiaries. According to the beneficiaries, they did not realise the benefits that they had anticipated at the beginning of the project. Additionally, although no evidence has yet been provided on total food security or financial impact of the project, anecdotal evidence suggested that the objectives and targets set by TNFSP, including an anticipated R405,000 total derived income, will not be met by the end of the project period (March 2007). Difficulties cited by the community include a negative financial impact due to the costs of transportation and acquisition of productive inputs, including chicken feed. This resulted in beneficiaries using their own money, as one beneficiary commented, *'we also have to pay R300 to go and fetch the chicken feed at Fellwana (another village). On top of that we also have to pay the people who assist to load the chicken feed'* (Khanya-aicdd, 2006:8).

Also cited was the quality and frequency with which the CBWs assisted the beneficiaries. Some beneficiaries complained that they did not see the CBWs often enough to address problems in a timely manner. Further, when CBWs were present, they sometimes passed incorrect information or did not convey correct information meant for the beneficiaries. Examples included incorrect advice regarding planting to the Talla village members, and a lack of advice regarding mulching which may have resulted in crop losses in 13 of the 15 participating villages.

Overall, the project faced continuous environmental obstacles. As one beneficiary commented, *"we are struggling with water. It is difficult to ensure that our project is sustainable because of the lack of water"* (Khanya-aicdd, 2006: 7). Other examples include damage by animals e.g. birds, crop disease, and chicken death due to Newcastle disease and coccidiosis. The evaluation report suggests a risk that this project could negatively affect future community efforts if the projects continue to fail and value has not been added to the beneficiaries' lives. However, caution was noted that this was a new project, and the results of the evaluation may not necessarily be a true reflection of the average production for the remainder of the project period. Moreover, the TNFSP was purposely set-up to test a specific model and the evaluation does not bring out clearly.

In contrast to this, the Ramalema Environmental Pollution Prevention Project was found to have a positive impact on the community and met most of its stated goals. One of the major impacts of the pilot is that the area in which it operates is cleaner (stated by the CBWs, FA, stakeholder forum and the board), although no tangible evidence was provided to support this statement. The pilot project has also succeeded in teaching the youth and

¹⁰ An evaluation report on the work of CBWs in SA is available on www.khanya-aicdd.org/cbw/publications

other community members in five [5] villages about the benefits of a clean and unpolluted environment. The community also gave evidence of the health effects of air pollution. The community is encouraged to bring waste into Ramalema's system of refuse collection to earn money for the area through recycling and possibly create jobs in the future. In addition, awareness raising has taken place in local schools where school children have been taught to recycle rather than to burn refuse. Thus, the project has been deemed a success by most participants involved.

Projects within the health sector also had widespread success going by beneficiaries' assessment. In Golang Batcha, CHoiCe and Kodumuela, the evaluation found that the community was significantly more empowered because of continuous information and support received from CBWs. Patients listed the positive effects that CBWs had had on their lives, including:

- the knowledge that someone is caring for you;
- the advantage of not having to go to the clinic on a daily basis (avoiding long queues);
- individualised attention which allays apprehension, reduces anxiety, and counters the effects of stigma;
- continued education about illness and prognosis, and provision of information about preventative health behaviours. (in Khanya-aicdd, 2006: 37)

It was also found that CBWs had a positive impact on the families of beneficiaries both in supporting the patient in taking care of their families and in transferring knowledge about health services and treatment to family members. Both patients and family members of patients cited CBWs as indispensable and integral to government health systems because they provided human contact (caring / 'hand-holding'), health awareness, enhanced adherence to critical medicinal dosages, reported new cases to clinics, followed up TB defaulters, took referrals of new patients from clinics, and performed health education activities.

For example, CBWs in Kodumela listed the various ways that they felt they had impacted on beneficiaries' lives. These involved:

- being a conduit for information;
- being the link person between the community and service providers/facilitating agent;
- mobilising the community for learning campaigns;
- educating community members about the HIV/AIDS pandemic;
- improving the health-seeking behaviour of the community;
- reducing the numbers of TB defaulters through regular follow-ups, etc. (in Khanya-aicdd, 2006: 79)).

Statistics on contact between CBWs and clients from the projects evaluated indicate the extent to which CBWs are making an impact in the communities served. However, a note of caution must be added in that contact statistics, submitted to the DoH on a monthly basis, are not verified by a supervisor, with erratic, inexplicable statistics reported at times. (Khanya-aicdd, 2006: 38)

Table 6.1 (a) Data on Services rendered by Golang Batcha CBWs

Month/Service	Aug06	Jul	Jun	Apr	March	Feb	Jan	Oct05	Sept	Aug
DOTS	128	176	95	149	158	170	129	159	175	180
HBC	42	54	14	35	25	46	41	122	72	-

DOTS = Direct Observation Therapy Short-Course (TB treatment) treatment points (one patient) (DOTS average 7,2 per CBW for this period (21 CBWs).

HBC = Home-based Care visits (any non-TB medical visit to a home, e.g. wound dressing, health talk, immunisation campaigns, etc.).

Table 6.1 (b) Detailed overview of services rendered and data collected by CHoiCe CBWs

Core activity statistics Jan – August 2006	
CBW numbers (active volunteers)	
Highest number - Feb 2006	138
Lowest number - Aug 2006	120
Average	131
Clients served - sick people	23,091
Families reached - Healthy Homes	114,929
Total families / households	138,020
Included in the households	
Child-headed families (included in OVC)	620
Grandparent headed households	2,523
Activities within the households	
PLWAs supported	1,062
Total no. of TB follow-up visits	25,858
Visits Conducted - Seriously Ill	7,277
Food parcels distributed	1,243
Visits with volunteer coordinator	879
OVCs Served	10,787
No. of OVCs referred (Social 837), Medical (843)	1,680
Condoms distributed (Male and Female)	103,235
Hours spent HBC	102,989
Hours spent otherwise	8,299
Referrals total	11,773
- Medical, Social Welfare, VCT, TB	
PLWA Monthly Support Groups	39
PLWA reached	622
Treatment Kits Refilled by DoH (incl. CHoiCe 54)	1,602
Number of patients treated from treatment kits	1,511
Community-wide activities	
HIV & AIDS Awareness Total Attendance	44,325
TB Awareness Total Attendance	72,626
Total Cub and Scout attendance	4,112
Children's Group Therapy attendance	326
Granny Groups attendance	739
Deaths reported in the communities	455

Table 6.1(c) Annual services rendered by Kodumela CBWs

Indicators	Annual
Clients served (all services)	103,082
OVCs served	808
Visits conducted	12,774
Families visited	11,765
Child-headed families	85

The above tables show that each of the health care CBW pilot projects was able to consistently address the needs of a large number of community beneficiaries.

Golang Batcha's most significant impact, according to the CBWs and supported by their activity statistics, was in the field of tuberculosis care. Golang Batcha managed to improve the treatment outcome (cure, adherence rate, etc.) of TB patients in the seven clinics. A TB nurse in a Mangaung clinic who was interviewed, said that the CBWs are adding "genuine value to society" by improving the health status of communities. Through their efforts, patients now have better access to services and proper use of services (Khanya-aid, 2006: 37).

At Kodumela, in addition to performing general health care tasks, CBWs distributed food parcels from the Greater Tzaneen Municipality (GTM) on an ad hoc basis (as they know where the nutritional needs are the highest), obtained documents for bedridden patients (identity documents, certified copies, etc.), and raised health awareness through plays, dramas, etc., at schools and community halls. In addition, clothes and groceries were given to OVCs for June and July 2006, sponsored by ABSA, although no mention was made of the value or quantities donated. A vegetable garden was established at Kodumela for patients though no indication was given as to the production results, value of donations / input costs, sustainability plans for the garden, etc. The ADP also assisted in the formation of a children's choir which was formed in July 2005, and the CBWs taught children indigenous games, which points to psychosocial support rendered to vulnerable children.

6.2 Impact of the pilots on CBWs

A central concern of the CBW was the difficulty of balancing volunteerism and maintaining a livelihood. Retaining CBWs was reported to be difficult in each of the pilot projects because CBWs often choose to take paid employment when the opportunity arises. Situations arose in which the CBWs experienced a negative impact because their voluntary work was prohibiting them from performing/searching for formal employment. At Ramalema, CBWs reported that sometimes they found it difficult to even find the means to buy food and cited hunger as an impediment to their productivity in the project. All these examples point to a recommendation that a paid model might be better practice. This was also supported by patients/clients at Golang Batcha who felt that the CBWs were significantly underpaid and even exploited. However, even at CHoiCe, where CBWs received employment-like benefits such as maternity leave, there was a significant problem with CBW retention. In September 2006, CHoiCe had only 120 carers compared to 228 in 2005.

The struggle of volunteering while trying to support oneself is further compounded by the difficulties and perils that volunteers sometimes face. In Golang Batcha volunteers reported high levels of personal grief, stress and frustration (powerlessness) with patients dying and defaulting on DOTS treatment at fairly regular intervals and a lack of structured support

available in terms of counselling or debriefing (clinic nurses did not seem helpful in this regard). Additionally, CBWs' daily tasks involve a fair deal of personal risk including verbal abuse or physical harassment by community members, being bitten by patients' aggressive dogs and the risk of assault, crime or sexual violence by patients or members of the public – adding further to the stress CBWs endure in performing their duties.

I was almost raped by one of my patients. When I arrived at the patient's home on that particular day, the door was slightly open. This was unusual as I know the patient was bedridden. As I entered someone closed the door and to my surprise, it was the patient. He told me that he is going to rape me. I just screamed until someone came to my rescue....

Other risks faced by CBWs include the possibility of contracting an infectious disease. "Because we deal with people who suffer from TB another risk is hand to mouth infection due to poor protection and because we do not have gloves to protect ourselves" (Khanya-aicdd, 2006:39). At both Golang Batcha and Ramalema. CBW workers commented on the often long and difficult distances they have to travel to reach patients or to participate in clean-up campaigns, suggesting a need for more support with transport for the CBWs.

With regard to motivating factors, all of the pilot projects cited training and networking as extremely important benefits accrued through involvement in this work. At CHoiCe, the evaluation team commented that, "The CBWs are empowered, very well-trained (CHoiCe offers health, organisational development and managerial training in-house), and CBWs are proud to be CHoiCe-affiliated." (Khanya-aicdd, 2006: 61). The table below indicates the number of CBWs at Kodumela who received training during the period 2005/2006.

Table 6.2 Training conducted for Community HBC programme and caregivers 2005/06

No. of trainees	Type of training
22	DOTS
27	Home nursing
26	Wellness
13	Counselling
9	Hope
4	Making beds
2	Oral care

Another motivating factor for the pilots was a high level of networking opportunities available to their CBW workers. Through the CBW project in SA, Golang Batcha CBWs were exposed to other CBWs. They visited other projects in Limpopo, and the Phaphamang (TNFSP) programme in the Free State, using cross-sector visits to share lessons with others in-country. Ramalema CBWs had networking opportunities created with other CBW NGOs, These opportunities increased their visibility within their communities, and increased their employment potential in the process.

Finally, the sense of personal satisfaction and pride that CBWs derive from their work cannot be overstated. CBWs commented that before the CBW project they were without a purpose in life, but now have a sense of personal empowerment and pride in engaging in a project with tangible impact. The value and sense of importance they received from the community in doing their work led to high levels of work satisfaction and a strong sense of commitment to the community. These benefits were extremely important in keeping CBWs motivated to continue.

6.3 Impact of the pilots on other service providers

The impact on service providers was that of helping to relieve the burden currently experienced by public sector service providers trying to meet the needs of the community. All the health-sector pilots were providing a great service to the local clinics and hospitals. They established links between community members and health providers and were able to tackle complicated and sensitive issues often outside the realm of clinics, such as domestic violence and substance abuse. A Department of Health and Social Development official commented on the work of CHoiCe Trust, that “*the Primary Health Care system could not function without CBW workers*”. Other perceived impacts included:

- Involvement in case management 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. CBWs conducted education sessions on many subjects including hygiene, nutrition, reproductive health, HIV & AIDS and TB;
- Changing the attitude and behaviour of some patients, particularly regarding adherence to DOTS dosages.

Concerning the specific pilot sites, TNFSP has created links between community beneficiaries and the Department of Agriculture, which did not exist previously, allowing for better distribution of resources. Kodumela was found to have alleviated some of the burden on local faith-based organisations in dealing with AIDS, they had also assisted the municipality with getting food parcels to needy families, and they had recommended new families for housing to the relevant department, thereby creating linkages between community members and other service providers.

The only negative impact perceived on service providers was that the relationship between CBWs and clinic staff or nurses was sometimes strained by issues of conflict or jealousy. To better understand this issue, a focus group was staged with nurses during the evaluation exercise. Nurses said they generally experienced CBWs as very helpful, however, they stated that government policy was needed concerning CBWs and job descriptions for CBWs are necessary to provide clarity regarding CBWs’ roles in PHC. Lastly, the nurses commented that the DOTS (TB) PHC staff should be increased to cope with the supervisory workload needed if the CBW system was to work effectively.

6.4 Changes in the way the pilots worked

The piloting organisations` said very little regarding changes in the way they operated during the pilot period. One element, reiterated by the Golang Batcha, CHoiCe, Kodumela, and Ramalema projects, was the introduction of networking and collaboration between projects. This was seen as a positive change because it enabled CBWs to widen their perspectives on care and support to clients. Each of the pilots was in favour of the continuation of such networking ventures in the future. Since such networking required organisations to report on their activities we can assume that the pilots engaged in greater reflection on their practice and increased documentation thereof.

6.5 Cost-effectiveness of the pilots

In order to carry out a cost-effectiveness analysis of the pilot projects, it was important to have the following information:

- Complete costs attributable to the establishment and operation of the project;
- Indicators of impact and, preferably, impact indicators which are likely to ensure the sustainability of the project);
- Data for comparison from similar service providers, preferably established or conventional models' data,...

For the natural resources sector pilot projects it was difficult to assess the cost-effectiveness as the perceived impacts were not easily quantifiable. More stringent record keeping of vegetables or eggs produced, consumed or sold and of expenditure and income by beneficiaries would be needed. With regards to TNFSP, the budget below served as a baseline for understanding the cost-effectiveness of the project.

Table 6.5 (a) Actual costs for the 2-year project period (includes donated items)

(ZAR)	Classification
126,760	Administration expenses
59,202	Establishment costs - Capital (Administrative)
311,000	Establishment costs - Hand-outs Agricultural inputs and implements (Chicken feed, day-old chickens donated, implements)
4,500	Establishment costs - Marketing / awareness
78,750	Establishment costs - Organisational Development
40,040	Marketing / awareness
98,000	Project management - Administration
456,000	Project management - Leadership
77,789	Project management - Overheads
183,750	Project management - Specialist inputs
47,300	Quality management - Overheads
127,686	Quality management - Specialist inputs
115,000	Quality management - Training inputs
1,725,777	Grand Total – calculated project costs for total 2-year project period

However, the impacts against which this budget can be assessed were difficult to define. Very few indicators were detected during the impact study which clearly indicates the sustainability problems of the project. Neither commercial viability in terms of vegetable and / or chicken production nor sustainable food security have been demonstrated, and there is no evidence of sustained future hand-outs / grants from possible donors in this regard.

The most significant impact of the TNFSP to date is the networks established within the Thaba 'Nchu community (ward 41) through the project manager, facilitators, the Mangaung Local Municipality, CBWs, the CBOs, village leadership, District and Provincial Department of Agriculture, and other possible stakeholders / service providers. This not only provides a supplementary service to that which the Provincial Government is able to perform, but also provides a good escalation network, particularly when technical advice is sought (e.g. state veterinarian, private sector NR entities, Department of Agriculture). This network can be fruitfully used to share experiences with other food security projects, source markets, and to form agricultural co-operatives etc, in the future.

Similarly, Ramalema was not able to identify significant impact indicators. However, it was argued that the network established between the communities in the five villages, the stakeholder forum of Ramalema, its board, the FA, and the CBWs, were Ramalema's greatest impact.

More success in determining cost-effectiveness levels was found in the health-sector projects, which were able to measure costs against services delivered. In Golang Batcha, for example, one significant impact indicator was the number of DOTS visits (described above). With regard to costs, due to the Golang Batcha CBWs use of PHC infrastructure, and that training and operational expenses are dealt with either through the conventional health system or from CBWs' pockets, the organisation had an incredibly small costing component, only the R1000 stipend given to CBWs. Thus the cost per significant impact is only $R1\ 000 / 20$ (number of working days) / 7.2 (number of DOTS visits per day) = R6.94.

CHoiCe and Kodumela had much larger costing components. The tables below show the expenditure of the CHoiCe programme over the course of the fiscal year 2005, and a comparison of the expenditure and budget for Kodumela during 2005.

Table 6.5 (b) Summarised income and expenditure of CHoiCe FY 2005

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 6.5 (c) Cost-effectiveness of the Kodumela Pilot

2005 Budget and Actual	Budget 2005	Actual 2005	Variance (B – A)
Stipends (Funded by DoHSD, and Kodumela own funding)	180,000	180,000	0
Salaries - coordinator and administrator	36,000	38,884	(2,884)
Travel	25,200	30,581	(5,381)
Catering & Groceries		28,108	(28,108)
Office costs (incl. furniture & equipment budget R20 000)	40,400	39,452	948
Health promotion	6,000		6,000
Audit	6,000	2,687	3,313
Service delivery requirements	65,217	39,625	
Wheelchairs	6,900	5,746	1,154
Bicycles	7,350	4,632	2,718
Magnetic name tags	3,150		3,150
HBC kits	21,000	14,603	6,397
Uniforms	18,225	14,644	3,581
Household material	3,600		3,600
Emergency food parcels	4,992		4,992
Administration	26,400	25,752	648
Subtotal	205,217	205,088	
Total costs 2005/06	385,217	385,088	129

In the case of CHoiCe, expenditure can be compared to the identified impact indicators below. However, attempts were not made to express costs per impact indicator as there was not sufficient data to carry such an analysis. Rather, it can be said that CHoiCe achieved the impacts listed below with a total expenditure of R3 million per year. The impact indicator which defines most of the above indicators, is the time spent on Home-based Care, i.e 102,989 hours for the 8-month period. The total cost divided by the HBC hours gives us a a cost per HBC hour of R19.58.

Table 6.5 (d) 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

For Kodumela, the costs listed in table 6.5 (e) can be compared against the following indicators, although, once again, cost per significant impact was not calculated.

Table 6.5 (e) Significant impact indicators for all CBW activities at Kodumela

Number of patients in the programme	2,717
Clients served (all services), thus individual service actions	103,082
Total calculated annual time spent to achieve the service actions stated above with 30 CBWs, working 20 days per month and 4 hours per day)	28,800 hrs ¹¹
Cost per patient for a year's support (Rand)	142 ¹²
Cost per service incident (Rand)	3.74 ¹³

6.6 Comparison of cost-effectiveness of CBW and conventional systems

A comparison of the cost-effectiveness of CBW and conventional systems was deemed applicable only to certain pilots. In the case of TNFSP, the comparison would be between the effectiveness of CBWs and the reach, effectiveness and cost of conventional agricultural extension officers. However, data on the impact of the project could not be quantified sufficiently to commence a cost-effectiveness assessment calculation.

Ramalema functions partly because the Greater Tzaneen Municipality has failed to create a designated land-fill site and provide the services associated with it. Comparison with conventional models would not add value to this study.

However, the cost effectiveness of pilots in the health sector was more readily comparable due to existing service statistics from Primary Health Care analysis and World Health Organisation statistics. These comparisons suggest that CBW workers in the health sector are good value for money and that the pilots can be considered cost-effective.

At Golang Batcha, the CBWs significant impact average of 7,2 DOTS support points per CBW, on average, per working day, for ten months selected, indicates that it costs R1 000 per volunteer (stipend) to support 7,2 TB patients daily. Applying this ratio to the salaries of the PHC Professional staff below (halving their days, to compare with the CBWs 4-hour a day), the number of patients that the professionals below would have to see to justify their salaries, if their duties were equal to those of CBWs (for comparison purposes only, as it seems clear that CBWs duties cannot be compared with any professional PHC official), is as follows:

Table 6.6 (a) Ratio to the salaries of the PHC professional nurse

Level	Annual Salaries ®	Monthly salary ®	Patients implied/ day using 7,2 per R1000	Minutes / patient (4-hour day)
Professional Nurse	117,110	9,759	70	3.4
Staff Nurse	63,240	5,270	38	6.3
Clinic Assistant	55,340	4,612	33	7.2

Considering CBWs' significant travel time (averaging from 26 minutes to 45 minutes to reach one patient¹⁴), HBC visits, health care talks in clinics, and TB report-back activities in

¹¹ 80hrs/cbw/month = 80*30x12 months

¹² R385088/2717 number of clients in the programme

¹³ R385088/103082 clients served in all services

¹⁴ Based on 5 CBW diaries over a 6 month period

clinics, paying R1 000 for 7,2 DOTS daily (assumed) visits it could be argued that GB CBWs represent good value for money.

In addition, comparison to World Health Organisation statistics also corroborates the cost-effectiveness of Golang Batcha, CHoiCe, and Kodumela. The above cost-effectiveness calculations were compared with cost statistics obtained from the World Health Organisation (WHO), specifically for SA. As available information was only for the year 2000, the SA Consumer Price Index (CPI) (headline inflation rate), was used to adjust these costs to September 2006 (CPI from 2000 to September 2006 = 136.3 compared with 2000 = 100).

Table 6.6 (b) Cost per bed day & Cost per out-patient visit

Health care sector	(Rand) Sept 2006
Primary	55.08
Secondary	78.12
Tertiary	115.57

The duration per out-patient visit is not available from the WHO statistics. However, if the Golang Batcha cost per visit of R6.94 is used (for time comparative purposes only, as Golang Batcha CBWs are performing supplementary services to the PHC hospitals and clinics), a Golang Batcha CBW visit costs 12.5% of the cost per out-patient visit to hospital level.

If the CHoiCe cost per hour of R19.58 is used (for time comparative purposes only, as CHoiCe CBWs are performing supplementary services to the PHC Hospitals and clinics), an out-patient could be treated for 3.5 hours – which would be an extremely long visit, when compared with the 20 minute-standard per visit to health centres.

In addition, if the Kodumela cost per service incident of R3.74 is used (for time comparative purposes only, as Kodumela CBWs are performing supplementary services to the PHC Hospitals and clinics), an out-patient may be seen / treated 18 times by a Kodumela CBW compared to a conventional clinic nurse for the same cost.

Table 6.6 (c) Hospital Costs-Per bed – in-patient

Health care sector	RAND Sept 2006
Primary	168.26
Secondary	219.51
Tertiary	299.83

Comparing Table 6.6(c) to Golang Batcha's costs, it is clear that the saving to the Health Service is significant if the HBC and TB DOTS support provided by the CBWs is reducing hospital admission of patients. The Primary Health Care sector's cost of R168.26 per day for hospitalisation may be compared with the cost of the time that a CBW spends with a patient. If one divides the total hours per day per CBW by the number of visits per day (4 / 7.2), the average time per CBW visit per day is 0.55 hours (33 minutes)¹⁵, costing R6.94. This seems to compare very favourably with the R168.26 cost per day for hospitalisation. It may be argued, however, that this is not a fair comparison, as hospital care (24 hours)

¹⁵ This amount of time is not the full amount of time spent with the client time as travel time has not been deducted.

cannot be compared with GB CBWs' patient visits as "hospital costs" include food, drinks and 24-hour specialised care with dressings, washing, medication etc. However, it is valid to look at savings to the health service by reducing the cost of unnecessary hospitalisation.

In the case of CHoiCe, if one divides the total number of HBC hours for the 8-month period by the total number of visits in terms of TB follow-up and seriously ill patients (table 6.1 (b), one arrives at a time of 3.1 hours per visit at a cost of R60.80 per visit (excluding travel time). This compares very favourably with the R168.26 cost per day for hospitalisation, due to regular visits by a CBW.

At Kodumela, the cost per visit is R3.74 – this includes visits which may well prevent hospitalisation (e.g. DOTS support). This compares very favourably with the R168.26 cost per day for hospitalisation. The lack of comprehensive statistics on the breakdown of services rendered by Kodumela is, however, problematic.

Cost per visit for public primary care facilities, viz. health centres, at different levels of population coverage is provided in the next table. This includes all cost components including depreciated capital items, but excludes drugs and diagnosis.

Table 6.6 (d) Costs per visit for health centre by population coverage for a 20 minute consultation

Population coverage levels	RAND September 2006
50%	36.76
80%	29.25
95%	31.80

Population coverage refers to the percentage of the population with physical access to primary health facilities, defined as living within 5 kilometers or 1 hour away from the facility.

Using the most conservative coverage level of 50%, the health centre costs R36.76 per 20-minute consultation. Spending this amount on a Golang Batcha CBW would allow for a 2.9 hour visit to a patient's home (compared with the standard TB DOTS visit of 0.55 hours), which seems to be a favourable comparison.

The same comparison of cost-effectiveness calculations were also made for CHoiCe: spending this amount on a CHoiCe CBW would allow for a 1.9 hour visit to a patient's home, which seems to be a favourable comparison. As CHoiCe seems to be focussing on bedridden patients, this may not be a very good comparison, as their patients may not be able to get to health care facilities themselves.

Spending this amount on a Kodumela CBW would allow for 9.8 service incidents, which seems to be a favourable comparison.

6.7 Impact of the CBW project on policy and systems

Neither TNFSP nor Ramalema were able to identify particular significant impacts or possible impacts on policy and systems, though this may be due to the early stages of both pilots, with potential impact increasing as the pilot's efforts and effects grow. Two possible impacts, both limited in their conceivability, but worth mentioning, include the possibility

that with success, TNFSP might cause communities to abandon their original farming systems/methods to implement the new chicken farming and crop growing techniques gained. However, evidence of this thus far is non-existent. At Ramalema, there was a concern that such an NGO should not be responsible for / replace the local municipality's responsibilities in terms of basic service delivery.

Within the health sector pilots, possible impact on policy relates to the importance of CBWs to the current health system and how the government might respond. The DoH stated that CBWs are indispensable to the PHC system, corroborating the findings of all other interviewees during this study, from patients to TB nurses. Limpopo DoHSD also indicated that the HBC CBW system is "here to stay." The challenge is whether the DoH feels that the CBWs are sufficiently indispensable to merit scaling up their status into a newly-formed nursing tier.

PART D LESSONS LEARNT AND RECOMMENDATIONS

7 Good practice emerging from the pilots

7.1 Revisions to the models

Proposed revisions to the models were relatively minimal. The most prominent, stated by TNFSP and Ramalema, projects where CBWs did not receive any financial incentive, was the need to consider remuneration of CBWs so that they might be better able to obtain a livelihood and commit to the objectives and goals of their project. A second proposal was to increase the capacity of those in supervisory positions within the projects/organisations so that they might become better leaders with more credible oversight of CBW projects.

Specific recommendations were also made for each of the projects. With regard to TNFSP, the evaluation strongly recommended that future projects of a similar nature should narrow their conceptual focus to either be aimed at food security or at creating commercial self-sustainable ventures, not both / a mixed approach. The CBWs work may be complicated by a mixed approach, as there is no consolidated focus by beneficiaries on either food security or commercial self-sustained venture creation. Interviews with the DoA confirmed the practical difficulty experienced in 'graduating' food security projects to commercial self-sustainable ventures. Additionally, it was recommended that specialist practitioners (specifically regarding food security and / or commercial agricultural venture creation) should be consulted before a project such as TNFSP to ensure it is designed for optimal success, particularly regarding viable crop types (TNFSP performed its own trials, with heavy crop losses), small stock selection, etc., and optimal project management design. CBWs must be selected for their proven commitment and passion for farming. The TNFSP data also suggests that a 'hand-out' mentality persists among the majority of beneficiaries so beneficiaries' expectations must be carefully managed when the project is introduced to the community.

With reference to Golang Batcha it was emphasized that future models must strengthen the potential of governance structures to attract external stakeholders in order to raise financial inputs and better ensure sustainability.

7.2 Generic good practice emerging

7.2.1 Who are the CBWs and how are they selected

The CBWs evaluated were almost exclusively women, most in their middle age, between 30 and 52 years. Many were either selected or interested in participating because they had previous experience of volunteering in their communities. This is illustrated by several quotes from CBWs collected during the evaluation

I already had started doing volunteer work while I was in my final school year. I always liked to do volunteer work in the community. I started in 1999 to assist TB patients.

I used to work as a DOTS supporter in the past. I was also involved in other community projects...

I was sick and had no one who looked after me at home. After I became healthy again, I decided to help community members who are less fortunate.

I always wanted to combat poverty in my community and saw the call as an opportunity to make a contribution.

Although each of the projects (except for TNFSP) indicated that no formal criteria for selection of the CBWs had been established, several of the pilots did devise lists of characteristics they felt were important for a CBW to have. These included:

- An ability to uphold confidentiality;
- Be based in and drawn from the community he/she serves;
- Understand the local context;
- Be accountable to the community and to a facilitating agent;
- Be able to maintain and ensure quality service delivery;
- Reliability;
- Honesty;
- Respect;
- Report writing skills.

At Ramalema, Golang Batcha, and CHoiCe projects, any person felt to have the desirable characteristics for a CBW was selected. Selection was slightly more particular at Kodumela where recommendations were made through word of mouth and CBWs chosen by the community. TNFSP had the most formalized process whereby CBWs were selected by the community at public community meetings, using sound democratic methods.

Critiques of the selection process, or lack thereof, are primarily concerned with the fact that little attention was paid to whether potential CBWs had any previous experience or knowledge in the area in which they were volunteering, be it vegetable production or AIDS home care. This may be detrimental to the sustainability of the CBW system.. However, it may also be argued that at this stage in the pilot process, the projects could not afford to be so selective in acquiring volunteers, especially when they are not paid. As one woman commented:

We were selected at a community meeting. There were no selection criteria. We were also told that we are not going to receive any money. Many people joined, but after a few weeks or months, decided to quit...

Additionally, criticism was made regarding using unemployed women as the primary volunteers for pilot projects as women are most likely to leave when paid employment opportunities arise.¹⁶ On a similar note, the lack of payment or, in some cases, reimbursement of costs, for potential volunteers was both discouraging and discriminatory in some women's eyes. They felt that many more women were interested than those that actually participated, but could not afford to attend the initial workshops required.

My ward councillor informed me that they are looking for volunteers. He also told me that those who are interested would have to pay for their own transport to the workshop. Many people wanted to become volunteers, but did not have the money to attend the two-week long workshop...

¹⁶ Many of the women in these projects are the main bread winner in the households. Indeed, the majority of them are single headed households

Finally, it is worth noting that a specific situation plagues Golang Batcha's attempts to attract or recruit new CBWs. The Free State DoH's "next in line" admission criteria means that when a CBW leaves the organisation, it is 'impossible' to replace them as the DoH will determine which applicant in the Free State is next on the list in terms of HBC CBW admission, although they may not necessarily be resident in areas where Golang Batcha operates.

It is recommended that community involvement and participation in selecting CBWs be an essential requirement for any programme using CBWs. If the process is handled by outsiders who know little, if anything, about the internal social dynamics of the community, many problems can occur. Facilitating agents can set specific standards and advise on important criteria to be taken into account when selecting, especially regarding gender balance. If the community have selected the CBW, it will encourage their commitment to the process, their support for the CBW and their feeling that the CBW is answerable to them.

7.2.2 The work CBWs do and tasks they perform

The goal of each of the CBW programmes is to provide the community with guidance and support on a range of issues, from agricultural production to health to environmental management. While the tasks of the CBWs varied, as seen below, the purpose behind the work is always the same, to support and uplift their community and provide services that are currently unavailable or inadequate.

The evaluation found that on top of their primary work in health care, CBWs in Golang Batcha, Kodumela and CHoiCe were overburdened by additional responsibilities that they were asked to take on by overworked and under-capacitated local health facilities. CBWs frequently took on the delivery of services in IMCI and AIDS counselling and gave local health talks. This trend must be monitored to see how CBWs respond when new tasks or functions are added without them always having the necessary training or skills to take on such tasks and with sometimes extra demands on their time.

The orientation of both TNFSP and Ramalema to the natural resources sector was found to be fitting to these two projects, as both were located in areas of great need for food security and environmental cleaning, respectively.

As already noted in the previous section, the work of the CBW is not without risk as they are sometimes walking alone in dangerous areas and going into the houses of people they do not know or have mental illness. For this reason, many of the CBWs felt that it is important that they work in teams and that their work be compensated adequately, with insurance cover to protect them in case something happened to them.

The tasks performed by CBWs is dependent on the nature of the project they are involved in. At Ramalema for instance, CBWs followed a daily and weekly schedule, engaging in recycling of paper and glass and cleaning streets, taxi ranks, and other public places. The CBWs also refer certain occupational health and hygiene matters to the government environmental health practitioners for investigation such as suspected poor hygienic practices by a food services provider.

At TNFSP the tasks performed by CBWS were largely related to providing technical advice and support regarding crop and egg production.

Within the health sector, CBWs performed a wide range of tasks. Specific tasks include:

- TB DOTS support;
- Encouraging TB patients to undergo VCT, and if they are HIV positive, then encouraging them to disclose their status;
- Tracing TB defaulters;
- Home-based care (washing bedridden patients, turning patients in bed, cooking);
- Identification, care and referral of vulnerable children/ orphans;
- Mentally disturbed – referral to the appropriate professionals;
- HIV & AIDS support and counselling;
- Food parcel distribution;
- Assistance to patients/community members with applications for government social grants;
- Health campaigns (nutrition, HIV & AIDS, immunisation etc.);
- Referrals to social workers, government departments, etc.

Most of the CBW projects reported that CBWs consistently engaged in a wider variety of tasks than those formally allotted to them. Comments included:

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...

I am from an informal settlement and mostly encounter situations where patients are hungry, but cannot afford to buy food. I often hear patients say 'sorry mom, I am hungry, how do you expect me to take medication on an empty stomach?' I do not have any choice, but to buy food for these patients. Maybe this is part of our duty...

Our patients have become part of our families. If they pass away, we would wash the body before it is taken to the mortuary. We would also attend their funerals and console the bereaved family...

This suggests that a current challenge to the CBW system may be defining where CBW's work starts and ends, so that workers do not overextend themselves or become a one-stop solution for all of the community's problems.

7.2.3 The hours they work and how they work

There is a consensus that CBWs work more hours than suggested in the models for them to meet the needs of their beneficiaries. CBWs are normally only expected to work between 08:00 and 17:00, Monday to Friday. However, CBWs talked of beneficiaries coming to them with problems and requests during the night and over the weekend. As one CBW reported, *"Patients already start knocking at our doors at 4:45 in the morning. We cannot chase them away..."*

Additionally, travel time contributed greatly to the amount of time worked by CBWs. In the case of Golang Batcha, travel time was estimated to be between three to five hours for some CBWs. Only CHoiCe reported that its CBWs were able to keep within the allotted 25 hours per week.

All of the CBWs engaged in both group meetings and individual visits, which varied in level of formality. At the most formal end, CHoiCe Trust's CBWs engaged in highly structured and well-documented meetings overseen by a volunteer coordinator who verified individual CBW visits and reported all statistics to the project manager. Ramalema CBWs also meet regularly on a weekly basis, At Golang Batcha, TNFSP, and Kodumela, regular meetings

were held as well, either monthly or weekly, and often included training or presentations. However, at each of these locations no documentation or recording of the meetings was found, which left the CBWs unable to verify what they had done at the meetings or issues discussed that needed follow-up. The recommendation here is to rectify this anomaly immediately. A major concern raised by the CBWs in respect of the monthly meetings was that they did not get any feedback from the facilitators or the project manager.

Most of the meetings held were those coordinated by the facilitating agent or the project manager. The CBWs did not seem to meet on their own, which defeats the concept of peer learning and learning through demonstration, as was expected to happen in the TNFSP. Additionally, while CBWs went on daily visits for their work, these visits were rarely monitored or verified except in the case of CHoiCe, which has a highly developed reporting structure.

7.3 Training, support and supervision

7.3.1 Facilitating agent and role

The role of the FA varied. The best example of FA involvement came from the CHoiCe pilot. Here the FA has a strong managerial and strategically-minded focus, which is transferred to the CBWs through capacity and relationship building with the volunteer coordinators. This increases the likelihood of the CBWs sustaining their work once they operate in their newly-formed CBO structures. There is an ongoing effort by the FA to create a positive work environment for CBWs; benefits such as shoes, bibles, calculators, splash-proof jackets, skirts and shirts are supplied to the CBWs on a rotational basis, and a dedicated counsellor is assigned to provide counselling to CBWs.

At Kodumela, the FA meets with CBWs on a monthly basis where the CBWs submit reports and give an oral presentation. The FA also visits patients at their homes and at clinics to assess whether the CBWs do their work properly. One CBW commented that occasionally, there are instances *“where the FA will go out of its way to buy groceries for a family which we as CBWs feel need urgent support.”*

CBWs at Ramalema felt that the FA played a minimal role, as most of the CBWs were volunteers and relatively self-managed. It was noted, however, that the FA did play an important networking role in informing other stakeholders of the activities of Ramalema and its needs. At Golang Batcha, while the FA did provide technical support, CBWs felt that they were not often prioritized due to time constraints and the other responsibilities of the FA. At TNFSP CBWs reported that the FA could be more hands on with beneficiaries (a lack of rapport detected in the focus group discussions). Additionally, TNFSP seemed to lack practical agricultural experience (based on information relating to the paid facilitators possessing mainly theoretical agricultural knowledge and experience) and communication skills (mainly based on the possible lack of rapport detected between the FA and beneficiaries). Thus, it is suggested that the role of the FA cannot be limited to an administrative/management function as he/she needs to be working in the field as well, to facilitate a more hands-on approach, render technical guidance and create rapport with the CBWs and ultimately, with the beneficiaries.

7.3.2 Training CBWs received (initial and ongoing)

At TNFSP, CBWs received permaculture training, training in layer chicken management and vegetable production, on how to interact with members of the community and, towards the end of the project, training in financial management for a micro-business. At

Ramalema some CBWs received training in business management and marketing. The health sector CBWs had similar experiences, each receiving relatively similar training including:

- Caregiving;
- Personal hygiene;
- DOTS (1 week);
- Breastfeeding training workshop;
- HIV & AIDS and VCT (20 days);
- Home-based Care;
- Child care;
- Prevention of mother to child transmission (of AIDS);
- Trauma;
- Mental Health;
- OVC;
- Conflict management.

CHoiCe CBWs also had on-going on the job training and wider skills transfer in financial management.

An important issue that affected all the pilot projects was that when new CBWs were added to the projects to replace CBWs who had left, they often received little or insufficient training in comparison to their co-workers. This leaves new CBWs at a disadvantage and weakens the impact of the programme if not addressed. Allied to this is concern about CBWs leaving the organisations after training. It is acknowledged that volunteers finding work is a great thing. The challenge is how the FA can continue to replace and provide the necessary training to new entrants.

A concern from the CBWs perspective was whether this training would actually translate into marketable skills in the future. As one CBW commented,

We have got the training, but where do we go from here? This training should translate into us getting preference when it comes to jobs, especially in cases in which we meet the minimum requirements, eg the government CDW Learnership programme.

These are issues to be considered if the CBW projects will continue to draw volunteers into their programmes.

7.3.3 Ongoing support and supervision and from whom

The most prevalent form of supervision and support comes from the facilitating agent and networks that the FA may have put in place. In the TNFSP facilitators meet with the CBW on a monthly basis to gather statistics, share lessons learnt and problems encountered. They are also available when advice is needed. These monthly meetings served an important role *“it provides us with the opportunity to reflect on work and motivate those whose morale is low because of bad experiences,”* one CBW stated. These meetings also act as forums for sharing and cross referencing of successes and challenges faced.

Other sources of support and supervision included churches, the DoHSD, volunteer coordinators, and Primary Health Care nurses. CHoiCe also provided psychological support in the form of a dedicated counselor to its CBWs. Most of the pilots indicated adequate supervision, but Golang Batcha did mention that they felt that supervision and support was lacking. One comment made in this regard was:

It is difficult to say whether support mechanisms are in place. We only meet on a monthly basis with the FA. Other than that, there is no support whatsoever

Important issues arising around support and supervision included the fact that a lack of remuneration makes it difficult to enforce supervision, a lack of continuing support after training has been completed, and lack of feedback from supervisors.

7.4 Linkages of CBWs to other support agencies

The most prevalent link found amongst the CBWs was to other government departments. TNFSP for example, is supported by the Free State Department of Agriculture, the State Veterinarian, and the Agricultural Resource Council, all of whom provided them with support, resources, and training.

Both Golang Batcha and CHoiCe were intimately connected with the Departments of Health and Social Welfare through local clinics and received training from the Department and support from local nurses. CBWs at Golang Batcha were also part of the Ngenani Emxholweni Consortium of Home-based Carers in Bloemfontein. As CBWs at CHoiCe commented,

We usually meet with CBWs from other organisations when the Department of Health, for example, calls a meeting. However, there is a lot of red tape on who participates...

Thus, although there are a wide variety of support agencies available to CBWs, the sheer number of organisations can sometimes contribute to confusion and/or jealousy. In the case of clinic nurses, jealousy was often present during the start-up of the CBW programmes, although the CBWs and nurses soon learned to work together.

Nurses used to look down on us in the beginning. But they are now rejoicing with us. They are happy for us and for the R500 stipend we currently receive.

7.5 Accountability

7.5.1 In what way are CBWs accountable to communities and the FA?

Accountability to the community was strongest at TNFSP, while the other pilot projects often felt confusion about community accountability. At TNFSP CBWs felt accountable to their communities simply because of the services they provided, and commented thus;

I am a servant of the community because they selected me. The community expects us to serve them with distinction. The community has the right to demand that we be dismissed because they choose us..

The nature of our job is such that we cannot think about ourselves first. I have placed the interests of the community above mine and those of my family.

However, at Golang Batcha, Kodumela, CHoiCe, and Ramalema, CBWs were significantly accountable to the FAs. This reduced the level of accountability to their community. In each of these areas there was no mechanism through which the CBWs were accountable to those they served.

Most of the CBWs felt highly accountable to the FA, as the FA held the ability to hire and fire those who were not meeting performance standards. CBWs in each of the projects compiled monthly reports and statistics for submission to the FAs. Additionally, at CHoiCe and Kodumela, CBWs had signed contracts with the FA making them legally accountable. The contracts included a code of conduct which indicates how the CBWs are expected to behave when interacting with the community. However, this was an issue at Kodumela, where one CBW commented,

We signed contracts, but we never had the chance to read the contracts. We were forced to sign the contracts immediately...

Conversely, at TNFSP, where CBWs are not paid and there are no contracts, accountability was often difficult to enforce as the CBWs have no contractual obligations to the FA and could not be held liable if they failed to turn up or complete their duties.

7.5.2 Accountability to others

Through reporting on their activities and keeping statistics on clients reached, CBWs were able to account to both the government departments from which they received support, like the Departments of Health and Agriculture, and donors. In the case of Ramalema, monthly stakeholder meetings were held to inform others about the current achievements of the project.

At Golang Batcha confusion among the CBWs about the role of the local municipality and their accountability to it seemed to be a major issue. Two of the CBWs summarized this confusion as follows:

We are constantly told that we are not under the control of the municipality. Sometimes we are even told that the municipality has nothing to do with us. What surprises us is that the Co-ordinator uses the municipality's letterhead in her correspondence. Moreover, we have to submit reports to the professional nurse for our stipends to be paid.

In each of the pilot projects, save TNFSP, the FA was the mechanism for hiring and firing, with consultation from the CBWs. At TNFSP it was noted that while the FA technically did the hiring and firing, it was really the community that controlled the process, as they would protest decisions made by the FA if they did not agree, and usually got their way.

7.6 Financing the CBW system

7.6.1 Monetary & non-monetary incentives to CBWs

CBWs at three of the projects received stipends. CBWs at Golang Batcha received R1000 a month, while CBWs at CHoiCe and Kodumela received R500 a month. However, it should be noted that the CBWs at Kodumela are currently faced with the predicament that only 11 of them would be financed through the DoH starting in September 2006. Kodumela has attempted to finance those CBWs not covered through the DoH, but is faced with limited funds. CBWs at TNFSP and Ramalema did not receive monetary compensation, which may affect their commitment to the project in the long term. When the unpaid CBWs were asked what kept them motivated in their work, they commented that,

We survive on social grants, especially child grants. My husband is not working, it is difficult...

I keep going on because I hope that our community's health status will improve and, on a personal note, that my living circumstances will improve.

Additionally, CBWs that were remunerated commented that their stipends frequently went towards expenses associated with their job, such as transportation or helping out community members, suggesting that even with a stipend CBW systems may be difficult to sustain.

Beneficiaries at all of the pilot projects, received additional incentives in the form of in-kind items, such as uniforms, shoes, bicycles, stationery, bags, and diaries. Additionally, CBWs at TNFSP and Kodumela reported the networking benefits and training as additional incentives. Finally, at TNFSP it was noted that the initial intention of the project was that a CBW will become a model of 'good practice' for the 20 members in their group to learn from. This would be both an indirect and direct benefit for the CBW because they are the first to benefit when tools or seeds for 'demonstration' sites are distributed.

7.6.2 Withdrawal and sustainability

The likelihood of sustainability varied greatly depending on the pilot project considered. Each CBW project is dealing with its own unique institutional and funding constraints, and it is therefore difficult to make cross-project generalizations. None of the projects studied could confirm their sustainability with 100% certainty, and the level of commitment varied from the Kodumela project, which indicated a strong commitment to CBWs, to Ramalema and TNFSP, which forecasted a low likelihood of long-term sustainability.

Kodumela, while not as developed as CHoiCe, seems to have the most structured and stable future, along with commitment by CBWs and external stakeholders. World Vision International works in an area for 15 years, and then withdraws (aiming to leave self-sustainable operations behind), thus they will leave Kodumela in 2016. However the EU funding for stipends was to cease at the end of 2006, but the DoHSD indicated they will fill the funding gap, although not for all CBWs.

Despite these financial uncertainties, the Department of Health and Social Welfare (DoHSW) has mentioned that the CBW system is here to stay as part of the Expanded Public Works Programme. The HBC programme will be rolled out even further (there are already around 2 500 stipend-paid carers in Limpopo province, just on the part of the Department of Social Development alone). Furthermore, the CBW pilot project has broadened awareness of Kodumela and its operations, with the Department of Public Works having contacted Kodumela for purposes of learning more about its operations and a potential partnership arrangement being developed. The Home-based Care section of Kodumela has in fact been registered as a CBO, but still falls under Kodumela ADP for assistance in terms of administrative and financial expertise.

In terms of the CHoiCe Trust pilot, they were relatively certain of future sustainability. CHoiCe is consistently recognised as a top-of the range organisation, but it faces a large upheaval in the coming year, which could threaten its sustainability. The government has instructed that CHoiCe CBWs be reorganised into CBOs of a maximum of 30-strong CBWs. The not-for-profit registration applications for the above CBOs have been completed and sent to the national Department of Social Development. This is a prerequisite to getting funding for next year. ChoiCe is acting as a mentor for these CBOs because the DoHSW only funds organisations that have been running successfully for a year or more. There are no guarantees that the new CBWs will sufficiently "lean on CHoiCe" until an acceptable level of sustainability is reached.

Even though the CHoiCe CBWs display a high level of loyalty to the organisation, the programme has experienced significant CBW turnover – to the tune of 25% of the total staff complement (due mainly to well-trained CBWs moving into lay counsellor positions which is better paid). Recruitment of new CBWs is, however, an ongoing priority for CHoiCe. The turnover may be reduced if the stipends for CBWs are increased to match the level of the lay counsellors.

The outlook for the other pilot projects is less hopeful. At Golang Batcha, future attempts at sustainability are seriously hampered by the recruitment conditionalities stipulated by the DoH. If the recruitment anomaly noted previously stays in place, Golang Batcha will not be able to recruit new members and will almost certainly not sustain its operations. Currently, only 21 of the original 42 members remain. Financially, Golang Batcha is heavily dependent on the DoH and local municipality funding. Neither of these bodies has been able to give tangible evidence regarding future financial commitments, nor a plan for sustainability, suggesting that Golang Batcha may not be a top priority. One recommendation for Golang Batcha's future is to introduce income generating activities or voluntary savings (loan) schemes for CBWs to develop SMMEs. This would be a way of empowering and strengthening the group to be more sustainable in future as they continue to provide this essential service.

At TNFSP, future sustainability is limited by a lack of foreseeable future funding. As NDA funding runs out, proposals have been made that the project must become self-sustaining. It has been proposed that while each group will get an initial stock of tools and seeds, further replenishment will come from the group's own operations, and so they will be forced to be self-reliant from the outset. Some groups will develop significantly, e.g. to become marketing co-ops which can fund their own activities in major ways; others are likely to remain small, but the benefits should nevertheless be significant. Although this is presented as a sound objective, current outlook does not provide evidence that such capacitation is currently happening in the community.

Finally, Ramalema has suggested that their future is bleak. Although the project has been chosen as a pilot village by the Department of Environmental Affairs, and the work is part of the area Integrated Development Plan, current evidence suggests that several important elements of sustainability are missing. Due to the lack of remuneration, CBW turnover has been high, and many of the original CBWs have been lost. Those that remain are hindered by the lack of transport for refuse removal and the lack of an identified landfill site, which is necessary if the project is to continue.

7.6.3 What happens to the CBWs (as individuals, collectively)

For both of the projects where CBWs are not remunerated, i.e. TNFSP and Ramalema, it was foreseen that CBWs would eventually leave the project to seek paid employment and the project would most likely cease to exist. A different situation is present with Golang Batcha, although it presents the same result. As the CBWs at Golang Batcha are remunerated and relatively well trained it is foreseen that they will attempt to acquire higher, better-paid positions as lay counsellors, thereby leaving Golang Batcha. This situation, coupled with the project's recruitment difficulties, will most likely make it difficult for GB to continue to exist.

Prospects are better for CBWs at CHoiCe and Kodumela. CHoiCe predicts that most of their CBWs will continue to be employed in the sector, either with them or with the new CBOs they are forming. However, they acknowledge that future career paths are not necessarily clear and the lack of prospects can be de-motivating. Similarly, Kodumela

expects to retain most of the CBWs due to the personally empowering nature of the work. However, they also admit that the lack of employment opportunities elsewhere plays a factor in their retention rates.

7.6.4 How is the local CBW system linked to community structures

The health sector pilot projects are intimately linked to the community through the local health structures, including hospitals and clinics. Additionally, as in the case of CHoiCe, they are linked to schools, and in the case of Kodumela, the church. TNFSP structures are linked directly to the community as the community chooses the CBWs. These linkages suggest inroads to sustainability, but it should be noted that the professional level of these linkages is varied.

7.7 Specific issues for each of the models in South Africa

The onset of the CBW project in SA in 2004 involved an in-country review of different projects which were using community-based volunteers to deliver services in communities. Different models for implementing community-based worker systems emerged from the review according to number of hours worked and whether or not CBWs received a stipend (see section 5.2 above). This section reviews the functioning of these models within the five pilot projects.

7.7.1 5-8 hour volunteer

CBWs in the Thaba Nchu Food Security Programme were intended to implement the 5 to 8 hours a week model. However, CBWs indicated that 5-8 hours per week is not enough to provide adequate and regular support to the 20 beneficiaries in their groups. The core to this model is volunteerism; CBWs giving their time to support the other 20 community members, while, simultaneously continuing to manage their own livelihoods. The concept of a CBW was someone who is already a skilled farmer and that he or she would be sharing indigenous knowledge, as well as new knowledge gained through the programme, relating to an agricultural livelihood i.e. that the CBW work would mesh with the CBW's everyday farming activities but maybe this did not happen so well in practice. Whether this was the reason or it was challenges such as the lack of water or the serious poverty levels in these communities, CBWs have struggled to simultaneously provide the necessary support needed by their group members and actively provide for their own livelihoods.

Another issue of this model is the lack of volunteer contracts, which leaves room for poor accountability mechanisms i.e. I'm not paid therefore I cannot be held accountable. A CBW -paid model might be better practice, and detailed, clearly understood volunteer contracts might be the answer to providing clarity regarding the duties and responsibilities of CBWs. Further, an income generating component in the project could be incorporated to assist CBWs to secure their livelihoods.

7.7.2 20 hour volunteer

The Ramalema Environmental Pollution Prevention Project CBWs work approximately 20 hours per week without a stipend. A negative impact on CBWs is that as unemployed people they struggle to buy food, and it is difficult to be productive when hungry, which points to the unsustainability of non-remunerative volunteerism in this area. CBWs also walk long distances in extreme weather conditions because the organisation does not pay for transport.

In addition to the issues identified for the 5 – 8 hours unpaid model for TNFSP, and particularly regarding the non-sustainability of the model in the absence of a minimum livelihood capability for the CBWs, the following issues were identified:

- Where CBWs operate within formal structures, such as CBOs, it may be worthwhile in terms of their own formalisation, to register as non-profit organisations with the national Department of Social Development – this may afford these CBOs more credibility when applying for donor funding etc.;
- Internal controls and corporate governance must be attended to as they are an important factor in the sustainability of any organisation where finances are involved, including CBW CBOs.

7.7.3 20-30 hour paid a stipend

In this model CBWs work a 20 to 30 hour week. However, most CBWs claimed to exceed this limit, although no clear documentation of this was obtained. From three CBWs' diaries, taken from Golang Batcha and CHoiCe, it was ascertained that travel time per day could be anything from 3 to 5 hours and more, leaving little time for caring (core time). It is, however, unclear how accurate these time measurements are, or whether they are representative of all the CBW groups in SA.

Both Golang Batcha and CHoiCe Trust expressed the need for designing specific legislation to formalize and regulate Community Home-based Care. It is argued that these CBWs be formally incorporated into the primary health care system (ie a new nursing tier), with employment benefits, workmen's compensation, an advocacy body (governing body), etc. It is important for the credibility of the stipend-paid health care worker system as a whole, that minimum training requirements, funding allocations (how many stipends funded per CBO), funding levels (what stipend does each carer receive), be standardised per province, and for SA as a whole. If this is not done, significant variance in terms of effectiveness may arise in the different provinces.

The Kodumela Area Development Programme CBWs requested debriefing sessions for health care volunteers, given the emotionally charged environment in which the CBWs operate. One way of increasing such support in this model would be linking CBWs and CDWs as well as creating community forums in the hope of creating a platform for discussion on serious issues affecting the community.

A prerequisite to the formalisation idea is ensuring effective and efficient management of the CBWs in order to maximise the organisation's impact. Where CBWs operate within a CBO structure, it is extremely important to build sufficient management capacity and ensure the cost-effectiveness of the CBO, as well as to make sure there is capacity for the sourcing of operational funding.

8 Summary and recommendations

This section summarises the results of the research. It asks whether the CBW pilot organisations in South Africa have been able to deliver the benefits that it was hypothesised that such systems could achieve. It then goes on to make a number of recommendations drawn from the research to guide future implementation.

8.1 The effectiveness of the CBW pilots

The impetus behind the development of CBW system is the need to improve service delivery. The professional personnel currently employed in the public service and NGOs is not sufficient to meet the huge needs of the population. It is too expensive to increase the number of health workers, extension officers and other professionals, hence the idea of deploying a cadre of workers at a lower level who are less trained and receive lesser compensation but to whom some of the work of the professionals can be devolved.

Apart from saving costs and reaching more people in need, the premise was that, as CBWs are drawn from and work close to the grassroots, they would also serve as the voice of their communities communicating their needs and increasing their say in how service delivery should be conceived. Ideally, this should result in a more appropriate and effective service.

The study was an action-review process in which policy makers and organisations shared their perspectives, experiences and practice. The study carried out a preliminary review of a number of case studies in South Africa and then a more in-depth evaluation of five organisations working with CBW workers to see if the aims expressed above were being met. The initial review of a number of case studies suggested that CBWs are adding value in a range of sectors from natural resources to health care. However, the more in-depth study of the pilot projects suggests that the health sector CBWs have been more successful than the example drawn from the natural resources sector. As there is only one example from the NR sector, it is not possible to say that the use of CBWs in this sector is not appropriate or whether the project struggled because of flaws in the project design, poor management or environmental challenges that have been discussed in this study.

There was evidence of success in other NR projects in the preliminary review. The environmental sector project had carried out good work but sustainability of funding for such work was a big question that had not been resolved. This also raises serious concerns around project conceptualisation and funding regimes. For example, how feasible is it for a project to have significant impacts on its beneficiaries within a two-year funding framework? The evaluation recommends a more conservative approach in setting targets and goals

The health sector projects were able to give evidence of considerable impacts and it seems as if their value to the health service will ensure their continued funding though some vulnerabilities were detected. Overall, the value of the model was supported with considerable evidence that CBWs are value for money and are giving a good service in a very cost-effective manner.

8.2 Keep it simple

Turning our attention to recommendations emerging from the research, some organisations called for clear job descriptions for CBWs. The design of service delivery must be focused on specific tasks, not addressing issues outside the expertise of the CBW. The goals must be unambiguous, not addressing multiple and convoluted outcomes. For example, the TNFSP was designed as a food security project (i.e. providing nutrition to the beneficiaries of the project), but included the aim of graduating beneficiaries to commercial operations. The pilot design should either have focused on food security (with long-term commitments in terms of donation of seeds, pullets, growing mash, vaccinations, etc.), or focused on commercial venture creation from the outset, but not a combination of the two. The facilitating agent must also define what the CBWs can and cannot do and what they can achieve within their working hours. For example, although Golang Batcha volunteers were originally expected to perform only home-based care, they later came to be expected to deliver services in IMCI, to give health talks, get IDs from Home Affairs, help people get government grants and deliver food parcels. The broadening from the original concept of giving care to people with HIV/AIDS to a broader health remit came about to avoid singling out people with AIDS given the current stigma of the disease and is understandable but it is important not to continue loading new tasks on someone with one set of skills and who is already working more hours than required or CBWs will build up resentment and risk burn out. In addition, people who enrolled because they enjoy HBC may not have an aptitude for counselling or for making health presentations which require different skills,

Giving CBWs more extensive tasks also has ramifications for training. All the organisations talked about losing staff and the problem that the new staff did not receive as much training. It is only to be expected that some of the volunteers will leave if offered paid employment, or higher paid employment, as they need to support themselves and their families and many CBWs stated honestly that they saw the training and work experience gained as a way of improving their job prospects therefore one must devise systems on the assumption of quite a turn over in staff. Therefore training must not be too extensive and expensive so that organisations can afford to repeat the training for new recruits and also be able to offer training on a large scale.

8.3 Build strong stakeholder relationships

A strong network between all stakeholders is identified as an essential element of the CBW system. The community, CBWs and facilitating agents are all key stakeholders who need to be involved at all stages of the CBW system. For the system to work effectively all need to be aware of their roles and responsibilities, which must be clearly articulated, so that they each know what they can expect of the other.

Communities often have unrealistic expectations of what a CBW can be expected to achieve. The community needs to know what they can expect of the local CBW and of the facilitating agent. Challenges that were identified in the projects studied was a 'hand - out' mentality' in the food security project and CBWs feeling that they must answer any request from a community member leading them to feel overburdened. Another challenge was community ownership. In most projects, the CBWs saw themselves as answerable to the FA rather than the community and there did not seem to be mechanisms in place for ensuring community ownership. These need to be put in place if the system is to fulfil its promise of delivering a 'bottom up' rather than a 'top down' service in communities.

The facilitating agent needs to create a healthy working environment, where CBWs can be free to raise their grievances and address specific concerns surrounding service delivery. It is vitally important that facilitating agents improve their facilitation skills and their capacity to work with and understand the different community dynamics and constraints that CBWs face in their work.

The role of local and provincial government and government sector departments must also be clarified and agreements set up regarding training for the CBW managers and the CBWs themselves. Departments such as the DoH and DoHSD must consider the possibility of creating a governing body to oversee CBW systems, and implementing legislation to govern their activities. These departments and the proposed governing bodies may be in the best position to translate the findings from this report and others into tangible policy and legislation outputs.

Further, government should continually refine and implement a deeper range of macro pro-poor policies on a sector-by-sector basis, while engaging, assisting and supporting the design and implementation of appropriate programmes with stakeholders.

8.4 Formalisation and standardisation

In order to enhance the potential and sustainability of CBW systems, it is critical to formalise and professionalise CBW mechanisms and procedures.

The basis for formalising the CBW systems should be the creation of standardised recruitment procedures. Evidence should be obtained regarding candidates' suitability including checking of qualifications and obtaining references. As part of the selection process, the community and CBWs should be given a job description so that they understand what is expected, and, if selected, CBWs should be asked to sign a formal contract. Such contracts should clearly state the available resources for the project, the expected involvement including financial and material contribution on the part of the CBW, and the intended impact of the project, in order to allay any false expectations. Additionally and where applicable, registration of CBWs for unemployment insurance and Workmen's Compensation will ensure that they can receive the benefits of a formalised work environment as well. The evaluation also recommends that CBWs be issued with uniforms in order to enhance community identification of CBWs and improve professional appearance on the ground.

It is also recommended that government departments strongly consider the formalisation of CBW positions through remuneration. Remuneration would increase the long-term commitment of CBWs and improve their livelihoods. It is sometimes suggested that CBWs could become involved in income-generation projects to create their own income. The risk here is that running the small enterprise would divert their energies away from their community work and that their community work would take second place. One possibility would be to mesh the income generation with their work in the community as in the NR sector where CBWs are expected to farm for their livelihood as well as extending agricultural know-how to others. Ideas could be explored on the lines of Kenya's Health Store Foundation where a franchise system was set up with community health workers selling basic, widely needed drugs to people in areas not serviced by government clinics. The idea would be along the lines of a system whereby CBWs would have a franchise operation for specific items sourced from a central agency in bulk at a very low price that they could sell on to clients after careful training in dosage etc but serious consideration would have to be given to the ramifications of this idea and whether the role of salesperson can sit easily alongside the role of a caregiver.

Once selected, CBWs should participate in standardised training processes. Appropriate training programmes for CBWs with high impact potential and rigorous pre-and post assessment should be identified and implemented in order to increase the level of professionalism with which CBW work is practiced. Such training should include both the practical aspects of their work, such as basic health care or agricultural training, as well as issues around understanding how the FA is structured, managed and funded so that CBWs can begin to assume management of their own projects.

Finally, long-term strategic plans should be devised to address currently recognized challenges and generate specific strategies for future prevention of similar problems. Such a recommendation may also be expanded at the national level to consider the creation of a CBW governing body that would introduce specific legislation governing CBWs and create national strategic plans regarding the implementation of CBW programmes.

8.5 Improve monitoring and evaluation

Every organisation must have a continuous performance reporting mechanism. The information recorded should directly relate to the strategic goals of the organisation and serve as a measurement of performance against such goals. The introduction of this type of monitoring and evaluation tools will allow for immediate recognition of areas where performance is falling short of projection and will facilitate action to rectify such situations. At the centre of such a reporting system would be the daily records kept by CBWs on issues such as daily activities, visits made, crops planted, etc, along with difficulties or problems the CBW may have encountered and minutes of any meetings attended. These statistics must be carefully captured and standardized in order to ensure their usefulness. Also of importance will be issues of daily expenditure, which can be evaluated to give a greater understanding of the financial demands placed on CBWs and used to inform future discussions relating to the pay of CBW workers. Reporting systems will also allow for better understanding of current workloads and allow a workload distribution system to be created which can ensure greater equity between CBW carers and capture the full breadth of activities taking place in CBW organisations. There should be regular reports to boards and stakeholder/community organisations. At the organizational level, there needs to be systems of financial control and financial transparency. It was clear from the section of the research where attempts were made to evaluate the cost-effectiveness of service delivery using CBW systems that such research cannot be carried out unless data on activities and costing is consistently recorded carefully and kept by organisations.

8.6 Government as funder

The evaluation recommends that the majority of CBW funding should come from the state, particularly for stipends, as CBWs supplement existing state services, such as clinics, agricultural extension work and refuse management. Continuous funding from the state will ensure long-term sustainability of CBW systems and give FAs and CBWs the ability to concentrate on doing the job well rather than having to worry about long term funding. It is easier to raise funds from donors for aspects of delivery such as training and training materials or resources such as computers or uniforms. However, donors are reluctant to commit long-term recurrent costs such as salaries.

8.7 Role of NGOs and private sector

NGOs and the private sector have a very important role to play in supporting CBW systems and their sustainability.

Firstly, NGOs and the private sector can act as support through their expertise and experience in specialist sectors such as agricultural production or HIV/AIDS home-based care. It is recommended that such experts be consulted before projects are commenced in order to ensure that projects are designed for optimal success, particularly regarding the finer details such as stock selection or project management design. This will ensure that projects start on the most secure footing possible and are designed for success and sustainability. Projects should also create links with other organisations present in any CBW project area in order to share ideas and knowledge. Such linkages can provide valuable resources to CBW workers, create networks of support, and actively work against the jealousy and rivalries sometimes present between different groups of community workers, such as CBWs and nurses. It may even be important to create community forums in order to facilitate such discussions.

Secondly, NGOs can play a major role in support of CBWs in implementation. Their experience and innovation can contribute to the ongoing redesign of CBWs' roles and responsibilities, and provide the necessary back-up structures, training and support.

Thirdly, NGOs and the private sector can be a significant source of financial and material support to CBW systems. Especially at the initial stages, where self-sustainability of projects is often not an option, CBWs are hampered by their lack of consistent financial support. Uneven or uncertain funding limits the ability of a project to consider long-term goals or remunerate CBW workers. In attempting to find sources of financial and material support to ensure initial start-up and help projects to establish themselves, CBW projects should make the effort to obtain the support of such organisations. These recommendations will be best achieved if networking and agreements between CBW system agents such as the FA and NGOs or the private sector are strengthened. The informal linkages currently in place between these stakeholders should be formalised through documented agreements in order to improve the enabling environment and ensure project sustainability.

8.8 Way forward

This action-research project was initially intended to run from March 2004 through to March 2007, but has been extended to September 2007 to allow the partners to develop guidelines for good practice, and to share these at a regional workshop with practitioners and decision makers in Eastern and Southern Africa region. The pilot projects involved have collectively been learning about CBW systems through this 4-country action-research project and a range of other work using volunteers of various types, including those highlighted throughout this report. The task now is to respond to the big question, "How can we take forward these learnings to scale up and mainstream the CBW systems, to contribute to much more widespread services to poor people in all communities?" The prevailing task is to make the CBW system practical and sustainable. At the last national South Africa workshop, which took place in November 2006, a task team with clear terms of reference and activities was mandated by the workshop to take forward the process. This included national and provincial policy makers and implementing agencies. The last section of this report is the action plan for South Africa, which gives an indication of how the work that has been captured in this report will be carried forward into the future.

8.9 Action plan for South Africa

Activity	Action	Undertaken by...	Completed by (2007)
Finalize SA country report	Circulate 4-C W/S Report	Khanya–aicdd	May 31
	Distribute draft SA report inc SCM	Khanya–aicdd	April 30
Finalise 4 Country Reports	Finalise 4 country synthesis report	Khanya–aicdd	June 30
	Other reports from other countries available for reference in the website	Khanya–aicdd	April 30
Steering Committee	Confirm with Sadi Luka about chairing of Steering Committee	Mpotseng/lan	June 8
	Bring the identified stakeholders on board •Public Works •dplg •dpsa	Khanya–aicdd, Mvula Trust, and DSD Frank Monene	May 4
Building broader interest	Discuss importance of work with Presidency	Ike Tshitlho	8 June
	Discuss importance of work with provincial network	Ike/Patrick	8 June
	Contact SAPS – relevance of CBWs for reservists	Monene	15 June
	Make contact on ECD – Alani provide contacts for UNICEF, Frank to follow up with DoE	Alani Frank	8 June
	Discuss wider implications of urban rangers with Environmental Affairs, also with DEAT	lan	8 June
	Consider paper at conference by PW on Employment creation	Patrick to discuss with Rashnee	
	Presentations to the provincial interdepartmental forums and clusters	Khanya, DSD	June/July
	Arrange for presentation to ISRDP/URP interdepartment task team	Mpotseng	July
	Introduce the CBW concept to new unit for NPOs in FSDoH	Puseletso to inform Patrick	July
		Mpotseng/Monene	29 May
	African Palliative Care – conference in Nairobi Sept 19-21 eg on utilization of CBWs – abstracts by end of 31 May (do paper after guidelines)	Patrick/Alani	31 May Conf Sept
	Monitor report by HST on additional areas for Social EPWP to widen use of CBWs and when may be relevant to be involved	Frank	Ongoing
	Develop the standard format for documenting CBW experiences – make it available in the web-site. Consider database of initiatives	Rahel/Khanya	Discuss 25th
	Linkage to policy	Possible workshop for decision-makers post regional workshop	DOH Involve Khanya-aicdd (Vincent re lobbying policy makers)
Circulate report of the Community Development Policy workshop		Mpotseng	30 June
Pursue CBWs in discussions with DSD		Khanya/DSD	July

Activity	Action	Undertaken by...	Completed by (2007)
	Oupa leading on getting common approach around community development (Frank EPWP to follow up)	Frank	8 June
	Regulatory Framework – needs local consultation and buy-in. Involve Lorna Scheppers so part of Guidelines	Patrick	31 May
Guidelines	Develop guidelines for implementing CBW models including generic scope of practice and M&E	Specific people led by Patrick	July
	Finalise individuals to assist in writing guidelines – i.e. CHoiCe, HPSA, Mvula trust, HST	Khanya–aicdd and partners	End of May
Regional Workshop	Do initial concept and circulate	Patrick	8 June
	Finalise who attends	Patrick+SC	15 June
	Conduct the regional workshop	Khanya–aicdd and partners	3-5 Sept
Widening implementation	Consider accessing funds from the Global Fund	WVSA and CHOICE (Monene to follow up)	End of June
	Write proposals to implement recommendations from pilots	WVSA and CHoiCe	End of June
	Consider use of CBW in learning sites pilot	Khanya/DSD	July
	Use pilots to draw/involve other Department's and stakeholders	Khanya, DSD	June/July
Minutes out	Circulate	Monene	25 th May
Next Steering Committee		All	Week of 16th or 23rd July (not Mons/Fridays)

Annex 1 References

- Friedman, I. (2004): 'Community-based health workers.' *The SEED Trust: Health Programme*. 161-180.
- Government Gazette (1994): "White Paper on Reconstruction and Development", Government Gazette, No 16085, Vol. 353, November 1994;
- Khanya, (2001): Institutional Support for Sustainable Rural Livelihoods
- Khanya-aicdd, (2005): 'Policy Overview: Community-driven development in South Africa.' *Bradford Centre for International Development*., WP 3
- Khanya-aicdd, (2004): South Africa in-country Review Report
- Khanya-aicdd, (2005): Literature Review: Community-based workers and service delivery.' *Bradford Centre for International Development*.
- Khanya-aicdd, (2006) Evaluation of Community-Based Worker Systems in South Africa
- May, J. (2004): 'Accumulation failures and poverty traps in South Africa.' *International Poverty Centre: In Focus*. 9-13.
- Mdhluli, L. (2006): 'Case Study: Community-based workers and HIV/AIDS in Bloemfontein, South Africa.' *Bradford Centre for International Development*. 1-30.
- Office of the President: "Social and Economic Impacts of Government Programmes Since 1994", Synthesis Report, Papers 6.2 and 6.7 of the 'Ten Year Review Research Programme', prepared for the Policy Co-ordination and Advisory Services