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Issues Impeding the Efficiency and Effectiveness of the Ward Based Primary Health Care Outreach Teams: Support Needed for Policy Planning

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Table of Contents

Why PER on Ward Based Primary Health Care Outreach teams: CHWs 4

What seems to be the real challenge – Volatile Funding 5

Performance Analysis 6

Training not standardised 6

The limits of monitoring and evaluation 7

Budget Structure 7

Salaries not standardised 7

Poorly developed Programme 6

Analysis of the Logical Framework 8

Analysis of expenditure items and patterns in the WBPHCOT programme 8

Spending pressures in Provinces why are there vast differences in expenditure totals? 10

Lack of uniformity in budgets for CHWs 11

Costing model analysis 12

Limitations 12

Methods used for the costing model and questions answered. 13

The main costing worksheets 13

Costing model outcomes 13

Savings and trade-offs: moving towards cost effective measures for efficiency and effectiveness 15

Trade-offs 17

Conclusion and Recommendations 18

Conclusion 18

Recommendations 18

Annexures 19

Programme Elements 19

Sources used for this PER 20

Acronyms/Abbreviations

- **AIDs** Acquired Immune Deficiency Syndrome
- **CHW** Community Health Worker
- **COE** Compensation of Employees
- **DHIS** District Health Information System
- **EPWP** Expanded Public Works Programme
- **HIV** Human Immunodeficiency Virus
- **M&E** Monitoring and Evaluation
- **NDoH** National Department of Health
- **NDP** National Development Plan
- **NGOs** Non-Governmental Organisations
- **NPIs** Non-Profit Institutions
- **NPOs** Non-Profit Organisations
- **PEPFAR** Presidential Emergency Funding for AIDS Relief
- **PER** Performance Expenditure Review
- **PHC** Primary Health Care
- **WBPHCOT** Ward Based Primary Health Care outreach Teams

Why PER on Ward Based Primary Health Care Outreach teams: CHWs

A health system lacking personnel for delivering the health services in a country is an ailing one, the irony in that is also worth noting. The inefficiencies in South Africa's health sector personnel continue to hold back health service delivery to the citizens, especially the poor. The World Health Organisation emphasises the importance of community based services delivered through the primary health care platform. The emphasis placed on strengthening primary health care (PHC) is driven by its propensity to reach many people at a local level. Greater resources are directed towards preventative health care and health education thereby preventing illnesses that is more costly to both the individual and the government. In this model of health care delivery, community health workers are recognised as a cadre that is fitting and convenient for acting as a bridge for communities to access health care. The government has committed to 'strengthening the effectiveness of the health system' by moving from a largely curative, high cost care model, to one that promotes cost-effective PHC services delivered in communities. The National Department of Health Re-engineering of PHC strategy is designed to facilitate this move. This strategy focuses on three components namely; School health services, district health specialist teams and municipal ward based primary health care outreach teams. For or the purpose of this PER only the Municipal Ward Based Primary Health Care Outreach Team[1] will be reviewed.

The National Development Plan 2030 and National Health Insurance White Paper firmly present the importance of establishing a sustainable and effective CHWs programme. Whilst the NDoH is delightful of having made an effort in developing Ward Based Primary Health Care Outreach Teams (WBPHCOT) and enforcing implementation in provinces and districts, there seems to be more that needs to be done. Research on CHW programmes in South Africa provides evidence of challenges faced by these programmes. Grievances have ascended from issues regarding poor administration of the programme, lack of financial resources, CHWs incentives, poor working conditions to the level of training given to CHWs[2]. The need to give this programme special attention arises from

[1] According to NDoH (2011) these teams consist of 6 community health workers, 1 professional nurse and 2 HBCG. This is often referred to as community health worker programme.

"Community Health Workers provide health education and referrals for a wide range of services and provide assistance and support to the communities, families and individuals with preventative health measures and gaining access to appropriate curative health and social services. They create a bridge between providers of health, social and community services and communities which may have difficulty in accessing these services." (*International Labour Organisation, 2008*).

[2] Nxumalo, N., and Goudge, J., (2013), Support Needed for Community Health Workers to Improve Access to Care: Lessons from three CHW programmes in South Africa. Policy Brief. *The centre for Health Policy: Health Policy and Systems Research.* University of Witwatersrand. Available, [Online], at: http://www.chp.ac.za/PolicyBriefs/Documents/CHP%20Policy%20Brief%20Community%20Health%20Workers%20NN%20final%20260813.pdf

empirical evidence of CHWs potential to decrease the cost of primary health care and improve access to care for those in remote areas. The NDP highlights that shifting life-saving tasks to lower cost personnel saves the health system money and saves as many lives. In developing strong ground for strengthening and enhancing financial resources towards this programme, it is important to review and analyse the baseline. This means that this PER will explore and analyse current policy and its implementation, by means of reviewing financial and non-financial performance of the programme.

There are three main areas that make up this PER. It is the logical framework, which intends to provide a logic understanding of planning and implementation of the programme; expenditure analysis, presenting the key cost drivers, demand and cost elements; and finally, the costing model and an aspect on the savings components. The costing model becomes important in influencing financial planning for the programme; it is presented as a proposal showing cost linkages, causality in cost-bearing elements aligned to the intent of the programme.

What seems to be the real challenge – Volatile Funding

There has not been a national policy covering community health workers and this has adversely affected the sustainability, efficiency and effectiveness of the programme. Ward Based Primary Health Care Outreach teams as adopted by the Minister of Health from the Brazil model, was introduced for implementation in South Africa in 2011. It reads as a good policy ready for implementation and producing effective outcomes. However implementation of the programme is not fully fledged mainly because of the financial challenges and management of the programme. The first phase of the implementation of this programme began in all provinces in areas identified as the neediest ones. According to the norms and standards for the policy; each ward in South Africa is meant to have at least one WBPHCOT which consists of 1 professional nurse (as a supervisor), six CHWs, and 2 home based care givers.

It is evident that financing this mandate is an issue. Funding opportunities differ per province, but there is one common source of funding and that is the Expanded Public Works Social Sector Grant. There are also grants from the HIV/AIDS programme and from non-governmental organisations. However these grants are time-bound and that there is no dedicated budget from the NDoH for this programme. This means that if a grant has come to an end there is a possibility for disruption of services. Hence this report asserts that funding for this programme is unstable and unsustainable. Despite these drawbacks, government and non-governmental grants are still important to this programme for continuation of service delivery. Budget line items are easy to develop, but it is the initial funding that is difficult to obtain.

WBPHCOTs Performance Challenged by poor development of the programme

It appears that the problem of effectiveness in these programmes has been obstructed by poor programme development and planning, inefficient and ineffective training, supervision, working conditions and monitoring and evaluation of this programme. One must note this; finances are one of the key factors underpinning this. This is impacting on the sustainability of the programme and service delivery.

About 703 WBPHCOTs were reported to have de-registered from the department, leaving 3158 teams registered; from this number, only 2879 are reporting to DHIS. Western Cape Province is not reporting to DHIS since their community health work is rendered by the NPOs and not the WBPHCOTs. However the NDoH has come up with ways in which these services can be reported to the department to keep track of what is happening in the province. The teams that de-registered were not functional, because they lacked the capacity to execute the tasks and meet all the norms and standards of this programme. For instance a CHW is not allowed to do visits without supervision from the Outreach Team Leader who is a professional nurse. One of the highlighted challenges is that some nurses do not have experience in community health work and some have declined to work in this type of setting.

Poorly developed Programme

One of the key findings is that there is no national policy on this programme. All that is out there is a draft policy, policy briefs and policy papers but no actual gazetted policy. This could also be one of the problems in the implementation of this programme. While it is clearly documented that this cadre has great potential to contribute to improving health outcomes, the performance of these people is hindered by a number of challenges. It is worth noting that one of the challenges in exploring and analysing the baselines of this programme is that administration services and reporting of this programme are very poor. This creates an issue in tracking the number of teams per province as well as the number of community health workers, the work they do, how they perform and the effectiveness of the work they do. One of the key areas that need to be strengthened is the management and administration of the programme. There needs to be a balance on the actual people who deliver the service to the end users and those that ensure that the workers are well capacitated and well-staffed for the work that needs to be done.

Training not standardised

Teams that are functioning and reporting have CHWs trained by the national department of health and their training is funded by the President's Emergency Plan for AIDs Relief (PEPFAR) funded

partners. Due to financial constraints faced by the government, many provinces are dependent on PEPFAR funded implementation partners. This is not sustainable enough for this type of a programme; hence there is a need for identifying potential areas where savings could be obtained and reprioritised.

A programme element like training of the CHWs and the supervisors is managed at the national level. NGOs that were previously providing training services for CHWs were told that NDoH will now take control of that. However it appears that not all CHWs have been trained according to the stipulations of the guidelines. Attributed to this is insufficient capacity of NDoH.

The limits of monitoring and evaluation

Most of the inputs, outputs, processes and outcomes were developed for the health department; the department only has overall inputs and outputs for the programme. It does not capture information on each programme element. That on its own illustrates that there is a problem with monitoring and evaluation (M&E) in this programme. It is not useful to monitor and evaluate comprehensively the district and the teams whereas policy development, planning, administration and training of the CHWs is done at the national level. It is equally important to monitor all activities and process that make up the entire programme at the national and provincial level. What has been observed is that the M&E system for this programme is an ailing one. Reporting on expenditure is lacking, even though financial performance is as important as non-financial performance since it informs the quality and level of service delivery.

Budget Structure (Refer to Expenditure annexure)

One of the key issues identified is the fact that the budget structure is not transparent. This has also been confirmed by the director of the programme from NDoH when he was interviewed on information regarding spending in this programme. He stated that there are issues with the budget structure and they are working on reforming it. Both national and provincial budget structures for this programme require improvement. This will allow one to monitor the spending of the programme and aligning that to the service delivery.

Salaries not standardised

The data explored shows that funding for this programme is mainly from the government. There are also organisations assisting certain provinces with the implementation of the programme and ensuring that the activities carried out are relevant to the policy stipulations. It was also found that implementation of this programme varies across provinces, in as much as there are national guidelines for directing implementers, the provincial strategies are different. This is also prevalent when one looks at the stipends of this cadre; for instance in Gauteng they are paid R2500 whilst in

provinces like North West they are being paid R1500. This is one of the major issues, in that there are no standardised salary scales for this cadre. There has been an outcry from the affected parties regarding this matter.

Analysis of the Logical Framework

In developing the logical framework and presenting the theory of change the main challenging factor was the fact that this programme is initiated and developed by NDoH, implemented by provinces, districts and the non-profit organisations, then the WBPHCOTs at the lowest level. To logically link work done by provinces and districts was a challenge. It was also a challenge to map out some of the activities because this programme does not have a stable and clear line of funding and implementation begins at the provincial level down to the sub-districts. In government it is said that 'function follows funding', in a case where this is not clear, it becomes difficult to link and observe theory of change in the process. Each activity/process, outcome, output is reliant on the other programme elements performance. Therefore it could be suggested that indicators be even set for another programme elements deliverables.

The logical framework developed presents the processes and inputs needed to ensure that there is fulfilment of what each programme element intends to bring for the entire programme. This is measured by the indicators for all the process stages. This is helpful in M and E since it allows for easy mapping of areas of improvement and areas that have great strengths. One must also note that failure of one programme element could have a knock on effect to the whole programme. Hence it becomes important to pay considerable attention in capacitating the responsible people for ensuring achievement of the outputs and outcomes of the programme element. In the reviewed programme, it has been observed that in the absence of a policy when initiating a programme, a lot of other things do not work well. Absence of the policy in this programme has led to poor development of strategies in implementing the programme, lack of uniformity among provinces and unavailability of stable and sustainable budget from the government. The NDoH is supposed to be driving the development of this programme; however, there are hurdles at that level, so one cannot hold provinces accountable for what is currently happening in this programme.

Analysis of expenditure items and patterns in the WBPHCOT programme

This has been the most challenging part of this PER. This is due to challenges encountered with collecting and compiling expenditure data. Attributable to this is what was mentioned in the previous paragraph on the obscurity of the budget allocation and hence expenditure as a whole. It is also apparent that this programme has a number of sources of funding; the list includes the EPWP

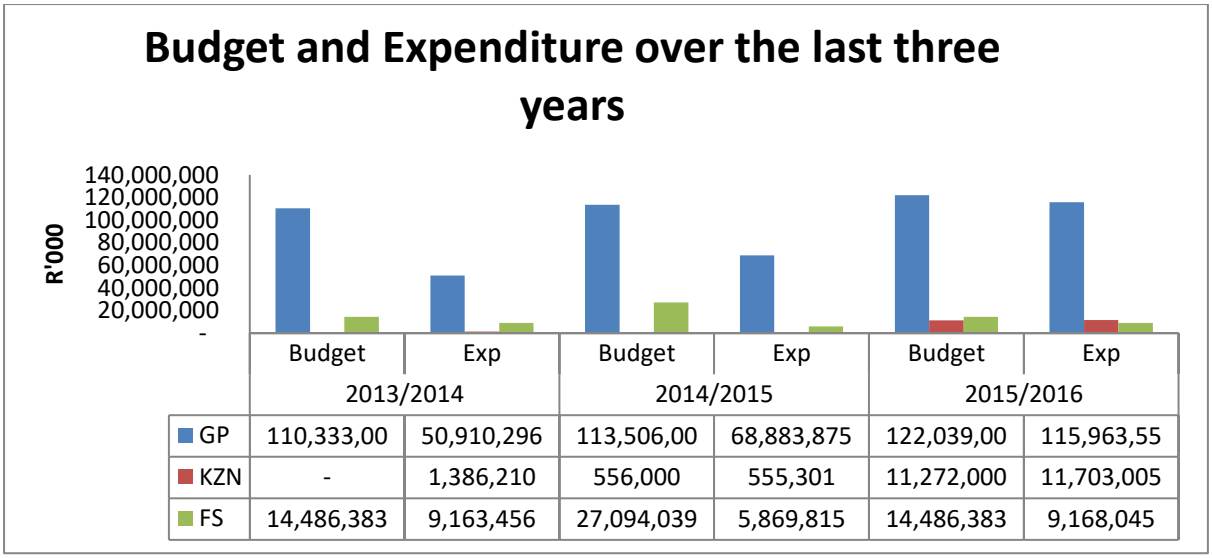
Social Sector Grant. The reports reviewed on the grant are vague in a manner that gives no picture of what is being spent on the stipends of CHWs. This again limits the exploration and extensive analysis of the expenditure for the programme.

As a result three provinces were used to analyse expenditure because they had clear budget structures that showed at least the main cost drivers and how money was allocated and spent. These provinces are Free State, Kwa-Zulu Natal and Gauteng. Analysis was done for the last three financial years, being 2013/2014, 2014/2015 and 2015/2016. One thing that should be noted when exploring this analysis is the fact that this programme is an unfunded mandate from the provincial perspective, expenditure is therefore limited. It is also mentioned that some of the expenses incurred under this programme are sometimes paid from other programmes and it is not easy to trace such expenditure. This makes it even more difficult to have a proper all-encompassing expenditure analysis.

Data found from these three provinces is what one would expect to see in a programme with no dedicated budget. The main cost driver is Compensation of Employees (COE) of CHWs.

In Gauteng and Free State COE accounts for 99.5% of the total budget allocation, which goes to the stipends of CHWs. In KZN 100% of the budget goes to COE. Other inputs of the programme do not have budget allocation, this also differs across provinces. KZN and Gauteng rely more on EPWP social sector grant, although Gauteng has Outreach and school services in objective level 6, but this was not used in this analysis since it is not clear how much goes into school health teams and outreach teams, consequently only the EPWP programme was used to do this analysis. Whilst in the Free State province this is different, the allocation and spending is not under the EPWP social sector grant. The Community health workers are clearly labelled in the responsibility segment. Even though this programme does not require extensive equipment and machinery, but there is required equipment for the CHWs to carry out the tasks delegated. Almost all the provinces have reported that their services are limited by the unavailability of basic essentials for them to perform their duties. This could be a budget issue or poor integration of CHWs in the health sector for them to be able to utilise facility equipment and basic things like gloves.

Figure1: The graph below presents expenditure and budget allocation over the last three financial years



	Budget	Exp	Budget	Exp	Budget	Exp
	2013/2014		2014/2015		2015/2016	
GP	110,333,00	50,910,296	113,506,00	68,883,875	122,039,00	115,963,55
KZN	-	1,386,210	556,000	555,301	11,272,000	11,703,005
FS	14,486,383	9,163,456	27,094,039	5,869,815	14,486,383	9,168,045

Spending pressures in Provinces why are there vast differences in expenditure totals?

Over the past three years Gauteng province has had a larger allocation from the EPWP Social Sector grant. This is because they have a high number of households and have had a high number of ward based outreach teams and CHWs. This has also enabled the province to have an allocation for goods and service, unlike the other two provinces that only has a budget allocation for the compensation of CHWs. Expenditure of Gauteng reached 56% of the total allocation for the year 2013/2014, the reason to this is unknown and Free State spent 63% of their total allocation. This is mainly because of the districts did not even spend a rand in this year. What is not clear is the fact that this district is recorded twice in the database for budget allocation. This could have been a mistake because it has happened consecutively over the last three years. This needs to be rectified. In 2013/14 the province of Kwa-Zulu Natal reported that they did not receive the EPWP social sector grant as a result they had to pay from their provincial share and put the CHWs in the provincial payroll. It was decided that these employees be paid from the sub programme: 'Other Community Services' until the grant was obtained from 2014/15 onwards. This is why there is no budget showing for this province in 2013/2014 under Community Based Services which is the programme in which the CHWs budget is recorded (see table below).

Table 1: Audited Outcomes

R thousand	Audited Outcome			Main Appropriation	Adjusted Appropriation	Revised Estimate	Medium-term Estimates		
	2012/13	2013/14	2014/15	2015/16			2016/17	2017/18	2018/19
1. District Management	218 582	217 300	230 547	238 592	250 041	250 788	289 975	292 643	318 637
2. Community Health Clinics	2 480 318	2 790 347	3 072 816	3 321 028	3 547 112	3 520 981	3 880 589	4 148 564	4 399 023
3. Community Health Centres	955 647	1 048 435	1 208 843	1 388 550	1 388 550	1 408 786	1 564 694	1 688 184	1 787 259
4. Community Based Services	790	-	2 580	13 000	13 000	26 289	40 000	32 000	34 726

In 2014/15 KZN spent 99.9% of their allocated budget of R556m however this figure, obtained from Vulindlela (R556m) is not consistent with the Audited outcome for 2014/2015. If one looks at the above table, the audited outcome was R2.5million. The reason to this is that expenditure for this programme was effected in the 'Other Community Services sub-programme'. It is not clear where the allocated money was spent. Vulindlela downloads and BASS downloads show nothing on this programme, no budget allocation no spending, yet the audited outcome presents R2.5m.

This structure of the budget allocation and financial injection affects deliverables of the programme. Investment on human resources alone is not enough. A programme would rather have 1 or 2 CHWs with all the necessary equipment required for performing the required tasks than to have 20 000 ineffective CHWs due to resource-limitation. This in reality is a waste, it limits service delivery, monitoring of CHWs and undermines the whole purpose of the programme of decreasing queues in the clinic, decreasing costs in clinics; most importantly saving lives of people and improving their health status. The aforementioned cannot be attained if the CHWs are not well capacitated with the necessary equipment and supplies. So some CHWs end up being paid for nothing. The number of teams has been growing very fast over the last two years which means growing number of CHWs.

Lack of uniformity in budgets for CHWs (Refer to Expenditure annexure)

What was also observed during the expenditure analysis is that the budget structure is not transparent, and consistent; basically lacks uniformity in all provinces. This was also confirmed by the director of this programme from the NDoH. This is attributable to different funding sources and lack of uniformity in the implementation of the programme. However it still requires special attention. Different provinces have different terminologies for this cadre which was also a challenge in tracing data in Vulindlela and BAS database.

One of the areas that must be improved on is financial reporting, focus is placed more on performance reporting since the CHW are monitored by their supervisor and they report monthly which is also not proving to be useful. There is no information on how the Non-profit organisations (NPIs) use the transfers. This became a stumbling block in exploring expenditure patterns and

expenditure items. It is not traceable how and if the administration fees are paid to the organisation or not.

Costing model analysis

Limitations

- Time constraints limited the amount of work that could have been done in this project and outcomes which could have been useful for the National Treasury and the health sector moving forward with policy decisions for this programme. However work started in this project will be continued with to enhance scope for informing decision makers.
- What is missing from this costing model is the costing of the impact of interventions implemented by CHWs compared to the facility service delivery. It would have been interesting to see how much the state could save by using community health workforce in promoting preventative measures than offering these services at the facility level which ends up being congested and unable to serve the whole population in need of services especially in rural areas.
- A comparison could have been made with the costs calculated in this costing model with the costs averted through the interventions implemented by CHWs. At this point the cost benefit analysis cannot be done since there isn't enough data for that type of work to be conducted.
- This programme lacks uniformity which has contributed to the variety of stipends since different provinces pay different stipends and even within provinces the stipends vary. Scenarios in the baseline had to be developed to ensure an exploration of a number of existing stipends for CHWs.
- Assumptions in the scenarios have not been measured with the current baseline and status quo of the communities' health needs, this is mainly because evidence of the current baseline is not sufficiently available, reporting for the NDoH is very poor. This has also limited further exploration of scenarios that could be more cost-effective.
- Due to time constraints and data limitation this model was unable to compare costs saved from using CHWs to deliver services to the communities and homes as compared to the costs incurred when services are delivered in the facility. Community health workers approach is argued to save health sector a lot of money if implemented well since it allows for shift of some services from the facility level to be delivered by CHWs; they also address the congestion of clinics.

Methods used for the costing model and questions answered.

The review of the programme implementation, the policy research done together with the logical framework provides enough information on what needs to be costed. The costing model has been designed to allow for exploration of different scenarios with different variables. It presents cost implications for different inputs for service delivery. It uses the Investment Case prepared by the NDoH and the Implementation guidelines for provinces. These documents are used to ensure alignment of policy intent to the costs that will be incurred in implementing this programme. The investment case suggests that 55 000 CHWs will be needed for full coverage of the population in South Africa. However this cannot be done in one year hence the costing model uses a phasing approach assuming a need per year. These are just general assumptions.

The costing model intends to answer the following questions:

- How much does it cost to employ 10000-60000CHWs using different salary scales, namely the farm worker scales, EPWP scales, DPSA level 1 scales, Domestic Worker scales?
- Can the CHWs be civil servants or NGO based?
- The costs of supervision
- Cost for part-time and full-time working CHWs?
- How much will it cost in the 2017/2018, 2018/2019, 2019/2020 years and for the total MTEF?

The main costing worksheets

- Phasing – This is the main sheet, demand variables and assumptions for cost related to the employment and supervision of CHWs
- Summary of total costs

The NDoH has developed a costing model for the WBPHCOTs in their draft investment case. The assumptions are based on the methodology used in prioritising areas, this takes into consideration the disease burden and poverty level of the area. The number of teams needed and the personnel figures is based on that scrutiny. The costing model uses four scenarios demonstrating possible costs to be incurred for compensating 10 000-60 000 CHWs. Assumptions are also made on an increasing number of CHWs as phasing takes place in the next three years.

Costing model outcomes

The scenarios are based on inputs changeable in the base scenario. The supervision scenarios are based on demand assumptions for an identified number of CHWs. A norm of 2:6 is used. This analysis uses the numbers highlighted in blue as the baseline for comparing with the scenarios

developed. However in the costing model attached, these are changeable for exploring other scenarios.

The base scenarios

Table 2: CHWs remuneration

CHWs current wages

Year	16/17	17/18	18/19	19/20	Total MTEF
Number of CHWs	20 000	30 000	40 000	50 000	
Wages pm	2 000	2 142	2 288	2 441	
Unit cost pa	24 000	25 704	27 452	29 291	
Cost R'000	480 000	771 120	1 098 075	1 464 557	3 333 752
Additional Funding/savings	-	291 120	618 075	984 557	1 893 752

Table 3a: Supervision

Enrolled / Professional Nurse - CHWs' supervisors

Years	16/17	17/18	18/19	19/20	Total MTEF
Number of supervisors	3 333	5 000	6 667	8 333	
Salary pm	14 405	15 428	16 477	17 581	
Unit cost pa	172 860	185 133	197 722	210 969	
Cost R'000	576 200	925 665	1 318 147	1 758 079	4 001 892
Additional funding/savings		349 465	741 947	1 181 879	2 273 292

Figure 1 is the base scenario all the scenarios are compared to this scenario. The areas highlighted in blue have a drop-down for exploring other scenarios. 2016/17 is used as the base year however one will notice that there is a drop down for changing the no. of CHWs and the wages pm, this is mainly because there is no uniformity in the payment of stipends currently. The number of CHWs is not known, those who are currently working in the WBPHCTOs and the others. It is therefore important to have all the numbers assumed by different appraisals done in this field. Logically, if the number of CHWs increases, the costs increase. The increase in costs is driven both by inflation and the increasing number of CHWs. The scenarios that follow use the same pattern as the base scenario however additional/savings amount is derived from comparing the scenarios to the base scenario.

Table3b: Summary of CHWs stipends costing, if the baseline is R2000 (Scenario 1 is Full-time and scenario 3 is part-time).

	Scenario 1					Scenario 3				
	16/17	17/18	18/19	19/20	Total MTEF	16/17	17/18	18/19	19/20	Total MTEF
Farm Worker scales	R 666 919	R 1 071 406	R 1 525 682	R 2 034 878	R 4 631 965	R 430 954	R 430 954	R 985 874	R 1 314 909	R 2 731 736
EPWP Scales	R 567 792	R 912 158	R 1 298 913	R 1 732 425	R 3 943 496	R 264 970	R 425 674	R 606 159	R 808 465	R 1 840 298
Domestic Worker Scales	R 535 368	R 860 069	R 1 224 738	R 1 633 494	R 3 718 301	R 344 736	R 553 818	R 788 637	R 1 051 845	R 1 840 482
DPSA scales	R 1 561 320	R 2 508 261	R 3 571 763	R 4 763 839	R 10 843 863	R 1 171 020	R 1 881 244	R 2 678 891	R 3 572 971	R 4 799 353

Table3c: Summary of Supervision Scenarios if nurses are incentivised with R2000 for supervising full-time CHWs and R1000 for supervising part-time CHWs.

	Scenario 1				
	16/17	17/18	18/19	19/20	Total MTEF
	Scenario 1				
Supervision Cost	R 160 000	R 255 841	R 363 459	R 483 826	R 1 103 126
	Scenario 2				
Supervision Cost	R 80 000	R 127 921	R 181 730	R 241 913	R 551 563

Considering the current fiscal state of the country it is not financially feasible to employ CHWs at DPSA level one salary scale. From all the explored scenarios it is evident that the part time scenarios will save the state millions of rands, from a CHW perspective and supervision. At this point, where the interests of this cadre and end-users of services takes important position in devising effective strategies, the principle of cost-effectiveness needs to be applied.

If one uses the baseline of R2000 stipend for CHWs There is no money that can be saved from the full time scenarios however money can be saved from the stipends of CHWs. It is only if one goes down to the baseline of R1000 where savings can be realised.

Savings and trade-offs: moving towards cost effective measures for efficiency and effectiveness

Since the design of the costing model can be easily manipulated and is flexible for exploring different options, it has allowed identification of potential savings.

Below is the summary of the scenarios where savings can be seen (The narrative refers to these tables)

Table4a: farm worker salary scales scenario with supervision

FW&S					
	16/17	17/18	18/19	19/20	Total MTEF
Scenario 1 (Full-time CHWs, Part-time Supervisors)					
Total Cost R'000 pa	R 826 919	R 1 327 247	R 1 889 141	R 2 518 704	R 5 735 092
Additional funding/(-savings)	-R 229 281	-R 369 538	-R 527 081	-R 703 932	-R 1 600 552
Scenario 2 (Part-time CHWs, Part-time Supervisors)					
Total Cost R'000 pa	R 510 954	R 820 248	R 1 167 603	R 1 556 822	R 3 544 673
Additional funding/(-savings)	-R 545 246	-R 413 705	-R 589 545	-R 786 775	-R 1 790 025

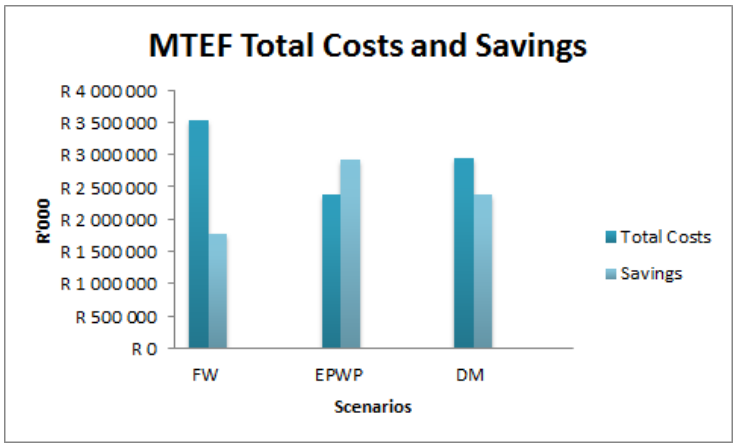
Table4b: Domestic Worker Salary scales scenario with supervision

DW&S					
	16/17	17/18	18/19	19/20	Total MTEF
Scenario 1 (Full-time CHWs, Part-time Supervisors)					
Total Cost R'000 pa	R 695 368	R 1 115 910	R 1 588 197	R 2 117 320	R 4 821 427
Additional funding/(-savings)	-R 360 832	-R 580 875	-R 828 025	-R 1 105 316	-R 2 514 217
Scenario 2 (Part-time CHWs, Part-time Supervisors)					
Total Cost R'000 pa	R 424 736	R 681 739	R 970 367	R 1 293 758	R 2 945 864
Additional funding/(-savings)	-R 631 464	-R 552 214	-R 786 782	-R 1 049 839	-R 2 388 834

Table4c: Expanded Public Works Programme salary scales scenario with supervision

EPWP&S					
	16/17	17/18	18/19	19/20	Total MTEF
Scenario 1 (Full-time CHWs, Part-time Supervisors)					
Total Cost R'000 pa	R 727 792	R 1 167 999	R 1 662 372	R 2 216 251	R 5 046 622
Additional funding/(-savings)	-R 328 408	-R 528 786	-R 753 850	-R 1 006 386	-R 2 289 022
Scenario 2 (Part-time CHWs, Part-time Supervisors)					
Total Cost R'000 pa	R 344 970	R 553 594	R 787 889	R 1 050 378	R 2 391 861
Additional funding/(-savings)	-R 711 230	-R 680 358	-R 969 260	-R 1 293 219	-R 2 942 837

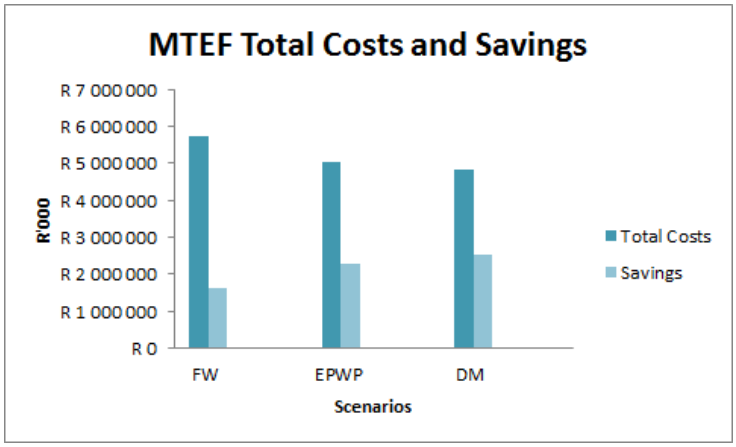
Figure 2:



Above is a graph showing the amount of costs to be incurred in the Total MTEF period, phasing the number of CHWs as shown in the base scenario. Savings come solely from supervision. There are no savings from all the scenarios in CHWs remuneration; the costs are even more than the baseline of

CHWs earning R2000. DW scenario is leading on savings with R2.5billion, EPWP R2.3billion and FW R1.6billion.

Figure 3: Scenario 2 (Baseline of R2000 stipend, phasing from 2017/18, 2018/2019 and 2019/2020)



This scenario is part-time based. Savings on CHWs stipends using the baseline of R2000 for Stipend can be realised from all the scenarios. EPWP is showing R2.9billion of savings followed by DW scenario showing R2.4billion and FW showing R1.8billion of savings.

Rather than having 1 full-time supervisor for the whole team why not have 2 supervisors working in shifts to supervise CHW S., either part-time or full-time CHWs.

Trade-offs

It is clear in this model that employing CHWs at a part-time basis is less costly compared to full-time rates. This is also true for supervisors, the Investment case assumes that each team needs one supervisor, so six CHWs need 1 supervisor who is full-time. However through this model it is recommended that there be two supervisors per team, and they must be part-time. This entails that the nurses from the facility will spend 50% of their daily time in the facility and 50% in the field (supervising the CHWs). It is assumed that by using nurses from the facilities the only costs that could be incurred is an incentive to top-up their salaries for doing community service in supervising CHWs. Evidence from discussions with the province of Kwa-Zulu Natal province suggests that the WBPHCTOs are experiencing nurses not wanting to supervise CHWs. Through this model it is recommended that giving them an incentive for doing this type of job would motivate them to agree in supervising CHWs and save the state millions of Rands and there is no need to employ NEW nurses to do this job. This will save the state millions of Rands. This practice is traceable in Brazil; this is the same country where the Minister of Health adopted the WBPHCTOs model for community health work. This approach is cost effective.

Conclusion and Recommendations

Conclusion

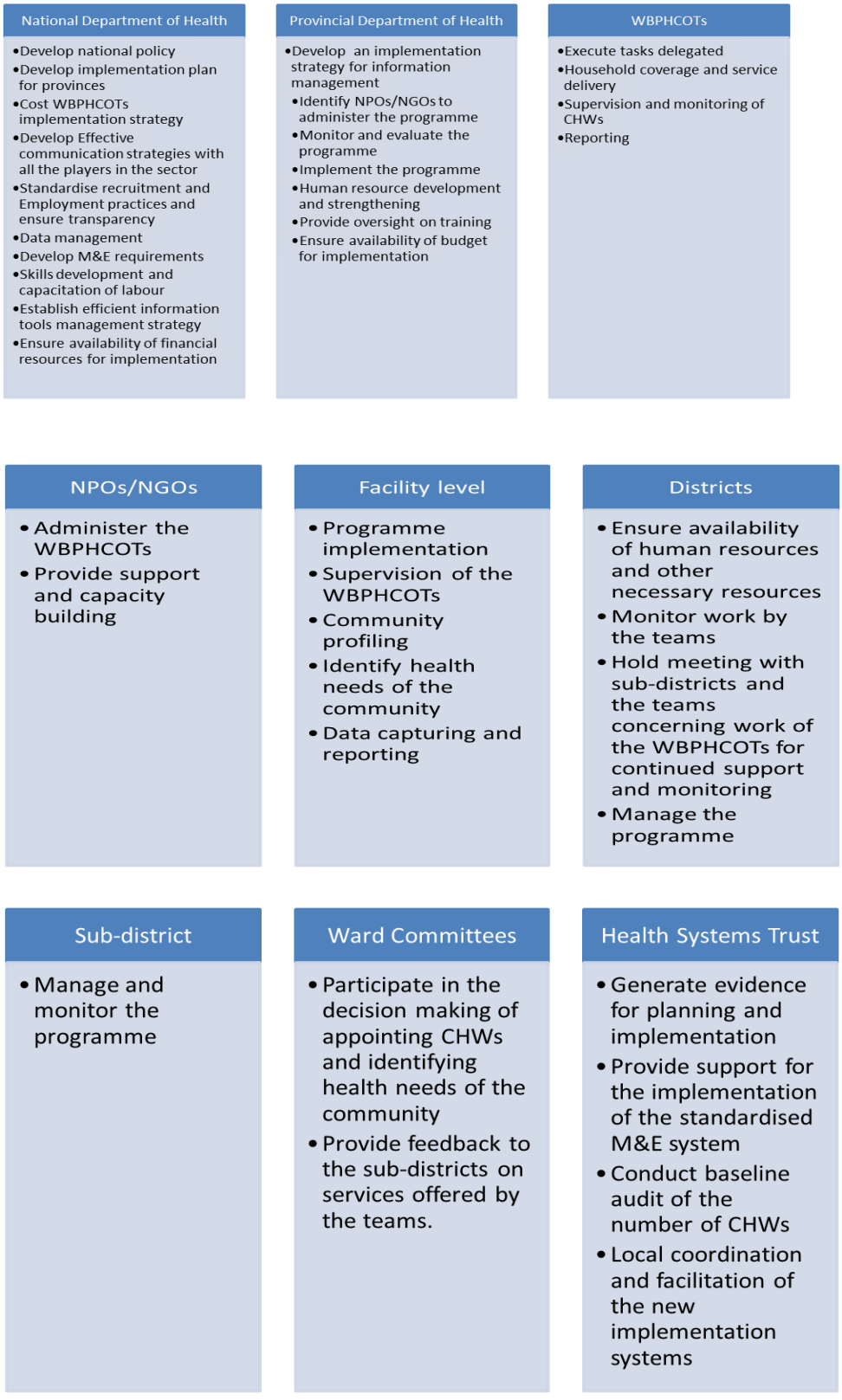
Community health workers programme in South Africa has been existing for a long time and to this point, it not clearly known what their roles are and what they are doing. This has made the ultimate goal of this project unobtainable since there is insufficient evidence of what is currently happening in this programme. This is highly attributable to the inefficient M&E system and reporting as a whole. The NDoH stated that they are working on addressing the issues of tracing evidence, and obtaining the baseline numbers of CHWs and the work they do. The way in which the demand of the CHWs was measured, is questionable. Hence at this point it is important that a more detailed analysis and research be done to measure the need to allow credible assumptions to be developed in costing this programme. The costing developed for this programme can be changed to explore different scenarios should new information be available for demand variables. But a draft investment case from the department of health was used to estimate the costs. Time constraints and resources limited research that needs to be done for this type of work, especially for such a complex and complicated programme. The main problems identified in this programme were lack of evidence of the baseline and volatile funding.

Recommendations

It has been presented quite a number of times in the report that there is no clear evidence of what is currently being done by the CHWs, how many they are, the demand and what their roles are. This write-up recommends standardisation of roles of this cadre. It is true that CHWs roles can also overlap to the social services since these two are interrelated, this has happened in the past for South Africa where the health sector and social development worked together in implementing CHWs programme. Perhaps redefining the CHWs roles could bring back an integration of the roles addressing social needs and health needs of the people. This could also address the budget pressures as allocation for funding this programme could be voted for, by the both departments hence addressing the issue of funding.

Annexures

Programme Elements



Sources used for this PER

- WBPHOCTs policy
- Toolkit for Implementation of WBPHOCTs
- Estimates of the Provincial Revenue and Expenditure (EPRE)
- Provincial audit reports
- Newspaper articles
- Human Resources for Health
- South African Medical Journal
- Rural Health Advocacy
- Google Scholar
- Health System Trust
- BAS database
- Vulindlela database
- Minutes from IGR provincial visits
- DoH website
- DPW website
- Draft Investment Case for Ward Based Primary Health Care Outreach Teams