



SUPPORTING THE EARLY
CHILDHOOD WORKFORCE AT SCALE

Community Health Workers and the Expansion of First 1000 Days Services in South Africa

EARLY CHILDHOOD WORKFORCE INITIATIVE

The Early Childhood Workforce Initiative (ECWI) is a global, multi-sectoral effort to mobilize countries and international partners to support and empower those who work with families and children under age 8. This initiative is jointly led by Results for Development (R4D) and the International Step by Step Association (ISSA), and supported by a consortium of funders including Bernard van Leer Foundation, Open Society Foundations, ELMA Foundation, and Jacobs Foundation.



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Executive Summary

INTRODUCTION

There is increasing awareness of the environment and suite of services that young children need for an optimal start in life, and many of these services support the mother and family before the child is born. Early nutrition, care, and stimulation can significantly impact children's lifelong development.¹ All parents and caregivers, especially the most vulnerable, can benefit from additional information and support to enhance their capacity to provide responsive care. Increasing access to a variety of integrated services spanning health, social development, and education that are delivered by a qualified and supported early childhood workforce are necessary to empower and enable parents to support the optimal development of their children.

It is with this holistic and multi-sectoral lens that The Early Childhood Workforce Initiative (ECWI), led by the International Step by Step Association (ISSA) and Results for Development (R4D), aims to support and empower those working with young children and their families. Through ECWI, R4D is carrying out a series of country studies focused on the experiences of a particular workforce role and ways to support and strengthen that role at the policy level. This study, the third in the series, looks primarily at the role of the Community Health Worker in providing supportive health, nutrition, parenting, and stimulation services to young children and their families in South Africa.

The National Integrated Early Childhood Development Policy (NIECDP) (2015) is an important step in South Africa's shift from a health system focused on curative, disease-based services to one based on prevention and health promotion. The NIECDP identifies a comprehensive vision of early childhood development (ECD) services to be delivered by 2030, seeking to strengthen and integrate these services across all government departments. While recognizing the

Department of Health's Community Health Workers (CHWs) present role in providing supportive health and nutrition services, the NIECDP envisages these CHWs playing a significant, and expanded, role in strengthening overall maternal and child developmental outcomes by providing parenting support and opportunities for early learning and stimulation through additional home visits and community-based activities for families and young children through the age of two, commonly defined as part of first 1000 days services. The evolving role of the CHW in ECD services is set against the backdrop of continued Primary Health Care Re-engineering efforts.

South Africa's CHWs are increasingly providing first 1000 days services, yet the road to implementation varies by province.

RESEARCH AIMS AND METHODOLOGY

This study is intended to provide insight into how the Department of Health is endeavoring to implement the NIECDP, with particular focus on the role of CHW. It examines the experience of two provinces and aims to consider the implications for service delivery across the country, as well as provide recommendations to enable, prepare and support the CHW workforce to deliver on this expanded suite of early childhood services. Given that many countries are considering

¹ Yoshikawa, H., & Kabay, S.B. (2015). *The evidence base on early childhood care and education in global contexts* (background paper for the Education for All Global Monitoring Report 2015). Paris: UNESCO.

expanded roles of para-professionals such as CHWs, it is also hoped that this study will contribute further to the knowledge base around delivering integrated health and development services for young children across a range of contexts.

The team employed a mixed-methods approach including a review of the literature, followed by in-depth interviews and focus group discussions with key stakeholders at the national, provincial, and local levels to address three primary research questions:

1. What is the status of implementation of the first 1000 days services in the NIECDP by the Department of Health?
2. What are the barriers and opportunities for the Community Health Worker to deliver the first 1000 days services outlined in the NIECDP?
3. What lessons can be drawn from their experience?

PARA-PROFESSIONALS IN EARLY SERVICES

Especially in the first 1000 days, there is an opportunity for health departments, as the primary point of contact for families and very young children experiencing change and growth, to take the lead in ensuring comprehensive interventions that support the five critical domains of nurturing care.² As global focus shifts towards the potential of community-based caregivers to address inequitable health systems and aid countries' drive towards universal health coverage (UHC),³ there is increasing belief, and evidence that, well-supported para-professionals, including CHWs and other home visitors, can be effective partners in delivering these services.

HEALTH SYSTEM CONTEXT

In 2011, the Government of South Africa initiated Primary Health Care (PHC) Re-engineering, an overhaul of the health system meant to be a step towards improving health outcomes, including poor infant mortality rates and child health indicators, and towards realizing the MDGs. Services would be strengthened through the provision of a population-based approach rooted in the electoral wards, rather than a more vertical approach.

Each Ward-based Primary Healthcare Outreach Team (WBOT) should be linked with the local health facility and include six to ten Community Health Workers (CHWs) under the leadership of an enrolled nurse⁴ who manages and supervises the services. CHWs serve as the primary point of contact for the population, tracking and addressing basic health concerns and making referrals to facility-based services.

CHWs provide a broad range of services in the home and community setting, including health promotion and prevention information on maternal and child health (immunization and vitamin supplementation), HIV, TB, and chronic diseases. They also provide treatment adherence support, general counselling, and basic first aid, and make health referrals for additional services. Each CHW is assigned approximately 250 households (varies based on geography, density, and burden of disease) per annum;⁵ however, there is limited information about the specific set of services CHWs provide, the time each service takes, and the relative quality of service provided.⁶ While as many as 72,000 community-based workers have been identified in South Africa, their training, skills, and functions vary considerably, resulting from their experience as predominately auxiliary workers trained and employed in vertical programs (e.g. TB, HIV/AIDS, etc.) to provide home-based care to the ill or infirm.⁷

In the ensuing years, the nine provinces have made considerable progress towards establishing WBOTs and community-based services in line with PHC

² Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vaivada, T., ... & MacMillan, H. (2017). Nurturing care: promoting early childhood development. *The Lancet*, 389(10064), 91-102.

³ Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annual review of public health*, 35, 399-421.

⁴ In the 2018 Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams (WBOT Policy Framework), the Outreach Team Leader (OTL) was changed from Professional Nurses to Enrolled Nurses who have been oriented to community health nursing. However, there are insufficient numbers of trained Enrolled Nurses, and teams are commonly led by un-trained Enrolled Nurses. The team is to consist of one OTL, 6-10 CHWs, and one data capturer.

⁵ National Department of Health (2018). Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/19 - 2023/24. Pretoria.

⁶ Daviaud, E. & Besada, D. (2017a). Resource Requirements for Community-Based Care in Rural, Deep-rural and Peri-urban Sub-districts: A comparative analysis in 2 districts In Gauteng and KwaZulu-Natal. Medical Research Council, South Africa.

⁷ National Department of Health, 2012. Annexure B1. Human resource requirements for re-engineering primary health care in South Africa.

Re-engineering. In particular, the CHW home visits have extended care to rural, remote, and otherwise marginalized populations while alleviating pressure on the formal health facilities, and increasing focus on social determinants of health.⁸ However, a series of recent evaluations,⁹ including a rapid appraisal of the WBOT model in National Health Insurance (NHI) pilot sites across seven provinces,¹⁰ found full implementation to be hampered by significant challenges integrating the WBOTs into the formal health system and identifying appropriately qualified and trained staff, as well as other financial and operational issues that should be considered in light of the NIECDP and evolving role of the CHW.

THE NATIONAL INTEGRATED EARLY CHILDHOOD DEVELOPMENT POLICY (NIECDP)

The 2015 National Integrated Early Childhood Development Policy (NIECDP) established a multi-sectoral framework for ECD services, defined a comprehensive national program with essential components, identified responsible government departments and partners, and sought to create a national office and coordination structure for ECD.

The Department of Health (DoH), with its existing ward-based and CHW footprint in the community, serves as the primary support and health and nutrition service provider for pregnant women, new parents, and children under age two. Under the NIECDP, the DoH is now responsible for new core services for the first 1000 days, such as providing parenting support programs and opportunities for learning and play for very young children in the home and community or group setting. The NIECDP stipulates that these services are to be provided by the CHWs and Health Promoters within the WBOTs. While the NIECDP describes the overall domains of care that can support families and young children, it does not define specifics related to the services CHWs are to provide, frequency, topic areas.

PROVINCIAL CASE STUDIES

The two provincial case studies focused on the experience of the Western Cape (WC) and KwaZulu-Natal. The provinces not only have differing contexts and organizational models for their community health services, they are also at differing points along the implementation pathway; this diversity was intentional as it allows for the documentation of valuable lessons that may be more broadly applicable to the National government and other provinces.

WESTERN CAPE OVERVIEW

The Western Cape Government Department of Health (WCG DoH) has a long-established model of contracting with non-governmental organizations (NGOs) to deliver health and wellness services, including CHW services. The Western Cape has made significant progress laying the groundwork that will enable it to implement an expanded service package through CHWs focused on the first 1000 days and consistent with the NIECDP. Notably, the province has established a widespread campaign, the First 1000 Days Initiative and started to align their 2017/18 Service Packages for NGO Funding with the Initiative.

KWAZULU-NATAL OVERVIEW

CHWs in KZN are known as Community Care Givers (CCGs) and form the backbone of the community and household level services in the KZN Department of Health (KZN DoH); KZN is also one of the few provinces that employs the CCGs through the DoH (although they remain short-term contractors). As in other provinces, CCGs form a key part of the Ward Based Outreach teams (WBOT); however, while each CCG is responsible for fewer households (60), there are more CCGs per team (15) and teams are led by both a Professional Nurse (PN) and an Enrolled Nurse (EN) based at a health facility.

To date, KwaZulu-Natal has primarily focused on improving child survival. But, while many of KZN's initiatives focus on health and nutrition, the province is starting to take a more holistic view of children's health

⁸ Jinabhai, C. C., Marcus, T. S., & Chapona, A. (2015). Rapid appraisal of ward based outreach teams.; Marcus, T. S., Hugo, J., & Jinabhai, C. C. (2017). Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa. *African journal of primary health care & family medicine*, 9(1), 1-8.; Sodo, P., & Bosman, A. (2017). Progress of the municipal ward-based primary healthcare outreach teams in Vhembe, Limpopo Province. *Strengthening Health Systems*, 2(1), 18-22.; Austin-Evelyn K, Rabkin M, Macheke T, Mutiti A, Mwansa-Kambafwile J, Dlamini T, et al. (2017) Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa.; Schneider, H., Schaay, N., Dudley, L., Goliath, C., & Qukula, T. (2015). The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, South Africa. *BMC health services research*, 15(1), 436.

⁹ Marcus et. al. (2017); Sodo and Bosman, (2017); Austin-Evelyn et. al. (2017); Schneider et. al. (2015).

¹⁰Jinabhai et. al. (2015).

Lessons drawn from the Provincial implementation experience

Western Cape	KwaZulu-Natal
<ol style="list-style-type: none"> 1. There is broad support for expanding first 1000 days services, but additional policy clarity is needed from NDoH to begin meaningful implementation. 2. Management capacity and monitoring and evaluation systems are essential to NGO service delivery models 3. System strengthening can be achieved by leveraging high-performing NGOs to support weaker ones or contracting NGOs to delivery specialized services. 4. Training and supervision remain central to the ability to provide comprehensive, high-quality services and should be enhanced. 5. A broad-based initiative such as the First 1000 Days Initiative in the Western Cape can help establish a multi-sectoral platform for services and enhance visibility of key topics. 	<ol style="list-style-type: none"> 1. Integrating CHWs (CCGs) into the formal health system facilitates training, communication, and service targeting. 2. Ensuring clear career pathways can facilitate service delivery and improve overall system functioning. 3. Providing additional training on reflective supervision will enhance the capacity the of the CCG supervisor and support the delivery of first 1000 days services 4. KwaZulu-Natal can further leverage War Rooms and maternal and child health initiatives already in place to strengthen first 1000 days services. 5. The lower number of households served per CCG may allow for more intensive and additional forms of support to families and children in the first 1000 days.

and well-being, as evidenced by the Ibhayi Lengane pilot in association with Ilifa Labantwana, which is a relationship-based support tool specifically for the first 1000 days that emphasizes the love, play, and support. The lessons above highlight the Province's progress and how they can continue to drive towards more comprehensive first 1000 days services and positive outcomes for families and young children.

FINDINGS

Based on data collected during interviews and focus group discussions at the provincial and national levels, including a consultation with five provincial CHW coordinators, the following key findings were identified:

1. There is broad support for strengthening first 1000 days services, but limited awareness of the NIECDP

Across stakeholders, there was strong support for further strengthening first 1000 days services and widespread recognition that interventions for children under age two have can have a significant impact on persistent challenges such as infant mortality, malnutrition, and stunting. These services were also seen to be in line with the health system's broader shift towards a life-course approach in the health system.

Awareness and understanding of the NIECDP varied significantly. At the national level, all interviewed stakeholders were familiar with the NIECDP and the role of the DoH, and perceived the Policy as strengthening their existing package of services, rather than a new set of responsibilities and services. This, in part, sheds light on why any implementation has

been quite tightly bound to the existing health and nutrition services, rather than focused on incorporating comprehensive caregiver support, improving parent-child attachment, or opportunities for play and stimulation.

At the provincial and sub-national levels, awareness of the NIECDP is somewhat limited. Provincial leads expressed knowledge of the policy, but during a consultation with CHW Coordinators of five provinces, including representatives from the Western Cape and KwaZulu-Natal, no-one reported being aware of the policy, despite its impact on their services and the workforce for which they are responsible.

2. There is no standard service package for the first 1000 days and limited technical capacity has led to continued reliance on health, nutrition, and growth monitoring services.

The effectiveness of first 1000 days service implementation is contingent upon a shared understanding and further elucidation of the services noted in the NIECDP and the resulting expectations for CHWs. According to nearly all stakeholders interviewed, there is clear need to further define not only the package of services and their priority level, but also for NDoH to provide additional guidance as to how progress by provinces will be assessed, including frequency and quality of services and outcomes will be measured.

However, there was some recognition that the DoH (across levels) lacked technical capacity and resources to translate the NIECDP into a defined package of services that could be widely implemented. For instance, there was support for the concept of providing caregiver support to vulnerable populations

like teenage mothers, but less discussion about what that support entailed, what the key messages were, or how to engage with parents and empower them to provide responsive care for their children. Without a better understanding of how holistic child development can be supported and the relationship-based techniques underpinning these services, guidance from NDoH is likely to remain centered on health and nutrition.

Moreover, there are inherent challenges to designing an implementable service package when the Maternal, Women's and Child Health division is responsible for ECD (and the Road to Health Booklet), but the Primary Health Care division is responsible for the CHWs. Stakeholders noted that there were competing interests and service objectives as a result of this structure. Defining a comprehensive service package will require additional coordination and alignment between these divisions, as well as consultation with and support from the Department of Social Development, NGOs and experts in the field.

3. Tension between expanding CHW roles and simplifying them presents a significant challenge to implementation.

Despite recognizing the value in an expanded set of first 1000 days services, CHW Coordinators noted that the expanded parental support and stimulation tasks outlined in the NIECDP may extend beyond the scope of the CHW role and run counter to the prevailing aim to simplify the CHW role. Furthermore, as the NIECDP implementation is unfunded, the very practical challenge of adding new services without new resources or significant guidance on resource re-allocation, remains.

Currently, there are no defined parent support or early learning responsibilities in the draft 2016 WBOT CHW scope of work, only a generic provision to "provide extra support for healthy behaviors during early childhood, including exclusive breastfeeding," which has been interpreted to be more connected to child health than to development support. One NDoH stakeholder noted that the CHW scope of work will remain broad, and once the training is developed, competencies related to maternal and child health, parental support, and child development to guide practice will follow.

4. Ongoing implementation challenges of primary health care reforms stunts the implementation of first 1000 days services.

Despite progress, implementation of PHC Re-engineering has been hampered by human and financial resource constraints that negatively impacts the provinces' ability to extend first 1000 days services.

Many provinces have had trouble adequately staffing the WBOT model, resulting in service gaps or providers without appropriate training. This includes at the team leadership level where enrolled nurses were often substituted for professional nurses, but not provided the specific training to supervise or manage CHWs (who are often employed by external NGOs). Low pay, and in some cases, high education expectations, further narrows the CHW candidate pool and results in high turnover.

The conceptualization of the WBOTs as outreach services, separate from the formal health system and without dedicated funding presents an on-going challenge. The NDoH-commissioned Investment Case¹¹ and the 2018 WBOT Policy Framework are intended to assist Provinces in their discussions with the Treasury and to secure needed funding for the WBOT platform rather than solely in vertical health programs (e.g. HIV/AIDS care). However, the fact that resources are needed to provide *existing services* makes it that much more difficult to envision that any *additional* funding, above and beyond the current needs, will be allocated for CHWs to deliver expanded first 1000 days services.

5. Enhanced, aligned, and on-going training and supervision at all levels, with a focus on developing supportive relationships and understanding child development, is still needed.

Stakeholders need additional training once the package of first 1000 days services is defined, recognizing that training is needed at all levels of the health system to ensure continuity of care and to provide support and increase understanding of the CHW role. On-going training would allow for skill-building over time,¹² which would also mitigate the risk that services would be "checked-off" for the sake of compliance. Commendably, there are currently efforts to streamline and revise the CHW training content and process, alongside the NDoH 2018 WBOT Policy Framework.

¹¹ Daviaud & Besada (2017b). Saving lives, saving costs: Investment Case for Community Health Workers In South Africa. What costs and what benefits For the health sector, for the economy and For society. Prepared for the National Department of Health. Medical Research Council, South Africa.

¹² Putcha and Mitter (2017).

However, there are concerns that the training review is being conducted without the full participation of the Maternal, Child and School Health Directorate, which may result in less emphasis on ECD messaging and services that would be critical to the implementation of first 1000 days services. The development of a comprehensive, core curriculum would be beneficial to further align training across the provinces, regardless of how they provide community-based services.

While supervision plays a key role in ensuring sustainable and quality services, especially when expanding services, it has not been adequately addressed across the provinces. Excessive supervision responsibilities, staffing challenges, and non-existent reflective or supportive supervision training for CHW supervisors often results in supervision that is overly compliance-based and focused on service planning. Furthermore, there is limited practical managerial training for CHW supervisors, or peer development practices and mentorship opportunities for CHWs.

6. Coordination within and across sectors is an essential element in raising awareness of and expanding FTD services

Regardless of variation in models and status of implementation, there is a need for strong multi-sectoral coordination in order to expand first 1000 days services. The efforts of the two examined provinces, which have pursued different implementation and contracting modes, highlight the need for intentional collaboration across sectors, particularly across the Departments of Health, Social Development, Education, and Home Affairs. While both provinces have platforms for inter-sectoral coordination, and stakeholders recognize the need to work more closely with other departments, the next step will be to effectively leverage – and likely adjust and improve their respective platforms – to provide comprehensive services in the first 1000 days.

RECOMMENDATIONS

The following recommendations are intended to support the expansion of the first 1000 days services; however, implementation relies on a strong community-based system. Other efforts to address several WBOT implementation challenges will provide the conditions for an integrated first 1000 days program with far-reaching impact. However, for this to occur, the National Treasury will very likely need to allocate additional resources. The NDOH and

investment cases in development should inform this disbursement.

1. Define the baseline package of first 1000 days services and clarify the role of the CHW.



► Target Audience: National Department of Health

The NDoH should provide additional policy and programmatic clarity on the package of services and the role of the CHW or other health worker in their delivery.

- Doing so should serve to highlight the focus is not just survival.
- Doing so will enable the provinces to assess their current service packages and workforces against the National standard, diagnose gaps, and make informed plans to invest in and strengthen services, thereby enhancing the likelihood that they meet the 2024 and 2030 targets laid out in the NIECDP.
- In the absence of a defined service package and role, guidance on the appropriate number, timing, content of the visits, or indicators used to measure service quality and outcomes, provinces cannot engage in functions critical to the success of NIECDP implementation, such as costing and human resource planning.

2. Develop competencies and training aligned to the first 1000 days service.



► Target Audience: National Department of Health, Provincial Departments of Health

Once a service package is defined, NDoH should develop corresponding core training modules, which allows for continuous skill development and competency attainment. Training should include all aspects of nurturing care – in addition to health and nutrition; help practitioners to support caregiver behavior change through reflection, modeling, and coaching; be offered regularly; and be defined for all members of the WBOT, especially supervisors.

There are three training opportunities in the near-term that should be considered:

- Immediate term: NDoH and the provinces should ensure that all WBOT and facility-based providers receive training on the revised Road to Health Booklet, while emphasizing the expanded child development and engagement messages.

- Short-term: Provinces should identify vulnerable populations and provide additional training to CHWs and supervisors on maternal and family support and child development in those identified areas.
 - Provinces could potentially leverage support from the Department of Social Development, or contract high-performing home visiting programs to provide additional training or supplemental services that expand WBOT and CHW capacity to provide comprehensive maternal and child services.
- Short-to-Mid-term: NDoH should continue efforts to simplify and standardize national training curricula and approaches to respond to discrepancies resulting from the current, more decentralized approach.

3. Provide appropriate supervisory and support mechanisms to enable CHWs to take on additional service responsibilities.



► **Target Audience: National Department of Health, Provincial Departments of Health**

Provinces should make a concerted effort to stabilize service ratios and commensurate with their responsibilities by providing additional training to those in supervisory positions.

- WBOTs need to be adequately staffed to ensure proper supervision ratios, and supervisors need to be adequately trained to lead, supervise, and develop their staff
- Supervisors need basic managerial and operational training, as well as training on content related to the first 1000 days.
- Supervisors also need to be trained to understand and address the complex and emotionally taxing situations that CHWs encounter and provide them supportive — and not just compliance-based — supervision.

4. Undertake a diagnostic of the CHW and first 1000 days services currently provided to inform expansion.



► **Target Audience: Provincial Departments of Health**

Provinces should conduct a diagnostic of their current service delivery, regardless of the delivery model.

- Such diagnostics should include more detailed information on which services CHWs currently provide, how long they take, their relative quality, and the extent to which the needs of vulnerable populations are met.
- This information would be critical to determining the capacity of CHWs to take on additional first 1000 days services, especially related to parenting support and early stimulation, and establishing guidance on dosage, service ratios which would allow provinces could cost, plan for, and make informed decisions about how to effectively serve their vulnerable populations.
- This information would also prove essential for additional collaboration and coordination with other sectors, such as DSD, and would ensure that services are aligned, and all vulnerable populations covered.

5. Strengthen multi-departmental and multi-sectoral collaboration and coordination and ensure alignment of objectives.



► **Target Audience: National Department of Health, Provincial Departments of Health**

National, provincial, and local stakeholders must improve collaboration and coordination to better deliver first 1000 days services and to ensure that resources are efficiently stewarded. Stakeholders must also consider the whether current Department of Health structure sufficiently allows the various divisions to align and pursue complementary objectives.

Enhanced communication and coordination is recommended across multiple levels:

- National: Improve intra-departmental coordination, especially between the Primary Health Care division which oversees the CHWs and the Maternal and Child Health division responsible for ECD policy and the revised RtHB. NDoH should lead coordination efforts with the other lead departments, including the Departments of Social Development and Basic Education, as well as NGOs and experts, and define the package of services essential to the first 1000 days and develop the training curricula. NDoH should also ensure alignment with the investment case produced by DSD.
- Provincial: Improve coordination and planning across health and social development; coordinate to undertake diagnostic referenced above; define roles and responsibilities to reduce duplication

- Local (e.g. district, sub-district, ward): Improve communication and coordination to ensure that referrals are effectively addressed, and services delivered. Ensure that first 1000 days needs and services are addressed in the relevant multi-sectoral platforms (ex. War Room meetings)

Review the Department of Health structure to ensure alignment:

- Raise the profile of the NIECDP at the National level and address what system alignment is truly needed for implementation.
- Consider and address the challenges inherent in tasking the Maternal and Child Health division to be responsible for the ECD policy when the CHWs who are expected to deliver many of the services are part of the Primary Health Care division, which has little formal obligation to the policy.

6. Consider the creation of a new service role, the FTD Lead, situated between the CHW and Enrolled Nurse



► **Target Audience: National Department of Health, Provincial Departments of Health**

NDoH should consider formally creating a new role, the FTD Lead, within the WBOT.

- This would help with the implementation of first 1000 days services by creating a focal point for maternal and child health and early childhood development, embedded in the health system.
- In the short-term, FTD leads could be trained and deployed in high-needs areas and serving either a single WBOT or multiple, depending on service needs.
- This could establish a more formal career pathway for CHWs.

The FTD Lead could:

- coordinate and lead parent support groups and related early learning opportunities within the communities
- provide additional support to CHWs, including accompanying them on home visits to develop capacity
- support capacity-building and provide on-going training to CHWs

- ensure there are linkages between other community services and sectors

It is not recommended that this role be a formal supervisor for the CHWs, which would require additional training and lead to line management confusion.

7. Raise awareness of the NIECDP and the role of first 1000 days services



► **Target Audience: National Department of Health, Provincial Departments of Health**

NDoH and the provinces should establish or promote broad-based communications campaigns linked to NIECDP and the importance of the first 1000 days.

- Well-crafted public awareness campaigns would reinforce the need for integrated services and highlight that benefits to the child and family and health system savings are realized by investing in mutually-reinforcing services, (e.g. supporting “love” and “play” can also improve the care of the child and health/nutritional outcomes).
 - Communication campaigns and materials would further support alignment within the health platform. Materials should be made available from providers at all touchpoints (e.g. CHWs, health posts, clinics, facilities, and hospitals, etc.)
- Existing initiatives can be further adopted, scaled, or aligned in order to implement this recommendation,
 - Such resources include NDoH’s Side-by-Side campaign alongside the revised Road to Health Booklet, Western Cape’s First Thousand Days Initiative, or Ilifa Labantwana’s #LovePlayTalk, as well as materials emerging from WHO and UNICEF’s Nurturing Care Framework.

CONCLUSION

This study has shown that while the adoption of the NIECDP is commendable, multiple actions need to be taken to realize its potential and expand first 1000 days services to vulnerable populations. There is increasing awareness of the policy within the Department of Health and understanding of the critical importance of the first 1000 days. However, the default is to rely on the aspects of the policy which most closely mirror the Department’s experience and expertise, in this case,

the health and nutrition domains. To initiate meaningful implementation of the NIECDP, the NDoH needs to commit and orient itself towards the full policy, and address the areas where it lacks experience, which include providing more comprehensive psychosocial, parenting, and early stimulation support. To sustainably deliver these services in South Africa or any context, enhanced intersectoral coordination will be essential.

Finally, this study underscores the importance of considering the context in which the workforce

operates when assessing the viability and sustainability of expanding services. In South Africa, this means addressing the implementation gaps that limit the effectiveness of the CHWs and WBOTs, which includes a lack of dedicated funding, and challenges with staffing, training, caseload, and supervision. These systems-level gaps, if appropriately addressed, will strengthen the foundation on which first 1000 days services can be successfully implemented and improve the likelihood of durable positive outcomes for young children and families.

Introduction

There is increasing awareness of the environment and suite of services that young children need for an optimal start in life, and many of these services support the mother and family before the child is born. Early nutrition, care, and stimulation can significantly impact children's lifelong development.¹³ All parents and caregivers, especially the most vulnerable, can benefit from additional information and support to enhance their capacity to provide responsive care. Increasing access to a variety of integrated services spanning health, social development, and education that are delivered by a qualified and supported early childhood workforce are necessary to empower and enable parents to support the optimal development of their children.

It is with this holistic and multi-sectoral lens that The Early Childhood Workforce Initiative (ECWI), led by the International Step by Step Association (ISSA) and Results for Development (R4D), aims to support and empower those working with young children and their families. Through ECWI, R4D is carrying out a series of country studies focused on the experiences of a particular workforce role and ways to support and strengthen that role at the policy level. This study, the third in the series, looks primarily at the role of the Community Health Worker in providing supportive health, nutrition, parenting, and stimulation services to young children and their families in South Africa.

The National Integrated Early Childhood Development Policy (NIECDP) (2015) is an important step in South Africa's shift from a health system focused on curative, disease-based services to one based on prevention and health promotion. The NIECDP identifies a comprehensive vision of early childhood development (ECD) services to be delivered by 2030, seeking to strengthen and integrate these services across all

government departments. While recognizing the Department of Health's Community Health Workers (CHWs) role in providing supportive health and nutrition services, the Policy envisages these CHWs playing a significant, and expanded, role in strengthening overall maternal and child developmental outcomes by providing parenting support and opportunities for early learning and stimulation through additional home visits and community-based activities for families and young children through the age of two, commonly defined as part of first 1000 days services.

While the national policy level provides support for this shift to health prevention and promotion in the first 1000 days, the scope of the CHWs' role and the services they are required to provide is still being defined in national and provincial health policies under Primary Health Care Re-engineering. Implementation of these policies also varies widely across South Africa's nine provinces.

This study is intended to provide insight into how the Department of Health is endeavoring to provide robust and developmentally appropriate services for families and young children through the age of two within the framework of the NIECDP, with particular focus on the CHW. It presents a unique opportunity to examine the experience of two provinces, to consider the implications for service delivery across the country, and to provide recommendations to enable, prepare, and support the CHW workforce to deliver on this expanded suite of early childhood services. Given that many countries are considering expanded roles of para-professionals such as CHWs, it is also hoped that this study will contribute further to the knowledge base around delivering integrated health and development services for young children across a range of contexts.

¹³Yoshikawa, H., & Kabay, S.B. (2015). *The evidence base on early childhood care and education in global contexts* (background paper for the Education for All Global Monitoring Report 2015). Paris: UNESCO.

STUDY METHODOLOGY

This study is structured as an exploratory case study, with a focused review of the implementation in two provinces and seeks to highlight the barriers and opportunities for scale-up of expanded first 1000 days services in South Africa.

Three primary research questions guided this study:

1. **What is the status of implementation of the first 1000 days services in the NIECDP by the Department of Health?**
2. **What are the barriers and opportunities for the Community Health Worker to deliver the first 1000 days services outlined in the NIECDP?**
3. **What lessons can be drawn from their experience?**

To address these research questions, the team employed a mixed-methods approach including a review of the literature, followed by in-depth interviews and focus group discussions with key stakeholders at the national, provincial, and local levels.

The initial desk review focused on the policy context in South Africa, examining policies related to the health and development of young children. The study team then completed in-depth literature reviews of the Community Health Worker in the Primary Health Care system and the home visiting workforce typically delivered through non-governmental organizations (NGOs) and supported by the Department of Social Development (DSD). These reviews examined the implementation experience in South Africa and included global systematic reviews of the workforce and sustainability challenges.

The second phase of work included key informant interviews with stakeholders in the National Department of Health (NDoH) to better understand the national perspectives and policy landscape. The team then sought to understand the implementation experience of two provinces by conducting interviews and focus group discussions with stakeholders at the Provincial, District, and local levels, including CHWs. In consultation with the NDoH, the team selected the Western Cape and KwaZulu-Natal for in-depth study. These two provinces were selected in part because they have relatively more developed community-based service platforms that could serve as a basis for implementing the services envisioned in the NIECDP.

The demography and geography of the provinces was considered, as was the differing modes of delivering community-based services (in KwaZulu-Natal CHWs are employed by the Department of Health whereas the Western Cape has a long tradition of providing services through contracted NGO partners). In addition, the research team also engaged a home visiting program in the Western Cape to better understand the scope of their role and services.

Finally, a focus group was held with representatives of five provinces (KwaZulu-Natal, Western Cape, Eastern Cape, Gauteng, Free State) to discuss their current CHW systems and the emerging findings from the provincial case studies. This focus group served to highlight challenges and opportunities related to CHW practice and implementation of the NIECDP.

Several limitations to this study should be addressed. Most notably, this is an exploratory case study, not intended to be nationally representative of the South African experience. As noted above, the provincial experiences analyzed in this study are distinct and implementation experience can vary both across and within provinces. The study attempted to mitigate these factors by holding a focus group with other provincial representatives to ensure comparability of experience. Furthermore, this study is intended to provide a broader understanding of how the national and provincial governments are addressing and implementing the NIECDP, and the barriers to doing so; it is not intended to define the package of first 1000 days services that should be implemented by CHWs.

REPORT ROADMAP

Section I of this report describes the importance of the first 1000 days in the trajectory of a child's lifelong health and development and briefly reviews the impact para-professionals, such as CHWs and home visitors, can have on this period. Section II describes the national policy context, including Primary Health Care Re-engineering and the National Integrated Early Childhood Development Policy, focusing on the roles and responsibilities of the Department of Health. Section III describes in greater detail the current cadre of CHWs and their role. It also reviews common features of home visiting programs and highlights lessons from the literature that can serve to inform the design of CHWs' emerging role. Section IV presents the two provincial case studies that feature the Western Cape and KwaZulu-Natal. Section V highlights the cross-cutting findings from these case

studies, other field-work, and the literature. Section VI presents a brief costing estimation to illustrate two potential methods of scaling up first 1000 days services. Section VII concludes with recommendations for national and provincial departments of health to prepare and support the CHW workforce to deliver on this expanded suite of services.

It should be noted that the analysis of the role of the CHW is guided by a framework which included four

dimensions – Recruitment, Selection and Training; Role and Workload; Supervision and Support; and Workforce Conditions. Existing evidence suggest that these dimensions are drivers of CHW (and early childhood personnel more generally) effectiveness¹⁴ and performance.¹⁵

¹⁴Jaskiewicz, W., & Tulenko, K. (2012). Increasing community health worker productivity and effectiveness: a review of the influence of the work environment. *Human resources for health*, 10(1), 38

¹⁵De Kok., M. et al. (2015). Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. *Health Policy and Planning*, 30:1207-1227.

I. Child Health and Development: The First 1000 Days

The early care, nutrition and stimulation a child receives during the first 1000 days, spanning conception to the child's second birthday, plays a pivotal role in their health, development, and well-being, as well as their later ability to learn and earn.¹⁶ Unfortunately, for too many children, this is a period when adversities accumulate and their potential to thrive decreases. However, the impact of supportive, promotive experiences is also amplified during this time, and can mitigate some of the risks young children may face, highlighting the need for comprehensive ECD services for all, especially the most vulnerable.¹⁷

The 2017 Lancet series on ECD defines the concept of nurturing care to include parent and family interactions in a stable environment sensitive to five domains, the child's health, nutrition, security and safety, responsive caregiving, and early learning needs.¹⁸ Across sectors, a range of interventions addressing maternal health and stress, parenting support, attachment and bonding, and micronutrient and child feeding, can positively impact child development outcomes, including improvements in nutrition and growth, and reductions in morbidity, mortality, disability, and injury. However, the Lancet (2017) finds that the most effective, promising, and sustainable interventions target multiple risks and are integrated, multi-sectoral approaches anchored in nurturing care.

As integrated practices, such as those that combine health and nutrition with parenting and stimulation messages, achieve better outcomes for young children, there is an imperative to build off existing service platforms to deliver these services and target the most vulnerable and at-risk populations.¹⁹ In the first 1000 days, supportive services span nutritional

support (antenatal, breastfeeding, complementary feeding), social services (birth registration, social grant access, protective services), maternal and child health services (early antenatal booking, pregnancy, delivery, newborn and child health care, immunization, maternal mental health and substance abuse screening, developmental screening), support for primary caregivers (parental support, information about child development), and stimulation for early learning (play and communication); furthermore, ensuring effective delivery and take-up of these services requires multi-sectoral coordination.²⁰

FIGURE 1.
Domains of Nurturing Care



Source: Nurturing Care for Early Childhood Development; a framework for Action and Results. UNICEF and World Health Organization.

¹⁶ Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vaivada, T., ... & MacMillan, H. (2017). Nurturing care: promoting early childhood development. *The Lancet*, 389(10064), 91-102.

¹⁷ Grantham-McGregor, S., & International Child Development Committee. (2007). Early child development in developing countries. *The Lancet*, 369(9564), 824.

¹⁸ Black, M. M., Walker, S. P., Fernald, L. C., Andersen, C. T., DiGirolamo, A. M., Lu, C., ... & Devercelli, A. E. (2017). Early childhood development coming of age: science through the life course. *The Lancet*, 389(10064), 77-90.

¹⁹ Yoshikawa, H., & Kabay, S.B. (2015).

²⁰ Ilifa Labantwana (2013) *The Essential Package. Early Childhood Services and Support to Vulnerable Children in South Africa*. Claremont: Ilifa Labantwana.

EVIDENCE OF INTEGRATED SERVICES AND THE USE OF PARA-PROFESSIONALS

Especially in the first 1000 days, there is an opportunity for health departments, as the primary point of contact for families and very young children experiencing change and growth, to take the lead in ensuring comprehensive interventions that support these five critical domains of nurturing care.²¹ As global focus shifts towards the potential of community-based caregivers to address inequitable health systems and aid countries' drive towards universal health coverage (UHC),²² there is increasing belief and evidence that, well-supported para-professionals, including CHWs and other home visitors, can be effective partners in delivering these services.

In low- and middle-income countries, CHWs, generally those with "no formal professional or paraprofessional certificate or degree in tertiary education,"²³ have been shown to significantly improve maternal and child health as well as contribute to the control of communicable diseases and aid health prevention and promotion orientation.²⁴ However, the settings, tasks, level of education, training, employment type, and integration with the formal health system of these para-professional and CHWs varies significantly.²⁵ CHWs often provide a range of health promotion messages and basic curative services by conducting community outreach activities, including home visits, and link patients with health and other services (e.g. birth registration, support grants).²⁶ There is often a distinction made between generalist CHWs and those addressing specific health issues, e.g. maternal and child health including reproductive health and family planning, TB care, malaria, and so on.²⁷

Central to many CHW programs is the use of home-visits, however, there are also stand-alone home visiting programs that often have a more targeted maternal and child focus compared to the generalist CHW (these home visiting programs are discussed more in Section III.) Recent global reviews of the evidence show that home visiting by para-professionals can improve child development outcomes, nutrition and growth, while reducing negative outcomes such as mortality and disability.²⁸ A comprehensive home visiting program trained CHWs in Jamaica to engage families in play and stimulation activities, and encourage praise and positive parenting techniques during weekly hour-long home visits, while also providing formula; long-term follow up found significant positive effects for the stimulation group including lower rates of depression and anxiety, and positive effects on caregivers' mental health.²⁹ Children also demonstrated persistent positive impacts, with long-term follow-up showing improvements in cognition and school performance, as well as higher rates of employment and earnings compared to their peers.³⁰ In Pakistan, Lady Health Workers, a cadre of para-professional women providing community health services in rural, remote, and disadvantaged communities, delivered the Care for Child Development Program by integrating nutrition and psychosocial stimulation messages into an existing home visiting program (10 minutes of the home visit was reallocated towards these service messages) for mothers in rural and remote areas. A randomized control trial of the intervention showed significant positive effects of counseling mothers on responsive stimulation on young children's cognition, language, motor and social-emotional development at age two,³¹ and on cognition and pro-social behaviors at age four.³²

²¹ Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vavada, T., ... & MacMillan, H. (2017). Nurturing care: promoting early childhood development. *The Lancet*, 389(10064), 91-102.

²² Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annual review of public health*, 35, 399-421.

²³ van Ginneken, N., Lewin, S., & Berridge, V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Social Science & Medicine*, 71(6), 1110-1118.

²⁴ Perry et. al, (2014).

²⁵ Lehmann, U., & Sanders, D. (2007). Community health workers: what do we know about them. The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. Geneva: World Health Organization, 1-42.

²⁶ Perry et. al, (2014).

²⁷ Lehmann & Sanders, (2007).

²⁸ Britto et. al, (2017).

²⁹ Walker, S. P., Chang, S. M., Powell, C. A., Simonoff, E., & Grantham-McGregor, S. M. (2006). Effects of psychosocial stimulation and dietary supplementation in early childhood on psychosocial functioning in late adolescence: follow-up of randomised controlled trial. *bmj*, 333(7566).

³⁰ Walker, S. P., Grantham-McGregor, S. M., Powell, C. A., & Chang, S. M. (2000). Effects of growth restriction in early childhood on growth, IQ, and cognition at age 11 to 12 years and the benefits of nutritional supplementation and psychosocial stimulation. *The Journal of Pediatrics*, 137(1), 36-41; Walker, S. P., Chang, S. M., Powell, C. A., & Grantham-McGregor, S. M. (2005). Effects of early childhood psychosocial stimulation and nutritional supplementation on cognition and education in growth-stunted Jamaican children: prospective cohort study. *The Lancet*, 366(9499), 1804-1807.

³¹ Yousafzai, A. K., Rasheed, M. A., Rizvi, A., Armstrong, R., & Bhutta, Z. A. (2014). Effect of integrated responsive stimulation and nutrition interventions in the Lady Health Worker programme in Pakistan on child development, growth, and health outcomes: a cluster-randomised factorial effectiveness trial. *The Lancet*, 384(9950), 1282-1293.

³² Yousafzai, A. K., Obradović, J., Rasheed, M. A., Rizvi, A., Portilla, X. A., Tirado-Strayer, N., ... & Memon, U. (2016). Effects of responsive stimulation and nutrition interventions on children's development and growth at age 4 years in a disadvantaged population in Pakistan: a longitudinal follow-up of a cluster-randomised factorial effectiveness trial. *The Lancet Global Health*, 4(8), e548-e558.

II. National and Health System Context

Young children under age 6 account for roughly a tenth of South Africa's population and just over 1 million children are born each year. The opportunities and services they receive vary greatly based on where and to whom they are born. Approximately two-thirds will be born in the poorest 40% of households and face a range of threats to their optimal development.³³

Improved maternal and child health services, including immunization rates, have contributed to reductions in the infant and under-5 mortality rates (respectively 27 and 40 per 1,000 in 2015); however, it is cause for concern that the neonatal mortality rate has stagnated for the last decade.³⁴ Low-birth weight (13%) and persistent malnutrition continues to affect young children, as 21% of children under 5 were classed as stunted and 44% as Vitamin A deficient.³⁵ Over 20% of children under age 6, mostly those living in rural areas, lack adequate access (distance) to health clinics and facilities, while a quarter live with poor water and sanitation conditions.³⁶

While significant progress has been made in early and formal learning opportunities, the economic and geographic divide continues to impact access to and enrollment in these services. For example, a child aged 3-5 in the bottom income quintile has only a 50% chance of accessing group learning programs, compared to 90% likelihood in the top quintile. And while primary enrollment is high, children from poorer households consistently enter Grade R behind their more advantaged peers, suggesting a need for earlier intervention. The recent Early Learning Outcomes Measure, a population-level preschool assessment

designed to assess the extent to which children aged 50-69 months meet developmental standards across five core domains,³⁷ found almost a full standard deviation difference between children from the bottom quintile to those in the top two quintiles.³⁸ Overall, there is a lack of comprehensive data to understand what parenting or support services are available, which could inform service delivery.

PRIMARY HEALTH CARE RE-ENGINEERING AND THE WARD-BASED OUTREACH TEAM

Primary Health Care Re-engineering

In 2011, the Government of South Africa embarked on a process of Primary Health Care Re-Engineering (PHC Re-Engineering), moving away from a vertical, facility-based system, to a community-oriented approach focused on prevention and health promotion.

The post-apartheid government introduced Primary Health Care to South Africa in 1996, establishing a system that relied on formal professional nursing and medical personnel. This facility-based system did not incorporate community based caregivers who continued to operate, and addressed some of the needs of the historically disadvantaged black population and those in rural or otherwise marginalized communities.³⁹ In the late 1990s, in response to the TB and HIV/AIDS epidemics, the South African government and international NGOs increased funding of community

³³ Hall, K., Sambu, W., Berry I., Giese, S., and Almeleh, c. (2017). South African Early Childhood Review 2017. Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana

³⁴ Hall, K. et. al. (2017).

³⁵ Hall, K. et. al. (2017).

³⁶ Hall, K. et. al. (2017).

³⁷ The ELOM assesses children age 50-69 months across domains: Gross Motor Development, Fine motor coordination and visual motor integration, Emergent numeracy and mathematics, Cognition and executive functioning, and Emergent literacy and language.

³⁸ ELOM Technical Manual, 2016. Source: South Africa Early Childhood Review, 2017. Ilifa Labantwana.

³⁹ National Department of Health (2018). Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/19 - 2023/24.

based caregivers with a limited scope of practice for TB, HIV/AIDS and other specific interventions (malaria, breastfeeding, immunization uptake).⁴⁰ However, it was not until 2011, when faced with almost two decades of poor health outcome indicators,⁴¹ as well as the challenges of the quadruple burden of disease (consisting of HIV and TB, non-communicable diseases, high maternal and child mortality, and violence and injuries), that there was another significant shift in the primary health care policy.

Influenced by the community caregiver experience in Brazil,^{42,43} the Minister of Health of South Africa announced PHC Re-Engineering in 2011, an overhaul of the health system meant to be a step towards improving health outcomes, including poor infant mortality rates and child health indicators, and towards realizing the MDGs. Services would be strengthened through the provision of a population-based approach, rather than a more vertical approach. Three service streams were initially identified: District Clinical Specialist Support

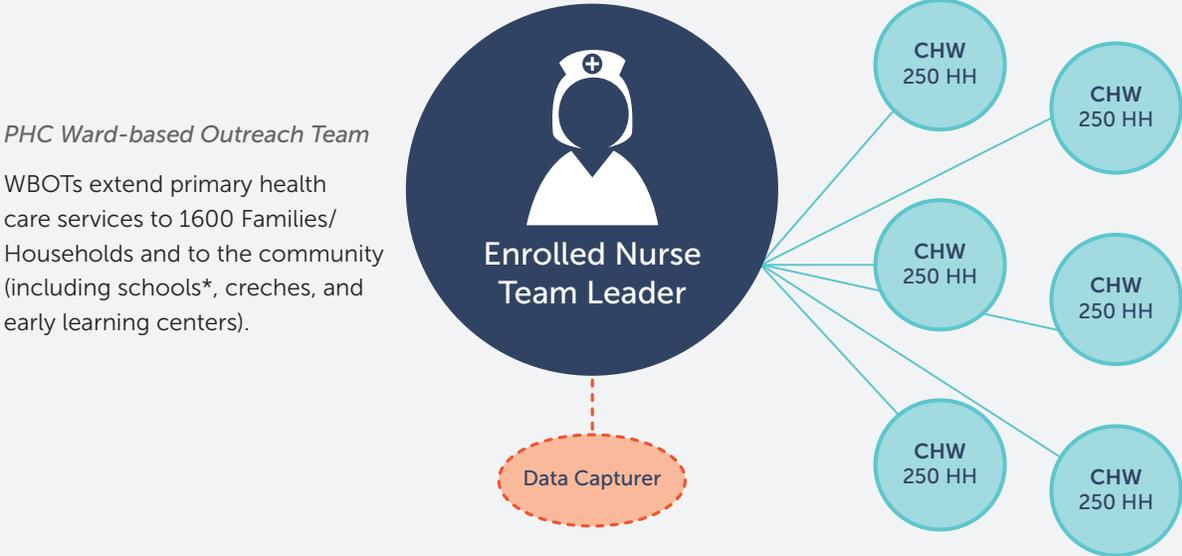
Teams to improve facility-based services, and School Health Services and Municipal Ward-based Primary Healthcare Outreach Teams (WBOTs) based on CHWs to extend health services within the community.

The Ward-Based Outreach Team

Across the country, there are 52 health districts and 4,277 electoral wards. The district health management team is tasked with ensuring population coverage and the work allocation of the WBOT,⁴⁴ however, the province retains significant control.

Based on the 2011 policy, each WBOT was to consist of a professional nurse, six CHWs, and ideally an environmental health officer and health promoter,⁴⁵ however this guidance was updated in the 2018 WBOT Policy Framework to include six to ten CHWs and one data capturer per WBOT, led by an Enrolled Nurse oriented to community health nursing. (Figure 2). Each WBOT is linked to a health facility where the team

FIGURE 2.
PHC Ward-based Outreach Team (WBOT)



Source: Adapted from the National Department of Health (2018). Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/19 - 2023/24.

*Outreach to schools in each ward differs from the School Health Service, a distinct stream in PHC Re-engineering.

⁴⁰ Schneider et al., et al. 2015. The challenges of reshaping disease specific and care oriented community based services Towards comprehensive goals: A situation Appraisal in the Western Cape Province, South Africa. *BMC Health Services Research*. September 2015.

⁴¹ National Department of Health, 2012. Human Resources for Health Strategy for the South African Health Sector, 2012/13 – 2016/17.

⁴² The Ministerial visit to Brazil demonstrated the impact that CHWs working in teams could have on health outcomes.

⁴³ National Department of Health, Provincial Guidelines for the Implementation of the three streams of PHC Re-engineering. September 2011.

⁴⁴ Ibid.

⁴⁵ Ibid.

leader, an enrolled nurse⁴⁶ manages and supervises the services as well as links with the community, schools, clinics, crèches, and home-based patients. The CHW serves as the primary point of contact for the population, tracking and addressing basic health concerns and making referrals to facility-based services. Each WBOT is responsible for approximately 1600 families, or approximately 250 families per CHW and each household is to be visited at least quarterly.

While the national government is responsible for setting policy and national guidelines, the nine South African provinces are responsible for the implementing the policy, including the delivery of services, funding, and monitoring and evaluation. Funding is largely derived from national taxes allocated to provinces, supplemented by conditional grants for national programs from the Treasury. Currently, the HIV grant is the only significant health-related conditional grant.

IMPLEMENTATION OF PHC RE-ENGINEERING

Since 2011, provinces have made considerable progress towards establishing WBOTs and community-based services in line with PHC Re-engineering. In particular, the home visits have extended care to rural, remote, and otherwise marginalized populations, while alleviating pressure on the formal health facilities, and increasing focus on social determinants of health.⁴⁷ Furthermore, while still predominantly paper-based, data tracking and management in the District Health Information System (DHIS) has been significantly strengthened.⁴⁸ However, a series of recent evaluations,⁴⁹ including a rapid appraisal of the WBOT model in National Health Insurance (NHI) pilot sites across seven provinces,⁵⁰ found full implementation to be hampered by significant challenges that should be considered in light of the NIECDP and evolving role of the CHW, including:

- **Integration challenges** as WBOTs were, in essence, add-on outreach services, and insufficient efforts were made to integrate them into the formal health system. While some CHWs are employed through

the government, they are not accorded the status of full governmental employees or eligible for full conditions of service or benefits.

- **Human resource challenges** including a dearth of professional nurses specified to lead WBOTs, leaving some teams without leadership, using lower cadres such as enrolled nurses as team leaders, and generally contributing to a lack of supervision or mentoring beyond data collection. Furthermore, professional nurses struggled to balance their clinical and WBOT responsibilities.
- **Training and competence challenges** as CHWs have limited formal education and, often, diverse experience as disease-specific carers, and the training courses provided were said to be poorly timed, insufficient, and not aligned with the scope of work or realities of the job. Furthermore, training was not extended to others in the health facility or system, affecting their view and understanding of WBOT services.
- **Financing challenges**, including no dedicated budget lines in NHI pilot sites, often requiring teams to tap NHI or other grants, which were restrictive and impacted on the availability of uniforms, name tags, kit bags, and other supplies. Transportation costs, especially in rural areas.
- **Jurisdictional challenges** as CHWs were employed by NGOs, they often formally reported to health facility staff, adding to the sense of ambiguity around their role, complicating management relationships, and negatively affecting their motivation.
- **Infrastructure challenges** as health clinics had limited space or resources available to support the CHWs who were required to check in and out of there each day or their materials (including case files).

The PHC Re-engineering implementation barriers, and when applicable, opportunities, for implementing expanded first 1000 days services through this cadre are discussed further in the context of the two provincial case studies as well as the findings and recommendations.

⁴⁶ In the 2018 Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams (WBOT Policy Framework), the Outreach Team Leader (OTL) was changed from Professional Nurses to Enrolled Nurses who have been oriented to community health nursing. However, there are insufficient numbers of trained Enrolled Nurses, and teams are commonly led by un-trained Enrolled Nurses. The team is to consist of one OTL, 6-10 CHWs, and one data capturer.

⁴⁷ Jinabhai, C. C., Marcus, T. S., & Chapona, A. (2015). Rapid appraisal of ward based outreach teams.; Marcus, T. S., Hugo, J., & Jinabhai, C. C. (2017). Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa. *African journal of primary health care & family medicine*, 9(1), 1-8.; Sodo, P., & Bosman, A. (2017). Progress of the municipal ward-based primary healthcare outreach teams in Vhembe, Limpopo Province. *Strengthening Health Systems*, 2(1), 18-22.; Austin-Evelyn K, Rabkin M, Macheka T, Mutiti A, Mwansa-Kambafwile J, Dlamini T, et al. (2017) Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa.; Schneider, H., Schaay, N., Dudley, L., Goliath, C., & Qukula, T. (2015). The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, South Africa. *BMC health services research*, 15(1), 436.

⁴⁸ Jinabhai et. al. (2015).

⁴⁹ Marcus et. al. (2017); Sodo and Bosman, (2017); Austin-Evelyn et. al. (2017); Schneider et. al. (2015).

⁵⁰ Jinabhai et. al. (2015).

THE NATIONAL INTEGRATED EARLY CHILDHOOD POLICY (NIECDP)

The Government of South Africa has long recognized the role of early childhood development in affecting children’s long-term developmental and social outcomes. Building on a series of documents that established the scope and benefit of ECD services,⁵¹ the 2015 National Integrated Early Childhood Policy (NIECDP) established a multi-sectoral framework for ECD services, defined a comprehensive national program with essential components, identified responsible government departments and partners,

and sought to create a national office and coordination structure for ECD. The NIECDP recognizes ECD as a universal right and public good, acknowledging the personal, community, and societal benefits of such services, and aims to provide comprehensive,⁵² universally available and equitable ECD services from conception until formal school entry, prioritizing service delivery for the most vulnerable.⁵³

Under the NIECDP, provinces are responsible for the funding and delivery of first 1000 days services, including the decision to contract individual NGOs and partners to deliver necessary services. The Departments of Social Development, Health, and Basic Education are the three lead departments for the implementing of the

TABLE 1.
Core ECD Services for Young Children in the NIECDP by Responsible Lead Department

Lead Department Responsible	Conception - birth	0-1 years	1-2 years	2-3 years	3-4 years	4-5 years	5-6 years
Department of Health	Publicly provided antenatal, maternal, and postnatal care services, and for children under age 6 Including immunization, nutrition, and breastfeeding support						
	Parenting support programs						
		Learning and play opportunities for those at risk of poor development					
				Screening and health services in creches and ECD centers			
Department of Social Development	Inclusive learning opportunities of adequate quality for children 0 – 5 Social assistance for children/child support grants Social protection services						
Department of Basic Education		Early learning curriculum (0-4) that links to Grade R curricula					
						Grade R	
Department of Home Affairs	Free birth registration						
<p>*Services provided in conjunction with the South African Social Security Agency (SASSA)</p> <p>Italics indicate planned services or those not universally delivered</p> <p>Source: Government of South Africa (2015). National Integrated Early Childhood Development Policy</p>							

⁵¹ Foundational policies and documents include, but are not limited to, Department of Social Development’s National Integrated Plans; Children’s Act, No. 38 (2005); Diagnostic Review on Early Childhood Development (DR-ECD) (2012); White Paper on Families (2012), South African Integrated Programme of Action for Early Childhood Development – Moving Ahead (2013/14 – 2016/17), and Ilifa Labantwana’s Essential Package.

⁵² Within the policy, the following components of ECD are provided for: health care and nutrition programs; social protection programs; parent support programs; opportunities for learning; national public early childhood development; communications; water, sanitation, refuse removal and energy sources; food security; play facilities, sport and culture.

⁵³ The NIECDP covers children from conception to formal school entry. This is defined as when children enter Grade R or until they reach the age of 7 years in the case of children with developmental difficulties and/or disabilities, whichever occurs first.

BOX 1.

Supportive ECD Initiatives Coordinated by the National Department of Health

Road to Health Booklet: The Road to Health Booklet (RtHB) is meant to be given to all families at the time of birth and is the key document used by CHWs and the health system to track child growth and immunization. The RtHB also contains select messages around breastfeeding, developmental milestones, and how to interact with your child. The National Department of Health is currently in the process of revising this booklet with the support of Ilifa Labantwana. The revised version, slated for release in early 2018, is now structured around five priority areas: Nutrition, Love, Protection, Healthcare, and Extra Care. This version takes a much more holistic view of child development than its predecessor and contains key messages within each priority area. It is designed to be much more user-friendly, with easy to understand scenes to relay the messages to all audiences.

Side by Side Campaign: Linked to the release of the revised RtHB, the NDoH is launching the Side by Side Campaign to support uptake and understanding among caregivers and health providers (including CHWs). This campaign centers on the five priority areas in the RtHB and on helping caregivers understand their role and natural capacity to support young children's development through nurturing care.

MomConnect: MomConnect is an SMS-based service that delivers health and development messages, operated by the Department of Health. Expectant mothers receive regular text messages on the development of their fetus, aligned to the gestation. After birth, mothers can sign up to receive similar messages through the child's first year. There are discussions about extending the MomConnect messages through the age of 2. Messages are available in all official languages.

NIECDP. In total, the NIECDP defined service roles and responsibilities across thirty government departments and affiliates. The NIECDP also sets a series of staggered goals for implementation: by 2017 all the necessary legal, organizational, and funding arrangements should be in place; by 2024 a set of essential services should be delivered⁵⁴ and by 2030, the comprehensive set of services should be delivered.^{55,56} A review of the ECD services in the NIECDP is available in Table 1, and other services supportive initiatives for young children are included in Box 1.

ROLES AND RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH IN THE NIECDP

In the NIECDP, the Department of Health, with its existing ward-based and CHW footprint in the community, serves as the primary support and service provider for pregnant women, new parents, and children under age 2. Service responsibilities include health and nutrition programs, which historically fall under Health's remit. The DoH is now responsible

for new core services for the first 1000 days, such as providing parenting support programs and opportunities for learning and play for very young children in the home and community or group setting. The NIECDP stipulates that these services are to be provided by the CHWs and Health Promoters within the WBOTs. While the NIECDP describes the overall domains of care that can support families and young children, it does not define specifics related to the services CHWs are to provide.

In the short-to-medium term (2017–2024), the National and Provincial Departments of Health are responsible for developing sufficient numbers of trained CHWs, and ensuring that they complete a specialized, accredited short course that includes an ECD module. This course is to be developed by the National Department of Health in collaboration with the Departments of Social Development, Basic Education, and of Higher Education and Training, and to be implemented at a provincial and/or municipal level.⁵⁷ The DoH is also responsible for maintaining adequate support, mentoring, and oversight of these front-line workers. See Box 2. for the complete terms of the responsibilities allocated to the Department of Health.

⁵⁴ Essential Services defined in the NIECDP include: Free birth certification; Basic health care for pregnant women, infants and young children; Food and nutrition - maternal, infant and child services; Parental support; Safe care and quality early learning – in the absence of parent; Early learning support services – home, community & center based; Information about ECD

⁵⁵ Comprehensive Services defined in the NIECDP also include Social protection services; Protection from abuse and neglect; Subsidized & affordable water, sanitation & energy; Access to safe housing; Play, recreational & cultural amenities

⁵⁶ An integrated human resources strategy for the NIECDP is being developed, including an analysis of the workforce requirements, gaps, and challenges. This study has been commissioned by the Department of Basic Education in collaboration with UNICEF and will be released in early 2018.

⁵⁷ Department of Social Development and UNICEF. (2015.) National Integrated Early Child Development Policy. P110.

BOX. 2.

Roles and Responsibilities for the Department of Health as outlined in the National Integrated Early Childhood Development Policy

Health promoters and community health workers as part of the ward-based PHC outreach teams are responsible for the provision of:

1. Health and nutrition programs for pregnant women, infants and children (***including screening for maternal mental ill health, substance abuse, exposure to violence, and developmental difficulties, as well as nutrition counselling***)
2. ***For parenting support programs***
 - a. Support groups for pregnant women at facilities and in communities and homes;
 - b. Mother-father and baby support and early learning groups for women at the health facilities and at a community level;
3. ***Opportunities for learning and play for 0-2s through health facilities and CHW home visits for children at risk of poor development.***
 - a. Two home visits to high-risk pregnant women (which includes mothers younger than 19 years, HIV-positive mothers, mothers with mental health or substance abuse problems, and mothers exposed to domestic violence);
 - b. Bi-monthly home visits to at-risk mothers.

*These three service areas are the focus of this study, as well as the mentoring, support and oversight provided. The services in bold italics are new or expanded responsibilities assigned to the Department of Health in the NIECDP.

The Department of Health, in close collaboration with the Departments of Social Development and Basic Education are responsible for publicly providing (by developing, funding and implementing) prioritized programs:

- ***Support for pregnant women, new mothers /fathers and children under 2 years of age.***
- Review and strengthen a national multi-sectoral comprehensive food and nutrition strategy for children under 5 years for delivery of comprehensive food and nutritional support in facilities and homes
- ***Provision of universal developmentally appropriate early learning opportunities for young children from birth in line with the National Curriculum Framework (NCF) 0- 4 and National Early Learning and Development Standards (NELDS)***

The services will be provided through clinic and outreach teams. WBOT team leaders employed by the Department of Health to provide mentoring, support and oversight of the community health workers and WBOTs so as to maintain the quality of service provided.

Source: Adapted from the National Integrated Early Childhood Development Policy, 2015.

III. CHW Workforce in South Africa

This section provides an overview of community health workers, including information about their role, preparation, and barriers to effective practice.

The recent WBOT Policy Framework (2018) defines a CHW in South Africa as “any worker who is selected, trained and works in the community. CHWs are the first line of support between the community and various health and social development services.”⁵⁸ While as many as 72,000 community-based workers have been identified in South Africa, their training, skills, and functions vary considerably, resulting from

their experience as predominately auxiliary workers trained and employed in vertical programs (e.g. TB, HIV/AIDS, etc.) to provide home-based care to the ill or infirm.⁵⁹ The WBOT Policy Framework notes that nearly 55,000 CHWs (9,159 WBOTs) would be needed to cover the entire South African population; however, the priority is to serve the most vulnerable, defined as those municipalities with a high multi-dimensional poverty index.⁶⁰ Together, this suggests that a principle barrier to service delivery is the effective training and distribution of CHWs to high-needs areas.

BOX 3.

Community Health Worker Draft Scope of Work (2016)

The CHW will report to the outreach team leader (OTL) and perform the following activities:

1. Conduct community, household and individual level health assessments
2. Identify potential and actual health risks and assist the household or individual to seek appropriate care
3. Screen and refer individuals for further assessment and testing, where appropriate
4. Identify pregnant women and conduct home visits during pregnancy and the postnatal period to promote healthy and safe births and identify danger signs needing extra care*
5. Provide extra support for healthy behaviors during early childhood, including exclusive breastfeeding*
6. Provide screening and health promotion programs in schools and early childhood development centers in partnership with school health team and other health care workers
7. Counsel on and provide support for family planning choices*
8. Provide follow-up and assistance to persons with health problems including distribution of medicines...and help with adherence to treatment and treatment defaulter tracing
9. Promote and work with other sectors and undertake collaborative community-based interventions, such as early childhood development, palliative care and geriatric care
10. Establish and manage support groups, e.g. treatment adherence and disease specific groups

*Note: The * doesn't necessarily indicate a new role for the CHW as many of these services were described in earlier CHW implementation and guidance documents, however, the 2016 Draft Policy has raised the profile of the activity by including it in the CHW scope of work. See Annex I. for a more detailed look at the CHW roles and responsibilities in policy, as well as a comparison to maternal and child health home visiting services.*

Source: National Department of Health (2016). Draft Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams.

⁵⁸ National Department of Health (2018). Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/19 - 2023/24.

⁵⁹ An audit of CHWs by the Department of Health in 2011 identified about 72,000 CHWs, the figure still quoted in planning documents for the 2015 ECD policy. Nearly 50,000 of these CHWs were identified as home-based carers (HBC) or community care givers (CCGs) while others include lay and adherence counsellors, DOTS supporters, peer educators, further highlighting the diversity of this workforce (National Department of Health, 2012. Annexure B1. Human resource requirements for re-engineering primary health care in South Africa.)

⁶⁰ Per the WBOT Policy Framework (2018), this is defined as score above .6 according to Statistics South Africa's Upper Bound Poverty Line. Details are not provided for how many CHWs and WBOTs that translates into. It is assumed that this would strongly correlate with the vulnerable population identified as priority in the NIECDP.

CHWs provide a broad range of services in the home and community setting, including health promotion and prevention information on maternal and child health (immunization and vitamin supplementation), HIV, TB, and chronic diseases. CHWs also provide treatment adherence support, general counselling, and basic first aid, and make health referrals for additional services. Each CHW is assigned approximately 250 households (varies based on geography, density, and burden of

disease) per annum.⁶¹ CHWs conduct an initial household assessment (lasting approximately one-hour) and then are meant to conduct quarterly visits to track and address the needs of all family members (lasting approximately 30 minutes).⁶² Additional visits are provided depending on the needs profile of the family members; frequency, length, and duration depends on the type of care and support provided. CHWs are expected to spend approximately 70% of their time on home visits and 30%

TABLE 2.
Key CHW Workforce Domains

Workforce Dimension	Community Health Workers Based on 2011 Ward Based Primary Health Care Outreach Teams Implementation Toolkit policy and 2018 WBOT Policy Framework.
Recruitment, Selection and Training	<p>Person specification:</p> <ul style="list-style-type: none"> • Grade 12 required for new CHWs as of 2018 WBOT Policy Framework; recognized prior learning and training for current CHWs. • No age or gender requirement stated. • Functionally literate and numerate with at least 1-year experience as a community-based health worker and some previous training. • Resides in the area that they will be serving ("area" can be expanded based on service needs) • Complete competence requirements and sign a performance agreement. <p>Training:</p> <ul style="list-style-type: none"> • Core content includes health messages on HIV/ TB prevention; strategies for prevention of mother to child HIV transmission (PMTCT); the consequences of alcohol use/abuse; the importance of breastfeeding; and how to avoid malnutrition. • Pre-Service Training varies substantially based on province and implementing partner, with as little as 2 weeks of training. The 2011 Policy established a 3-phase training program; however, implementation was uneven and the majority of CHWs who participated only completed Phase 1. Efforts are underway to simplify, standardize, and accredit training. • In-Service Training is not defined in the policy except that Team Leaders are to provide on-the-job training.
Role and Workload	<p>Role and responsibilities:</p> <p>Caseload: One CHW is responsible for 250-270 Households in most provinces (KwaZulu-Natal is an exception with 60 households) and works 4.5-8-hour days.</p> <p>Dosage: Dosage depends on the family needs and the services rendered. At a minimum, each household is to be visited quarterly. Visits average 30 minutes in length.</p>
Supervision and Support	<p>Monitoring: Primarily paper-based data collection; there are a few ICT-enabled pilots</p> <p>Supervision: Type and frequency varies and is not defined in policy.</p> <p>Supervisor to CHW ratio varies substantially in practice; 1:6 ratio 2011 Policy, approximately 1:10 in 2012 NDoH Framework for Accelerating MNCWH&N Interventions.</p>
Workforce Conditions	<p>Employment Status: Employed by contracted NGOs in most provinces with one-year contracts.</p> <p>Payment: Average payment between R1700-2500 per month.</p> <p>Resources: If provided, most transportation services are coordinated by the NGOs, some can be reimbursed for fuel.</p> <p>Funding and Costs: CHW programs most commonly receive funding from the Department of Health's HIV Conditional grant; CHWs are often paid through the EPWP. The largest cost drivers are stipends and training.</p>

⁶¹National Department of Health (2018). Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/19 - 2023/24.

⁶² Daviaud, E. & Besada, D. (2017a). Resource Requirements for Community-Based Care in Rural, Deep-rural and Peri-urban Sub-districts: A comparative analysis in 2 districts In Gauteng and KwaZulu-Natal. Medical Research Council, South Africa.

on other activities,⁶³ however, there is limited information about the specific set of services CHWs provide, the time each service takes, and the relative quality of service provided.⁶⁴ An overview of the recruitment, training, support and other workforce dimensions known to impact CHW performance,⁶⁵ (and which are key to understanding CHWs' capacity to take on additional first 1000 days services) is provided in Table 2.⁶⁶

LESSONS FOR CHW FROM HOME VISITING PROGRAMS

As the DoH expands first 1000 days services through CHWs, there is an opportunity to learn from home visiting programs currently in operation across South Africa, particularly those focused on supporting maternal and child health, parenting, and child development.⁶⁷ Evidence from a range of countries, including South Africa, suggests that home visiting programs improve caregiver and child outcomes: caregivers report fewer feelings of isolation, engage in more stimulating activities with children, and breastfeed at higher rates and for longer, while children exhibit improved nutrition, growth, and developmental

outcomes, with reductions in mortality and disability.⁶⁸ These programs are often operated by NGOs and are supported, in part, by the DSD. However, there is no nationally endorsed home visiting program or formal coordinating body, and therefore, data on the workforce and national reach of services is limited. Furthermore, there is a limited body of evidence on how to successfully integrate ECD messages into existing CHW and maternal and child health programs.⁶⁹

Many home visitors are trained to address core health and nutrition deficits, as well as the risk factors that families may face (e.g. income/poverty level, substance abuse, exposure to violence), and the overall package of services may not appear significantly different from that of the CHW (see Annex I. for two tables comparing the roles and nature of CHW programs to home visiting programs). However, home visitors place greater emphasis on supporting and enabling caregivers to provide responsive care for their children and engaging in stimulation and developmental activities. Other significant differences include the type of training and support each receives, the frequency and length of visits, and caseload. An example of one such program is provided in Box 4.

BOX 4.

Early Learning Resource Unit's Family Community Motivator (FCM) Program

The Family Community Motivator (FCM) Program in North West province supported by the Department of Social Development. Through individualized home visits, the FCM program focuses on the supporting the caregiver's emotional needs and enabling them to create safe and stimulating home environments for young children.

Intervention:

- Caregivers with children 0-2
- 18 hour-and-a-half long home visits over 10 months; monthly group workshops
- FCMs model and coach caregivers and children to engage in early learning activities using locally-sourced materials.
- Frequent, in-depth sessions establish trust that can help create lasting change

Training:

- Four, 5-day training modules over 6 months
- Holistic ECD focus in addition to health

Role & Workload:

- 20-40 caregivers per FCM

Supervision & Support:

- 1 supervisor to 10 FCMs, regular individual and group-based supervision opportunities.

⁶³ National Department of Health (2011). WBOT Implementation Toolkit

⁶⁴ Daviaud and Besada (2017a.)

⁶⁵ Jaskiewicz, W., & Tulenko, K. (2012); De Kok, M. et al. (2015); Lehmann, U., & Sanders, D. (2007).

⁶⁶ A version of this table that compares the CHW and the home visiting program and a second table that compares their roles and responsibilities are included in Annex I.

⁶⁷ Whole home visiting is an approach also used by CHWs to deliver services, the dedicated maternal and child health programs described here are referred to as home visiting programs in this report.

⁶⁸ Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vaivada, T., ... & MacMillan, H. (2017). Nurturing care: promoting early childhood development. *The Lancet*, 389(10064), 91-102.

⁶⁹ Walker, Polly. (2017). "Tomorrow's CHWs: Early Child Development. Interview with Aisha K. Yousafzai" *Tomorrow's CHWs: Early Child Development | CHW Central*, CHW Central, Feb. 2017. Accessed Dec. 2017.

Based on a review of home visiting programs, a number of good practices, which may influence policy and programmatic decisions around how best to support CHWs, emerge.⁷⁰ These include the following:

- Recruit home visitors from the community they will serve.
- Align programs and service formats to clear objectives (e.g. support stimulation, improve parenting practices).
- Develop a structured, age- and developmentally-appropriate curricula aligned with key developmental periods, but empower home visitors to adapt sessions based on the participants' needs.
- Engage with caregivers and children on a consistent basis for at least a year, starting antenatally.
 - Allow parents and caregivers to attempt play and communication activities and receive feedback to support practice.
 - Supplement home visits with group sessions which can enable caregivers to their practice skills as well as develop a broader support network.
- Provide broad-based training on community development, human rights, adult education, child development, and early stimulation methodology

and facilitation (including learning through play and how to work with children) – in addition to core health and nutrition domains.

- Combine theory with practice, incorporate role-playing, videos, and other adult-learning techniques, and build capacity to respectfully engage with caregivers to facilitate behavior change.
- Protect the home visitor's well-being and development by ensuring adequate training, supervision, and support.

SUMMARY

CHW and home visiting programs can positively impact child outcomes.⁷¹ However, they can also be difficult to implement given the complexities of the systems and the multiple risk environments of those they serve. For these roles, the inclusion of curative tasks, a mix of financial and non-financial (e.g. recognition) incentives, availability of supervision, and continuous training are important elements of well-functioning systems, while barriers to effective practice to include a high workload, lack of clarity on the scope and role, limited resources and logistical support, and the absence of clear career pathways.⁷² These dimensions are particularly important to be aware of when the scope and services of the CHW are changing, as is the case in South Africa.

⁷⁰ Adapted from Burt, F., Girdwood, E., and Murray, C. (2013). Clarifying Human Resource Priorities for Early Learning Stimulation in South Africa: A Case Study in North West Province. Commissioned by Ilifa Labantwana.; Walker, P. (2017) and author review of home visiting programs

⁷¹ Nkonki, L., Tugendhaft, A., & Hofman, K. (2017). A systematic review of economic evaluations of CHW interventions aimed at improving child health outcomes. *Human resources for health*, 15(1), 19.; Peacock, S., Konrad, S., Watson, E., Nickel, D., & Muhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC public health*, 13(1), 17.

⁷² De Kok, M. et al. (2015); Lehmann, U., & Sanders, D. (2007). ; White, M. S., Govender, P., & Lister, H. E. (2017). Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal. *African Journal of Disability*, 6(1), 1-8.

IV. Provincial Case Studies

While the early sections of this report focused on the broader context of the first 1000 days policies and system of care in South Africa, the following case studies examine the implementation experience in the Western Cape and KwaZulu-Natal, with an eye towards identifying lessons and enhancing future policy and practice.

WESTERN CAPE

Child Health Context

The Western Cape is home to just over 655,000 or 11% of children under age 6 in South Africa, 95% of whom reside in urban areas.⁷³ While approximately 10% these children live in households with poor water and sanitation, 37% live below the upper poverty line.⁷⁴ Health services are accessible for the majority of the population, and close to 90% of infants complete the primary immunization course; however, nutritional support, including Vitamin A coverage, still lags. While birth registration is high (95%), too few eligible children under age 6 receive the child support grant, including in the first year when it could have significant impact.⁷⁵ These and other interrelated challenges, such as rapid in-migration, affect the health and quality of life outcomes of children.

Health Care Organizational Model

The Western Cape Government Department of Health (WCG DoH) has a long-established model of contracting with non-governmental organizations (NGOs) to deliver health and wellness services, including CHW services.

BOX 5. Western Cape CHW Program At-A-Glance

- *Title:* Called Community Health Workers (CHWs)
- *Employment Status:* CHWs are contracted on an annual basis by WCG DoH-contracted NGOs
- *Coverage:* 3,636 CHWs in the Western Cape; highest CHW to population ratio in Karoo (1.45:1000) and lowest in Cape Winelands (.54:1000)⁷⁷
- *Recruitment Requirements:* Recommended Grade 12 required or recognized past learning (RPL) and experience working in the communities; recruitment coordinated by the NGO
- *Training:* Pre-qualification course supplemented by modules on Women/Maternal/Neonatal/ Child Health, TB, HIV, Chronic Disease, which includes mental health and injuries; Training coordinated by the NGO with support from the WCG Community-Based Services (CBS) Coordinator.
- *Salary:* CHW Band 1: R1870, Band 2: R2020, Band 3: R2190; NGO Supervisor: R3865 – 4135 (2017/18 service year) and for 4.5 hours / day
- *Caseload:* Recommended 1 CHW per 130 Households for 4.5 hours / day; however, caseloads are often much higher

Provincial officials noted that WCG DoH decided to stick with the NGO-contract model, citing historical arrangements as well as the fact that they have developed expertise in this model and the associated, well-functioning contract mechanisms to enforce it. NGOs are contracted by the WCG DoH for a period of three years and undergo a structured performance evaluation process each year.⁷⁶ Portfolio managers oversee the

⁷³Hall, K. et. al. (2017).

⁷⁴Statistics South Africa: General Household Survey (GHS) 2015. Data analyzed by Children's Institute, University of Cape Town. The upper poverty line was R965 per person per month and is referred to as the minimum required to afford both food and basic non-food items.

⁷⁵Hall, K. et. al. (2017).

⁷⁶ Contracts may be revoked if performance standards are not met, particularly in the first year.

⁷⁷WCG DoH (2014). CBS Expenditure Review 2012/13. Powerpoint Presentation.

contracting process and performance management is conducted at a substructure/district level.

CHWs are the frontline providers within the WC's Home and Community Based Care (HCBC) program that focuses on wellness, health promotion, prevention of ill health, and self-management support. Approximately 90 NGOs provide CHW services, employing 3,636 CHWs. An NGO Supervisor (non-professional) provides supervision and/or group facilitation for under the leadership of an NPO Coordinator (Professional/Enrolled Nurse). There is one NGO Supervisor and one NGO

Coordinator for every 15-20 CHWs. NGOs with over 30 CHWs must also employ an NGO Project Manager.

The CHW base salary is R1870 for 4.5 hours of service per day and there are two additional pay bands aligned with the level of training completed. NGOs are funded through the Extended Public Workers Program (EPWP) and the HIV conditional grant. The CHW to household and population ratio can vary quite dramatically depending on area, from .54 to 1.45 CHWs per 1000 persons in Cape Winelands and Karoo, respectively, and ensuring coverage and consistency is a further challenge for the health system.⁷⁸

BOX 6.

Example of Health and Wellness Service Providers Contracted by WCG DoH

The Philani Mentor Mothers Program

► Home Visiting NGO with maternal and child health experience contracted to provide CHW services

Operated by the NGO Philani, the Mentor Mothers program is a home visiting program operating in the Western and Eastern Cape focused on maternal and child health (with 150 Mentor Mothers serving approximately 8000 families in 2014). The program was established in the 1970s to address severe cases of malnutrition in children that were not adequately treated within its clinics and who required a more intensive, home-based intervention. Typically, Mentor Mothers are women who have successfully raised children in the face of adversity.

The WCG DoH contracts the Philani Mentor Mothers program to deliver the CHW package of services (in addition to their standard practice). Mentor Mothers undergo an intensive 6-week training course which includes 2 weeks of generalist CHW training. Mentor Mothers maintain a caseload of approximately 500 households (which includes approximately 40-50 pregnant women or mothers with young children).

Philani is considered a best-practice service and that is well-placed to provide more comprehensive first 1000 days services, given the NGO's maternal and child health focus; however, Philani is not representative of most NGOs contracted to provide CHW services. For instance, the Philani model incorporates almost a month of training using cognitive-behavioral change strategies and focuses on a broad range of challenges facing families and emphasizes supervision. WCG DoH has also tapped Philani to provide additional training and support to lesser-performing NGOs.

The Parent-Infant Home Visiting Program

► Home visiting NGO contracted to provide supplementary first 1000 days services

The Parent Centre's Parent-Infant Home Visiting Program (PIHV) is an example of a home visiting program almost exclusively focused on supporting the caregiver's mental and emotional well-being and developing positive parent-child relationships in the first 1000 days.

WCG DoH's NGO contracting model allows them to leverage affiliate service partnerships that support more specific, intensive service models like the PIHV. This program does not provide generalist CHW services. Instead, PIHV receives referrals from health facilities and CHWs and engages caregivers in 20 intensive, hour-long sessions spanning the first trimester to approximately six months after birth, with a specific focus on increasing attachment, developing a positive parent-child relationship, and supporting the caregiver's mental and emotional well-being. The home visitors in this model go through much more extensive training, are supervised by a qualified social worker, psychologist or registered counselor in a ratio of 1:4.

While the specialty focus and intensive supervision that is core to the program's success suggests that it is not a candidate for scale-up, The Parent Centre has developed a 3-day core course, that could be easily leveraged as a core module on parent support in the training of CHWs. The PIHV is primarily funded by DSD, with support from DOH and private funders, and highlights the necessity of collaborating across sectors in order to provide comprehensive services to families and young children, especially the most vulnerable.

⁷⁸ Previously, the WCG DoH calculated services by population, in contrast to NDoH which typically reported services against households. Efforts have been made to align the data collection and tracking with NDoH.

While this contracting model can be beneficial for delivering comprehensive first 1000 days services, it can present some challenges. On the one hand, contracting with NGOs can enable support to diverse populations, as organizations may be well connected in particular communities and able to tailor services to vulnerable populations. However, this may pose risks and perpetuate disparities in coverage if NGOs are not present in areas where services are needed. At the same time, this model is likely to be less effective when contracting with NGOs which have less relevant experience. For example, expanding to first 1000 days services via an NGO with origins in TB care may be more difficult than one which has specialized in the provision of maternal and child health care. Two programs described in Box 6 illustrate contract and service delivery options present in WC.

THE STATUS OF IMPLEMENTATION OF THE NIECDP AND FIRST 1000 DAYS SERVICES

At the Provincial and District levels, those interviewed were very familiar with NIECDP, and importantly, demonstrated awareness of the enhanced focus on supporting parents and ensuring opportunities for play and stimulation for very young children. Provincial leads highlighted that this approach was welcomed and consistent with on-going PHC Re-engineering efforts, including efforts to establish a life-course model of care and better address social determinants of health. However, while there is significant desire to build capacity and enhance on-the-ground services, much of WCG DoH's work to date has focused on awareness-building. A review of their efforts and supportive platforms, including the development of the First Thousand Days Initiative, revisions to the NGO Service Package, and Catch and Match program are described below.

The Western Cape has made significant progress laying the groundwork that will enable it to implement an expanded service package through CHWs focused on the first 1000 days and consistent with the NIECDP. The province has sought to integrate first 1000 days services into its programs and activities related to infants, children and mothers, as well as its planning meetings. The WCG DoH's approach, including some of their organizational structure, is based on the *Survive, Thrive and Transform*⁷⁹ format adopted by

⁷⁹ *Survive* relates to ending preventable deaths – maternal, stillbirths, neonates, as well as babies in the various stages of development; *Thrive* relates to the child and mother realizing their full physical, cognitive/mental and social potential, as well as exercising the right to sexual and reproductive health; and *Transform* relates to policy and cultural transformation with a strong inter sectoral focus, which should address problems such as teenage pregnancy, substance abuse, malnutrition, environmental health and maternal mental health and parenting within the home and community.

the World Health Organization's Global Strategy for Women's Children's and Adolescent's Health.

First 1000 Days Initiative

As part of Goal 3 of the Provincial Strategic Plan 2014-2019 (PSG 3) which aims to increase wellness and safety as well as tackle social ills, the WCG DoH established the First 1000 Days (FTD) Initiative. It is a multi-sectoral initiative coordinated by the Department of Health with the ultimate objective of ensuring that parents and caregivers in the first 1000 days are cared for, nurtured, and empowered to raise children who are happy, curious and resilient, and maximize their developmental potential for the benefit of the wider community.

- **Situation Analysis:** As an early planning step in 2016, the Perinatal Task Team, which brings together representatives from the medical and government communities, drafted a rapid situational analysis on the first 1000 days in the Western Cape which enabled the WCG DoH to create a uniform platform from which to base their actions. The key recommendations from this included: creating an Intervention Framework, developing a comprehensive Package of Care to be applied across the care continuum, prioritizing evidence-based interventions, and improving information systems to better enable process and outcome monitoring.

FIGURE 3.
First 1000 Days Initiative Logo



- **Logo, Website and Communication Activities:** The development of a logo (see Figure 3) and website further helped to brand the FTD Initiative. The logo contains images representing health and nutrition

“grow”), nurture and support (“love”), and safety and stimulation for early learning (“play”) and is essential to the public communications campaign, which included messaging disseminated through taxis ads, social media, and radio. Key messages are also shared with families and providers through pamphlets in hospitals and sub-district health facilities. In addition, WCG DoH has led “FTD roadshows” intended to bring together various health departments, the NGOs, and other sectoral departments (Social Development, Education, etc.)

- **Theory of Change:** As a multi-sectoral initiative, WCG DoH brought together a range of partners to develop the initiative’s Theory of Change (ToC). Bringing together stakeholders from the Departments of Social Development, Education, Cultural Affairs and Sport, and Transport, as well as the City of Cape Town, NGOs, and researchers for the ToC process allowed them to co-develop a vision of success, which was premised upon intersectoral collaboration. Multiple actors noted that, while this process was challenging, and resulted in a highly complex ToC, it was essential to establishing buy-in and garnered support for the long-term vision.

This set of actions has built awareness around the importance of the first 1000 days, while also engendering support from other actors critical to its realization.

NGO Service Package

Another significant and concrete step taken by the WCG DoH is to start to align the 2017/18 Service Packages for NGO Funding with the FTD initiative. Within the CHW program, WCG DoH added “promotion of key family practices including care for early childhood development” and “child stimulation and play” (defined as counseling caregivers on healthy growth and development, focusing on play and communicating with the child) to their key intervention strategies, demonstrating their commitment to providing comprehensive first 1000 days services. However, while referencing these strategies is a first step, it is difficult to say if CHW practice on the ground has changed as a result, as little is known or defined about how the NGOs are trained or equipped to deliver these services, if they are actually delivered, and their relative quality.

The 2017/18 Service Package also highlights efforts to standardize and align CHW training, noting that “CHWs will be taken through a Basic orientation to community health work, as well as a refresher course, and/or Practical Approach to Care Kit (PACK) Community⁸⁰ program and in future the new NQF level 3 Community Health Worker qualification.” This will be an important further step in ensuring quality throughout the system; however, additional efforts will be needed to ensure that these materials adequately prepare CHWs to deliver first 1000 days services.

Catch & Match Program

The implementation of the FTD Initiative will likely be supported through the further development and roll out of the Catch and Match program, an enhanced and integrated community-based model of care, first piloted in 2015. The main goal of this program is to improve access to care by strengthening screening (“Catching”) and referral (“Matching”), facilitated by mobile health platforms. CHWs will use a cellphone application to upload real-time patient data into an enhanced electronic health system (collectively known as “Digital Health”). This is further aided by the development of the Single Patient Viewer which will enable all providers, including CHWs, to access the client’s health history, enabling better, more timely, targeted care and referral, which can be especially important in the critical first thousand-day period. While this initiative holds significant promise, especially if further aligned with other service sectors, there are privacy concerns that come will allowing non-governmental, non-professional CHWs to access clients’ complete personal health data. This highlights need for a training that can assist CHWs to appropriately understand health record and deliver care.

Despite commendable progress in raising awareness of the first 1000 days, those interviewed correctly identified that the challenge remains to coordinate action that leverages these platforms and improves on-the-ground service delivery in the first 1000 days. Provincial and district-level stakeholders highlighted the need to strengthen inter-sectoral departments in order to generate success and ensure that referrals are addressed in a timely way between health and social development, for example. Moreover, while there has been significant progress on the “grow” component of the program, additional guidance is needed on the “love and play” components, including on what services and activities to incorporate, service dosage, ratios, and impact

⁸⁰ For instance, the PACK Community Care Worker and PACK Child, as presently described, focuses exclusively on chronic health conditions and managing common childhood health conditions. Similar PACKs could be developed to focus more broadly on first 1000 days issues and supportive care.

measurement. Lastly, despite recognition of the value of the inter-sectoral coordination, this approach should pervade the system, including at district and sub-district levels. It should not remain only high-level collaboration, as was the case with the development of the ToC.

BARRIERS AND ENABLERS TO IMPLEMENTING THE FIRST 1000 DAYS SERVICES

This section briefly reviews the current CHW role across key workforce dimensions to better understand the potential barriers and enablers of scaling up first 1000 days services through this workforce.

Recruitment, selection and training

CHWs are recruited, selected, and trained by the contracted NGO, which can free up the WCG DoH and district/substructure staff to focus on contact management, broader training needs, and system coverage and quality. However, the DoH must trust the NGO to recruit adequately qualified individuals. The Service Package outlines that CHWs should have Grade 12 or equivalent Recognized Prior Learning (RPL), community experience, and agree to the training package. While commendable, those interviewed, particularly the CHWs, noted that education level was not the main determinant of success, rather it was the ability to support and engage with families and communities in a respectful manner, leading them to, in turn, take-up of health messages and services. Given the relationship-based nature of many of the first 1000 days services, this warrants a review of the education requirements, especially in areas facing staffing challenges.

As NGOs also coordinate CHW training, there can be significant variation in content and quality. This variation was cited by provincial leads as a catalyst for efforts to standardize the CHW training. With the introduction of first 1000 days services, it will be especially important to develop core components or modules that can be uniformly delivered and against which CHW competencies can be assessed.

CHWs emphatically indicated that they need additional and on-going training to provide quality services. One CHW noted, "We go above and beyond," noting that they are faced with complex situations that exceed their current training. The type of training requested varied from wound care to emotional support, further highlighting the breadth of CHW services and the variation between NGO providers. CHWs also did not

feel they had the capacity or proper training to facilitate group support sessions or coach families to actively engage with children in support of their learning and development. On-going training is also needed as CHWs said that they came from various disease-based backgrounds. As a result, they had developed unique areas of expertise, and were more comfortable providing those services, as opposed to generalized or developmental care.

Role and Workload

Regarding the role and responsibilities of the CHW, one district-level official noted that "Don't think that just because it is the first point of care, that it is simple." CHWs already provide a broad set of services, which may constrain their ability to perform additional tasks related to the first 1000 days; CHW coordinators noted that their capacity to take on these services is also likely due to their limited levels of education.

While progress has been made, there is a continued need to ensure that families and communities understand the CHW's role in providing health prevention and promotion services, as CHWs indicate they can be asked to assist with house cleaning or bathing, a vestige of the earlier care system. And while the workload, in terms of households covered per CHW, was not said to be a particular challenge, CHWs did note that they were often called at all hours, stemming from their role as the first point of contact in the health system.

More importantly, those interviewed at the district and provincial level repeatedly requested additional clarity from the province or NDoH as to the composition of the CHW service package with regards to first 1000 days services. For example, they indicated that the newly-added roles to the NGO service package, including parental support and stimulation activities, remained aspirational because there had not been any changes to or guidance on the exact services that CHWs are expected to deliver. Interviewees also consistently expressed the need to harmonize and clarify the roles and services across sectors. For example, interviewees suggested that there was still confusion between proposed parenting and stimulation services under the NIECDP and those provided by the DSD, which is to be expected because there is no national policy arrangement. Such role definition merits further deliberation and clarification on the part of WCG DoH and should be facilitated through the multi-sectoral FTD Initiative, in consultation with the NDoH and NDSD.

Supervision and Support

Supervision and support also varies and is primarily the domain of the contracted NGOs, apart from broad guidance by the WCG DoH. However, according to CHWs, there was a higher-than-optimal CHW to supervisor ratio ranging 1:18 in one group of interviewees to 1:30 in another. One group of interviewed CHWs described the use of a cascade model, with the one main supervisor and five team leaders with six CHWs apiece. On the whole, supervisors were said to be too busy to provide effective guidance, leading to inconsistencies in how support and information is delivered. There is a mix of individual and group supervision, and while frequency varies, both groups of CHWs interviewed reported a single group meeting per month to review cases and/or skills.

One CHW Supervisor highlighted the need for additional management skills training, noting that she never received formal training to become a supervisor, and expressed the need for additional skills on supervising and mentoring as well as data tracking and work planning. Provincial and district-level leads confirmed there was no standard training and that many supervisors were likely faced with similar challenges. Per the HCBC guidelines, CHW Supervisors are non-professionals, which further suggests that they may be ill-equipped to effectively manage others and require additional training to do so effectively. Despite the seeming lack of attention paid to supervision, stakeholders at all levels indicated that it was critical to success and needed redress. This suggests a severe challenge to the potential expansion of first 1000 days services, which, as discussed, are highly dependent on adequate training and supervision.

Workforce Conditions

The CHWs interviewed demonstrated an intrinsic motivation for their job, especially as financial and non-financial incentives are limited, and believe the services they provide to be essential to the community. Furthermore, the CHWs appear to be valued by the community, with one recalling her patient saying "She [the CHW] is my only hope. She is my doctor." While CHWs play an important role in the community, District-level officials noted there was still some bias towards the facility-based and tertiary services, even for conditions and needs well-within the domain of the CHW and community-based services, which further suggests need to clarify roles with the community.

Despite the official 4.5-hour day, CHWs described putting in over-time as they were often called at

all hours to attend to emergencies, which, while making them feel valued, also contributed to burnout. Discussion of extending CHW service hours to 8 hours per day was met with mixed reaction by CHWs who noted that they appreciated the ability to send and receive their children from school and were reluctant to work during the hours of 4-7pm, periods of higher violence. However, they did acknowledge that the working hours meant they may not adequately serve those who work or are otherwise out of the house; this should be investigated more as it will affect service delivery and targeting, especially in the first 1000 days. For example, a home visit during the week could support the grandparent caring for the young child, but the parent might benefit from other support and services made available at nights or weekends.

There was uniform support for additional pay, including more stepped pay options, as well as additional career pathway opportunities, as many left the profession for other higher-paying roles. This was acknowledged by district and provincial-level officials who noted it was under review. Career pathways are important for motivation and retention but can be particularly valuable when extending new services, as it allows for more targeted training and develops in-house capacity which can be leveraged for on-going capacity building as skills are shared with other CHWs.

Despite general recognition of the value CHWs provide, mid-level staff indicate that funding can still be uncertain, inadequate, or disproportionately distributed. District officials noted a bias towards facilities in allocation decisions, commenting that the "tertiary hospitals receive the lion's share of the money," and that this needs to be remedied if the shift to community-based services is to succeed. Provincial level officials made similar comments, noting the need for political commitment to community-based and first 1000 days services, and dedicated funding, which is in part dependent on a formalized service package which can be appropriately costed. The current instability in the funding model also negatively affects NGOs, which can only establish short-term contracts with CHWs or other providers.

District officials acknowledged that while they aim to provide preventative care, they are still just reacting, and that additional funding would allow them to focus on the drivers that would enable this shift: adequate training, supervision and mentoring support, and sufficient numbers of CHWs. Indeed, these elements will be key to the success of the CHW platform and its ability to adequately deliver first 1000 days services.

LESSONS TO INFORM FUTURE SERVICE DELIVERY

There are a number of lessons which can be drawn from the Western Cape implementation experience, including the following:

1. There is broad support for expanding first 1000 days services, but additional policy clarity is needed from NDoH to begin meaningful implementation.

Officials across levels expressed familiarity with the NIECDP and strong commitment to a comprehensive package of first 1000 days services that has already manifested in multiple ways. However, they emphasized the need for clarity from the national Departments of Health and Social Development on which elements of the “love and play” dimensions should be prioritized, measured, and defined as core CHW services. Additional evidence and guidance on dosage, service ratios, and which indicators will be used to assess progress would facilitate further implementation and consistency within and across provinces. The WCG DoH could also undertake evaluations or diagnostics to better understand present service delivery, capacity to expand into these services, and to answer some of the above questions.

2. Management capacity and monitoring and evaluation systems are essential to NGO service delivery models.

The NGO service delivery model is dependent on well-established management capacity and monitoring and evaluation systems throughout the provincial, district and sub-district departments of health, which appears to work well in the Western Cape. This enables the province to continuously review NGO performance, provide additional support, or terminate agreements with non-performers. A provincial framework and plan, with a set of clear targets against which planning and funding of NGO projects could be benchmarked can help ensure coverage and quality once all and NGO services are pieced together.

3. System strengthening can be achieved by leveraging high-performing NGOs to support weaker ones or contracting NGOs to deliver specialized services.

The NGO service delivery model allows for flexibility, however, there is also a risk of coverage gaps or

providing sub-par service to areas with few or weak NGOs that should be monitored and addressed. One way to strengthen the overall system is by identifying and contracting high-performing NGOs to train, mentor, or share best practices with lesser-performing ones. Importantly, this must also be factored into their service contracts and they must be adequately compensated. Specialized NGOs and programs, such as The Parent Centre, can also be contracted to provide training or complementary, in-depth services in areas of higher-need, which can facilitate rapid skill-building and significantly augment the delivery of first 1000 days services. Finally, the NGO model allows for rapid experimentation and the piloting of new initiatives which can further benefit the overall system. While promising, these three strategies are highly dependent on good data collection and monitoring and evaluation processes organized by the province.

4. Training and supervision remain central to the ability to provide comprehensive, high-quality services and should be enhanced.

Training and supervision are key elements of a well-functioning system and there is evidence that both need to be significantly enhanced in the Western Cape, especially as more services are to be delivered. There is the need to systematically diagnose the current training gaps and proactively fill them with initial and on-going training. It is also urgent to address the inadequate training of supervisors, who lack the bandwidth and competencies to provide the necessary guidance and support to the CHWs. Supportive, reflective supervision is especially critical with regards to the expansion of first 1000 days services, as these are new skills and services for CHWs, and which will require on-going training and support to effectively develop and deliver.

5. A broad-based initiative such as the First 1000 Days Initiative in the Western Cape can help establish a multi-sectoral platform for services and enhance visibility of key topics.

The development of the First 1000 Days Initiative in the Western Cape served to bring multiple partners and sectors together to develop a unified vision for children and families, taking a social determinants of health approach. Allowing these partners to collectively develop the theory of change garnered buy-in and reinforced the potential for inter-sectoral collaboration to achieve the desired outcomes. That the FTD Initiative is not tied to a single department (e.g. Health, Social Development) increased its broad appeal

and allowed for the cross-cutting messages to be used in each sector. An accompanying comprehensive communication campaign also served to increase awareness by deploying easy-to-understand messages in a multitude of public venues, which furthered understanding and buy-in across settings. This type of multi-sectoral initiative can be a good model for other provinces seeking to improve collaboration and extend services, as it brings together multiple sectors, experienced NGOs, and academics to help frame and then realize their maternal and child health and development objectives.

KWAZULU-NATAL

Child Health Context

KwaZulu Natal (KZN) is the second most populous province in the country, with just over 1.3million or 21% of the country's children under the age of 6. Despite being the second largest contributor to the nation's GDP, poverty remains a staggering challenge. Roughly three-quarters of children under 6 live in poor households, and 61% live in rural areas. These factors negatively affect children's overall well-being and early development, partially evident by the high rates of childhood malnutrition and stunting, and their ability to access to health facilities. High rates of HIV/AIDS and TB have further challenged the health system. There is also a high rate of migration in and out of KZN, including economic migration, which has resulted in more children primarily reared by caregivers other than their parents.

Community-based Services Organizational Model

CHWs in KZN are known as Community Care Givers (CCGs) and form the backbone of the community and household level services in the KZN Department of Health (KZN DoH) and a critical component of the overall Re-engineering of the PHC system. As in other provinces, CCGs form a key part of the Ward Based Outreach teams (WBOT): each CCG is responsible for approximately 60 Households in a geographically determined area, and each team consists of

approximately 15 CCGs led by a Professional Nurse (PN) and an Enrolled Nurse (EN) based at a health facility.⁸¹

There are more than 10,000 CCGs in KZN, the largest number of community-based care workers in all provinces, although there are still some communities without the full complement of CCGs or other WBOT team members. A significant portion of these CCGs were formerly disease-specific workers (e.g. for HIV/AIDS or TB). CCGs are employed directly by the KZN DoH as official contract public health staff for a fixed term of 24 months, in line with the Expanded Public Works Programme (EPWP). The base salary is R1936⁸² per month for 5 hours per day, 20 days per month. With experience, CCGs can progress to become CCG Supervisors, earning up to R2500 per month. Stipends are paid primarily from the Conditional Grant for HIV/AIDS and TB. As a contract worker under the EPWP, there are certain benefits (e.g. some sick leave and maternity leave); however, they are not eligible for the full benefits package of facility-based health professionals.

Central to the organization and delivery of services in KwaZulu-Natal is Operation Sakuma Sakhe (OSS), KZN's flagship program and intergovernmental coordination model. Translating to "Stand up and Build," OSS is a community and government partnership model that

BOX 7. KZN CCG Program At-A-Glance

- *Title:* Called Community Care Givers (CCGs)
- *Employment Status:* CCGs are employed by the KZN Department of Health
- *Coverage:* 10,060 CCGs in KZN, 495 of which are CCG Supervisors
- *Recruitment Requirements:* Grade 12 (or recognized past learning)
- *Training:* Standardized 12-month foundation phase training (National Qualification Framework (NQF) Level 4. Second Module on MCWH and the Integrated Nutrition Program to be completed after field placement
- *Salary:* R1936 per month; supervisors R2500 per month
- *Caseload:* approximately 1 CCG per 60 Households

⁸¹WBOTs are further supported by District Clinical Advanced Service Teams (DACSTs) which consist of an Advanced Nursing Midwife, Obstetrician and Gynecologist, Pediatrician, Medical Specialist and an Environmental Health Officer and serve as a backup team for the WBOTs, providing immediate support for mothers or their infants in cases where the WBOTs cannot manage emergencies at community or household level

⁸² This amount is calculated annually based on the EPWP minimum daily wage set by Dept of Labor.

seeks to holistically address the issues that affect communities, such as poverty, unemployment, crime, substance abuse, HIV & AIDS, and TB. A weekly “War Room” meeting is held, chaired by the Local Municipal Ward Councillor, bringing together community members, leaders of community workers, and government representatives from across sectors⁸³ to discuss the ward’s needs, identify appropriate interventions, and coordinate services. In this model, CCGs represent the health sector, while similar cadres address community development projects, food security, sport and recreation, and crime prevention.

THE STATUS OF IMPLEMENTATION OF THE NIECDP AND FIRST 1000 DAYS SERVICES

KwaZulu-Natal has made impressive strides in line with South Africa’s push to address maternal, newborn, and child mortality and morbidity outcomes. Provincial priorities, similar to those in other provinces focused on improving child survival, included the establishment of “mother’s waiting lodges” to support healthy birth practices for those in rural areas, and the scale-up of an antiretroviral treatment (ART) and Prevention of Mother-to-Child Transmission (PMTCT) program for pregnant women, resulting in a significant reduction in the mother-to-child HIV transmission rate, and an increase in the child survival rate. The focus has been squarely on promoting an integrated package of maternal and newborn health services, with noteworthy efforts to increase breastfeeding practices.

At the provincial level, there is awareness of the NIECDP and commitment to provide holistic services for families and young children. While KZN provides commendable services related to maternal and child health, nutrition, and social protection, they have not as of yet made widely accessible services for caregiver and parental support, or early stimulation and play, and are clearly still in the “survival” mode. However, KZN has a strong foundation on which to continue strengthening and expanding their first 1000 days services.

Maternal and child health efforts have been supported by the “War Room” concept of bringing government services closer to the community, and to this end they have developed Phila Mntwana or Wellness Centers. Other complementary activities include Human Milk Banks, and the development of a Boarder Mother

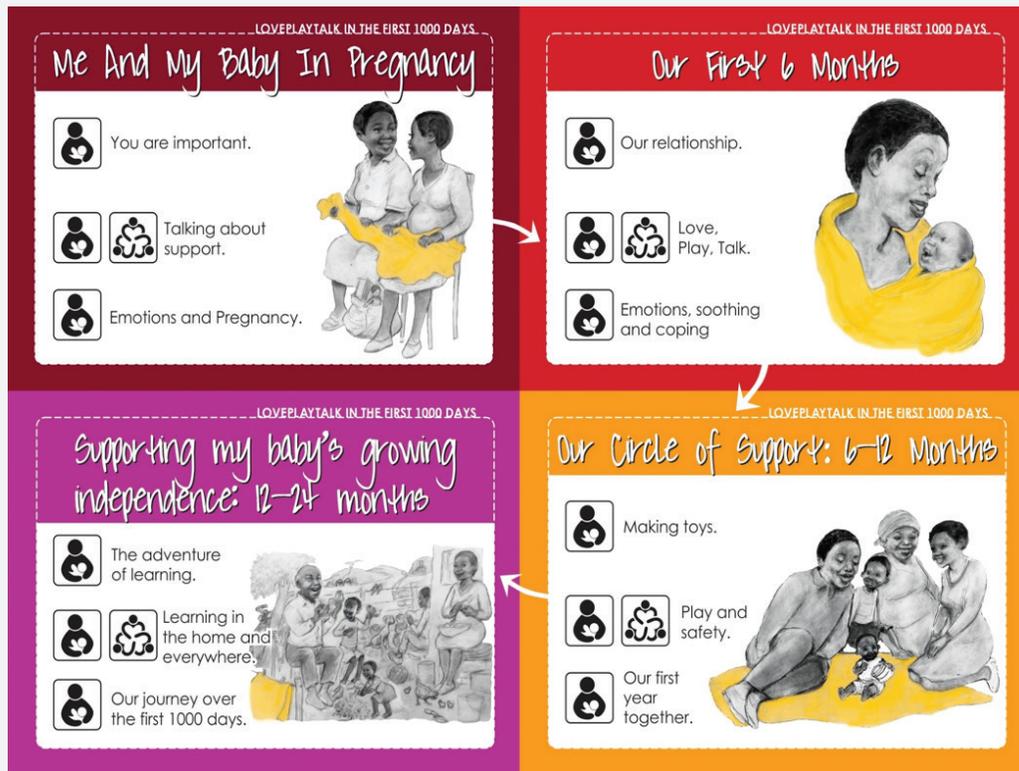
Policy. Recent policy documents and initiatives demonstrate their broader thinking and consideration of a comprehensive ECD package centered around the first 1000 days, including the language of attachment and play. In particular, they have engaged Ilifa Labantwana to pilot a parenting support tool through the CCGs, known as Ibhayi Lengane or The Baby Blanket. These interventions are briefly described below:

- **Phila Mntwana:** In 2013, KZN DoH launched the first Phila Mntwana Centre, to address community health needs and particularly to tackle severe acute malnutrition (SAM) in children under 5. These centers are attached to health facilities but focus exclusively on child and maternal health, so as to reduce wait times and increase coverage. There are now 728 centers which provide the basic maternal and child health services including growth monitoring, screening for malnutrition, supplying vitamin supplements, promoting breastfeeding and tracing defaulters of immunization, and child wellness services. Phila Mntwana Centres are staffed by the CCGs on a rotating basis. These centers are intended to be child-friendly and include pictures, charts, and sensory activity materials on the walls.
- **Human Milk Banks:** The Province has prioritized the promotion, protection, and support of breastfeeding as a key infant and child survival strategy through multiple initiatives. Within KZN, 59.3% of mothers exclusively breastfed their infants at 14 weeks of age and only 23.5% do so at 6 months.⁸⁴ One strategy to address the needs of teenage mothers returning to school, mothers returning to work, and the prevalence of caregivers aside from the mother was to develop Human Milk Banks. There are currently 15 established breastmilk banks in the spanning 9 of the 11 districts. Upon launch, Dr. Dhlomo, KZN MEC for Health, said that “As a department we firmly believe that an investment in the health of children is an investment in the future of the nation. We have committed to do everything possible to provide all necessary help for babies in their first 1000 days of life. Optimal nutrition during this period is critical to ensure optimal child health, growth and development.”
- **Boarder Mother’s Policy:** Approved in April 2017, the Boarder Mother’s Policy seeks to ensure that children receiving treatment in hospitals have continued access to the primary caregiver, who will be given

⁸³ Representative departments include: Health, Education, Social Development, South African Social Services Agency (SASSA), Police and Home Affairs

⁸⁴ Communication with Lenore Spies, Director: Nutrition & MCWH at KZN DoH.

FIGURE 4.
Ibhayi Lengane – Caregiver Messaging Cards



free accommodation on the premises during the child’s stay. This policy recognizes that “promoting holistic care to ensure the wellbeing of the child... requires ongoing access to love, play and support.”⁸⁵ The policy also makes explicit reference to growth, play, and love, which is supported through the caregiver relationship.

- **Ibhayi Lengane:** Ibhayi Lengane, or The Baby Blanket, is a relationship-based support tool specifically for the first 1000 days. The tool was developed in partnership with Dlalathathi and the Africa Centre for Population Health in consultation with the KZN DoH and designed as an add-on for existing health

programs. This intervention includes relationship-based training, supervision, and support for CCGs who conduct three structured home visits (one visit with the family and two with the mother and baby at key developmental periods). Visits are aided by simple, user-friendly material that illustrates the caregiving messages⁸⁶ (see Figure 4). The use of Ibhayi Lengane by CCGs aims to support mothers and caregivers directly using a relationship-based framework for skills transfer, ensuring that caregivers have the capacity to maintain their supportive relationships with children after the intervention ends. KZN DOH regards this tool as part of their integrated approach to child care and development.

⁸⁵ KwaZulu-Natal Department of Health. (2017). Boarder Mother Policy

⁸⁶ Ilifa Labantwana completed a feasibility study of Ibhayi Lengane with results to be published Spring 2018.

BARRIERS AND ENABLERS TO IMPLEMENTING THE FIRST 1000 DAYS SERVICES

This section briefly reviews the current CCG role across key workforce dimensions to better understand the potential barriers and enablers of scaling up first 1000 days services through this workforce.

Recruitment, Selection, and Training

Community Care Givers are recruited to serve in the communities in which they reside, which facilitates entry into the households and increases their understanding of the challenges faced by the community members. CCGs are expected to have completed Grade 12 (there is a provision for recognized past learning, be between 18 and 50 years of age, and demonstrate an interest in and track record of community engagement. However, there are mixed views about the education requirement: some stakeholders believe it allows for easier, better training of CCGs who are capable of more advanced tasks, while others suggest that it should be relaxed given difficulty of hiring and the province's higher employment objectives.

That CCGs that are directly affiliated with the KZN DoH also has a significant positive impact on training, as they can provide alignment and consistency throughout the system.⁸⁷ KZN DoH participated in the development of standardized training for all CCGs in KZN, which is also aligned with the certain requirements of South African educational bodies. The KZN Integrated Community Care Giver Training Curriculum, developed and provided by the provincial government (Amatigulu Training Centre), includes modules to be delivered over a 12-month foundation phase which includes a theoretical basis as well as a practical assessment. The training takes place in teams where the more senior CCGs serve as mentors for the junior CCGs, and hands-on training in the homes and other worksites is coordinated under the guidance of the outreach team leader. The initial training is to be complemented by additional modules on maternal and child well-being and health (MCWH) and the Integrated Nutrition Program coordinated by the districts. Training on the additional modules are provided by the provincial, district, and facility program managers, usually to the CCG supervisors or WBOT team leaders who are then responsible for cascading the training.

⁸⁷ If training is consistently delivered by the government or authorized and well-monitored organizations.

Given that there is a uniform training package, provided by the MCWH and Nutrition Programs, efforts to identify which skills need to be added to facilitate expanded first 1000 days services, and to subsequently roll out such a module, should not pose a significant challenge.

Role and Workload

Community Care Givers are expected to provide an expansive set of responsibilities related to health promotion and prevention, including disseminating information on (including, but not limited to) HIV/AIDS, sexually transmitted infections, TB, male circumcision, maternal and child health and nutrition, health and hygiene, and providing treatment and adherence support in addition to their administration tasks. The integrated scope of practice has been developed to ensure that the CCG is capable of performing social service and referral roles, such as identifying eligible caregivers and facilitating access to child support or foster child support grants. Regular meetings with team leaders are held to discuss and adapt the content of the health messages and information to respond to the changing needs of the community.

Despite the broad set of existing responsibilities, the CCGs we interviewed noted that they would be interested in further strengthening their services related to child development and caregiver support. Discussions with the CCGs also indicated that if these expanded support and developmental services are established, they should be in the home or community setting, as some mothers have family or cultural factors which preclude them from coming to the clinic. They noted that, at present, there is little they can do to support families needing these services, apart from referring parents to clinics or reporting the situation to their supervisors. If trained on more content to directly support caregivers (including fathers and those in primary care roles) and address their well-being, develop secure relationships with the child, or facilitate play and stimulation activities, then CCGs would be empowered to provide on-site services and meet the needs of the community.

Supervision and Support

Each supervisor is responsible for approximately 15 CCGs and conducts periodic home visits with the CCGs to monitor practice and provide support. The

supervisor and the Outreach Team Leader also conduct weekly preparation meetings before community visits. However, stakeholders reported since WBOTs are still being established and vacancies remain, supervisors were often responsible for more than 15 CCGs, which can impact the frequency and quality of one-on-one supervision. Importantly, while CCG supervisors may have content knowledge related to health promotion and prevention, they lack training in reflective supervision which would further support practice, especially if additional early childhood services are to be added. However, there was repeated mention of the presence of informal supervision or support opportunities, starting with the training model which allowed new CCGs to be supported by more established CCGs. CCGs in KZN also tend to go out in pairs, which can reinforce good practice if they are learning from one another to improve their skills. However, they noted that usually one person provided health services while the other supported with household services (e.g. cleaning, bathing support).

Workforce Conditions

Stepped pay and opportunity to become a CCG Supervisor were noted to be important and appreciated elements of a career pathway. However, CCGs and Supervisors felt that the stipends offered under the EPWP framework were too low for the work and breadth of services they deliver. Moreover, take-home pay is often even lower as they purchase mobile airtime out of their stipend, an essential for their work with the community. And while CCGs only work for five hours a day, their hours are often dependent on the needs of the community, which can further complicate their work-life balance. However, given the high unemployment rate, those interviewed noted that they had limited alternatives. CCGs indicated that they would be open to taking on additional tasks related to the first 1000 days; however, their salary would need to reflect the addition of such responsibilities.

With regard to status of the workforce, the formal affiliation with KZN DoH helps to elevate the profile of the CCGs. Facility-based health staff have a better understanding and greater respect for the CCG roles and responsibilities. CCGs noted that they themselves played an important role in providing services to the communities and perceived that they were valued. KZN has also made important strides in defining the difference

between home-based care workers (HCBC) who primarily assist with household cleaning, personal hygiene care, and basic care to the sick and the CCGs who deliver health services and promotion messages.⁸⁸ These are important aspects to consider which can impact on motivation and retention,⁸⁹ and will likely support the sustainability of new first 1000 days services.

Within the communities, CCGs conduct their work on paper-based forms, which can be time consuming and prone to error. DoH stakeholders further indicated the monitoring and evaluation (M&E) is not well developed and considered a work in progress. As the system is changing, there is an opportunity to further integrate first 1000 days service indicators into a revised data collection and M&E service system which would allow for greater understanding of present CHW practice (and capacity to take on new roles), help to determine community need, and aid in prioritizing key services and tracking outcomes. The War Room format also allows practitioners to share data and is an effective platform for coordinating referrals across government departments; efforts should be made to ensure early childhood and first 1000 days issues are being addressed in this platform.

LESSONS TO INFORM FUTURE SERVICE DELIVERY

While many of KZN's initiatives focus on health and nutrition, the province is starting to take a more holistic view of children's health and well-being, as evidenced by the Ibhayi Lengane pilot and Boarder Mother's Policy, both of which emphasize the need for ongoing love, play, and support. The lessons below highlight the Province's progress and how they can continue to drive towards more comprehensive first 1000 days services and positive outcomes for families and young children.

1. Integrating CHWs (CCGs) into the formal health system facilitates training, communication, and service targeting.

Integrating CCGs into the formal health system demonstrates commitment to community-based services and elevates the status of the CCG role. The standardization of training gives KZN DoH a more accurate picture of the skills profile and needs of this cadre, which is particularly useful when considering

⁸⁸ Both are part of the greater WBOT structure, however, HCBCs are typically volunteers (not employed or contracted by DoH) with less education and significantly less training (10 days at NQF Level 1-2). With additional training, HCBCs are eligible to become CCGs.

⁸⁹ De Kok, M. et al. (2015).

upskilling and adding to the current training modules to better serve families in the first 1000 days. Furthermore, clear lines of communication and reporting structures allows for information to more easily flow through the system, helps to ensure consistent messages across service providers, and can be used to better target and serve vulnerable populations (for example, areas with high teenage pregnancy rates).

2. Ensuring clear career pathways can facilitate service delivery and improve overall system functioning.

The tiered workforce system in KZN, informed by the EPWP structure, allows for progression and skill-building from the HCBC to CCG and then CCG supervisor. This not only establishes a career pathway for those entering the community-based health care system but helps to differentiate which health services require additional experience or knowledge and enables basic task-shifting, contributing to the efficiency of the system.

3. Providing additional training on reflective supervision will enhance the capacity of the CCG supervisor and support the delivery of first 1000 days services.

Despite the benefits accrued from a more direct and integrated system, service delivery and quality are still heavily influenced by supervision and support. Providing CCG supervisors with additional training on reflective and supportive supervision should increase performance outcomes and contribute to program sustainability, especially if additional psychosocial, caregiver support and stimulation are to become core elements of the CHW's role.

4. KwaZulu-Natal can further leverage War Rooms and maternal and child health initiatives already in place to strengthen first 1000 days services.

The War Room meetings and OSS experience serve as a strong platform for addressing early childhood

and first 1000 days services in an integrated, multi-sectoral way. War Rooms also serves as an opportunity to engage and align services with other sectors, such as the DSD to improve efficiency, and target the most vulnerable, as well as reinforce the fact that extending first 1000 days services is complementary to and supportive of other community well-being goals.

KZN also has the opportunity to strengthen and extend services for families and young children through initiatives like the Phila Mntwana Centers. For instance, Phila Mntwana Centers could host parenting and other support groups and guide caregivers through stimulating and child friendly activities, building off the sensory walls already developed; this could be impactful given the reach of the Phila Mntwana centers and the fact that they are staffed by CCGs who could provide additional support using the Ibhayi Lengane tool in the home visits. The Milk Banks could be an opportunity to provide targeted support to potentially vulnerable caregivers as well as guidance around developing secure relationships. However, there are still relatively few of these banks in operation; implementing these supportive services through the Kangaroo Mother Care Wards, which are in operation at all hospitals, would reach a much larger segment of the population.

5. The lower number of households served per CCG may allow for more intensive and additional forms of support to families and children in the first 1000 days.

As KZN has the largest number of CCGs, the 60 households served by each CCG is fairly low compared to the other provinces.⁹⁰ It is likely for this reason that recent evidence points to CCGs in KZN spending nearly twice as long per home visit as compared to CHWs in Gauteng.⁹¹ While more information is needed, including about potential differences in services provided, there appears to be an opportunity to increase the scope of CCG service by reallocating some of the visit time to focus more explicitly on parental well-being, the caregiver relationship, and supporting holistic child development.

⁹⁰ While coverage is variable, 60 households per CCG is low in comparison to the 250 households per CHW noted in the 2011 policy implementation document and 2018 WBOT Policy Framework.

⁹¹ Daviaud and Besada, (2017a.) Home visits in peri-urban areas averaged 40 minutes long in KwaZulu-Natal (uMzinyathi) compared to 15-20 minutes in Gauteng (Sedibeng). In both provinces visits in rural areas also lasted significantly longer than in urban and peri-urban areas.

V. Findings

This section highlights the findings from the provincial case studies, the focus group discussion with five provincial CHW coordinators, and interviews with senior leadership at the National Department of Health. Furthermore, it discusses implications for scale-up across the country. Lessons from the literature have also been considered in the context of the information gained in the interviews and visits.

1. There is no standard or agreed-upon service package for the first 1000 days.

The effectiveness of first 1000 days service implementation is contingent upon a shared understanding and further elucidation of the services noted in the NIECDP and the resulting expectations for CHWs. According to nearly all stakeholders interviewed, there is clear need to further define not only the package of services and their priority level, but also for NDoH to provide additional guidance as to how progress by provinces will be assessed, including frequency and quality of services and outcomes will be measured. However, this package of services has not been defined and to define it will likely require more collaboration between the directorates responsible for ECD (Maternal, Women's, and Child Health) and CHWs (Primary Health Care) as well as consultation and support from the Department of Social Development, NGOs and experts in the field.

2. A varied understanding of the implications of the NIECDP for the Department of Health constrains implementation of first 1000 days services.

At the national level, all interviewed stakeholders were familiar with the NIECDP and the breadth of responsibilities assigned to the Department of Health. For example, these national-level stakeholders understood the outlined services and suggested that they fell within their remit, and were aligned with past

planning documents, including NDoH's Strategic Plan on Maternal, Newborn, Child and Nutrition Health, 2012 – 2016. They perceived responsibilities outlined in the NIECDP as further strengthening their existing package of services, rather than new set of services to be added. In other words, the interpretation of these services remained quite tightly bound to the existing health and nutrition services, rather than incorporating a focus on comprehensive caregiver support, improving parent-child attachment, or opportunities for play and stimulation. Furthermore, the NIECDP implementation is unfunded, and the very practical challenge of adding new services without new resources or significant guidance on resource re-allocation, remains.

In contrast, awareness of the NIECDP is limited at the sub-national levels and even amongst CHW Coordinators. During the field interviews, provincial leads expressed knowledge of the policy, and described some of their related services, including the First 1000 Days Campaign in the Western Cape and the Ibhayi Lengane pilot in KwaZulu-Natal. However, during the focus group held with CHW Coordinators of five provinces, which included representatives from the Western Cape and KwaZulu-Natal, participants reported being unaware of the policy, despite its impact on their services and the workforce for which they are responsible. And while some participants at the district-level were aware of the NIECDP, few of the CHWs had knowledge of the policy, suggesting the need for additional awareness-building activities around the policy and the implications for their services.

3. There is broad support for strengthening first 1000 days services, including parental support, early stimulation opportunities, and additional outreach to the most vulnerable.

In discussions with National, Provincial, and local stakeholders, there was strong support for further strengthening first 1000 days services and widespread

recognition that interventions for children under age two can have a significant impact on persistent challenges such as infant mortality, malnutrition, and stunting. Stakeholders also affirmed their commitment to serving the most vulnerable and acknowledged the potential transformational impact these services could have. Participants noted that strengthening the first 1000 days services followed the broader shift towards a life-course approach in the health system, and was aligned with Health Care 2030, the SDGs, and general awareness of the importance of the early years. In particular, the Metro districts in the Western Cape noted there was simultaneous “top-down and bottom-up” support for such policies as they were also being asked to help relieve pressure from the tertiary hospitals in their area, and these services were an important means of doing so. It will be essential to capitalize on this energy, as well as the momentum around the revised Road to Health Booklet, to push for a clearly-defined scope of services for the first 1000 days.

4. Limited technical capacity and understanding of child development services has led to continued reliance on health, nutrition, and growth monitoring services.

Provincial and district stakeholders routinely emphasized progress on components of the NIECDP that fell within the traditional scope of the Department of Health’s services, rather than the more comprehensive family and early learning services. They cited three primary reasons for the lack of attention on these components:

- Limited understanding of the key messages or services needed to promote child development, and importantly, fewer indicators against which to measure progress.
- Persistent high levels of deprivation in some provinces and communities, including KwaZulu-Natal, and the feeling that they must focus on “Survive” before attending to “Thrive” or “Transform”
- Beliefs among some South Africans that parenting and warm relationships came naturally, and that child development was spontaneous (and any developmental issues could be addressed later)

Furthermore, there was some recognition that the Department of Health (across levels) lacked technical capacity and resources to translate the NIECDP into a defined package of services that could be widely implemented. For instance, there was support for the concept of providing caregiver support to vulnerable

populations like teenage mothers, but less discussion about what that support entailed, what were the key messages to be conveyed, or how to engage with parents and empower them to provide responsive care for their children. Without a better understanding of how holistic child development can be supported and the relationship-based techniques underpinning these services, guidance from NDoH is likely to remain centered on health and nutrition. Similarly, the provinces seek more direction to unpack what “parenting support” or “support for early learning opportunities” looks like in practice and how they will be asked to demonstrate progress, a key part of their plan development process.

5. Tension between expanding CHW roles and simplifying them presents a significant challenge to implementation.

Despite recognizing the value in an expanded set of first 1000 days services and their important linkages to addressing broader social determinants of health, CHW Coordinators noted that the expanded parental support and stimulation tasks outlined in the NIECDP may extend beyond the scope of the CHW role and run counter to the prevailing aim to simplify CHW tasks. This represents a potential source of tension between the NDoH and other provincial representatives.

There is consensus that CHWs already have a broad scope of activities and implementation would be aided by a more defined package of services and activities determined by NDoH. Currently, there are no defined parent support or early learning responsibilities in the 2016 Draft WBOT Policy Framework CHW scope of work, only a generic provision to “provide extra support for healthy behaviors during early childhood, including exclusive breastfeeding,” which has been interpreted to be more connected to child health than to development support. One NDoH stakeholder noted that the CHW scope of work will remain broad, and once the training is developed, competencies related to maternal and child health, parental support, and child development to guide practice will follow.

6. Implementation of first 1000 days services has been stunted by a number of factors linked to the ongoing implementation of primary health care reforms.

A significant barrier to the roll-out of comprehensive first 1000 days services is the unsteady implementation of critical primary health care reforms. Despite

progress, implementation has been hampered by human and financial resource constraints.

With respect to human resources, many provinces have had trouble adequately staffing the WBOT model at the CHW and outreach team leader levels. As a result, there are many wards with too few CHWs, without properly trained outreach team leaders, or without leaders at all. Stakeholders across all levels interviewed noted that high education expectations narrowed the CHW candidate pool while low pay led to high turnover among CHWs and should perhaps be reconsidered. The earlier WBOT staffing model called for professional nurses as outreach team leaders. However, there is a dearth of these skilled professionals, leaving teams to supplement with lesser-trained enrolled nurses. The NDoH's WBOT Policy Framework (2018) approved enrolled nurses (who have been oriented to community health nursing) as team leaders, noting that this is a more cost-effective option given the shorter training Enrolled Nurses receive; however, questions have been raised about their lack of experience and ability to effectively manage CHWs, especially as most CHWs are employed by NGOs. If they are to do this well, investments will need to be made in their training and in their supervision.

Inadequate or poorly distributed financial resources, including a lack of a dedicated funding stream, have also hampered implementation. As noted, WBOTs developed as outreach services of health facilities and without a secure or consistent line of funding. CHW coordinators described the need for partners (internal and external) to invest in the WBOT as a health service platform rather than solely in vertical health programs (e.g. HIV/AIDS care). The NDoH commissioned Investment Case⁹² and the WBOT Policy Framework are intended to assist Provinces in their discussions with the Treasury and secure funding to sustain and improve the WBOT platform; however, some feel funding would be more accessible if CHWs were fully integrated into the public health system. The current absence of funding limits opportunities to invest in much-needed platform improvements related to ICT, training, and supervision. Furthermore, that resources may be needed to provide *existing services* makes it that much more difficult to envision that any *additional* funding, above and beyond the current needs, will be allocated for CHWs to deliver expanded first 1000 days services.

7. Enhanced, aligned, and on-going training at all levels, with a focus on developing supportive relationships and understanding child development, is still needed.

Stakeholders noted the need for additional training once the package of first 1000 days services is defined, and for training to be provided at all levels to reinforce content and messages across the health system, as well as support CHW practice. In addition to greater emphasis on supporting caregivers, establishing secure relationships, and overall child development, district-level officials and participants from Philani and the Parent Centre noted the importance of using videos and role plays in addition to theoretical training. Progressive, on-going training would also help support CHWs capacity to provide these services and allow for skill-building over time,⁹³ which would also mitigate the risk that services would be "checked-off" for the sake of compliance.

Commendably, there are currently efforts to review and revise the CHW training content and process, alongside the NDoH WBOT Policy Framework. Phase 1 and 2 of the CHW training consists of 645 topics and there is recognition at the National and Provincial levels that this needs to be simplified and streamlined. However, there are concerns that the training review is being conducted without the full participation of the Maternal, Child and School Health Directorate, which may result in less emphasis on ECD messaging and services that would be critical to the implementation of first 1000 days services. The development of a comprehensive, core curriculum would be beneficial to further align training across the provinces, regardless of how they choose to provide their community-based services.

8. Providing adequate supervision remains a challenge

Despite its importance in ensuring sustainable and quality services, and its particular relevance to delivering new services, adequate supervision and mentoring remains a significant challenge across the provinces. A number of factors identified negatively impacted supervision, including the following:

- Excessive supervision responsibilities as supervisors oversee large numbers of CHWs, in part due to staffing challenges, resulting in limited supervision for CHWs.

⁹² Daviaud & Besada (2017b). Saving lives, saving costs: Investment Case for Community Health Workers In South Africa. What costs and what benefits For the health sector, for the economy and For society. Prepared for the National Department of Health. Medical Research Council, South Africa.

⁹³ Putcha and Mitter (2017).

- Non-existent reflective or supportive supervision training for CHW supervisors, resulting in supervision that is overly compliance-based and focused on service planning and does not meet CHWs emotional needs.
- Limited or inconsistent practical managerial training for CHW supervisors: national-level stakeholders noted that supervisors – who are often enrolled nurses – are not systematically provided training on how to manage, interact with, or support staff; instead, trainings are exclusively content-based.
- Limited or inconsistent use of shadowing, peer development practices, or mentorship opportunities.

9. Coordination within and across sectors is an essential element in raising awareness of and expanding FTD services

Regardless of variation in models and status of implementation, there is a need for strong multi-sectoral coordination in order to expand first 1000 days services. The efforts of the two examined provinces, which have pursued different implementation and contracting modes, highlight the need for intentional

collaboration across sectors, particularly across the Departments of Health, Social Development, Education, and Home Affairs. While both provinces have platforms for inter-sectoral coordination, and stakeholders in both provinces recognize the need to work more closely with other departments, the next step will be to effectively leverage – and likely adjust and improve their respective platforms - to provide comprehensive services in the first 1000 days.

In addition to coordinating and collaborating with other sectors, there is a need for additional engagement with other departments within the health system. The CHW platform falls under the Primary Health Care Directorate at NDoH; however, the Maternal, Child and School Health Directorate is responsible for the early childhood development package and the Road to Health Booklet. This division presents significant challenges for ensuring that CHWs are effectively trained and supported to delivery early childhood and first 1000 days services. It also offers insight into why the interpretation of the NIECDP within the NDoH has focused on elements of health and nutrition.

VI. Costs of an Expanded First 1000 Days Service Platform

While it is difficult to cost a package of services that have not yet been defined, this section attempts to provide estimates for two possible scaling scenarios. These are calculated using the framework established in the recent CHW investment case⁹⁴ commissioned by the National Department of Health.⁹⁵

Ward-based outreach teams are an under-resourced platform currently accounting for approximately 4% of annual PHC expenditure.⁹⁶ This is a significant underspend, especially for a community-based care platform considered to be at the heart of PHC Re-engineering. In a recent investment case for CHWs commissioned by NDoH, Daviaud and Besada (2017b.) found the platform to be highly cost-effective across interventions in mother and child health, HIV/AIDS, TB, hypertension and diabetes, and in some cases, cost-saving for the health system. However, to achieve this benefit, as well as benefits to the society and economy at large, an adequately resourced platform needs to be implemented. Their costing of such a platform to cover South Africa's approximately 46 million uninsured persons totaled R5.6 billion or 11% of annual public sector PHC expenditure.

Daviaud and Besada's calculations are based on the existing scope of CHW services, and do not take into account the potential for expanded developmental, parenting support and early stimulation services to be delivered through CHWs, which would likely increase the amount of time spent on maternal and child health

activities.⁹⁷ It is beyond the scope of this study to define explicit services and the time needed to deliver them; however, based on the literature and findings of the provincial case studies, two scenarios which would allow for increased attention on these important first thousand day services are costed and considered against the base case presented by Daviaud and Besada.

The research team used the framework in the investment case to model two potential scenarios for scaling up first 1000 days services. These use the investment case estimates that 7,734 WBOT teams will be needed to cover the uninsured population⁹⁸ and define core cost drivers as salary, equipment and resource kits, and training. Both scenarios maintain that CHWs are paid R2500 per month (approx. 4.5 hours/day) and are trained for approximately 16 days per year at a cost of R6,000 per CHW.

- **Base Case:** As in the investment case, WBOT teams are composed of 6 CHWs and 3 HBCs, led by an enrolled nurse. Each CHW is responsible for 250 households. A full-coverage platform would cost R5.6 billion annually; a platform only covering the poorest two wealth quintiles would cost R2.5 billion.
- **Scenario 1:** To account for a much-expanded scope of developmental and stimulation services, CHWs would be responsible for a smaller set of households. If each CHW covered 125 households⁹⁹ instead of 250, fully-staffed WBOTs would need 6 additional

⁹⁴ Daviaud & Besada (2017b).

⁹⁵ Consideration should also be given to the Investment Case commissioned by the Department of Social Development and efforts should be made to ensure that services are delivered as efficiently as possible.

⁹⁶ Daviaud, E. & Besada, D. (2017a). Resource Requirements for Community-Based Care in Rural, Deep-rural and Peri-urban Sub-districts: A comparative analysis in 2 districts In Gauteng and KwaZulu-Natal. Medical Research Council, South Africa.

⁹⁷ Daviaud, E. & Besada, D. (2017b). They assume that 40% of CHW time is spent on Maternal and Child Health activities.

⁹⁸ Daviaud and Besada (2017b.) specify costs for the uninsured population based on the assumption that others have access to private services and do not readily utilize the community-based system

⁹⁹ Reducing the CHW caseload to 125 Households from 250 would significantly alter the amount of time each CHW is able to spend with each household, allowing for more intensive services to be delivered, and is more aligned with suggestions made by other researchers and the experience in other countries, including the recommendation by Singh (2013) that suggests a ratio of 1:500 persons. This caseload was also informed by the number of visits per capita Daviaud and Besada (2017a.) which found the home visits per capita to be below projections based on demographic structure and burden of disease, although this is also likely do the current understaffing of the WBOTs. A better estimate would need to be determined based on the agreed service package, demographic and geographic composition, and burden of disease estimates.

CHWs. A full-coverage platform with 12 CHWs and 3 HBCs would cost R7.9 billion annually; a platform of this model only covering the poorest two wealth quintiles would cost R3.55 billion.

- **Scenario 2:** Another role, focused almost exclusively on delivering expanded maternal and child health and development services in the first 1000 days, could be added to each WBOT. This role, potentially an FTD Lead, would be between the level of CHW and Enrolled Nurse, and paid approximately R7500 per month. Hired by the implementing NGO, this role could provide the community-based developmental screening, attachment and parent support, play and early stimulation services in home- and community-based settings, and potentially play a role in providing additional support to CHWs, offsetting some of the work of the Enrolled Nurse. A full-coverage platform with 6 CHWs, 3 HBCs, and one FTD Lead, would cost R6.58 billion annually; a platform of this model only covering the poorest two wealth quintiles would cost R2.96 billion.

These scenarios are presented to roughly indicate the costs associated with two different service delivery models that could potentially strengthen the system. All models are compared with the R2 billion that is currently invested by the public sector annually (Figure 5). While these are more expensive than the base case, and Scenario 1 quite significantly so, they should also be considered against the additional return on investment for the entire system. For example, the investment case (base case) modeled the health impact of scaling up a primary set of maternal and child health services, not an expanded set of services as envisioned in the scenarios above. Expanded services would likely exceed the estimated 3,500 under-five deaths prevented each year and yield additional health and economic returns. Furthermore, these costs likely exceed those required to deliver on the NIECDP as the policy suggests targeting the most vulnerable 30% (as compared to the full uninsured population or bottom 45%); this would bring the cost down to under R2 billion for Scenario 2.

FIGURE 5.
Estimated costs of the WBOT platform under three scenarios



Source: Calculations by the research team based on the Investment Case presented in Daviaud & Besada (2017b).

Scenario 1 would allow for additional time spent with families and children, where CHWs could provide services more aligned with traditional home visiting programs. However, this would require additional training for all CHWs, above and beyond what is accounted for in the Daviaud and Besada calculations, and it may be some time before a sufficient number of CHWs were recruited, trained, and supported to provide quality service. Scenario 2 would create a new FTD lead post within the WBOT (or potentially one post shared across multiple WBOTs further reducing costs) and while this role would require more intensive training than would be provided to the CHWs, it could be implemented faster and in a more targeted way, and it would also address some career pathway concerns.

In either scenario, additional consideration should be given to the content training for other members of the WBOT and facility-based system to ensure that the messages and services are consistent, as well as leadership training necessary to provide CHWs with supportive supervision – both of which affect the quality and sustainability of the model. Consideration should also be given to how a system could be effectively implemented on a geographic or other basis that would not potentially exclude vulnerable families in non-serviced areas.¹⁰⁰ Finally, the CHW salary costs at R2500 per month should be considered against the national minimum wage of R3500,¹⁰¹ and the overall EPWP framework may need to be amended, if the CHWs are to be an integral, long-standing part of the health system.

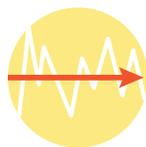
¹⁰⁰ Daviaud and Besada (2017b.) – Saving lives, saving costs.

¹⁰¹ However, R3500 is considered the minimum wage for 8-hours service per day

VII. Recommendations

While this section provides recommendations for the Department of Health across levels to support the implementation of expanded first 1000 days services, full realization of the potential of this expansion relies upon a strong community-based system. Efforts to address several WBOT implementation challenges, including staffing, supervision, training, funding, and integration within the formal health system will provide the conditions for an integrated first 1000 days program with far-reaching impact. However, for this to occur, there will very likely need to be additional resources allocated by the National Treasury, the disbursement of which should be informed by the NDoH and investment cases in development.

1. Define the baseline package of first 1000 days services and clarify the role of the CHW.



► **Target Audience: National Department of Health**

The National DoH should provide additional policy and programmatic clarity on the package of services and the role of the CHW or other health worker in their delivery.

- Doing so should serve to highlight the focus is not just survival
- Doing so will enable the provinces to assess their current service packages and workforces against the National standard, diagnose gaps, and make informed plans to invest in and strengthen services, thereby enhancing the likelihood that they meet the 2024 and 2030 targets laid out in the NIECDP.
- In the absence of a defined service package and role, guidance on the appropriate number, timing, content of the visits, or indicators used to measure service quality and outcomes, provinces cannot engage in functions critical to the success of NIECDP implementation, such as costing and human resource planning.

2. Develop competencies and training aligned to the first 1000 days services



► **Target Audience: National Department of Health, Provincial Departments of Health**

Once a service package is defined, NDoH should develop corresponding core training modules, which allows for continuous skill development and competency attainment.

- Training should include all aspects of nurturing care, emphasizing responsive caregiving, early learning, and safety and security, in addition to health and nutrition.
- Training should leverage adult-learning methodologies and help practitioners to support caregiver behavior change through reflection, modeling, and coaching.
- Trainings should be offered regularly, allowing for new workforce entrants to be quickly trained and for existing practitioners to continue to upgrade their practice.
- Training should be defined for all members of the WBOT, especially supervisors.

There are three training opportunities in the near-term that should be considered:

- **Immediate term:** NDoH and the provinces should ensure that all WBOT and facility-based providers receive training on the revised Road to Health Booklet, while emphasizing the expanded child development and engagement messages.
- **Short-term:** Provinces should identify vulnerable populations and provide additional training to CHWs and supervisors on maternal and family support and child development in those identified areas.
 - Provinces could potentially leverage support from the Department of Social Development or contract high-performing home visiting programs to provide additional training or supplemental services that expand WBOT and CHW capacity to provide comprehensive maternal and child services.

- **Short-to-Mid-term:** NDoH should continue efforts to simplify and standardize national training curricula and approaches to respond to discrepancies resulting from the current, more decentralized approach.

3. Provide appropriate supervisory and support mechanisms to enable CHWs to take on additional service responsibilities.



► **Target Audience: National Department of Health, Provincial Departments of Health**

Provinces should make a concerted effort to stabilize service ratios and provide additional training to those in supervisory positions.

- WBOTs need to be adequately staffed to ensure proper supervision ratios, and supervisors need to be adequately trained to lead, supervise, and develop their staff
- Supervisors need basic managerial and operational training, as well as training on content related to the first 1000 days.
- Supervisors also need to be trained to understand and address the complex and emotionally taxing situations that CHWs encounter and provide them supportive — and not just compliance-based — supervision.

4. Undertake a diagnostic of the CHW and first 1000 days services currently provided to inform expansion.



► **Target Audience: Provincial Departments of Health**

Provinces should conduct a diagnostic of their current service delivery, regardless of the delivery model.

- Such diagnostics should include more detailed information on which services CHWs currently provide, how long they take, their relative quality, and the extent to which the needs of vulnerable populations are met.
- This information would be critical to determining the capacity of CHWs to take on additional first 1000 days services, especially related to parenting support and early stimulation. Similarly, it would help establish guidance on dosage and service ratios, which would allow provinces to better cost and plan services for vulnerable populations.
- This information would also prove essential for additional collaboration and coordination with other sectors, such as DSD, and would ensure that services are aligned, and all vulnerable populations are covered.

5. Strengthen multi-departmental- and multi-sectoral collaboration and coordination and ensure alignment of objectives



► **Target Audience: National Department of Health, Provincial Department of Health**

National, provincial, and local stakeholders must improve collaboration and coordination to better deliver first 1000 days services and to ensure that resources are efficiently stewarded. Stakeholders must also consider whether the current Department of Health structure sufficiently allows the various divisions to align and pursue complementary objectives.

Enhanced communication and coordination is recommended across multiple levels:

- **National:** Improve intra-departmental coordination, especially between the Primary Health Care division which oversees the CHWs and the Maternal and Child Health division responsible for ECD policy and the revised RtHB. NDoH should lead coordination efforts with the other lead departments, including the Departments of Social Development and Basic Education, as well as NGOs and experts, and define the package of services essential to the first 1000 days and develop the training curricula. NDoH should also ensure alignment with the investment case produced by DSD.
- **Provincial:** Improve coordination and planning across health and social development; coordinate to undertake diagnostic referenced above; define roles and responsibilities to reduce duplication
- **Local (e.g. district, sub-district, ward):** Improve communication and coordination to ensure that referrals are effectively addressed, and services delivered. Ensure that first 1000 days needs and services are addressed in the relevant multi-sectoral platforms (ex. War Room meetings)

Review the Department of Health structure to ensure alignment:

- Raise the profile of the NIECDP at the National level and address what system alignment is truly needed for implementation.
- Consider and address the challenges inherent in tasking the Maternal and Child Health division to be responsible for the ECD policy when the CHWs who are expected to deliver many of the services are part of the Primary Health Care division, which has little formal obligation to the policy.

6. Consider the creation of a new service role, the FTD Lead, situated between the CHW and Enrolled Nurse

► **Target Audience: National Department of Health, Provincial Departments of Health**

NDoH should consider formally creating a new role, the FTD Lead, within the WBOT.



- This would help with the implementation of first 1000 days services by creating a focal point for maternal and child health and early childhood development, embedded in the health system.
- In the short-term, FTD leads could be trained and deployed in high-needs areas and serving either a single WBOT or multiple, depending on service needs.
- This could establish a more formal career pathway for CHWs

The FTD Lead could:

- coordinate and lead parent support groups and related early learning opportunities within the communities
- provide additional support to CHWs, including accompanying them on home visits to develop capacity
- support capacity-building and provide on-going training to CHWs
- ensure there are linkages between other community services and sectors

It is not recommended that this role be a formal supervisor for the CHWs, as it may require additional training and lead to line management confusion.

7. Raise awareness of the NIECDP and the role of first 1000 days services

► **Target Audience: National Department of Health, Provincial Departments of Health**

NDoH and the provinces should establish or promote broad-based communications campaigns linked to NIECDP and the importance of the first 1000 days.



- Well-crafted public awareness campaigns would reinforce the need for integrated services and highlight that benefits to the child and family and health system savings are realized by investing in mutually-reinforcing services, (e.g. supporting “love” and “play”

can also improve the care of the child and health/nutritional outcomes).

- Communication campaigns and materials would further support alignment within the health platform. Materials should be made available from providers at all touchpoints (e.g. CHWs, health posts, clinics, facilities, and hospitals, etc.)
- Existing initiatives can be further adopted, scaled, or aligned in order to implement this recommendation.
 - Such resources include NDoH’s Side-by-Side campaign alongside the revised Road to Health Booklet, Western Cape’s First Thousand Days Initiative, or Ilifa Labantwana’s #LovePlayTalk, as well as materials emerging from WHO and UNICEF’s Nurturing Care Framework.

CONCLUSION

This study has shown that while the adoption of the NIECDP is commendable, multiple actions need to be taken to realize its potential and expand first 1000 days services to vulnerable populations. There is increasing awareness of the policy within the Department of Health and understanding of the critical importance of the first 1000 days. However, the default is to rely on the aspects of the policy which most closely mirror the Department’s experience and expertise, in this case, the health and nutrition domains. To initiate meaningful implementation of the NIECDP, the National DoH needs to commit and orient itself towards the full policy, and address the areas where it lacks experience, which include providing more comprehensive psychosocial, parenting, and early stimulation support. To sustainably deliver these services in South Africa or any context, enhanced intersectoral coordination will be essential.

Finally, this study underscores the importance of considering the context in which the workforce operates when assessing the viability and sustainability of expanding services. In South Africa, this means addressing the implementation gaps that limit the effectiveness of the CHWs and WBOTs, which includes a lack of dedicated funding, and challenges with staffing, training, caseload, and supervision. These systems-level gaps, if appropriately addressed, will strengthen the foundation on which first 1000 days services can be successfully implemented and improve the likelihood of durable positive outcomes for young children and families.

Annex I. – CHW and HV Comparison Tables

The following two tables compare the roles and workforce dimensions of CHWs and home visitors in South Africa.

TABLE 3.
Comparison of CHW and Home Visiting Program Tasks

Tasks and Responsibilities	CHW <i>Provides services for all members of the household</i>	Home Visitor <i>Provides services for the caregiver and the young child</i>
1. Conduct community, household and individual level health assessments		
Complete biographical profile with information on health status	Yes	Yes
Determine level of health and social risk facing household and individuals		
Assess need for services ease of access to health and social services		
Identify vulnerable households		
2. Identify potential and actual health risks and assist the household or individual to seek appropriate care		
Provide basic first aid and treat minor ailments (wound care, diarrhea, pneumonia)	Yes	Yes
Refer patients to other health facilities	Yes	Yes
Educate & support for health promotion and prevention for...		
HIV	Yes	Yes
TB	Yes	No
Chronic Diseases	Yes	No
Provide screening and referral services for...		
Maternal mental ill health	Yes*	Yes
Substance abuse		
Exposure to violence		
Developmental delays		
Identify high-risk pregnant women (including those under the age of 19, HIV-positive, mental health or substance abuse issues, and/or exposed to violence) and provide additional home visits/services	Yes*	Yes
3. Provide extra support for healthy behaviors during early childhood, including exclusive breastfeeding		
Educate & support for healthy behaviors for Maternal and child health...	Yes	Yes
Refer patients for antenatal care services (ANC)	Yes**	Yes
Support birth preparedness and provide information on the prevention of mother to child HIV transmission (PMTCT)		
Support post-natal and newborn care		

Tasks and Responsibilities	CHW <i>Provides services for all members of the household</i>	Home Visitor <i>Provides services for the caregiver and the young child</i>
Promote exclusive breastfeeding and counsel on Infant and young child feeding (IYCF)	Yes**	Yes
Support and track immunizations		
Provide growth monitoring; Screen for malnutrition		
Provide Health and nutrition advice		
Educate & support for...		
Child development	No***	Yes
Secure attachment		
Playful learning and child stimulation		
4. Counsel on and provide support for family planning choices		
Educate & support for family planning	Yes	Yes
5. Provide follow-up and assistance to persons with health problems including distribution of medicines according to the Central Chronic Medicine Dispensing Model and help with adherence to treatment and treatment defaulter tracing		
Provide basic counselling	Yes	No
Provide psychosocial support across the life cycle, including an integrated approach to adherence support for TB, HAART and other chronic disease treatment	Yes	No
6. Promote and work with other sectors and undertake collaborative community-based interventions, such as early childhood development, palliative care and geriatric care		
Identify and understand community resources	Yes	Yes†
Assist community members to access services (health and other required services); make referrals for services offered by health and other sectors as needed and provide follow-up (e.g. birth registration, child support grant, ID cards)		
Advocate for improved health and community services		
7. Establish and manage support groups, e.g. treatment adherence and disease specific groups		
Provide parent support groups (for pregnant women and parents)	Yes*	Yes
Provide treatment adherence and disease specific support groups		No
8. Provide screening and health promotion programs in schools and early childhood development centers in partnership with school health team and other health care workers		
Conduct health assessments and use screening tools for identifying health problems	Yes	No or limited

* These services are outlined in the 2015 NIECDP, however, implementation status is unknown.

**These services detailed in the 2012 NDoH Framework for Accelerating MNCWH&N Interventions and assumed to be provided.

***These services are not defined in CHW policy but are common services provided by home visiting programs.

†Home visiting programs will provide these services as it relates to ECD, e.g. not palliative care and geriatric care.

Source: The primary categories in the table (in bold) are listed in the 2016 Draft WBOT Policy Framework. The key tasks within each are populated with more detailed information from an earlier CHW documents, including the NDoH Annexure B3. Community Health Workers. Human Resources for Health, Strategy for the South African Health Sector 2012/13 – 2016/17, 012 NDoH Framework for Accelerating MNCWH&N Interventions, the 2015 NIECDP, and the Home Visiting literature.

TABLE 4.
Comparison of CHW and Home Visiting Programs

Workforce Dimension	Community Health Workers <i>Based on 2011 Ward Based Primary Health Care Outreach Teams Implementation Toolkit policy and 2018 WBOT Policy Framework</i>	Home Visitors <i>Based on a review of home visiting literature in South Africa</i>
Recruitment, Selection and Training	<p>Person specification:</p> <ul style="list-style-type: none"> • Grade 12 required for new CHWs as of 2018 WBOT Policy Framework. • No age or gender requirement stated • Functionally literate and numerate with at least 1-year experience as a community-based health worker and some previous training. • Resides in the area that they will be serving (“area” can be expanded based on service needs) • Complete competence requirements and sign a performance agreement. <p>Training:</p> <ul style="list-style-type: none"> • Core content includes health messages on HIV/ TB prevention; strategies for prevention of mother to child HIV transmission (PMTCT); the consequences of alcohol use/abuse; the importance of breastfeeding; and how to avoid malnutrition. • Pre-Service Training varies substantially based on province and implementing partner, with as little as 2 weeks of training. The 2011 Policy established a 3-phase training program (3 phases total), however, implementation was uneven and the majority of CHWs who participated only completed Phase 1. Efforts are underway to simplify, standardize, and accredit training. • In-Service Training is not defined in the policy except that Team Leaders are to provide on-the-job training. 	<p>Person specification:</p> <ul style="list-style-type: none"> • Requirements vary; Grade 9 or 11 commonly required. • Requirements vary; at least 25 years old and gender not specified (clear majority are women). • Functionally literate (English) and numerate; No previous formal training required. • Preference for those with children who are thriving in the face of adversity and demonstrate good listening, communication, and problem-solving skills. • Resides in the area that they will be serving; often identified in partnership with local leaders. • Complete training and competence requirements. <p>Training:</p> <ul style="list-style-type: none"> • Core content includes health messages on HIV/ TB prevention; strategies for PMTCT; the consequences of alcohol use/abuse; the importance of breastfeeding; and how to avoid malnutrition; child development; growth monitoring, use of play/development of playful materials; coping with maternal stress/depression. Some programs are aligned with and include the DoH’s CHW training. • Pre-Service Training varies by NGO, most require between 4 and 6 weeks of behavior-change training that includes a theoretical and field-based component and culminates in an exam. • In-Service Training varies by NGO; most provide at least 1-2 days per quarter.
Role and Workload	<p>Role and responsibilities:</p> <ul style="list-style-type: none"> • Caseload: One CHW is responsible for 250-270 Households in most provinces (KwaZulu-Natal is an exception with 60 households) and works 5-8-hour days. • Dosage: Dosage depends on the family needs and the services rendered. At a minimum, each household is to be visited quarterly. Visits average 30 minutes in length. 	<p>Role and responsibilities:</p> <ul style="list-style-type: none"> • Caseload: One Home Visitor is responsible for approximately 20-40 mothers (approx. 250-500 households) and work 4.5-8-hour days. • Dosage: The number of visits per family and length of the program varies. Most programs consist of at least 18 sessions over the course of one year. Visits average 1-2 hours in length and commonly occur twice a month. Many programs also pair home visits with parent support and group-based activities.
Supervision and Support	<p>Monitoring: Primarily paper-based data collection; there are a few ICT-enabled pilots.</p> <p>Supervision: Type and frequency varies and is not defined in policy.</p> <p>Approximately 1 Supervisor per 10 CHW (2012 NDoH Framework for Accelerating MNCWH&N Interventions).</p>	<p>Monitoring: Primarily paper-based data collection; there are a few ICT-enabled pilots.</p> <p>Supervision: Type and frequency varies, but most programs define a very engaged and supportive supervision style with check-ins each fortnight, one-on-one, and group meetings.</p> <p>Approximately 1 supervisor per 10 home visitors.</p>

Workforce Dimension	Community Health Workers <i>Based on 2011 Ward Based Primary Health Care Outreach Teams Implementation Toolkit policy and 2018 WBOT Policy Framework</i>	Home Visitors <i>Based on a review of home visiting literature in South Africa</i>
Workforce Conditions	<p>Employment Status: Employed by contracted NGOs in most provinces (7 of 9) with one-year contracts.</p> <p>Payment: Average payment between R2000-2500 per month.</p> <p>Resources: If provided, most transportation services are coordinated by the NGOs, some can be reimbursed for fuel.</p> <p>Funding and Costs: CHW programs most commonly receive funding from the Department of Health. The largest cost drivers are stipends and training.</p>	<p>Employment Status: Employed through NGOs with variable-length contracts.</p> <p>Payment: Stipends typically range from R1600 - 2500 per month.</p> <p>Resources: Transportation costs are usually borne by the home visitor; Cellphone allowances are common.</p> <p>Funding and Costs: Home visiting programs can be funded through a variety of sources, most commonly through the DSD and EPWP. Some programs are also supported by the DoH. Most programs also rely on private and/or donor funding. The largest cost drivers are stipends and training.</p>

References

- Austin-Evelyn K, Rabkin M, Macheke T, Mutiti A, Mwansa-Kambafwile J, Dlamini T, et al. (2017). Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa. *PLoS ONE* 12(3): e0173863.
- Black, M. M., Walker, S. P., Fernald, L. C., Andersen, C. T., DiGirolamo, A. M., Lu, C., ... & Devercelli, A. E. (2017). Early childhood development coming of age: science through the life course. *The Lancet*, 389(10064), 77-90.
- Britto, P. R., Lye, S. J., Proulx, K., Yousafzai, A. K., Matthews, S. G., Vaivada, T., ... & MacMillan, H. (2017). Nurturing care: promoting early childhood development. *The Lancet*, 389(10064), 91-102.
- Burt, F., Girdwood, E., and Murray, C. (2013). Clarifying Human Resource Priorities for Early Learning Stimulation in South Africa: A Case Study in North West Province. Commissioned by Ilifa Labantwana.
- Dahn, B., Woldemariam, A. T., Perry, H., Maeda, A., von Glahn, D., Panjabi, R., ... & Simon, J. (2015). Strengthening primary health care through community health workers: Investment case and financing recommendations.
- Daviaud, E. & Besada, D. (2017a). Resource Requirements for Community-Based Care in Rural, Deep-rural and Peri-urban Sub-districts: A comparative analysis in 2 districts In Gauteng and KwaZulu-Natal. Medical Research Council, South Africa.
- Daviaud, E. & Besada, D. (2017b). Saving lives, saving costs: Investment Case for Community Health Workers In South Africa. What costs and what benefits For the health sector, for the economy and For society. Prepared for the National Department of Health. Medical Research Council, South Africa.
- Dawes, A., Biersteker, L., & Hendricks, L. (2012). Towards Integrated Early Childhood Development. An Evaluation of the Sobambisana Initiative. *Cape Town: Ilifa Labantwana*. <http://ilifalabantwana.co.za/an-evaluation-of-the-sobambisana-initiative> (accessed 25 October 2016).
- De Kok., M. et al. (2015). Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. *Health Policy and Planning*. 30:1207-1227.
- Department of Health. (2011). Provincial Guidelines for the Implementation of the Three Streams of PHC Re-engineering. Pretoria: DoH.
- Department of Social Development and UNICEF. (2015). National Integrated Early Child Development Policy.
- Grantham-McGregor, S., & International Child Development Committee. (2007). Early child development in developing countries. *The Lancet*, 369(9564), 824.
- Government of South Africa. (2015). National Integrated Early Childhood Development Policy. Pretoria.
- Hall, K., Sambu, W., Berry L., Giese, S., and Almeleh, c. (2017). South African Early Childhood Review 2017. Cape Town: Children's Institute, University of Cape Town and Ilifa Labantwana
- Jaskiewicz, W., & Tulenko, K. (2012). Increasing community health worker productivity and effectiveness: a review of the influence of the work environment. *Human resources for health*, 10(1), 38.
- Jinabhai, C. C., Marcus, T. S., & Chapona, A. (2015). Rapid appraisal of ward based outreach teams.
- KwaZulu-Natal Department of Health. (2017). Boarder Mother Policy

- Lehmann, U., & Sanders, D. (2007). Community health workers: what do we know about them. The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers. Geneva: World Health Organization, 1-42.
- Marcus, T. S., Hugo, J., & Jinabhai, C. C. (2017). Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa. *African journal of primary health care & family medicine*, 9(1), 1-8.
- Mitter, R. & Putcha, V. (2018). *Strengthening and Supporting the Early Childhood Workforce: Training and Professional Development*. Washington, D.C.: Results for Development.
- Moosa, M. et al. (2017). Insights of health district managers on the implementation of primary health care outreach teams in Johannesburg, South Africa: a descriptive study with focus group discussions. *Human Resources for Health*. 15:7.
- National Department of Health. 2012. Annexure B3. Community Health Workers. Human Resources for Health, Strategy for the South African Health Sector 2012/13 – 2016/17.
- National Department of Health, 2012. Human Resources for Health Strategy for the South African Health Sector, 2012/13 – 2016/17.
- National Department of Health, 2016. Draft Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams. Pretoria.
- National Department of Health, 2018. Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/19 - 2023/24. Pretoria.
- National Department of Health, Strategic Plan for Maternal, Newborn, Child and Women's Health (MNCWH) and Nutrition in South Africa, 2012 – 2016.
- National Department of Health, Provincial Guidelines for the Implementation of the three streams of PHC Re-engineering. September 2011.
- Nkonki, L., Tugendhaft, A., & Hofman, K. (2017). A systematic review of economic evaluations of CHW interventions aimed at improving child health outcomes. *Human resources for health*, 15(1), 19.
- Nxumalo, N., Goudge, J., & Manderson, L. (2016). Community health workers, recipients' experiences and constraints to care in South Africa—a pathway to trust. *AIDS care*, 28(sup4), 61-71.
- Peacock, S., Konrad, S., Watson, E., Nickel, D., & Muhajarine, N. (2013). Effectiveness of home visiting programs on child outcomes: a systematic review. *BMC public health*, 13(1), 17.
- Perry, H. B., Zulliger, R., & Rogers, M. M. (2014). Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annual review of public health*, 35, 399-421.
- Putcha, V. (2018). *Strengthening and Supporting the Early Childhood Workforce: Competences and Standards*. Washington, D.C.: Results for Development.
- Richter, L. M., Daelmans, B., Lombardi, J., Heymann, J., Boo, F. L., Behrman, J. R., ... & Bhutta, Z. A. (2017). Investing in the foundation of sustainable development: pathways to scale up for early childhood development. *The Lancet*, 389(10064), 103-118.
- Rotheram-Borus, M. J., Le Roux, K., Le Roux, I. M., Christodoulou, J., Laurenzi, C., Mbewu, N., & Tomlinson, M. (2017). To evaluate if increased supervision and support of South African Government health workers' home visits improves maternal and child outcomes: study protocol for a randomized control trial. *Trials*, 18(1), 368.
- Schneider, H., Schaay, N., Dudley, L., Goliath, C., & Qukula, T. (2015). The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, South Africa. *BMC health services research*, 15(1), 436.
- Sodo, P., & Bosman, A. (2017). Progress of the municipal ward-based primary healthcare outreach teams in Vhembe, Limpopo Province. *Strengthening Health Systems*, 2(1), 18-22.
- van Ginneken, N., Lewin, S., & Berridge, V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Social Science & Medicine*, 71(6), 1110-1118.

- Van Niekerk, L., Ashley-Cooper, M., & Atmore, E. (2017). *Effective early childhood development programme options meeting the needs of young South African children*. Cape Town: Centre for Early Childhood Development.
- Walker, Polly. (2017). "Tomorrow's CHWs: Early Child Development. Interview with Aisha K. Yousafzai" *Tomorrow's CHWs: Early Child Development | CHW Central*, CHW Central, Feb. 2017, www.chwcentral.org/blog/tomorrows-chws-early-child-development. Accessed Dec. 2017.
- Walker, S. P., Chang, S. M., Powell, C. A., & Grantham-McGregor, S. M. (2005). Effects of early childhood psychosocial stimulation and nutritional supplementation on cognition and education in growth-stunted Jamaican children: prospective cohort study. *The Lancet*, 366(9499), 1804-1807.
- Walker, S. P., Chang, S. M., Powell, C. A., Simonoff, E., & Grantham-McGregor, S. M. (2006). Effects of psychosocial stimulation and dietary supplementation in early childhood on psychosocial functioning in late adolescence: follow-up of randomised controlled trial. *bmj*, 333(7566), 472.
- Walker, S. P., Grantham-Mcgregor, S. M., Powell, C. A., & Chang, S. M. (2000). Effects of growth restriction in early childhood on growth, IQ, and cognition at age 11 to 12 years and the benefits of nutritional supplementation and psychosocial stimulation. *The Journal of Pediatrics*, 137(1), 36-41. doi:10.1067/mpd.2000.106227
- White, M. S., Govender, P., & Lister, H. E. (2017). Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal. *African Journal of Disability*, 6(1), 1-8.
- Yousafzai, A.K. et al. (2016). "Effects of responsive stimulation and nutrition interventions on children's development and growth at age 4 years in a disadvantaged population in Pakistan: a longitudinal follow-up of a cluster-randomised factorial effectiveness trial." *Lancet Global Health* 4: 548-558.
- Yousafzai, A. K., & Aboud, F. (2014). Review of implementation processes for integrated nutrition and psychosocial stimulation interventions. *Annals of the New York Academy of Sciences*, 1308(1), 33-45.
- Yousafzai, A. K., Rasheed, M. A., Rizvi, A., Armstrong, R., & Bhutta, Z. A. (2014). Effect of integrated responsive stimulation and nutrition interventions in the Lady Health Worker programme in Pakistan on child development, growth, and health outcomes: a cluster-randomised factorial effectiveness trial. *The Lancet*, 384(9950), 1282-1293.
- Yoshikawa, H., & Kabay, S. (2015). The evidence base on early childhood care and education in global contexts. Background paper for UNESCO 2015 Education for All Global Monitoring Report.



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