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social development

Department:
Social Development
REPUBLIC OF SOUTH AFRICA

PRESENTATION

NCOP SELECT COMMITTEE: SOCIAL SERVICES

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CHIEF DIRECTORATE: HIV AND AIDS

PROGRESS REPORT

APRIL – AUGUST 2006

1. INTRODUCTION

The goals and objectives for each goal are as follows:

Goal 1: Develop policy, standards and frameworks in relation with Care and Support programmes

Objectives:

- Review current policy framework for CBC
- Develop norms and standards for CBC
- Develop framework for the management of CBC organizations
- Research on care and support
- Develop the M & E framework for care and support

Goal 2: Facilitate and monitor the implementation of care and support programme

Objectives:

- Design implementation guidelines for care and support programmes
- Facilitate the scaling up of programme
- Facilitate the replication of good practice models
- Monitor and evaluate the implementation of programme

Goal 3: Building and strengthening the capacity of CBC organisations

Objectives:

- Facilitate the training of cadre of community caregivers
- Develop managerial skills of CBO organizations
- Monitor and evaluate training programmes
- Facilitate the accreditation of service providers

Goal 4: Coordinate and support stakeholders within the Care and Support Programme

Objectives:

- Conduct stakeholder analysis
- Mobilize resources available for care and support programmes
- Streamline donor programme requirements
- Document and disseminate information
- Monitor and support all coordination

The progress on the first goal: Develop policy, standards and frameworks in relation with Care and Support programmes:

A study was commissioned by the Department of Social Development in partnership with The Joint Economics, AIDS and Poverty Programme (JEAPP) for the evaluation of costs and process indicators for home/community based care and support programmes.

This study consists of two phases. The primary objective of phase I was to carry out a mapping exercise to identify different models of HCBC programmes and list all HCBCs operating in four selected districts. The four districts are Ehlanzeni, Sekhukhune, Ugu and the Nelson Mandela Metropole. The objective of Phase II was to identify possible measurable process indicators and highlight factors in HCBCs that promote and hamper responses as well as to conduct a cost evaluation of CBOs and NGOs from a random selection of CBO and NGO models of HCBC identified in Phase I.

Key Findings –non financial

Management of HCBC:

- In terms of coverage the fewer the number of clients per caregiver, the greater the intensity of visits.
- All HCBC, except one have a management board who are non-executive members advising the project team. The majority of care givers are unpaid volunteers from poor communities helping other poor and destitute people. Care givers themselves suffer from burn-out and require emotional support.
- Funding from the government departments have primarily been for the payment of stipends. Those carers who offer their labour only as a package of care feel unwelcome, *"They ask us so what have you brought us."* One of the fundamental requirements for care is to ensure that the individual's basic needs such as food, hygiene and living conditions are being met. Mostly nursing and domestic care services are provided by the carers. All other services are referred.
- Integration of services with other NGOs and CBOs is limited and inconsistent.
- HCBC have done well in achieving their annual objectives. However, there is no recording of expenses if the programme or activity is not funded or if staff members use their own funds. Institutional memory is contained in the memories of a few management and caregiver staff.
- Almost all caregivers have a minimum of grade 10 qualification; many have grade 12 and some tertiary qualifications. Most caregivers have some form of HCBC training before conducting home visits. Caregivers are requesting training in counselling particularly bereavement counselling and the 59-day HCBC training course because they believe it is linked to the receipt of stipends.
- Some management staff members also have other forms of HCBC training but request more management training. The key management challenge is to obtain funding as well as other forms of support from government departments.

- The key caregiver challenges are the receipt of stipends, funding and supplies from either the Departments of Social Development or Health.

Services provided:

- The content of a home visit service depends on the length of the visit as well as supplies provided. Caregivers managed to package their care according to a 20 minute, 30 minute, one hour, or three hour treatment options.
- Both health and social care services are being offered. Services such as preventative services, intervention, capacity building, training of family caregivers, poverty alleviation, treatment of minor wounds, nutritional support and a referral system to government departments are being offered. There is almost no referral to other organisations offering service to the community.

Beneficiaries targeted:

- All 13 HCBC target their efforts towards Orphans and Vulnerable Children (OVCs) and sick family members, and to a lesser degree, the youth, older persons or people with disabilities.

Key Findings - Cost Evaluation

The costs of six main services have been evaluated; home visits, food parcel, feeding scheme, support group, skills development, VCT, health promotion and day care.

Home Visits

The total annual direct cost of home visits ranges from R26,760 to R316,604. The main cost drivers are the cost of labour and cost of supplies. The variance in cost is reflected in the cost of supplies or the "content of service". The "content of service" depends on whether the service is accompanied by supplies donated by the Department of Health. The cost of supplies is proportionally higher in the four HCBCs in Ugu because they receive home-based care kits, gloves, protein porridge and condoms from DOH. The total cost per beneficiary is not a good measure in itself because it may encourage budgeting for an inadequate service. The cost per visit has been calculated and the variability in these costs depends on the number of client visits made per annum. The number of client visits ranged from 3 to 118 times per annum therefore reflecting huge variances in cost per visit. For this reason an ideal frequency of one visit per week per client was set. Eight of the 12 HCBCs were under-visiting and therefore they will need to budget much more per beneficiary should they decide to increase their number of visits. When the content of service is similar and the frequency is fixed or standardised, it results in comparable costs per beneficiary.

Food Parcels

Food parcels are distributed by only seven of the 13 HCBCs. The total direct cost ranged from R9,000 to R228,560. The variance in the cost of food parcels can be explained by the content of the food parcel, the number of beneficiaries and the frequency per annum (number of times a family receives it). There is no one agreed upon standard of the content of the food parcel across HCBCs. The content of the

food parcel distributed by the Provincial Department of Social Development in Limpopo could be used as a benchmark. The direct cost per beneficiary of this food parcel is R5,714.

Feeding Scheme

The feeding scheme is provided by seven of the 13 HCBCs mainly from the Eastern Cape and Kwa Zulu-Natal. The cost of the feeding scheme service range from R14,833 to R109,590. The main cost drivers are labour to prepare the food and the cost of groceries. The cost differences are in the content of the meal and number of meals. Most feeding schemes consist of one meal per day. The supply of meals is often interrupted by a lack of funding or funding delays. Even when the number of people accessing the service increases, the same quantity of groceries is purchased. This may compromise the quality of the meal. Even if the standard frequency is set at one meal per day, there are huge variances in cost per beneficiary due to content of the meal.

Support Group

Five of the 13 HCBCs offer the support group service. The number of times, the length of time the group spends together and the number of members attending a single session differs across programmes. The cost of providing the support group service ranges from R2,400 to R9,742. The main cost driver is the cost of the facilitator. All support group attendees receive a meal when they are at the centre costs of which are captured under the feeding scheme. When a standardised frequency is set at 72 hours per beneficiary then the variances in cost is explained by the number of members attending a single support group. The recommended number by DOH is 10 and the numbers in this study ranges from 6 to 70.

Skills Development

Six HCBCs offer a skills development service. The main skills offered are bead work, sewing, paper mache and food gardening. The number of beneficiaries range from 6 to 67. None of the HCBCs document records of income and expenditure relating to this activity. The cost per beneficiary per annum ranges from R268 to R1,996. Variances in the costs are related to the cost of the tutor, training, equipment and number of beneficiaries. Since HCBCs share the profits with beneficiaries, the focus should be on initial training and material costs, allowing the activity to become self-sustaining in subsequent years.

VCT (Voluntary Counselling and Testing)

Only the two Drop-in Centres in Ugu offer VCT services. The total direct cost ranges from R17,134 to R42,696. The main cost drivers in providing VCT are the labour costs of the lay councillors and to a lessor extent the materials needed to undertake the test. Dududu cost more than twice that of Ntokozweni and provided services to almost double the number of clients. Carers mentioned that individuals in the community are slow to accept VCT for fear of stigmatisation. The costs per beneficiary for Dududu are a third higher than Ntokozweni because Dududu has two lay councillors compared to one in Ntokozweni.

Health Promotion

This service is offered by five of the 13 HCBCs. The cost ranges from R7,100 to R33,600. The main cost drivers are labour costs incurred to deliver the health messages and incidental transport and telephone costs. One HCBC used literature supplied by DOH while another used condoms supplied by DOH. The number of clients provided with health education range from 931 to 3,200. Costs are sensitive to the number of clients and the content of the service.

Day Care

There are three HCBCs providing this activity (see Table 4.18). All three are from Ugu. The number of clients range from 30 to 65. Cost for this service ranges from R11,714 to R71,690. All three HCBCs provide day care facilities to orphans and vulnerable children. Cost per child is approximately R2000 and are similar across the three HCBCs.

Implications for Policy

- Guidelines for a minimal package of care (norms and standards) along with basic monitoring and evaluation tools should be developed and implemented.
- The setting up of a register of HCBCs whether funded or not should be on-going as per the Appraisal on HCBCs conducted by DOSD with a longer-term view of introducing standards of care to unfunded organisations.
- The Departments should consider the provision of supplies to all HCBCs irrespective of whether they are funded or not. In this way a register of all organisations can be maintained and minimal standards implemented.
- Since government financial resources are limited, the sustainability of HCBCs through capacity building, training of their management staff (on-going, not once-off) and training of all caregivers should be ensured. Training of management staff should include training in establishing and managing successful income-generation projects that can contribute to the longer-term survival of the HCBC programme. As part of the process towards an exit strategy, a mentorship programme could be developed to encourage local business communities to mentor HCBCs. The fact that HCBCs are community-based provides incredible benefits since the community is responding to its own needs. Individuals from the community who are employed should be encouraged to volunteer to take on mentoring roles and assist those who are holding management positions.
- Funding for stipends should be considered via the EPWP. Funding for service delivery should be targeted towards the number of beneficiaries and the content of the service being provided. In this way, HCBCs can be assured of providing an acceptable service. The funding request should include information about other sources of funding to avoid duplication and to ensure that the service can be adequately provided. Funding collaborations should also take place between the two core government departments.

- Uniform definitions of key vulnerable groups should be accepted and implemented across provinces to assist with the recruitment of clients and targeting of services.
- With regard to social grants, attention should be given to grant access by child-headed, granny-headed and youth-headed households. The implication of the suspension of disability grants especially for those taking ARVs, needs to be considered. Consideration should be given to revising the disability grant assessment tool relating to CD4 cell count. Grant recipients should be educated in the fact that grants are a temporary relief and that the appropriate financial management of funds occurs at household level to secure long-term livelihood.
- Palliative care is being constrained by the need to distribute medication. There is a need to encourage retired medical staff to volunteer to supplement the services of carers.
- Stigma and discrimination relating to HIV and AIDS still hamper progress in dealing with the epidemic.
- The requirement that HCBC provide financial audited reports has financial implications for the HCBC programme as well as the donor since funding for the audit needs to be incorporated in the request for financial support. .

Usefulness of the data

HCBC can use the data for their strategic planning, writing of business plans and funding proposals. They can also use the analysis for self-reflection and evaluation. Once the basic input sheet has been completed with existing costs from the financial records of the HCBC programme and from records of donations, they are able to calculate their total costs and therefore cost per beneficiary, per unit of measure and what their budget should be.

NORMS AND STANDARDS

Since 2000 several guidelines have been developed but it became clear that there is still no uniformity in the types and quality of services that organisations are rendering. The above-mentioned study also again highlighted the fact that there should be norms and standards for community-based care and support services. A consultative process was initiated by the Department to develop these norms and standards. The first draft was compiled and circulated for comments.

Norms and standards will ensure the following:

- That quality services are rendered and funds are utilized efficiently with a clear correlation between funds invested and a quality of service rendered.
- Provide a minimum package of care and support services to be rendered within a HCBCS programme.
- Provide guidelines for a monitoring and evaluation framework.
- Close the gap between the emerging and developed NGOs rendering HCBCS programme, especially in terms of funding.

- Provide some level of certainty about staff ratio.
- Guide training and development needs at all levels of the organization that host HCBCS programme.
- Assist government to deal with the ever increasing number of NGOs rendering HCBCS programme.
- Guide the completion of a toolkit for starting and running a HCBCS programme this ensuring standardization of practice.
- Ultimately, norms and standards will ensure the protection of the rights of beneficiaries.

ESTABLISHMENT OF MONITORING AND EVALUATION SYSTEM FOR HOME/COMMUNITY-BASED CARE AND SUPPORT

Background

A recent rapid appraisal of funded HCBC programmes conducted by the National Department of Social Development in 2005-6, established that there were close to 1 490 reported projects nation-wide providing a wide and varying number of services. Some of these projects were funded by the Department of Social Development, some by the Department of Health, while others were funded by donors, charities and other independent organizations. In addition to this program, other prevention programs which address gender and youth in relation to HIV and AIDS epidemic in South Africa.

The projects also differed substantially in terms of size, funding sources and services offered. Each project is expected to develop its own monitoring and evaluation system and report on these to the provincial departments periodically. However, given the varying scale and nature of these projects, not to mention the fact that the M&E systems evolved – if any – would be completely different, it does not appear feasible that the district or provincial departments can firstly, collate this information and secondly, analyze and disseminate the results in a fashion that would be useful to policy makers.

There are also thought to be many non-funded organizations, and there is no record at all of their existence. Indeed, most of these will not be known to any government organization al all. Previous audit reports indicated lack of compliance regarding monitoring and evaluating of our funded NGO's.

After the coordination period of two years, DoSD and JICA agreed on the technical cooperation in the establishment of M&E system for HCBC and the record of discussions was signed by both parties in March 2006.

The purpose of the project:

To implement comprehensive M&E system for HCBC at all levels of governance and service delivery in South Africa.

The expected outputs of the project:

1. Existing M&E systems are integrated into comprehensive M&E system
2. Monitoring capacity of HCBC service providers is strengthened
3. Comprehensive M&E system and MIS commence the operations at all levels of governance & service delivery

The four-year cooperation in the form of project formally started on the 5th of June, 2006, when a Japanese-side coordinator (Long term expert) reported to HIV and AIDS chief directorate.

Progress of the project:

1. Task team was formulated at national level under the administration of
   - the project director-Dr.Kganakga
   - the project manager-Ms. J. De Beer
   - the project coordinator-Ms.M.Lerobane.

   Team consists of the members from
   - HIV Chief Directorate
   - Population Development & Research Chief Directorate
   - M&E Chief Directorate
   - IT Chief Directorate
   - Department of Health
   - Partners: USAID and DfiD
   - JICA

2. Plan of operations was reviewed by task team and revised
   a. Activities were broken down to the lower level
   b. Cost drives were identified for the activities in the first two years (the fiscal years 06-07 and 07-08)
   c. Activities with the need of local consultants were identified for the first two years

Challenges:

a) As the project aims for the INTEGRATED M&E system, the participation of all the stakeholders is vital. Especially, Department of Health from the beginning stage of the project.
b) The concept of the integrated M&E system for HCBC has to be accepted by all the provinces.

c) Budget for computer software development was not included in the master plan of the project. The acquisition of the budget will determine the scale and quality of the system.
d) There are other projects which are very closely related to HCBC M&E system. Mode of collaboration with these projects has to be discussed and agreed upon in the early stage of the project.

Way forward:

1. 1st fiscal year (up to March 2006)
    a. The IT related activities will be reviewed and costs will be estimated.
    b. Detailed budget for the project implementation will be submitted.
    c. Concept paper of the project will be prepared.
    d. Coordination meeting with Department of Health will be held at Chief Director's level and the task team members from DoH will be assigned.
    e. The project will be presented in the Provincial Coordinators Meeting.
    f. Provincial visits will be conducted.
    g. The study of existing M&E system will be conducted
2. 2nd fiscal year (April 2006 – March 2007)
    a. The report on the study of existing M&E system to be finalized
    b. The standardized indicators of the HCBC program, which are the objects of monitoring, will be agreed for all levels of governance and documented.

A number of researches have been commissioned to address the strategic information and enhance knowledge around orphans and vulnerable issues in South Africa. The following are some of the research undertakings;

a) Estimation of orphans using vital registration data:

- This project involves linking identified birth and death data collected through the national vital registration data collected by Department of Home Affairs

- Close working relationship has been established with the Department of Home Affairs, the Department of Social Development and the researcher, Dr David Bourne, Chief Research Officer from the School of Public Health, University of Cape Town.

- The due date for this is November 2006 provided no deficiencies are found in the data supplied.

b) Database on ovc

A study has been requested for the identification of current data systems on OVCs in South Africa at provincial levels and at an international level with special

reference to SADC countries (in particular Tanzania and Botswana). This study will be undertaken by the HSRC, with the following deliverables:

- A comprehensive list of data systems currently available on ovc in Southern Africa
- A comprehensive list of the methodology used to gather the respective data
- A comprehensive contact list of organizations that have gathered this data
- Recommendations should be made regarding:
    - How the data systems can be more broadly utilized in SA to develop a comprehensive system for the care and support of ovc
    - How the data collection and processing can be improved.

c) An analysis on the lessons learnt in addressing the ovc situation in Southern Africa has been commissioned and the Health Development Africa has been appointed.

The expected deliverables for the project is a comprehensive analysis of the lessons learnt in addressing the ovc situation and the strengths and weaknesses of research done, policies in place and interventions implemented with regard to the needs, care and support, identification and registration of ovc in Southern Africa

d) An audit of data sources at a local level including public and civil society sources has been done with the assistance of UNICEF. The study was very limited and only focused on a few organizations but the following could be highlighted:

- Organisations and databases are relatively new
- Diverse services and different definitions of ovc
- Donors often provide impetus for databases
- Most organizations are using paper-based and just a minimal electronic programmes
- Information is generally collected during service delivery
- Usually restricted access
- A database increases efficiency in reporting, tracking, fund-raising and targeting.

A decision was taken that guidelines will be developed on how to set-up a database in an organization.

e) A proposed study on the impact of the home/community-based care and support porgramme as a strategy to mitigate the health and socio-economic impacts of HIV, AIDS and other debilitating diseases in South Africa. The study is a joint undertaking between the National Department of Health's HIV and AIDS and Primary Health Care Units as well as the National Department of Social Development's Chief Directorate on HIV and AIDS. A technical task team is currently developing the terms of reference for the study.

The progress on the second goal: Facilitate and monitor the implementation of care and support programme

At the beginning of the financial year all provinces submitted operational plans, they were assessed and comments were sent to provinces for amendments. The directorate ensured that the plans reflected the provincial targets, activities, outputs and the budget for the financial year 2006/07.

Complementing these plans were the business plans for 2006/2007 for the Expanded Public Works Plan that were received from all nine provinces. The plans were appraised jointly by the HCBC team from Departments of Health and Social Development. Written comments were sent to provinces for amendments of the plans. Revised business plans were received from some provinces.

The current reporting tool for Community Based Care Programme was reviewed and inputs from provinces were requested. The aim of the tool is to enable provinces to report on aggregated quarterly programme milestones, expenditure for the quarter, challenges and future plans for the programme.

The achievements for the period of this report are:

PROVINCES	Eastern Cape	Free State	Gauteng	KwaZulu Natal	Limpopo	Mpumalanga	Northern Cape	North West	Western Cape	TOTAL
Identified OVC	6 037	2 941	18 080	23 090	864	350	309	2 242	540	54 453
Child Headed Households	473	151	1 706	2 727	81	250	66	383	150	5 987
Children on ARV supported	6	-	10	-	17	250	-	-		283
Families Assisted	6 899	2 279	12 583	18 973	3 800	4 500	9 011	13 150	2 550	73 745
Older persons as caregivers	-	-	2 183	-	169	150	-	-		2 502
Foster Care Referrals	4 148	315	1 534	1 372	189	200	11	443		8 212
CSG Referral	-	-	10 561		58	-	173	659		11 451
Counselling	2 119	-	2 157		273	500	3	655		5 707

Food Parcels Distributed	2 698	0	2 079	7 990	9 600	4 500	443	7 040	5 400	39 750
Food Supplements			2 073		18 000		-	1 300		21 373
School Uniforms	-	0	34 247		59		48	1 087		35 441
Funded NGOs, CBOs, FBOs	20	114	29	0	46	52	9	0	57	327
Drop in Centres	-	23	-		23		0	0		46
Cooked Meals	1 408	-	5 159		11 040		-	0		17 607
Organisations complying		-	29		164	52	9	28		
Caregivers receiving Stipends	527	1137		421	2 000	870	450	439	300	6 144
Caregivers not receiving Stipends	1 496	-		2	2 460	170	166	-		4 292
Caregivers Trained in HCBC	247	0	6	930	1 789	718	122	25	110	3 947
Caregivers accredited training	0	0	6		-	450	0	-		456
New Child Care Forums	35	11	0		-	20	0	0		66
Supported Child Care Forums		129	123		13		20	73	16	374
No of coordinating structures established	12	0	11		-	4	0	1	16	44
No of Income Generating Projects	40	0	40	89	108	20	2	0	15	314
New Support Groups	82	0	2		21	52	8	0		165
Existing Support Groups		77	68	28	12		20	42	30	277

USAID and UNICEF assisted the Department (in consultation with provinces) to document 9 projects (one in each province). The main reason for this was to identify lessons learnt in provinces and also to identify gaps. The following projects were documented:

- ChrisTanna Care and Support Group, Pabalello, Upington
- Sweetwaters Drop-in Centre, KwaZulu-Natal
- Simunye, Home-based care, Msogwaba,
- Fanang Diatla Self Help Organisation, Limpop
- Khululeka Womens's Group, Western Cape
- Tafelsig United AIDS Project, Western Cape

The progress on the third goal: Building and strengthening the capacity of CBC organisations

HIV AND AIDS Coordinators Meeting

A three day workshop in which day one was DOSD coordinators meeting; day 2- joint meeting with Dept of Health coordinators; and day 3- HWSETA workshop was organized for HIV and AIDS coordinators. During these three days critical issues were discussed such as the training of community care givers and HWSETA's role in the process.

The audit of caregivers in hcbc projects in South Africa was finalized and presented to Exco. The key findings of the audit were:

- Majority of caregivers are youth (age 20 – 35 years)
- 90% of the caregivers are female
- Educational levels of caregivers and coordinators are fairly high (majority have gone beyond grade 10)
- 72% of the coordinators receiving a monthly stipend
- 39% of caregivers are not receiving stipends
- Volunteerism are still an important aspect of hcbc
- Many caregivers expressed dissatisfaction with the quality of training received
- Many caregivers have attended training programmes that are not accredited by the HWSETA
- Financial hardship was the main reason cited for not receiving the needed/appropriate training
- No standardized hcbc training material
- Many hcbc training service providers are not accredited with the relevant accreditation body
- Variable provincial training on hcbc
- Most of the hcbc training is provided by national NGOS
- Most of the training is out-dated (2 – 3 years old)
- Very few trained caregivers have competency certificates
- Lack of a standardized national training curricula
- Accreditation of service providers/trainers hampered by lack of a "portfolio of evidence"
- ***Qualifications registered with HWSETA are mainly health focused***
- A mentor-learnership programme for caregivers can help speed up accreditation of their skills on the basis of acquired experience.

The module on psychosocial support

A module on psychosocial support was developed by REPSSI as part of six modules for the training of community care givers. The module was submitted to the Department of Health for incorporation into the training package and printing but not yet delivered.

An audit of caregivers was done in the previous financial year but only presented at Exco during May 2006. This audit will assist with the roll-out of appointing and training of community caregivers.

HOME/COMMUNITY-BASED CARE AND SUPPORT CAPACITY BUILDING PROGRAMME (DSD/DFID)

HCBC services are implemented by a range of civil society organisations (CSOs) that can be broadly categorized as Community Based Organisations (CBOs), and Non-Governmental Organisations (NGOs). The AIDS epidemic resulted in a dramatic increase in the need for HCBC services and led to an uncoordinated increase in the number of organisations offering HCBC. The emerging HCBC organisations often lack the required management skills to implement their mandate effectively.

Achievements

- After the quality of the situational analysis report was found unsatisfactory, Cadre agreed to rewrite the report.
- ToR were finalised and the EOI was advertised. From the 32 organisations that expressed interest 8 were short listed to respond to ToR. An evaluation team identified a prospective service provider (NICDAM – Community Connections).
- Partnership with the Limpopo and Kwa- Zulu Natal was formalized and preparatory work started in all 3 provinces (including Eastern Cape). All provinces demonstrated remarkable buy-in and enthusiasm in the programme. In Kwa-Zulu Natal, buy-in was received from the Provincial MEC and the Director General of Social Development.
- The HCBC reference group remains active in programme – drafting of ToR, review of situational analysis report and evaluation of bidders.
- The HCBC capacity building model was presented and was well received by EXCO members.
- The Programme Manager participated in other departmental activities such as Netherlands proposal, development of operational plans, revision of quarterly reports and finalization of local integration tools.

Challenges

- Despite the service providers' attempts to improve the quality of the research report, it is still unacceptable. It has not yet been finalised and has delayed other processes.

- The process of appointing the service provider took long (approximately 3 months) because the situational analysis report was not ready to be distributed to the service providers during the process of report writing. Hence the submission date of tender documents was delayed by a month.
- Selecting one service provider to implement in two provinces proved to be strategically incorrect because the selected provider was not sufficiently BEE compliant and had opportunities in the department. Furthermore using one service provider would not contribute to the pool of [illegible] the department could use in the future. One service provider was eventually appointed to as a sole training [illegible]
- The contract could not be immediately signed because it was [illegible]

In preparation for this management [illegible] of management skills and of the capacity of organisations providing HCBC services and assess the minimum level of management skills and capacity required to effectively render such services. This contributed into the development of capacity building and mentorship model that should now be improved and implemented. .

Selected findings are:

- Most HCBC service providers do not have sufficient management strategies and do not consider their vision, mission and goals in decision making, service delivery and other functions. Many CBOs developed [illegible]