Assessing the costs of providing care to Orphans and Vulnerable Children (OVC) by Home Based Care (HBC) Programs in South Africa

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1. Background

WHO defines home-based care (HBC) as "the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards a dignified death". Some authors define home-based care simply as the provision of care to sick people in their homes (Gilks, et al., 1998 as quoted in Kumaranayake, et al., 2000:19) and also on surviving family members (Schneider and Russell, 2000:14).

Home-based care programs have sprung up in poor and rich countries in response to the HIV/AIDS epidemic (UNAIDS, 2002:155). According to the South African National Department of Health, home-based care emerged in South Africa in the late 90s as a response to a rapidly growing HIV/AIDS epidemic and the limited resources within health institutions to respond effectively to the crisis. The idea was conceived from the notion that community health workers to assist with caring for patients and that some ailments are better treated in the home. Home-based care is defined in South Africa as the provision of comprehensive health and social services by formal and informal caregivers in the home or close to the home excluding institutional care that does not have out-reach programs

The literature indicates that the types of services offered by HBC programs differ substantially. According to the National Department of Social Development in South

Africa, HBCs offer a range of services from income generation to poverty alleviation as indicated below:

- Preventative services – life skills education, information and communication
- Intervention – VCT, placement of children in foster care or adoption, provision of domestic help
- Capacity building – training family members and other care-givers, support groups
- Poverty alleviation – income generation and other self-help skills, covering education costs to ensure children are at school, access to social grants
- Treatment – provision of nursing care and materials, ensuring treatment compliance, transport for sick individuals to and from health care facility
- Nutrition for children and sick adults
- Referral system providing a network of services

HBC organizations deliver services to beneficiaries located in urban and rural areas. Since there is a higher prevalence of HIV/AIDS in urban areas, it is expected that HBCs will be concentrated in urban areas.

Previous studies on HBC programs in South Africa indicate that most HBC programs are managed by non-governmental organizations (NGOs) and community based organizations (CBOs) with limited financial capacity to cost services provided (DOH, DOSD, 2003). HBC programs operate with skilled, semi-skilled or unskilled community caregivers which points to vast differences in cost structures and quality of service.

The definition of Orphans and Vulnerable Children (OVC) is vaguer. There are different policies as well as community definitions that are often used for OVC. However, with the *Children on the Brink* report of 2004, a joint publication of UNAIDS, UNICEF, and USAID, an attempt has been made to consolidate the different definitions into one bigger concept. Within this document, orphans are defined as "children under age 18 whose mothers or fathers (or both) have died, which is mainly used by policymakers and donors in targeting their program interventions.

The total number of orphans is equal to the sum of maternal orphans and paternal orphans, minus double orphans (because they are counted in both the maternal and paternal categories. Through the early 90s, programs focused on targeting "AIDS orphan" which has since become highly inappropriate because it may contribute to "AIDS exclusivity", where children who are affected by HIV/AIDS are treated differently than those who are made vulnerable due to other causes. This can result in stigmatization of children and can worsen their situation within their community. It is universally agreed that there is merit in distinguishing between different causes of orphanhood and vulnerability only as far as this allows for a better understanding of circumstances, vulnerability, and need[1]. Studies have shown that there are no statistically significant differences in anthropometric measures between orphans and non-orphans in under-five nutrition programs. When assessing school attendance, the literature also shows that the gap between orphans and non-orphans in closing with more orphans than non-orphans attending school in some countries

1 Smart, Rose (2003). "Policies for Orphans and Vulnerable Children: A framework for Moving ahead", Policy Project

At the community level, studies have shown that communities go beyond the definition of orphans and use their own definition and categorization of vulnerability. In a study of three community models of providing care and support to OVCs in Malawi and Zimbabwe, Phiri et al[2] found that each community considers the factors that contribute to vulnerability in its area and establishes criteria to identify its most vulnerable members. Typically, children living on their own and children whose two parents have died were given highest priority. Others given priority attention include children who have lost one parent and receive no assistance from the extended family and children who live in a household headed by a female grandparent. Some of the children deemed to be most vulnerable were not orphans and were termed "social" as opposed to "biological" orphans due to neglect or the inability of parents to care for them due to illness.

In the study conducted the Human Sciences Research Council (2004) in Botswana, Zimbabwe and South Africa, the researchers asked 152 respondents ranging from caregivers, community leaders, NGO staff and community members how they would define orphans and vulnerable children. The study found that there was general agreement that the age limit of a child should be 18 years. The overall response that orphan hood appeared to support the construct that the loss of either or both parents would indicate a situation of vulnerability. The remainder of the definition centered around three core areas of dependency:

[2] Phiri, Stanly; Nzima, Masauso and Geoff Foster (2000). "Expanding and Strengthening Community Action: A study to explore ways to scale-up effective, sustainable community mobilization interventions to mitigate the impact of HIV/AIDS on children and families."

- Material problems; including accessed to money, food, clothing, shelter, health care and education;
- Emotional problems; including experience of caring, love, support, space to grieve and containment of emotions;
- Social problems; including lack of supportive peer groups of role models to follow, or of guidance in difficult situations and risks in the immediate environment.

The challenge in supporting and expanding community responses for children affected by and living with HIV and AIDS is the alignment of targeting by donors and policymakers as opposed to communities. Defining OVCs sets the basis for the range and nature of need faced by children, However, by setting rigid definitions for targeting OVCs, donors and policymakers may fail to reach several children in need of assistance. It is suggested that donors have more flexible targeting policies and leave responsibility of the defining and prioritizing vulnerability of children to the community. What is required is a 'bottom-up' approach in targeting interventions to vulnerable children. External agencies should take guidance from the community level to set parameters for assistance. The challenge then would be how to balance the specific community needs with standard operating procedures and policies of external agencies.

2. Why is this research important?

HBC for OVCs has been positioned as an alternative to institutional care by many authors within the literature. HBC is said to be an effective way of involving families and

communities, especially in HIV/AIDS care and support (WHO, 1991 as quoted in Cohen and Trussell, 1996:210). When patients become terminally ill with AIDS, they prefer to be cared for at home. Parks and Weiss (1983 as quoted in Walker, 1991:242) reported that survivors whose family members died at home or in a hospice felt less guilty than relatives of patients who died in hospital. Whilst the hospital provides good medical and hygienic conditions, it isolates the patient from the family.

The literature also points to HBCs relieving some of the burden placed on limited resources of institutions that care for children. One of the key benefits identified in existing literature is the fact that HBC programs can help reduce the number of days a sick person needs to be hospitalised by providing an integrated service in the home in conjunction with health care providers and other partners including the family and the person receiving care (Schopper, 1992; Stewart et al., 1999:1077).

This study seeks to assess the costs of providing services to terminally ill adults in the home. There have been several studies that cost services provided to HIV/AIDS patients in hospitals, the latest of which was done in the Western Cape by the University of Cape Town in 2005. However, very few studies have looked at costing services provided to HIV/AIDS patients by HBCs.

3. The research question

The question in South Africa at this time is whether HBC for OVCs is a viable alternative or complement to institutional care.

In order to address the issues above, the author will seek to answer the following questions:

1) *What types of services are offered to OVCs in the home by HBCs*? The study will identify all the services provided to children and what can be done in the home as opposed to institutional care.

2) *What is the cost of providing care for OVCs in the home*? By estimating the unit cost per child or per service we are better able to provide information on how much the scale up of services would cost. In considering unit costs per patient, the study will only take into account direct costs. It should be noted that indirect costs such as care provided to the patient by family members will not be included in this study.

4. Research on the costs of HBC services

The literature reveals a wide range of program interventions provided by FBOs with a lack of minimal standards. FBOs provide variety of service packages for different contexts making comparisons of effectiveness across programs difficult. Further, the lack of minimal standards for training of volunteers and staff as well as program approaches raises a challenge in terms of setting benchmarks for evaluating program quality.

This is particularly significant since it makes cost and quality comparisons across programs challenging. There are few studies that consider the cost of providing services to OVCs by FBOs. Most costing studies reveal a myriad of costing approaches on a variety of services to differing populations in different time periods. This makes comparisons the data tenuous. Thus cost differences may not reveal differences in efficiency between programs, especially since most are working with the scarce resources.

While there have been a number of studies that have sought to compare the costs of caring for children in an institutional setting (orphanages) as opposed to reintegrating them into the community, few of these studies that adequately costed the time spent by volunteers on providing care for orphans within the community. In Benin, the Ouidah orphanage provides care through primary schools at a cost of US$1,315 per annum per child whereas the Adi Keith home for orphans cost US$1,943 per child per annum. Reintegration of orphans into the community was significantly cheaper than placing children at home, but it is unclear whether all the time costs of the volunteers in the community were factored into the reintegration costs.

BENIN & ERITREA - SIZE & STRUCTURE OF AVERAGE ANNUAL ECONOMIC COST PER CHILD IN SIX PROJECTS

(12% discount rate)

	Benin: Child Protection Fund			Eritrea Orphans		
Project	GRADH Child Labor	Red Cross Street Children	Ouidah Orphanage	Reintegration	Adi Keith Group Homes	Adoption
Years	2001-03	2001-03	2001-03	2001-03	2003	2001-03
Personnel Share (%)	45%	20%	41%	6%	9%	52%
Other recurrent (%)	44%	31%	56%	90%	27%	48%
Capital Share (%)	11%	50%	3%	4%	64%	0%
Total cost (%)	100%	100%	100%	100%	100%	100%
Avg annual cost per child in US $	**$566**	**$646**	**$1,315**	**$96**	**$1,943**	**$29**

Source: [3]

The Bethany Project enabled 656 volunteers to support 8,004 vulnerable children at an annual cost of around $2.50 per child. The Families, Orphans and Children Under Stress (FOCUS) program enabled 142 volunteers from seven faith-based partners to support 6,500 children at an annual cost of $3-4 per child, with around half the program expenditure being spent at community level (Lee et al. 2002; Phiri et al.2001).4

Institutional care such as orphanages has been considered the highest-cost option for providing care[1] In South Africa, registered residential care is estimated at US$7,932 per child per annum. The World Bank reported that the annual cost for one child in residential care in the Kagera region of Tanzania was over US$1,000, almost six times the cost of supporting a child with a foster family. In South Africa, Desmond et al

[3] Prywes, Menahem et al. (date?). "Costs of Projects for Orphans and other Vulnerable Children: Case Studies in Eritrea and Benin". http://info.worldbank.org/etools/docs/library/121864/Costs%20of%20OVC%20Projects%20in%20Benin%20&%20Eritrea.pdf

[4]From Foster, Geoff (2005). "Under the Radar – Community Safety Nets for Children affected by HIV/AIDS in poor households in Sub-Saharan Africa"

estimated the cost per OVC per annum for adoption of US$1,248 and foster care of US$1,032.

Other services to children were costed by the Kagera study. It was estimated that the cost of the feeding scheme per annum to be US$69 per child and the cost of educational support per annum to be US$13 per child. In Rwanda, the cost per child was US$147 for health and nutrition services (food assistance) and US$26 for education (vocational training) and US$4.28 for psychosocial support in 2003. In Zambia, income-generation cost US$157, health and nutrition cost US$114 and psychosocial support US$8.62 per child per annum.

4.1 Costing methodologies and its limitations

Several studies estimate costs from a provider perspective excluding the cost of time that family and community members involved in HIV/AIDS sacrifice (Johnson, et al., 2001). The allocation of costs becomes challenging if service providers do not record labor time (Cyrillo, et al., 2000:7).

It is often difficult to calculate accurate estimates of unit costs, because many organizations do not keep patient records that are sufficiently detailed to allow one to determine the number of patients on record that are actually in active care.

Costing studies are also very sensitive to assumptions about the duration of care (Johnson et al., 2001). The quality and structure of the cost data makes interpretation very difficult. Costs are reported against broad cost centers, which do not allow specific activities and interventions to be costs, at least not without more in-depth interviews (Booysen, et al., 2001). Data are often incomplete, while little data is kept on capital expenditure and donations. HBC programs seem to lack the necessary knowledge and capacity to document costs (Goudge, et al., 2001).

5. The dataset for this study

The dataset originates from a study conducted by Naidu et al for the Health Economics Research Office (HERO) in 2005. Detailed information on costs related 13 HBCs within three districts in South Africa were collected during the period September to November 2005. The three districts chosen to conduct the cost evaluations were Ugu district in KwaZulu-Natal province, the Nelson Mandela Metropole in the Eastern Cape and Sekhukhune district in Limpopo. Of the 13 HBCs, four were in the Nelson Mandela Metropole, five in Sekhukhune and four in Ugu. The sample was purposively selected to include relatively big and small HBCs in urban and rural settings with varying numbers of patients/clients and staff.

Sample of HBC programs

District		Name of the HBC	Type of organisation	Primary funder	Total employees	Location
Nelson Mandela	1	Action & Outreach	NPO	NGO	18	Urban
	2	Jongilanga	NPO	Church	16	Urban

Metropole, E.Cape[5]	3	Masiphathisane	NPO	Project Members	6	Urban
	4	Masixhasane	CBO	Church	7	Urban
Ugu, KZN	1	Dududu Drop-in Centre	Drop-in Centre	DOH/DOSD	32	Rural
	2	Fisokuhle	NPO	DOSD	9	Rural
	3	Ntokozweni	Drop-in Centre	DOH/DOSD	24	Rural
	4	Sicelimpilo	NPO	DOSD/Church	24	Rural
Sekhukhune, Limpopo	1	Ithekgeng[6]	NPO	DOSD	11	Rural
	2	Kukanang	NPO	DOH	13	Rural
	3	Kgwana	NPO	DOH	29	Rural
	4	Itshepeng	NPO	EU/DOH	8	Rural
	5	Hlogotlou	NPO	DOH	19	Rural

Source: HERO, 2005

The advantage of this dataset is the level of detail available on costs and services provided by each HBC as well as information on the skills of each staff member. Though the data will not be generalizable to all HBCs in South Africa, it will be indicative of the type of services provided, quality of care and its related costs.

6. Analytic Approach

The study attempts to ascertain the unit costs of providing care to OVCs in the home.

Activity-based costing principles were followed. All services rendered to OVC have been identified and then the direct costs relating to providing these services have been apportioned. Some services such as home visits and the feeding scheme have been provided to adults and children. In the case of home visits, all costs relating to servicing adults were removed. Labor costs were apportioned to OVC based on estimated effort spent on OVC. The estimated effort was determined based on the number of visits made to OVC versus the number of visits made to adults. In the case of the feeding scheme, it has been assumed that adults consume double the children's portion of food.

[5] NPO registered but not funded
[6] Last year was DOSD funded, funding interrupted and will be funded again

In this study, only direct costs linked to providing the service have been costed since it was difficult to separate overheads relating specifically to OVC services. Direct costs relate directly to the provision of services such as food parcels and include the cost of delivering services such as transport costs.

Direct costs have been classified as either financial or economic costs. Financial costs, for the purpose of this study, include all costs incurred and paid for by the HBC programme. All financial data was collected on a monthly basis over a 12-month period. Economic costs are costs not paid for by the organisation and which are primarily donations in the form of labor or goods. Financial costs and economic costs together equal direct cost of service.

Volunteer labor time has been calculated at R500 per month for 12 months since funded programs pay their staff approximately this amount. **At the time of the study 1 Dollar was equivalent to 6 South African Rands**. Supplies donated by the Departments of Health and/or Social Development have been captured according to the prices paid for these supplies by the respective departments.

The following cost measures were estimated:

1. The annual direct cost of service, broken down by cost category.
2. The direct annual cost per beneficiary (the direct cost of service divided by the number of OVC beneficiaries served).

7. Limitations of the study

As mentioned previously, because the sample was not randomly selected and given the relatively small number of HBCs that were surveyed, the results will not be generalizable to all HBCs in South Africa. However, the advantage of this type of study is in the richness of the data and while the data may not be representative, it is certainly indicative of the current situation amongst HBCs.

It will not be possible to conduct a cost-effectiveness study per se since the researchers did not try and gauge the quality of services provided from the patient's perspective. Further, the South African government has not set minimum standards for care and support for HIV/AIDS patients and it therefore difficult to have a benchmark against which it is possible to measure the quality of care. The best proxy for measuring the quality of care at this stage, are the skills and experience levels of the service providers.

8. Results

According to the *Children on the Brink* report of 2004, necessary services for OVCs should include at a minimum;

1) Strengthening the capacity of families to protect and care for orphans

2) Mobilize community-based responses to provide assistance

3) Ensuring access for OVC to essential services

4) Improving policy and legislation for OVC

5) Raising awareness for a supportive environment for children

According to the World Health Organization (WHO), one in five Faith Based Organizations are engaged in home-based care activities for children[7] In terms of services that are geared towards children and orphans, most HBCs engage in:[8]

- Material support, including the provision of clothing, food or meals.
- School assistance programs that provide fees for primary and sometimes secondary school, as well as the provision of uniforms, equipment, books and boarding fees without which an OVC would be disadvantaged in their education.
- Increasing awareness of HIV.
- Home visits through the help of volunteers to provide home-care for the terminally ill, offer advice and assist with household income-generating activities.
- Counseling and psychological support activities such as sports and cultural activities and personal support.
- Assistance with medical care through the provision of fees or medicine.
- Income generating projects to raise funds and providing OVCs with experience and training in vocational skills.

In the South Africa dataset, it was found that there were four main services (home visits, food parcels, feeding schemes and day care) offered although all services were offered by all HBCs with some HBCs offer more services than others.

[7] CMMB and Global Health Council (2005). "Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS."
[8] Tearfund (2005). The Warriors and the Faithful.

OVC services offered by HBC programs

District of South Africa	Name of HBC	Home visits	Food parcels	Feeding scheme	Day care
Nelson Mandela Metropole, E Cape	**Action & Outreach**	x	x	X	
	Jongilanga	x		X	
	Masiphathisane			X	
	Masixhasane		x		
Ugu, KZN	**Dududu**		x	X	x
	Fisokuhle		x		
	Ntokozweni	x	x	x	x
	Sicelimpilo	x	x	x	x
Sekhukhune, Limpopo	**Ithekgeng**	x			
	Kukanang	x			
	Kgwana	x			
	Itshepeng	x	x		
	Hlogotlou	x			
	Total	**9**	**7**	**6**	**3**

Source: Naidu, 2006

A further analysis of home visits shows that caregivers provide a range of activities in the home which is otherwise may not considered as 'service delivery' by external organizations. This includes helping children with their homework, bathing them to spiritual education.

8.1 Home visits

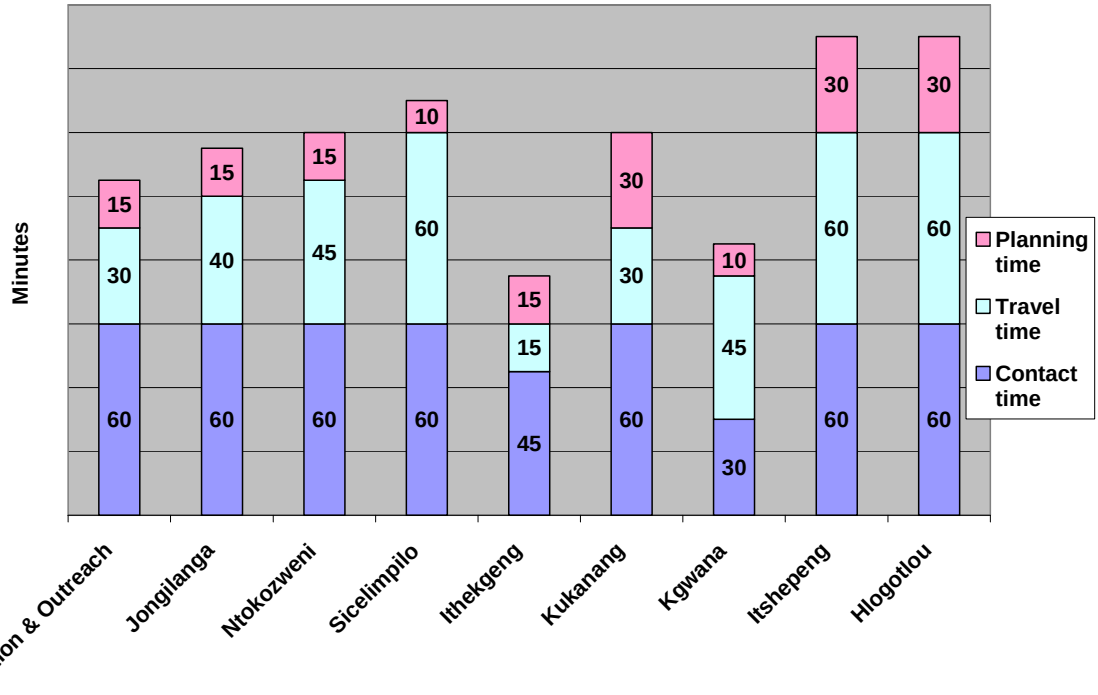
Since the length of time of home visits differs according to individual household needs, accurate costing requires that the time spent at each household is recorded. Community caregivers' mostly record data on home visits on a household rather than on an individual basis since their services benefit all household members

The major cost driver in making a home visit to OVC is the labor time of the community caregiver which can be split into contact time, travel time and planning time. Estimates of contact time range from 30 minutes (Kgwana) to 60 minutes in most of the HBC organizations. Kgwana visit 60 OVC almost twice per week and therefore keep their

contact time short. The travel time to a household ranges from 15 minutes to 60 minutes, depending on the location of the household in relation to the HBC facility. Planning time ranges from 10 to 30 minutes per household visit. In many cases, one day per week is allocated to planning, record-keeping (in some instances) and other administration.

On average, there is time to conduct no more than three household visits per day. For example, at Action and Outreach, three household visits would consume about 5.25 hours[9] and 7.5 hours per day at Itshepeng and Hlogotlou.

Average total time (minutes) spent on home visits by category



8.2 Services rendered during home visits

The type of activities performed during home visits are shown in the table below. Most common activities performed during home visits are psychosocial counselling, checking

[9] 105 minutes per household x 3 = 315 minutes/60 = 5.25 hours

children's homework and providing HIV and AIDS education. However, many of these services could be provided at schools by community caregivers which indicates there is room for additional planning to reach children in the most efficient manner to provide these activities.

Activities performed during home visits

	Action & Outreach	Jongilanga	Ntokozweni	Sicelimpilo	Ithekgeng	Kukanang	Kgwana	Itshepeng	Hlogotlou
Province	**EC**	**EC**	**EC**	**KZN**	**LP**	**LP**	**LP**	**LP**	**LP**
Supervision of homework	√	√	√		√	√	√	√	√
Counselling	√		√		√		√		√
HIV and AIDS & health, nutrition, children's rights	√	√	√	√	√	√	√	√	√
Assistance with identity documents	√	√	√	√	√	√	√	√	√
Teach OVC to cook	√		√			√			
Cooking		√						√	
Laundry		√						√	
Bathe children		√							
Accompany children to school		√							
Monitoring of ARV and other medication		√				√			
Accompany children to clinic/hospital		√	√	√					
Accompany children to play		√							
Domestic chores			√		√				
Spiritual education				√					
Establish food gardens						√			
Safety education						√			
Infants to clinic for immunisation							√		
Checking appropriate use of grants								√	√
Monitoring of ARV and other medication		√							

More specifically the activities are:

- **Supervision of homework** – this activity usually entails helping the child with homework, checking whether the child completed his or her homework and

signing the homework book on behalf of the guardian. One HBC discussed difficulties with homework supervision because they are not trained in the school's curriculum. This activity could be enhanced if the child's school attendance was monitored and recorded as well as the child's school performance documenting from the school report passing or failing. In Ithekgeng, community caregivers invite OVC to their homes in order to provide after care and supervise children's homework.

- **Psychosocial counseling** is provided to the family including children. For this activity to be provided at an optimum, all community caregivers should undergo psychosocial counseling training. Masixhasane's project manager in 2006 is a full-time psychologist and is available to OVC on a part-time basis. Other HBCs could enlist the volunteer help of social workers from the area to assist them with training to provide this service adequately.
- **Health and HIV and AIDS education** is provided by all HBCs during home visits to OVC. In Sekhukhune, all five HBCs also check the "Road to Health" card for immunisation. Health training includes training in nutrition and in one case also training concerning children's rights. Sicelimpilo further provides training to the entire family. Kgwana accompany infants to the clinic to receive immunisation.
- **Assistance with identity documents**. Most HBCs refer the child to the social worker or directly to home affairs. Dududu (2006) helps abandoned children obtain identity documents by establishing the child's family name and following up with Home Affairs. Instead of referring children to home affairs, community

caregivers from Sicelimpilo accompany children to Home Affairs to apply for identity documentation.

In addition, between one and three HBCs provide the following:

Cooking – Three HBCs teach children how to cook and two HBCs prepare meals for the children at the children's homes.

Laundry - Two HBCs help children with their laundry and one HBC show the children how to launder.

Bathe children – only one HBC reported providing this activity.

Accompanying children to school or supervising their recreation time – only one reported performing this activity.

Domestic chores – two HBCs reported performing domestic chores such as cleaning the house.

Spiritual education - only one, which is church-based offer spiritual education during home visits.

Establishing food gardens – only one reported performing this activity at the homes of OVC.

Safety education - only one reported performing this activity.

Checking appropriate use of grant income – two HBCs provide this function.

Monitoring of ARVs and accompanying sick children to hospital – one HBC monitors the use of ARVs

Accompanying children to hospital. – three HBCs perform this activity.

8.3 Direct cost of home visit

This section begins with a discussion of a standardised home visit service (content and frequency). A standardised cost has been determined against which actual costs for each HBC program compared and differences explained.

Measures of the home visit service reported are the direct cost per home visit, per beneficiary, total cost of the service and the cost per contact hour.

8.4 Standard direct cost of home visit

A standard service was determined from the literature through the combined experiences of the program managers of the HBC programs. The purpose of the standard is to evaluate organisations against this standard rather than make comparisons across organisations. For a home visit service, it is recommended that in a one hour contact visit, the beneficiary should receive services as itemised in the first column of the table below. Each OVC should be visited at least once per week, that is, 48 times per annum (column 2). Column 3 outlines the operating assumptions used to cost the standard. Telephone and transport costs are excluded since most organisations are unable to obtain funding to cover these expenses. Most community caregivers earn a stipend of R500 per month.

The standard cost for a one hour contact visit is thus R10.42. For an OVC receiving at least one visit per week, this equates to R500 per beneficiary per annum. This standard assumes one OVC per household so as not to underestimate the cost.

Standard home visit service

Service	Minimum Standard (frequency)	Operating assumptions
Home Visits: Referrals & networking Laundry Home Work supervision HIV and AIDS education Psychosocial support Cooking and other domestic chores Assistance with access to social grants Monitoring of treatment Accompanying children to health facility	Each household should be visited at least once per week	Content: no telephone and travel cost included 3 household visits per day, 12 household visits per week (one day per week for planning) Community caregiver stipend costed at R500 per month

8.5 Actual direct cost of home visit

The table below summarizes the actual cost per household visit, per beneficiary and the total cost of the service. These are discussed in the following sections.

Actual direct cost of home visit

		Direct cost (Rand 2005)				
Actual	**Province**	**Household visit**	**Beneficiary per annum**	**Total cost of service per annum**	**# of Beneficiaries**	**# of Visits per annum per beneficiary**
Action & Outreach	**EC**	6.99	387	10,823	28	70
Jongilanga	**EC**	6.75	485	22,298	46	110
Ntokozweni	**KZN**	14.10	50	9,589	192	7
Sicelimpilo	**KZN**	6.53	287	12,356	43	82
Ithekgeng	**LP**	30.93	153	13,950	91	11
Kukanang	**LP**	8.50	143	8,280	58	35
Kgwana	**LP**	21.76	783	47,005	60	83
Itshepeng	**LP**	11.96	132	4,606	35	18
Hlogotlou	**LP**	29.56	355	67,757	191	22

8.6 Cost per household visit

The direct cost per household visit is calculated by dividing the total cost of service by the number of household visits. The cost per household visit ranges from R6.53 (Sicelimpilo) to R30.93 (Ithekgeng).

Differences in direct cost per visit compared to the standard cost per visit of R10.42 can be explained by the number of household visits made with the available labor time. In some cases too many visits are made per caregiver in which case the caregivers may be overworked. This is the case with Sicelimpilo, Jongilanga and Action and Outreach. In other cases too few visits are made per caregiver increasing the cost per visit. Too few visits mean that there could be additional capacity to serve more beneficiaries with the current staff. In the case of Ntokozweni, some community caregivers are paid a higher labor rate which contributed to a higher cost per visit.

The extent to which Hlogotlou and Ithekgeng and Kgwana exceed the standard is unusual. This might reflect the quality of the data, in other words, they may have underestimated the number of visits made.

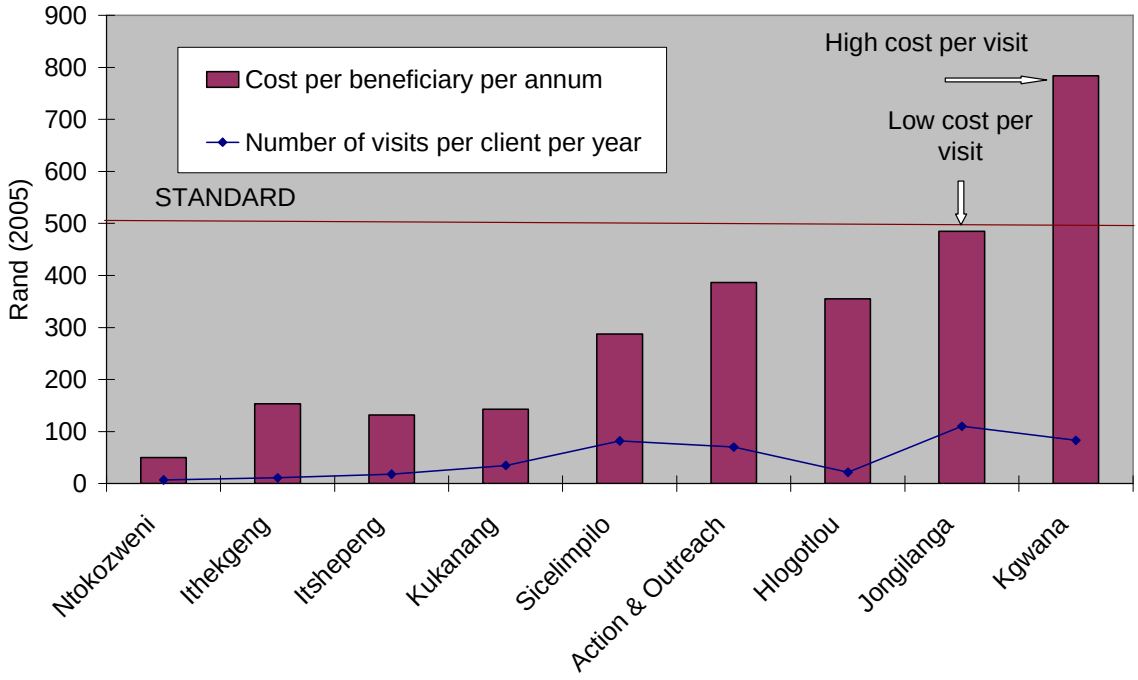
8.7 Cost per OVC beneficiary – home visit

The actual direct cost per beneficiary per annum is a function of the direct cost of service per annum divided by the number of OVC. The direct cost per beneficiary ranges from R50 (Ntokozweni) to R783 (Kgwana). The variance in the cost per beneficiary per annum is explained by the number of visits per beneficiary and the cost per visit with the standard cost per beneficiary of R500 per annum. In general, the lower the number of visits a beneficiary receives during the year, the lower the cost per beneficiary (as can be

seen in Ntokozweni, Ithekgeng and Itshepeng) and vice versa. The figure below shows this general trend. However, in some cases the cost per visit is particularly low or high which affects the cost per beneficiary. In the case of Kgwana, both the cost per visit and the number of visits is high leading to a very high cost per beneficiary. In the case of Jongilanga, the number of visits is very high at 110 but the cost per visit is low hence the cost per beneficiary is below the standard cost.

It must be noted that the cost per beneficiary is not a good measure in itself because it may encourage budgeting for an inadequate service (frequency and content of service). There is much variation in the number of annual visits per annum per OVC beneficiary. Five of the nine HBCs providing home visit services visit their beneficiaries less than once per week. Community caregivers should plan to visit their beneficiaries at least once per week. It should be noted that exceeding the standard number of visits of 48 per annum should not be considered a problem even though it increases the cost per beneficiary. It may simply reflect the fact that the beneficiaries are in need of more visits. A high cost per beneficiary caused by a high cost per visit should however, be investigated.

The relationship between number of visits per beneficiary and cost per beneficiary per annum



8.8 Total annual direct cost of service – home visit

The total direct cost shows that the only cost driver in the provision of this service is the cost of labor for the community caregiver. Most community caregivers walk to their beneficiaries' households hence the cost of telephone and transport is usually not budgeted for.

Direct cost of home visits by cost category (percentage)

	Province	Total (Rand 2005)	Cost category (%)	
			Labour	Total
Action & Outreach	**EC**	**10,823**	100.0	100.0
Jongilanga	**EC**	**22,298**	100.0	100.0
Ntokozweni	**KZN**	**9,589**	100.0	100.0
Sicelimpilo	**KZN**	**12,356**	100.0	100.0
Ithekgeng	**LP**	**13,950**	100.0	100.0

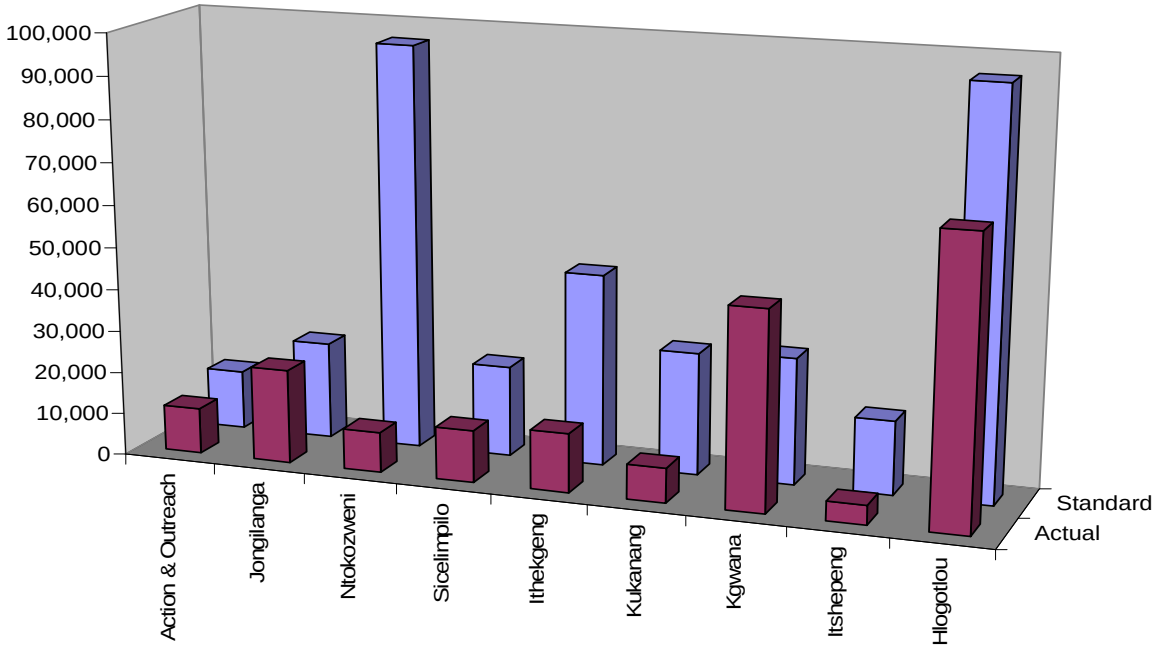
	Province	Total (Rand 2005)	Cost category (%)	
			Labour	Total
Kukanang	**LP**	**8,280**	100.0	100.0
Kgwana	**LP**	**47,005**	100.0	100.0
Itshepeng	**LP**	**4,606**	100.0	100.0
Hlogotlou	**LP**	**67,757**	100.0	100.0

The direct cost of the home visit service for all HBC programs is shown in table above. Variations in the direct cost of home visits between HBCs are due to factors already mentioned elsewhere in this section as well as the number of beneficiaries served.

Using each organisations actual number of beneficiaries and the standard cost, it is possible to show the gap between their actual cost (excluding telephone and transport expenses) and the standard cost. This is based on the standard calculation which excludes telephone and transport and assumes weekly visits of one hour contact time.

In the case of Ntokozweni, a far greater budget is required to visit their 192 beneficiaries at least once per week instead of their current seven times per annum. The situation for Ithekgeng and Hlogotlou is similar. In the case of Kgwana, they visit their beneficiaries twice as often as the standard. However, each caregiver makes far less than the standard number of visits per annum. This shows extra capacity, in other words, they could serve more beneficiaries with their current number of staff. Thus they could plan to recruit more beneficiaries.

The budget gap between actual and standard total direct cost of service



8.9 Cost per contact hour

Cost per contact hour is computed by dividing total direct costs by contact hours. Contact hours are a good measure of performance since they represent the benefit to the beneficiary.

The cost per contact hour from the table below shows a range from R6.53 (Sicelimpilo) to R30.93 (Ithekgeng). The cost per contact hour is similar to the cost per visit because the length of visit is usually one hour. Ithekgeng and Kgwana highlight the usefulness of this measure. For both these organisations the cost per contact hour is higher than the cost per visit because their visits are less than one hour. Thus it costs even more for their beneficiaries to receive one hour of contact time. It is therefore safer to evaluate the cost

per contact hour if the length of a visit is not standardised because it more accurately reflects the cost of serving a beneficiary making organisations more comparable.

Direct cost per contact hour

	Rand 2005				
	Province	**Number of contact hours**	**Direct cost of home visits**	**Household visit**	**Direct cost per contact hour**
Action & Outreach	**EC**	1,548	10,823	6.99	6.99
Jongilanga	**EC**	3,304	22,298	6.75	6.75
Ntokozweni	**KZN**	680	9,589	14.10	14.10
Sicelimpilo	**KZN**	1,892	12,356	6.53	6.53
Ithekgeng	**LP**	338	13,950	30.93	41.24
Kukanang	**LP**	974	8,280	8.50	8.50
Kgwana	**LP**	1,080	47,005	21.76	43.52
Itshepeng	**LP**	385	4,606	11.96	11.96
Hlogotlou	**LP**	2,292	67,757	29.56	29.56

10. CONCLUSIONS AND RECOMMENDATIONS

The major services offered by the 13 HBCs are home visits, food parcels, feeding scheme and the day care service. Although most staff received some form of home-based care training, very little training in the care of OVC has been received. Training of Community caregivers specifically in the care of OVC is required.

The variances in cost of service per beneficiary are explained by the frequency of the service as well as differences in the content of service. The cost per beneficiary measure cannot be used for planning purposes because an inadequate service will be planned for.

The more appropriate cost to be used for planning is the unit cost such as the cost of a home visit. An attempt has been made to standardise the service and the frequency to evaluate organisations against this standard. Using the standard costs as a starting point, policymakers could budget appropriately. and HBC organisations could also use the standard costs as a guideline for their funding proposals.

Comparing unit cost to the standard cost (with the standard being 100 percent), some organisations fall below the standard for some services while others fall below the standard for all services. There are large gaps between actual cost and the cost for a minimum standard. Organisations falling close to the standard line can be deemed to be acceptable. Home visit costs well above the standard are problematic since this is due to low number of visits achieved with the available labor.

Funding for service delivery should be targeted towards the number of beneficiaries and the content of the service being provided. In this way, HBCs can be assured of providing an acceptable service.

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