A SOCIO-ECONOMIC IMPACT ASSESSMENT STUDY OF THE SOUTH AFRICAN WOMEN IN DIALOGUE DEVELOPMENT CARAVAN PROGRAMME

EXTERNAL EVALUATION OF THE SAWID DC PROGRAMME

BY

HUMAN SCIENCES RESEARCH COUNCIL
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Table of Contents

LIST OF FIGURES

LIST OF TABLES

LIST OF BOXES

ACCRONYMS

CSG	CHILD SUPPORT GRANT
DC	DEVELOPMENT CARAVAN
DID	DIFFERENCE IN DIFFERENCE
DSD	DEPARTMENT OF SOCIAL DEVELOPMENT
ECD	EARLY CHILDHOOD DEVELOPMENT
EPD	ECONOMIC PERFORMANCE AND DEVELOPMENT
FBW	FREE BBASIC WATER
HSRC	HUMAN SCIENCES RESEARCH COUNCIL
ID	IDENTITY DOCUMENT
MOU	MEMORANDUM OF UNDERSTANDING
M&E	MONITORING & EVALUATION
NGO	NON-GOVERNMENTAL ORGANISATION
OAG	OLD AGE GRANT
PHC	PRIMARY HEALTH CARE
PRA	PARTICIPATORY RAPID APPRAISAL
SAW	SOCIAL AUXILIARY WORKERS
SAWID	SOUTH AFRICAN WOMEN IN DIALOGUE
SETA	SECTOR EDUCATION AND TRAINING AUTHORITY
STATSSA	STATISTICS SOUTH AFRICA
TOR	TERMS OF REFERENCE

1 INTRODUCTION, RESEARCH QUESTIONS AND APPROACH

1.1 INTRODUCTION

Globally evidence suggests that despite significant efforts to reduce and eradicate poverty those who were poor over the last two decades are likely to have remained poor. This is in the context of improvements in economic growth and human development (Lenhardt *et al*, 2013).

South Africa, almost two decades since democracy, continues to experience unprecedented levels of unemployment, poverty and widening inequality in comparison with international standards (Tregenna *et al*, 2008). It is posited that the consumption levels of the poorest decile in South Africa are below those of countries such as China, Peru and Indonesia (Tregenna *et al*, 2008). The Gini Coefficient in South Africa, a measure of income inequality, increased from 0,66 in 1993 to 0,68 in 2000 and to 0,70 in 2008 (Leibrandt *et al*, 2010). Poverty in South Africa is distributed along spatial, gender and age dimensions. Rural households, those living in informal settlements and young and female headed households share disproportionately in the experience of poverty (RSA, 2011).

This is despite South Africa having invested significant resources towards redistribution with the aim of mitigating the harsh effects of poverty in the short term, while trying to break the cycle of intergenerational transmission of poverty. These redistributive policies have included the implementation of one of the largest cash transfer programmes globally currently reaching about 14 million beneficiaries, the scaling up of public employment programmes, rolling out of free health care for pregnant women, lactating mothers and children under 6 years and improving access to basic services such as water, sanitation and housing among other interventions (Leibrandt *et al*, 2010).

Importantly research evidence from 33 demographic and health studies (including South African Studies) suggests that many of the benefits of poverty and developmental interventions have not reached the poorest quintiles. The analysis suggests that the main factor blocking access to these benefits and services for the poorest quintiles is the role that national policies play in addressing chronic poverty (Lenhardt *et al*, 2013). According to Lenhardt *et al* (2013) this analysis is reinforced by research conducted by the African Power and Politics Programme which identified three preconditions which would unblock barriers to services, benefits and interventions for those in the poorest quintiles. These include:

a. Development of coherent sectoral policies and institutions;
b. Clear top down pressure on stakeholders to provide quality services; and
c. An enabling environment for local government to adapt interventions and solve problems to access at that level.

Indeed, the poorest segments are often unaware of their eligibility to certain programs or do not know how to activate the process of accessing them. It is against this background that “The SAWID Development Caravan action learning pilot approach was therefore designed and refined over more than 7 years with the objective to.

- To distinguish between relative and persistent household poverty, target and capacitate the households and to measure their trajectories from impoverishment to improved well – being - stability.
- To facilitate social and economic inclusion of the poor households
- To support municipal and community capacity-building for better coordination and integration of services.

1.2 OBJECTIVES

The overall aim of this study was to research and evaluate the social and economic impact of implementing the Development Caravan (DC) programme in the lives of families involved across two pilot sites in Fetakgomo and Limpopo by applying, inter alia, a participatory research approach. The entire DC programme entails: the recruitment and selection of Social Auxillary Workers (SAWs); the training of the SAWs; institutional linkages for implementation; and service delivery to the families in the two pilot sites.

Table 1. SAWID DC pilot sites

Site	No. of wards	No. of SAWs	No. of HHs	No. of members
Fetakgomo	13	26	263	1405
KwaMbonambi	13	32	275	1870
TOTAL	**26**	**58**	**538**	**3275**

Source: SAWID (2013)

The study will be carried out in the two pilots of the DC sites Umfolozi Municipality in Uthungulu District of Kwazulu Natal and Fetakgomo Municipality in Sekhukhune District of Limpopo Province. It will cover the project interventions since the beginning of the project. The specific objectives of the study are as follows:

1) Highlight the baseline: Families and community situation as assessed in 2010.
2) Outline each of the Development caravan interventions in chronological order.
3) Collate quantitative data on the number of family members who have directly benefited from each of the interventions; particularly the impact of Psychosocial approach in changing the mindset of the families.
4) Gather qualitative information on the family and community benefits from Development Caravan interventions
5) Record impact of DC interventions as evidenced through community change.
6) Record impact of community mobilization techniques, stakeholders' analysis, capacity building efforts and facilitation of linkages.
7) Record case studies of individuals and families who have benefited
8) Assess the feasibility of the model
9) Assess possible replication mechanisms, potentially involving more stakeholders and consideration (and justification) for other similar projects.

The study will attempt to answer the following research questions.

- What are the "most significant changes" brought about by DC Program interventions? Would these results have been achieved in a different way?
- How are these valued and appreciated by the community and the targeted beneficiary?
- What personal experiences and lessons are shared by different stakeholders? What are the differences?

- What are the measures of success or areas of improvement in the views of different stakeholders.

1.3 Theory of change

The analysis of the DC programme impacts originates from a theory of change that recognises the global effectiveness of anti-poverty programmes in tackling poverty for people, while promoting broader developmental impacts. The global evidence base on anti-poverty programs frames a model for understanding the possible impacts of the DC programme. The central arguments for a system of anti-poverty programmes include:

- The poor fight alongside the non-poor in accessing services because of a lack of proper profiling of who deserves the services
- The poor do not know where to go to access services
- Targeted development assistance to a family's needs and not generalised application
- SAWs help professionalise women's work
- A one-stop-shop / integrated synchronised approach that provides assistance holistically
- There should be a minimum level of attainment for extremely poor households – DC minimum conditions

In the absence of previous studies of DC model type programs in South Africa, global evidence documents a typology of pathways – both (1) social and (2) developmental through which using the SAWs as development facilitators drives change for individuals, households and the society more broadly.

The Theory of Change for the DC programme outlines how change is expected or supposed to happen. It is difficult to interpret the results of an evaluation without any programme theory. How does the DC programme work? That is exactly the theory of change.

Modelled after the Chilean and Tunisian anti-poverty programmes, the DC the DC is a synchronized poverty eradication system for local communities in nodal areas to mobilize support and catalyze community self-organization through targeting families with a basket of services and stakeholder engagement, in partnership with their local municipalities and other stakeholders (SAWID ToR, 2013)." It attempts to improve the targeting of existing social services, by stimulating the demand for these services among indigent families in local communities, thereby reorganizing and expanding the supply of services.

The stimulus to demand is done through visits of social auxillary workers (SAWs) to indigent households. The SAWs inform, encourage and help the families to apply to the network of services they have available. The role of the SAWs is to work within the families to help them restore their basic socio-emotional capabilities, and foster behaviours conducive to labour market success changes better family welfare, and engage them in a process to identify a family strategy to exit extreme poverty.

On the supply side, different government agencies and local providers of social services coordinate in assessing the needs of each municipality and in providing the adequate supply of services so that the programs are channelled and tailored to the neediest population within each municipality. The

DC programme was introduced in Fetakgomo (Limpopo) and KwaMbonambi (KZN) in 2010, and was supposed to be gradually phased in over time.[1]

The take-up of various social services tailored to the family needs is perceived as a means to activate a process towards exiting poverty. Over time, the programme aimed at removing structural bottlenecks by strengthening the human capital of adults and expanding their employment opportunities and productive activities (via education completion/training/public employment or self-employment programs).

As described above, the DC invests staff (SAWs) to visit poor families, informing, encouraging and helping them to apply to the network of services they have available.

A major assumption is that DC participants are better off after than before the program intervention. This is how the programme is supposed to work in theory. Ideally, the evaluation would assess the situation of programme beneficiaries before and after the programme intervention however a major limitation is that there is no base for this group. Hence, the study will seek to assess individuals and households' level of achievement of various indicators of poverty such as health, education, etc. in comparison to a group of households who did not participate in the programme.

SAWID used various methods to select households for participation in the programme in the two pilot sites. This included community profiling, referrals by ward councillors, family identification, verification to confirm status and usage of the municipal indigent register. The identification of non-participants (so-called Non-DC) followed pretty much the same methodology.

1.4 Evaluation approach

As randomisation was precluded from the evaluation design when the Development Caravan program came into being in 2010, this study employs matching methods to establish attribution of impacts to DC minimum conditions. Participants in the study were separated into 'treatment' and 'control' groups based on whether or not they were recipients of the DC program. Members from each group were matched using SAWIDs profiling methods for selecting beneficiaries to the program (basically the municipality's indigent register plus referrals from community leaders), which in turn was based on observable characteristics. By comparing the members of each matched pair, we were able to estimate what mean difference of household's exposure to the DC program was in terms of important outcomes clustered into social, human, economic and environmental capital development outcomes.

1.5 Organisation of the report

Aside from this introductory section, the report is structured as follows:

- Section 2 – Gives international best practice.
- Section 3 – Gives an overview of the SAWID DC programme.
- Section 4 – Evaluation methodology.

[1] By design, the DC programme was supposed to have 3 phases that would be phased in over time however, due to financing challenges, the programme exited in Fetakgomo after Phase 2 while it is still continuing (albeit under different management) in KwaMbonambi. This is elaborated on in a later section.

- Section 5 - Gives the results of the socio-economic impact assessment.
  - Social capital development outcomes
  - Human capital development outcomes
  - Economic capital development outcomes
  - Environmental capital development outcomes
- Section 10 - Program feasibility
- Section 11 – Conclusion
- Section 12 – Recommendations

2 INTERNATIONAL EXPERIENCES WITH ANTI-POVERTY PROGRAMMES

According to Galasso (2011), there is a general consensus that households living in extreme poverty are deprived along multiple dimensions, which reinforce each other to jointly lock them into indigence. She also argues that despite this, there are limited examples of interventions that take this multi-dimensionality into account with the aim of helping the extreme poor escape indigence in a sustained manner by addressing different structural constraints simultaneously. Castaneda *et al* (2005) indicate that there are numerous household targeting systems around the world that target the poor, however, they also draw attention to the design of these programmes, arguing that these targeting systems can work, but can also fail, and their success depends highly on their design and implementation.

In this study we take a look at of poverty alleviation programmes that have been implemented in a number of countries with the aim of assisting the poor and taking them out of poverty and extreme poverty. The programmes that we examine are the Chilean *Chile Solidario*, Mexico's *programa Nacional de Educatión, Salud y Alimentación* (PROGRESA), Honduras' *Programa de Asignación Familiar-Fase II* (PRAF) and Nicaragua's *Red de Protección Social-Fase I* (RPS).

2.1 Tackling Multidimensional Poverty: the sustainable Livelihoods Approach

Worldwide, development assistance increasingly shifted towards the agenda for poverty reduction in the 1990s and 2000s and this can be clearly seem, for example, in the millennium development goals (MDGs), where the intent to half poverty and increase global well-being by 2015 is made, Brocklesby and Fisher (2003). How poverty is conceptualised can affect outcomes in terms of poverty profiling as well as targeting measures aimed at alleviating poverty. Furthermore, there needs to be a way of identifying the poor from the non-poor if any attempt is to be made to learn more about the poor, particularly regarding where they are and distinguishing them from the rest of the population. In efforts to adapt different poverty conceptualisations to South Africa, typical debates and trade-offs such as those relating to the dimensionality of poverty (i.e. one-dimensional versus multidimensional) and monetary versus non-monetary, come into play, HSRC (2014). As Laderchi, Saith and Stewart (2003: 2) put it "to devise policies to reduce poverty effectively, it is important to know at what we are aiming."

In terms of measurement, the importance of clarifying how poverty is defined is deemed to be of vital importance as these definitions of poverty imply specific indicators of measurement will be used, and they could result in the identification of different individuals and groups as being poor, and also necessitate different solutions for poverty reduction, Laderchi *et al* (2003).

There are three broad concepts of wellbeing related to poverty measurement that are identified in literature. The first one is the utilitarian view (Sen, 1979) and it sees poverty as severe deprivation in utility. Income and consumption are the most widely used proxies for utility as utility cannot be measured directly. The second broad conceptualisation of poverty (based on Sen, 1987) is that which sees wellbeing as a product of the capability to function in society. Lacking in these capabilities, which include health, education, sufficient income, security, self-esteem, etc. is therefore considered to be the cause of poverty. The last concept concentrates on whether individuals or households have reached (or can reach) a given dimension of wellbeing that includes attaining certain levels of health, nutrition, education, income, etc. According to this conceptualisation, poverty constitutes the non-attainment of minimum levels of these dimensions.

Also important to note is that this approach spells out the multidimensionality of poverty, (HSRC, 2014).

Sustainable livelihoods approaches developed from the evolving perspectives on poverty, participation and sustainable development. The idea of sustainable livelihoods consolidated into an approach and/or a number of similar approaches by the late 1990s, and it was developed and/or implemented by intergovernmental organisations such as the United Nations Development Programme (UNDP), the World Food Programme (WFP), the Food and Agriculture Organisation (FAO); non-governmental organisations such as Oxfam and CARE international; bilateral donors such as the British Department for International Development; as well as research institutions such as the Overseas Development Institute in London. The conceptual understanding of poverty as well as its causes that form the foundation of sustainable livelihoods approaches has had significant influence on thinking and practice throughout the development arena. From a donor perspective, sustainable livelihoods approach actions as an operational tool to assist work on poverty reduction. (Brocklesby and Fisher, 2003; Carney and Britain, 2003).

The approaches are based on an 'asset-vulnerability' approach of poverty understanding. They aim to combine lessons of best practice in development with a set of guiding principles that are supported by an analytical framework, which then work as a tool in analysing issues and target interventions. Organisation that work with sustainable livelihoods approaches have common guiding principles, however frameworks and methods do differ (Brocklesby and Fisher, 2003).

Box 1 outlines a set of sustainable livelihoods principles (as of 1990), taken from Ashley and Carney (1999) in Carney and Britain (2003).

Box 1. SL principles

The poverty-focused development activities should be:

People-Centred

Sustainable poverty elimination will be attained only if external support on what matters to people being assisted, understands the differences between groups of people and works with them in ways that are compatible with their current livelihoods strategies, social environment as well as ability to adapt.

Responsive and Participatory

The poor people being assisted must be key players in identifying and addressing livelihoods priorities. Those coming from the outside need to follow processes that enable them to listen and respond to the poor.

Conducted in Partnership

…with both the public and private sector.

Multi-Level

The process of poverty elimination presents a huge challenge that can be overcome only by working at several levels, making sure that micro-level activity informs the development of policy and an effective enabling environment, and that macro structures and processes support people in building their own strengths.

Sustainable

A balance must be reached between the four key dimensions of sustainability, i.e. economic, institutional, social and environmental sustainability. All four are important, hence a balance must be found between them.

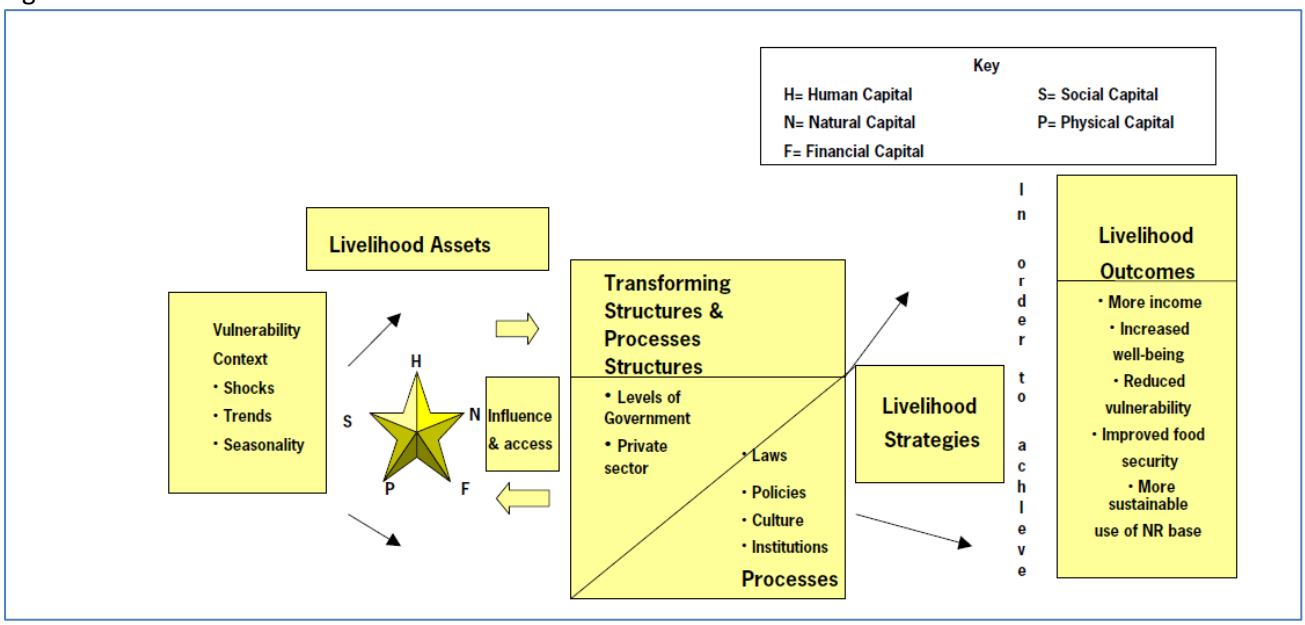
Dynamic

External support should be aware of the dynamic nature of livelihood strategies, respond flexibly to the situations of those being assisted, and develop long-term commitments.

Source: Ashley and Carney (1999) in Carney and Britain (2003), p.13

Figure 1 depicts the DFID's framework for sustainable livelihoods.

Figure 1. A framework for sustainable livelihoods.



Source: DIFD (1999) in Krantz (2001), p. 19

2.2 Implementation of the Programmes

Introduced in 2002 by the Chilean government, ***Chile Solidario*** has four components to it: an intensive psycho-social phase; cash transfers; cash subsidies; and preferential access to social services. Furthermore, the programme functions through a two-pronged strategy by working on both the supply and demand side of public services, (Carneiro, Galasso and Ginja, 2010).

The *psycho-social* phase involves outreach activities by a local social worker or technical staff to each home of the target families and it lasts for 2 years, with decreasing intensity. The social worker works with the families during these visits in identifying the families' main problems, along with taking core steps needed to solve them, raising awareness of social services that are available and stimulating take up. In this component, the multidimensional aspects of depravation are tackled by identifying a set of minimum critical conditions necessary to have 'acceptable' levels of well-being. These conditions include education, legal documentation/identification, health, family dynamics, housing, employment, income, etc., with families having 8-12 of these minimum conditions that need to be fulfilled during this phase. Families sign a 'partial contract' with the social worker committing to putting effort in meeting the requirements, with these contracts also indicating government's responsibility for supplying the services and resources needed by these families, (Carneiro, Galasso and Ginja, 2010).

The *cash transfer* component is on condition that the beneficiary families meet the above mentioned contract. The transfers last for 2 years with amounts declining over time; is uniform across all the households; and is meant to be compensation for the incurred transition costs during the connection to supply side services within the families' municipalities, (Carneiro, Galasso and Ginja, 2010).

In terms of *guaranteed cash subsidies* component, at the begging of the programme, families were allocated vacancies assigned to the municipalities, competing with non-Chile Solidario families. The constraint on the vacancies on the cash subsidies were later relaxed, allowing eligible families that apply for the subsidies to be automatically enrolled as recipients, (Carneiro, Galasso and Ginja, 2010).

For the *preferential access to social services* component; the programme beneficiaries get preferred access to social services by getting priority access to the existing supply side if they chose to activate their demand for those services. This component therefore aims to make the target population 'visible' to their local municipalities, (Carneiro, Galasso and Ginja, 2010).

Mexico's *programa Nacional de Educatión, Salud y Alimentación* (***PROGRESA***) was started in 1997. There are two components to *PROGRESA*'s cash transfers. The programme design demands for the money to be given to mothers. The educational transfers are conditioned on enrolment, and an 85% attendance record by the children, allowing them to repeat a grade a maximum of two time. Children above the age of 7 (the starting age for grade 3) are eligible for the education transfers, and these transfers increase by grade, and they are also higher for girls than for boys in middle school, (Caldes, Coady and Maluccio, 2006).

PROGRESA's second transfer component is for health, food security and nutrition. This transfer is conditional on household members attending monthly nutrition and hygiene information sessions, as well as going for regular visits at health clinics for preventative health checks. The food security and education transfers are independent of one another, with the possibility of households receiving only one of these even if they qualify for both transfers. Furthermore, beneficiary households with children under the age of 3 also receive a monthly nutritional supplement on top of the cash transfers, (Caldes, Coady and Maluccio, 2006).

The Honduran *Programa de Asignación Familiar-Fase II* (***PRAF***) poverty alleviation programme started in 2000, and just like *Chile Solidario,* it includes both demand side and supply side components, and these consist of transfers.

On the demand side, there is an education subsidy that is conditioned on children being enrolled in school, as well as on their regular attendance. It is provided for children that have not yet completed grade 4, and there are up to a maximum of three education transfers per household available. There is also a health, food security and nutrition transfer provided for pregnant women along with children under the age of 3, with a cap of two transfers per household, and is distributed twice a year. This transfer also has conditions and they are that the pregnant women and the children must make monthly visits to health clinics for growth monitoring and preventative check-ups, (Caldes, Coady and Maluccio, 2006).

On the supply side, *PRAF* makes a direct investment of resources into services. Under education, PRAF provides grants to school parent associations. On the health, food security and nutrition side, *PRAF* runs a community-based child growth and monitoring programme providing mothers with one-on-one counselling. It also makes grants out to local health service committees in order to improve the quality of health care that is provided by the government's health system, (Caldes, Coady and Maluccio, 2006).

Nicaragua's *Red de Protección Social-Fase I* (***RPS***) also has both demand side and supply side components to it.

On the demand side, participating households receive health, food security and nutrition transfers every month, and this is conditional on attending health and nutrition workshops, as well as taking children under the age of 5 to scheduled health controls. There is also an education transfer that demands that recipient households with children between 7 and 13 years that have not completed grade 4 enrol in school and that these children have an attendance rate of over 85%. In addition to this, the recipient households also get an annual transfer for each eligible child upon enrolment earmarked for school supplies, (Caldes, Coady and Maluccio, 2006).

On the supply side of *RPS,* there is a transfer paid to teachers per beneficiary child described above. Under health and nutrition, private health care providers are contracted, trained and paid by *RPS* in order to deliver those services required by the programme. These services include vaccination, provision of anti-parasites, vitamins, and iron supplements, as well as growth and development monitoring, and they are provided free to beneficiary families with a focus on children below 5 years of age. Children between the ages of 2 and 5 are seen twice every month, while those under the age of 2 are monitored one a month, (Caldes, Coady and Maluccio, 2006).

2.3 Beneficiary Selection

All the above evaluated household targeting programme that are aimed at reducing poverty use a variety of methods to select their beneficiaries.

Initially, the *Chile Solidario* made use of a proxy means test (a method that intended to capture key socio-economic correlates of unsatisfied basic needs) to target families in extreme poverty. However, like all Chilean social programs, it switched to using a novel instrument that intends to measure household income generating capacity along with their vulnerability to shocks since 2007, Carnerio, Galasso and Ginja (2010). Galasso (2011) indicates that *Chile Solidario*'s pilot programme was called Puente and operated in 4 provinces. She shows that 225,000 households, the estimated number of Chile's households in deprivation, were covered from 2002 to 2005. Galasso (2011) further points out that even though the programme started out with the primary goal of alleviating poverty; it later evolved to also protecting households from falling back into poverty when faced by uninsured risk by adding a complementary social protection focus.

PROGRESA (Mexico) was targeted in two stages. Stage one involves the identifying of the most marginal rural localities by making use of a marginal index constructed from national census. The selected localities are then visited to make sure that they have access to the necessary infrastructure such as schools and health clinics. The second stage consists of classifying the families in the selected localities as either poor or non-poor based on income and other household characteristics. A general assembly was held after beneficiary households were selected, and here the objectives of the programme were explained, and also explained were the beneficiaries' rights and responsibilities, (Caldes, Coady and Maluccio, 2006).

According to Caldes, Coady and Maluccio (2006) *PRAF* (Honduras) was geographically targeted to Honduran poor municipalities, and these were chosen by ranking all municipalities according to the average rates of stunting that were observed in the national census of the height of first graders that was conducted in 1997. From this, seventy municipalities with the highest rates of stunting were then considered eligible for the programme. Of the seventy, fifty were randomly selected, leaving the other twenty un-selected as a control group for the programme evaluation. Transfers were then started in November of 2000, and the programme was operating in 50 rural municipalities and had 47,800 beneficiaries by end of 2002, (Caldes, Coady and Maluccio, 2006).

The *RPS* (Nicaragua) started with a pilot in the rural areas of the northern par of Nicaragua's central region. The pilot program was implemented in two out of the seventeen relatively poor departments, and these were chosen by making use of a combination of poverty and operational criteria. Six out of 20 municipalities were then then chosen in a similar manner. Using data from the 1995 national census, a marginal index was constructed along with an index score for each of the 59 rural administrative areas consist of one to five villages. Of these, 42 were selected to take part in the first stage of the pilot phase of the programme, and 21 of these were randomly excluded for two years, and these we then used in the programme evaluation as the control group. Eighty percent of the households remaining in the 17 administrative areas and that were not part of the evaluation were select for phase two of the pilot. The programme pilot covered 2% of the rural households in Nicaragua by the end of 2002, (Caldes, Coady and Maluccio, 2006).

2.4 Programme Impact

Galasso (2011) shows that results from the first two years of the *Chile Solidario* programme indicated gains along different aspects of education such as adult literacy, preschool enrolment and the enrolment into school 6 to 15 year olds. She also indicates that there was a milder impact on health outcomes such as preventative health visits for women and children under the age of 6, as well as enrolment in the public health system. It is indicated further by Galasso (2011) that there was a strong uptake of employment programmes, although at the time the study was conducted, this participation had not (yet) translated into employment effects. It is also shown that there was evidence that on average, the programme beneficiaries had increased their awareness of social services available in their communities and were more likely to be optimistic about their future socio-economic situations. Lastly, Galasso (2011) found no significant impact on household income per capita, however she noted that participating households were more likely to be recipients of social assistance transfers.

According to Caldes, Coady and Maluccio (2006), the human capital impacts of *PROGRESA* and *RPS* have been quite substantial. Under nutrition, they indicate that *PROGRESA* had a large impact in reducing the probability of stunting amongst recipient children (which initially had been very high at 44%), and increasing their annual mean growth rate by one centimetre per year. In addition, they show that there was evidence of significant increase in food consumption as well as dietary diversification. *RPS* is also shown to have had a substantial impact on a variety of health and health indicators. For example, there was a 6 percentage points decrease in the prevalence of stunting for children under the age of 5 (from 40% prior to the programme) as well as a 30 percentage points (from 60% prior to the programme) increase in children aged 3 and under that were weight. Similar to *PROGRESA*, there was a substantial increase in overall food consumption as well as dietary diversity, with households consuming more fruits, meat and fats.

Under education, Caldes, Coady and Maluccio (2006) indicate that *PROGRESA*'s major impact was in increasing enrolment rates in secondary school. Furthermore, the programme increased enrolment rates by 15 percentage points in the first year of middle school for girls and by 7 percentage points for boys, amongst those who completed primary school successfully. In the RPS programme, primary school enrolment rates increased by 13 percentage points from approximately 70% for those in grades 1 to 4.

Caldes, Coady and Maluccio (2006) however show that the human capital impact of the *PRAF* programme was rather small, especially when compared to that of *PROGRESA* and *RPS*. They show that although visits to health clinics by children for vaccination and growth monitoring had increased, the programme did not appear to have improved health outcomes. They further indicate

that it had little impact on primary school enrolment rates (although it is noted that these were already substantially high), however, they show that there was an improvement in dropout rates.

There is a wide range of techniques utilised to in the evaluation of projects or programmes and below is a summary of some of the most common qualitative and quantitative methods used which include surveys, interviews, focus groups, and observations, (NSR, 2010).

Method	When to use it	Advantages	Disadvantages
Surveys They are popular forms of data collection, especially when collecting data from large groups and standardisation is important. They have two components; questions and responses.	They are typically used when information is to be collected from a large number of respondents and/or when a clearly defined set of questions need to be answered, and in-depth probing of responses is not necessary. Surveys are also useful for both formative and summative purposes.	Good for gathering descriptive data Can cover a wide range of topics Are relatively inexpensive to use Can be analysed using a variety of existing software	Data may provide a general picture but lack depth Self-report may lead to biased reporting May not provide adequate information on context
Interviews They are used as a method of data collection when it is assumed that the participants' perspectives are meaningful, knowable and can be made explicit. Their perspectives are also assumed to affect the success of the project. Also, an in-person or telephone interview, as opposed to a paper-and-pencil survey is selected when interpersonal contact is vital and opportunities for follow-up are desired.	Patton (1990) in NSF (2010) indicates that interviews are particularly important in answering the following questions: What does the program look and feel like to the participants? To other stakeholders? What do stakeholders know about the project? What thoughts do stakeholders knowledgeable about the program have concerning program operations, processes, and outcomes? What are participants' and stakeholders' expectations? What features of the project are most salient to the participants? What changes do participants perceive in themselves as a result of their involvement in the project?	Usually yield richest data, details, new insights Permit face-to-face contact with respondents Provide opportunity to explore topics in depth Allow interviewer to experience the affective as well as cognitive aspects of responses Allow interviewer to explain or help clarify questions, increasing the likelihood of useful responses Allow interviewer to be flexible in administering interview to particular individuals or in particular circumstances	Expensive and time consuming Need well-qualified, highly trained interviewers Interviewee may distort information through recall error, selective perceptions, desire to please interviewer Flexibility can result in inconsistencies across interviews Volume of information very large; may be difficult to transcribe and reduce data

Focus groups These combine elements of both interviewing and participant observation. Focus group sessions are interviews and they use group interactions to generate data and insight that are unlikely to emerge otherwise. Focus groups also inherently allow for the observation of group dynamics, discussion, and first-hand insights into respondents' attitudes, behaviours, etc.	Focus groups provide answers to same types of questions as in-depth interviews, with the exception that they take place in a social setting. Specific application of this method include: Identifying and defining problems in project implementation Pretesting topics or idea Identifying project strengths, weaknesses, and recommendations Assisting with interpretation of quantitative findings Obtaining perceptions of project outcomes and impacts Generating new ideas	Similar to those of interviews	Similar to those of interviews
Observations In this technique, an individual or individuals collect first-hand data on the interventions, processes or behaviours that are being studied. The evaluator(s) can develop a holistic perspective of the project by directly observing operations and activities.	During the formative phase, observations can be used to determine whether or not the project being operated or delivered as per plan. During the summative phase, observations could be used to conclude whether or not the project (programme) has been a success.	Provide direct information about behaviour of individuals and groups Permit evaluator to enter into and understand situation/context Provide good opportunities for identifying unanticipated outcomes Exist in natural, unstructured, and flexible setting	Expensive and time consuming Need well-qualified, highly trained observers; may need to be content experts May affect behaviour of participants Selective perception of observer may distort data Behaviour or set of behaviours observed may be atypical

Source: NSF, 2010, review of the most common quantitative and qualitative methods employed in project evaluation, p. 58 – 66.

Galasso, 2006 and 2011, evaluates the Chilean poverty alleviation programme '*Chile Solidario*' and we take a look at the evaluation processes she followed.

To evaluate the programme, Galasso, 2006 and 2011, makes use of Chile's nationally representative household survey, the *Caracterización Socioeconómica Nacional* (CASEN), which is the chief source of household welfare in Chile. A wide range of topics are covered by the survey, and these range from demographics, income, employment, health status, education as well as the use of services to public subsidies and transfers. In 2003, the ministry in charge of the *Chile Solidario* and CASEN (MIDEPLAN) added a few questions on programme participation to the survey. The CASEN sample size was then augmented to over-sample *Chile Solidario* beneficiaries, and approximately 5,000 beneficiary households from the programme's 2002 and 2003 cohorts totalling 71,000 households were interviewed. MIDEPLAN agreed to interview only a subset of participants along with their 'matched' comparison one year apart in order to allow for the possibility of following up the programme impact over time. There was a follow-up survey conducted in 2004, and a third round of the longitudinal survey that was scheduled for 2006 to form a three year longitudinal panel.

A representative sample of participants together with a sample of matched only those households with similar propensity scores of participants, was used in the follow-up survey of 2004. Box 1 gives further details on the construction of the 2003-2004 *Chile Solidario* panel sample, and Figure 1 shows the structure of the CASEN/ *Chile Solidario* longitudinal panel 2003-2004/06.

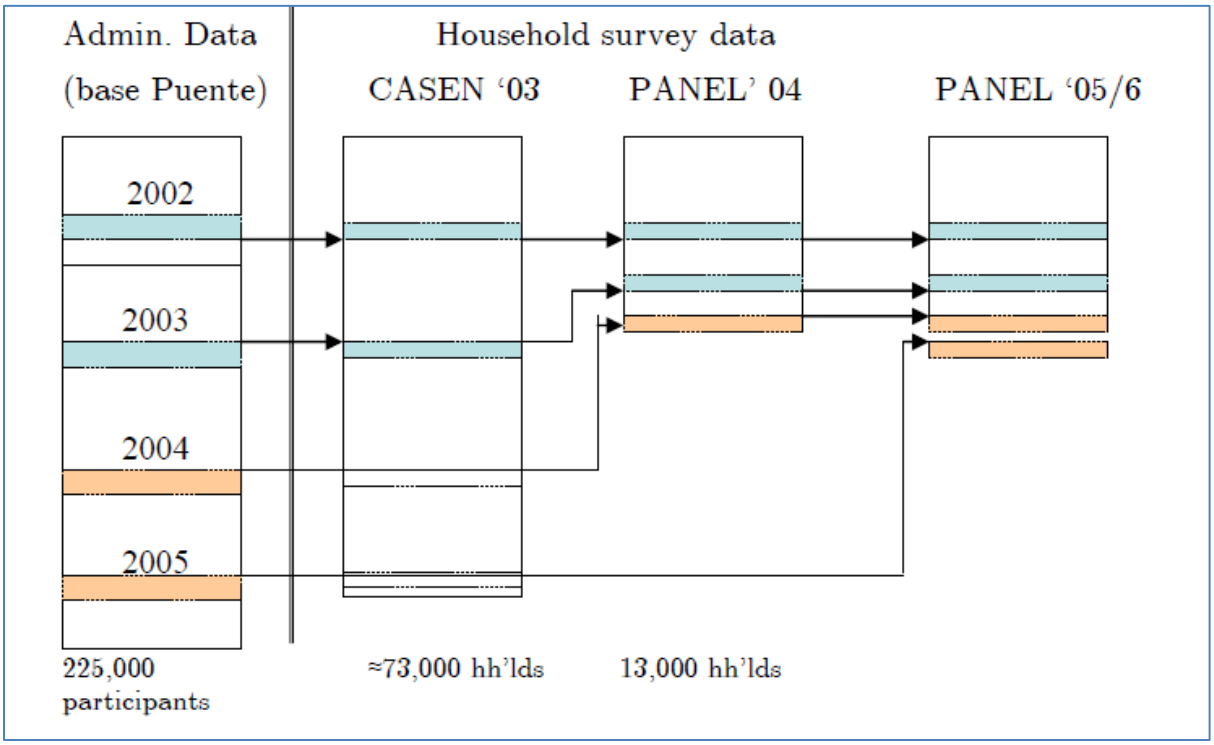
Box 2. Construction of the *Chile Solidario* panel sample 2003-2004

The objective of the panel survey was to follow up over time only a sample of the CS beneficiaries and their matched comparison group. The selected longitudinal sample was composed of about 3,400 participating households (comprising of 60% of the beneficiaries interviewed in the CASEN 2003, and of 186 new beneficiaries of the 2004 cohort identified by cross-checking the administrative list of beneficiaries and with the names/addresses of the original CASEN). The matched comparison group was constructed by estimating a propensity score of participation into the program separately for four broad geographic areas. The list of covariates included household size and age composition, whether the household belongs to an ethnic minority or speaks a minority language, head characteristics (age dummies, education dummies, marital status dummies, labour force history in 2000), housing characteristics, asset indicators, household non-labour income per capita, a rural indicator and dummies for the regions, and interactions between housing indicators and rural. The matching was done among households who reported having filled in a ficha CAS. The prediction of the propensity score and the balancing of the covariates performed better than in the case where the comparison group was drawn from all the households sampled in the CASEN). The matching was done choosing the 3 nearest neighbours for each beneficiary within each geographic area. Matching was done with replacement, based on the log of the odds ratios24 and imposing a common support in the propensity score among both beneficiaries and non-participants. Comparison households were forced to be chosen within the same geographic area and zone (rural/urban) for practical convenience. The final sample of original non-participants selected by MIDEPLAN for the panel includes 9,500 households.

Source: Expect from Appendix 2, p. 39, Galasso, 2006.

Figure 1: Structure of the CASEN/ *Chile Solidario* longitudinal panel 2003-2004/06

Source: Galasso, 2006 and 2011



Finally, the identification strategy used to conduct the evaluation required that the actual CAS[2] (proxy means) score used in the selection of households into the programme, and made use of the 2003-2004 panel sample to make the analysis for the programme evaluation. Galasso, 2006 and 2011, then makes use of different data analysis methods to make the evaluation of the *Chile Solidario* programme. For example, she uses (and reports) weighted means for socio-economic characteristics, demographics, household income and other intermediate indicators used for the analysis, of both participants and non-participants to investigate whether the programme is well targeted or not. Additionally, she also makes use of regression analysis to using the programme longitudinal panel data to make an assortment of analyses for the evaluation.

In the evaluation of Peru's '*Juntos*' programme, Perova and Vakis, 2009, point out that "unfortunately" an impact evaluation framework had not been incorporated in the *Juntos* programme design at the beginning of the programme. Hence they show that the feasibility of evaluating the programme's impact depended on the use of existing data on programme beneficiaries and the possibility of credibly constructing counterfactual control groups by making use of econometric techniques.

For their data needs, Perova and Vakis, 2009, make use of four data sets. The first one is the household survey Encuesta Nacional de Hogares (ENAHO), which allowed for the identification of the 2006 and 2007 *Juntos* participants. ENAHO is an annual survey that comprises rich household data on spending and consumption patterns, household assets, health, education and household civic participation. The second data set used is one from the *Juntos* registry exercise that was undertaken by Instituto Nacional de Estadística y Informatica (INEI), and this was a complete census of all households living in those

[2] The CAS score is a summary index of unsatisfied basic needs, which is used as a conditional requirement for participation in the *Chile Solidario* and many of Chilean's other social programmes.

districts selected to take part in *Juntos*. The third data source used is the Registo Nacional de Municipaidades (RENAMU) for the years 2006 and 2007. This dataset contains information on economic activity, public services, infrastructure as well as other districts characteristics, and these could be used to take district-level heterogeneity into account. The last dataset that is used is the 2005 national population census, and it is utilised especially because it could be used to differentiate between participating and non-participating districts to calculate pre-treatment means of the variables of interest at district level.

For the control group and in order to improve the matching exercise, a pool of potential control households is limited to *Juntos*-eligible districts. Due to data availability, programme design as well as its subsequent roll-out, the matching techniques were are used to construct a control group that is created from households who did not receive the Juntos transfers, but are similar to beneficiaries. Lastly, evaluation of programme impact is done by comparing the means of outcome indicators of interest between the beneficiary group and the control group by making use of parametric and non-parametric methods.

3 SOUTH AFRICA'S POVERTY REDUCTION STRATEGY

3.1 The Medium Term Strategic Framework (MTSF)

The MTSF is "a framework to guide government's programme in the electoral mandate period (2009 – 2014)" The Presidency, 2009: 1. Hence it is clear that this is the government's most important policy document as it guides all planning as well as resource allocation in all areas of government, with the different national and provincial departments drawing their strategic plans and budgets by aligning them with those of the MTSF, and municipalities basing their Integrated Development Plans (IDP) on the MTSF as well. The MTSF states all the important strategic objectives for the period beginning 2009 to 2014 and economic growth and development, along with decent work for all and education and skills development are at the heart of it. From these five core objectives flows sub-objectives, with four of them directly related to poverty reduction, and they are as follows:

- Halving poverty and unemployment in half by 2014
- Ensuring a more equitable distribution of economic growth's benefits and reducing the excessively high inequality levels
- Improving the nation's health profile and skills base and ensure universal access to basic services
- Building a nation free of all forms of racism, sexism, tribalism and xenophobia

The first objective does not only aim to fight poverty, it also sets a target of halving poverty levels by the year 2014, hence fighting poverty from the demand side of the economy. The second objective aims to ensure that the country's economic growth benefits are enjoyed by all, and hence this involves decreasing the high inequality levels that are currently prevalent, thus also taking many out of poverty and/or improving their livelihoods. Objective four above intends to tackle poverty by ensuring that all people have access to basic services along with improving the nation's health profile, therefore addressing the supply side of the supply-side (human capital and service provision). The last listed objective aims to address all forms of discrimination that adversely affect people's ability to live freely and without oppression and this includes fighting racism, sexism, tribalism and xenophobia.

- Ten policy priority strategic areas follow from the above objectives and six of these relate directly or indirectly to poverty and these are:
- More inclusive economic growth, decent work and sustainable livelihoods
- Economic and social infrastructure
- Rural development, food security and land reform
- Access to quality education
- Improved health care
- A developmental state including improvement of public services
- *Priority Strategy 1: Speeding up growth and transforming the economy to create decent work and sustainable livelihoods*

This strategy's objective is to ensure prompt, appropriate and effective response to the currently present constraints that are hindering optimal economic growth and the translation of economic growth into jobs that meet the employment needs of the country's vast labour force. The MTSF furthers aims to promote decent employment and income security, as well as sustained investment to build up the country's economic capacity and improve industrial competitiveness. Consequently, five main pillars have been identified under this strategy as areas of policy intervention and these are:

- The promotion of economic growth, broad-based industry, decent employment creation, reduced income inequality, as well as other constraints to development. Additionally, the MTSF also identifies a stable macroeconomic environment that is employment enhancing as a priority.
- The implementation of a trade and industry policy and expanding the country's industrial base, all that will contribute towards the creation of decent work on a large scale. The ultimate target of this is to create more decent work opportunities that are also sustainable, increase domestic production for the local and regional markets, and increase the exports ratio by GDP by 2014.
- Undertaking measures to create an economy that is more inclusive by broadening the impact of growth to ensure that its benefits sectors of society, particularly the poor and marginalised.
- Promoting Small and Medium-Sized Enterprises (SMEs) and cooperatives, as well as strengthening competitiveness in the markets.
- Making sure that SA keeps up with global technological trends and exploits fully the country's comparative advantages, e.g. through usage of information and communication technologies (ICTs). Again, the MTSF makes it clear that it is important that the country recognises the importance of science and technology as sources of industrial competitiveness and sustained growth.

3.1.1 Strategic Priority 2: Massive programme to build economic and social infrastructure

Under this strategic priority, government intended to continue with the infrastructure investment programme intended for the expansion and improvement of economic and social infrastructure. This includes energy, water, sanitation, transportation, and information and communications infrastructure. This is aimed at increasing access, quality and reliability of public services, as well as to support economic activities, whilst still bearing in mind environmental sustainability the pursuit of maximum employment impact. The goal is to ultimately achieve an investment ratio of over 25% of GDP by the year 2014.

3.1.2 Strategic Priority 3: Comprehensive rural development strategy linked to land and agrarian reform and food security

The MTSF points out that millions of South Africans reside in areas that are characterised by underdevelopment and extreme poverty, and that many of these are in the rural areas. In this regard, it shows that government's approach to spatial development should encourage policy actions that are responsive and beneficial to the needs of the different contexts prevailing in each area, the location of poverty as well as the primary levels of economic potential. Overall, the objective is to develop and implement a comprehensive rural development strategy that goes beyond the wrongly perceived dichotomy between rural and urban, and that will meet the needs of improving rural households' quality of life, enhance the nation's food security through a broader base of agricultural production, and the exploitation of the varied economic potential that benefits each area. There are numerous areas of policy interventions given by the MTSF to achieve these and they include:

- The aggressive implementation of land reform policies
- Stimulating agricultural production with a view to contributing to food security
- Improving service delivery to ensure quality of life
- Implementing a development programme for rural transport
- Skills development

- Revitalisation of rural towns
- Exploring and supporting non-farm economic activities
- Institutional capacity development
- Cooperative development

3.1.3 Strategic Priority 4: Strengthen the skills and human resource base

Education has enjoyed the largest portion of the national budget since the country's democracy due the government's aggressive investment in education and training. The MTSF indicates that although this sizable investment in education has steadily improved the country's human resources and skills base through, optimal progress has not been achieved as the achievements have not taken place at the desired scale. Education and skills have thus been identified as vital for every member of society to reach their potential in both the economic and social lives, hence the goal is to achieve quality outcomes in the education system. The following are therefore elements of strategy to achieve these:

- Creating a culture of achievement and improving learner outcomes with a target of an overall 20% improvement in the key education indicators by 2014 and improving South Africa's position in cross-country tests.
- Increase participation in and improved quality of early childhood development services, with universal access to Grade R and double the number of 0-4 year-old ECD learners by 2014.
- Expand access to and capacity of secondary education with a view to increasing enrolment rates to 95 per cent by 2014 and ensuring that as many young people as possible are able to access and complete secondary education.
- Provide adequate basic services such as water sanitation and electricity to schools; and progressively improve access to facilities such as libraries, classrooms and laboratories.
- Intensify efforts to ensure that all schools have safe and supporting environments for all children.
- Supporting and developing a teaching profession that is dedicated to providing education of high quality, with high levels of performance as well as ethical and professional standards of conduct.
- Creating conditions for effective school management including M&E functions and performance management.
- Broaden access to post-secondary education and improve higher education throughput rate by 20% by 2014, including access by people with disability.
- Ensure that training and skills development initiatives in the country respond to the requirements of the economy, rural development challenges and social integration. The main aim would be to increase the number of skilled personnel in the priority skills areas such as design, engineering and artisanship categories that are critical to manufacturing, construction, cultural activities and other priority economic sectors identified in the NIPF.

3.1.4 Strategic Priority 5: Improve the health profile of all South Africans

Government's central goal of health care services has been to improve access to health services and to achieve better clinical and patient outcomes, and the MTSF has recognised a call for an overhaul of the entire health system due to the poor quality of health that is worsened by the high burden of disease. The health sector has experienced significant increases in real expenditure since 2004, and this is reflected in expanded infrastructure, upgrading of facilities as well as broadening available health service packages. Nevertheless, the above stated concerns relating to the country's health sector has

prompted the government to want to transform the public health system in order to improve quality of care and public facilities, enhance human resources. It also wants to step up the fight against such diseases such as HIV/ AIDS and TB as well as other communicable diseases in addition to lifestyle and other causes of ill-health and mortality. Moreover, the MTSF indicates the government's aim to reduced overall inequality in the country's health system. Elements of strategy in the MTSF pertaining to heath include:

- Phasing in a National Health Insurance (NHI) system within the time period between 2009 and 2014 based on the principles of health care coverage for all, cost containment, equitable healthcare financing, compulsory/mandatory participation, risk equalisation, and simplified administration.
- Increase institutional capacities to deliver health-system functions and initiate major structural reforms to improve the management of health services at all levels of healthcare delivery, but particularly hospitals.
- Strengthening treatment of TB to combat the high rates of immune suppression and the emergence of the multi-drug resistant and extremely drug resistant strains.
- Implementation of the Comprehensive Plan for the Treatment, Management and Care of HIV and AIDS so as to reduce the HIV-incidence rate by 50% by the year 2011 and ensuring that the target of reaching 80% of those in need of ARV treatment by 2011 is achieved.
- Enhancing the ability of public health services to respond to a range of noncommunicable diseases, injuries and trauma.
- Introduction of new child vaccines to reduce cases of diarrhoea and pneumonia, which are significant causes of child morbidity.

3.1.5 Strategic Priority 10: Building a developmental state including improvement of public services

The MTSF indicates the government's strong commitment to the improvement of the state's capacity for growth and development, and the strengthening of the capacity of the local government's sphere is identified as a critical area of focus. The MTSF further shows that although significant developments have been made in meeting the strategic goals set in the document, challenges still remain. These challenges include poor quality of some of the public services provided and overall capacity gaps in local government. In light of this, the MTSF states its main objectives as further strengthening the capacity the state's capacity to enable it to improve the delivery and quality of public services as well as promoting a culture of a transparent, honest and compassionate public service. Furthermore, the government is also committed to making information about available public services and opportunities to citizens.

There are many other documents outlining the government's strategy with regards to poverty, and these are at all levels of government including at provincial and municipal level, as well as for different government departments, and these are all based on the MTSF in one way of another. There are however two other important policy documents that we take a quick look at and these are New Growth Path (NGP) and the National Development Plan (NDP) 2030.

The New Growth Path (NGP) initiated by government in 2010 announced South Africa's mass joblessness, poverty and inequality as the core challenge facing the country. The NGP's target is to grow employment by five million jobs by 2020, and decrease unemployment levels by 10 percentage points from 25% to around 15%. It points out the need to maximise two key variables to achieve this; the rate

of economic growth and the employment intensity of that growth. According to the programme, GDP should rise to between 4% and 7% a year and the employment intensity of this growth kept between 0.5 and 0.8.

Likewise, the National development Plan (NDP) 2030 pronounces that South Africa can eliminate poverty and reduce inequality by 2030, but to achieve this, change, hard work, leadership and unity are required. The NDP 2030 has pointed out the need to create jobs; improving education and training; providing quality health care and expanding infrastructure among others to achieve its goals. The commission proposes to create 11 million jobs by 2030 and it recognises labour intensive manufacturing, mid-skill service exports and process outsourcing as good for both growth and job creation.

3.2 The SAWID DC Program Overview

"SAWID is an independent South African women's platform committed to hearing the voice of every woman and to improving the status of women by engaging national government, the private sector, civil society (including non-governmental organisations, community-based organisations, faith-based organisations and donors) in partnership to shape community, provincial and continental agendas. The SAWID Forum is impartial and not-for-profit and is tied to no party-political interests.

"SAWID is a non-governmental organisation (NGO) that was established in 2003. For a decade now SAWID has been at the forefront of building capacities of communities to fight poverty. They achieve this by facilitating dialogue, mobilizing local resources and by increasing the capacity of individuals and communities to rely on themselves to make positive change. A dedicated volunteer Board of Directors, National Council of 24 women, as well as a series of Professional Advisory Commissions that is made up of sector specialists, academics and professionals, lead SAWID."

SAWID was founded by a forum of around 100 women, drawn from all sectors of South African society, who met at the University of Pretoria in July 2003. They had been convened by a Steering Committee of volunteers, facilitated by Ms. Zanele Mbeki, spouse of the President of South Africa. The convenors had been inspired by the outcomes of a Peace and Reconciliation Dialogue with women from the Democratic Republic of the Congo (DRC) which had taken place in March 2003. Women gathered at the July 2003 SAWID Forum to break the barriers of race, language, culture, age and geographic divide that still separated them, and they articulated their vision, mission, values and objectives as follows:

The goal of the development caravan as stated by SAWID is:

> "…aimed at systematically and effectively addressing poverty and all its manifestations of indigent families by improving personal capacities and increasing access to a variety of resources, institutions and support mechanisms, in order to create sustainable livelihoods."

SAWID (2012a: 13) indicates that its DC is a "synchronised poverty eradication system for local communities in nodal areas to mobilise support and catalyse community self-organisation through targeting families with a basket of services and stakeholder engagement". The South African DC model by SAWID was designed based on the Tunisian and Chilean development caravan models, and was named the 'development caravan' because of its planned movement from one identified community to another (Silinda, 2009). The SAWID DC is a psycho-social poverty eradication approach that a holistic in

nature. It operates by recruiting and training local youths to become Social Auxiliary Workers (SAW) over a period of 18 months, after which they are employed by the programme. The SAW's duties include assisting identified poor families to be taken out of poverty by linking them to available resources and services. This is done in partnership with local municipalities along with other stakeholders in government, as well as civil society and the private, while being managed by trained social workers and site managers, (SAWID, 2012b).

The three phases of the DC programme are 1) household development, 2) community development and 3) community socio-economic development. At the end of 2013, SAWID had only implemented phase one of the programme, which becomes the subject of the current evaluation, and is the phase we largely focus on.[3]

In the household development phase of the DC programme, focus is on strengthening the capabilities of the households and for participation in development, linking them to services and support and facilitating social inclusion (SAWID, 2010).

In this phase, the focus is on providing psychosocial support to the family. This component is carried out through the Social Auxillary Workers (SAWs) as they establish a personal relationship with each of the families to whom they are assigned. The SAW works with each family during home visits which occurred with diminishing frequency throughout the 24 months (two years) of the intervention. The intervention included two distinct phases:

The DC minimum conditions in each category are:

PERSONAL IDENTIFICATION

1. All members of the family must be incorporated into the Civil Registry and have an identity document or birth certificate.
2. Members of a family who have a disability should be registered as such in the Department of Social Development Registry and be receiving a disability grant.

FAMILY DYNAMICS

3. The family should have adequate abilities to deal with conflict.
4. There should be a fair distribution of household chores, so that girls do not do the bulk of the household chores.
5. The family should be linked to community resources and development programmes available through local networks (sports clubs, senior citizens' centers, action groups and community organisations, amongst others.)
6. Children who qualify for free education should be registered to receive it.
7. Families with reported incidents of domestic violence should be enrolled in an appropriate support programme.
8. A family with a child in jail should support him/her and collaborate in their rehabilitation programme.

FOOD SECURITY

9. The family has access to basic nutrition, three meals a day.
10. The family has a door-sized garden

[3] Results on this phase relating to socio-economic development outcomes are limited due to…

PRIMARY HEALTH

11. The family must be registered in the Primary Health Care System.
12. Pregnant women should have medical check-ups corresponding to the guidelines established by the Ministry of Health.
13. Children under six years of age should have their medical check-ups and vaccinations up to date according to the guidelines established by the Ministry of Health.
14. Women over 35 years should have a periodic Papanicolaou smear test.
15. Members of the family who suffer from a chronic illness should be under the supervision of a doctor from the corresponding health center.
16. Family members with a disability, who would benefit from rehabilitation, should be participating in a rehabilitative program.
17. All members of the family should be given personal healthcare information.

EARLY LEARNING, EDUCATION AND SKILLS DEVELOPMENT

18. Children in the preschool age should attend a preschool or kindergarten program.
19. If the mother works and there is no other adult able to care for the children, children under six years of age should attend a day-care program.
20. Children under 15 years of age should attend an educational institution, or be in the process of reintegration if they have previously dropped out.
21. Children 12 years of age or older should be able to read and write, or in the process of learning.
22. Children with disability who are able to study should be incorporated into the standard or special education system.
23. An adult responsible for the education of the children should be in contact with the school and have attended the most recent parent/guardian's meeting.
24. The adults should be able to read and write (or those who desire to learn to read, write and perform basic mathematics should be in the process of learning.)

INTEGRATED HOUSING

25. The family should have a house with the minimum standards: mud covered in cement; enough rooms for privacy of individuals.
26. If the family wishes to apply to the municipality housing program, they should be in the application process.
27. The family should have access to clean water 6 metres from the house.
28. The family should have appropriate and safe sewage disposal.
29. The family should have appropriate waste disposal provided by the municipality,
30. The family should have safe and reliable energy for lighting and equipment.
31. The family should have access to a public road for emergencies and access to markets.

SOCIAL INCOME AND EMPLOYMENT

32. All members of the family who have the right to the Family Support Subsidy should be receiving it.
33. All members of the family who have the right to Social Security Assistance should be receiving it.
34. The family should have an income above the line of extreme poverty, and be registered on the indigent list of the municipality.
35. The family should have a budget organised to their resources and priorities.
36. At least one member of the family should have a regular job and a stable salary.
37. No child under 15 years of age should leave school in order to work.
38. All unemployed persons should be registered with the Municipal Employment Information Office.

A baseline study of families and community situation (and needs) of those being targeted by the SAWID DC programme was conducted in 2010 and Table 2 chronicles the findings.

Table 2. Baseline as assessed in 2010

Dimension	Baseline
Family Dynamics	701 individuals were in need of attention for psycho social services.
Income	The income of the client base ranged between R250 and R1300 per month, with social grants being the main source of income.
Housing	92% of the client base, i.e. 2000 people or 189 households, was in need of houses or decent homes.
Food Security	No home had a well administered food garden except for 6 community gardens which existed and 29 of our members or clients were part of.
Identification	1050 ID's and for adults as well as well as birth certificates for the elders
Health	There were 650 individuals that were in need of services with HIV/AIDS, TB; immunization for children; and education on chronic diseases such as sugar diabetes and BP
Education and Skills	60% of the clients had not been to high School and they are heads of the homes. 189 have passed grade 12 and 9 have been to technical college but never finished due to financial difficulties
Energy	120 homes were in need of electricity or had illegal connections
Water	Water is fetched from a community tap
Sanitation	65 homes had no decent toilets and 78 had no water in their yard

Source: SAWID, 2013

It is from this base that SAWID hopes to improve on the lives of the indigent in their chosen pilot communities.

3.2.1 *Strategic objectives*

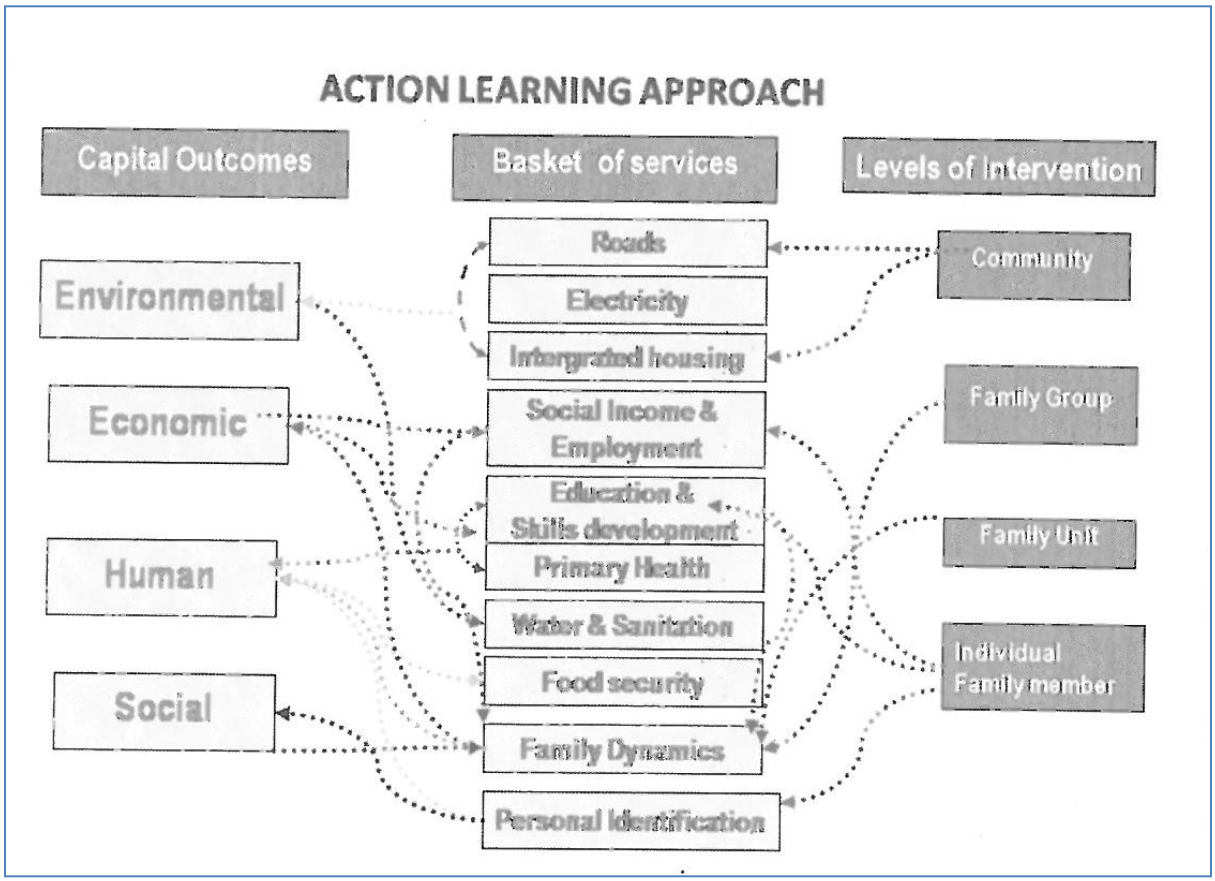
Similar to the international approaches of employing the SL framework to poverty eradication, SAWID also utilised this (adapted framework) in their DC programme in the two pilot sites, which has areas of overlap or convergence. The objectives of the DC model as stated by SAWID (2012a: 14) are as follows:

- To facilitate the eradication of absolute poverty in nodal areas by strengthening the capacity of targeted households to graduate out of indigence;
- To amplify civil society voices in service delivery and policy making;
- To support municipal and community capacity building for better coordination and mobilisation of resources;
- To ensure that social cohesion results in social capital.

Figure 1 depicts the DC model framework; it shows the different levels of intervention, the services that the programme aims to link the poor to, and the programmes expected outcomes. The Development

Caravan works with individuals, family units, groups of families and with communities, and it does this through the SAWs. It aims to link beneficiaries to services such as electricity, water and sanitation, education, social income and primary health care. The aim of the DC is to ultimately build human, social, economic and environmental capital for the poor families it aspires to help, therefore improving the overall quality of life for these.

Figure 2: SAWID Development Caravan Framework



Source: SAWID, 2012a

In partnership with Ponahalo De Beers Disadvantaged Woman's Trust, SAWID is currently replicating the DC model in Viljoenskroon in the Moqhoka Municipality in the Free State. So far, 21 SAWs have successfully completed their training in September 2012, however, the project has only registered a few successful cases as it is still in progress. This project has received buy-in and support from the local municipality. Assistance with access to social security, along with access to such services such as mobile clinics are already being provided to beneficiary families (SAWID, 2012b).

Development Caravan's Goal

"The project is aimed at systematically and effectively addressing poverty and all its manifestations of indigent families by improving personal capacities and increasing access to a variety of resources, institutions and support mechanisms, in order to create sustainable livelihoods."

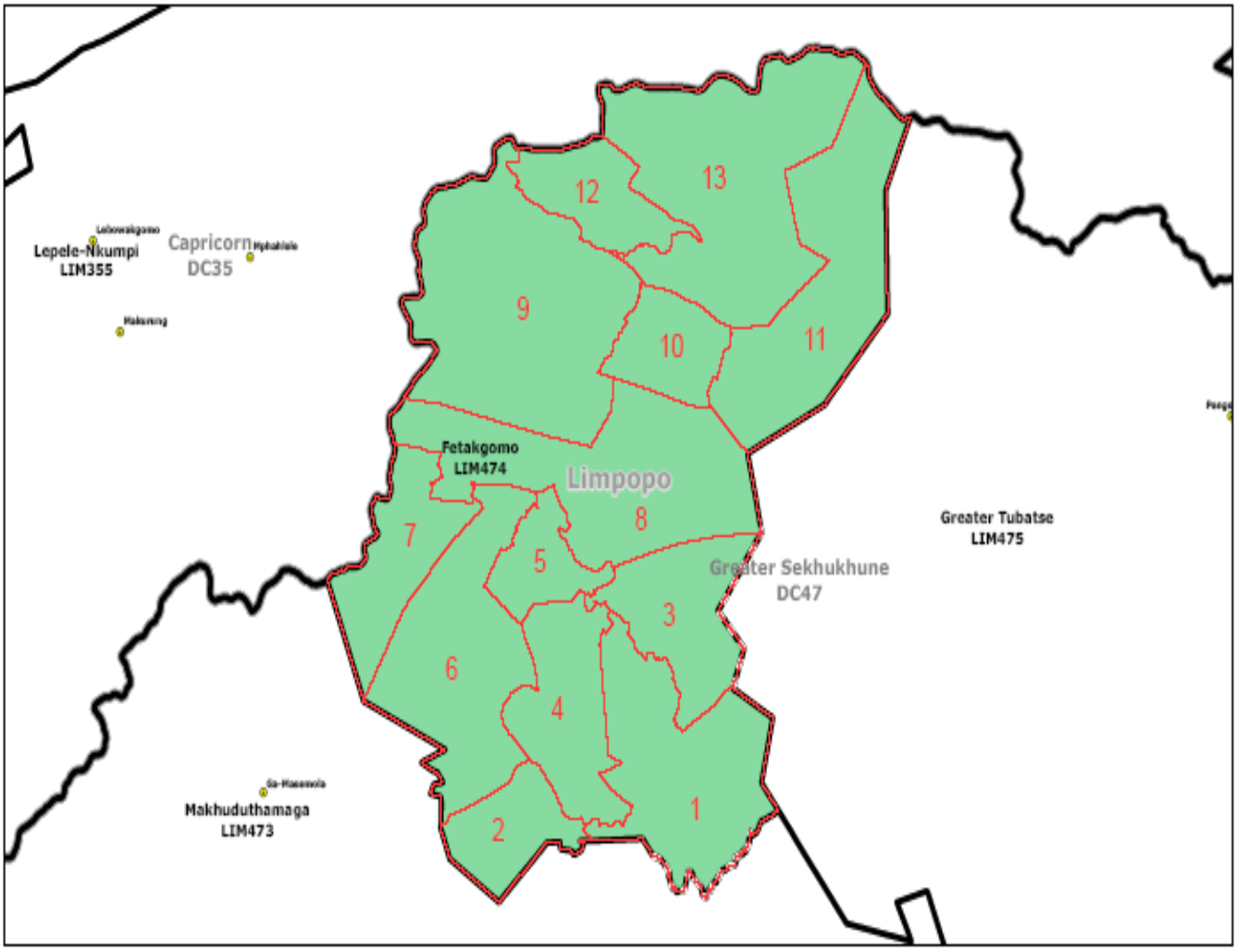
3.2.2 *Justification*

Despite many efforts that the South African government is making, many South African families are still living in conditions of poverty and squalor. There are multiple reasons to this including a) family incapacitation, b) high unemployment rates, c) a lack of targeting and using a one-size-fits-all approach, and d) a lack of integration of services.

3.2.3 *Overview of pilot sites*

The DC was piloted in two areas; the Mfolozi Municipality in Uthungulu district of KwaZulu-Natal and the Fetakgomo Municipality in Sekhukhune district in Limpopo, municipalities that were identified as they fall under the declared nodal area. Nodal areas are deemed to be those areas that represent the highest concentrations of poverty in the country and have suffered severe neglect in terms of development. 600 families from these areas were identified to take part in the pilot programme, and 65 young men and women from the same municipalities were in training in Social Auxiliary Work. The SAWs make use of a variety of approaches to engage communities around issues of poverty eradication with the purpose of establishing an enabling environment in order to assist with local problem solving to promote and sustain behaviour alteration, generate demand for services, as well as holding service providers accountable for services. They do this by working through existing organisations and networks. Poor families are linked to government services, and a case-work approach is used to restore family systems, stronger community networks and increased family participation within and outside the household. Ultimately, the DC increases resource availability by incorporating organic economic development with indigenous practices (SAWID, 2012a; Silinda, 2009).

Map of uMfolozi pilot site



In partnership with Ponahalo De Beers Disadvantaged Woman's Trust, SAWID is currently replicating the DC model in Viljoenskroon in the Moqhoka Municipality in the Free State. So far, 21 SAWs have successfully completed their training in September 2012, however, the project has only registered a few successful cases as it is still in progress. This project has received buy-in and support from the local municipality. Assistance with access to social security, along with access to such services such as mobile clinics are already being provided to beneficiary families (SAWID, 2012b).

Map of uMfolozi pilot site

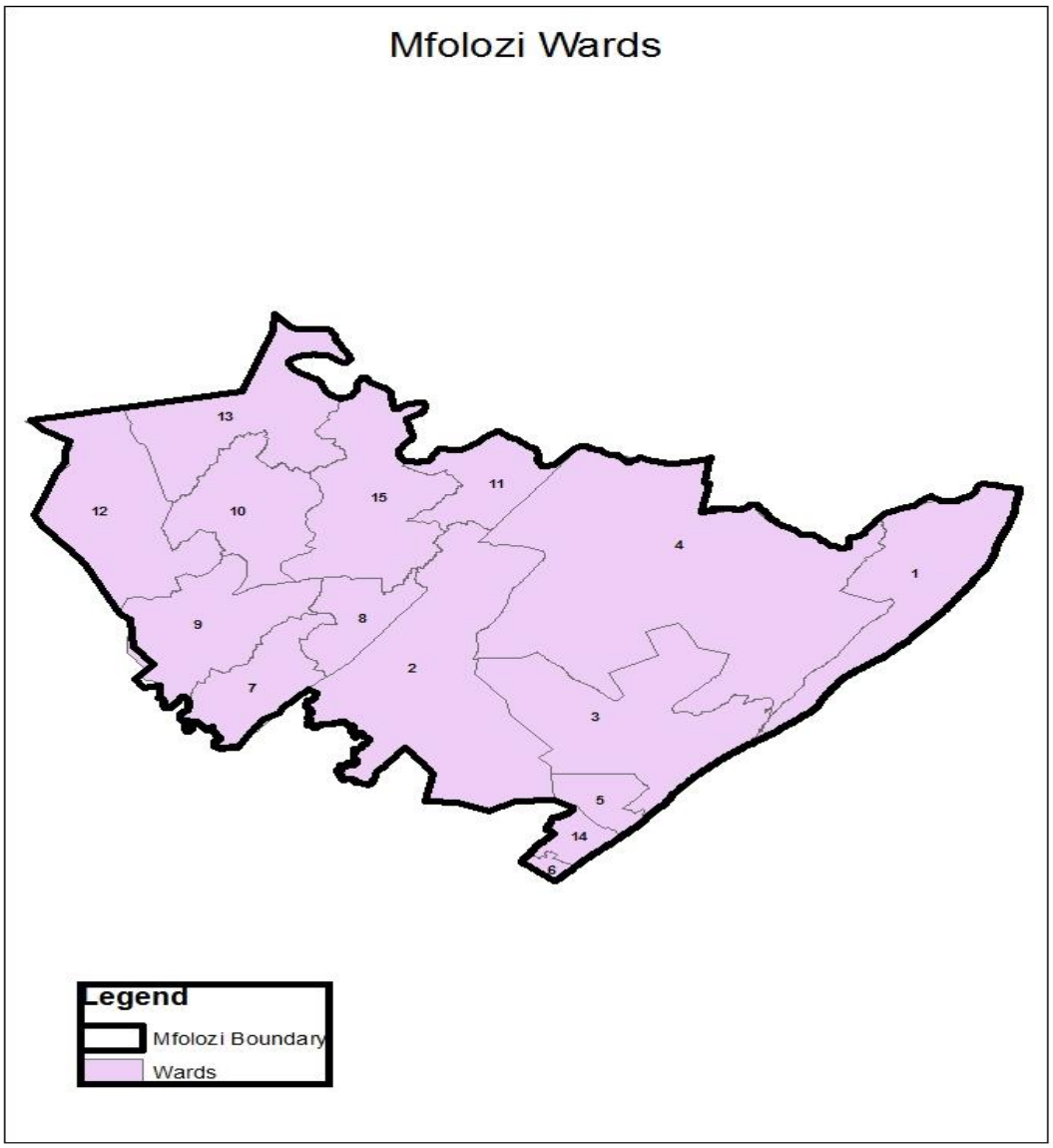


Table 3 shows the two provinces where the Development Caravan model was piloted. A total of 79 Development Facilitators were trained. 772 Families with 4460 family members are participating in the research program.

Table 3: Pilot sites

Site	Population	No. of wards	No. of SAWs	No. of families	No. of members
Limpopo Province (Fetakgomo municipality)	98 814	13	26	263	1405
KwaZulu-Natal	122 889	13	32	275	1870

(KwaMbonambi / Umfolozi municipality)					
Total		**33**	**58**	**538**	**3275**

Source: SAWID

Fetakgomo is one of the most economically depressed municipalities in Limpopo and in South Africa. It has 22 631 households. The 2005 Census results indicate that 73.4% (45 253) of the population does not have any income, while only 0.41% of the population has an average income of more than R12 801 per year. The area is located in the summer rainfall zone and is occasionally prone to drought.

Formerly known as Kwa-Mbonambi, Umfolozi Municipality is located 30 km away from the Richards Bay and Empangeni towns. According to the 2005 Census, it has a total population of 122 889 and 25 582 households and registered a 67.9% poverty rate.

Umfolozi Local Municipality is located in the Uthungulu District Municipality in the province of KwaZulu-Natal and the Fetakgomo Local Municipality is situated in the Sekhukhune District Municipality of the Limpopo Province.

3.2.4 Socioeconomic Profiles

Human development Index (HDI)

Human Development as seen through the Human Development Index (HDI) was first developed in 1990 and published by the United Nations Development Programme (UNDP). It is a composite (statistical) relative index of life expectancy, education and income designed to compare human development across regions and population groups. The HDI values can range between 1 and 0, with 1 indicating a very high level of human development and 0 indicating no human development, (UNDP, http://hdr.undp.org/en/statistics/hdi; Global Insight definitions, 2014).

uMfolozi Municipality

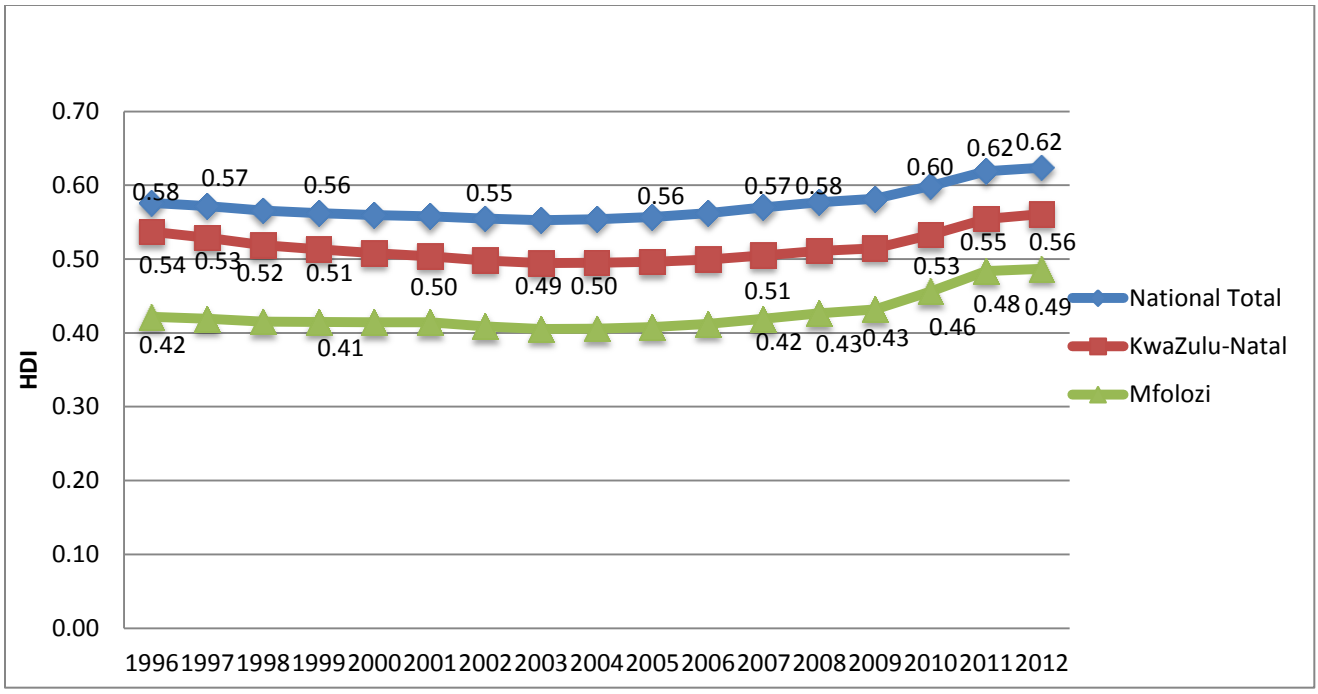


Figure 3. Human Development Index (HDI) for uMfolozi Municipality and related regions, 1996 – 2012. Source: Constructed using Global Insight data, April 2014.

Figure 3 depicts the HDI for uMfolozi municipality, along with the indices for KwaZulu-Natal (a province under which uMfolozi falls under) and that of the country as a whole. It shows that the HDI for the province, KwaZulu-Natal, has been higher than that of uMfolozi municipality for the entire duration of the period under consideration, while the HDI for the country has also been higher than that of the province. The municipality's HDI has generally shown an upward trend, indicating increasing human development, with a value of 0.42 in 1996 and a higher value of 0.49 in the year 2012.

Fetakgomo Municipality

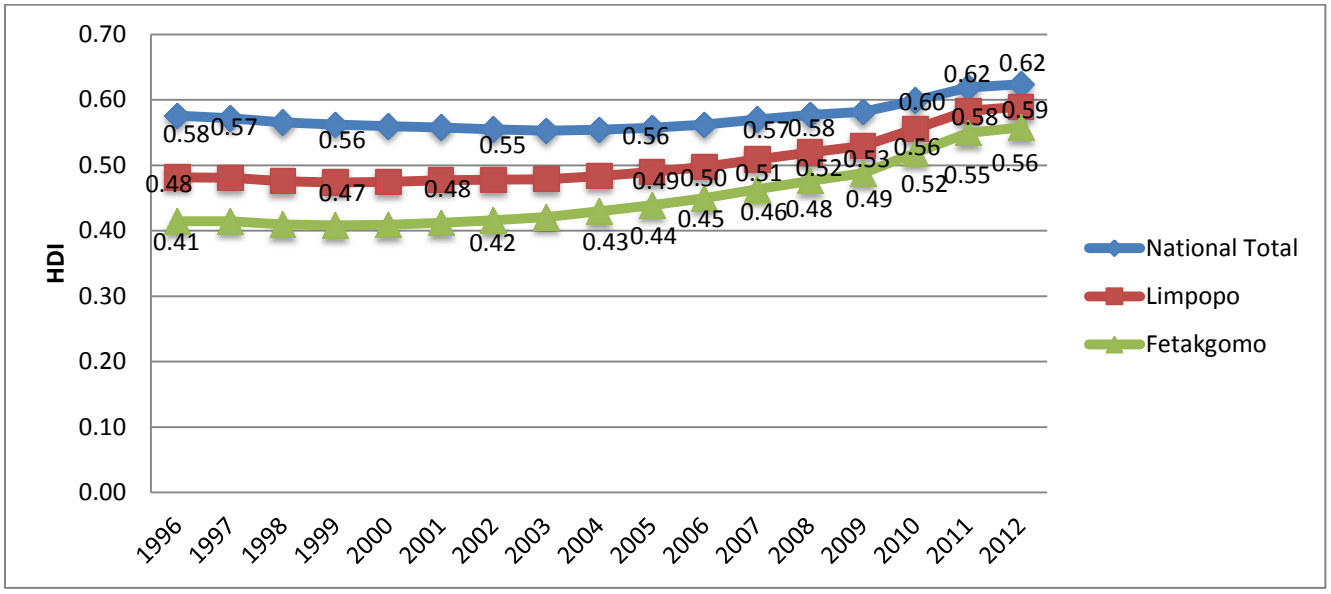


Figure 4. Human Development Index (HDI) for Fetakgomo Municipality and related regions, 1996 – 2012. Source: Constructed using Global Insight data, April 2014.

The HDI of Fetakgomo municipality along with those of the Limpopo province and the country as a whole are shown in Figure 3. The municipality's HDI is shown to have been increasing steadily from 1996 at 0.41 to 2012 at 0.56. This trend is similar to that of the province as Limpopo has also experienced a steady increase in its HDI (except in 1999 when it decreased to 0.47 from 0.48 in 1998).

uMfolozi Municipality

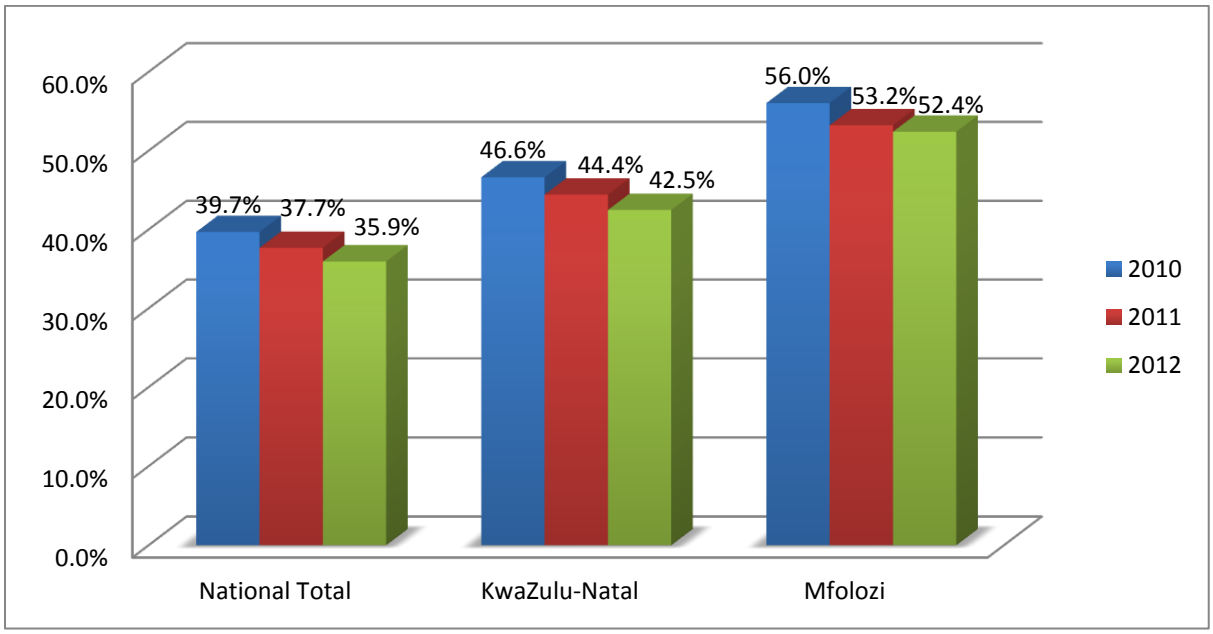


Figure 5. Percentage of people living in poverty in uMfolozi Municipality and related regions, 2010 – 2012. Source: Constructed using Global Insight data, April 2014.

Figure 5 shows the percentages of people living in poverty in uMfolozi, KwaZulu-Natal and SA as a whole. Of the three, uMfolozi has the highest percentage of people living in poverty, and in 2012 these made up 56% of the municipality's population. During this period, approximately 37% and 40% of KwaZulu-Natal and SA's populations respectively were living in poverty. Although uMfolozi has a high percentage of its people living in poverty, this indicator has been showing a decreasing trend, and this is also the case for the province and the entire country. The South African government has made the fight against poverty a priority since 1994 and this can be seen in its many strategies devoted eliminating poverty in the country.

Fetakgomo Municipality

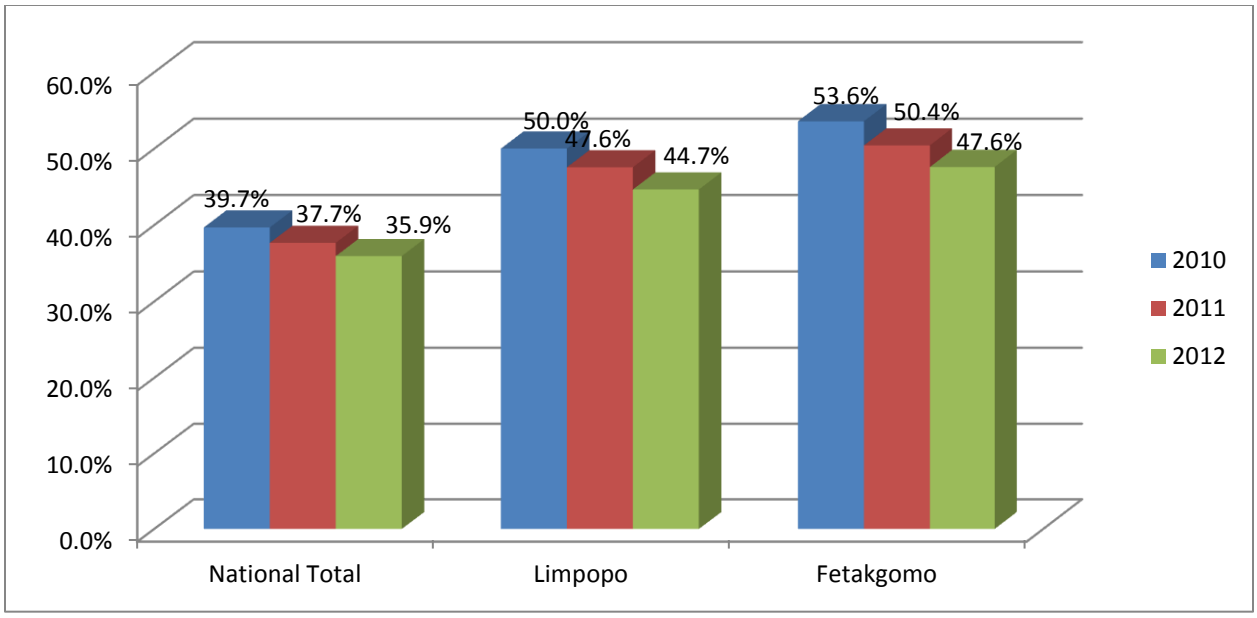


Figure 6. Percentage of people living in poverty in Fetakgomo Municipality and related regions, 2010 – 2012. Source: Constructed using Global Insight data, April 2014.

Fetakgomo municipality has a higher percentage of people living in poverty than Limpopo as a whole, while Limpopo has a high percentage of people living in poverty than the country in its entirety, and this is depicted in Figure 6. There has been, however, a decrease in the proportion of people living in poverty for the three regions, and Fetakgomo experienced a 6 percentage points decrease in its percentage of people living in poverty from 2010 to 2012.

Inequality: the Gini Coefficient

The Gini coefficient measure the extent to which the distribution of income amongst households or individuals deviates from a perfectly equal distribution. The coefficient ranges between 0 and 1, with 0 representing a perfectly equal distribution and 1 implying perfect inequality. In practice, the Gini coefficient is likely to lie between 0.25 and 0.70 (World Bank, 2014).

uMfolozi Municipality

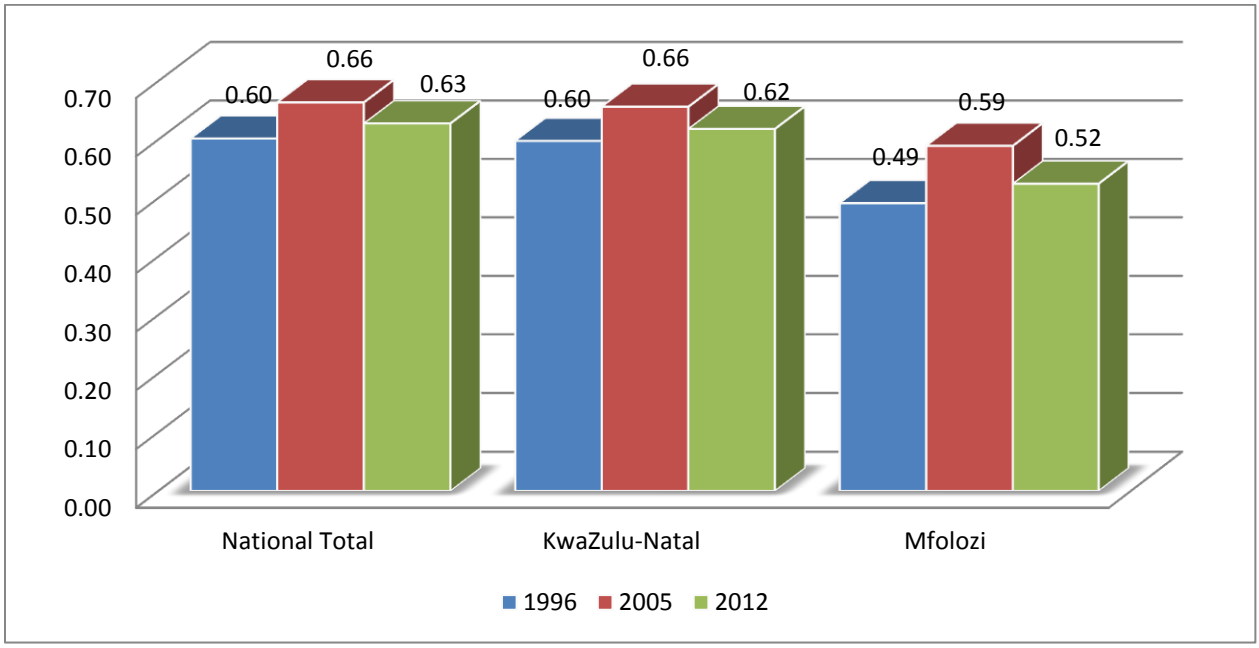


Figure 7.Gini Coefficient for uMfolozi Municipality and related regions, 1996, 2005 and 2012. Source: Constructed using Global Insight data, April 2014.

The Gini coefficients of uMfolozi municipality along with those of KwaZulu-Natal and South Africa are depicted in Figure 7 and uMfolozi had the lowest coefficient of the three for all the periods under consideration. For uMfolozi, the Gini coefficient was 0.49 in 1996, however this value rose up to and around the year 2005 indicating increasing inequality, nevertheless, this value decreased again, and indication of decreasing inequality, and in 2012 it stood at 0.52 (still higher than in 1996 though).

Fetakgomo Municipality

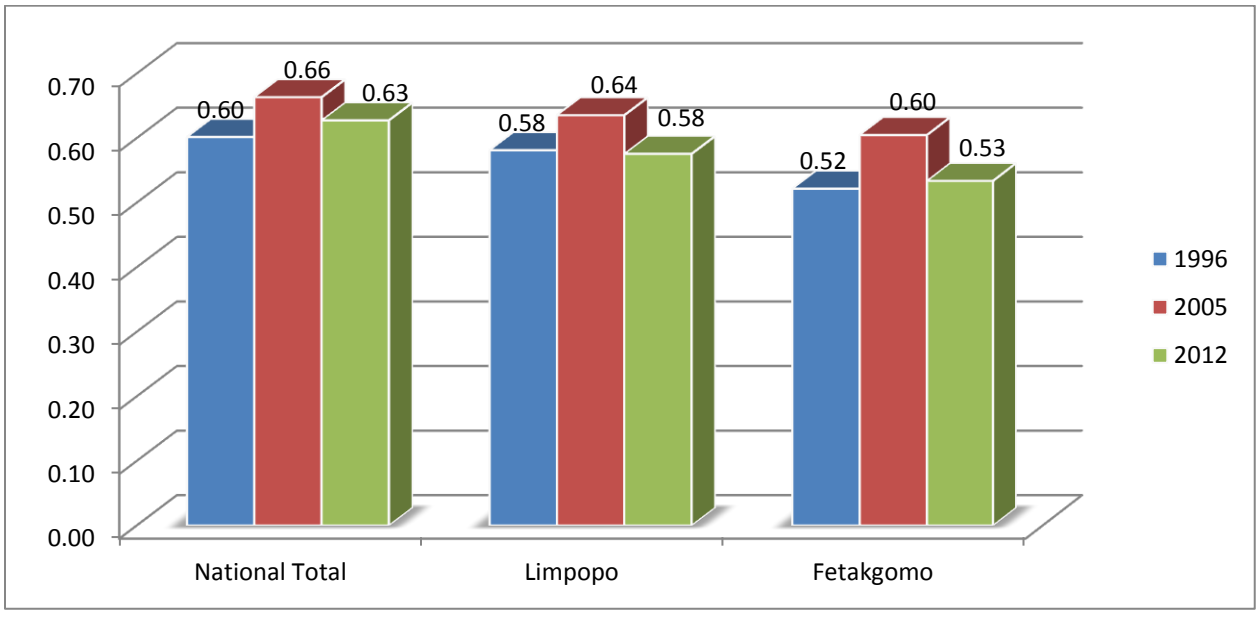


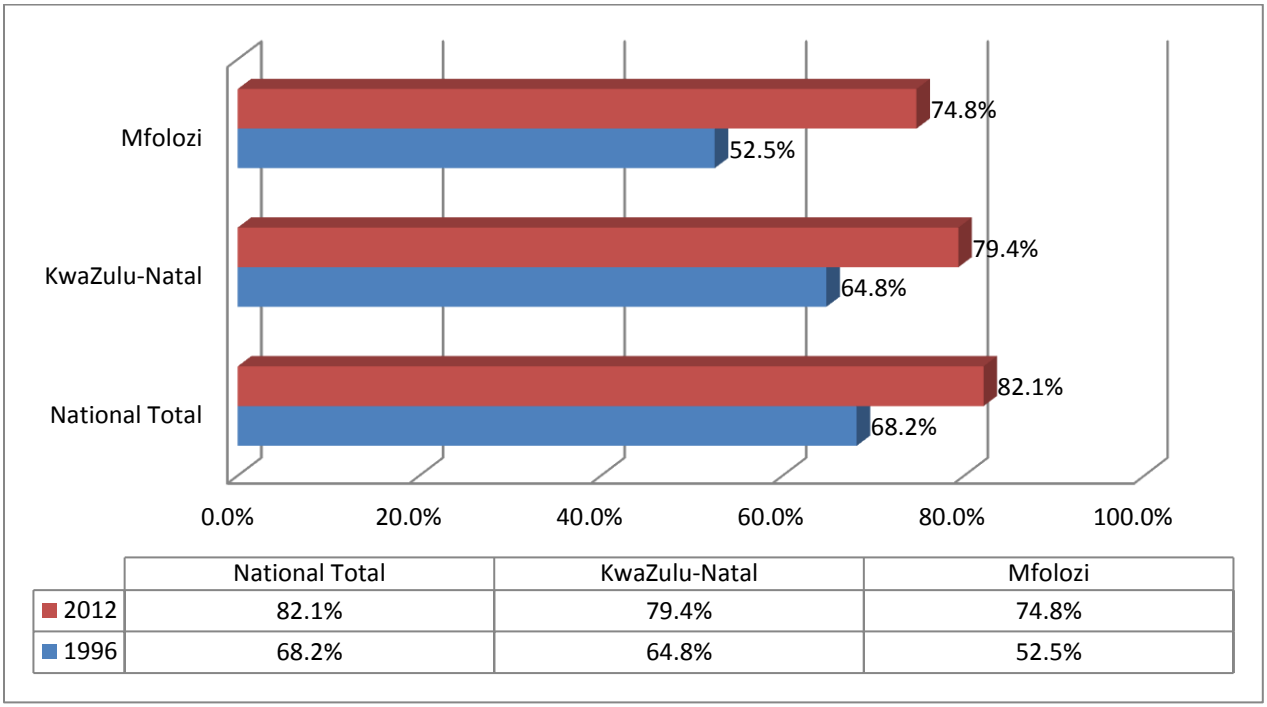
Figure 8.Gini Coefficient for Fetakgomo Municipality and related regions, 1996, 2005 and 2012. Source: Constructed using Global Insight data, April 2014.

Figure 8 shows the Gini coefficients of Fetakgome municipality, the Limpopo province and South Africa. The pattern is very similar to the one seen in the analysis of the uMfolozi Gini coefficient, both the nations and the province's (Limpopo) Gini coefficients are higher than that of the municipality (Fetakgomo), indicating inequality to be lower in the municipality than in the province and the country as a whole. Again, we see that there was an increase in the Gini coefficient for all three regions around 2005, but it decreased again, reaching 0.53 in 2012 for Fetakgomo.

Functional Literacy

The reported functional literacy of those aged 20 and above measures the percentage of people in a region who have completed their primary education (grade 7) and are therefore considered functionally literate. People deemed functionally literate are assumed to have a level of reading and writing that enables them to manage daily life and employment, (Global Insight definitions, April 2014).

uMfolozi Municipality

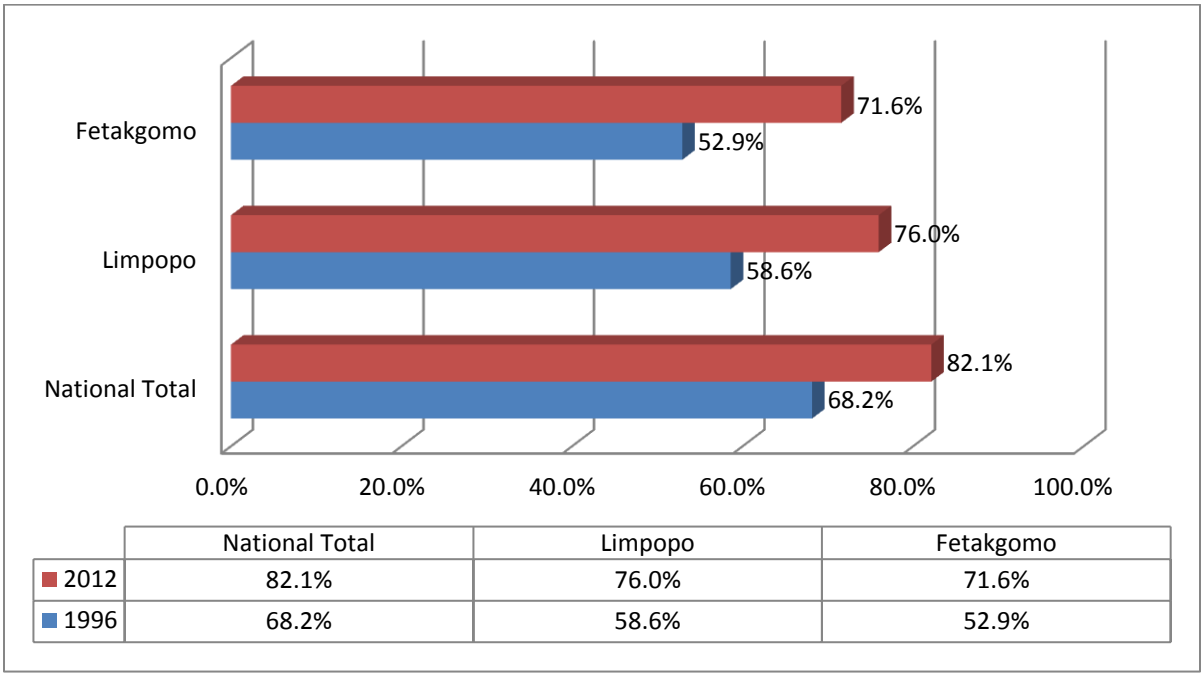


	National Total	KwaZulu-Natal	Mfolozi
2012	82.1%	79.4%	74.8%
1996	68.2%	64.8%	52.5%

Figure 9 Functional Literacy for uMfolozi Municipality and related regions, 1996 – 2012. Source: Constructed using Global Insight data, April 2014.

The functional literacy rates of adults (people aged 20 and above) in uMfolozi, KwaZulu-Natal province and South Africa are shown in Figure 9. There are higher levels of functional literacy in both the country as a whole and the province than in uMfolozi municipality. All have experienced high increases in their functional literacy rates from 1996 to 2012, and uMfolozi's rate of functional literacy went up by 22.3 percentage points from 64.8% in 1996 to 79.4% in 2012. This can most likely be attributed to the country's high investment in education since the beginning of democracy in 1994.

Fetakgomo Municipality



	National Total	Limpopo	Fetakgomo
2012	82.1%	76.0%	71.6%
1996	68.2%	58.6%	52.9%

Figure 10 Functional Literacy for Fetakgomo Municipality and related regions, 1996 – 2012. Source: Constructed using Global Insight data, April 2014.

Figure 10 shows the functional literacy of those who are aged 20 and above for Fetakgomo municipality as well as Limpopo and South Africa. Fetakgomo's functional literacy rate (71.6% in 2012) is shown to be less than that of the province (76% in 2012) and South Africa (82.15 in 2012). Fetakgomo's functional literacy rate is however shown to have increased quite significantly from 52.9% in 1996 by 18.7 percentage points to 71.6% in 2012.

4 METHODS FOR ASSESSING THE IMPACT OF THE DC PROGRAM

4.1 INTRODUCTION

The goal of an impact evaluation is to measure causal programme impacts as differences in outcomes between the beneficiaries and their counterfactual, that is, a proxy for what outcomes would have been for this group had they not received the programme. All impact evaluation strategies are designed to identify a method for constructing a proxy for these counterfactual outcomes, typically using information on non-beneficiaries. This requires controlling for the effects of confounding economic and contextual factors that make programme beneficiaries systematically different from an average non-beneficiary. These confounding factors can include the relative poverty of beneficiaries in targeted programs, exposure to economic shocks, or differences in household characteristics (e.g. demographics, parental schooling, or social networks) that affect the impacts of the programme. Impact estimates that imperfectly control for these confounders suffer from 'selection bias'.

In this section, we describe the methods we have used to assess the impact of the Development Caravan Programme. We begin by outlining the 'gold standard' approach and explain why our approach, by necessity, diverges from this. We then describe the approach we take in this report, matching and enumerating its strengths but also being careful to note its weaknesses.

The evaluation framework for the DC programme is informed by evidence of impact evaluations of poverty alleviation models in developing contexts, in South Africa and from international experiences and the anticipated outcomes of this evaluation study.

Typically, literature on programme evaluations methods addresses four elements as being critical for any evaluation *viz*.:

- Evaluation strategy
- Evaluation design
- Data collection methods, and
- Analysis technique

These are briefly discussed due to their relevance to the present study, each in turn.

4.2 Evaluation Strategy

An evaluation strategy has a bearing on the validity of an evaluation's conclusions. The kind of conclusion that can be drawn from an evaluation of a program's results pertain to ***causal inferences***.

The major task of an evaluation that attempts to determine programme outcomes is to eliminate or estimate the relative importance of rival explanations. This is accomplished through a combination of assumption, logical argument and empirical analysis, each of which is referred to as an evaluation strategy.

When comparing two groups, the beneficiary group is compared to a similar group that did not receive the program. The differences observed between the two groups could then be attributed to the programme. The assumption, of course, is that the two groups compared were reasonably similar. This comparison design is not without limitations however, it is sufficient if one manages to rule out other rival explanations in determining the extent to which a programme has caused an observed result. The ability to generalise in these types of evaluations is limited to the assertion that under identical circumstances, implementing the program elsewhere would result in the same outcome.

Conceptually, this is how one would make a causal inference. Two groups that are identical in every respect (save for the programme) are compared. Any difference between the two situations can be attributed to the programme. These evaluations are for programs that are already in place, which makes this a case of *ex-post* impact assessment. That includes the evaluation of a pilot project, as an input to the *ex-ante* assessment of whether the project should be scaled up.

A key challenge for this impact evaluation is that the "control group" is generally identified at the time the intervention commences. This is not the situation in respect of the DC pilot. To address this challenge the research will draw on matching methodology to identify groups of households who share similar socio-economic characteristics.

For this evaluation, in order to compare the outcomes of the two groups of households, the control group identification strategy will explore the fact that a family's eligibility to the DC program depended on (among other criteria), the profile of the area, which classified them as nodal. Areas with similar socio-economic characteristics in their dimensions to the DC participating household areas will be selected. The dimensions will be similar with just one difference, that the households did not receive the program. Therefore, any difference in the outcomes of the households in these two groups can be attributed to participation in the program. In order to avoid contamination, these non-participating households will be selected from either a different local municipality in the same district or from households in the same municipality.[4]

4.3 Evaluation Design

To improve the quality, validity and reliability of the evaluation, it is suggested that a mixed methods design be adopted that includes both qualitative and quantitative design approaches, referred to as *triangulation* (Rossi, et al., 2004; Denzin, 1978). Adopting both qualitative and quantitative methods in impact evaluations can generate statistically reliable measures of the magnitude of impact and provide greater depth of understanding of the reasons why a programme was or was not effective and what needs to be adapted to make it more effective (Garbarino and Holland, 2009).

Moving from the traditional methods of learning (largely utilising quantitative methods) towards the utilization of qualitative evaluation methods enables an analysis of poverty as a dynamic process rather than a static outcome and allows for the use of social analytical frameworks that interpret observed patterns and trends which include the analysis of socially differentiated outcomes. Qualitative analysis also has the potential to generate sophisticated, robust and timely data and analysis and when combined with quantitative instruments which have greater coverage and generalizability, can result in an impact evaluation that maximises on their comparative advantages.

The programme evaluation design incorporates several types of triangulation, including *methodological triangulation* (the convergence of data from multiple sources both quantitative and qualitative), *data triangulation* (the convergence of multiple data sources), and *investigator triangulation* (use of several or different investigators) (Denzin, 1978).

However, “programs are generally not assigned randomly across the population of units. So we cannot attribute to the program the observed differences in measured outcome indicators between units who receive the program and those who do not. The measured differences we see in the data could just be due to the fact that the program participants were purposely selected. (This is often called “selection bias.”).” In such instances, ***randomization*** is the theoretical ideal, and a natural benchmark for assessing non-experimental (sometimes called ***“quasi-experimental”) methods***.

As the DC programme pilot was already launched in 2011 as project in two sites in Limpopo (Fetakgomo) and KwaZulu-Natal (KwaMbonambi), the appropriate methodology employed for this project became an *ex-post* impact assessment. The DC participants were not obtained from a random allocation of the

[4] To be clear, participating households are beneficiary households included in the SAWID DC program. Non-participating households are households who would have been eligible for participation, using SAWID’s profiling criteria however, were not included as part of the program due to sufficient sample sizes for the pilot having been met.

program among eligible beneficiaries in a way that creates comparable treatment and control groups. Instead, various profiling methods were used, including the municipal indigent lists as well as consulting members of the community to assist in identifying households that were deemed to be extremely poor. This is how SAWID arrived at their pilot site number of households to include in the program. We followed the same method in identifying a sample non-participating households to use as a 'control group' for the impact evaluation. This, therefore, justified using comparison of means methods for this evaluation. The DC program impact on the outcomes being evaluated could be measured by the difference between the means of the samples of the treatment group and the control group.

The *sequencing* of design and methods (both qualitative and quantitative) was determined by the evaluation team, based on the information that is already available for beneficiaries and beneficiary households (to facilitate efficiency, effectiveness and impact assessment), and taking into account the context of the evaluation and the sequence of data requirements (read in conjunction with 'data collection methods' that follows).

4.3.1 Constructing treatment and comparison groups with non-random assignment

By the programme designer's own admission, when the DC programme was conceptualised, the creation of an experimental control group was not considered (key informant interview, May 2014). The most proper way, statistically, to evaluate a program's impact is to perform an evaluation with a control group of that kind. When not being able to use experimental methods, some kind of non-experimental method to estimate the impact is required. Considering that the characteristics determining eligibility in the DC programme are not random, selecting households that had similar socio-economic characteristics as the DC programme beneficiary households is used to build up a counterfactual scenario – termed non-DC households in this study). This methodology is considered a valid way of estimation in non-experimental studies of impact evaluation and is applied to identify an adequate control group whenever this group cannot be built up from randomization of the intervention.

DC Beneficiary Household Sampling

According to SAWID records there are approximately 538 households enrolled in the DC Programme in the two pilot sites with 275 households in KZN and 263 in Limpopo. Using a 10% sample size we generated a sample size of 54. While a sample size of 5% is often recommended in evaluation research in order to ensure representativeness and generalizability in impact assessments (Powell, 1998), the larger 10% sample size chosen was informed by the relatively small total population of the pilot.

The households are distributed across wards within each local municipality. Fetakgomo and KwaMbonambi both have 13 wards each. Fetakgomo has 6 'urban' wards; 9 'rural' wards and KwaMbonambi has 8 'urban' wards; 5 'rural' wards. The selection of households within these wards was done proportionally to ensure that we had spatial representation. In addition, the selection was informed by the need to ensure that households selected covered the various dimensions of the SAWID DC programme.

Care was taken in the final sampling to ensure that the sample incorporated representativity in terms of gender, ensuring that female and male headed households were included, as well as in terms of

household composition. In this regard, the consideration was to ensure that different types of households were included in the sample.

Non beneficiary households Sampling[5]

We intended to undertake a total of 60 household interviews with non-beneficiary households, which translates to 30 household interviews each per DC site. As indicated earlier, ideally the control group is identified at the outset of the project implementation. This was not the case with the DC programme design and hence the study utilised matching methodology to identify non beneficiary households which closely resembled the SAWID DC household beneficiaries with the only exception that they would not have received SAWID support.

There were two options for selecting the sample of non-beneficiaries. The first option was to sample those households not in receipt of DC services in a local municipality *neighbouring* that where the DC programme was piloted. The ward to be selected would have had to closely resemble one of the wards where the DC was currently being implemented. It would be important in selecting the ward to identify what, if any, poverty alleviation interventions have been implemented in that ward, and which were not available to the DC ward that it is supposed to match. This exercise draws on municipal profiling of wards and a scan of relevant programme interventions in that ward by government in the preceding three years. The selected sample of households would be identified from indigent lists provided by the Local Municipality and/or the Department of Social Development. Care would have to be taken to ensure that the selected households are similar in terms of poverty ranking and other characteristics.

The limitation of this approach is that we could not match perfectly, nor could we control fully for other factors that may have influenced the household situation. Furthermore, this approach has additional time and cost implications. However, the argument in favour of this method is that it is unlikely for there to be any ***"contamination"*** of the selected households. Contamination refers to the situation where the household, despite not being directly involved in the DC programme, may have knowledge of the DC programme or may have indirectly been affected by the intervention in a positive or negative manner.

The second option was to identify a sample of non-beneficiary households within the *current* local municipality where the DC programme pilots took place. To avoid potential "contamination", the households selected would not be physically close to a household which is currently involved in the DC programme. The identification of the non-beneficiary households would be as outlined above, namely to access indigent lists from the local municipality and/or Department of Social Development, and to ensure that the selected households are similar in their poverty rankings, and other socio-economic characteristics.

The limitation of this approach however, is that it is possible that non-beneficiary households would be "contaminated" by the DC intervention. Given that the number of DC households in the pilot sites is small in comparison to the total population and number of households in the DC site, it appeared to be likely to identify households which had not had direct knowledge of, or had been affected by the DC pilot. The argument in support of adopting this approach includes that the socio-economic characteristics of the community are likely to be the same, access to government and other support is also likely to be the same. This option became the research team's preferred approach.

[5] The terms 'comparison group', 'control group, and non-DC households are used interchangeably throughout this report to refer to these households.

Furtherto undertaking a household survey of DC and non-DC households, other data collection methods included key informant interviews, case studies with individual beneficiaries, as well as conducting focus groups with community representatives who had knowledge of and/or were directly or indirectly affected by the programme. Table 4 indicates how the sample was identified and selected for each level of participant.

Table 4. Sample selection

#	Participant	Sample selection
1	SAWID program management (at national level)	2x internal (SAWID program management involved in the DC implementation) 1x external (SAWID board member / Trustee)
2	Key informants	Selected with the help of SAWID DC Programme stakeholders, list used to select program beneficiaries and to ensure representativity and inclusivity. NGOs, private sector, training agency, government sector (national and local) all selected. 10 each from each site
3	Social Axillary Workers (SAWs)	Two groups selected, one from each pilot site Male and female SAWs sampled to ensure gender inclusivity and diversity Two groups selected with a minimum of 6 people each.
4	Household survey	DC households and non-DC household comparison groups purposively selected as elaborated on above
5	Case studies with individual DC programme beneficiaries	Purposively selected – elaborated above

A key sampling challenge encountered during the course of this exercise was the reliability (or lack thereof) of recorded data on numbers of households, as small discrepancies were found across different data sources. A further complication was that information on the DC program is not kept at a central place such that data for the program had to be sourced independently from each of the two pilot site managers.

4.4 Data Collection and Analysis Methods

The evaluation strategy for the DC programme encompassed two evaluation criteria in order to be able to respond to the terms of reference *viz*. efficiency and impact. Following Aliber, Aihoon and Karuri's (2007) evaluation method, evaluating the effectiveness and the impact of the DC programme involved a combination of data from qualitative and quantitative approaches to analyse and triangulate information from different sources. Data for the evaluation came from the DC program's strategic document, policies, official program documents and other secondary databases, as well as surveys, interviews, case records for each family, case studies of program staff, individuals and families, partners and other stakeholders (Table 5).

Table 5. Evaluation methodologies and data

Evaluation criteria	Evaluation activities	Data sources
Measuring the	Literature review on evaluating	Theoretical and empirical literature;

efficiency of DC program	other models such as the DC - design, efficiency, success rate, scalability, etc.	evaluation findings
	Survey of SAWID management at national level	Purposively identified sample of SAWID program management and board members
	Key informant interviews	SAWID DC program staff based at the two pilot sites (site managers and social workers), program partners (Government, NGOs, Training agencies, Private sector and other stakeholders) identified with the help of SAWID
	Quantitative analysis of case record data (individual and family demographics, benefits, etc.)	DC pilot site databases
	Qualitative analysis of efficiency of DC program	Surveys, interviews, case studies and focus group discussions
Measuring the impact of DC program – within beneficiaries	Literature review on evaluating other models such as the DC - evaluation strategies, sampling frame, assignment mechanism, etc.	Theoretical and empirical literature; evaluation findings
	Semi-structured interviews with DC beneficiary & non-beneficiary households	10% sample of participating households (i.e. total 160 households for the study; 80 from each site)
	Focus group discussions	Focus group discussions with Social Auxillary Workers employed by the DC program in each pilot site
	Quantitative analysis of DC program impact	SAWID DC program progress reports (used to report on 2011 baseline increase), DC household records, monitoring data, strategic documents, policies, etc.
Measuring the impact of DC program – within wider community	Community focus group	Purposely selected sample of community leaders (e.g. councilors, indunas, youth leader, business people, etc.)
	Individual case studies	Case studies from individuals and families who have benefitted from the DC programme

In terms of the efficiency measures employed in in this study, this considered the following (among others):

- How were resources/inputs (funds, expertise, time, etc.) converted into outputs?
- Were the resources and inputs converted to outputs in a timely and cost effective manner?
- Are there verifiable monitoring and reporting of DC program performance in terms of the primary objectives of the program?

The indicators by which a program is to be assessed are appropriate to the type of program. Knowing impact is a means of measuring the aggregate benefits from the program. Good data is needed on outcome measures for both ***participants and non-participants*** to give a reliable estimate of the program's impact. In terms of measurement of impact therefore, as previously stated, Chile is one of two countries (the other being Tunisia) on which the SAWID DC program was modelled against and as such, there are many similarities between the two programs. Hence, the design of this evaluation study adapts from Carneiro and Galasso's (2010) evaluation of the Chilean model, known as the Solidario model, which, among other things, aimed to provide psycho-social support to indigent families and increase their access to social services.

In evaluating the impact of DC program on the lives of the poor, this evaluation will consider a set of the DC program's 38 minimum conditions under each dimension to be attained by participating households, as far as data availability will permit, and in order to have a focused and informative analysis. These will serve as indicators for measuring impact.

Finally, a note about the ethical considerations for this study: The HSRC research focuses on people, and the bulk of the information and data gathered is accordingly likely to be of a personal nature to the participants in the research. Researchers and the research leadership in the HSRC are very aware of the ethical considerations related to research with human subjects, and these concerns are built into planning and review process of all research proposals. Where formal ethical clearance of research proposals is required, such proposals are submitted to established ethics committees for research on human subjects in South Africa. The research ethics committee (REC) examines and approves all research projects in advance. The REC granted approval in April 2014 for this study to be undertaken, subject to minor changes.

4.4.1 Research tools

The evaluation study aimed to address the study objectives through the application of a range of research tools targeted to a select group of stakeholders. Table 3 above provided an overview of the methods to be used for collecting data during the DC program evaluation.

The collection of the project level information using scientifically verifiable qualitative and quantitative methods formed the core part of this phase. The study combine the strengths of purpose-built household surveys, focus groups and key informant interviews to collect information from a range of SAWID DC project stakeholders including SAWID management, operational staff, DC beneficiaries, non-beneficiaries and other role players active in the implementation of the DC pilot project.

Table 4: Data Collection Tools and Sampling

#	Data collection tools	Purpose	Sample per site	TOTAL sample
1	Beneficiary HH survey (***HH impact***)	What are the perceptions of community members regarding DC program interventions? Experience of SAWID in their lives	50	100

		Socio-demo 4/5 key sections[6] (*educ; health; unemployment; water&sanitation; access to savings*)		
2	Comparison Non Beneficiary HH survey	What are the experiences of non-beneficiary households in addressing their vulnerability?	30	60
3	Key informant interviews	Analyse manner in which things have been done and decide how they can be improved. For example, how were the various activities carried out?	8	16
	SAWID Management SAWID Board SAWID Senior Staff	Analyse purpose and expectations in respect of the DC Pilot. Identify perceived value and impact. Assess key learnings and challenges experienced in ensuring sustainability.		3
	SAWID Partners	Assess value of partnership with SAWID, Analyse sustainability of DC model	2	4
	SAWID Site Level Stakeholders *(site manager; social worker)*	What are the perceptions of field staff regarding DC program interventions?	2	4
	***DC External** Stakeholders (NGOs; Govt depts., Training Agencies, Private Sector etc .)*	What are the perceptions of field staff and of community members regarding DC program interventions?	5	10
4	SAWs FGD questionnaire	What are the perceptions of field staff regarding DC program interventions?	2 FGD (6 SAWs per discussion)	4
5	Beneficiary Household case studies	To understand the perceptions of impact and value of the DC on the household	10 (to cover all 10 dimensions	20
6	Quantitative Data Analysis	Extract and analyse information from DC beneficiary files;	All files	All files
7	Community Stakeholder Focus Group Discussion	To understand the value of the DC of the indirectly the community in general. Participants will include community leaders, non-beneficiary households etc.	1 FGD per site (6-8 participants)	2

Case Studies of DC Beneficiary Households

A case study approach is a systematic approach which aims to provide description of a particular phenomenon. It relies heavily on multiple sources of data including documentary evidence, interviews, archival records and observations. It is aimed at developing an in-depth understanding of a particular issue with the aim of generating new insights. It will require firstly that the subject "case" to be analysed is defined as the main unit of analysis, it also requires that a case study design be selected.

Case studies are generally used to:

- Assess impact from the perspective of policy design and implementation;
- Evaluate the impact of the DC programme on the alleviation of poverty;
- Verify and validate findings from the surveys and other techniques, and at the same time yield information that cannot be accessed through the other methods; and
- Elicit information on causal linkages through real-life interventions and describe interventions and how they differ or correlate with the original programme design.

The case studies should provide in-depth information and analysis on the *successes, challenges and possible outcomes*, *strengths and weaknesses* of the programme by eliciting perceptions and judgemental information that is not accessible through surveys. Case studies can capture the *'how' and 'who'* questions in an integrated manner. Hence, the case study of SAWs will seek to ascertain the benefits of the programme

4.5 Analysis Technique

Qualitative data was translated and transcribed (where relevant) and the software program Atlas-ti was used to analyze the data. Atlas-ti produces themes from the data that enable the researcher to make sense and meaning of the thematic content. This way, an experienced researcher can also use an "ethnographic" bias in understanding the data. This is especially important to understand deep-seated cultural issues and "community-norming". In essence, Atlas-ti makes the task of a Thematic Content Analysis easier by generating logical themes that can be managed by the researcher and constructed into themes that link with the objectives of the study.

The quantitative data was analysed using the statistical package STATA and other analysis techniques to investigate significant differences between the beneficiary and non-beneficiary households. Excel was also used to analyse trends and to identify unique household and individual cases to select for case study analyses.

5 RESULTS AND DISCUSSION

Household data enables a richer interpretation of the results of socio-economic impact analyses. The literature on poverty consistently identifies certain core individual and household socio-economic characteristics as being dominant amongst the poor, such as unemployed people, households populated by women, poorly educated households, larger households (in terms of size) and grant dependent households. The literature also alludes to notions of more female-headed households tending to be poor than is the case for male-headed households. From the household survey, these variables were analysed and the results thereof are presented in the section that follows.

5.1 Demographic characteristics of the sample

The demographic profile of a population is a good indication of its stage of development. Each stage in its transition is defined by a range of characteristics (e.g. birth rate, death rate, dependency ratio, etc.) that can easily been inferred from its population pyramid. Typically, there are four stages in the transition and these are associated with a regions level of socio-economic development. Stage 1 represents a fairly, underdeveloped region whilst stage 4 reflects the highest level of development

similar to that which is found in advanced countries. To get an indication of the demographic profile of the study population, its demographic pyramid was constructed.

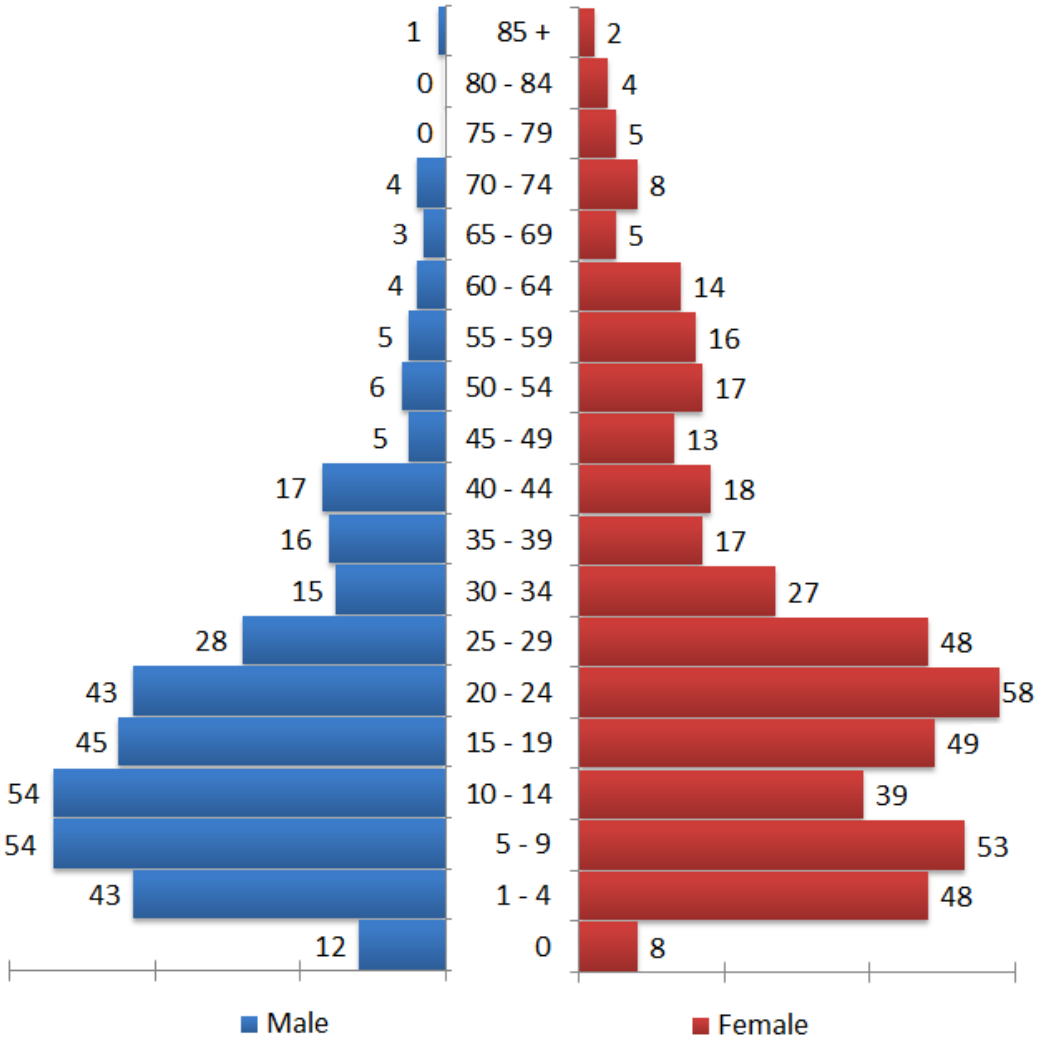


Figure 11 Demographic age-sex pyramid for SAWID DC survey population.
Source: Author calculations.

If we ignore the 0 age group which includes children born in 2014, Figure 11 suggests that the study population has characteristics of a region that is in its expansive stage which would be 1 or 2. The shape of this pyramid is characteristic of a population that is in the lower stages of development. Its tapering head is indicative of a relatively short life expectancy due a high death rate, which seems to be relatively higher for males than for females. These observed differences in life expectancy would suggest the presence of more female-headed households and relatively high dependency ratios. Alternatively, the significant drop in the male population might be explained by a high outward migration rate amongst males. With respect to this study we would therefore expect to find a high number of child support grant receiving households with fewer old age grants. What will be interesting is to see the extent of coverage and the role that the DC intervention might have played in facilitating that access. If the sharp decrease in the male population is being caused by outward migration for employment purposes we also expect to find households that are receiving some form of remittances as a source of income.

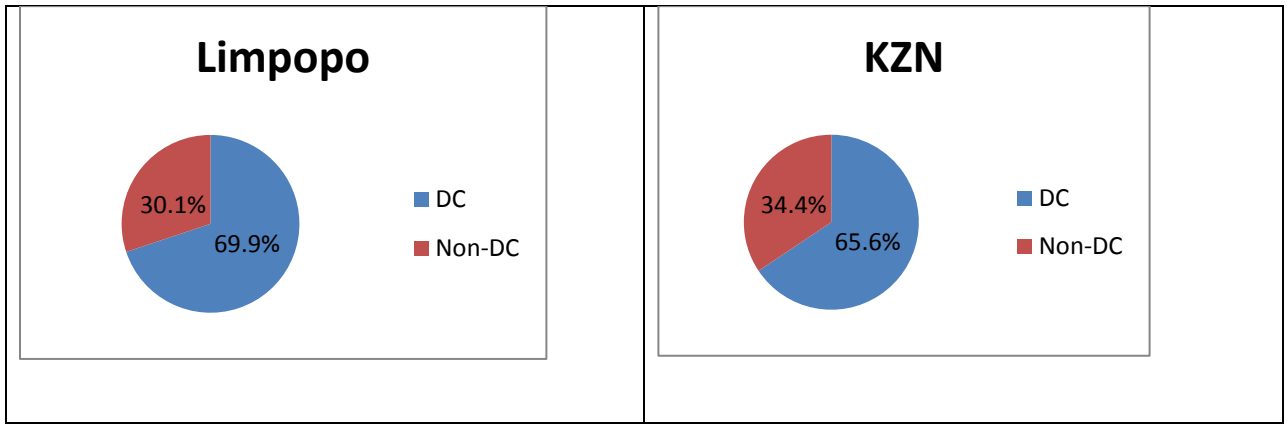


Figure 12 Evaluation survey samples according to DC pilot site (N=147).

Overall, there were a total of 147 households interviewed for the study. The split between DC and non-DC households in both sites is illustrated in Figure 12. As discussed in Section 4, the controls (non-DC sample of households) came from the same local municipalities as the treatment group (DC households) and these were selected in the same manner using the approach employed by SAWID to select the DC program participants. Some non-DC households were sampled from the municipalities' indigent list while others were chosen based on information about the poverty status of the households obtained from the SAWs as well as local authorities.

The non-DC households were purposively selected and there were more DC households than non-DC households, which is an acceptable norm for studies of this kind. The intention was to sample 160 households (80 from each site, split into 50 DC and 30 non-DC households respectively). However, due to challenges encountered during fieldwork, such as inaccessible roads, households that could not be found (because only village or area names were given and no physical addresses with which to use to locate the households) as well as refusals to participate in the study, the eventual overall sample was 147 (83 households from Limpopo split into 57 DC and 26 non-DC and 64 households from KZN split into 40 DC and 24 non-DC households).

Table 6 Average household sizes

Average household size	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
	2.9	2.7	4.0	4.7

Source: DC evaluation household survey (2014), N=146.

Changes in age structure and household incidence rate also have an impact on the household size, although the latter is also influenced by many other factors such as culture, traditions, education levels, income levels, etc. Over the years, it has been observed in South Africa that the size of an average household in the country has been declining (Census, 2011).

The average household size for all DC households was 3.4 whereas that of non-DC households was 3.6 (Table 6). Disaggregated according to site, average DC household size in Limpopo was larger than that of their non-DC counterparts however the reverse is true of the sample from KZN. If household size be an indicator of the poverty status of a household, then these results could suggest that the DC programme intervention may have contributed in making inroads towards alleviating the poverty situation of

participating households overall and the intervention also performed particularly better in KZN than it did in Limpopo.

Table 7 Household had members who passed away in the previous year

Household has members who died	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Yes	8.9	4.2	64.3	18.2
No	91.1	95.8	35.7	81.8
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014)

The mortality rate and/or the incidence of death is also mentioned extensively in the poverty literature, with poor households experiencing more of this than their non-poor counterparts. A question was asked in the study of the survey participants to indicate if there are any of their household members that had died in the previous year and the results of this are depicted in Table 7. That DC households are in the majority of those who had a household member that died in the preceding year than their non-DC counterparts may be an indication that these households are more vulnerable to poverty and that the DC programme intervention may not have made inroads in this regard.

Table 8 Mean years household education

Mean years household education	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
	7.4	6.7	5.7	7.2

Source: DC evaluation household survey (2014), N=146

Yet another indicator of a household's poverty status is the mean years of members' education. This was calculated for the study sample and the results are shown in Table 8. Overall, DC households are poorly educated than non-DC households however, disaggregated according to site, the DC households in Limpopo are more educated than their non-DC counterparts whereas DC households from KZN are poorly educated when compared to their non-DC counterparts. To the extent that the mean years of education of a household may be telling of the DC programme intervention's impact, the results in this regard seem to be mixed.

Table 9 Sex of head of household

Sex of head	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Male	20.7	28.0	26.2	22.7
Female	79.3	72.0	73.8	77.3
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=146

Table 12 indicates that the majority of all sampled households are headed by women when compared to male-headed households. There are larger proportions of DC households that are headed by women in Limpopo (79.3%) than in KZN (73.8%), and even larger proportions of women-headed households in Limpopo (79.3%) compared to their non-DC counterparts (72.0%). In KZN, the reverse is true where the proportion of female-headed households is larger among non-DC households (77.3%) than in DC households (73.8). The literature talks of female-headed households usually being low-income households than is the case for male-headed households. These results therefore are an indication of

the poverty status of these households and in so far as the DC programme aimed to target poor households, this is at least an indication that this was successful.

The household demographics presented in the aforegoing section are telling in as far as the nature and character of DC households is in comparison to non-DC households. Since this analysis cannot strictly ascribe any differences between the two groups of program beneficiaries (DC households) and non-beneficiaries (non-DC households) to the DC programme's intervention, it can only be inferred that the differences between the two groups are due to the intervention since these households are both assumed to have started off at the same rate in terms of their socio-economic characteristics. This will be the consistent assertion with the analyses that follow under the social, human economic and environmental capital development outcomes.

6 SOCIAL CAPITAL DEVELOPMENT OUTCOMES

6.1 INTRODUCTION

The social capital development outcomes component of the DC programme concentrates on four key indicators *viz*. personal identification, family dynamics, social networks and social grant access. The personal identification section deals with people without birth certificates and green bar coded ID books. According to one of the DC site managers, the programme sought to give information to household members on which documents are needed for application for various services, and then facilitating access to these documents (key informant interview, May 2014). They (the DC staff) would contact the relevant government department to identify the specific support needed. The site manager explained during the interview that "*the families must do this for themselves and only if they get stuck did the SAWs go with the client to explain and get help*."

The site manager further explained that, "*with family dynamics, we are looking at members without burial societies and relationship amongst members together with the social problems, e.g. domestic violence and all kinds of abuse. The programme administered psychosocial support to the family on an individual basis. The social workers that supervise each site also intervene on all areas which the SAWs have to deal with. The SAWs motivate people to go for services such as outreach programmes with SANCA, bereavement counselling, and encouraging pregnant teenagers to become engaged in social ill awareness campaigns* (key informant interview, May 2014)."

The specific minimum conditions of the DC programme regarding personal identification are:

- All members of the family must be incorporated into the Civil Registry and have an identity document or birth certificate.
- Members of a family who have a disability should be registered as such in the Department of Social Development Registry and be receiving a disability grant.

According to the DC programme intervention, under the family dynamics component, the minimum conditions are:

- The family should have adequate abilities to deal with conflict.
- There should be a fair distribution of household chores, so that girls do not do the bulk of the household chores.

- The family should be linked to community resources and development programmes available through local networks (sports clubs, senior citizens' centers, action groups and community organisations, amongst others.)
- Children who qualify for free education should be registered to receive it.
- Families with reported incidents of domestic violence should be enrolled in an appropriate support programme.
- A family with a child in jail should support him/her and collaborate in their rehabilitation programme.

This section assesses the family dynamics of SAWID DC and non-DC households. The family dynamics includes factors such as children, who are in jail, incidences of domestic violence, chronic illnesses, alcohol and drug problems and conflict. The evaluation is based on DC and non-DC households in KZN and Limpopo pilot sites.

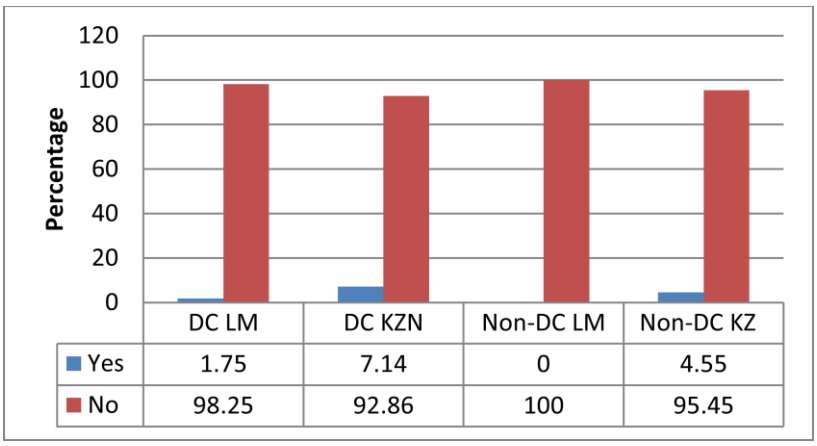
6.2 Personal Identification

In order to investigate how the DC programme intervention performed regarding this minimum condition, we stratified household members from our sample into two. First, members 16 years of age and above who did not have a green barcoded identity book were singled out and second, members of age younger than 16 who did not have a birth certificate were also selected. The variable that was used to analyse this condition therefore combined the two sub-samples of these select individuals from our household survey for evaluation.

Consistently, DC households from Limpopo, KZN and for the programme overall who contained members without either an ID book or a birth certificate outnumbered non-DC households (results not shown). It is little comfort though, that the proportions of households with members without these personal identification documents, as minimum condition that was sought to be addressed by the DC programme, were lower than for those households in which members possessed these necessary documents – on average 10 percent - in all cases. This may be indicative of the success to which the DC programme intervention may have been in achieving this condition.

6.3 Family Dynamics and Social Networks

Respondents were asked if their family had a child who was in jail. Figure 13 indicates the percentage of households that had a child in jail in the two pilot sites. It indicates that in Limpopo (LP) 1.75% of the households had a child in jail and KZN had 7.14%. Over 90% of the respondents indicated no to the question for both sites.

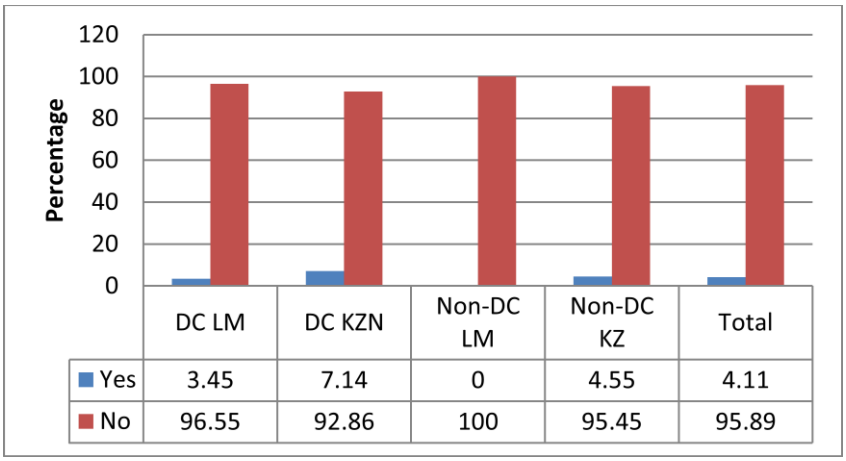


	DC LM	DC KZN	Non-DC LM	Non-DC KZ
Yes	1.75	7.14	0	4.55
No	98.25	92.86	100	95.45

Figure 13 Jail

Source: DC evaluation household survey (2014)

Respondents were also asked if their family experienced any incidence of domestic violence. Figure 14 indicates the percentage of households that had experienced domestic violence in the two pilot sites. It indicates that in LP 3.45% of the household's experienced domestic violence and KZN had 7.14%. The Non-DC household in KZN indicated 4.55%. Over 90% of the respondents indicated no to the question for both sites.

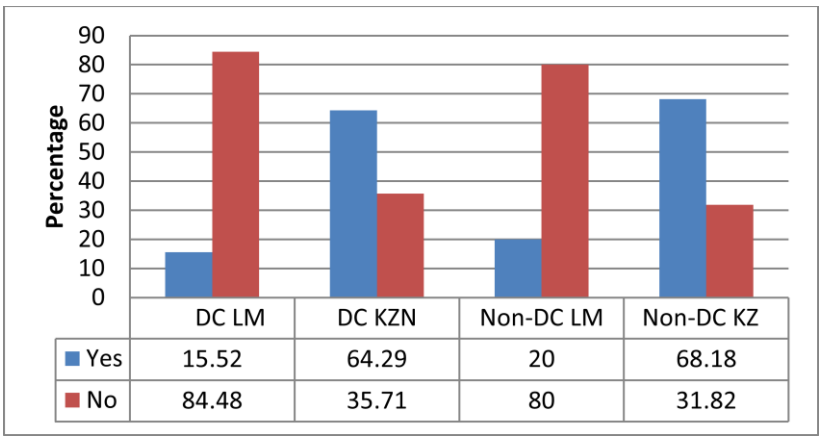


	DC LM	DC KZN	Non-DC LM	Non-DC KZ	Total
Yes	3.45	7.14	0	4.55	4.11
No	96.55	92.86	100	95.45	95.89

Figure 14 Domestic Violence

Source: DC evaluation household survey (2014)

Respondents were asked if their family had a member that suffered from chronic illnesses. Figure 15 indicates the percentage of households had a chronically ill member. It indicates that in Limpopo 15.52% of the households had a chronically ill member and KZN had 64.29%. The non-DC households in LP indicated 20% when compared to KZN 68.18%. Over 80% in LP indicated no and 31.82% in KZN.

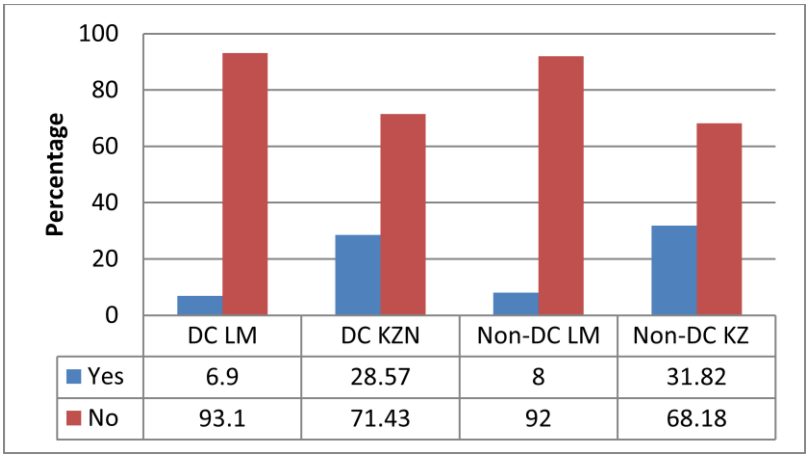


	DC LM	DC KZN	Non-DC LM	Non-DC KZ
Yes	15.52	64.29	20	68.18
No	84.48	35.71	80	31.82

Figure 15 Chronic Illness

Source: DC evaluation household survey (2014)

Respondents were asked if their family had a member that had any alcohol drinking problems. Figure 16 indicates the percentage of households that had a member with a drinking problem. It indicates that in Limpopo 6.92 % of the households had member with a drinking problem and KZN had 28.57%. The Non-DC households in Limpopo indicated 92% when compared to KZN 68.18%. The respondents that indicated no were much higher in the DC and Non-DC households for both sites.



	DC LM	DC KZN	Non-DC LM	Non-DC KZ
Yes	6.9	28.57	8	31.82
No	93.1	71.43	92	68.18

Figure 16 Alcohol Problem

Source: DC evaluation household survey (2014)

Respondents were asked if their family had a member that had any drug abuse problems. Figure 17 indicates the percentage of households that had a member with a drug problem. It indicates that in Limpopo, 3.45% of the households had member with a drug problem and KZN had 2.38% households. The Non-DC households in LP that indicated 'no' were 96.55% when compared to KZN, at 97.62%.

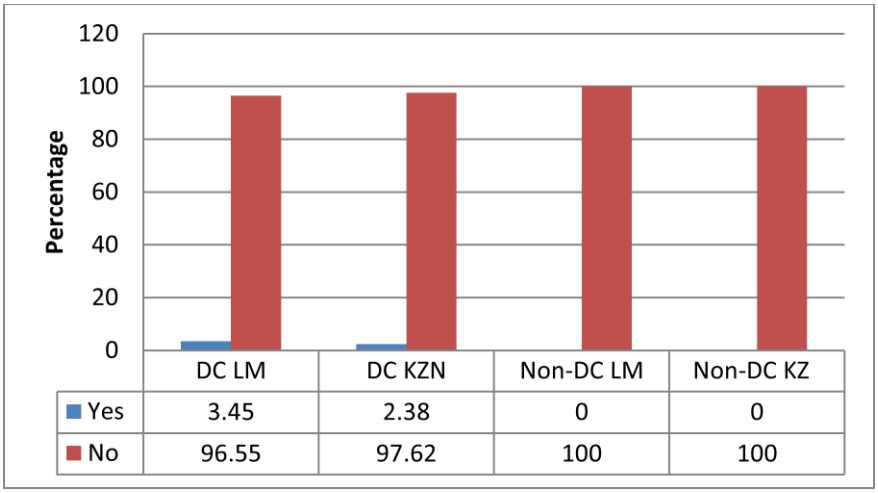


Figure 17 Drug Abuse

Source: DC evaluation household survey (2014)

Respondents were asked if their family experienced any instances of conflict in the past twelve months. Figure 18 indicates the percentage of households that experienced conflict. It indicates that in Limpopo 3.45% of the households experienced conflict when compared to KZN 10.05%. The Non-DC households in Limpopo that indicated no were 96% when compared to KZN 68.18%.

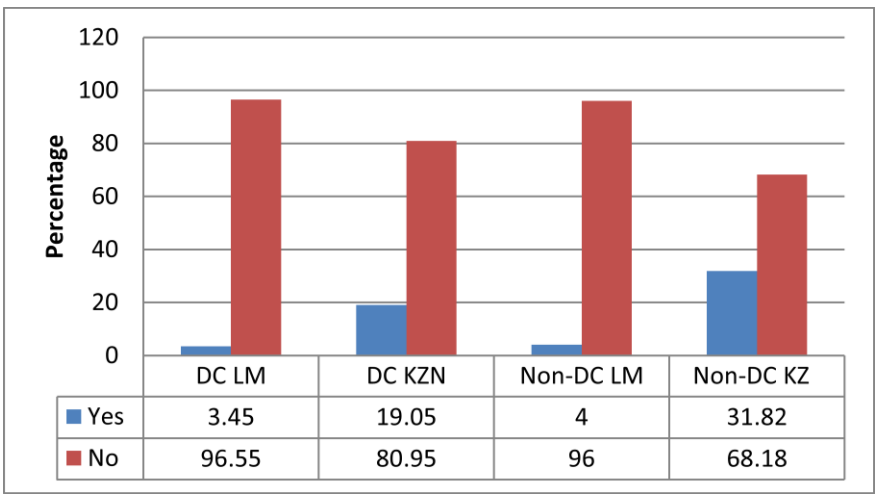


Figure 18 Conflict

Source: DC evaluation household survey (2014)

Turning now to household networks, the perception that poverty is associated with social exclusion has been the subject of public debate in many countries.

Respondents were asked if they had a family member that belonged to any social or community groups. According to Table 10, the DC households that indicated that they belonged to a stokvel in Limpopo made up 11.32%, burial society were 84.21% and belonging to a community garden group were 5.56%.

The figures for DC KZN households were stokvel at 45.71%, burial society comprised 40.63% and community garden group were 5.88%.

Table 10 Social/Community Groups

Household Networks (%)	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Stokvel	11.32	13.64	45.71	47.62
Burial society	84.21	65.22	40.63	0
Community garden group	5.56	0	5.88	0

Source: DC evaluation household survey (2014)

Table 11 indicates the division of household chores for the DC pilot sites Limpopo and KZN. The table indicates that female children do most of the cooking and cleaning for both DC sites in LP (37.5%) and KZN (51.35%). This is followed by mothers LP (21.43%) and KZN (21.62%). The male child figures indicate that they do less (LP 8.93% and KZN 5.41%) when compared to fathers who did even much less (LP 1.79 and KZN 0%). Non-DC households indicate similar division of labour with the female children bearing the disproportionate portion of the chores (LP 32% and KZN 42.11%).

Table 11 Cleaning and cooking

	Cooking and cleaning				
	DC LM	DC KZN	Non-DC LM	Non-DC KZ	Total
Grand-parents	14.29	5.41	12	15.79	11.68
Mother	21.43	21.62	24	10.53	20.44
Father	1.79	0	0	0	0.73
Female Child	37.5	51.35	32	42.11	40.88
Male Child	8.93	5.41	12	10.53	8.76
Other household members	12.5	16.22	20	21.05	16.06
Not Applicable	3.57	0	0	0	1.46
Total	100	100	100	100	100

Source: DC evaluation household survey (2014)

Table 12 indicates the division of chores for fetching wood and water. The female child bears much of the responsibility for both sites (LP 25% and KZN 33.33%) which is followed by the mother (LP 19.64% and KZN 17.95%). The male child indicated a figure of 17.86% in Limpopo and 12.82% in KZN. Non DC households also indicated similar figures. The Non-DC female child in Limpopo did 24% of this work and in KZN 42.11%, while the male child did much less, at LP 15.79% and KZN 15.83%.

Table 12 Fetching fuel wood and water

	Fetching fuel wood and water				
	DC LM	DC KZN	Non-DC LM	Non-DC KZ	Total
Grand-parents	12.5	5.13	12	5.26	9.35
Mother	19.64	17.95	28	10.53	19.42
Father	3.57	0	0	0	1.44
Female Child	25	33.33	24	42.11	29.5
Male Child	17.86	12.82	16	15.79	15.83

Other household members	14.29	12.82	20	15.79	15.11
Not Applicable	7.14	17.95	0	10.53	9.35
Total	100	100	100	100	100

Source: DC evaluation household survey (2014)

Table 13 indicates the division of labour for farming activities for the two sites. The figures indicate that grandparents conduct the bulk of farming activities, in Limpopo (10.71%) and KZN (7.5%). Non-DC households conduct 12% and 4.76% in Limpopo and KZN respectively.

Table 13 Farming activities

	Farming activities				
	DC LM	**DC KZN**	**Non-DC LM**	**Non-DC KZ**	**Total**
Grand-parents	10.71	7.5	12	4.76	9.15
Mother	7.14	30	8	14.29	14.79
Father	0	2.5	0	0	0.7
Female Child	0	0	4	0	0.7
Male Child	0	7.5	0	9.52	3.52
Other household members	7.14	7.5	8	9.52	7.75
Not Applicable	75	45	68	61.9	63.38
Total	100	100	100	100	100

Source: DC evaluation household survey (2014)

Table 14 indicates the members of the family who are responsible for herding cattle. The DC households in LP indicate that 9.09% grandparents herd cattle and 0% in KZN. The Non-DC household in LP indicate that 12% of the grandparents herd cattle. Mothers are also involved in herding cattle, with 5.45% in Limpopo and 2.7% in KZN. In Limpopo, other household members also herd cattle (7.27%) while in KZN the male child was most prevalent (10.81%).

Table 14 Herding cattle

	Herding cattle				
	DC LM	**DC KZN**	**Non-DC LM**	**Non-DC KZ**	**Total**
Grand-parents	9.09	0	12	0	5.8
Mother	5.45	2.7	4	4.76	4.35
Female Child	1.82	0	4	0	1.45
Male Child	3.64	10.81	4	4.76	5.8
Other household members	7.27	0	4	0	3.62
Not Applicable	72.73	86.49	72	90.48	78.99
Total	**100**	**100**	**100**	**100**	**100**

Source: DC evaluation household survey (2014)

Table 15 reflects members of households that are responsible for household maintenance. The DC household in LP indicate that 29.09% of this chore is carried out by mothers when compared to 32.5% KZN. Grandparents also indicated a relatively high number in LP at 14.5% when compared to KZN at 10%. The male child was also responsible for this activity in LP at 14.55% and at 12.5% in KZN. The

female children did slightly less (LP 9.09% and KZN 10%). Non-DC households indicated that mothers were at 36% in LP and 21.95% in KZN.

Table 15 Household maintenance

	Household maintenance				
	DC LM	**DC KZN**	**Non-DC LM**	**Non-DC KZ**	**Total**
Grand-parents	14.55	10	12	15.79	12.95
Mother	29.09	32.5	36	21.05	30.22
Father	3.64	7.5	4	5.26	5.04
Female Child	9.09	10	16	15.79	11.51
Male Child	14.55	12.5	16	10.53	13.67
Other household members	9.09	2.5	16	10.53	8.63
Not Applicable	20	25	0	21.05	17.99
Total	**100**	**100**	**100**	**100**	**100**

Source: DC evaluation household survey (2014)

Table 16 indicates the figures for members of the household that take care of the elderly, sick and young children. According to the table, mothers indicated relatively high figures. LP DC households scored 24.56% and KZN households 25%. The female child also indicated slightly high figures LP (19.3%) and KZN (17.5%). With non-DC households a similar picture emerges for LP mothers (36%) and KZN (19.05%) and the female child in Limpopo (16% and 23.81%).

Table 16 Care of elderly/sick of young children

	Care of elderly/sick of young children				
	DC LM	**DC KZN**	**Non-DC LM**	**Non-DC KZ**	**Total**
Grand-parents	14.04	15	8	19.05	13.99
Mother	24.56	25	36	19.05	25.87
Father	3.51	0	0	0	1.4
Female Child	19.3	17.5	16	23.81	18.88
Male Child	1.75	2.5	4	0	2.1
Other household members	7.02	7.5	12	9.52	8.39
Not Applicable	29.82	32.5	24	28.57	29.37
Total	100	100	100	100	100

Source: DC evaluation household survey (2014)

In sum, in terms of family dynamics, DC households seem not to be affected by family conflict issues that include children who are in jail, family members that have alcohol problems, drug abuse and domestic violence. However, having family members who suffer from chronic illnesses was a major feature in these households. To the extent that these family dynamics issues differed between DC and non-DC households, the evidence seems to suggest that both these categories of households are affected equally and to similar extents such that no major differences could be discerned between the two groups, even when these results were disaggregated according to site.

In terms of social networks, households who were in the majority were those who contained a member belonging to a burial society. This was the most prevalent social group that both sets of DC and non-DC

households belonged to, with DC households making up a larger proportion than non-DC households. It emerged during one of the interviews we conducted with a DC site manager that this (belonging to a burial society) was one of the specific things that the programme seeks to facilitate with their beneficiary households. This is however equally prevalent in the DC and non-DC households such that the intervention of the programme cannot be strictly ascribed to the proportions of households that have taken this up.

With effect to the division of household chores between the female and male child in the household, the results indicate that this is still largely executed along gender lines, with the responsibility still falling largely on girls. Again however, this distinction is not apparent between DC and non-DC households such that the general trend with this in the areas may not be discounted as a factor. Hence, even though the DC programme set out to ensure that girls are not unfairly overburdened with household chores, this situation may be more influenced by other factors, such as culture.

7 HUMAN CAPITAL DEVELOPMENT

7.1 Introduction

A broad conceptualization of poverty as espoused by Sen (1979) sees wellbeing as an outcome of human capabilities which include health and nutrition status and access to education and skills development.

In this section of the study, an assessment of the wellbeing status households in respect of the capabilities mentioned above is presented, differentiated according to DC and non-DC households in pilot sites of KwaZulu–Natal and Limpopo. The SAWID DC Programme outlined minimum conditions for each of these capabilities which are being presented below with the relevant findings.

7.2 Results of the Estimation of DC Impact on Primary Health Care

Disability

The term disability is widely used although no single definition exists internationally. Disability covers a range of health and social conditions which identify some form of capacity limitations in respect of physical, mental and social functioning (Stats SA, 2005).

Respondents were required to indicate whether there were family members living with disabilities in their households, and if they had accessed rehabilitation programmes, participation in which was a minimum condition for the DC. A total of 65 households reported having a family member living with disability of which 74% (48) were DC households and 26% (17) were non-DC households.

In terms of the types of disability, a significant number (26) of both DC (20) and Non DC households (6) reported the type of disability as being 'other'. It is unclear why such a large number was thus recorded, given that different disability types were listed.

Where the type of disability was defined the study found that in DC households physical disability was predominant (11) followed by intellectual disability (6), hearing (5) and sight (4). For Non DC households the type of disability reported was sight (4) followed by two each for sight, hearing and intellectual disability. Both DC and Non DC households reported 1 family member each with emotional disabilities. This data compares well with the national data with sight (32%) and physical disability (30%) being the predominant forms of disability followed by emotional and intellectual disability.

Of those households with a family member living with a disability a higher percentage was found in Limpopo than KZN site. Disability prevalence was 45% and 29% respectively in DC households in the Limpopo site (29) and in the KZN site (19). This may be explained as an outcome of the criteria used for household selection in the DC programme in both sites

The percentage of self-reported disability particularly among DC households in the sample is higher than the national disability prevalence of less than 3% (SANHANES, 2013). Prevalence data for Limpopo and KZN are at a similar level. The DC criteria used for participant households may again explain these results.

Regarding difficulty in carrying out daily living activities the study found 58% of the households reported no difficulty while 42% reported experiencing difficulty with daily living. Of those experiencing disability, 70% were DC households with a substantially higher percentage of KZN DC households experiencing difficulty (63%), compared with 25% experiencing difficulties in Limpopo DC households.

In response to the question of whether the person with disability was receiving support, the study found 53% (34) of all households had not received support while 36% (23) had received support and with 11% (7) of households indicating support was not applicable. Interestingly, an overwhelming 78% of DC households reported receiving support compared with 22% of non-DC households.

Despite the higher prevalence of disability in DC households in the Limpopo site, only 21% of those households received support compared to 63% of DC households in the KZN site. Family members were reported as the main source of support to both DC and non-DC households, with the mother reported as the predominant person. Only 3 households reported accessing SAWID support with 2 of them being DC households and these reports pertained to the KZN site only. Similarly, only 3 households reported accessing government support, all of them from DC households.

Regarding the nature of support received for accessing services by those household where a family member was disabled, the study found 81% (22) of DC households accessed support compared to 19% (5) Non DC households. Grant support was the predominant form of support accessed by 45% (10) of DC households, followed by access to hearing aids (5), and wheelchairs (2). Access to information was very low, with 2 households reporting this equally between DC and Non DC households. Only 1 Non DC household reported access to special employment programme.

In terms of rating the quality of assistance received in respect of disability, over 83% of DC households and 60% of non-DC households reported the quality as good or very good. Satisfaction with assistance by DC households in both sites was almost equal.

Chronic Illness

Perceptions of general health were explored in the study, relevant to the DC minimum condition that members of the family suffering from chronic illness should be accessing health care services from a doctor in a health care centre. A significantly high proportion of both DC and Non DC households (101) reported a family member as experiencing chronic illness with more than 60% (63) being found in DC households. In terms of the type of chronic illness experienced just over a third of the respondents (37) reported other as the type of illness. The second and third most prevalent forms of chronic illness were high blood pressure (23) followed by HIV/AIDS (22). Comparisons between DC and non-DC households by type of illness were not significant except for slightly higher reporting of HIV/AIDS in non-DC households. The chronic disease profile of DC households across the two sites was almost the same while with the KZN Non DC household's prevalence of chronically ill people in the household was two thirds that of the households in Limpopo site. Two factors could contribute to this pattern namely the high HIV/AIDS prevalence in KZN (SANHANES, 2013) as well as the geographical variations on chronic disease screening rates with Limpopo reporting among the lower rates of screening nationally.

21% (23) of the households in the study reported a family member having to stay away from work or schooling to care for a chronically ill family member and off these households more than double were from DC households (17). An alarmingly high percentage (79%) of these family members was from the KZN site.

In exploring the issue of who had been consulted about the illness 42% of households in both sites reported not accessing any health care provider and 41% reported accessing services of the community clinic. Disproportionately the study found that 66% of those who had not consulted a health care provider were from DC households in Limpopo compared with 5% in KZN DC households. In comparison 19% of non-DC households in Limpopo and 11% of non-DC households in KZN had not consulted a health care provider. The main reason offered was that it would be pointless or not necessary.

Support for accessing health care services came largely from family members for both DC and Non DC households. 5 households reported accessing support from the SAWID DC of which 4 were DC households with 3 of them being found in the KZN site. Treatment services were the main form of health care received with more DC households accessing treatment (62%) compared with non-DC households (38%). There appears to be a high level of satisfaction with the health services received with 86% of all households in both sites reportedly satisfied with the service.

Pap Smear Screenings

The DC minimum condition indicates that women over 35 years should have a periodic Papanicolaou Smear test. Pap smears are important screens for cervical cancer which has high mortality rates mainly due to late diagnosis and treatment. It is reported that cervical cancers claim over 3400 lives annually in South Africa with fewer than 20% of women having had the test (Hoffman, 2003). Majority of the households (86% DC and 74% non-DC) had not accessed this test in the past year. Differences between the sites however reveal a slightly different picture as reflected in Table x below.

Table 17 Access to Pap Smear Test by women over 35 in the household

Response	DC LM	DC KZN	Non DC LM	Non DC KZN	Total
Yes	18.67	9.88	18.52	29.41	17.95
No	81.33	90.12	81.48	70.59	82.05
Total	**100%**	**100%**	**100%**	**100%**	**100%**

However of those who had the screening 36% were from non-DC households in KZN and 33% were from DC households in Limpopo. Support provided to access the Pap Smear was report in 44% of DC households and 56% of non-DC households with the main forms of support being information and education (64%) and referral services (24%). The main sources of support reported by all households in accessing Pap Smears were government agencies (35%) and SAWID DC 24%. No households in the KZN DC reported accessing support from the DC for a pap smear. Overwhelmingly the quality of support was rated good or very good across all households.

Pregnant women accessing health care services

The DC minimum condition required that pregnant women in the household access regular medical checks in accordance with Ministry of Health guidelines.

In just over a third of all households in this study (37% = n 49) of the sampled households in both districts had a women who had been or was currently pregnant. DC households across the sample had almost double the number of pregnancies (31) in comparison with non-DC households (18) and similarly KZN households had almost double the number of pregnancies reported than LP households. Of those who were or had been pregnant 94% (47) reported having regular medical check-ups. This was true across both DC and Non DC households with no discernible difference. This result reflects positively for maternal and child wellbeing in the context of over 1400 women who die annually from complications of childbirth and pregnancy with 62% of these deaths being considered potentially avoidable (DoH,

2013). These deaths were attributed to poor access of women to available health care particularly by disadvantaged populations. Of particular concern would be at what stage of the pregnancy the women had accessed health care as evidence suggests that one third of pregnant women accessed health care in their fifth month of gestation, and in doing so delayed the early identification and management of preventable conditions such as hypertension and obstetric haemorrhage which contributed to maternal mortality (DoH, 2013).

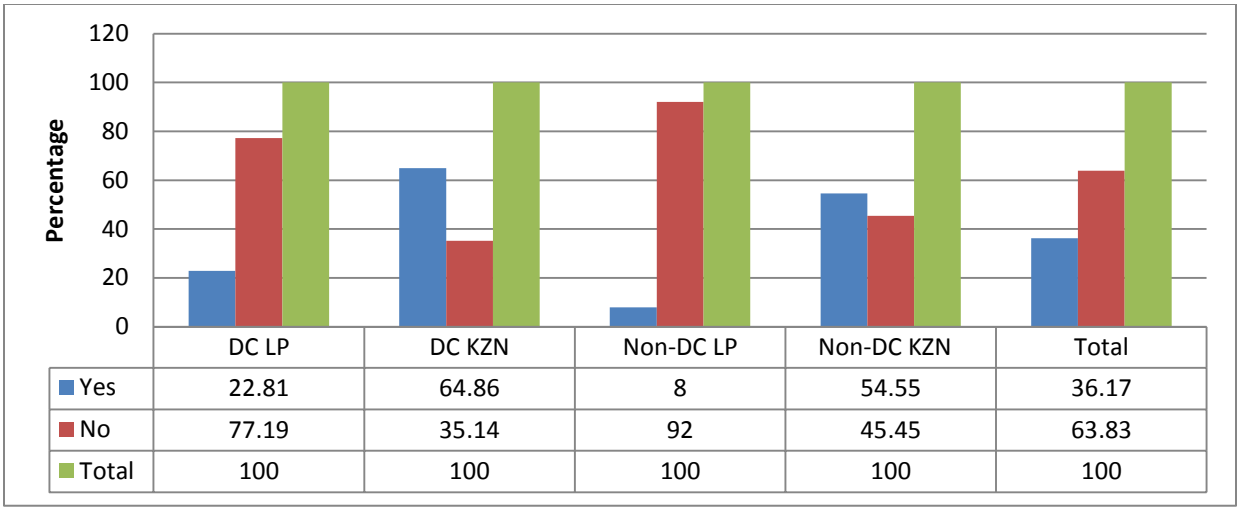
A limitation of this study is that it did not probe respondent's awareness of Ministry of Health guidelines and the extent to which this had been complied with. Hence while the results reflect positively on health care access it remains unclear at what stage of the pregnancy health care services were accessed. Of the three households which reported pregnant women not accessing medical check-ups as per guidelines the predominant reason proffered was that it did not appear necessary followed by the person being too busy to access services.

There were very few cases where SAWID was mentioned outright as having rendered a family assistance with a certain issue. A possible explanation for this is that SAWID might be mentioned in the same breath as "an NGO" or community organisation and vice versa. For instance, when asked "where did the household receive the food gift / donation from" some state SAWID some state community organisation. Also, people might have confused the fact that SAWID offered facilitation assistance and did not themselves provide the food parcels. Hence, facilitating access to a resource might have been misconstrued as having provided this resource themselves.

7.3 Results of the Estimation of DC Impact on Food Security

This section evaluates the food security of DC and Non-DC households in the two pilot sites Limpopo (LP) and KwaZulu-Natal (KZN). According to the SAWID DC Programme the minimum condition households are required to have to participate in the programme is a door-sized garden. The programme sought to ensure that households have access to basic nutrition and three meals a day.

The respondents were asked if the household had a garden. Figure 19 indicates that 36% of households reported having a food garden. It depicts that in LP only 23% of DC households had a garden while a significantly higher figure 65% of KZN DC households indicated they had a garden. When compared to Non-DC households a significant number in KZN (54.55%) indicated that they had a garden when compared to a very low figure of 8% in LP. In general KZN seemed to have been doing well with respect to households having gardens.



	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
Yes	22.81	64.86	8	54.55	36.17
No	77.19	35.14	92	45.45	63.83
Total	100	100	100	100	100

Figure 19 Household food gardening

In response to the question why the household did not have a garden, Table 18 indicates the main reason given by households was a lack of infrastructure, with 27% of households in respect of both DC and non-DC households. The figures indicate that in general, households indicated that they lacked infrastructure, equipment (24%) and agricultural inputs (19%).

Table 18 Reason why household does not have a food garden

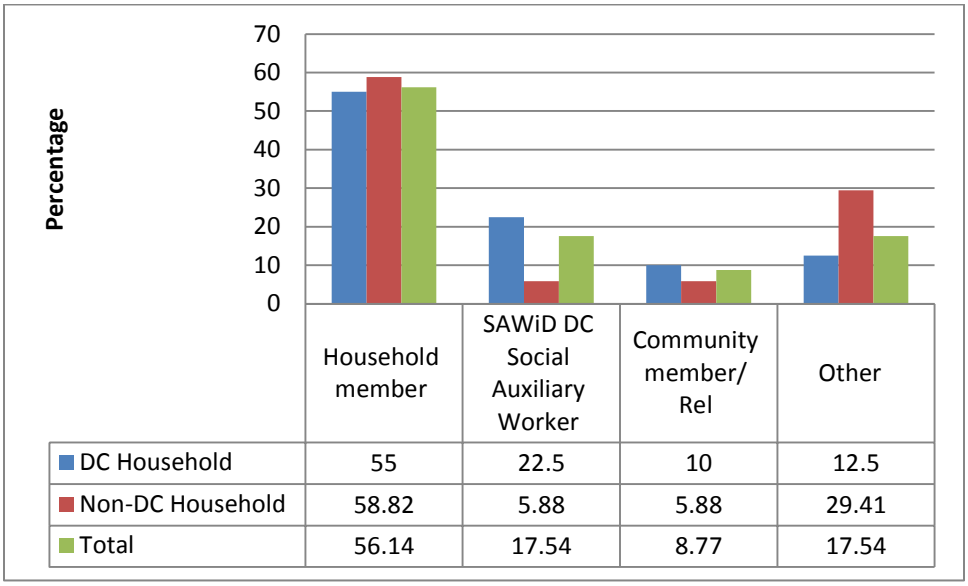
There is no space for	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
Lack of agricultural inputs	11.63	33.33	4.76	60	19.1
Lack of Infrastructure	30.23	20	28.57	20	26.97
Lack of Equipment	25.58	20	28.57	10	23.6
Lack of Information	4.65	6.67	4.76	0	4.49
Lack of Extension sup	2.33	0	0	10	2.25
Total	**100**	**100**	**100**	**100**	**100**

The respondents were asked the main reason for having a food garden. Table 19 indicates the percentage of households that reported that 50% of DC households in Limpopo reported that the food garden was developed as the main source of food for the household as compared with the DC households in KZN where 71% of households reported food gardens as an extra source of food for the household. This finding resonates with evidence which suggest that household food security is heavily dependent on income (Baipethi and Jacobs, 2009).

Table 19 Main reason for engaging in food gardening

	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
As a main source of food	50	16.67	0	10	22.92
As the main source of income/earning a living	8.33	8.33	0	0	6.25
As an extra source of income	8.33	4.17	0	10	6.25
As an extra source of food for the household	33.33	70.83	100	70	62.5
As a leisure activity	0	0	0	10	2.08
Total	**100**	**100**	**100**	**100**	**100**

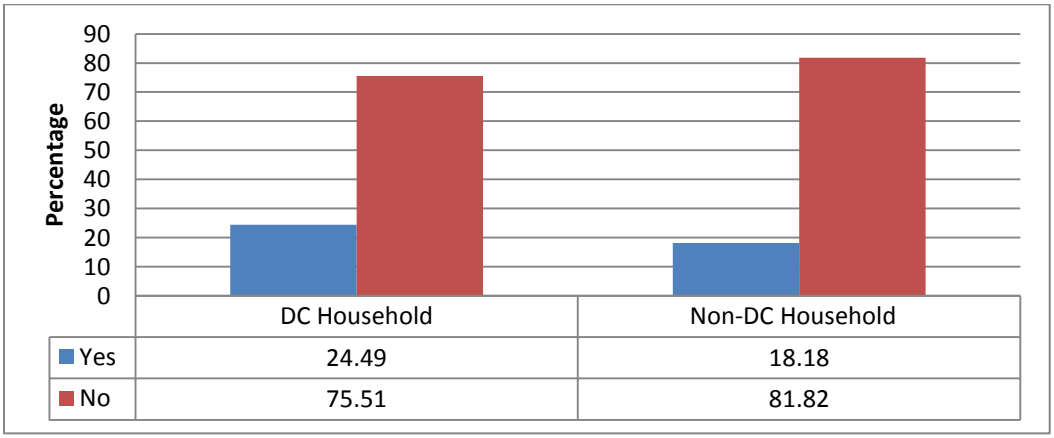
The motivation for initiating a food garden in DC households was reported to be a household member (55%) followed by 22.5% of DC households which reported the SAWiD Social Auxiliary Worker as the motivator (Figure 20). Only 10% of DC households reported a community member as the motivator for the household establishing a food garden. In comparison a similar percentage of Non-DC households (59%) reported that a household member had motivated them to establish the garden but a significantly lower number 6% attributed it to a community member.



	Household member	SAWiD DC Social Auxiliary Worker	Community member/ Rel	Other
DC Household	55	22.5	10	12.5
Non-DC Household	58.82	5.88	5.88	29.41
Total	56.14	17.54	8.77	17.54

Figure 20 Motivator for initiating food garden

The respondents were asked if they received any support with starting the garden. Figure 21 reflects that most households received no support at all. A slightly higher percentage of DC households accessed support for initiating a food garden (24.49%) compared to the non-DC households 19%.



	DC Household	Non-DC Household
Yes	24.49	18.18
No	75.51	81.82

Figure 21 Support for initiating food garden

In terms of identifying the source of the support received 50% of the DC households reported that the DC Social Auxiliary Worker had provided the support. Interestingly 25% of non-DC households also reported having received assistance from the SAWID Social Auxiliary Worker. Non DC households

reported relatives/community members as the primary source of support for their food garden as indicated in Table 20.

Table 20 Source of support for initiating a food garden

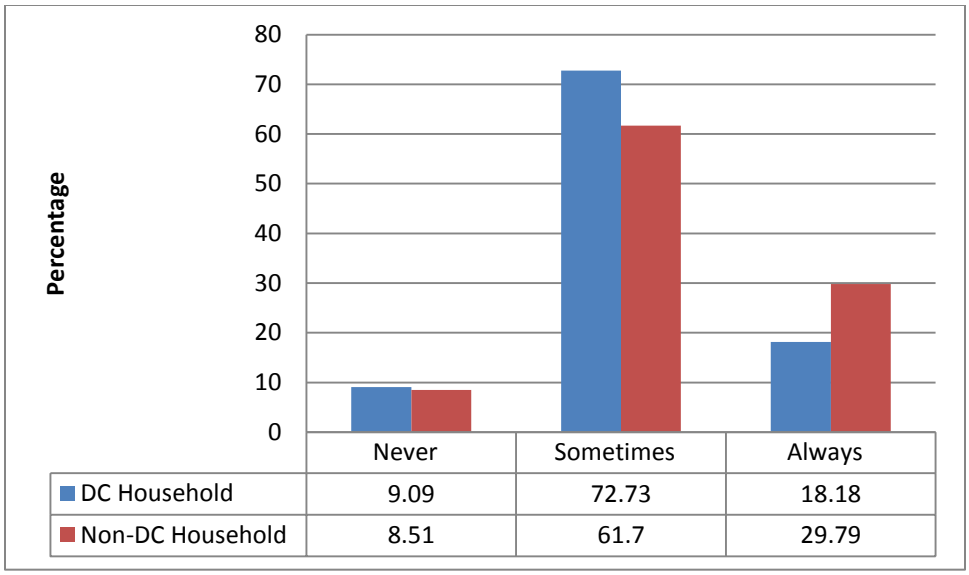
	DC Household	Non-DC Household	Total
Community member/Relative	16.67	50	25
SAWiD DC Social Auxiliary	50	25	43.75
Non-SAWiD Related NGO	8.33	25	12.5
Government agency	16.67	0	12.5
Other	8.33	0	6.25
Total	100	100	100

With respect to the type of support households received the main form of support for both DC and non-DC households was in respect of agricultural inputs (62.5%) followed by access to information(25%) as reflected in Table 21.

Table 21 Type of support received for initiating food garden

	DC Household	Non-DC Household	Total
Agricultural Inputs	63.64	60	62.5
Information	27.27	20	25
Extension support	9.09	0	6.25
Other	0	20	6.25
Total	100	100	100

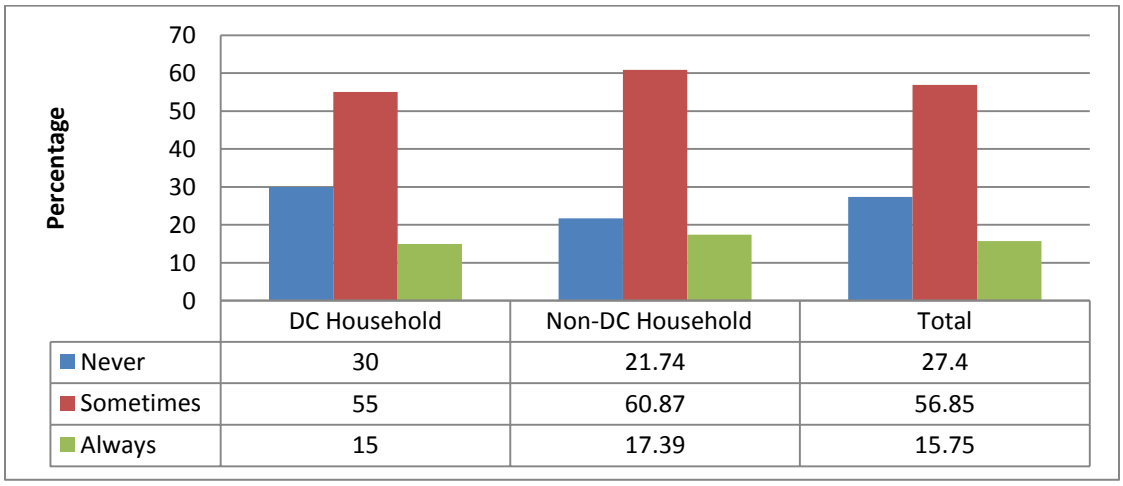
The respondents were asked if they worried about their household running out of food. As Figure 22 illustrates the study revealed that a relatively high percentage of DC Households (73%) where sometimes about running out of food. A slightly lower percentage of Non-DC households (62%) indicated this as a concern. Of significance was the lower percentage of DC households who reported always being concerned about food shortages (18%) compared to 30% for non-DC household.



	Never	Sometimes	Always
DC Household	9.09	72.73	18.18
Non-DC Household	8.51	61.7	29.79

Figure 22 Household ran out of food

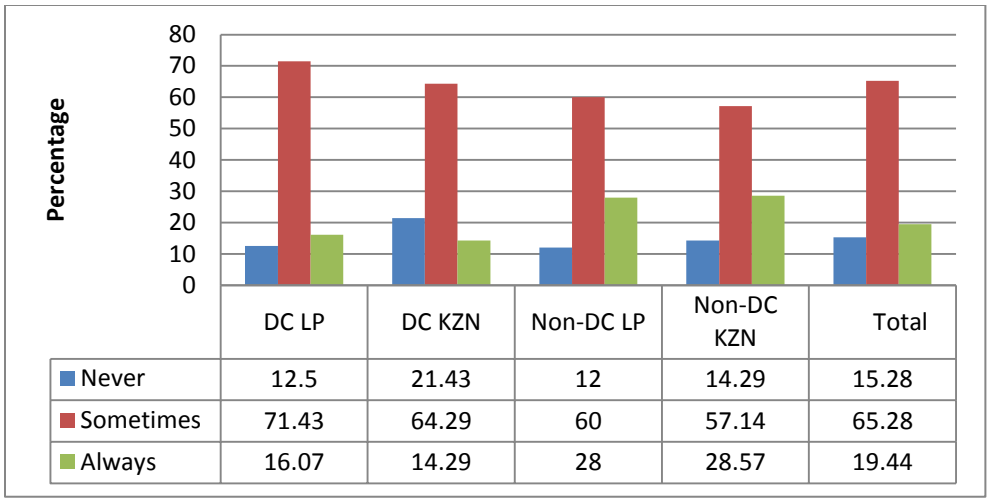
In exploring experience of hunger respondents were asked if family members had to skip a meal. Figure 23 illustrates that a significant percentage of both DC and non-DC households sometimes had skipped a meal (57%) with DC households being slightly lower at 55% compared to non-DC households with 61%.



	DC Household	Non-DC Household	Total
Never	30	21.74	27.4
Sometimes	55	60.87	56.85
Always	15	17.39	15.75

Figure 23 Experiences of hunger

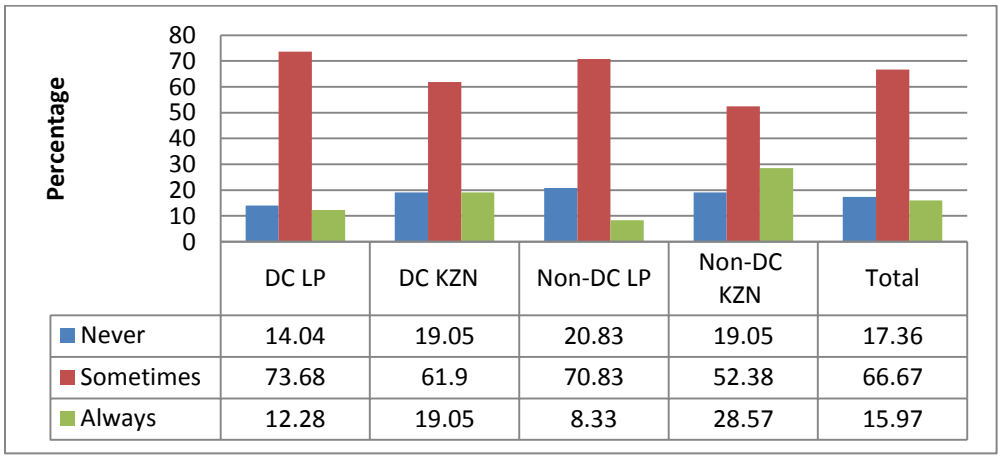
With regard to perceptions of hunger, the respondents were asked if the family ate less than it thought it should consume. Figure 24 indicates that 71.43% of DC LP households indicated they sometimes ate less compared to 64.29% of DC KZN households.



	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
Never	12.5	21.43	12	14.29	15.28
Sometimes	71.43	64.29	60	57.14	65.28
Always	16.07	14.29	28	28.57	19.44

Figure 24 Perceptions of Hunger

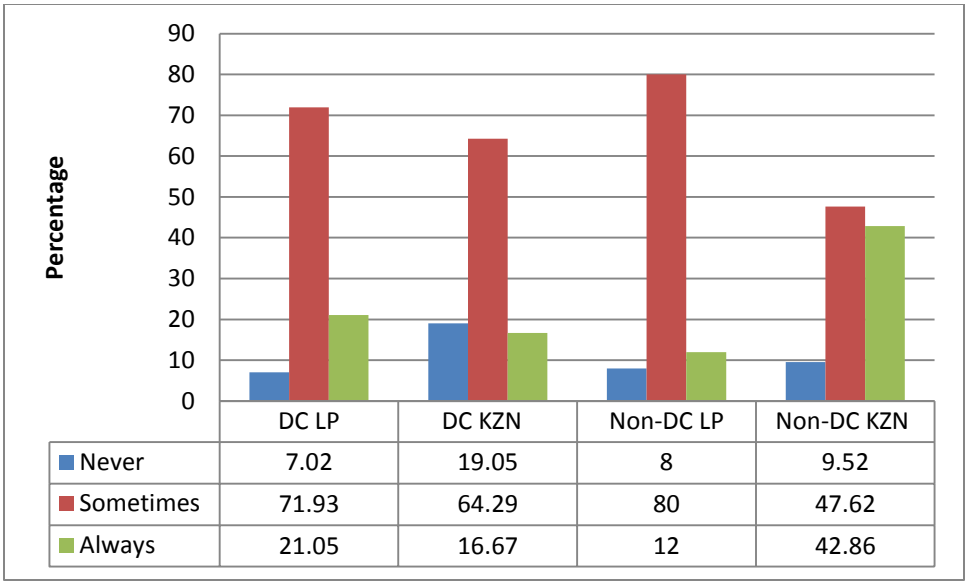
Respondents were asked if their households had ever experienced food shortages. According to Figure 25, 73.68% of DC LP indicated that they sometimes ran out of food as compared to 62% DC KZN households. Significantly fewer DC household indicated that they always ran out of food in LP (12.3%) and in KZN (19%).



	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
Never	14.04	19.05	20.83	19.05	17.36
Sometimes	73.68	61.9	70.83	52.38	66.67
Always	12.28	19.05	8.33	28.57	15.97

Figure 25 Food Shortages

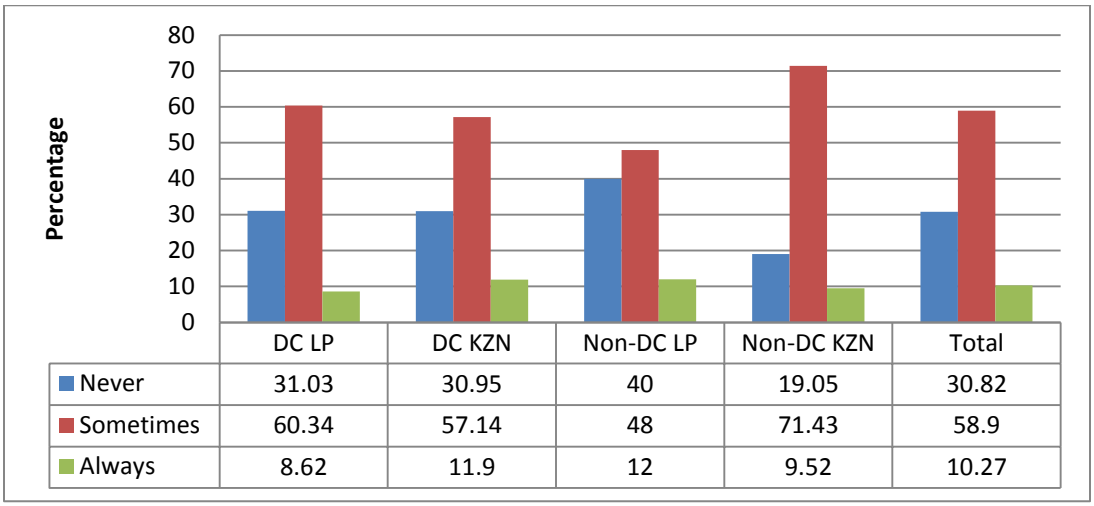
The respondents were asked about the diversity of the household diet in relation to the various food groups. Figure 26 indicates that in DC LP 72% of households and 64.29% of DC KZN households sometimes ate a few kinds of food.



	DC LP	DC KZN	Non-DC LP	Non-DC KZN
Never	7.02	19.05	8	9.52
Sometimes	71.93	64.29	80	47.62
Always	21.05	16.67	12	42.86

Figure 26 Food diversity

The respondents were asked if someone in the family was sometimes hungry but did not eat. 60% of DC LP households reported having someone in the family who was hungry but did not eat as compared to 57% of DC KZN households. In contrast, 71% of non-DC households reported a family member being hungry but not eating (Figure 27).



	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
Never	31.03	30.95	40	19.05	30.82
Sometimes	60.34	57.14	48	71.43	58.9
Always	8.62	11.9	12	9.52	10.27

Figure 27 Food consumption regularity

Food expenditure patterns were probed in terms of how much was spent weekly on food.

According to Table 22 below 26% of households spent less than R 50 per week on food with wide variations between the two provinces. 36% of households in DC LP and while 17% of DC KZN households spent between R0 – R50 per week on food.

Table 22 Weekly food expenditure

	DC LP	DC KZN	Non-DC LP	Non-DC KZN	Total
R0 - R50	36.36	17.07	34.78	4.55	25.53
R51 - R100	23.64	14.63	21.74	0	17.02
R101 - R150	10.91	9.76	17.39	9.09	11.35
R151 - R200	7.27	9.76	4.35	4.55	7.09
R201 - R250	0	4.88	8.7	0	2.84
R251 - R300	1.82	0	4.35	0	1.42
R301 - R350	0	2.44	0	0	0.71
R351 - R400	3.64	0	0	4.55	2.13
More than R401	1.82	0	0	0	0.71
Don't know	14.55	41.46	8.7	77.27	31.21
Total	100	100	100	100	100

The respondents were asked to consider food adequacy of the household over the past month. Figure 28 indicates a very high percentage of households who perceived the amount of food available to them as being less than adequate. Among DC households 70% of LP households and 79% of KZN households thought that their food was less than adequate. A frighteningly 91% of non-DC households reported that the food available to their household was less than adequate.

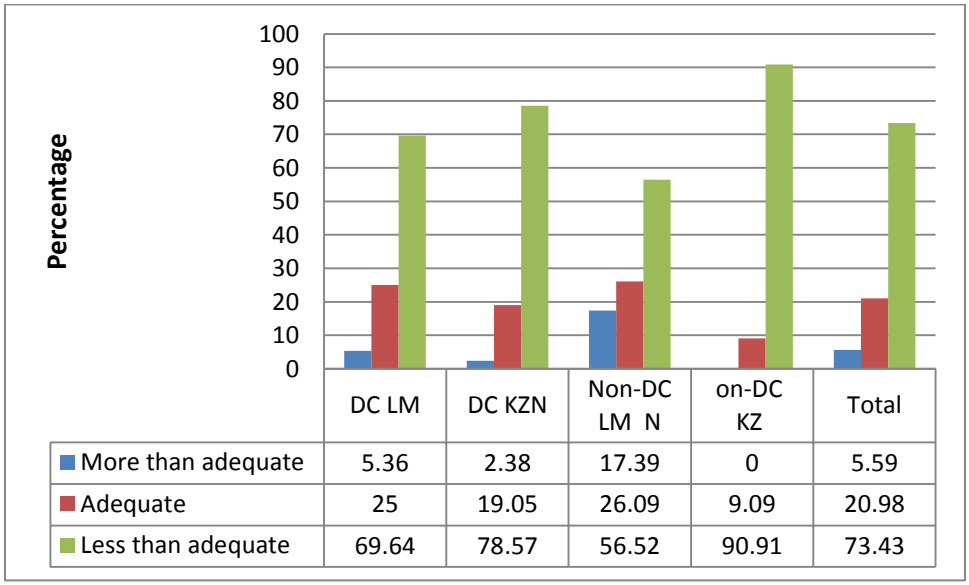
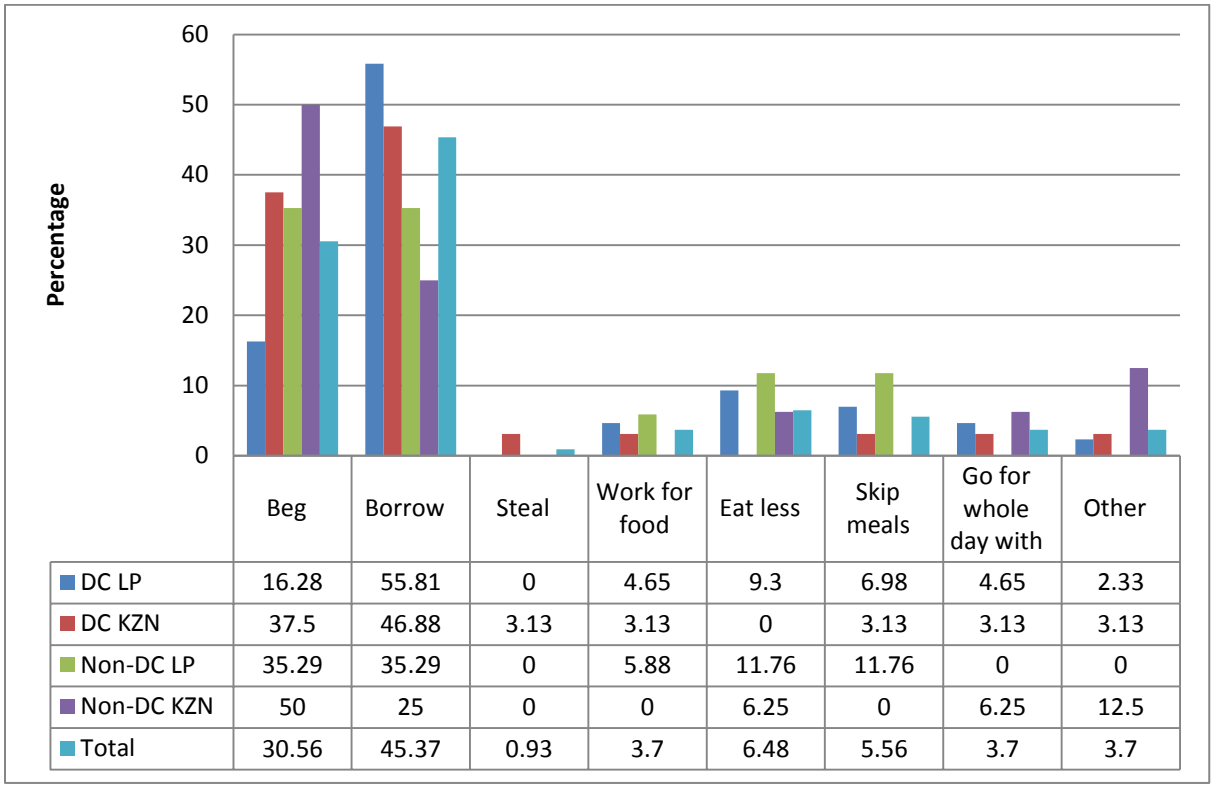


Figure 28 Food Adequacy

Respondents were asked to comment about household coping mechanisms they utilised to deal with the food shortages. Figure 29 indicates that main coping strategy was to borrow food 45% of all households resorting to this strategy. More specifically this strategy was employed by 56% of Limpopo and 47% of KZN DC households. Begging was the second most prevalent strategy employed by households with 16% of DC LP households and a relatively higher figure of 37.5% of DC KZN households resorting to begging. In comparison high percentages of Non-DC households in KZN and LP resorted to begging and borrowing as the figure below reflects.



	Beg	Borrow	Steal	Work for food	Eat less	Skip meals	Go for whole day with	Other
DC LP	16.28	55.81	0	4.65	9.3	6.98	4.65	2.33
DC KZN	37.5	46.88	3.13	3.13	0	3.13	3.13	3.13
Non-DC LP	35.29	35.29	0	5.88	11.76	11.76	0	0
Non-DC KZN	50	25	0	0	6.25	0	6.25	12.5
Total	30.56	45.37	0.93	3.7	6.48	5.56	3.7	3.7

Figure 29 Household food shortage coping mechanisms

The study results reflect a positive trend of food gardening particularly in respect of the KZN DC households. More importantly, just over one fifth of the households (22.5%) reported receiving assistance from the SAWID DC in initiating food gardens. The focus on food gardens and eating three meals a day however will not necessarily address nutrition security, which urgently needs to be addressed. This refers to the need to ensure that a person consumes sufficient amounts of a range of food products to ensure dietary diversity which enables the person to access all necessary nutrients required for a healthy diet.

7.4 Results of the Estimation of DC Impact on Early Childhood Development

The DC minimum conditions outlined for Early Childhood Development were twofold, namely those preschool going aged children should attend a preschool programme and that children whose adult caregivers are working outside of the home or otherwise not available should access day care services. The focus of the SAWID DC on ECD is aligned with key government priority nationally to accelerate and expand access to ECD for poor and vulnerable children, particularly with a focus on children under 5 as this age cohort is seen as those most in need (Biersteker, 2008a).

The study results showed that only 29% of children in the study households were accessing ECD services in any form. This finding resonates with national level data on ECD access which estimates that between 26 %– 29% of children under the age of five participate in ECD services outside their home (Stats SA, 2009). However when the results were disaggregated for DC and non-DC households the results

revealed that only a quarter of DC households accessed ECD in any form compared with over 39% of children in non-DC households. A further analysis of the data as indicated in Table x below for the two sites revealed stark differences in access to ECD services with ECD access being more than three times higher in Limpopo (48%) than in KZN (13%) amongst DC households. Access to ECD by non-DC households was in fact slightly higher for both the sites.

Table 23 ACCESS to Early Childhood Development Services

ACESS to ECD	Type and Location of Household				
	DC LM	DC KZN	Non DC LM	Non DC KZN	Total
Yes	48.4	12.9	19.4	19.4	100%
No	30.3	44.7	10.5	14.5	100%

The type of ECD service accessed was largely centre based ECD programmes at 68% followed by 21% of ECD services accessed being home based care services or parenting programmes. This in keeping with the national trend of access to out of home ECD services being patronised largely by children in the 3 to 5 year age cohort (Richter et al, 2012).

90% of the households in the study reported no support for accessing ECD services and of the remaining 10% the majority were from DC households. The main form of support provided was reported as linkage to an ECD service at 58% followed by 21% who accessed the ECD subsidy and 11% who accessed sponsorship. The access to ECD subsidies reflected in this sample is higher than the national average of 10% of poor children accessing the ECD subsidy (Gustaffson, 2010). Here too the trend was similar to that above with double the DC households accessing ECD support compared to non-DC households. DC and non-DC households in KZN appeared to receive almost no support in accessing ECD. The main institution providing support was identified as government agencies and only one DC household in LP identified SAWID as the support agent. More than two thirds of the DC households rated the quality of support provided as good or very good reflecting high level of satisfaction with the support received.

Access to ECD services particularly for the very young child is seen as a critical opportunity to intervene in and strengthen the development of children, especially vulnerable children from compromised environments. Nelson (2000) suggests a 1000 day window of opportunity from conception to 23 months exists and that the failure to address the needs of children during this period can have an irreversible impact on the child's future well-being. The basket of ECD services which are seen to promote and protect the development of young children include access to and quality nutrition, health care, parent and family support and cognitive development support among others (Richter et al, 2012). Within this context it is encouraging that 21% of the services accessed were home based care and parenting programmes.

However the overarching finding is that ECD access for children in both the DC sites is low and more particularly the SAWID DC does not appear to have made any significant impact on expanding access to ECD for poor children.

School Attendance

The DC minimum condition stipulates three indicators for assessing DC performance namely that:

- Children under 15 years of age should attend an educational institution, or be in the process of reintegration if they have previously dropped out;
- Children 12 years of age or older should be able to read and write, or in the process of learning;

- Children with disability who are able to study should be incorporated into the standard or special education system;
- An adult responsible for the education of the children should be in contact with the school and have attended the most recent parent/guardian's meeting.

A worrying pattern of non-school attendance for children under 15 emerged with 46% of children in the sampled households not attending school. Of those not attending school 74% were from DC households and just over half of those were from KZN DC households (52%) and 21% were from LP DC households. In contrast just above a quarter of non-DC households had children not attending school. The main reason for non-attendance at school was given as affordability. It was reported that 44% of DC households in KZN, 19% of DC households in LP and 43% of non-DC households were not being able afford school fees. According to Department of Basic Education (2012) 60% of learners drop out of school annually between Grade 9 and Grade 12, hence the results are not markedly different from national norms. What remains disconcerting is that school attendance in DC households was poorer than for non-DC households. More intriguing would have been that both the sites are identified as national poverty nodal points and hence it would be likely that the schools in those sites would be fee free. The study did not probe fully if those paying fees were attending schools in the community or elsewhere in order to understand this better. Here again only 1 incident of SAWID SAW providing assistance with school fees was reported and interestingly this was for a non-DC household in KZN.

A key factor in inhibiting school access in the past has been the costs of schooling including fees, school uniforms and the travel costs associated with attending school. In 2007 the Department of Basic Education promulgated a fee free schools policy in 2007 to address issues of equity in access to education. According to Stats SA (GHS, 2011) two thirds of children do not pay school fees and of these 96.5% attended no fee schools. There were regional variations with 77% of LP schools being fee free while in KZN 53% of schools were fee free as at 2010 (DBE, 2010).

It was thus unsurprising that 13% (39) of the sampled households in both sites paid school fees. What was surprising however was of those households who were paying school fees a larger proportion were from DC households (77%) compared to 23% non-DC households. Of those paying school fees 46% (18) were from DC households in LP, 31% (12) from DC households in KZN and 24% (9) from non-DC households in KZN. In KZN fewer non-DC households paid fees while in LP none of the non-DC households paid fees.

The South African Schools Act no 84 of 1996 makes a strong case for parent participation in their children's education (RSA, 1996). Evidence suggests that giving parents a greater voice in the decision making regarding their children's education impacted on better functioning schools and improved outcomes for learners Against this background the study results are encouraging in that parental participation in the two sites was extremely high at 87% with higher participation being reflected in DC households (70%) compared to non-DC households (30%). Higher levels of participation could be seen in KZN DC households (43%) than in LP DC households (20%).

In terms of seeking assistance with school fee exemptions, 88% of DC households reported getting assistance with the majority of those being in LP DC households. However, only one household reported receiving assistance from the SAWID DC, with the main sources of assistance being family members (<44%) and government agencies (28%). The quality of the support was rated as being good and very good for over 96% of those households who had received assistance.

7.5 Results of the Estimation of DC Impact on Skills Development

Research evidence suggests that employment creation is key to increasing access to income and reducing poverty (Holmes et al., 2013). South Africa has one of the highest unemployment rates globally at 24,7% representing approximately 4,6 million people and with a particularly high youth unemployment problem. KwaZulu-Natal's share of unemployment was 20,9% while that of Limpopo was 17,8%. Of these more than 3,3 million young people between the ages of 15-24 were amongst the ranks of the unemployed. (Stats SA, 2013).

Many studies have explored the relationship between education, skills and access to the labour market more particularly how education and skills impact on labour market access(Bhorat and Liebrandt, 2001; van der Berg and Burger, 2003). Much of the problem for our high unemployment has been blamed on the lack of skills in the workforce, an inheritance from our apartheid history. Labour force studies from 1995 and 2003 show that overall those unemployed had lower levels of education. The LFS studies found that between 19% and 25% of those unemployed had matric as their highest level of education (Dias and Posel, 2007).

Against this context the SAWID DC minimum condition stipulates that adults should be able to read and write (or those who desire to learn to read, write and perform basic mathematics should be in the process of learning.)

The study explored two key issues namely the reason for young people not furthering their education and what measures were being taken by household members to further their skills development and thereby enhance their access to the labour market.

Respondents were asked the reason why a family member was not continuing with education and the three most predominant responses were lack of resources for fees (24%), inability to perform academically (21%) and failed examinations was the third most prevalent reason (16%). Pregnancy was cited as one of the reasons for 6% of the respondents and family factors was also noted as a reason for not pursuing further education (6%). These were also the main reasons for education not being pursued by DC households. Of particular interest is that 19% of DC households gave lack of funds as the reason while in non-DC households this accounted for 44%. Pregnancy as the reason for dropping out of education was relevant only for DC households.

A second issue which the study probed was that of skills development. Here the study found only 5 respondents who reported pursuing either a matric (1), participation in a learnership (2) or attending skills training (2) with the latter two mainly being pursued by DC household members.

A high percentage of the respondents indicated other. A closer look at this response shows that a number of factors including lack of financial support for further training, family child care responsibilities, job seeking, lack of knowledge of where to seek further education and lack of motivation were among the reasons proffered for not pursuing further education and skills development. This pattern was not very different between DC and non-DC households.

8 ECONOMIC CAPITAL DEVELOPMENT

8.1 INTRODUCTION

Income distribution is one of the most important indicators of social welfare, as income is a primary means by which people are able to satisfy their basic needs such as food, clothing, shelter, health, services, etc. Changes in income inflict changes in the standard of living, more specifically: a positive change in income can assist individuals, households, communities and countries to improve living standards. Knowledge of the volume of the disposable income and the expenditure patterns of households, therefore, can provide vital intelligence with respect to the sectors that are most dependent on the household income and therefore would be most affected in the case of the change in household income.

8.2 INCOME AND EXPENDITURE PATTERNS

Social income

In South Africa, access to social protection continues to play an important role in the lives of many households. Social grants are an important component of the social wage, which is credited for contributing significantly to the decrease in poverty in South Africa (StataSA, 2014; Leibbrandt *et al*, 2010). The significance of grants for poverty alleviation is also particularly important in the case of highly marginalised rural women. There is evidence to suggest that levels of vulnerability are relatively higher in the case of non-grant receiving female-headed households with respect to economic shocks (Ngandu et al, 2010). This would suggest that any intervention that can facilitate access to social assistance would go a long way in alleviating the plight of these vulnerable constituencies. At the same time in the presence of scarce resources, such an intervention would have to demonstrate significant impact to justify its use as an effective approach in the fight against poverty.

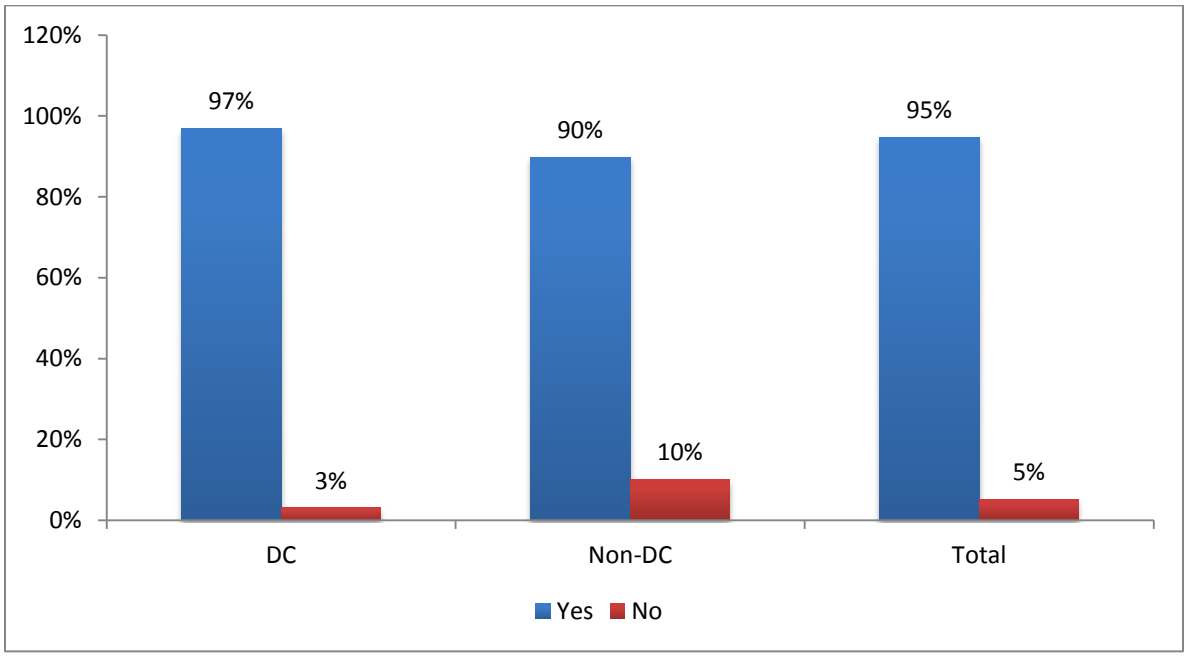


Figure 30 Household members still receiving a grant. Source: HSRC Survey (2014)

One of the key priority areas under the DC programme was to ensure that all eligible household members had access to some form of social assistance. In order to assess the level of access, respondents who had previously applied for grants were asked to indicate whether they were any household members that were still receiving the grant at the time of the survey. Figure 30 shows that of all household members who had previously applied for a grant, 95% of them were still receiving this form of social assistance. With respect to differences across the type of household, slightly more DC than Non-DC households had continued to receive the social transfer since applying for it.

In terms of access by type of social grant, 1, shows that all households (DC and Non-DC) rely heavily on the child support grant followed by the old age grant. The extent to which these two grants form a significant part of the household's gross income will be discussed in the next section.

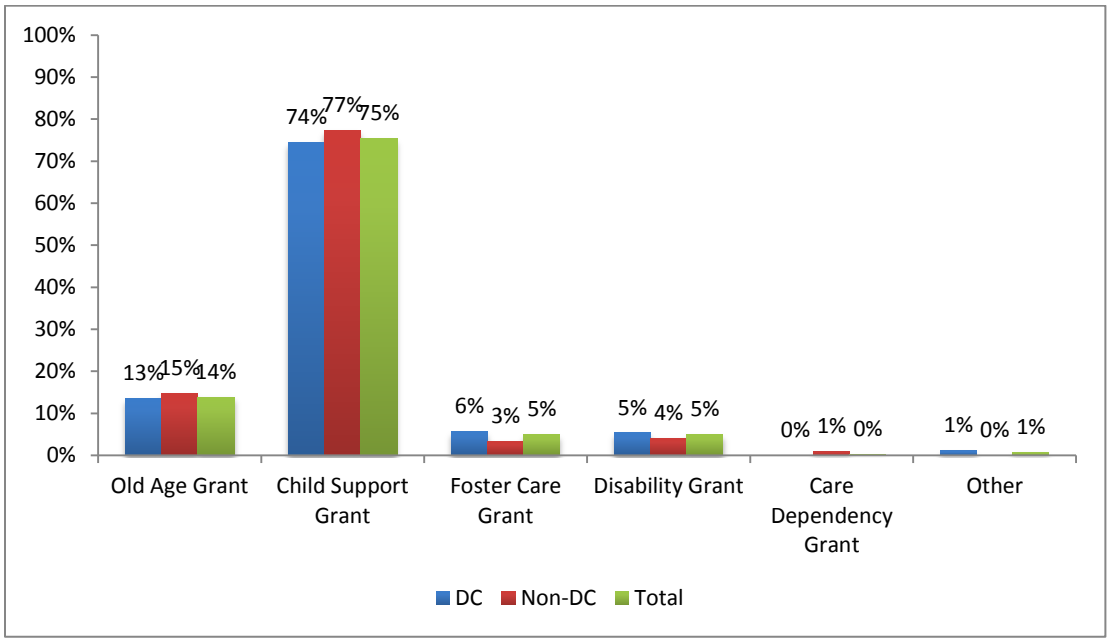


Figure 31: Type of grant by percentage of recipients
Source: HSRC Survey (2014)

At the heart of the DC programme was the understanding that households that faced extreme deprivation often failed to tap into the welfare system due to the lack of knowledge and/or the unavailability of the required documents to apply for a grant, among other things. To identify the support that they might have received in accessing the grant respondents were asked whether anyone had assisted them during the application process. Table 24 shows that out of over 365 grant receiving household members, there were only 8 cases that had received some kind of support in applying for the grant, 7 were DC and 1 was Non-DC.

Table 24 Did [..] receive any support in accessing this grant?

	DC	Non-DC	Total
Yes	7	1	8

Source: HSRC Survey (2014)

When asked to identify the organisation or person who had assisted them, 3 DC cases had received assistance from the SAWs, whilst 4 had received assistance from a government agency (Table 25). The one Non-DC case had also received assistance from the latter.

Table 25: Who assisted […] in accessing this grant?

	DC	Non-DC
SAWiD DC SAW	3	0
Government agency	4	1
Total	**7**	**1**

Source: HSRC Survey (2014)

For those household members where an application had not been made, they were asked to give reasons as to why this was the situation. Of the 34 cases that had not applied 71% where DC households with the remainder being Non-DC. The two most common reasons for not applying were related to outright ineligibility and the lack of documents (Table 26). Whereas 70% of Non-DC and 46% of DC households had not applied due to the former, 42% of DC cases had not applied to due to the lack of documents.

Table 26: Reasons for NOT applying for a social grant

	DC	Non-DC	Total
Social grants applied for by, or paid to, someone in another household	4%	0%	3%
Ineligible for a social grant because the person does not qualify	46%	70%	53%
Person cannot apply as is not the child's mother/ not primary care giver	4%	10%	6%
Person is ineligible as receives a different grant (e.g. FCG, CDG)	0%	10%	3%
Lacks the documents required (birth certificate, ID card, affidavits, etc.)	42%	0%	29%
Costs involved in applying are too high	0%	10%	3%
Other reason (Child is still a new born)	4%	0%	3%
Total	100%	100%	100%

Source: HSRC Survey (2014)

This result is somewhat puzzling, given that addressing issues around ensuring that households had the necessary documents to allow them to access the welfare system was one of the fundamental key priority areas of the DC intervention. Furthermore, the low number of people that indicated that they had received assistance would further question the implied theory of change on the entire program. As stated earlier the prima facie assumption that motivated the inclusion of civil registry documentation as a component of the DC was the potential wide spread occurrence of individuals who were not accessing the welfare system as a result of the lack of birth certificates, ID cards, affidavits, etc. In addition, it appears as if more DC households reported that applications had not been made due to the lack of information. This finding raises concerns regarding the processes that went into the selection of key priority areas for the DC intervention. Finally, the use of the SAWs with respect to assistance with grant application is further called into question given that of the seven DC households that received assistance 4 cases indicted receiving it from a government agency.

What could explain this pattern of responses? One possible explanation could be the possibility of the presence of measurement error, for example, this can arise as a result of a poorly phrased question which confused respondents causing them to underreport any assistance they might have received from the SAWs. However, the possibility of this in this survey is rather low since, SAWiD DC SAW, was one of

the options for this question. Alternatively, it is also possible that South Africa's extensive social grant coverage and frequent occurrence of grant related issues in the popular media is the source of the assistance underreporting. As a result, this might create a sense of entitlement of welfare benefits that prevents households from recognising any assistance that they might have received with accessing grants as being significant.

The poverty line and household income

To facilitate the assessment of the extent to which the DC intervention was able to meet its income related conditions, Figure 322, below, presents the gross monthly income distribution of the surveyed population. As mentioned in the previous section the clustering of income around the R801 – R1 600 band is consistent with the respective rand values of both the CSG (in the case of households with more than one recipient) and the OAG. This is the income level reported by most (41%) of the households. The second distinctive group of households in the R1 601 – R3 200 income band could represent multiple grant-receiving households.

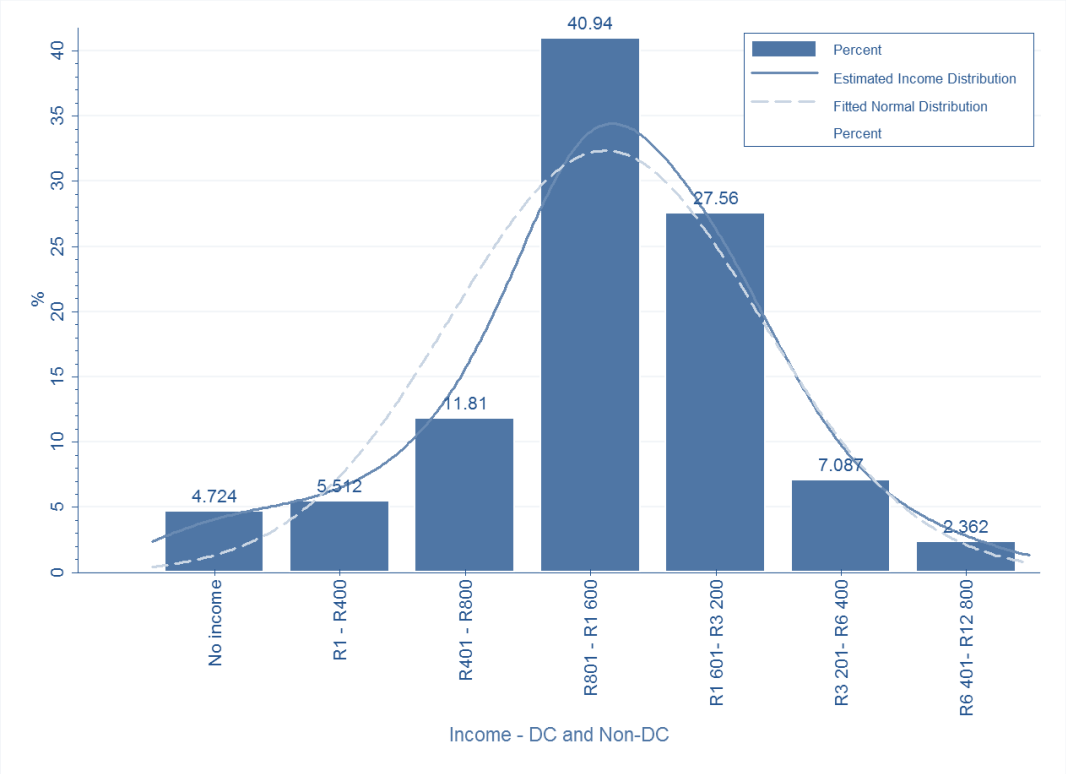


Figure 32: Estimated Income Distribution - Gross Monthly Income (Combined DC and Non-DC)
Source: Author Calculations

The extent to which the estimated income distribution density approximates the fitted normal distribution would suggest very low levels of with-in group income inequality. Furthermore, given the fact that the estimated distribution also includes Non-DC households, would suggest that the sampling of the latter might have picked households with relatively similar income characteristics. This would make that sample of households an appropriate comparison group.

An important objective of the DC was to ensure that each family would have income above the line of extreme poverty. To assess the extent to which this was achieved or not the recently updated lower-

bound StatsSA 2011, poverty line was used, as seen in Table 27. This gives an inflation adjusted per capita per month poverty line of R443. It is important to note that they are a number of poverty lines in South Africa and this study chose the latter given the recognition of Statistics South Africa as a credible and a relatively accessible source of the country's national statistics.

Table 27: Inflation-adjusted poverty lines (per capita per month in Rands)

Year*	Food poverty line	Lower-bound poverty line	Upper-bound poverty line
2000	141	209	308
2001 (September)	148	219	323
2002	166	241	352
2003	197	280	401
2004	199	282	403
2005	202	288	413
2006 (March)	210	300	431
2007	227	321	458
2008	259	360	507
2009 (March)	305	416	577
2010 (March)	307	424	594
2011 (March)	*321*	*443*	*620*

Source: StatsSA (2014)

Once the appropriate poverty line was chosen the surveyed populations was evaluated with respect to this line. The reported monthly income from the survey was taken and divided by the reported household size. Each household's per capita monthly income was then assigned to one of the two groups, those falling above and those falling below the lower bound poverty line. Figure 333 shows that the surveyed population is, to a large extent, split evenly above and below the poverty line.

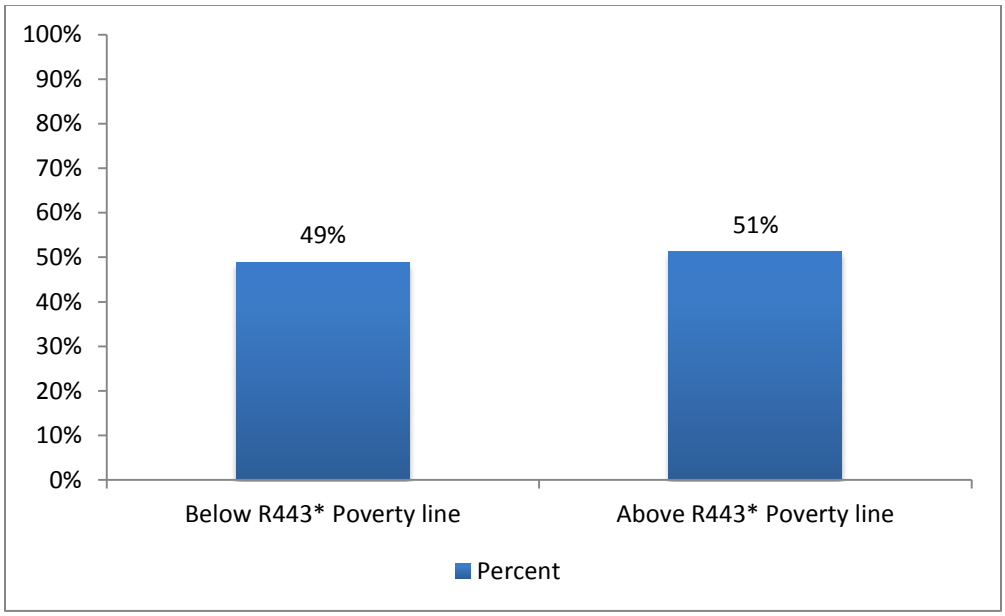


Figure 33: Household Income Above and Below the StatsSA Lower Bound income.
Source: HSRC Survey (2014), StatsSA (2014) * lower-bound StatsSA 2011, poverty line

With respect to the differences by household type Figure 344, shows that Non-DC households are marginally better off than the DC households as 55% of them are above the poverty line, relative to 48% for DC Limpopo and 51% for DC KwaZulu-Natal.

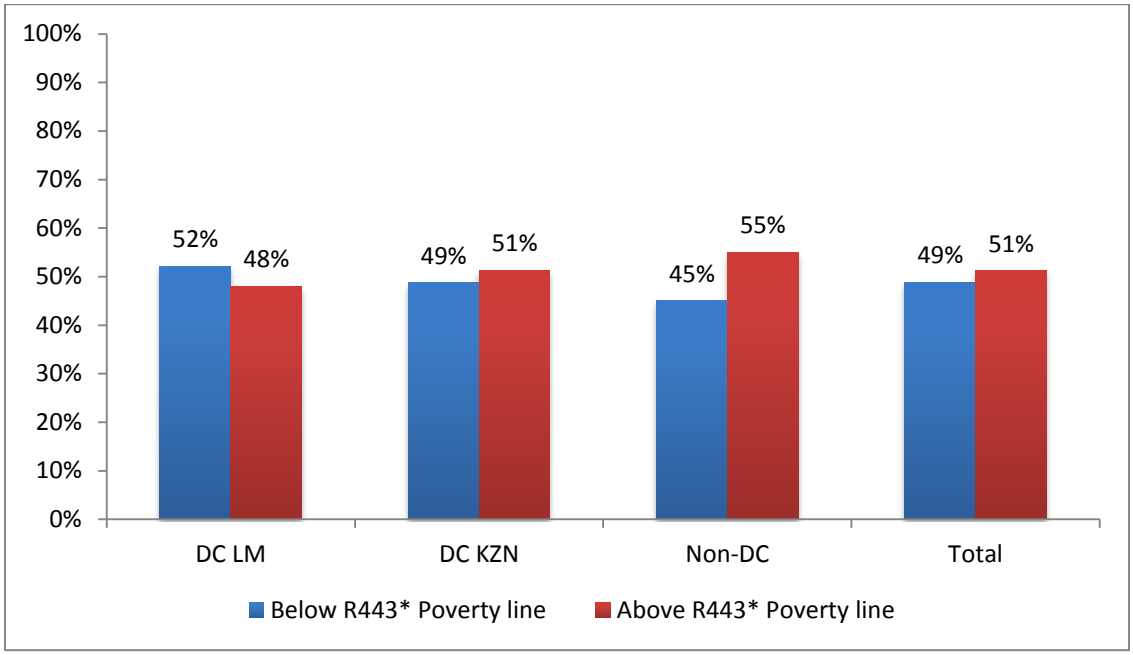


Figure 34: Household Income Above and Below the StatsSA Lower Bound pline by Type
*Source: HSRC Survey (2014), StatsSA (2014) * lower-bound StatsSA 2011, poverty line*

In order to check whether the observed differences in mean incomes between household type represents statistically significant differences, a two sample t-test was conducted. From the results of the test, as shown in Table 28, we can conclude that there is no difference between the means for DC and Non-DC households.

Table 28: Two-sample t test with unequal variances

Group	Obs	Mean	Std. Err.	Std. Dev.	[95% Conf.	Interval]
DC House	87	1671.264	148.8431	1388.316	1375.374	1967.155
Non-DC H	40	2085	342.8304	2168.25	1391.56	2778.44
combined	127	1801.575	148.6934	1675.689	1507.315	2095.835
diff		-413.7356	373.7472		-1162.751	335.2796

```
    diff = mean(DC House) - mean(Non-DC H)                        t =  -1.1070
Ho: diff = 0                     Welch's degrees of freedom =  54.9702

    Ha: diff < 0                 Ha: diff != 0                 Ha: diff > 0
 Pr(T < t) = 0.1366         Pr(|T| > |t|) = 0.2731          Pr(T > t) = 0.8634
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To understand these results we need to take a look at the income distributions for DC and Non-DC Households (Figure 35 and Figure 36).

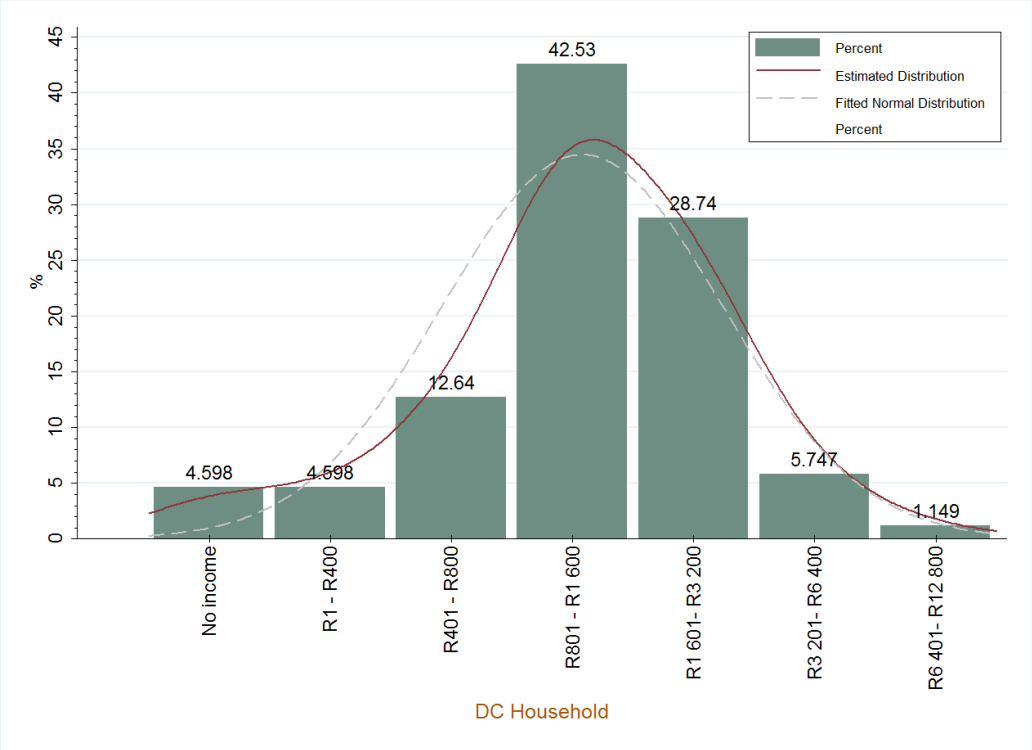


Figure 35: Estimated Income Distribution - Gross Monthly Income (DC Households)
Source: Author Calculations

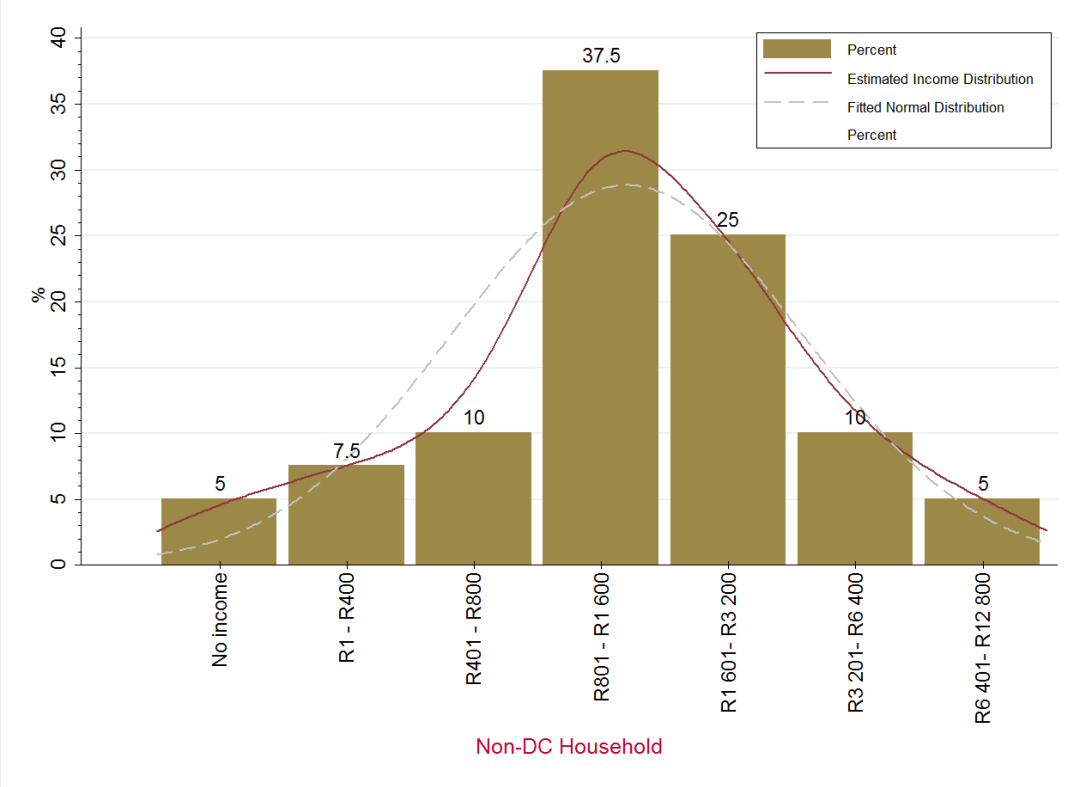


Figure 36: Estimated Income Distribution - Gross Monthly Income (Non-DC Households)
Source: Author Calculations

The two diagrams highlight the fact that the two samples have seemingly identical income distributions. This result is not surprising, as both populations seem to have the same income profiles that are heavily dependent on grant incomes. The statistical analysis in this section therefore makes it difficult to attribute any differences in mean income to the DC intervention. This would, within the limitations and shortcomings of the approach used, suggest that income outcomes in the surveyed population are independent of whether there is an intervention or no intervention.

Asset Ownership

The previous section has given a description of an income based-metric measure of poverty. However, there is evidence to suggest that in South Africa improvements in access to assets has been much stronger than improvements in income poverty and inequality (Leibbrandt *et al*, 2010). In other words, differences in asset accumulation might represent a better proxy for household socio-economic mobility and well-being than income based measures. In order for us to make this assessment for this impact study, households were asked to indicate, from a menu of items, whether they owned a particular asset or not. Figure 37 reveals that there is a fair amount of variation in terms of assets ownership across the two types of households. DC households barely edging off non-DC households in 4 of the 6 report asset categories, although it is also important to point out that the latter is marginally better off with respect to two of the larger assets, in terms of monetary value, namely TV and electric stoves.

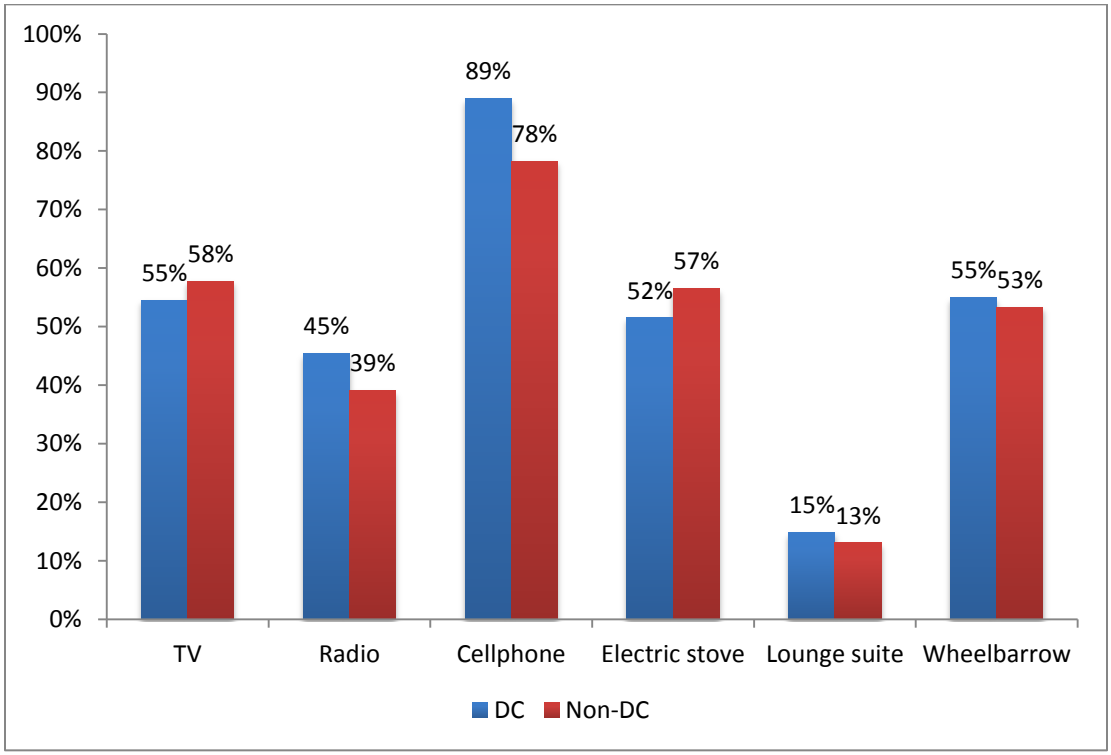


Figure 37: Access to Assets

Given this asset ownership profile it is also difficult to recommend the DC intervention over a case of non-intervention.

8.3 Impact on Employment

Employment is the primary means by which individuals who are of working age may earn an income that will enable them to provide for their basic needs. As such, employment and unemployment rates are important indicators of socio-economic well-being.

In assessing household composition in terms of those containing a salaried individual, we were evaluating yet another one of the DC's minimum conditions. In Limpopo, we found comparable proportions of households containing a person who was engaged in formal employment, as the question was asked, which were very low at 13.8% and 12.0% for DC and non-DC households respectively. In KZN, the situation was similar for DC households who made up 16.7% of households containing a salaried person against 4.6% of non-DC households. Unemployment levels in South Africa in general are very high, at around 25% using the narrow definition which excludes discouraged work seekers. Again, it can be said that the DC programme made inroads as far as this condition is concerned in KZN and had more of an impact that it did in Limpopo.

Something has to be said about the findings in this particular section of the DC minimum conditions and their outcomes. We endeavoured to study outcomes that are perceived as key dimensions that would allow participating households to escape indigence in a sustained way in the long run. However, some of these outcomes may take time to materialize as families slowly grow their skills and assets as part of their family 'life project'. This point was corroborated by one of the SAWID trustees during her key informant interview. She explained thus:

> "*The Development Caravan Phase One was never about job creation. The focus with this phase was on providing psychosocial support to the families. Only in a later phase will we start to work with the individual and families to develop self-sufficiency skills and to develop a culture of entrepreneurship. The DC programme designers realise that most of these poor households are dependent on social grants from the government however this is an unsustainable financial situation from the side of government as the number of recipients keeps on growing. At the same time, the people who are receiving these grants can be taught to ….* . (key informant interview, SAWID Trustee, May 2014"

Indeed, an examination of the DC programme's intervention phases pointed to a tiered approach where eventually, after a few years, progress on the achievement of outcomes starts to show.

9 ENVIRONMENTAL CAPITAL DEVELOPMENT

9.1 Introduction

This section focuses on the environmental indicators that mediate access to a number of services. As such a number of questions were included in the DC evaluation household survey to enable analysis on how households live and their access to various services and facilities such as housing, water, sanitation and energy. As with the preceding sections, the impact of the DC intervention will be done by contrasting levels of access of beneficiaries to that of the comparison group. The SAWID DC intervention had a number of minimum conditions, which were to be achieved by participating households. These were spelt out as follows:

- The family should have a house with the minimum standards: mud covered in cement; enough rooms for privacy of individuals.
- If the family wishes to apply to the municipality housing program, they should be in the application process.
- The family should have access to clean water 6 metres from the house.
- The family should have appropriate and safe sewage disposal.
- The family should have appropriate waste disposal provided by the municipality,
- The family should have safe and reliable energy for lighting and equipment.
- The family should have access to a public road for emergencies and access to markets.

9.2 Access to Housing

Housing is one of the basic human needs and has both direct and indirect implications on living conditions of households including health, welfare and social status in communities. Housing conditions constitute a very important dimension that the DC program aimed at improving. Owning a house reinforces the identity of the household as an independent unit and represents a capital that can be bequeathed to their children, together with the investment in human capital. Besides the ownership status, basic sanitary and housing infrastructure are important correlates of household welfare (FOSIS, 2004a). Having basic infrastructure has potential complementarities with health outcomes (access to safe water and sanitation), as well as family dynamics (in terms of a space that allows for better roles and interactions among different household members).

Table 29 Dwelling types

Main dwelling type	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Dwelling/house or brick/concrete block	91.1	80.0	80.0	36.4
Traditional dwelling/hut/structure made	7.1	12.0	12.0	50.0
Flat or apartment in a block of flats	1.8	0.0	0.0	4.6
Dwelling/house/flat/room in backyard	0.0	0.0	0.0	9.0
Informal dwelling/shack in backyard	0.0	8.0	8.0	0.0
Informal dwelling/shack not in backyard	0.0	0.0	0.0	0.0
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014)

Relative to Non-DC households, 80% of those in Limpopo occupy dwellings made of brick and concrete, a percentage similar to the DC in KZN (Table 29). The Non-DC survey households in KZN had the lowest

number (36.4%) of households that occupied brick and concrete dwellings with the majority (50%) occupying traditional hut structures made from mud. Only a small proportion of households (8% Non-DC LM and 8% DC KZN) occupied informal dwellings, such as a shacks in a backyard of a formal dwelling. This suggests that although households in the pilot sites do require formal housing, their needs are considerably lower than those observed in other local communities, for example, in Gauteng where one out of four households live in an informal dwelling (Census, 2011). A Chi Square test of association was conducted and it showed that the relationship between location of household and type of dwelling is statistically significant. The variation in terms of access to housing might be weakly attributed to the DC intervention, although the extent to which this can be done is limited by the absence of baseline data on both groups of study participants.

Table 30 Tenure status of the household dwelling

Tenure status	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Rented	1.8	0.0	0.0	0.0
Owned, but not yet paid	3.6	4.6	0.0	0.0
Owned and fully paid	62.5	59.1	55.3	27.3
Occupied rent-free	32.1	36.4	29.0	54.6
Other	0.0	0.0	15.8	18.2
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014)

The DC evaluation survey results in Table 31 show that DC households were in the majority of sampled households who occupied a Government dwelling. As the DC program aimed to facilitate access to public programs such as RDP housing (among other things), these results might imply that the program was successful in this regard, achieving more success in Limpopo than it did in KZN. However, these results should be interpreted with caution. It is possible, for example, that the lower percentages of households from KZN who answered 'no' to this question of whether they occupied a Government dwelling or not, might have purchased their own homes.

Table 31 Government dwelling or not

Government dwelling or not	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Yes	61.2	45.5	13.5	4.8
No	38.8	54.6	83.8	95.2
Other	0.0	0.0	2.7	0.0
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014)

Another possibility is that their household dwelling might have been allocated by a Traditional Authority (such as an Induna or King), which is not uncommon in a rural setting such as KwaMbonambi. Indeed, in the absence of data supporting this finding, it cannot be concluded with any degree of certainty that the program performed better in Limpopo than it did in KZN.

Table 32 Do you have enough rooms?

Enough rooms for privacy	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Yes	20.8	22.7	27.0	14.3
No	79.3	77.3	73.0	85.7

Source: author's calculations from fieldwork data (N=145)

Another housing-related question asked of the respondents was if the household had enough rooms for the privacy of household members, in line with one of the DC minimum conditions (Table 32). Judged by themselves, the majority of DC households from both sites in Limpopo and KZN responded 'no' to this question (79.3% and 73.0% respectively. In comparison to non-DC households, DC households who responded 'no' were in the majority over their non-DC counterparts in Limpopo however, the reverse is true of the sample from KZN, which might signal that the programme intervention did better in KZN than in Limpopo. However, to the extent that larger proportions of all categories of households surveyed answered 'no' to this question, may mean that this was not a major success for the programme all round.

9.3 Access to Water

Table 33 shows households' access to water. The situation in this case is quite different to that observed with regard to access to formal dwellings. Less than a fifth of all categories of households in the sample have access to water inside their dwellings. This situation is almost comparable for DC and non-DC households in Limpopo however, the DC households in KZN fared better than their non-DC households counterparts.

Table 33 Main drinking water source

Main drinking water source	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Piped (tap) water in house	15.5	16.0	14.6	9.1
Piped (tap) water in yard	34.5	40.0	24.4	4.6
Borehole in yard	1.7	0.0	2.4	0.0
Neighbour's tap	1.7	8.0	2.4	9.1
Public/communal tap	17.2	16.0	29.3	40.9
Water-carrier/tanker	1.7	0.0	14.6	9.1
Borehole outside yard	17.2	12.0	7.3	4.6
Flowing water/stream/	10.3	8.0	2.4	18.2
Stagnant water/dam/	0.0	0.0	2.4	0.0
Spring	0.0	0.0	0.0	4.6
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: author's calculations from fieldwork data (N=146)

Another of the DC programme's specific minimum conditions is that households should have access to clean water 6 metres from the house. Tables 34 and 35 show the results of the analyses of these conditions for DC households compared to non-DC households.

Table 34 Water clarity

Water clarity	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Yes	67.2	66.7	85.7	71.4
No	32.8	33.3	14.3	28.6
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=145

In terms of the clarity of water that households have access to, they were asked to provide a yes or no answer as to whether the water 'has no colour' and/or is 'free of mud.' A larger proportion of DC

households from KZN answered yes to this question (85.7%) than the proportion of DC households from Limpopo (67.2%). This is still reflective of the widespread water problem that is experienced in Limpopo in general. The DC and non-DC comparison groups of households from Limpopo attest to this with the almost even split of their responses to this question – 67.2% and 66.7% respectively. However, in comparison to the two sets of households from KZN, there's a clear difference between the two groups. DC households at 85.7% seem to be ahead of the non-DC households at 71.4% in having access to clean water.

Table 35 Distance to water source

Water distance	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Less than 200 metres	66.0	50.0	52.0	50.0
201 – 500 metres	25.5	31.3	28.0	22.2
501 – 1 kilometre	2.1	6.3	12.0	5.6
More than 1 kilometre	6.4	6.3	0.0	0.0
Don't know	0.0	6.3	8.0	22.2
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=106

Turning to households' relative distance to a water source, Table 33 illustrates the findings from the two sites. Although the specific subminimum condition of the DC program is that households must have access to water 6m from the house, we used the standard question and attendant categories asked in the Census (2011) and GHS (2012) household surveys to analyse households' access to safe drinking water. While in KZN there is not much difference between the two groups of households at 52.0% and 50.0% access for DC and non-DC households respectively, there is again a stark difference between the Limpopo households. A larger proportion of DC households from Limpopo (66.0%) have access to safe drinking water less than 200 metres from the household dwelling when compared to non-DC households at 50.0%.

The psychosocial perspective of the DC programme is a crucial part of this intervention in that individuals and households are not only assisted in gaining access to public benefits and programs that they are eligible for. The psychosocial component also sought to change the mindset of the people, that is, it went beyond pointing people in the right direction, providing information and facilitating access to these benefits and services, indeed, in the words of one key informant, the DC programme's role is

> "*not only to hold the beneficiaries' hands all the time but another key component of the programme is to help the indigent increase their self-sufficiency*." (key informant interview, May 2014)

It attempting to appraise this information-facilitation aspect of the DC programme, a question was asked of the respondents whether they knew about the Free Basic Water (FBW) programme that is offered to indigent households by the municipality (Table 36).

This is in terms of helping people graduate out of indigence not only as measured as the physical and material attainment but also in terms of awareness and empowerment and helping households know where to go and get help long after the programme's intervention.

Table 36 Knowledge about Free Basic Water

Free Basic Water knowledge	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC

Yes	19.3	29.2	54.8	54.6
No	75.4	66.7	38.1	45.5
Don't know	5.3	4.2	7.1	0.0
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014)

With particular reference to educating people about FBW access, it's unclear what role the DC programme played, for example, the same percentage of both DC and Non-DC households in KZN reported knowing about FBW, 54.8% and 54.6% respectively. Again the impact of the DC intervention in Limpopo is further called into question as more Non-DC households (29.2%) reported knowing about FBW than DC households (19.3%).

Table 37 Does your household qualify for FBW?

Does your household qualify for FBW	**Limpopo**		**KZN**	
	DC	**Non-DC**	**DC**	**Non-DC**
Yes	83.9	79.2	61.0	71.4
No	16.1	16.7	9.8	4.8
Don't know	0.0	4.2	29.3	23.8
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=142

That more DC households qualified for FBW in Limpopo than non-DC households may mean that the targeting done by SAWID was accurate in selecting indigent households (Table 37). In the absence of data to support this, this assertion must be approached with caution.

Table 38 Does your household receive FBW

Does your household receive FBW	**Limpopo**		**KZN**	
	DC	**Non-DC**	**DC**	**Non-DC**
Yes	17.5	16.7	51.3	52.4
No	80.7	79.2	46.2	42.9
Don't know	1.8	4.2	2.6	4.8
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=141

In terms of whether households receive this FBW, results were compared for the two sites (Table 38). DC households from Limpopo who do not receive FBW are in the majority when compared to those who do. These also constitute a slightly larger proportion when compared to non-DC households who do not receive FBW (although the difference is relatively small). In KZN, the majority of households receive FBW, both DC and non-DC. A conclusion could be drawn from these findings that the program performed better in assisting households access FBW in KZN than it did in Limpopo. However, we are also mindful of the prevailing water scarcity problem experienced universally in Limpopo.

Table 39 FBW assistance

FBW assistance	**Limpopo**		**KZN**	
	DC	**Non-DC**	**DC**	**Non-DC**
Mother	7.1	10.0	0.0	0.0
Relative of household	0.0	20.0	0.0	0.0
SAWID DC SAW	50.0	0.0	8.7	0.0
Government agency	14.3	50.0	43.5	90.0
No assistance	28.6	20.0	47.8	10.0
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=57

When asked who assisted with access to FBW, half of all DC household respondents in Limpopo reported having been assisted by a SAWID DC SAW in obtaining FBW (50.0%) and only a paltry 8.7% for DC households in KZN. When the response for those who were assisted by either a government agency and those that had received no assistance are combined it would appear as if the case of no intervention produces a superior outcome to the DC approach, this is, 100% for Non-DC KZN; 91.3% DC KZN; 70% Non-DC LM and 50% for DC LM received FBW by some other means either than a SAWID SAW.

9.4 Access to Sanitation

Table 40 provides information on access by households to sanitation. It indicates that about 3.6% of DC households in Limpopo and about 12.5% of DC households in KZN currently have no toilets. These figures are lower than the figures reported for the non-DC households in both sites with a much higher figure reported for non-DC households in Limpopo, at 22.0%). Overall, this is better than the situation in the country (GHS, 2012). Both DC and non-DC households in the two pilot sites who had access to toilets largely had access to pit latrine toilets ether with ventilation or without. This is again indicative of the type of settlements and dwellings that are found in rural communities such as Fetakgomo and KwaMbonambi.

Table 40 Toilet facility

Toilet facility	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Flush toilet connected to a public sewerage system	0.0	2.4	0.0	0.0
Flush toilet connected to a septic tank	7.3	0.0	4.2	0.0
Chemical toilet	14.6	2.4	12.5	0.0
Pit latrine/toilet with ventilation pipe	50.9	41.5	50.0	68.2
Pit latrine/toilet without ventilation pipe	23.6	29.3	20.8	22.7
None	3.6	22.0	12.5	9.1
Other	0.0	2.4	0.0	0.0
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=142

The DC minimum condition pertaining to sanitation strives to ensure that a family has appropriate and safe sewage disposal. According to **Error! Reference source not found.**, the largest proportion of all ouseholds from both sites are those with toilets located outside the dwelling. This is more so for DC beneficiaries than non-DC households.

Table 41 Location of the toilet

Toilet location	Limpopo		KZN	
	DC	Non-DC	DC	Non-DC
Inside dwelling	8.9	20.6	8.7	20.0
Outside dwelling – on stand	87.5	64.7	91.3	70.0
Outside dwelling – off stand	3.6	14.7	0.0	10.0
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Source: DC evaluation household survey (2014), N=133

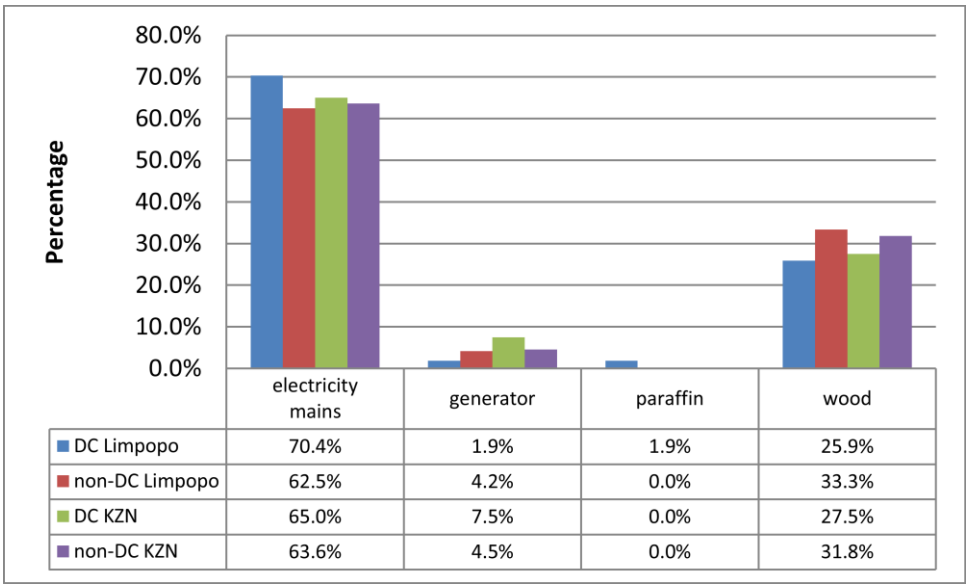
Other results that were analysed in relation to sanitation pertain to households' satisfaction with their toilet facility, ranked according to five different scales. The responses given were:

- Very satisfied – DC (10.0%); non-DC (9.3%)
- Satisfied – DC (26.7%); non-DC (32.6%)
- Neither satisfied nor dissatisfied – DC (15.6%); non-DC (11.6%)
- Dissatisfied – DC (35.6%); non-DC (34.9%)
- Very dissatisfied – DC (12.2%); non-DC (11.6%)

Overall, the levels of satisfaction of households with their toilet facilities were very low, which is indicative of the sanitary situation that they face with respect to type of toilet and location of facility.

9.4 Access to Energy

In relation to energy, a DC minimum condition is that "the family should have safe and reliable energy for lighting and equipment."

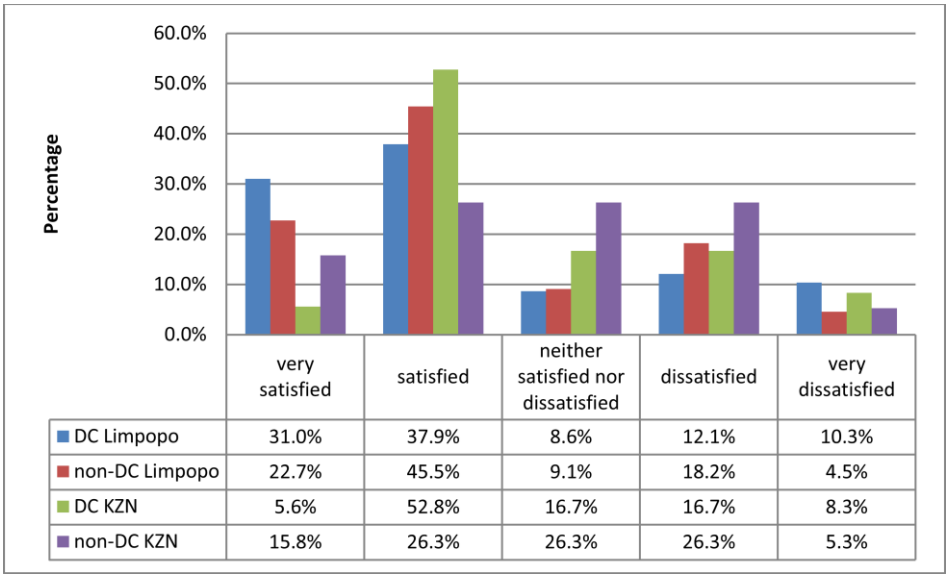


	electricity mains	generator	paraffin	wood
DC Limpopo	70.4%	1.9%	1.9%	25.9%
non-DC Limpopo	62.5%	4.2%	0.0%	33.3%
DC KZN	65.0%	7.5%	0.0%	27.5%
non-DC KZN	63.6%	4.5%	0.0%	31.8%

Figure 38 Main source of energy, N=140

Source: DC evaluation household survey (2014)

Figure 38 provides information on the access of households to electricity, using energy for lighting indicator as a proxy. The information presented in this table suggests that in the two pilot sites, DC households have marginally higher rates of access to electricity compared to non-DC households. More than 70% of DC households in Limpopo and 65% of households in KZN use electricity for lighting as compared to 62.5% and 63.3% of non-DC households in Limpopo and KZN respectively. This information correlates with the situation of access to formal dwellings (presented in Table 13), as greater access to formal housing would suggest greater access to electricity.



	very satisfied	satisfied	neither satisfied nor dissatisfied	dissatisfied	very dissatisfied
DC Limpopo	31.0%	37.9%	8.6%	12.1%	10.3%
non-DC Limpopo	22.7%	45.5%	9.1%	18.2%	4.5%
DC KZN	5.6%	52.8%	16.7%	16.7%	8.3%
non-DC KZN	15.8%	26.3%	26.3%	26.3%	5.3%

Figure 39 Satisfaction with energy services

Source: DC evaluation household survey (2014)

Household responses to satisfaction with energy services are depicted in Figure 39. The study found that a larger proportion of DC households from the Limpopo pilot site were very satisfied with their energy services (31.0%) when compared to just 5.6% of DC households from the KZN pilot site. these proportions were similar when comparisons were made between DC and non-DC households from both pilot sites. These results suggest that this minimum condition may have been met in KZN however more still needed to be done for the programme participants in Limpopo.

Another one of the DC minimum conditions stipulates that "*the family should have access to a public road for emergencies and access to markets*." Various questions were asked of the DC household respondents to gauge the state of their neighbourhood road infrastructure.

- Type of road is mainly gravel (71.7%) as compared to tarred (26.3%) or other (2.0%)
- Rate the condition of roads in the area:
  - very good – 11.1%
  - good – 21.2%
  - neither good nor bad – 15.2%
  - bad – 28.3%
  - very bad – 24.2%

Responses from DC program participants to the question asking if the condition of roads had changed over the past 3 years were a 'yes' for 23.5% of the respondents.

Overall, the results presented in this section show a mixture of achievements on the attainment of some conditions and for others, the results are not very definitive and cannot be pronounced with any degree of confidence. This is precisely what the analysis sought to verify in the section that follows.

10 IS THE DC MODEL FEASIBLE?

The analysis presented in the preceding section has indicated the relative differences in the attainment of various indicators set out as minimum conditions by the DC programme between households who received the DC programme intervention and those who did not (non-DC households). Overall, people who participated in the DC program show gains in living standards/outcome measures/minimum conditions, including more stable housing and, for some groups of participants, increased income.

To re-iterate, this analysis cannot strictly ascribe any differences between the two groups of program beneficiaries (DC households) to the DC programme's intervention. The rationale behind using a comparison group was to gain an external reference point that would, through an analysis of the pattern of responses, allow us to gauge whether the current status of DC households with respect to the DCs indicators are any different from a case of none intervention.

As the analysis has highlighted there are areas where the case of no intervention, the Non-DC comparison group, have outperformed DC beneficiaries. It is possible that gains from the DC program were concentrated in the first phase (i.e. family support phase) of the intervention and could have declined in the third year. If this is the case, it would mean that the gains are associated with programme contact, and suggests that these may not be sustainable over time and that some households do not develop adequate autonomy. Nonetheless, it is too early to tell and only after the program's impact is evaluated again after this initial phase will we be able to ascertain the DC's long-term impact for sure. However, the level/extent to which these differences are significant or not, becomes a crucial litmus test in assessing the impact of the intervention.

This has been found to be the case with other similar interventions to the DC program such as the Chile Soidario program (Larranaga, Contreras and Ruiz-Tagle, 2012). From their impact evaluation study of this program using qualitative studies, they found that a lack of information and disconnection from networks is produced after the first phase of the program.

10.1 Subjective assessment of impact of DC Programme

We employed a further technique in trying to assess impact and to investigate what the change made in the experimental group was that could be attributed to the DC programme intervention from base to final measurement in 2013.

The well-being implications made possible through the DC programme intervention can be appreciated in various ways. Table 42 depicts results for a question bearing on the DC programme household respondent's assessment of how his household compares now and compared previously to 3 years ago (at the time of the Soccer World Cup)[7]. Although these types of measures are highly subjective, the implications are striking: the majority 38.0% of respondents in Limpopo and 45.2% of respondents in KZN felt that their households were about the same while only about a fifth of respondents from both sites indicated that they were better off before the DC programme intervention. This is one indication of the impact of the DC programme, although somewhat weak. However, the results are corroborated by

[7] This is how the question was asked during the survey to assist respondents with recall by using the event of the soccer world cup tournament held in South Africa in 2010. This was to help assess the respondent's assessment of what life was like before the DC programme.

information collected from individual participants from the case study interviews, many of whom felt that they carried their burden on their own and very little was attributable to the programme's intervention.

Table 42 Respondents' self-assessment relative to 3 years ago

	Much-better	Somewhat better	About the same	Somewhat worse	Much worse off
'Compared with your situation 3 years ago (at the time of the Soccer World Cup, before the SAWID DC programme, and your situation now, would you say that your household is:'	20.7%	20.7%	41.3%	9.8%	7.6%

Source: DC evaluation household survey (2014), N=92

The results of another equally subjective measure of the DC programme impact are summarised in Table 43. Of those who answered the question, 45.7% indicated that they will recommend the programme. This suggests that although people felt that their lives were about the same now as they were before the programme intervention, they still saw value in participating in the programme.

Table 43 Respondents' self-assessment based on experience with the DC programme

	I would certainly recommend the programme	I might not recommend the programme	Am not sure	I will recommend the programme	I will most certainly recommend the programme
'Based on your experience with the DC programme, would you recommend this type of intervention for other households who are in the same situation as you were before being recruited onto the programme?'	16.3%	2.2%	21.7%	45.7%	14.1

Source: DC evaluation household survey (2014), N=92

The results of a more direct - though equally subjective - measure of the DC programme impact are summarised in Table 44. Of those who answered the question, the majority 34.4% thought that SAWs were extremely effective. As a big cog in the wheel of the DC programme, the SAWs' role was that of a go-between and to facilitate access to services between households and various service providers. These results therefore suggest that SAWs discharged their duties effectively and is a positive indictment of the SAWID poverty eradication model.

Table 44 Respondents' self-assessment based on experience with the DC programme

	SAWs are extremely effective	SAWs are effective	SAWs are somewhat effective	SAWs are ineffective	SAWs are extremely ineffective
'How would you rate the effectiveness of the DC SAWs in terms of executing their duties?'	34.4%	33.3%	20.4%	9.7%	2.2%

Source: DC evaluation household survey (2014), N=92

When disaggregated according to pilot site, these results did not differ much from the overall program results (results not shown).

In the end, survey participants from the DC households were asked to respond to the question "*In your own words, what is your understanding of how the SAWID DC programme helps a family in poverty?*"

The responses were many and varied, and these have been summarised into four categories as depicted in Figure 40.

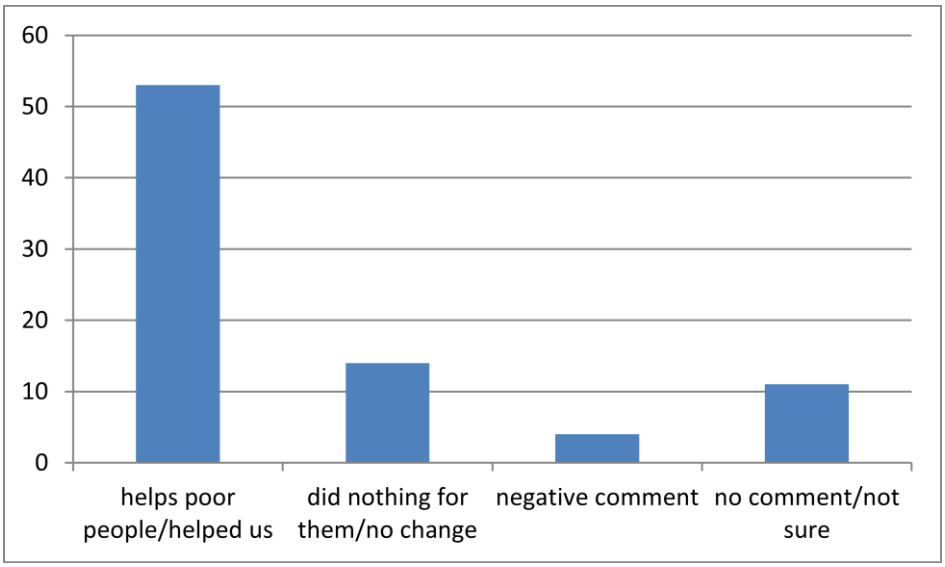


Figure 40 Participants' own understanding of the DC program

Source: DC evaluation household survey (2014), N=82

A selection of verbatim responses to the same question was also captured as follows:

"*It helps people to help themselves.*"

"*It does help families to stand up and do things for themselves.*"

"*They have helped me to know which right channels to follow when I encounter problems, for example in obtaining my son's ID.*"

"*To help us find ways to alleviate poverty.*"

"*…brings government services to the community.*"

"*They help people who are in poverty to do things to empower themselves and do most on their own.*"

"*They help to eliminate poverty. They give advice that if you are hungry you don't have to sleep without food.*"

"*SAWID DC has managed to decrease poverty in the houses that need help.*"

"*It (the DC programme) is really helpful because the SAW opened my mind to realise that there are departments that could assist poor people like me if I am interested to start a garden project.*"

The psycho-social aspect of the program can be garnered from these responses.

It is evident that generally, the programme participants had a good grasp of what the DC programme stood for, judging by the pattern of responses given.

Of the few respondents (n = 4) who gave a negative comment, generally the feeling with these was that they needed assistance getting access to a service, such as a child grant or and RDP house or free electricity, and they did not receive this from the SAW who was working their case, for one reason or another.

There were also those who thought that the programme was helpful, but that the SAWs could have done more to alleviate their plight, and so gave a mixed response (n = 14). For some included in this category, they admitted that they had received assistance for some of their needs but because not all of their needs were fulfilled, they gave the mixed response. Within this group were also those felt that even though the programme had helped them in some aspect, their lives had not changed for the better since joining the programme and hence their recorded response.

Overall however, the majority of the respondents gave a positive comment of how the programme had been very useful in their lives, with some even recommending that the programme be 'retained as a permanent feature'.

10.2 Findings from the qualitative survey

The feasibility assessment was designed to answer the following questions: were the needs for services in the DC pilot site communities matched with program systems of service delivery? Were there adequate human and other resources to bring the plan to fruition? Was the management system appropriate to the service system design?

Did the programme work according to plan?
Qualitative studies results show high valorisation[8] of Social Auxillary Workers among beneficiary families as 'bridges' to social programmes and in promoting self-esteem and faith in the beneficiaries' abilities, and these are necessary elements in an anti-poverty policy. This came out clearly in the analysis of case study results, focus group discussion results, as well as the key informant interviews with DC programme stakeholders. A selection of these is presented herein as verbatim testimonials of the programme's performance.

According to the SAWs interviewed, the DC goes a long way in addressing its strategic goal of helping to eradicate poverty in its multidimensional forms. As one of the SAWs put it "…*It is holistic, it touches all dimensions (of poverty) and involves the whole family….it provides a basket of services and it does not end at the household level but stretches to the community level as well*". Another SAW indicated that the DC meets its goals by addressing a number of elements and they listed them as personal identification;

[8] In psychology and social work practice, Social Role Valorisation is the name given to an analysis of human relationships and human services.

integrated housing; food security; health; early leaning, education and skills development; income and employment; and family dynamics.

Moreover, the majority of these SAWs were of the opinion that all the poverty dimensions that the DC set out to address were covered by their work; however there were those who thought that some aspects of the programme did not were not fully able to address the strategic goals. For example, they point out that under the integrated housing dimension, it was difficult to assist those that needed decent housing as members of the DC programme as this aspect most relied on government and the relevant municipalities. This nevertheless cannot be viewed as a failure in part of the programme as it had from the start specified that it would assist in this regard by connecting those with this specific requirement with the relevant government offices and these would then have to be assisted accordingly.

Available resources

Some SAWs indicated the lack of enough resources that impacted the effectiveness of the SAWs efforts. One indicated that "*the DC lacked many things such as office space, equipment such as computers and stationary to record the work of the SAWs. Transport for SAWs was lacking and it would be helpful in cases where the clients lived very far…*" Furthermore, Fetakgomo SAWs in a focus group discussion indicated that the programme's administration failed to meet their needs, and that they were sent to attend training in far off locations (in municipalities other than their own) but they had to use their own money to pay for accommodation as this was not provided. This was corroborated by the Mfolozi municipality SAWs who stated that they did not have the necessary transport means and therefore had to walk to the beneficiary families or use their own money for public transportation.

The Social workers like the SAWs point to the unavailability of sufficient resource and this quote from one SAW reflects this: "*resources were very limited and were a challenge, offices were available but were not adequate for 29 people and the telephone line was only available for the manage*r".

One social worker however showed that they and the SAWs had access to a wide range of resources that enabled them to implement the programme and these included the training that was provided as well as support from the municipalities, supports form traditional leaders. The social worker moreover indicated that support from these parties was further made valuable as "*they have mobile services and they invite our SAWs to take part in service delivery such as the taking of finger prints*".

Both the site managers, social workers and the SAWs indicated that the DC programme had a number of partners and therefore it received cooperation from these in their strategic goal of attempting to take people out of indigence. The following table lists these partners along with the assistance that they provided.

The social workers and the SAWs rated the assistance provided by the partners from very effective, moderately effective to effective, and the tallies basically show that the assistance was mostly regarded as being moderately effective followed by very effective. For example, although all the respondents indicated that the programme received assistance from the municipalities in the form of office space, a number of them said the office space was inadequate. Some of the other issues that were raised regarding some of the partnerships were the communication channel that were not very goods, delays in implementation, lack of cooperation, etc.

The SAWID national management indicated that they went into a number of partnerships to start and run the DC programme, for example:

> "*We tried with government with the War on Poverty but we were not empowered to write the MOU, however we managed to influence COGTA. We initiated the Women's Ministry to present a model to IDT and it worked. We also partnered with the private sector in the form of De Beers and Max Steel*."

The national management also indicated that they did partner with the IDT and received funding from this partnership although they thought that the funding was not sufficient. The IDT is shown to have been the DC's main partner and it assisted with programme design costs, systematic issues, physical space, etc. Other partnerships included those with municipalities (which provided office space); SETAs (for the accreditation of the SAWs); training colleges (for training); and NGOs and Food gardening partnerships (assisted with starting gardens in households). Private sector partnerships on financial literacy training was also reported for the KZN DC site.

Management and monitoring system

Through the analysis of the views of the SAWID national management it can safely be concluded that the DC programme did not have a proper Monitoring and Management system. It was indicated by one key informant from national management that "*the system was developed but never implemented*". The following points were also made by another similar key informant regarding the 'non-existence' of the M&E system:

- *There was no proper system in place*
- *Internal capacity for M&E was non-existent*
- *There was only one person responsible for the programme design / systems / training*
- *IDT was going to assist SAWID with their M&E but it never came through*
- *The DC is rooted in social issues that do not need measurement*

It can also be gathered that the only form of M&E that was conducted was the compilation of project reports and these were reviewed periodically to assess how the how the programme was working.

A management system that were built into the DC to ensure the smooth running of the programme was that of assigning the SAWs to social workers for both the management and monitoring of the SAWs work at an on-going basis. The social workers indicated that they met monthly as well as whenever there was need to do so; there were individual supervision sessions to check on the progress that was being made with the beneficiary families; the SAWs had to submit weekly, monthly and quarterly reports. The social workers also pointed out that they were responsible for the SAWs attendance register as well as the administering of their leave, hence they were responsible for ensuring that the SAWs reported for work when they were supposed to so. The SAWs themselves attested (during a focus group discussion) to this as they showed that they were being monitored by the social workers and that there were 10 SAWs reporting to one social worker. They also confirmed that they had to submit the weekly, monthly and quarterly reports to the social workers. In terms of the reporting system, one of the site managers however indicated that there was no given template or format for reporting; hence this could have negatively affected the consistency as well as the quality of the reporting process.

The social workers indicated that there were numerous of ways through which they monitored the SAWs and these are listed below:

- Through the above mentioned weekly, monthly and quarterly reports

- Through monthly progress meetings and when needed
- Individual supervision sessions to check on progress made with families
- Through the administering of the SAWs attendance register as well as their leave

The social workers also indicated that they had measures in place in order to review (on-going) performance of the SAWs and these are also listed below:

- Through group discussions and there was selection of topics that needed attention e.g. report writing during these
- BY checking of files on family reports as well as progress reports
- By paying visits to the beneficiary families being assisted by the SAWs

A DC site manager expressed dissatisfaction with the programme's M&E system. She stated that "*M&E for the programme was not done well as I believe you can't manage and at the same time supervise and then monitor and evaluate. I believe that there should have been people who should have monitored and evaluated our progress*."

Justification for the programme

The SAWID national management team seem to be mostly agreeing that the DC programme was run efficiently and that it was also run in a cost efficient manner. The following are some of their responses in terms of programme efficiency and effectiveness.

Effectiveness

"*All planned activities were achieved up to the point where we exited after phase 2"*

"The planned objectives and outcomes in the project document were achieved. The SETAs did the training and the programme was implemented. However, we did not achieve our intended outcomes because we had to exit after phase 2 due to lack of consistent funding."

Efficiency

"In my opinion, the resource and inputs of the DC programme were utilised in a cost-effective manner. There was very little wastage in terms of expenditure; we had a strict system of signing off. In Fetakgomo we obtained containers to use as offices and the claims for travel from SAWs were very small and this shows that there was no corruption bug. We also have audits by Delloitte to back this up."

"We are an NGO doing development work with very few resources; the programme funds were not mismanaged"

A programme's external stakeholder however expressed scepticism with regards to the efficiency of the programme (in the Fetakgomo municipality). The first issue raised by this stakeholder concerned the DC site manager. The view espoused was that the site manager did not have relevant experience in this type of development work as they had not been involved in any community work prior to their appointment. This stakeholder further argued that the site manager was not strict, being too lenient with them, which in turn affected the project negatively as this led to the SAWs not performing their duties optimally. The testimony used to corroborate this assertion was captured as follows:

"There was a case of a SAWID SAW who provided repeat information about a person who needed to obtain a pension grant when the person had obtained pension 6 months ago, which made us think that maybe the SAW might not have been doing their job properly and in fact we suspected that they might have been sitting at home."

A site manager indicated that they thought that the programme was somewhat effective as the programme dimensions were partly achieved. They confirmed that some dimensions were not completed and suggested that part of the reason for this was the lack of support and/or cooperation from other institutions as well as due to the "*the relationship between the SAWs and Social Development social workers was not good because the social workers felt threatened by the SAWs*."

The very same site manager however indicated that the DC had a significant impact on those who benefited from the programme; they believed that the success could be measured by:

"*Putting food on the table by establishing door sized garden, applying and receiving IDs and other relevant documents, as well as grants for beneficiaries. Some of our members are now working and some are at tertiary institutions with the help of the DC. Other members learned about the importance of budgeting. Much progress has been made with our beneficiaries and other community members."*

11 CONCLUSION

This report has provided an empirical evaluation of the SAWID Development Caravan (DC) programme piloted in two sites in Limpopo and KZN. The DC represents an innovative approach to poverty reduction by explicitly endorsing a multidimensional concept of poverty, aiming to ameliorate the conditions of families living in extreme poverty.

The data come from a household survey collected especially for the purpose of evaluating the DC programme, and from key informant interviews with internal and external programme stakeholders, focus group discussions with community level stakeholders and case study interviews with individual programme beneficiaries. The evaluation based on comparison of means estimator.

The study's main conclusions are as follows. First, SAWID's SAW model to facilitating access to services is a very potent way of ameliorating the conditions of families living in extreme poverty. Targeting indigent families is an important feature of the DC programme and has proven successful in reaching the poorest population. Employing this SAW model as development facilitator drives change for individuals, families and the community more broadly.

Second, one of the most interesting aspects of the DC programme is its ability to operate on both the supply and demand sides. Although the intervention takes place mainly on the demand side, through facilitating access to public services and programs and the implementation of psychosocial support, its success in improving household conditions has been favoured by the ability of the local municipalities to supply adequate services. The achievements reported in terms of physical infrastructure.

SAWID's multidimensional approach to poverty reduction considers the nature of poverty as being not only as a consequence of a lack of income (economic capital), but also as a result of low levels of social, human and environmental capital. Apart from positive but small impact on some of the outcomes, the results indicate that the DC programme had no significant impact on most of the social, human, economic and environmental capital development outcomes, which were about the same in the DC and non-DC households. It may be premature to realise the results of the DC program yet. The Chilean model used social workers in 3 – 5 years using 53 indicators over 7 dimensions. The SAWID model has only been implemented over 3 years. It is possible that the few gains observed are concentrated in the first phase, during which beneficiaries work with a social auxillary worker, and that these benefits may not be sustainable. To this effect, the study recommends that future research be conducted to see what effect the intervention has on the period of exposure.

For instance, DC households show absolute gains in most of the environmental outcomes, but these may be attributed to environmental conditions rather than the programme; this raises doubts about the premise that these families were initially marginalised from the economy.

The majority of the beneficiaries who received assistance with obtaining many of the benefits and services offered by SAWID failed to identify the program as having assisted them or supported them in obtaining these. Many identified a close family member or relation – a person rather than an institution such as an NGO or Government department official, etc. There are two possible explanations for this. First, it is possible that the respondents did not understand the question correctly. This would be true of the majority who answered 'mother' or 'father' or provided an answer other than an organisation. This would also be true if people think in terms of institutions as providers of documents (such as Home Affairs issuing IDs and birth certificate and DSD issuing child grants), as opposed to the assistance they

received from the development facilitators in linking them to the facilities and providing them with the requisite information for obtaining these benefits and services. Indeed, the SAWs facilitated access to these but the various stakeholders actually provided these to the beneficiaries.

On the other hand, it is also possible that people did not view the program as having assisted them in obtaining these benefits and services at all – either an indication of dissatisfaction or lack of support altogether.

The DC profiling methods do not provide information on the families' psycho-social competence, which is an important component of the DC program. Qualitative studies suggest that only a fraction of families developed skills that would allow them to access public services and benefits in an autonomous manner. Hence, the psychosocial aspect needs further mentoring.

12 RECOMMENDATIONS

The approach to measuring eligibility for the programme should be improved.

Recommendations:

1. Need to re-assess and enhance the tool used to identify poor households. Develop proper household socio-economic status profiling tools and select these uniformly.
2. Provide information on the families' psycho-social competence at baseline, which is an important component of the DC program. Current tool does not provide this.
3. Set proper metrics to track the indicators over time. Generate data to track the same households over time, at regular intervals to realise the real effects of the intervention. This could be done at three monthly intervals.
4. Set baseline before intervention in order to do a proper assessment of the impact later on. Set baselines for both treatment and control groups so can use more sophisticated and credible evaluation approached, such as the Difference-In-Difference (DID).

Do away with archaic systems of reporting. Information was not standardised, it was not stored centrally and it was not kept digitally. Definitions of some indicators were left to the interpretation of the site managers. For example, family dynamics was about conflict and domestic abuse to one while the interpretation for this was about members who did not belong to a burial society to another.

Recommendations:

1. The programme needs to develop appropriate M&E system that will be used to manage the performance of the program periodically and will standardise information from both sites. Preferably, have this information stored electronically. Also, the programme needs to have definitions for all indicators clearly defined so the same information is collected at any site for comparison.
2. The M and E system will include regular annual internal assessments as well as external evaluations, possibly coinciding with the end of Phase 2 of the DC. Some studies on similar programs such as the DC have recommended that, rather than limiting the program to a percentage of households living in extreme poverty during the base year, the target population should cover the larger group of households that take turns occupying the lower part of the socio-economic spectrum (Larranaga, *et. al*., 2011). Do this assessment to assess what gains would have been made then (which would either dis/prove the notion that gains tend to be concentrated in the first phase.

Provide effective management of the program at site level.

Recommendations:

1. National management needs to closely supervise and provide direction to site management. Site management likewise needs to do the same when it comes to the SAWs under their supervision. This will be assisted by development of clear strategic and operational plans for the DC nationally as well as for each site. This would then inform the development of performance monitoring contracts for Site Managers, social workers and SAWs which must be reviewed at regular intervals.
2. Provide the necessary resources to aid the SAWs in discharging their duties effectively. Their case loads are manageable however the distances to be covered, often on foot, when no

transport is available, in the blazing hot sun, often raining, makes this work difficult. Support in terms of reimbursement for travel costs would be one way to address this.

References

Adato, M. Carter, MR. and May, J (2006). Exploring poverty traps and social exclusion in South Africa using qualitative and quantitative data. **Journal of Development Studies**. Vol 42(2): 226 – 247.

Adonis, L et al (undated) Provincial screening rates for chronic diseases of lifestyle, cancers and HIV in a health-insured population.

Aliber, M. Karun, G. and Aihoon, K (2007). **Evaluation of Poverty Reduction Projects Funded by the Department of Science and Technology**: Revised Draft, study commissioned by the Department of Science and Technology. Pretoria: Human Sciences Research Council.

Baiphethi, M., & Jacobs, P. (2009). The Contribution of Subsistence Farming to Food Security in South Africa. *Agrekon , 48* (4), 459-482.

Bhorat, H. and Leibbrandt, M. (2001) 'Correlates of vulnerability in the South African labour market'. *In:* Bhorat, H., Leibbrandt M, Maziya, M., van der Berg, S., Woolard, I. *Fighting poverty. Labour markets and inequality in South Africa*. Cape Town: UCT Press.

Biersteker L (2008a) *Meeting the comprehensive social security needs of young children (0–9) in South Africa –what is needed to achieve access to a comprehensive and integrated social protection system?* Cape Town: Alliance for Children's Entitlement to Social Security.

Caldes, N., Coady, D. and Maluccio, J. A. 2006. The cost of poverty alleviation transfer programs: a comparative analysis of three programs in Latin America. World Development, Vol. 34, No. 5, pp. 818 – 837, 2006.

Castaneda, T., Lindert, K., de la Briere, B., Fernandez, L., Hubert, C., Larranaga, O., Orozco, M. and Viquez, R. (2005). Designing and implementing household targeting systems: lessons from Latin America and the United States. Social Protection Unit, Human Development Network, The World Bank, Washington DC.

Carneiro, P., Galasso, E. and Ginja, R. (2010). The impact of providing psycho-social support to indigent families and increasing their access to social services: evaluating Chile Solidario.

Department of Basic Education (2010) Report on the 2009/2010 Annual Survey for Ordinary Schools.

Department of Health (2013). Tenth Interim Report on Confidential Enquiries into Maternal Deaths in South Africa - 2011 and 2012.

Dias, R and Posel, D. (2007) Unemployment, Education and Skills Constraints in Post-Apartheid South Africa.

Galasso, E. (2011). Alleviating extreme poverty in Chile: the short term effects of Chile Solidario. Estudios de Economia. Vol. 38, No. 1, June 2011, pages 101 127.

Galasso, E (2011). Alleviating extreme poverty in Chile: the short term effects of Chile Solidario. **Estudios de Economia**. Vol. 38(1): 101 - 127.

Galasso, 2006. “With their effort and one opportunity”: Alleviating extreme poverty in Chile. World Bank, Washington DC.

Gustaffson M (2010) *Policy note on pre-primary schooling: An empirical contribution to the 2009 Medium Term Strategic Framework*. Stellenbosch Economic Working Paper No. 05/10. Bureau for Economic Research, Department of Economics, University of Stellenbosch.

Harber, C. & Mncube, V.S (2010). Is schooling good for development? The case of South Africa, submitted to the *South African Journal of Education. (National).*

Hoffman M et al., Limited Pap screening associated with reduced risk of cervical cancer in South Africa, *International Journal of Epidemiology,* 2003, 32(4):573-577.

Leibrandt, M., *et al*, ‘Trend in South African Income Distribution and Poverty since the Fall of Apartheid’, **OECD Social, Employment and Migration Working Paper***,* No. 101, OECD Publishing.

Leibbrandt, M., Woolard, I., Finn, A., & Argent, J. (2010). *Trends in South African Income Distribution and Poverty since the Fall of Apartheid*. Paris: OECD Publishing. Retrieved from http://dx.doi.org/10.1787/5kmms0t7p1ms-en.

McCord, A. (2004). Public works and overcoming under-development in South Africa. Conference on overcoming under-development in South Africa’s second economy, 28 & 29 October 2004, jointly hosted by UNDP, HSRC & DBSA.

National Science Foundation, 2010. The 2010 User-Friendly Handbook for Project Evaluation. Arlington,VA.

Newcomer, K. E., Hatry, H. P., Joseph, W.S. 2010. Handbook of Practical Program Evaluation. 3rd Edition, Jossey-Ross, John Wiley & Sons, Inc. San Francisco, CA.

Perova, E. and Vakis, R. 2009. Welfare impacts of the “Juntos” Program in Peru: Evidence from a non-experimental evaluation. The World Bank, Washington DC.

Ravallion, Martin. 2003. “Assessing the Poverty Impact of an Assigned Program.” In Francois Bourguignon and Luiz A. Pereira da Silva (eds.) The Impact of Economic Policies on Poverty and Income Distribution: Evaluation Techniques and Tools, Volume 1. New York: Oxford University Press

Rossi, P. H. and Freeman, H. E. (1993). Evaluation: A systematic approach (5th ed.). Newbury Park: Sage Richter L, Biersteker L, Burns J, Desmond C, Feza et al. (2012) *Diagnostic review of early childhood development*. Report for the Department of Performance Monitoring and Evaluation in the Presidency and the Inter-Departmental Steering Committee on Early Childhood Development.

Publications, RSA (2009) National Growth Path.

SANHANES utilized the WHO Disability Assessment Scale (DAS) to measure self-reported disability.

SAWID, 2013. Programme documents. Pretoria.

Sen, A (2000). **Social exclusion: concept, application and scrutiny**. Social Development Papers No. 1. Asian Development Bank.

Stats SA (Statistics South Africa) (2009) *General Household Survey 2009. Statistical release P0318.* Accessed June 2013, http://www.statssa.gov.za/publications/P0318/P0318June2009.pdf

Stats SA (2005), Prevalence of disability in South Africa Census 2001 / Statistics South Africa. Pretoria: Statistics South Africa, 2005.

Stats SA (2013) Quarterly Labour Force Survey, Quarter 3, 2013.

StatsSA. (2014). *Poverty Trends in South Africa: An examination of absolute poverty between 2006 and 2011*. Pretoria: Government of South Africa. Retrieved from http://beta2.statssa.gov.za/publications/Report-03-10-06/Report-03-10-06March2014.pdf

Tregenna, F and Tsela, M (2008). **Inequality, unemployment and poverty in South Africa**. Trade and Industrial Policy Strategies. Pretoria.

van der Berg, S and Burger, R (2003) Education and Socio-Economic differentials; A study of school performance in the Western Cape'. Development Policy Research Unit Working Paper, no. 73.

World Bank (2014). WWW document. URL http://data.worldbank.org/indicator/SI.POV.GINI (Accessed 14 April 2014).