Health and Welfare Sector
Education and Training Authority
HWSETA

SUMMATIVE EVALUATION OF THE ANCILLARY HEALTH CARE QUALIFICATION AND ITS ASSOCIATED SKILLS PROGRAMMES

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Summative evaluation of the ancillary health care qualification and its associated skills programmes

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The views expressed in this report are that of the Author and not that of the HWSETA.

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Executive Summary

The aim of the study was to evaluate the possible impact and outcome the Ancillary Health Care (AHC) qualification and its related skills programmes may have had on previous learners and the community. This course was designed to provide learners with the necessary skills and knowledge to help the community cope more efficiently with their health and wellness. Three provinces, namely: Kwa-Zulu Natal, Mpumalanga, and the Free State where identified as the provinces with the highest HIV and AIDS prevalence and other related diseases and, therefore, all learner surveys and in-depth interviews were conducted in these areas. The researchers further identified employers who provided training in the AHC course and conducted in-depth interviews with them in Gauteng and Kwa-Zulu Natal.

Overall, the learners found the course content to be useful and relevant to the job. They were able to apply skills learnt when performing their daily jobs. The majority indicated the love of working with people and intentions to pursue careers in nursing as reasons for taking the course. Many learners were still unemployed upon completion of the course and expressed disappointment at the delayed receipt of certificates. The delay in the delivery of certificates also meant individuals were unable to search for employment or enrol for courses to further their studies as they required proof that they had completed the AHC course.

Many providers and colleges advertised the course as a pathway into nursing. Many learners did not pursue this career while others were unable to do so as the course they had completed was not sufficient to meet the necessary requirements for acceptance into nursing.

Providers expressed the importance and value that carers add to communities. The knowledge that was imparted to the communities was without a doubt empowering. Providers also considered the level of education when employing carers. Most were considered for employment if they had completed the Ancillary Health Care Qualification. However, the issue of funding remains paramount. With more funding, organisations are able to employ more carers as there is huge demand for this type of assistance for the sick in communities. Also, with no funding, many volunteers eventually leave out of frustration.

This report seeks to shed light on the impact and outcome of the Ancillary Health Care qualification and to assess whether the AHC course is still relevant particularly when one considers that the needs of the communities may have changed over the years.

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1 Introduction

1.1 Background

Due to the burden of disease that is further exacerbated by a shortage of health care workers and a lack of accessibility to primary health care services, a need was identified to help communities manage their health and wellness more efficiently. This need led to the introduction of community workers and/or carers to assist the sick in the community who are unable to access healthcare for various reasons[1].

The Ancillary Health Care (AHC) qualification and its associated skills programmes were established with the aim of improving the basic health status of communities. The primary goal of the qualification is for learners to be able to assist communities manage their own health and wellness more efficiently. Furthermore, learners who complete the qualification will provide support services within a team of health care professionals and with the qualification, will be able to further their studies towards becoming professional health care workers.[2]

Several qualifications fall under the Home Based Care or Community Care Work occupation such as the Ancillary Health Care (NQF Level 1) and Community Health Work (NQF 2, 3 and 4) qualifications that are accredited by the Health and Welfare SETA[3]. Other qualifications are also available such as the 59-day and 69-day Training programmes offered and developed by the Hospice Association of South Africa and approved by the Department of Health[4]. The ARWYP Medical Centre offers a six-month Care Worker course, while NETCARE offers a Pupil Auxiliary 12-month Course that is registered with SANC. Although all these courses are different, NACOSA is actively involved in the establishment of a curriculum for Home Based Carers. This is a positive step towards the recognition and sustainability of the occupation especially for the AHC workers who are accredited by HWSETA.

The HWSETA, as a quality assurance body, was also a funder to learners enrolled in the AHC qualification. The Research and Information, Monitoring and Evaluation (RIME) division conducted a formative evaluation in 2008 which found that most learners were unemployed upon completion of the course. As a result, funding from the HWSETA ceased. Despite this, the registration of learners and providers increased over the years and more

[1]Uys, L.R. (2002). The practice of community caregivers in a home based HIV/AIDS project in South Africa. Journal of Clinical Nursing (11)99-108
[2] South African Qualifications Authority. (2015). Registered qualification: General Education and Training Certificate: Ancillary Health Care.
[3]National Certificate: Community Health Work (NQF Level 2); National Certificate: Community Health Work (NQF Level 3); FETC: Community Health Work (NQF Level 4)
[4]Fox, S. (2002). Integrated Community Based Home Care (ICHC) in South Africa: a review of the model implemented by the Hospice Association of South Africa. The Centre of AIDS Development, Research and Evaluation (CARDE) on behalf of the Policy Project. Pretoria: National Development of Health

employment opportunities were available especially in Kwa-Zulu Natal province and particularly within the private sector.[5]

In light of this, the HWSETA conducted a rapid assessment study to measure the impact of the Ancillary Health Care qualification and its associated skills programmes on learners.

1.2 Purpose of evaluation

The aim of the study was to evaluate the effectiveness, relevance, impact, sustainability, and efficiency of the Ancillary Health Care qualification and its associated skills programmes.

The study addressed the following objectives:

- Evaluate the **effectiveness** of the AHC qualification and its associated skills programmes towards achieving its objectives.
- Assess the **relevance** of the AHC qualification to the current needs of the communities.
- Evaluate the **impact** of the AHC qualification and its associated skills programmes on the delivery of health care by employers (e.g. NGO's, government departments, hospitals) working with communities.
- Measure the **sustainability** of the programme after the HWSETA had stopped funding.
- Evaluate the **efficiency** of the programme.

1.3 Scope of the intervention

- To measure the outcome of learners who trained in AHC and its associated skills programmes to find employment in communities;
- To assess any impact the course may have on learners' lives after the completion of the AHC course and its associated skills programmes;
- To measure the impact of an increase in the number of people within communities who are able to take better care of their health and wellness.

1.4 Structure of report

The report will begin with a description of the methodology that will include the data collection, sampling, and data analysis used. This will be followed by the analysis of results which will present the quantitative and qualitative data individually, and the report will end with recommendations and a conclusion.

2 Methodology

For purposes of this study the research team used both quantitative and qualitative methods of data collection.

[5] Health and Welfare Sector Education and Training Authority. (2015). Terms of Reference: Evaluation of the Ancillary Health Care qualification and its associated skills programmes.

2.1 Data collection

The target population for the study was learners, employers, and providers. A learner refers to any individual who enrolled in and completed the Ancillary Health Care qualification in 2012. To meet study objectives, the researcher selected learners who completed in 2012 as this would have provided ample time post qualification completion to measure outcome and impact. This talks to the evaluability of the programme.

A provider refers to any organisation that employs learners as carers after completion of the AHC qualification. "Provider" refers to those people who trained learners in AHC in 2012. The researcher included providers who are employers or providers who offer some assistance to learners in order to find employment.

2.2 Sampling

The nature of the study was a snapshot survey and as a result this limited the time that was available to collect data. Thus the research team opted to select sample through stratification of provinces with the highest prevalence of HIV and AIDS and other diseases. Based on a national study on HIV prevalence, incidence, and behaviour conducted by Shisana et al (2014), found that Kwa-Zulu Natal, Mpumalanga, and the Free State were provinces with the highest prevalence of HIV and AIDS and related diseases.[6] The research team therefore selected these provinces as these regions would have a higher demand for healthcare and this in turn would equal a higher number of carers in operation.

For the learners, the total target population was 1383. This is the combined number of learners who completed the AHC course in 2012 in the above-mentioned provinces. The researchers' aim was to complete 30 surveys and six in-depth interviews as indicated in Table 1 below.

For providers, the aim was to conduct interviews within the same provinces where the previous learners had studied. The research team used the HWSETA database to search for providers that had enrolled learners in 2012 and were also employers of the learners. The database provided only providers who are located in Gauteng and Kwa-Zulu Natal provinces and thus the research team planned to conduct six interviews within these two provinces.

Province	Surveys	In-depth Interviews
Free-State	11	2
Kwa-Zulu Natal	12	2
Mpumalanga	7	2

Table 1: Total number of learner interviews per province.

2.3 Data analysis

2.3.1 Surveys

After completion of the telephonic interviews, surveys were allocated unique identification numbers which were then captured. Once capturing was complete, the data was analysed using SPSS to provide simple descriptives.

[6]Shisana, O, Rehle, T, Simbayi LC, Zuma, K, Jooste, S, Zungu N, Labadarios, D,Onoya, D. (2014) South African National HIV Prevalence, Incidence and Behaviour Survey. Cape Town, HSRC Press.

2.3.2 In-depth interviews

All in-depth interviews were recorded with the respondents' permission and all recorded interviews were transcribed. The data was analysed to categorise information provided into themes that emerged during the interviews.

2.3.3 Limitations of the study

The turnaround time for project completion influenced the amount of time the research team was able to spend conducting fieldwork and collecting data. That is not to say that the objectives of the study were not met. Listed below are some of the challenges that were encountered by the research team:

- The quality of the sample list posed a few problems:
  - A certain amount of time had elapsed between completion of the course and when the study was conducted and learner contact details had changed;
  - Learners gave provider/school contact details;
  - In some cases, details of a relative who would be at work during the day were provided;
  - Some numbers continuously rang;
- Appointments made with participants were not always honoured (referring to both surveys and in-depth interviews).
- In some cases individuals refused to participate.
- The use of provider contact details and changing of numbers was the biggest hurdle with regard to contacting previous learners. Upon further investigation the research discovered that providers themselves are intentionally providing the HWSETA with their own contact details so as to prevent the HWSETA from contacting an individual directly. This would also prevent a learner from receiving a certificate if they have they have any fees outstanding.

3 Analysis of findings

In this section, the researcher began by conducting an analysis on the quantitative study followed by the qualitative. For the quantitative section, the researcher will begin with an overview of the demographics of the sample, followed by an analysis of simple descriptives. The qualitative section will provide a more in-depth view into the impact and outcome of the AHC qualification and its associated skills programmes.

As illustrated in Tables 2 and 3 below, the number of completed learner surveys was 31, with eight interviews conducted in the Free State, 11 in Kwa-Zulu Natal, and 12 in Mpumalanga. For the in-depth interviews, the research team managed to conduct four in-depth interviews with learners and three with providers.

Province	**Survey**		**In-depth Interview**	
	Initial	Actual	Initial	Actual
Free-State	11	8	2	1

Kwa-Zulu Natal	12	11	2	1
Mpumalanga	7	12	2	2
Total	**31**		**4**	

Table 2: Total number of learner interviews conducted per province

Province	**In-depth Interview**	
	Initial	Actual
Gauteng	2	2
Kwa-Zulu Natal	2	1
Total	**3**	

Table 3: Total number of interviews conducted with providers

3.1 Quantitative analysis

3.1.1 Demographics

The majority (48.4%) of respondents was between the ages of 25-34, followed by age 18-24 at 32.3%, and last 35-54 with 19.4%. In comparison to the formative study results, we can see that the majority of learners was between the ages 18-35. In both the summative study and the formative study, the majority of learners was under the age of 35 at 80.7% and 90% respectively. These high numbers can be attributed to the principles of the NSDS which states that preference should be given to the youth.

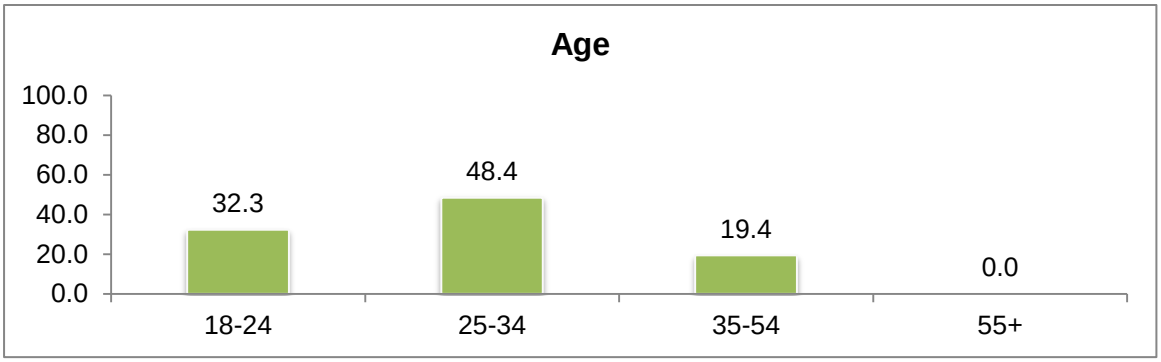

Figure 1: Age breakdown of respondents from the Summative study

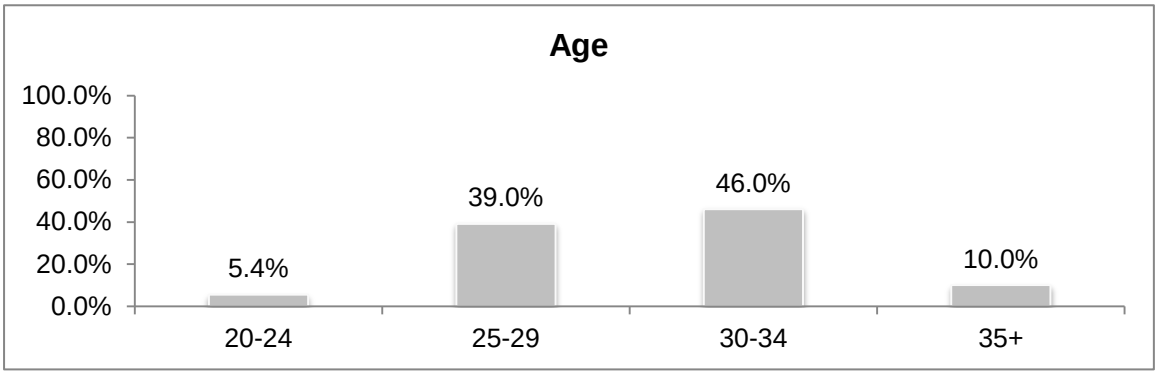

Figure 2: Age breakdown or respondents from the Formative study in 2008

Below is a breakdown of respondents per province. Mpumalanga had the most participants (38.7%) in the study, closely followed by Kwa-Zulu Natal at 35.5%, and Free State with the lowest at 25.8%.

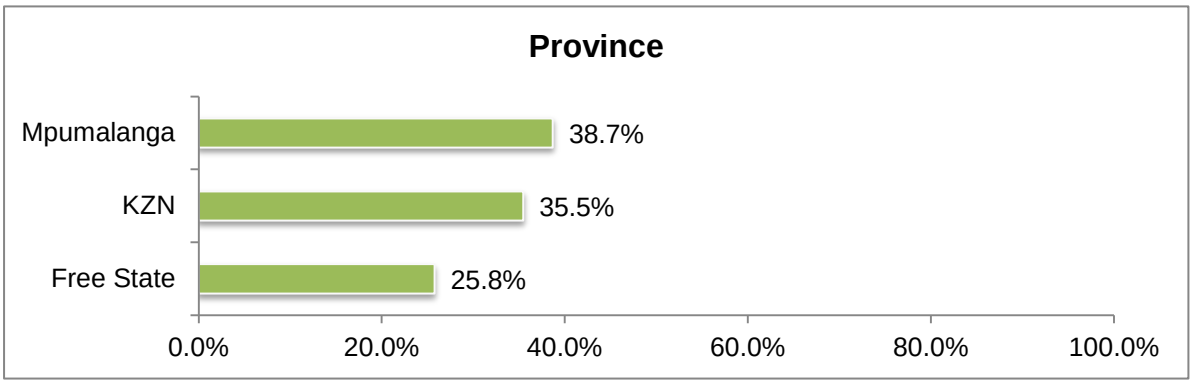

Figure 3: Province

Mostly females participated in the study or took part in the course. This comes as no surprise as carers tend to be mostly females. This form of work, generally, always has been done by females.

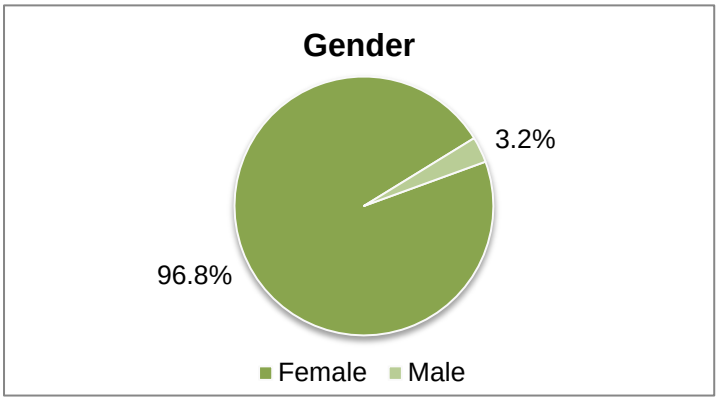

Figure 4: Gender of respondents

The majority of learners had completed Grade 12 (74.2%), followed by 13% who had completed Grade 11 (Figure 5). We see a similar trend in the number of matriculates in the formative study at 74% (Figure 6). What is interesting to note is that the AHC course is pitched at an NQF level 1 that is lower than matric; however, what can be assumed is that

learners opted for the AHC course as a form of entry into the job market. Later in the report we look at some of the reasons why the course was selected by learners.

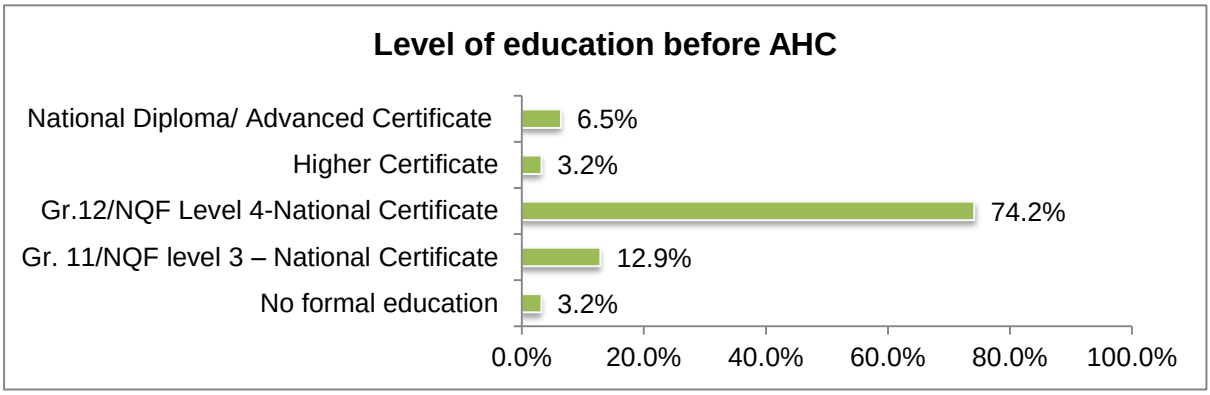

Figure 5: Level of education before AHC in Summative study

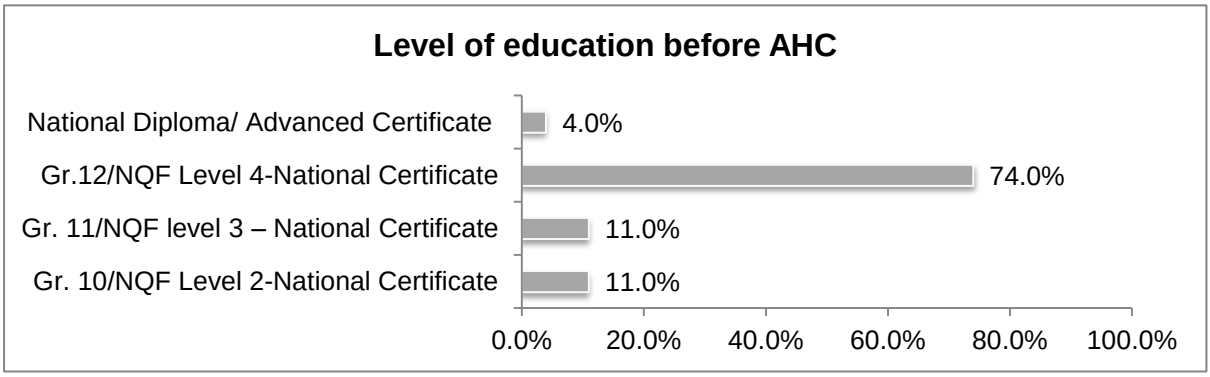

Figure 6: Level of education before AHC in Formative study in 2008

Participants level of Education before AHC Qualification				
	Province			
	Free State	**KZN**	**Mpumalanga**	**Total**
Gr. 11/N2 – National Certificate	1	1	2	4
Gr. 12/N3- National Certificate	4	10	9	23
Higher Certificate	0	0	1	1
National Diploma/ Advanced Certificate	2	0	0	2
No formal education	1	0	0	1
Total	**8**	**11**	**12**	**31**

Table 4: *Participants level of Education before AHC Qualification by province*

3.1.2 Training

After completion of the AHC course, many participants had only the AHC qualification as their current highest level of education. When asked the exact name of the qualification completed, there were many different responses. Table 5 below shows the names of the

different courses that learners had undertaken. While some participants stated that they had enrolled for Ancillary Health care, it was later changed to Community Health Work. No reasons for this change were provided by their respective schools. This prompted the researcher to look at the HWSETA database to see what accredited qualifications are available that are related to home-based care, care giver, or community care giver.

Course Name	Percentage
Ancillary community health work	6.5%
Ancillary Health Care	38.7%
Community Health Care Work	45.2%
Community health care in HIV/AIDS and home based care	3.2%
Home-based care...ancillary or something	3.2%
Pre- Nursing	3.2%

Table 5: Name of the course enrolled in by learners in 2012

Table 6 below shows some of the courses that are available and lead to the Home Based Care / Carer occupation which are accredited by HWSETA. These courses often precede one another from one level to the next and would build on each other to equip learners with the necessary skills to perform on the job. In some cases, the courses are used as a pathway into other careers such as nursing while other learners hope to build on their skills.

Qualification Title	NQF Level
Further Education and Training Certificate: Social Auxiliary Work	4
Further Education and Training Certificate: Counselling	4
General Education and Training Certificate: Ancillary Health Care	1
General Education and Training Certificate: Adult Basic Education and Training: Ancillary Health Care	1
Further Education and Training Certificate: Child and Youth Care Worker	4
Further Education and Training Certificate: Community Health Work	4
National Certificate: Community Health Work	2
National Certificate: Community Health Work	3
National Certificate: Community Health	5
Further Education and Training Certificate: Public Awareness Promotion of Dread Disease and HIV/AIDS	4
Further Education and Training Certificate: Community Development: HIV/AIDS	4
Further Education and Training Certificate: Community Development: Victim Empowerment	4
National Certificate: Victim Employment and Support	2
National Certificate: Community Development: Victim Empowerment	5
Further Education and Training Certificate: Institutional-Based Care	4

Table 6: List of courses provided by the HWSETA

When asked how the AHC course was funded, most learners said it was funded by their parents (32.3%), paid for by themselves (22.6%), by a partner (16.1%), bursary (12.9%) or any other individual such as a brother, grandmother, or brother (16.1).

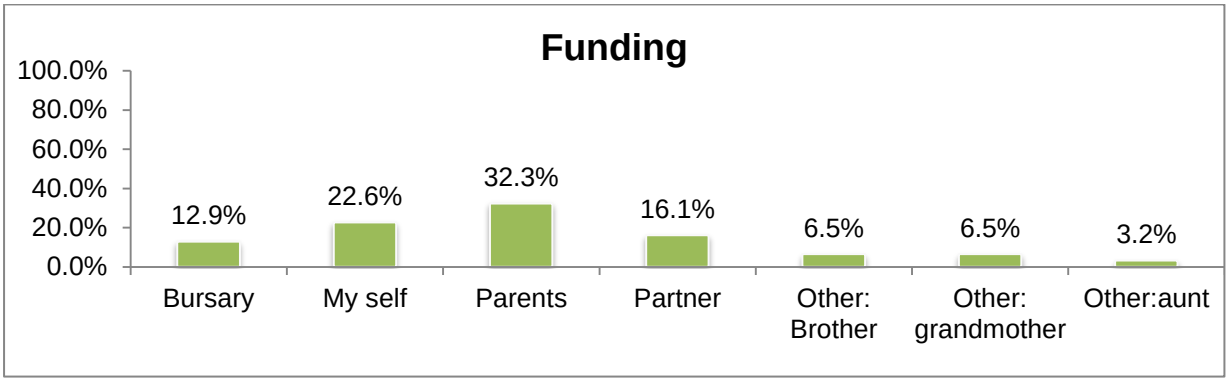

Figure 7: How the course was funded

A passion for helping the community was the major theme that was mentioned by the majority of individuals as a reason for selecting the course. For instance, learners stated that they had a passion for working with the community or they wanted to help people within their community. This is also linked to individuals wanting to pursue a career in nursing which is another theme that emerged. Most individuals stated that this was part of a career

pathway into nursing or, due to not having good enough matric results or no matric at all, the course was an alternative to aid them to reach the goal of becoming nurses.
Only a few gave other reasons for selecting the course such as lack of access to schools, a quick way to earn money, or not being able to achieve the career they wanted.

Theme	Sub theme	Frequency
Aspirations of being a nurse	Did not have a matric/matric marks were not the best	4
	Pathway to becoming a nurse	6
	Wanted to be a nurse	9
	Total	**19**
Passion for helping the community	Personal characteristics of the learner	4
	Passion for caring for people in the community	15
	They liked the course	2
	Total	**21**
Other reasons	Did not get into the career they wanted	1
	Cost of the course	1
	Access to schools	1
	Earn money	1
	Total	**4**

Table 7: Reasons for choosing course

Only a small number of respondents (25.8%) indicated that they had completed other courses (Figure 6) after completing the AHC course. It should be noted that these were courses at a similar level as the AHC qualification. Even though some individuals selected courses that were related to health, others chose to pursue different career pathways as shown in Table 7 below. This was surprising when taking into consideration those who stated that they had wanted to pursue careers in nursing. A few possible reasons for choosing these courses may be that they were offered for free, recommended by an employer, or even paid for by a funder.

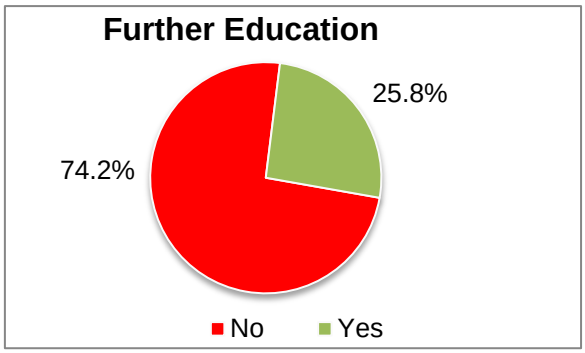

Figure 8: Completed any courses after AHC.

Business management	Dress making
Home-based care	Computer Course
Computer Sciences	Basic Fire-fighting
First Aid level 3	Environmental Safety
HIV/AIDS counselling	ARV Adherence
HR Course	Professional Assistance
N1- Motor Trade Mechanical Engineering	Motor Certificates
Short courses	TB Course

Table 8: Courses completed after AHC

3.1.3 Employment

In this section, the research team looked at the employment of learners and the type of employment in which they are involved.

Based on the graph below, only a small number of participants was working before taking the AHC course. This fits in well when taking into consideration that the majority of respondents had matric as the level of education before taking the course.

After the completion of the AHC course, only 32.2% learners were employed. It should be noted that only a third of the sample was employed and therefore results should be viewed with caution due to the small sample size. This was only a slight increase of 5.56% from 26.7% before enrolling for the AHC course. Once an intervention has occurred, a change should follow: more former learners should be employed. This certainly does question the intended objectives the AHC course should have on a learner post qualification.

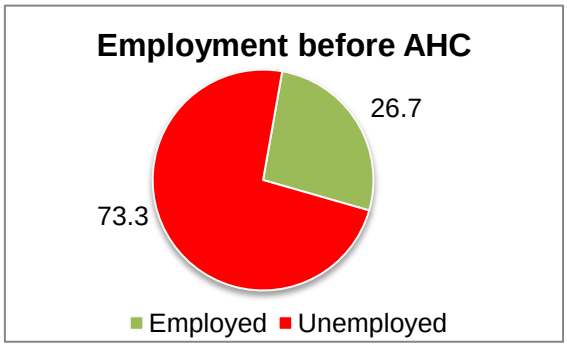

Figure 9: Employment status before the AHC course in the Summative study

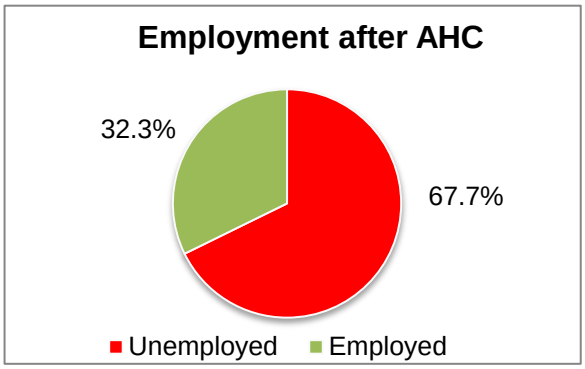

Figure 10: Employment status after AHC courses in the Summative study

When we compare the employment status of learners post the qualification (Figure 11) with the Formative study, the unemployment rate is lower at 21.6%; however, there was a higher rate of volunteers (73%) and only 5.4% of learners had part-time employment. The number of volunteers is alarming although more people were able to gain experience; this shows that even in 2008 the issue of stable employment was an issue as it is now.

Figure 11: Employment status after AHC in the Formative study 2008

Of those employed, a few were volunteers and did not regard this as being a "proper job". Furthermore of those employed, almost all were employed as some sort of care giver or care worker. Only two participants were employed in different positions: one was a cleaner and the other a helper.

Of those who were still employed after completing the AHC course, the majority was employed in the welfare sector (80%), and 10% was employed in the health sector. Only 10% was employed in different sectors. As shown in Table 9, most were employed as care givers though their conditions vary as to whether they are volunteers or working part-time or full-time.

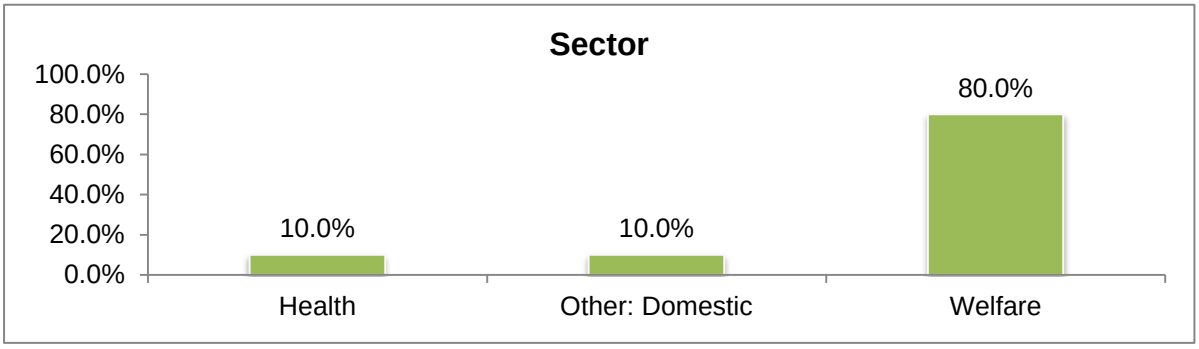

Figure 12: Sector currently employed

Position	N
Care-giver (including volunteer, full-time and part-time)	5
Mentor	1
Helper	1
Counsellor	1
Cleaner	1
Total	**9**

Table 9: Current positions

Only 70% of those employed considered that their employment was attributed to taking the AHC course. This may be because others are employed in different sectors or they may already have been working in the same organisation before they underwent training.

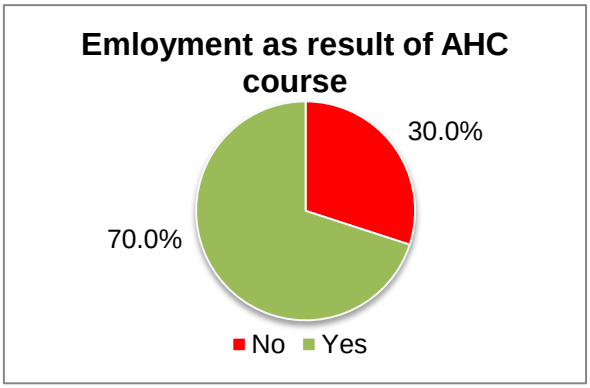

Figure 13: Employment as a result of AHC course

Those employed agreed that the course, skills learnt, and knowledge acquired were relevant to their current jobs.

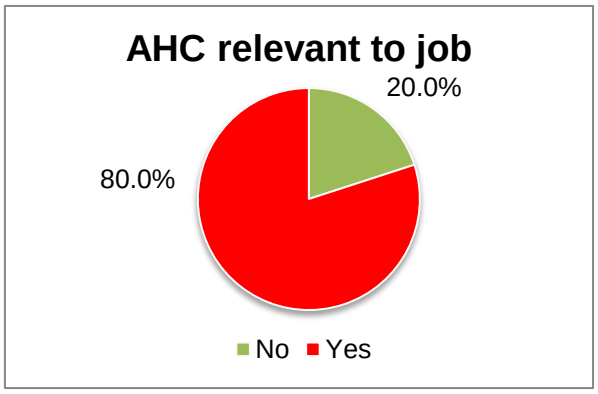

Figure 14: Relevance of qualification to the job

The biggest role for carers is to provide patient care (Table 9).This is one of the main purposes for providing home-based care, which means to provide care at home when an individual is not able to visit a clinic or requires assistance in personal care once discharged from hospital. The main theme involves checking patients' vital signs, feeding, and bathing them. Educating the community and families on how to take better care of the sick is an important role that carers play.

Theme	Sub theme	Frequency
Home Based Care		
Caring for patients	Checking for vital signs	2
	Feeding and bathing patients	5
	Cleaning houses of the patients	1
	Educating community members about their illnesses and managing them	2
	Total	**10**
Office administration	Booking appointments	1
	Entering calls	1
	Total	**2**
Other sectors		
Domestic sector	Cleaning	1
	Total	**1**

Table 10: Roles and responsibilities of current job

Though most respondents (66.7%) indicated that they receive a salary (Figure 12), they were only receiving a salary of between R1000- R1999 per month as shown in Table 10 which could still be considered as a low amount.

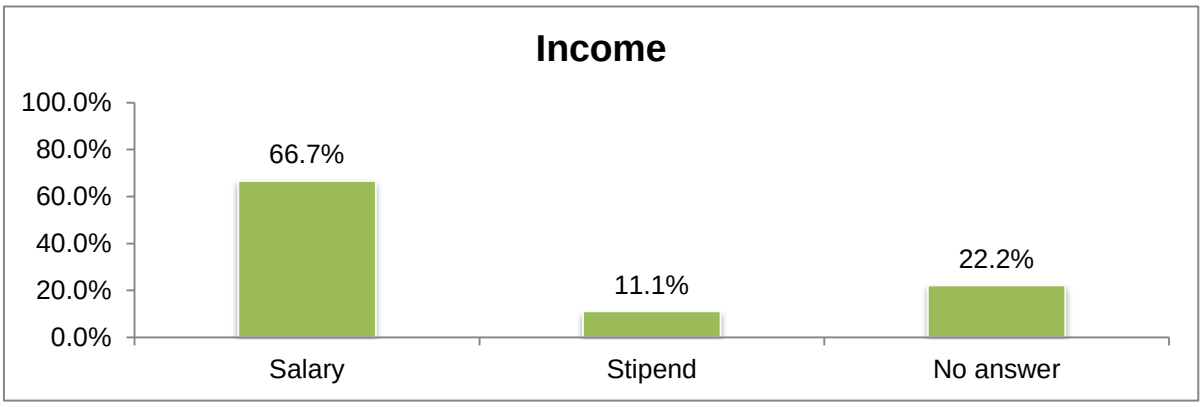

Figure 15: Percentage of those receiving a salary or stipend

Stipend or salary range	N
R0-R999	1
R1000-R1999	4
R2000-R4999	2
No answer	2
Total	**9**

Table 11: Income brackets of those employed

Many respondents advised that they were currently looking for employment and that was the main reason why they were still unemployed. Although they were looking for jobs, many advised that they are unable to find any and this may be attributed to no opportunities being available, they may still be awaiting feedback, or the delay in the delivery of certificates may be a hindrance to finding employment. Some individuals were forced to seek employment as companies had closed down, or they had left their jobs due to disputes with employers. Only one respondent advised being unable to seek employment due to recovering from injuries and being unable to perform tasks physically for an extended time.

Theme	Sub theme	Frequency
Looking for employment	Have not found one yet	13
	Waiting for responses	1
	Don't know	1
	Volunteering at the moment	1
	Total	**16**
Don't have a certificate	Delay in receiving certificates	4
	Total	**4**
Employer related	Organisation closes down	1
	Dispute with the employer	1
	Total	**2**
Health related reasons	Recovering from injuries	1

	Total	**1**

Table 12: Reason for unemployment

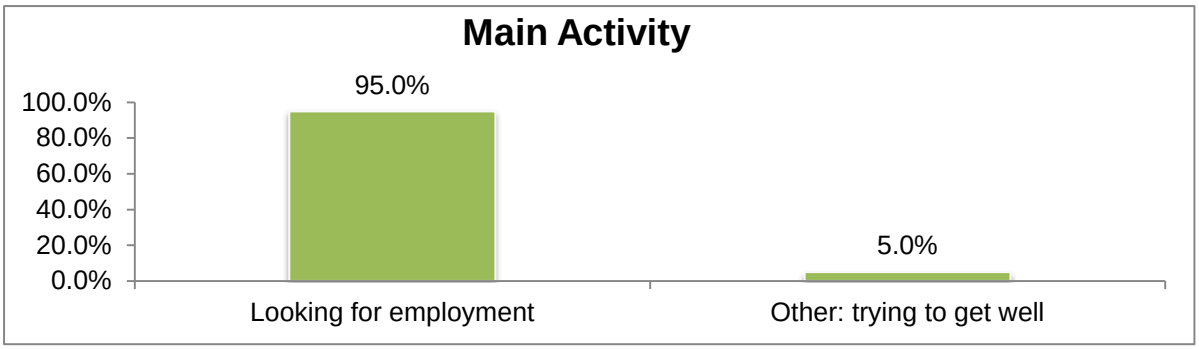

Figure 16: Main activity

To comprehend any form of the possible impact of the AHC qualification, the research team asked learners to describe the kind of impact the course may have had on them. Though many were thankful and enjoyed the learning experience, a few respondents reported an overall, positive change. Unfortunately, the result of job opportunities, an improved financial status, and the ability to use the course to move into a specific career path was not the experience of many individuals. However, it was interesting to note that individual growth and knowledge were the most mentioned impacts of the course.

Sub theme	Theme	Frequency
	Generally	
Generally	Individual growth	16
	Growth through the knowledge of helping people	13
	Total	**29**
Education	Able to further studies	1
	Total	**1**
Job opportunities	Increase in the number of part time jobs	1
	Total	**1**
Income status	Financial increase	2
	Total	**2**
No change	Leaner did not experience any change	8
	Total	**8**

Table 13: Contribution to one's life

As illustrated in Table 13, many learners considered that it was a good course and they would certainly recommend it. However, more opportunities for employment were necessary as many are still unemployed. More clarity on the course and its purpose was required.

Theme	Sub theme	Frequency
It's a good course	Improve current skills	4
	Enjoyed the course and recommend it	4
	Total	**8**
Opportunities	Educational opportunities	4
	Employment opportunities	4
	Total	**8**
Recognition of the course	Clarity about the course	1
	Accreditation	1
	Total	**2**
Receiving certificates	Delay in receiving certificates	1
	Total	**1**
None	No comment	6
	Total	**6**

Table 14: Further comments and recommendations

3.2 Qualitative Analysis

3.2.1 In-depth Interviews

Effectiveness

The first measure was to assess the effectiveness of the AHC qualification and its associated skills programmes towards achieving its objectives which are to equip learners with the necessary skills to work with sick individuals in the community and to offer learners the opportunity to study further once the qualification has been obtained. The course had equipped learners with necessary skills with some of them reporting that they had learned a lot, particularly how to work with the sick. Through the course, they were able to check blood pressure, identify those in need of medical attention and make referrals, educate those who were sick, their families and the community, and create a general awareness of health matters. This is also recorded in the survey with learners stating that through the course they were able to acquire more knowledge.

Some learners stated that they were unable to continue with their studies or simply did not pursue the option of furthering their careers or following a certain career into nursing. A lack of funding was one reason provided. One learner stated that when she enquired about enrolling for nursing, she was told by the college that her certificate and modules covered were not enough as she was from a different college and would be required to begin the Health Care Work course as a bridging course with the college. Financially this was not viable and as a result, she was unable to pursue nursing. Learners were also waiting for certificates which are required as proof at colleges when wanting to enrol for further education or even when applying for jobs.

Relevance

The second measure was to determine the relevancy of the AHC qualification and its associated skills programmes to the job and communities. On the one hand, the course was generally regarded as relevant to the job. It enabled learners to do their jobs more effectively and they learnt a lot about caring for people and they were now able to assist others. On the other hand, employers also recognised the relevance of the course and carers in the community.
As some organisations operate in regions with no district hospitals, patients are required to travel long distances to receive medication, while others are too afraid to visit clinics. Carers can assist with many of these problems and that certainly makes a difference within communities.

Impact
This refers to the delivery of health care by employers to the communities in which they operate. Though no official records were available to prove that carers and their respective organisations were making an impact, many reported that there was an improvement within communities in which the carers were working. Many people in the communities were more knowledgeable; people appeared to be taking things more seriously; carers were now recognised by the community who were stopping to ask questions and seek advice for themselves or letting the carers know about sick family members. It should be noted, however, that there are many problems and the needs of the community continuously change and thus it would be difficult to keep up with these needs.

Sustainability
The use of carers has become an important aspect within communities; however, with little or no money to fund home-based care programmes, the ability to retain these workers does remain a challenge. What has emerged from the research is that many of the learners have been lured into enrolling for the AHC qualification and its associated skills programmes with promises and the hopes that they will be able to pursue nursing as a career path upon completion of the course.

The course is now being commercialised to make it more appealing and when one considers the path learners are able to follow through the course, it certainly makes it attractive and the course will continue to gain in popularity.

Efficiency
The efficiency of this programme will be evaluated through the overall outcome and impact it has had on learners and on the community. From a learner perspective, the course was able to furnish learners with knowledge and skills. Thus they were able to be more effective in their jobs. Assistance from carers is necessary due to the lack of availability of hospitals or clinics and/or understaffed hospitals or clinics.

Much more help is required, because, due to a lack of funding, organisations are only able to employ a selected few while the rest are unable to find employment. The issue of receiving

certificates was raised as many are able to find employment but are required to present the certificate to be considered for employment.

4 Conclusion and Recommendations

The summative evaluation study was conducted to evaluate the effectiveness, relevance, impact, sustainability, and efficiency of the AHC qualification and its associated skills programmes. Though the HWSETA no longer funded the programme, the registration by learners and providers for the course continued to increase. Thus the need arose to conduct a rapid assessment to measure the impact and outcome of the AHC qualification and its associated skills programmes.

The study indicators were as below:

- Increased percentage of trained learners on Ancillary Health Care qualification and its associated skills programmes employed in the community
- Increased percentage of trained learners who reported a positive change in their lives after completing the Ancillary Health Care Qualification and its associated skills programmes
- Increased percentage of people in the community managing their health and wellness

The study was conducted with a mixed method approach using both surveys and in-depth interviews. The surveys and in-depth interviews were conducted with learners who had completed the qualification in 2012 and providers who were also employers of these learners.

The majority of the learners (80.7%) are between the ages of 18-35 years which is in line with the NSDS as the main focus is on youth development. 74% of learners had a matric as the highest level of education. This raises the question why individuals are taking a course that is of a lower level. The reason could perhaps be that the AHC course is used to gain entry into the job market. The courses selected after the completion of the AHC course were not at a higher level, and this could mean the courses are taken because they are free or employer-recommended.

Although many of the learners found the course to be enjoyable and had acquired more knowledge and skills that they were able apply to their jobs daily, not all were employed. With 67.7% of learners being unemployed after completing the AHC course, unemployment was one of the biggest issues that was raised. This issue is not only isolated with those who had completed the AHC qualification and its associated skills programmes. It is well known that South Africa does have a high unemployment rate. However, with regard to those who had completed the AHC qualification and its associated skills programmes, a few reasons were provided.

The first issue has to do with the availability of funding. How many carers are employed at one particular time in an organisation or clinic is always dependent on how much money is

available to pay salaries. As a result, not all those who complete the course will immediately find employment and when they do, it may not be within home-based care or even within a health-related field. As seen in the study, 10% of those who participated in the study were employed in a different field of work.

Some individuals simply work as substitutes and wait till they are called to substitute a carer either for a day or two or even for maternity leave.This has left many desperate and willing to take certain measures. Many are being taken advantage of by scams with advertisements making promises of jobs and asking interested individuals to pay a certain amount of money either for uniform or for administration purposes and only later do they realise that the employment agency does not even exist.

Employers are also hiring carers on a volunteer basis and do not pay them a salary due to the demand because there are many sick people in the communities that require medical assistance and people are willing to assist. However, these volunteers are trained, work for some time, and eventually leave because there is no income. Perhaps many join with the hope that in time an organisation will find funding to pay them. Of those receiving a salary, the majority (55%) of former learners reported only receiving a salary of R2000 or less a month. This situation makes it very difficult to retain people.

Delays in the delivery of certificates also hindered opportunities to find employment and was mentioned as one of the reasons for unemployment. Even when individuals were considered for a job, many were told they would still need to present proof of their qualifications to secure employment. On follow-up in some cases, providers themselves are no longer registered with the HWSETA as they have failed to comply with requirements and therefore certificates cannot be released. In other cases, an explanation is not given to learners regarding a delay in delivering certificates but the learners do eventually receive them.

The recognition of the qualification is also posing problems. When individuals attempt to enrol into nursing colleges, the qualification is not recognised and learners are been told to complete a different course that will meet the requirements for nursing. What is really disappointing in this regard is that many are choosing this course with the hope of pursuing their careers as health professionals only to realise they have wasted their time and money. The names of courses in some cases are being changed during the courses and as a result, the time required to complete the course becomes extended.

To assist and address the quality of the sample list provided to the research team, going forward the researcher proposes that the HWSETA make it compulsory for learners to provide contact details of their next of kin and provide an e-mail address as an alternative form of contact.

Furthermore it is recommended that the HWSETA resume funding for the AHC learning programme under the following conditions:

- Contract of employment for the learner prior to funding should be presented as a guarantee that a learner will be employed for a certain amount of time after completing the AHC course.
- A source of stipend or salary to be established prior to funding. A source would refer to any organisation that provides funding to an organisation to employ carers.
- Training of existing employees to enhance their skills.
- A complete overhaul of the course to make it more relevant to the needs of the community but also to allow learners to further their studies should they wish so to do.

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