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Irwin Friedman

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CHWs

Authors

Abstract

This article commences with a brief historical review of community health workers (CHWs),^a now also referred to as Community Caregivers, explaining that there was a favourable change in national policy commencing in October 2003 with significant commitment by the Minister of Health. The rationale for this cadre of worker has been previously reviewed. During 2004, a National Community Health Worker Policy Framework was drafted. The essential elements are outlined. Despite the progress, there remains a bewildering array of CHW cadres. First steps to deal with this involve the development of unified training standards. Both short-term and longer-term learning programme initiatives are well under way towards achieving this. Four levels of qualification have been registered with the South African Qualification Authority. Accreditation of programmes will provide learners with greater opportunities for career advancement and the ability to operate in a more generalist manner. Other important steps to deal with the confusion will be the promotion of intra- and inter-sectoral collaboration. This will involve developing appropriate coordination mechanisms, which will link with municipalities and local ward committees. District health managers will have a key role in promoting coordination and monitoring quality. Community health committees should be responsible for governance. Recommendations are provided for achieving integration at provincial, district and household level. In the absence of documented evidence, many of the observations made in this chapter are based on the author's personal opinion and offered as a contribution to understanding a complex situation. Given the absence of evidence, the views expressed should be understood as tentative.

^a The umbrella term 'Community Health Worker' (CHW) embraces a variety of health auxiliaries who are selected, trained and work in the communities in which they live. They include generalist ancillary health workers (AHCs), lay health workers, village health workers (VHWs), Onompilo, community resource persons (CORPs) as well as a range of more single purpose cadres such as community rehabilitation facilitators (CRFs), community-based directly observed therapy short-course (DOTS) supporters, HIV and AIDS communicators (HACS), home based care (HBC) workers, voluntary counselling and testing (VCT) counsellors, peer educators, first aid workers, etc. All these types of CHWs carry out one or more functions related to health / social care and are trained in some way in the context of the intervention. In the past the group had no formal certificated professional, paraprofessional or tertiary education. Excluded from this definition are formally trained nurse aides, medical assistants, physician assistants, paramedical workers who serve in emergency and fire services and others who are self-defined health professionals, health paraprofessionals or traditional healers. Community Caregivers has been a term that is currently being widely used.

and community caregivers

towards a unified model of practice

Introduction

Since the early 1950s there have been documented examples of the successful deployment of health auxiliaries. During the 1960s Barefoot Doctors were successfully used in developing the health services of China. World Health Organization's (WHO) 'Health for All by 2000' strategy and the Alma Ata Declaration in the 1970s continued to emphasise the value of lay health workers in extending primary health care (PHC).

In the early 1980s various forms of CHW cadres were introduced into health programmes in different places in South Africa (SA).

There is a considerable body of international evidence, gathered over more than three decades, that suggests that Community Health Workers (CHWs),^b or lay community-based health auxiliaries without professional training, have a vital role to play in complementing PHC services by improving their quality and outreach.¹⁻⁴ A more detailed review for the rationale for this cadre was presented in a previous Review.⁵

Communities look to CHWs in various forms to provide a range of community based care and support in resource poor settings, which formal services serve inadequately. This is more so where poverty, compounded by new health needs created by the HIV and AIDS epidemic, challenge the social fabric.

CHW programmes in SA, with strong support from international donors, flourished in the 1980s. With the exception of KwaZulu-Natal, which has provincial govern-

ment support, most organised CHW programmes floundered from 1994 after the national Department of Health (DoH) indicated its reluctance to support a national programme.¹ Since that time there has been a gradual loss of organised CHW programmes.^c They were replaced mainly by numerous small CBO projects fielding a disconcerting array of 'volunteers' and single-purpose workers that have less coherence and insecure funding. A positive development since 1999, as hospitals, hospices and similar institutions have become increasingly overburdened,⁶ and unable to cope, has been the formal training of a large number of home based caregivers to assist and support families caring for the sick and frail aged in the community.

In October 2003 a national Lekgotla on CHWs was held at which the Minister of Health and the national DoH, reversed the previous policy,⁷ and since have been vigorously encouraging provincial departments to rapidly establish generalist^d CHW programmes in disadvantaged communities throughout the country. A commitment was given to pay stipends of between R500 to R1 000 per month.

Similar initiatives in the national Department of Social Development envisage a cadre of social auxiliaries who could take on complementary roles in promoting social welfare. It is encouraging that there has been an active attempt between the two departments to collaborate. A national conference on Coordinated Action for children

^b These CHWs are also described in the South African Qualification Authority (SAQA) framework unit standards as ancillary health workers (AHWs).

^c This is a personal observation. The National Progressive Primary Health Care Network, which operated a Learning Centre specifically focused on the training of CHWs has closed. Zanempilo, a community based organisation that provides community based health care in the Western Cape had to retrench its CHWs, although it has recently received some funding and may be re-established.

^d The term CHW embraces a very wide range of different types of workers of uneven competence and relevance.

infected and affected by HIV and AIDS was held in June 2002, and it culminated in a plan of action to ensure that stakeholders, at all levels, work in a coordinated way to protect the rights of children who are infected and affected by HIV and AIDS and to ensure that the rights of children for food, shelter, social services and grants, education, health, counselling, alternative care, protection and nondiscrimination are protected.⁸ This resulted in a National Integrated Plan for the collaboration between the social cluster of the departments of Health, Social Development and Education. With the support of the departments of Education and Social Development the National Association of Childcare Workers⁹ has developed the 'Isibindi'¹⁰ support programme for childcare workers based on the 'Circles of Support' concept of that Khomanani campaign.

The Expanded Public Works Programme (EPWP)¹⁰ also supports this initiative and envisages that CHWs (used as a generic term) could play an important role in extending health and social services while making an important contribution to job creation. The EPWP is funding the Usobomvu Youth Programme, which is planning to train large numbers of young people as CHWs. There have been recent concerns, however, that the social cluster, consisting of the ministries of Social Development, Health and Education, are not developing the Expanded Public Works Social Programme as fast as had been hoped.¹¹

If the national thrust to establish large-scale CHW programmes throughout the country is to be successful, and scarce funds allocated to the effort, it is important to ensure that these are built on sound foundations. This article attempts to review the existing situation and indicate some of the steps taken to achieve a coherent national CHW programme over the last year. As a result of the multi-departmental initiatives there is an increasing tendency to use the term 'community caregiver' as the preferred name for the cadre, as 'community health worker' seems to some to be more 'health sector' specific.

Establishment of a National CHW Policy Framework

Following input from a wide range of stakeholders who attended the October 2003 Lekgotla, a national CHW Policy Framework¹² has been drafted and was released in early 2004. The framework was developed by the national DoH in consultation with other departments, the provinces,

municipalities, NGOs, academic institutions, other civil society structures, the Health and Welfare Sector Education Training Authority (HWSETA) and the South African Qualification Authority (SAQA).

In essence the document provides an outline of what is envisaged for a future national CHW programme.

The rest of this chapter deals with the current confusing range of community-based health workers and offers recommendations on an approach that would minimise this confusion. It is based on the author's opinion rather than substantiated fact. Suggestions are offered on how to establish local programmes.

Current community-based health worker cadres

Over the past decade, in the absence of a coherent national CHW policy, multiple programmes have been set up, leading to an array of uncoordinated health auxiliaries. The growth in the numbers has been large and unregulated. There were at the end of 2004 reported¹¹ to be 892 sites and 19 616 volunteers supported by the Department of Social Development. Only 5 988 volunteers are receiving a stipend in the current financial year. In addition, the Department of Health currently provides stipends to an estimated 19 810 volunteers across all of its HIV and AIDS programmes of the 60 000 plus community health related volunteers linked to the Department. Few of these have had the opportunity to receive standardised training and a variable quality of delivery has been the outcome.

The net result has been a diverse group of single-purpose workers being recruited to work in communities, industry and institutions with little prospect of career development. They are also not well coordinated among themselves or with the general health sector.

One important exception has been the establishment of a 59-day training course for home based care workers developed by the Hospice Association of South Africa (HASA).⁶ Although not accredited by SAQA this programme has provided a standardised form of training which has greatly accelerated the provision of quality community-based palliative care, often under the supervision of hospices. During the training caregivers attend a three-month course on basic skills of home care and palliative care. Training is holistic and based on a curriculum and materials developed by HASA and approved by the DoH for home based care.

e isibindi means literally liver in Zulu, but symbolically it means courage.

Overview of the Community Health Workers Policy Framework

The rationale for CHWs in South Africa is based on five imperatives:

- ✧ The State President's commitment in the State of the Nation Addresses^{13,14} to getting government closer to communities and serving them better.
- ✧ The need for expanded human resource and skills development using new learning pathways and opportunities for life-long learning.
- ✧ The increasing complexity of ill-health and poverty.
- ✧ The growing need for health promotion, community and home based care.
- ✧ National commitment to strengthening participation by people and civil society in development.

Broadly the policy states:

- ✧ CHWs are defined as community-based generalist health workers with a basic level of competence in health promotion, primary health care, health resource networking and coordination.
- ✧ CHWs should provide a limited range of services within the scope of their competence.
- ✧ They should also, in terms of their engagement with communities and households, determine health needs and facilitate the improvement of services.
- ✧ In situations where single-purpose community health workers (such as DOT supporters or VCT counsellors) operate, CHWs should improve the effectiveness of these and simplify life for community members by coordinating these activities.
- ✧ CHWs will receive a stipend, but will not be government employees and will be employed through civil society initiatives.
- ✧ The preferred model is a Government / NGO partnership where Government provides grants to NGOs, which employ the CHWs. This might vary according to local conditions.
- ✧ Although voluntarism will continue to be encouraged, volunteers should not be employed more than a few hours a week without remuneration. Volunteers also should not be misled into believing that they will necessarily get paid work.
- ✧ A Clinic Committee / Community Health Committee should provide a governance mechanism.
- ✧ There should be community participation in the selection and recruitment of CHWs.

The role of the CHW is to:

- ✧ Mobilise community members to determine health needs and take responsibility for their own health and access services.
- ✧ Act as an advocate to improve health.
- ✧ Coordinate the access of other health workers into households and communities in order to ensure effectiveness of services to communities.
- ✧ Provide specified primary health care services to community members.
- ✧ Provide basic counselling services.
- ✧ Disseminate health information.
- ✧ Carry out health promotion activities.
- ✧ Transfer health and wellness skills to the community.

- ✧ Refer to the appropriate agency when faced with a situation outside of their scope of practice.
- ✧ Link with other community service agents such as community development workers, agricultural extension officers, youth workers and social work auxiliaries.

Principles in the education and training of CHWs:

- ✧ Learning programmes should be based on registered unit standards, taking into account learning needs, knowledge, skills and values required by learners and the context.
- ✧ Training providers should be accredited by the relevant sector education and training authorities.
- ✧ Learnerships within the relevant sectors, including the NGO and CBO sectors should be established.
- ✧ Strong partnerships between the government and civil society are important.
- ✧ Sustainability and funding of CHW programmes should be based on a situation analysis and a rigorous monitoring system.
- ✧ Training should be undertaken by providers with skills in primary health care, the district health system, community development and education of development practitioners.
- ✧ Community representatives should be involved in the recruitment and selection process of CHWs.
- ✧ Trainees should be residents of communities in which they will work.
- ✧ CHWs should have a support system e.g. be part of an NGO / CBO and have access to a referral system.
- ✧ Training should be community-based and include a substantial proportion of structured learning time in the community.
- ✧ Training should be followed by a period of supervised practical work.
- ✧ People from vulnerable groups, such as people with disabilities should be empowered to participate as CHWs.
- ✧ In-service education should continue to be provided and should take into account the ongoing needs and views of the CHWs.

Mentoring and supervision:

- ✧ Quality assurance should form an important part of mentoring, supervision, support and monitoring.
- ✧ Community involvement, commitment of top management, redress of previous inequity, learner contribution, stakeholder participation and needs-based approaches are key principles.

Logistics of the programme:

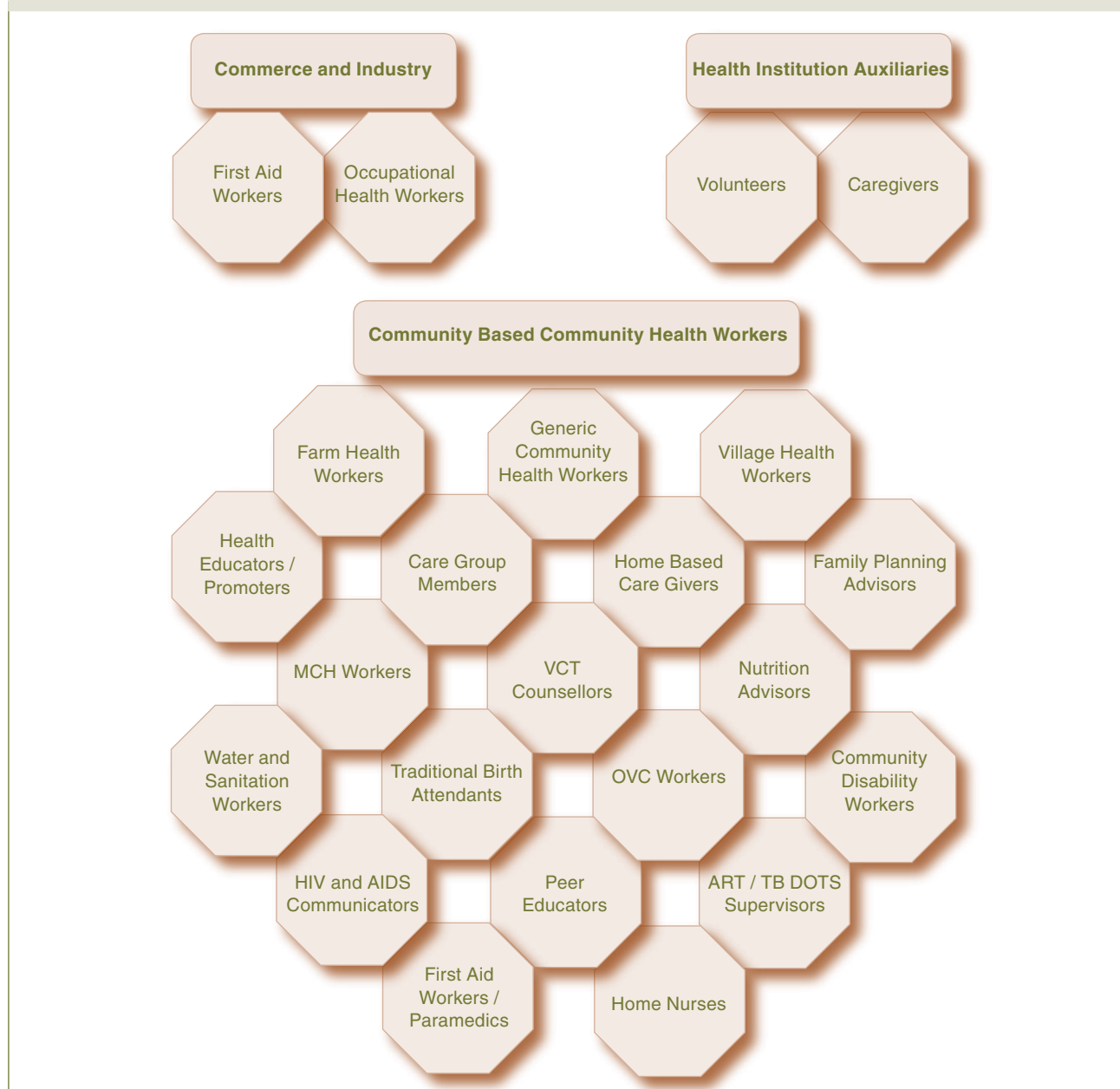
- ✧ Fully trained generalist CHWs would receive a minimum stipend of R1 000.
- ✧ In rural areas each CHW would cover from 80 to 100 households, the corresponding number being 100 to 150 households in urban areas.
- ✧ The maximum number would be 250 households to ensure that quality is not compromised.
- ✧ A geographic information system (GIS) would be developed together with a directory and operational monitoring and evaluation system.

This includes modules on the role of caregivers; basic information on STIs; HIV and AIDS; and TB; teaching and communication skills; spiritual and cultural issues; infection control; social support; principles of palliative care principles and basic nursing care; nutrition; and care of the caregiver. There is an initial 70 hours of classroom input linked to 160 hours of clinical placement, shared between hospice, primary health care clinics and participating hospitals. A particularly valuable aspect of the training is the ongoing support given to caregivers by psychologists and palliative-trained nurses combined with ongoing training and supervision.

However, despite the valuable training offered by HASA in many instances, CHW cadres with different skill levels have

worked competitively in the same communities often resulting, not only in wasted resources, but in conflict between the workers. A specific example of this conflict was documented by an ethnographer and cited in the 2002 South African Health Review.⁵ In some situations this involves a duplication of effort and a contestation for territory. In a series of community workshops¹⁵ that were conducted in eleven municipal areas of four provinces during 2002 to explore what could be done to enhance the capacity of municipalities and civic structures to respond to the HIV and AIDS epidemic, the issue of poor planning, collaboration and coordination in the provision of home based care was consistently among the most significant problems cited. Competition among NGOs and CBOs was seen as a major

Figure 1: Different types of CHWs and health auxiliaries



threat to effective collaboration. The lack of an integrated response and fragmentation of the health system remain a significant challenge. This suggests that the advent of an array of volunteers employed by different organisations or departments to deal with different aspects of the HIV and AIDS epidemic has greatly exacerbated the problem of coordination among various types of caregiver cadres. Currently this is an area that requires further ongoing research to establish how it impacts on patient care.

Figure 1 depicts the author's conceptualisation of the existing range of community health workers and other health auxiliaries. It is speculated that although there is a very wide array of CHWs working in a variety of non-connected frameworks, they could be clustered to work in a more coherent and integrated manner. This would enable them, as a whole, to deal more comprehensively with the challenges faced in the health sector. This approach presupposes, however, that the work undertaken by the diverse range of single-purpose community health worker cadres can be coordinated by a single generalist worker having the overall responsibility of ensuring a seamless community-based service for the client. This is the view proposed in the Community Health Workers Policy Framework¹² and reiterated by the National Minister of Health.¹⁶

Establishing unified training standards

Currently an audit of community-based health and allied social sector auxiliaries is being undertaken to determine how many there are and where they are based. This may throw some light on the characteristics and needs of these workers.^f

Until longer-term training issues for CHWs can be resolved, a standardised skills development programme has been 'fast-tracked'. Set at SAQA level three, this skills programme hopes to make curricula and learning materials available to service providers who will soon commence decentralised training.

In the longer term, CHW will be required to complete formal training. Over the past 4 years the Ancillary Health Worker Standard Generating Body (SGB) has written unit standards and qualifications for four SAQA levels for ancillary and community health workers.¹⁷ As a result of their work, there is now a framework for CHW training that is recognised by the

SAQA. Ultimately it may be possible for CHWs to gain access to a formal tertiary education or a career as a professional health service provider.

The training starts from basics at level one of the National Qualifications Framework (NQF), which is the equivalent of grade 9 at school or Adult Basic Education (ABED) level 4 shown in Table 1. This first level of the SAQA qualification is foundational and qualifies the learner to work as a basic home caregiver. On completion of this phase the learner can obtain a General Education and Training Certificate (GETC) in Ancillary Health Care. This qualification then forms the entry to higher qualifications leading through levels 2 and 3 of the NQF to level four at which stage the Further Education and Training Certificate (FETC) in Community Health Work can be obtained. The second level qualifies the learner to be a 'senior' home caregiver. Level 3 provides skills for a basic community health worker with level 4 being the qualification of a fully-fledged CHW.

These standards have all been approved by SAQA. The last of these were registered in January 2005. Quality is assured through HWSETA.

NQF Level	Band	Qualification Type
8 7 6 5	Higher Education and Training	<ul style="list-style-type: none"> ✧ Post-doctoral research degrees ✧ Doctorates ✧ Masters degrees ✧ Professional Qualifications ✧ Honours degrees ✧ National first degrees ✧ Higher diplomas ✧ National diplomas ✧ National certificates
Further Education and Training Certificate (FETC)		
4 3 2	Further Education and Training	National certificates
General Education and Training Certificate (GETC)		
1	General Education and Training	Grade 9 ABET Level 4 National certificates

Source: South African Qualifications Authority (SAQA)

^f Personal communication: Mrs Gugu Gumede, Cluster Manager, Human Resources Planning and Development, Department of Health, January 2005.

SAQA has adopted an eight-level framework, with levels 1 and 8 respectively being regarded as open-ended. Level 1 accommodates three Adult Basic Education and Training (ABET) certification levels as well as the General Education and Training Certificate.

This new qualifications framework helps to deal with the problem caused by a lack of standardised training, but still leaves open the question of coordination and the development of a support system for the optimal functioning of CHWs.

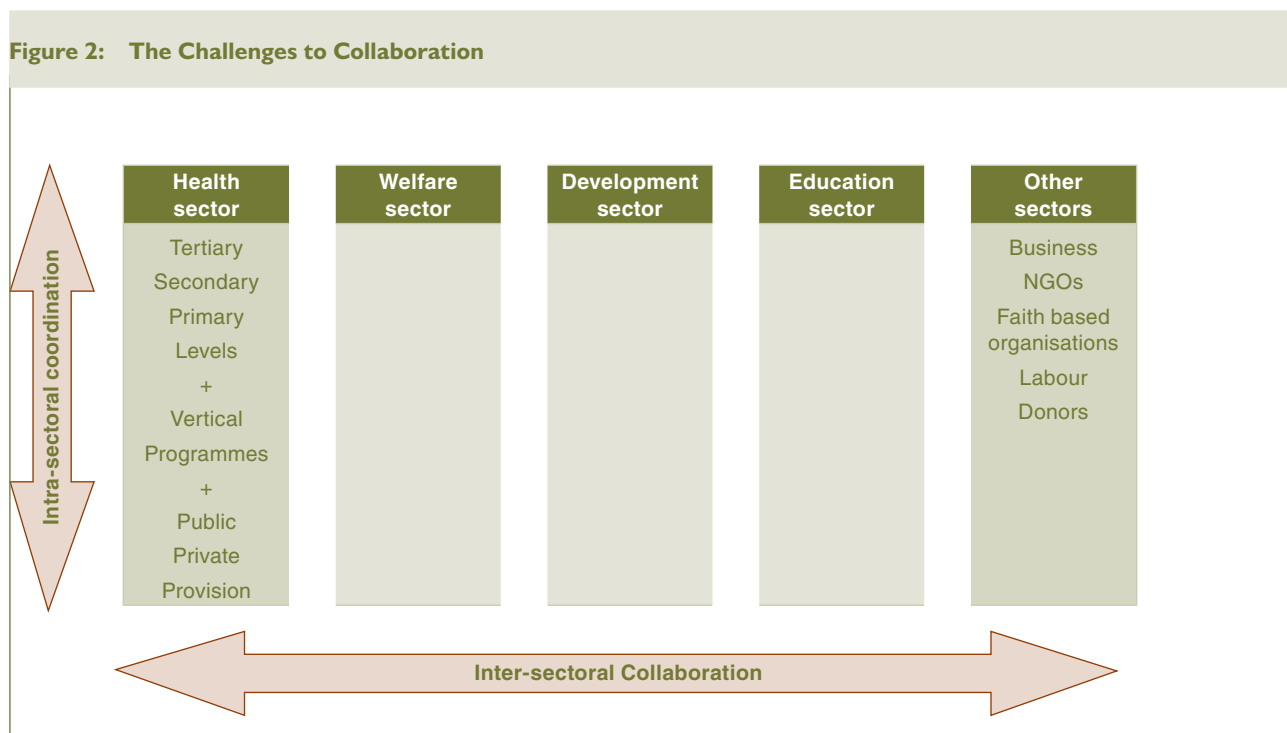
Building collaboration within and between sectors

The principles of PHC emphasise the central importance of collaboration. This stems from the recognition that improvements in wellbeing can only be achieved by a broad-based approach to development that involves multiple sectors and several levels of service delivery. This collaboration is especially important for community based health worker programmes, which must be effectively coordinated within the health sector itself as well as with other sectors.

Within the health sector itself there are three specific coordination challenges. The first is to ensure that there is a smooth relationship and referral flow from primary through to tertiary care levels. The second is to ensure that there is collaboration between vertical programmes, whose ultimate success is dependent on the synergy that exists between such programmes. The third is to bridge the divide between public and private provision.

All of these imperatives can be achieved if CHW programmes are placed within their proper context inside of a structured and well-ordered district health system which itself provides a framework for collaboration within the health sector. This implies that CHW programmes do not exist in a vacuum and are an integral part of the support structures that comprises the district health system. There is a great deal of evidence that inadequately supported CHW programmes are ineffective.¹

Just as coordination within the health sector is vital, so too is collaboration with other sectors such as welfare, education and others. This includes a range of stakeholders that are not part of the public sector.



Dealing with the diversity of development auxiliaries

Just as there is a confusing array of CHWs working in the health sector, so there is a large range of other community based development auxiliaries shown in Figure 3. Coordination is vital if integrated development is the goal.

At present no agreed system of coordination between these different workers has been established. It is the mandate of the municipal sphere of government to take responsibility for developmental issues and integrated development planning, and it is suggested that municipalities provide a mechanism for local coordination. A specific way of how this could occur would be through the ward committee together with the relevant health committee. The community development worker could play a lead role in this coordination.

Figure 3: The diversity of health, welfare and development auxiliaries

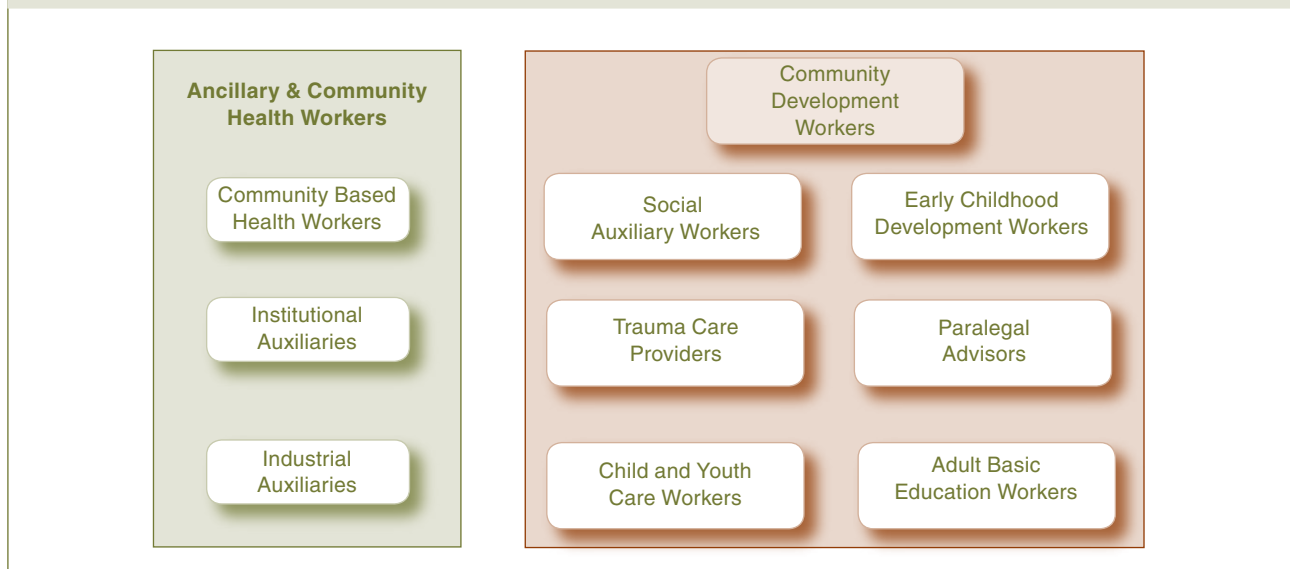
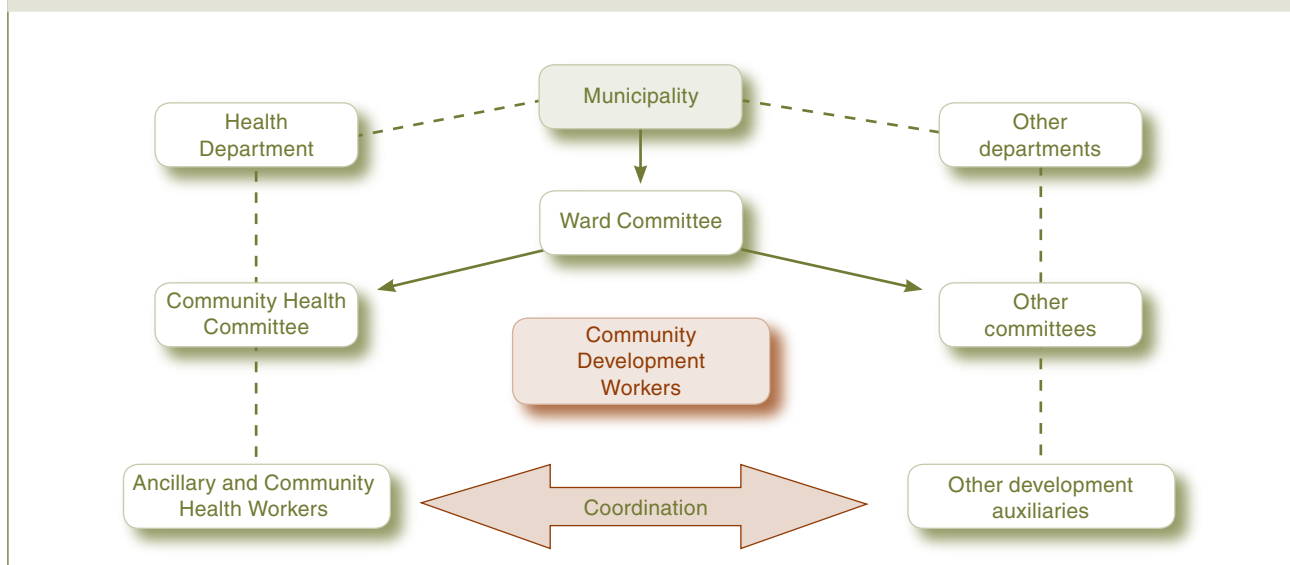


Figure 4: The coordinating function of municipal and community sub-structures



The challenge of coordination

One major difficulty faced by CHWs working at the interface between the community and the rest of the health sector, is that of multiple levels of accountability. This is made especially complex by the need to integrate vertical programmes, achieve intersectoral collaboration and community involvement. Figure 5 sets out a conceptual approach that clarifies the lines of accountability.

The District Health Manager (DHM) has a formal responsibility for monitoring the quality of services and providing support, but the district is not accountable for employing CHWs. The rationale for this is that it is desirable for CHWs to be employed and supervised by an NGO / CBO representing the community they serve.

Although CHWs are not employed directly by the district health, technical support and oversight are provided by Community Health Facilitators (CHF) skilled at working with community health workers, ancillary workers and community structures, empowering them to take on significant responsibility.

Line accountability for CHWs has previously vested in a community-wide voluntary organisation such as the community health committee (CHC) other community based organisation (CBO), which formally takes on the role of employer. It is the specific intention of the CHW policy that accountability of CHWs be to the local community, however the exact mechanism is still undefined. The new National Health Act makes specific provision for all facilities including clinics and community health centres to have advisory committees or Boards.¹⁸ The CHW is accountable to the structure for performance and health outcomes, although this is also closely monitored by the CHF. The CHC or CBO is in turn accountable to district health managers of the Provincial Health Department that is contracting the services, often through an intermediary NGO, which provides this service as an accredited provider.

CHC-like structures exist in many districts. They are appointed by communities to set priorities for health care interventions and as such, also have a role in monitoring and evaluating the work of other community projects. Voluntary oversight committees such as CHCs work most effectively when their input is provided on an occasional part-time basis and does not require intensive day-to-day supervision. There is currently a great need for capacity building within these community structures in order to equip them to take on their roles. This may include undertaking projects or acting as advocacy bodies representing the community in health care matters.

Although not employed by the government health services, the CHWs remain accountable for the quality of their work to health service personnel. This, however, should not be used as a control mechanism, but rather as an opportunity to provide ongoing mentoring, monitoring, training and technical support.

In terms of the training of CHWs, it is important that existing SAQA standards and material already developed be utilised as fully as possible. Currently, many existing training programmes are not yet accredited by the HWSETA. This deprives CHWs of recognition, which they need to enable them to progress in their careers. While there is a need for a standardised curriculum and obtain formal accreditation for the training, there is also the need for local flexibility so that CHW programmes can respond to the needs of their communities. Flexibility should never, however, be an excuse to avoid collaboration or re-invent the wheel.

All support level personnel also need training. It includes the health personnel who train CHWs, the CHFs as well as their own trainers who supervise the scope of their practice. In addition, programme managers and other administrative personnel responsible for managing the programme at higher levels also need training.

Unifying CHW programmes at provincial and district levels^g

The following model is proposed as a general approach to provincial programmes, accepting that there may be reason to accommodate specific local requirements. It is based on the author's opinions, due to current limited evidence.

Ideally each province should have a CHW Programme Director or Manager responsible for managing the provincial programme, controlling the budget and liaising with other vertical programme managers (e.g. HIV, TB, and nutrition) to ensure that all programme priorities are included in the CHW programme. The Provincial CHW Programme Manager should also be responsible for managing intersectoral collaboration with other departments, municipalities, the private sector and others at provincial level.

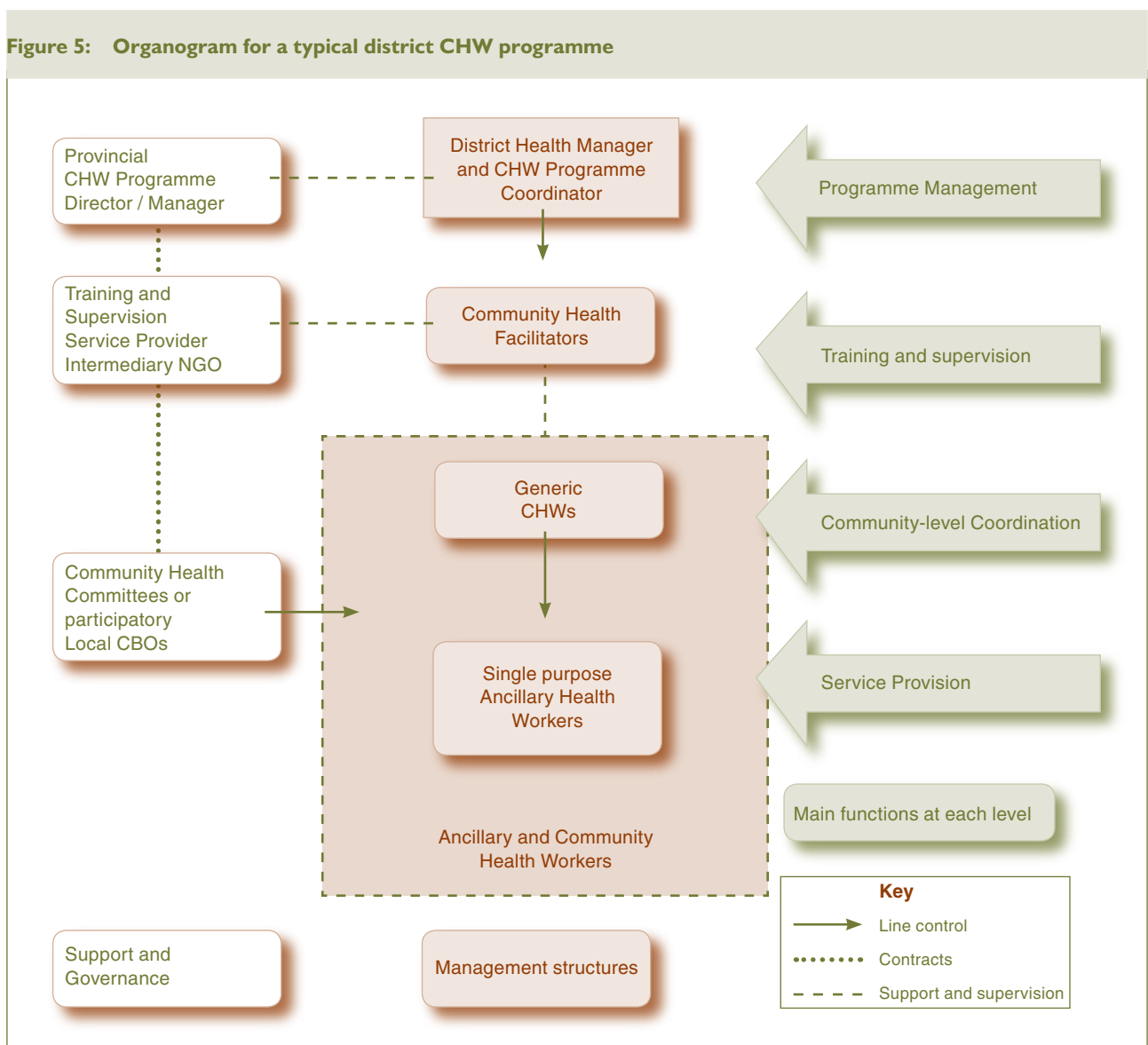
Direct line management of CHW programmes at district level should be coordinated by the District Health Manager or by a CHW Programme Coordinator as shown in Figure 5. The District Health Manager should be responsible for

^g Some of the elements of the model suggested are based on successful practice within KwaZulu-Natal and Western Cape provinces.

overall guidance of the CHW programme within the district. Technical support and detailed oversight of various groups of CHWs should be provided by CHF, accountable to the DHM. The CHF's role, as an employee within the district health establishment, should be to support, quality assure and supervise generic CHWs. The generic CHWs should coordinate single-purpose AHWs and other volunteers or care groups.

As indicated, the Generic CHWs and Ancillary Health Workers should not be directly employed by government and should rather be employed and paid by their local CHC or local CBO. This structure should be awarded a grant from the provincial DoH channelled via an accredited Training and Supervision Service Provider, most likely a Provincial-scale NGO, which should mentor and monitor the performance of these structures.

Governance of the programme should be provided by local CHCs or similar local participatory structures (e.g. local CBO), ensuring that local priorities and needs are addressed by the programme.



Special approaches are required in dealing with rural areas, which have extensive commercial farms or within occupational or industrial settings such as mines. These will not be dealt with here.

Integrating care in complex home situations

Generic CHWs are the important skeletal element in the community-based care framework. These CHWs may be insufficient to provide intensive home care. It is therefore important that the role of other single purpose ancillary health workers or volunteers, specialised in different ways to deal with HIV and AIDS, TB, rehabilitation or other problems, be recruited, to work in a coordinated way with the CHWs. Such AHWs may in time progress to become CHWs.

Hospice models which provide home based care using AHWs supported by skilled palliative health care professionals could significantly enhance the quality of home based care.

In figure 6, a model is presented to show how comprehensive community based care could be achieved in complex situations of deprivation. It illustrates how CHWs, adequately supported with resources and training could take on the role of coordinating and supporting community-based care for sick adults, orphans and other vulnerable children (OVC).

In this model, CHWs are provided with subsistence vouchers, which they can give to families and individuals in distress. These can be exchanged for food, seeds, clothing or other basic household essentials at local shops, boosting the local economy and avoiding the need to establish complex logistical systems to purchase and provide food parcels. While the issue of CHWs being responsible for the distribution of subsistence vouchers has pros and cons, the ability to provide some direct relief to families visited and circumvention of the very complex logistics of food parcel distribution is important for their effective functioning.

Primarily the role of generic CHWs is to support caregivers in households, supplemented when necessary by single focus Ancillary Health Workers or volunteers from neighbourhood care groups, community or FBOs or other such structures.

Organisational development should be undertaken to enhance the functioning of such groups.

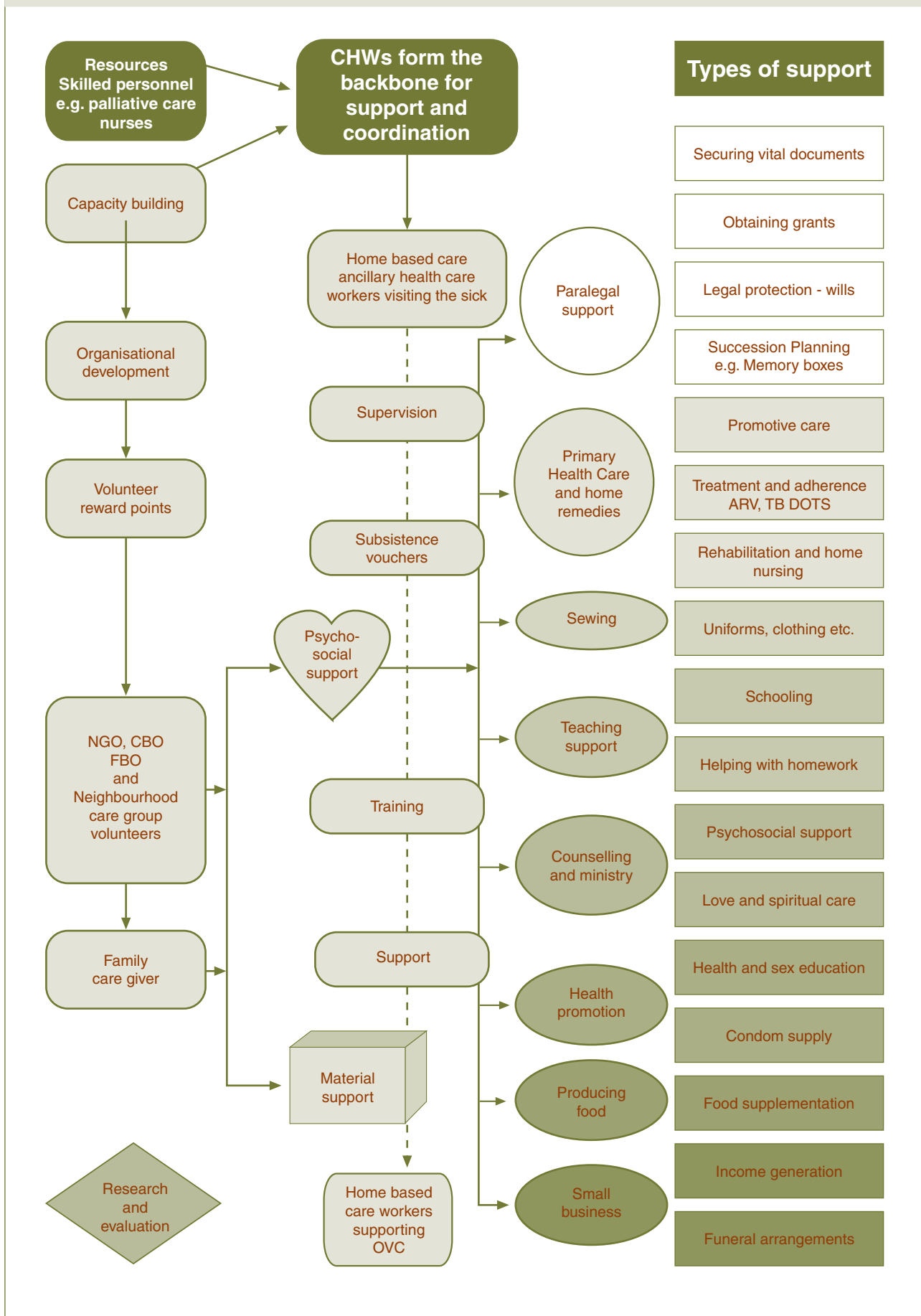
Where voluntary work is undertaken, credit should be given to such volunteers. This could be done through the allocation and recording of 'points', for hours of service worked. Where it is possible to provide benefits or incentives for this group,

these could be allocated in proportion to the accumulated 'points'. Specific benefits might include for example, opportunities for further education and training. This would document the amount of time invested by volunteers.

Conclusion and recommendations

- Each province should have a CHW Programme Director / Manager to control the budget and ensure intra- and intersectoral collaboration.
- Direct line management of CHW programmes at district level should be coordinated by the DHM.
- Technical support, mentoring and monitoring of CHWs should be provided by CHF, accountable to the DHM.
- Generic CHWs should supervise and coordinate single-purpose AHWs, volunteers and care groups.
- CHWs should be employed by CHCs or some other representative CBO, who would also provide a governance function.
- Funding for the CHCs should be made by a provincial DoH grant channelled through an accredited Training and Supervision Service Provider, probably itself a provincial scale NGO. (The European Union, which is providing technical support to the national DoH and several provinces to support Primary Health Care has recently tendered for such lead service providers in certain provinces).
- To achieve functional integration within complex settings within homes of vulnerable individuals, generic CHWs should supervise and coordinate the work of single-purpose AHWs.
- Skilled health professionals such as palliative care nurses could provide technical support and supervision to improve the quality of home based care programmes.

Figure 6: Comprehensive home based care model



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