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Health Systems Trust & The National Department of Health

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EXECUTIVE SUMMARY

Introduction: Community Health Workers (CHWs) or Community Care Workers (CCWs) are community-selected lay persons providing a community-based health service for which they have been trained; although their role has become increasingly important, there is currently concern regarding the effectiveness of programmes that utilise them. The research question is what constitutes best practice in the use of such workers. The term CHW includes all categories of such workers.

The objectives of the study were to: Assess the extent to which CHW deployment has been addressing important health priorities; document success stories and lessons, identify champions; understand the range of ways that CHW programmes have evolved in South Africa and compile recommendations & lessons learned to improve practice.

Methods: Separate studies were commissioned in each of the 9 provinces. A list of organizations was identified from key informants & provincial database in each province. Snowballing techniques & web-based searches were used to identify additional organisations. Qualitative in-depth interviews using checklists were conducted in a purposeful sample of about 3 to 5 projects per province to understand the evolution of projects and learn lessons that could inform "best-practice"

Results: In the past CHW programmes, focused on prevention, health promotion and development issues. Today they are increasingly used to provide services in care and support for people infected and affected by HIV & AIDS with a limited role in prevention, Their role is most notable in resource poor settings where health and social services are inadequate, poverty is endemic and HIV & AIDS challenge community resources and their ability to cope with the burden of care. Fragmentation has characterised the rapid evolution of projects

Conclusion: CHWs are most valuable in expanding health services, mobilizing communities around health & development, rather than replacing professionals. They have a particularly important role in the comprehensive home-based response to the HIV/AIDS and TB pandemics as well as in other more traditional areas of PHC. The inadequacy of the health services in poor communities has heightened the need for CHWs to make PHC more accessible to communities & to promote the responsible use of overburdened health facilities in the community. Recommendations for strengthening the programme for better practice deal with issues related to policy, leadership, accountability, participation, tasks & functions. Recruitment, support, training, remuneration and evidence-based action. It is important to gradually extend their role from single-

focus to more generic activities. Models for scaling up provincial programmes based on the principles of intersectoral collaboration are presented.

1. BACKGROUND

Beginning from the early 1950s various cadres of community based health workers[1], known by a confusing range of terms, including generic Community Health Workers (CHWs), Community Care Workers (CCWs), Ancillary Health Workers (AHWs), Lay Health Workers (LHWs) as well as specific focus workers such as Home and Community Based Workers (HCBC), DOT Supporters and the like, have been widely recognized as having a vital role in complementing existing primary health care services and improving their quality and outreach. A large number of models operating in different contexts, countries and dealing with a range of problems and diseases have been described.[2],[3],[4], [5]. In a study of randomized control trials throughout the world for the Cochrane Collection it was found in 2005 that formal evidenced-based analysis shows that LHWs offer promising benefits in promoting immunisation uptake and improving outcomes for acute respiratory infections and malaria, when compared to usual care. For other health issues, evidence was insufficient to justify recommendations for policy and practice [6].

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, all this at a very difficult time, as poverty compounded by new threats such the HIV/AIDs epidemic challenge the social fabric. Although generic CHW programmes flourished in South Africa during the 1980s mainly supported by international donors, with the one exception being KwaZulu, which had a homeland-government supported programme from 1985. Despite this encouraging start, most of the larger NGO programmes paradoxically floundered and struggled to sustain themselves from 1994 when the new democratic Government's legitimacy led major international donors to switch their funding priorities. Gradually, as larger NGOs weakened, they were replaced by numerous small CBO projects that had less coherence and insecure funding. A positive development since 1999, however, as hospices and similar institutions became increasing overburdened and unable to cope, was the formalization of training for an increasingly large number of home-based caregivers to assist and support families caring for their sick and frail aged in their homes.[7] Government began to provide increasing funding to small organizations that were undertaking home based care from that time. A 59-day training course for home based care workers developed by the Hospice Association of South Africa (HASA) was then developed jointly with the National Department of Health.[8] In 2001 National Guidelines for Community and Home Based Care were published. [9] The Guidelines clarified the meaning of terms such as home and community based care, which were also at the time an aspect of WHO policy.

"Home care is defined as the provision of health services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximum level of comfort, function and health including care towards a dignified death. Home care services can be classified into preventive, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories. It is an integral part of community-based care.

Community-based care is the care that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people, encourages traditional community life and creates responsibilities."

Although the generic term CHW embraces a very wide range of different types of workers of uneven competence and relevance, the National Minister of Health and the Department are vigorously encouraging provincial departments to rapidly establish CHW programmes in disadvantaged communities throughout the country. From 2004 both the National Department as well as at least three other provinces had formal CHW policies. Overall however, the tendency has been for policy to follow practice rather than to lead it.

Most programmes pay their CHWs either a salary, honorarium or stipend. Even internationally, though volunteer community health worker programmes abound, almost no examples exist of sustained community financing of CHWs. Even NGOs have to find ways of financially rewarding their 'volunteer' CHWs, with what are euphemistically called 'incentives'. Moreover, where there are programmes in which CHWs work on a completely voluntary basis, attrition rates are high and the few enthusiastic and reliable volunteers that remain become overloaded with tasks from other agencies and sectors. There is no reason to believe that the situation has changed over the last decade when a WHO draft document concluded that there was little evidence that the mobilisation of volunteers in CHW programmes was an effective policy[10]

Although remuneration of CHWs varied widely, some being pure volunteers, others earning up to R1,850 or more a month, in terms of an attempt to ensure country-wide equity, the National Health Ministry committed to paying stipends of between R500 to R1000 per month, depending on the level of qualification of the CHW.[11]

A recent study[12] of 300 grantee organisations throughout Southern Africa for the Siyabhabha Trust, the Welfare and Development arm of the South African Bishops Conference made some important observations about Community Based Workers (CBWs):

- Typically community based workers were women (87%), unemployed (57%) without a matric or other qualification (65%) and more likely to be single (40%) than married (36%). About half (49%) were in the 20 to 40 year age group.

- CBWs had a very broad range of activities that they undertook. In addition to CHWs and DOTS supporters, there were child carers; peer educators; food distributors; income generating project members; administrators; traditional healers and community development workers
- Nearly half (48%) were receiving a stipend, with the small proportion (13%) of men more likely (58%) to earn an income than women (46%). A high proportion of those earning an income (75%) were in the 20-30 year age group with younger and older women less likely to earn. Trained CBWs were also more likely to earn (56%) than those who had not been trained. The stipend range was between R150 to R3,000 per month and seemed unrelated to workload. Voluntarism was common with 42% having started by becoming volunteers in the past 18 months. Only about a 1/3 were getting regular income, it would appear because of inconsistencies in payment by Government departments. Those who received no stipends were nevertheless offered other support incentives based on availability.
- Most commonly (66%) each CBW had about 20 clients; about ½ managed to see each client once a week.

The Expanded Public Works Programme[13] has provided additional resources to fund the programme nationally and support further training. It envisages that Community Care Workers of different types could play an important role in developing 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. Despite this, there are concerns that the social sector aspect of this programme is not developing fast enough

If the national thrust to establish large-scale Community Health/Care Worker 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. A review of the existing situation and the state of the art is essential.

A first important step has been the development of a standardized curriculum. Since the early 2000's a Standard Generating Body (SGB) has written unit standards and qualifications for four NQF levels of CHW. The first level is for the ancillary health worker (AHW) which is foundational and qualifies the learner to function as a basic home and community based caregiver (HCBC). The second and third levels provides for the cadre known as the community care worker (CCW), with level 4 being the fully-fledged community health worker (CHW). These standards have all been approved by the South African Qualifications Authority (SAQA) and registered on the National Qualifications Framework (NQF) in January 2005. Over the past few years a programme to fast-track the training of CHW in a skills programme set at level 3 is being undertaken.[14] Two learning manuals in a Health for All series including A Guide for Community Health Workers, and Child Health, were published by Juta in 2003 to cater for the ancillary health worker level[15], [16]. The Reproductive Health and Preventing

Diseases manuals are still in the process of publication. During 2006 an additional series of five manuals set at level 3 were also published by Juta covering additional learning about primary health care, health and common diseases, personal development, community development and social care. All the training materials are based on the new outcomes-based education framework and include a range of participatory learning exercises.

Another important step that has been taken is an audit of community and allied social sector workers to determine how many workers exist and some of the characteristics of these workers.

Despite the progress being made with the development of a standardized curriculum, formidable problems exist in rapidly moving from this to establishing an effective national CHW programme.

2. PROBLEM STATEMENT

While the ideal of developing coherent and effective CHW programmes throughout the country is laudable, there are important obstacles in the way. The situation has not changed much since an early evaluation of National CHW programmes in 1983.[17] The study identified certain issues that needed to be clarified

1. Tasks and functions of CHWs
2. Selection and recruitment
3. Training
4. Remuneration
5. Career prospects
6. Attrition rates
7. Support services

In South Africa at the current time, many different models of community based practice exist, some excellent, some poor. Spurred on by a range of needs and opportunities, and a lack of clear policy, a confusing array of CHWs with various names and roles has gradually emerged over the last two decades. E.g. Onompilo, community caregivers, DOT supporters, peer educators, home based carers, institutional caregivers, among many others. Despite the attempt to clarify this in policy since about 2001, much of the initial confusion persists, and has even continued to grow. The large range of CHW models are matched by an equivalent assortment of training programmes and support mechanisms, only a few of which represent effective and well-thought through programmes. The result is a medley of initiatives, some excellent, but many often standing side-by-side or in competition with other projects of questionable value. This inconsistency has threatened to discredit the entire national programme. [18]

New issues have emerged with policy of offering stipends. Quite suddenly becoming a CHW has been seen as a way of getting a job in a situation of desperate joblessness. Consequently there has been a proliferation of pseudo voluntarism, some participants hoping for jobs in the community, others aiming to simply get training that they hope will increase the likelihood of finding formal employment elsewhere. Catering to this massive need has been the development of fly-by-night training institutions evolving to make money rather than deal with the need, and who hand out bogus certificates or make unrealizable promises to aspiring candidates some of whom pay exorbitant amounts for the opportunity.[19] Genuine CHW programmes have found navigating the immense bureaucracy of formal SAQA accreditation by the Health and Welfare Sector Education and Training Authority (HWSETA) almost impossible, and very few have comprehensive accreditation. At the moment this is the major bottleneck to expansion.

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Recruitment is often haphazard with self-selection being dominant, commonly resulting in individuals with inappropriate personalities, backgrounds and skills attempting to provide a service, often ineffectively. Frequently self-promoting candidates who have not been properly screened, and who are not necessarily the best people for the job do the work while more suitable self-effacing candidates are not considered.

New standardized curricula excepted, much of the existing training, where it is offered, often varies in length, content and methodology. More often than not there is no formal assessment of competence and no recognition of training given or proper certification.

Career pathways hardly exist for CHWs and those who would seriously like to practice must carefully consider whether it is a wise first step if they wish to progress towards a formal career in recognized professional disciplines such as nursing, medicine, pharmacy etc. Where becoming a CHW was clearly an inappropriate choice there has been no means of guiding candidates into alternative career paths that would more suit their needs. Some of the CHWs trained as caregivers, once faced with the day-to-day challenges of caring for the helpless, vulnerable and dying, discover late that this is not the work they want to do.

Mentoring, supervision, and other support mechanisms are frequently absent or very weak. Accountability is consequently poor. A major problem is that many of the lower level workers are not receiving adequate supervision. As a result there is a lot of unnecessary suffering of patients in many communities who do not get optimal care.. Without adequate support good CHWs become demotivated and burnt out.

For the above reasons, it is important for new programmes to be based on the best experience, including published evidence. Although considerable effort is

being made in the field to develop the evidence for a national model to serve as the basis for the CHW programme in different provinces, there is still little certainty whether this is the only or most appropriate model. Equally while there has been significant steps taken to standardize a curriculum that is aligned to unit standards in the National Qualification Framework, so as to ensure quality training and practical career pathways, it is still not known how to deal with the many excellent CHWs whose lack of literacy or formal education has been a barrier to them becoming more highly effective.

Excellent as the outcomes-based development of SAQA aligned courses may sound in theory, the real benefits of standardized approved courses versus the more informal approaches previously adopted to provide skills in situations dominated by oral tradition and low literacy has yet to be demonstrated. Many of the best CHWs are traditional healers and older women, motivated as much by philanthropy as to prospects of earning income.

3. STUDY OBJECTIVES

- Study the range of ways that programmes have evolved and are operating and investigate the ways that CHWs have been recruited, trained and supported.
- Assess the extent to which CHW deployment is addressing important health priorities and particularly how they are assisting the health and social service sector to deal with emerging threats such the HIV/AIDS and tuberculosis epidemics.
- Document success stories and lessons in the varied work being undertaken by a broad range of CHW programmes in all provinces.
- Identify how projects and individuals can be supported to scale up their efforts to collaborate more effectively in develop a national programme.
- Compile recommendations & lessons learned with a view to developing a more evidence-based approach for formulating national and provincial policy.
- Develop an approach to register of CHW programmes to complement an individual register as the basis for establishing a regulatory framework and mechanism.

4. METHODOLOGY

The work in the project was undertaken by the SEED Trust, supported administratively by the Health Systems Trust. The work was carried out primarily in the second half of 2005, except for the Northern Cape, which was done in January of 2007

In general the methodology for the study involved a process of :

- Interviewing stakeholders, mostly by phone, a list of researchers who had local knowledge or experience with CHWs were identified
- Using snowball methods, web-searches etc. provincial researchers identified a diverse range of CHW project types in the province to which they were assigned.
- Compiling of a table of CHW/CCW projects in each of the the provinces, listing the name, general description and contact details of the project (In MS-Excel)
- Preparing a rationale for the selection of three to five projects for special attention in each province.
- Visiting a purposeful sample of the projects to determine their structural and functional characteristics with a view to understand the natural history of the projects.
- Developing an in-depth understanding of each of the selected sites compared in terms of “best-practice” principles as defined below, using a checklist comprising a mix of quantitative and qualitative elements.
- Compiling an overview which drew from the research findings and addressed the study objectives and outputs required for the project
- Drafting a report incorporating the rationale, “best-practice” projects and provincial overview .

Research questions: Given the projects in this study were selected on the basis that they offered an opportunity to explore some aspect of best practice, they cannot therefore be regarded as typical of all projects. They are rather an illustration of some of what were regarded by the researchers in each provinces as projects worthy of consideration as examples of one or more good practices. A qualitative approach was used to try and deepen our understanding of how CHW projects arise, what needs they fill and how they perform their functions in complementing or competing with conventional and traditional health services. We were keen to learn in what specific roles have CHWs been successful. In what roles has their work been more questionable.

5. DEFINING BEST PRACTICE

Best practice has been variously defined, for example “The processes, practices, or systems identified in public and private organizations that performed exceptionally well and are widely recognized as improving an organization's performance and efficiency in specific areas.” [20] or “a technique or methodology that, based upon experience and research, has proven to reliably lead to a desired result.” [21]

The term best practice generally refers to the best possible way of doing something; it is used in the fields of business management, software engineering, and medicine. [22] Best practice is a comprehensive, integrated and cooperative approach to the continuous improvement of all areas of health care delivery.[23] A concept referring to the best way of doing something, normally a function or process within an organisation. Hence for example ‘best practice organisations’ - those who are at the forefront or have the best procedures.
Finally, best practices can be described as a system in which information is collected, analysed and used to reformulate recommendations for all those involved in efforts to resolve a problem. It involves the gathering and application of knowledge about what is working and not working in different situation and contexts through feedback-learning and reflection (UNAIDS , 2001)[24].

Table 1: Choosing best practice projects

Some of the criteria used in choosing a project for a “best practice” assessment	
♦ Reasonable in size, scope and coverage ♦ Showing appreciable effort towards a given CHW theme ♦ Exhibiting a high quality process. ♦ Has established an innovative process and achieved a significant outcome ♦ Has documented lessons learned. ♦ Has clearly documented processes used ♦ Wide community participation ♦ Appreciable degree of local ownership ♦ Has promoted capacity building within community	♦ Has demonstrated qualities for sustainability ♦ Has demonstrated qualities for replicability ♦ Availability of project literature, in particular pertaining to: ♦ Baseline information, ♦ Project progress monitoring, ♦ Follow-up surveys, ♦ Technical evaluations, other relevant research. ♦ Willingness of project administration and management to participate in the study ♦ Ideally at least, three years in existence

6. ETHICAL CONSIDERATIONS

The study involved primarily the gathering of existing public domain information and interviews with leadership in organizations of a public character keen to promote their work. There was no personal information required from informants and no CHWs themselves or community members interviewed. A formal ethical application was not made although the all interviewers informed their interviewees that there was no obligation to participate, confidentiality would be assured and that they could withdraw at any stage

7. RESEARCHER BIAS

While the lead researcher and provincial researchers acknowledge the need for objectivity in producing useful results based on sound evidence, they accept that that they have all at one time or another been advocates for CHWs, and this view could potentially colour the way that information is interpreted, despite their intentions not to do so.

Table 2: Evaluating best practice

Critera for evaluating "best practice"		
Good Process	**Good Outputs**	**Good Outcomes**
Appropriate actions, Empowering, Community involvement Acceptable Promoting local ownership Efficient Sustainable. Innovative Technically Sound	Relevant Effective Timely Quantifiable Adequate quantity Of low cost/benefit Accessible	Valid Expected Problem solving Lasting Wide and equitable coverage Sustainable Replicable

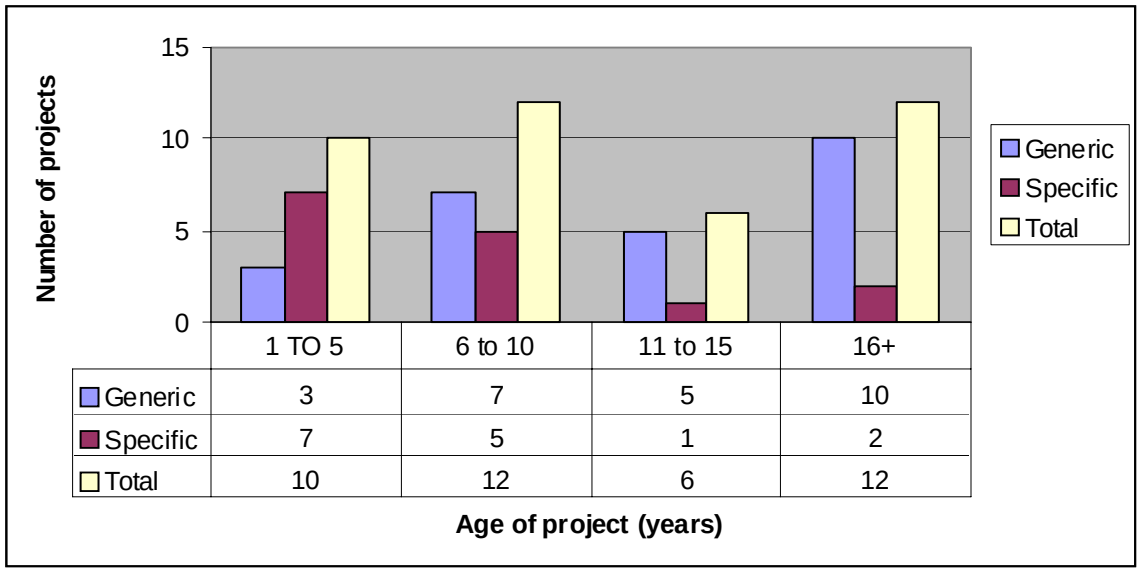
8. FINDINGS

8.1 The focus of CHW projects tends to broaden with age and experience

Focusing on one specific priority issue that is important to the community has often been a way of getting a project going. This focus tends to broaden and become more generic as projects become older and more experienced. The main reason for this is that community problems tend to present in a variety of ways. There are insufficient resources for an array of specific focus workers, so

over time, giving the diversity of presenting problems, CHW projects tend to increase the range of skills of CHWs. The average age of projects with a specific focus was 8 years, whereas the average age of projects with a generic or generalist focus was 18.2 years. One of the best examples of this is the Elim Care Group project in Limpopo, which started with a specific focus on eliminating trachoma, a major preventable cause of blindness and broadened this to a generalist CHW programme within a ten year period.

Fig. 1: Focus of CHW Projects by age of project



	1 TO 5	6 to 10	11 to 15	16+
Generic	3	7	5	10
Specific	7	5	1	2
Total	10	12	6	12

There are examples of NGOs taking a very specific initial focus, some on quite a large scale for example improving ART adherence (eg ARK) With experience and time, most such projects gradually broaden their focus as they realise the multi-dimensionality of community problems and gradually train their workers in more generic skills (eg. Choice). Having a very specific focus is usually simpler to fund in the short term, but gradually becomes a disadvantage and subject to donor fatigue. Skills from short-term specific projects can be very useful in building the range of competencies of CHWs as they broaden their competency.

8.2 Good governance

In general terms all of the projects in this study (100%) and most good practice organisations, whether large or small have a formal constitution and are accountable to a Board of independent people, though they may have been recruited by the champion(s) initially. A sound governance structure with democratic accountability to a Board is important in maintaining credibility of potential funders and donors. An effective management structure requires leadership in the form of a manager or director with a commitment to transparency, as for example the production of quarterly reports and annual audited statements.

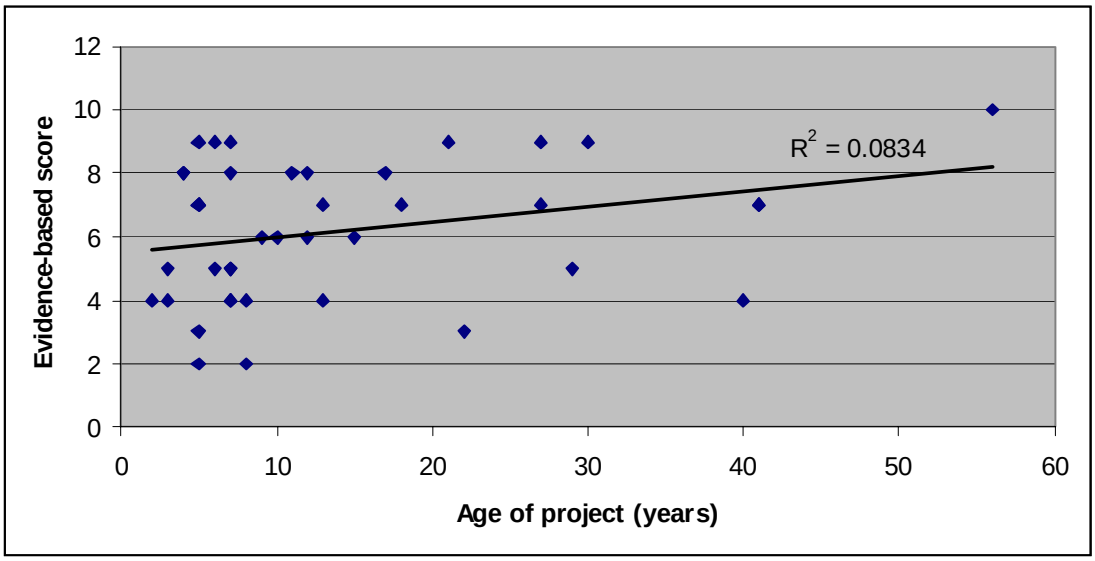
Although all the organisations recognised the need for good governance, few organisations (12.5% in this study), are meaningfully accountable to the communities that they serve, although most have some mechanism to report back on a periodic basis. Similarly most organisations recruit and select CHWs from amongst volunteers themselves. Few make this process fully accountable to the beneficiary community. This is important as CHWs are by definition supposed to be accountable to the communities they serve. Full accountability to democratic community-based management structures, which act as a liaison between health personnel and community based workers can do a great deal to promote the work.

8.3 More experienced projects use evidence for planning

An important starting point for any new project is undertaking a situation analysis before initiating the programme. This includes meeting local people and their leaders, drawing a map of the area showing its resources, understanding their perspectives on health and life and undertaking simple community-based surveys to understand more about the epidemiology of important diseases and conditions.

In the CHW project surveyed, the more experienced a project was, as measured by its age in years, the more likely it was to adopt the use of evidence into its programming. However, it was encouraging that many very young projects were using an evidence-based approach. Scoring for this included a combination of whether projects undertook needs assessments prior to intervention and whether this was followed up by regular monitoring and evaluation. Best practice involves undertaking a baseline survey to find out peoples needs before initiating the project; maintaining an understanding of client needs on a regular basis, collecting statistics, reporting, planning programmes based on findings and using rapid and participatory appraisal techniques.

Fig. 2. : Use of evidence-based planning by age of project



8.4 Successful projects are driven by champions

Successful projects are usually driven by skilled, energetic, charismatic people with a strong vision, also known as “champions”. Champions have at least four important attributes vital for success; talent, courage, tenacity and a positive mind set. Without this kind of impulse behind their work, many CBOs or NGOs do not thrive and may even close down when the champions that pioneered them leave. Champions are not easy for projects to recruit. It is they that recruit projects. Successful projects also tend to have more generalist approach and address a broader range of community needs. The CHWs correspondingly have a range of skills that they can apply in the community setting. They tend to place more emphasis on good supervisory practices such as regular supervision by a skilled professional health provider and collection of an appropriate set of statistics, In the projects visited for this survey most (73%) had an identifiable champion. Given that the search strategy was to search out and visit successful projects, this is perhaps not a surprising finding.

8.5 Funding and sustainability

The sustainability of projects depends on the availability of on-going funding, a diversity of funding sources and ability to mobilise volunteers or low-paid workers who in the face of their own poverty are willing to care for the needy in their communities because of their own altruism or the desire to improve their employment opportunities. Projects were scored according to the range of funding. Projects with Government funding or church funding were scored slightly high by virtue of the fact that few private donors will continue to fund projects on an ongoing basis in the absence of other sources of funding. While about half of the projects that were

Fig. 3. : Sustainability score by age of project in years

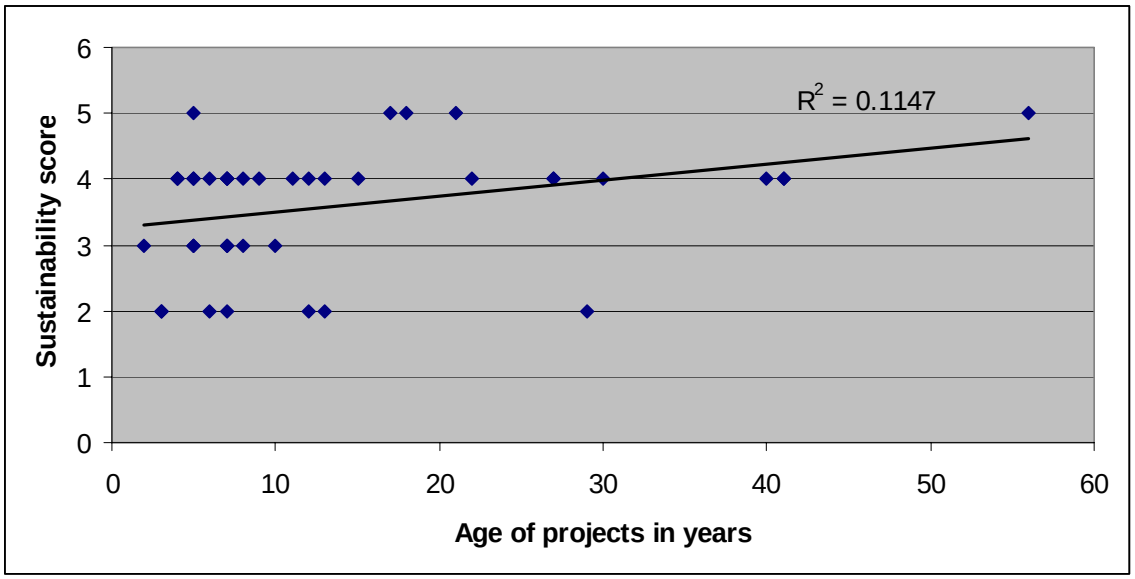
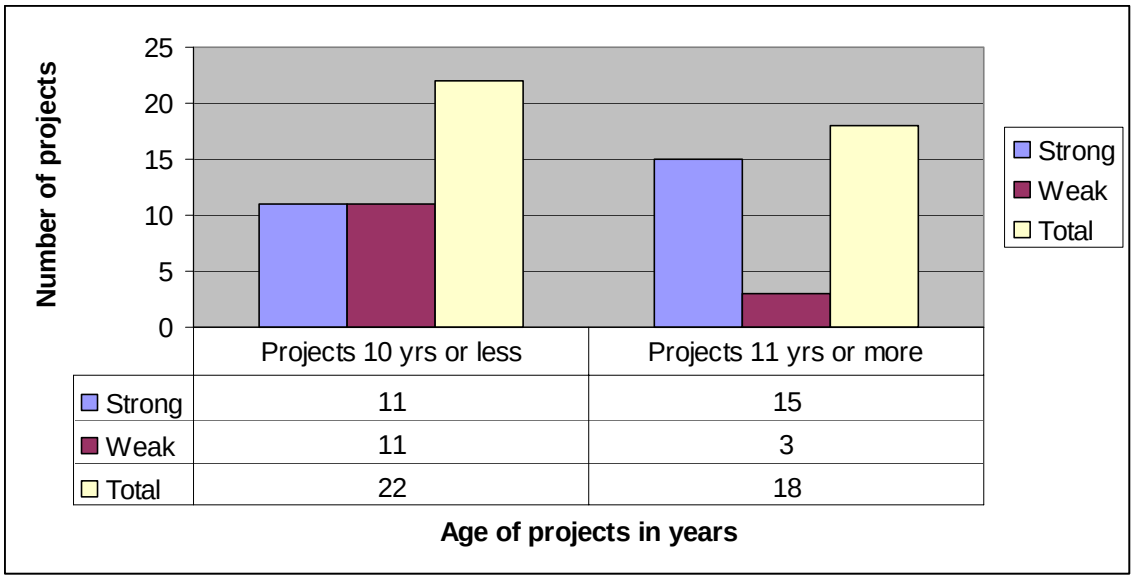


Fig. 4. : Proportion of strong or weak sustainability in younger and older projects



	Projects 10 yrs or less	Projects 11 yrs or more
Strong	11	15
Weak	11	3
Total	22	18

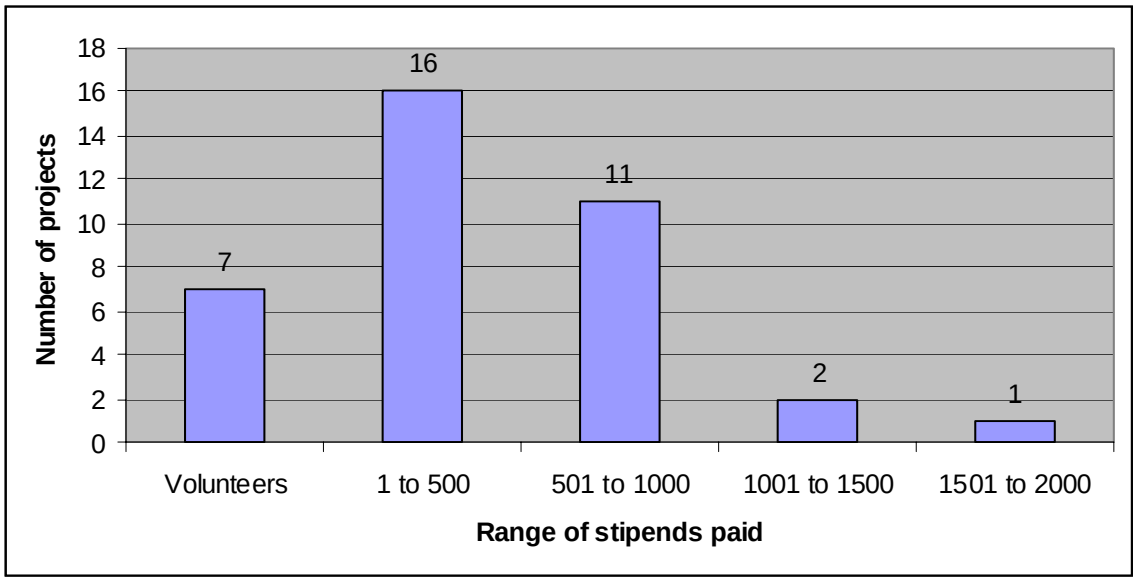
Nearly all the challenges that projects face relate to inadequate and sporadic funding. Funding recently has tended to be primarily earmarked for care, support and treatment, particularly of HIV and AIDS. There has been inadequate funding for health promotion, educational workshops and to build community capacity, for example skills of community health committees. Very little funding is available for management and administration and this has had an impact on the quality of supervision and limits community involvement as individuals may find that they incur out-of-pocket expenses which they can ill afford. (Zanempilo)

The older well established NGO programmes which were operational before the democratic transition were mainly funded by external donors and have tended to be sidelined or passed over since 1994 (Zanempilo, Elim). The ones that have survived have had to take on a more intermediary role (eg The Valley Trust, Progressive Primary Health Care KZN and Free State) or be part of a large more sector specific initiative such as FAMSA (Eastern Cape) or Red Cross (Makopane, Limpopo). The AIDS Foundation of SA has done particularly well because of the emphasis on HIV and AIDS related activities. There has been a huge outgrowth of a large number of small, very localised, HIV and AIDS focussed CBOs.

8.6 Voluntarism and stipends

Less than 20% of projects still encourage pure voluntarism among their workers. In this study the majority of projects were paying some form of stipend, although this varied considerably. About 43% of projects offered CHWs a small stipend of R500 per month or less. About 30% of projects pay between R500 and R1000. Less than 10% of projects paid more than R1000 per month. The median amount paid was R500.

Fig. 5. : Range of stipends paid to CHWs



CHWs may initially begin as pure volunteers, where the benefits of what they learn and an opportunity to express their altruism are sufficient inducement to encourage their participation without jeopardizing their own situation. As time goes on and the new information they are learning levels out and more and more is expected of them, it is reasonable that they will expect to receive a stipend to partially compensate them for their efforts, if they are not to jeopardize their own families. While the policy does not ignore the fact that pure voluntarism might be appropriate in the earliest days of their career, it recommends that at least R500

be the stipend in the first NQF level, but increase to a R1000 as they move to levels 2 and 3, possibly even higher once they are fully qualified as a CHW in their fourth year of training. Many projects, in addition to the small stipends provide their CHWs with other modest incentives such as uniforms, shoes, umbrellas etc. However, on the down side, not all projects are able to offer their CHWs regular supplies of consumables such as gloves, antiseptics etc.

This practice seems to be followed by several CBOs who start with an initial period of about a year of voluntarism during which training is given, and which serves as an informal probation period during which people's performance and commitment are assessed. They then move into a period of being given a stipend, and if they continue to progress may given additional status such as for example being considered a "facilitator" or "coordinator" (eg. Makopane Red Cross Society, Waterberg District, LP and Sentahle Home Based Care, Capricorn LP)

One significant anomaly is that the KwasZulu Natal CHW programme, the largest in the country has for many years been paying its CHWs more than R1500 per month and this has been the source of much confusion in the Province, because the national CHW policy has recommended amounts less than this. Lay counsellors, who tend to be young matriculants usually earn about R1,500 per month and usually work in clinics or stand alone facilities. (Eg Hlatlolanang Health and Nutrition Project)

8.7 Attributes of CHWs

Slightly older, less educated women seemed to provide better care. In some projects there has been a conscious attempt to include traditional birth attendance or traditional healers (Good example of this is to be found in Zanempilo, WC and The Valley Trust KZN) On the other hand, younger more educated workers seemed to provide information better, particularly to their peers. Peer group educators tend to be young post-school individuals who are enthusiastic and looking for ways to get a job thorough building personal experience.(Ingwavuma Orphan Care, KZN) There are many more young men in this group. Similarly, lesser educated nursing assistants can often be better motivators than more skilled professionals. They often have a better understanding of and ability to work with local people. Often becoming a good educator depends on developing a participatory teaching approach, which many who have been trained in formal educational settings find difficult to achieve.

Good CHWs know their communities well. They should enjoy working with people and care about them, be willing to commit, and work hard. Good practice is that they would have a map, even if its hand drawn and a file with the records of the clients that they visit neatly organized.

Practices introduced by respected local people are often adopted more readily Rural women are, contrary to belief, often highly respected and very innovative

and can help programme designers with programmatic improvements. They often give freely of their time as unpaid volunteers if they feel a project is worthwhile. Taking account of traditional views can often lead to approaches that are more effective than if these views were ignored. Allowing local people ample time to absorb messages, ask questions, argue and discuss until there is broader community understanding often leads to more profound diffusion of innovations in the longer run.

8.8 Functions and activities of CHWs

CHWs can perform many functions. It may not be possible to do all of them equally well, but a general understanding of each function is important if clients are to get a well-integrated service. Functions include home based care for people that are ill or dying, care of orphans or other vulnerable children, care of the elderly, counseling, nutrition support, gardening education. Almost all the projects (93%) in the study dealt with an aspect of HIV and AIDS. About 68% of the projects dealt with poverty or social issues and 63% dealt with chronic illness. Other issues dealt with by at least a 1/3 of the projects included TB, children's illnesses, malnutrition and terminal illnesses. Generally, issues such as working with the elderly, dealing with acute illness in adults, disability and mental health were dealt with by less than 20% of the agencies.

Fig. 6. : Types of problems that CHW agencies deal with

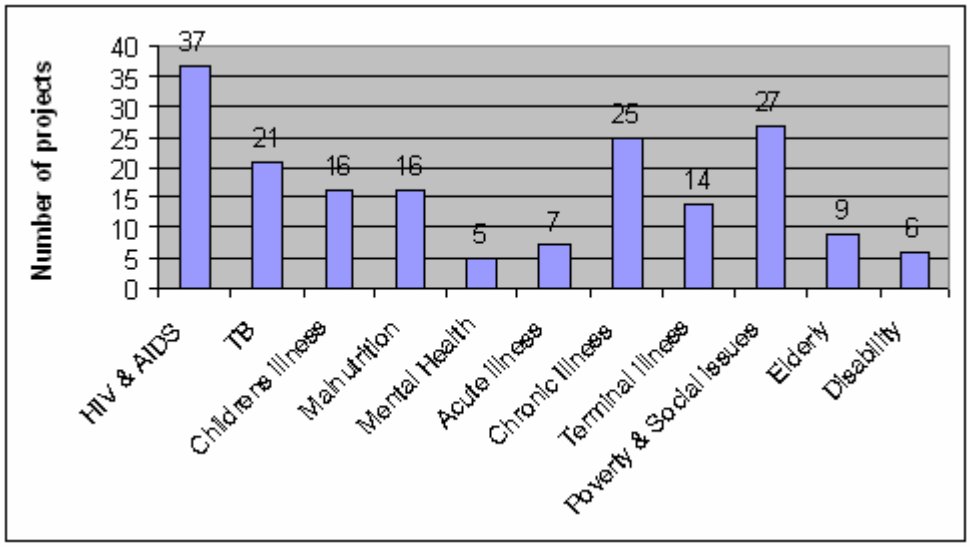
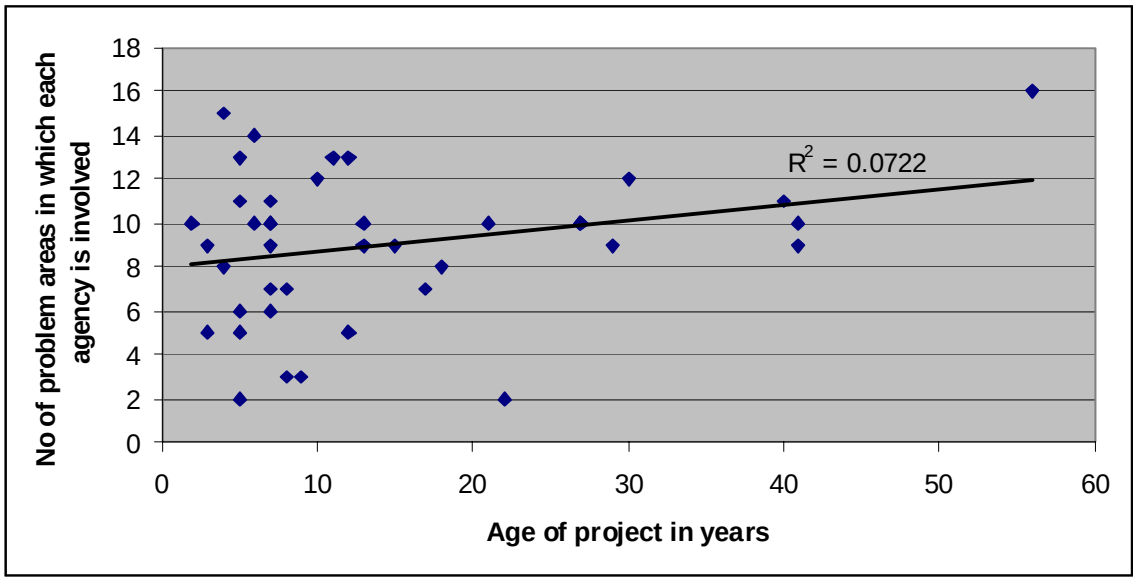


Fig. 7. : Number of problems with which agencies deal by age of the project



Although there is a lot of scatter in the number of projects that agencies less than ten years old deal with, there is a tendency for the more established CHW projects to deal with an increasing range of problems

Fig. 8.: Types of activities in which CHW agencies are involved

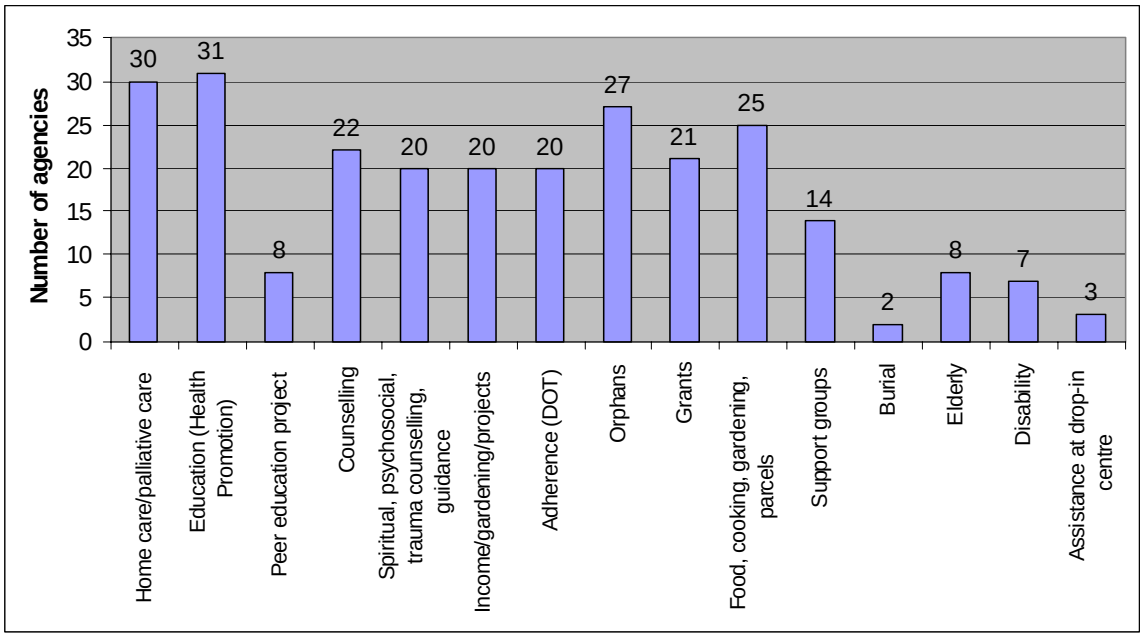
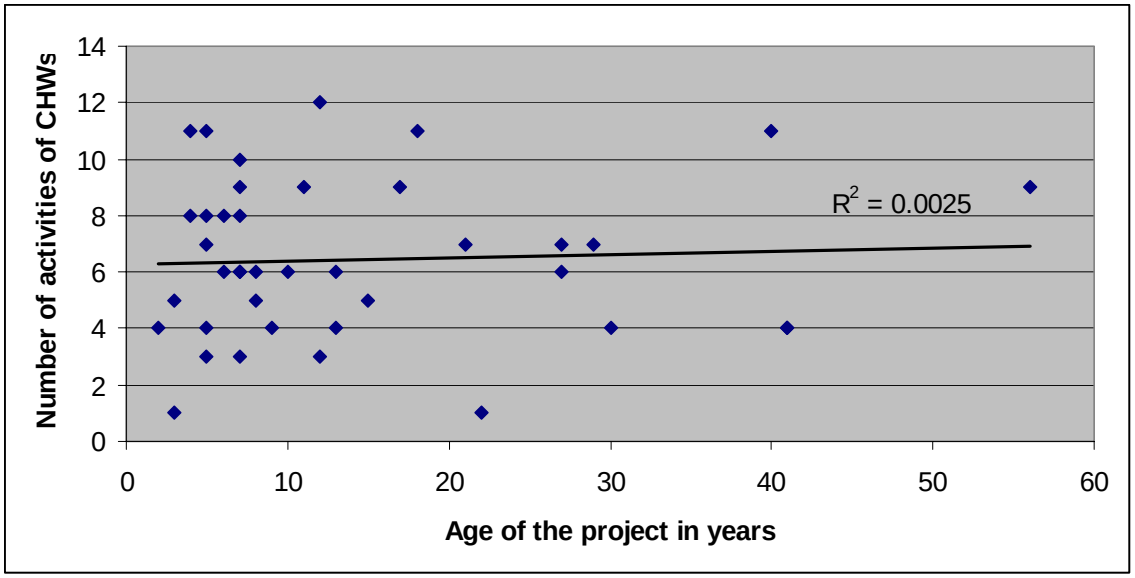


Fig. 9. : Range of activities undertaken by CHWs by the age of the project in years



CHWs are involved in a very diverse array of activities. More than 60% of all the agencies were involved in health promotion/health education, home-based/palliative care, caring for orphans and vulnerable children or some aspect related to nutrition, food provision, preparation or food security. About half of the projects were involved in providing counselling, assisting clients to access grants, some form of psychosocial support, income generation and providing adherence support in the form of DOTS.
In general terms home based worker caring for sick people generally are able to see and care for 3 families per day or 15 home visits per week, and 60 home visits per month. Orphan care workers, who are essentially looking after healthy children, can generally make between 5 and 10 visits a day.

Support groups were being provided by 35%. About 1/5 of the agencies were tackling uses such as peer educational support, care of the elderly, dealing with disability, assisting at a drop-in centre or providing support for burial. There was no significant trend in the number of activities being undertaken by the more experienced projects. On the whole the difference was mainly in the quality of service provision.

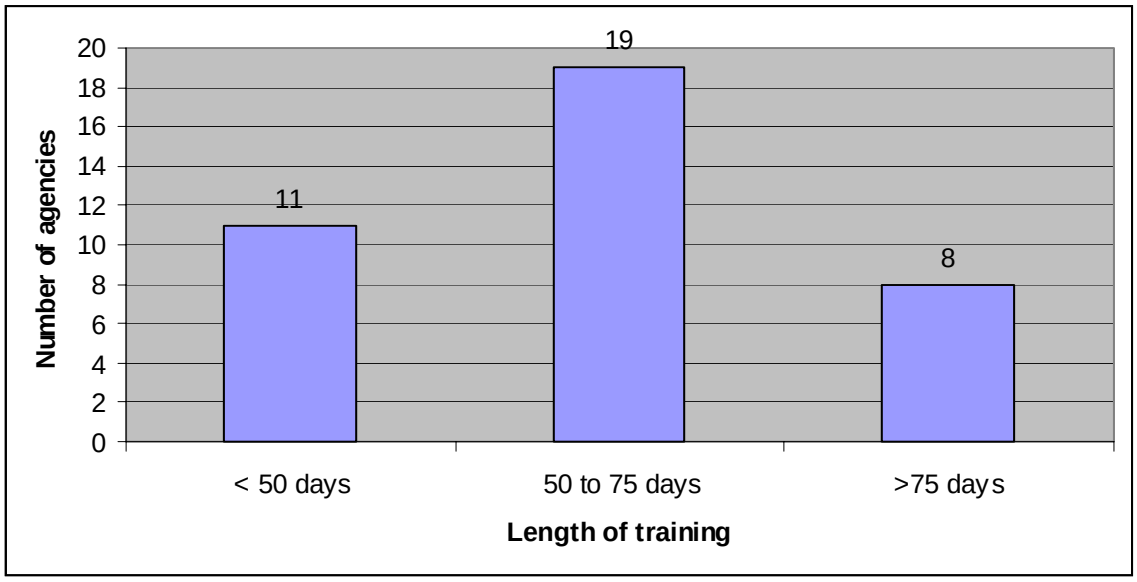
8.9 Recruitment

Very seldom did any of the CHW projects recruit their CHWs in a participatory way through a democratic community structure (12.5%). The majority of agencies recruited their CHWs directly (87.5%). This obviously falls short of the best practice requirements for community oversight of the work of CHWs and runs the risk that CHWs may not always be acceptable to the communities they serve. It also limits the ability that communities have for correcting problems that they note in the work of CHWs.

8.10 Training

In the absence of standardized training that meets SAQA requirements, most organizations opting to train CHWs for a role in HIV and AIDS arranged for them to attend the 59 day training programme and then supplemented this with additional short courses on a variety of supplementary topics. At least half of the organisations provided training of between 50 and 75 days. A further 20% gave additional training for more than 75 days. About 29% gave their CHWs less than 50 days of training.

Fig. 10. : Length of training of CHWs by their agencies



Very few of the agencies were themselves accredited by SAQA to undertake training. This was principally done by a few agencies who had the capacity to undertake training for both their own workers as well as those of other agencies.

8.11 Supervision

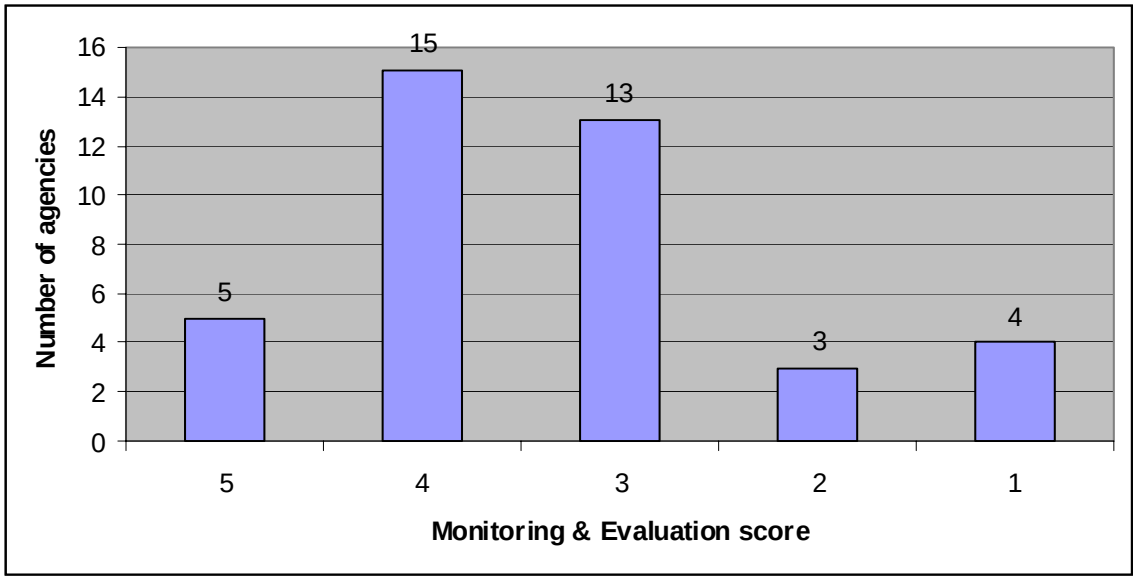
About 65% of projects had a professional supervisor. A few projects also had a second layer of supervision. Most projects used monthly meetings as a means of supervision. A few met more often, such as weekly. Very few had a regular quality control process in place where supervisory visits were made to the community accompanying the CHW.

8.12 Monitoring and evaluation

Ongoing monitoring and evaluation by the project, especially where the data is used effectively to look at programmatic strengths and weakness can be a

powerful way of improving the effectiveness and profile of the project. It can reveal those areas where real progress is being made and those where there is none.

Fig. 11: Monitoring and evaluation scores of agencies



Successful projects develop a confidential record keeping system for clients to maintain high quality care as well as providing data that gives insight into how to improve the services. Records are neatly maintained by CHWs in a file.

Having a computerized data base and other records is important, but having a well managed manual system is much better than a disorganized computer-based system that no-one understands.

8.13 Relationship with health and social services

The attitudes of health personnel towards CHWs is very important. A positive view of hospital and clinic staff can be a critical factor in strengthening their credibility and improving the two-way referral system. Support from the Government staff does not seem to built into the system consistently and is very dependent on a sympathetic staff member. This may change when the individual leaves Referrals from Government services to projects tends to be very poor. Most of the problems are identified by CHWs themselves. (Zanempilo).

18.14. Innovation

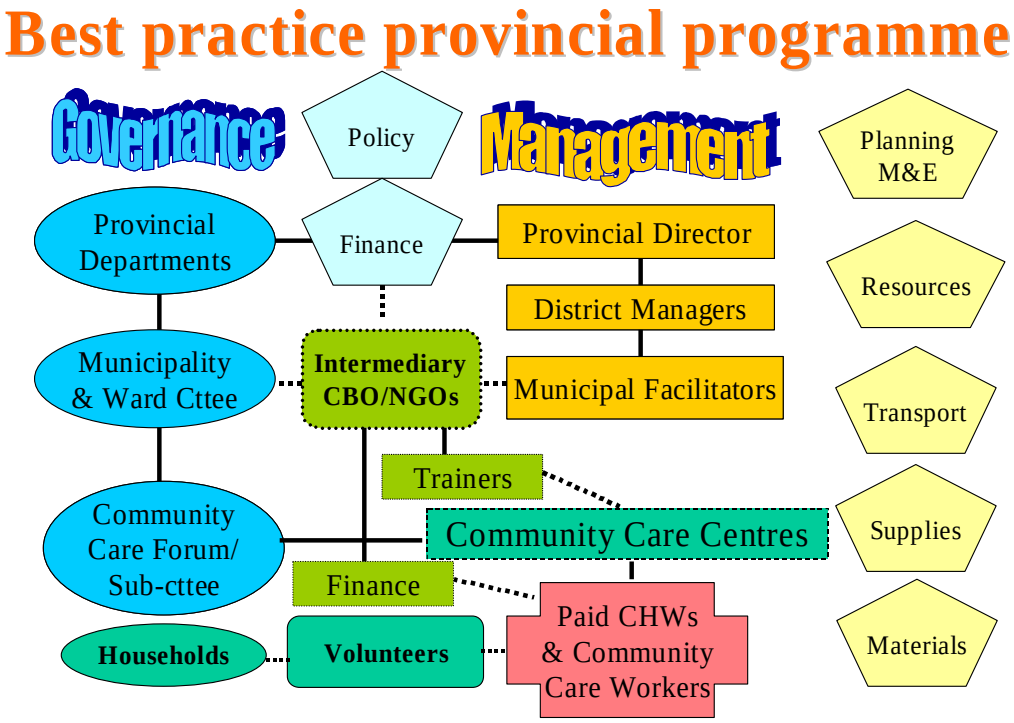
Successful innovations are not always expensive. Some of the very high impact innovations in CHW projects have been low cost solutions that have spread to impact on a large scale eg. Not sharing face cloths, preparing and using oral rehydration solution, etc.

Some of the most successful innovations have revolved around imaginative ways of improving communication eg. Use of songs and drama to trigger debate and discussion.

9. RECOMMENDATIONS

- **Policy:** There is a need for explicit new policies to clarify what has become an extremely chaotic situation.
- **Leadership:** Recognition needs to be given that it is champions who need to be encouraged more than managers appointed
- **Accountability:** Organisations need to be more accountable to the communities that they serve
- **Management:** The best practice management structures are participatory rather than hierarchical
- **Participation:** Needs to be enabling and empowering rather than an attempt to co-opt
- **Tasks & functions:** CHWs need to gradually develop generalist skills rather than being specialists in one area
- **Recruitment**: CHWs need to be elected by communities rather than appointed by agencies
- **Support:** Ongoing professional backup that is comprehensive and aimed at gradual improvements in quality is far preferable to sporadic high profile activity
- **Training:** Ongoing continuous training is preferable to the provision only of short course training at the beginning
- **Remuneration:** Payment of a stipend is important – voluntarism is valuable in the early stages; where it is ongoing it should be limited to a few hours a week.
- **Evidence based action:** The use of situation analyses, record-keeping, monitoring and evaluation to guide planning and implementation enhances sustainability.

Fig. 12: An example of best practice in a provincial CHW programme



Central to this model is the notion that every geographic constituency, envisaged here as the municipal ward, has a community care centre governed and managed by that community. The community care centre is the focus of integrated health, educational and social development (social cluster) activities for that ward including the supervision of paid community health workers. Community care centres currently exist in a variety of different, but related forms, such as drop-in centres, community multipurpose centres etc. The community care centre's (CCC) role is to coordinate the provision of all community based programmes to all the people of the ward drawing on the resources of national, provincial and local spheres of Government as well as the input of civil society. One aspect of the role is coordinating all CBOs and NGOs input .

Features in the model include the separation of governance and management; the active incorporation of the municipal sphere of government and its structure of ward committees; the delegation of powers to community level forums to elect the management committees of community care centres who manage the day to day activities of CHWs; the role of provincial departmental staff in facilitating involvement by contracting civil society rather than by line managing; the intermediary role of NGOs and CBOs to support democratic community structures by offering support in the form of training, financial management etc; the importance of clear policy and adequate finance from provincial treasuries; the need for a sequencing and steady flow of planning, M&E, resources (equipment, particularly the availability of transport, supplies, educational and other materials.

Fig. 13: Example of best practice in intersectoral collaboration

Best practice intersectoral collaboration

- Community involvement & accountability is an important current emphasis for all departments

Given that successful health promotion and primary health care requires active intersectoral collaboration, the mechanisms to bring this about at community level are a vital ingredient in the success of CHW programmes.

District level officials of the provincial social sector cluster (Health, Education and Social Development/Welfare actively engage with the local municipality officials and other departments in giving joint effect to the implementation of municipal integrated development plans (IDP) and provincial plans.

Fundamental to intersectoral collaboration at local level is the coordinating role of the democratically-elected ward committee, which is a general development community-based structure with a range of sub-committees. One of these is a community care forum which appoints or ratifies the appointment of the community care centre (drop-in-centre/multi-purpose community centre) management committee which is responsible for coordinating community-based health, educational and social development programmes in the ward.

Community Development Workers encourage collaboration among all community workers

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