Assessing the Implementation of the Government Funded Community Health Worker Programme in Selected Clinics of the Eastern Cape Province, South Africa

PRINCESS NONZAME MATWA

A minithesis submitted in partial fulfilment of the requirements for the degree of Masters in Public Health in the department of School of Public Health, University of the Western Cape.

Supervisor: Professor Uta Lehmann

December 2007

Assessing the Implementation of the Government Funded Community Health Worker Programme in Selected Clinics of the Eastern Cape Province, South Africa.

Princess Nonzame Matwa

2216539

Keywords

Assessing implementation

Community health workers

Eastern Cape Province, South Africa

HIV/AIDS

Home and Community Based Care

Human resources

National Community Health Workers Policy Framework

Policy Implementation

Social Sector Expanded Public Works Programme Plan

Volunteers

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CBO	Community Based Organisation
CBW	Community Based Worker
CC	Clinic Committee
CCHBHC	Comprehensive Community and Home-Based Heath Care
CCW	Community Care Workers
CHSW	Community Health Support Worker
CHW	Community Health Worker
CLO	Community Liaising Officer
DoH	National Department of Health
DoPW	Department of Public Works
DOTS	Directly Observed Treatment Strategy
ECDoH	Eastern Cape Department of Health
ENA	Enrolled Nursing Auxiliary
EPWP	Expanded Public Works Programme
HASA	The Hospital Association of South Africa
HBC	Home Based Care
HCBC	Home and Community Based Care
HIV	Human Immunodeficiency Virus
HP	Health Promotion
HWSETA	Health and Welfare Sector Education and Training Authority
ISRDS	Integrated Sustainable Rural Development Strategy
JLI	Joint Learning Initiative

LC	Lay Counsellor
LSA	Local Service Area
NCHWPF	National Community Health Workers Policy Framework
NGO	Non-governmental Organisation
NQF	National Qualifications Framework
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
SPF	Small Projects Foundation
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WHO	World Health Organisation

Abstract

Assessing the implementation of the government funded Community Health Worker Programme in selected clinics of the Eastern Cape Province, South Africa.

Introduction: From 2004 the Eastern Cape Department of Health (ECDoH) started implementing the new community health worker (CHW) programme in all its clinics, but so far little is know about its implementation process, its successes and challenges. **Aim**: This study assessed the implementation of the new government funded CHW programme at three clinics of the Eastern Cape Province. **Objectives:** The study had the following objectives: (1) To investigate how the CHWs were recruited and selected (2) To assess the (content and duration of) training undergone by CHWs; (3) To describe the activities carried out by the CHWs; (4) To identify the support and supervision given to CHWs; (5) To identify the nature of incentives provided for the CHWs; (6) To describe the arrangements of governance of CHWs; (7) To identify the gap between the actual implementation and the expected processes laid down in relevant CHW programme and policy documents, (8) To make recommendations for changes in the implementation of the CHW programme in the Eastern Cape Province. **Methods:** This study was conducted at three purposefully selected clinics from one local service area (LSA) in the Eastern Cape Province. A cross sectional, qualitative, and descriptive design was used in executing this study. Informed consent was obtained from study participants. Six (6) focus group discussions were conducted with three (3) groups of CHWs, one group of provincial health promotion (HP) managers and two (2) groups of clinic committees (CCs); and seven (7) in-depth interviews were conducted with the three (3) facility managers, a representative from the facilitating non governmental organisation (NGO), two (2) LSA programme managers and one (1) interview with two community liaising officers (CLOs). Interview guides were used to facilitate both the focus

groups and in-depth interview processes. The programme and policy documents were also analysed. Descriptive statistics were used to characterise the demographic profile of the 19 participating CHWs. Data from interviews were analysed using the framework approach.

Findings: The following themes emerged from the data analyses:

- Deficient involvement of communities in CHW issues;
- Inappropriate educational and language requirements for volunteers to be selected in the stipend programme;
- Limited accredited training as well as uneven non formal training given to CHWs;
- Tension between volunteer and employee status of CHWs;
- Poor communication between service delivery levels and interpretation of policies;
- Tension around the ownership of the new programme among stake holders.

Conclusion: The implementation of the new government funded CHW programme in the Eastern Cape Province did not completely reflect the stipulations of the relevant policies. There is a need to improve policy implementation at all levels of health service delivery in the Eastern Cape Province.

Declaration

I declare that *Assessing the implementation of the government funded Community Health Worker Programme in selected clinics of the Eastern Cape Province, South Africa* is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Princess Nonzame Matwa 14th December 2007

Signature: 

Acknowledgements

I owe profound gratitude to the management and staff of the School of Public Health at the University of the Western Cape who, each in their own commendable ways supported me emotionally and professionally throughout the course of my studies. I am immensely grateful to my supervisor, Professor Uta Lehmann, for her constructive criticism, comments and suggestions that helped to improve the quality of my minithesis. I sincerely thank the management of the ECDoH, the District, LSA and clinics for their personal participation, as well as permitting this study to be conducted in their clinics. A special 'Thank You' goes to the CHWs and the CCs for their participation. Without them this study would not have been a success. I highly appreciate the Small Projects Foundation (SPF), the NGO that disburses stipends on behalf of the ECDoH to CHWs, for providing very rich and important information for this study, as well as for their permission to reveal their identity. Above all, I thank the Almighty for making it possible for me to come this far!

Table of Contents

Chapter One: Overview of the study

1. Introduction

Community health worker (CHW) programmes hold benefits for health and social development services in the public sector. Since the inception of the Alma Ata declaration, the value of CHWs in extending primary health care (PHC) has been emphasised. One important approach in various countries and continents, among the different strategies attempted over the last 30 years, has been to use local human resources such as CHWs in the rural PHC setting, areas which have been and are increasingly under resourced with regard to staffing. For regions that are faced with severe health worker shortages, like the Sub-Saharan Africa , the World Health Report recommends a reduction of undue reliance on qualified health staff by devolving responsibilities to other less qualified health care workers, a phenomenon dubbed 'task shifting' (WHO, 2006). For example, in the absence of doctors or where they are in short supply, nurses can diagnose and treat patients (within their legal scope of practice) successfully. In South Africa, the nursing Act through the South African Nursing Council refers to this as the extended role of professional nurses (Nursing Act, *2005*). Similarly, community workers can potentially deliver a wide range of PHC services, thus freeing the time of nurses. People living with HIV can themselves also undertake much of the responsibility for their own care, with CHWs adequately advising them in self-management. In this way CHWs can build bridges between the health facility (nurses) and the community (WHO, 2003; WHO, 2006).

In South Africa CHW programmes run by NGOs have existed since the mid-1970s. During the 1980s a few notable programmes impacting on child survival flourished with support from international donors. However, there was a tendency for these programmes to only be

accountable to their funding sources (Friedman, 2005). This reliance on international donor funding had negative implications for the sustainability of service delivery. It also placed the power to decide national priorities to be addressed in this country in the hands of funding agencies in developed countries, which many a times lacked awareness and sensitivity to community issues (Van Wyk, et al.., 2006). In 1994 the new democracy introduced a district health system which rapidly provided free or low cost access to care at a time when the new pandemics were exploding. But despite an increasing brain drain of doctors and nurses, for five years CHW projects found little support with the new government and old programmes floundered and died. At the same time, particularly in response to HIV/AIDS and TB, many NGOs and small CBO initiatives have mushroomed, but with little or no co-ordination and a diverse range of uneven quality (Khanya, 2006).

1.1 Motivation for CHWs in South Africa

The early 2000s have seen a change in the policy environment with regard to community health workers, partly in response to the increased care needs created with the HIV/AIDS pandemic. Growing concerns regarding the impact of HIV/AIDS on the public health system and the needs of affected patients have highlighted the need for HCBC (DoH, 2001).
Two key policies inform and define the sector, namely the Expanded Public Works Programme (EPWP) and the National Community Health Workers Policy Framework (NCHWPF).

1.1.1 The Expanded Public Works Programme

The EPWP has its origin in the agreements of the Growth and Development Summit between organised labour, business and government in June 2003. Its broad aim is to create

"temporary work opportunities for the unemployed, using public sector expenditure". The policy further aims to ensure that "all of the work opportunities generated by the EPWP are therefore combined with training, education or skills development, with the aim of increasing the ability of people to earn an income once they leave the programme". Within the social sector, which includes the health sector, the EPWP "employs people, through NGOs and community based organisations (CBOs), to work on home-based care (HBC) and early childhood development programmes" (all above quotes from the Department of Public Works (DoPW), not dated).

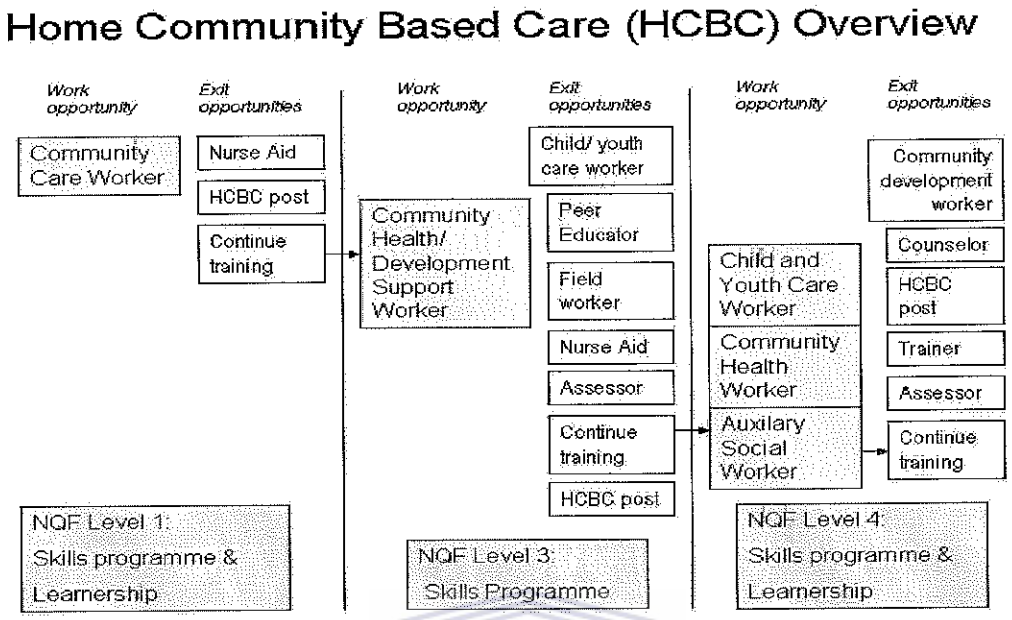
Within the Department of Health the programmes identified for the EPWP are:

- Directly Observed Treatment Strategy (DOTS)
- Voluntary Counselling and Testing (VCT)
- Nutrition advisors
- Lay counsellors
- Community Health workers (Social Sector EPWP Plan, 2004).

The principles of the EPWP which are relevant for this study are that those employed through the EPWP should be volunteers, i.e. have done voluntary work in their communities; that EPWP employees should undergo skills training in line with NQF requirements which ultimately lead to a formal qualification; and that matriculants should be targeted for higher-level training at NQF level 4.

The following diagram, taken from the EPWP Social Sector Plan illustrates the intended training, work and career opportunities within the sector (See Figure 1).

Figure 1: Overview of Home Community Based Care (HCBC)



Source: Social Sector EPWP Plan, 2004.

The Social Sector EPWP Plan recommends a minimum of 10 home-based carers per site offering HBC and estimates that 35,000 CHWs at NQF level 4 are needed nationally. The plan sets out that while specific HBC programme at all levels should be organized through skills programmes (according to the Skills Development Act) and funded through the National Skills Fund, generic health workers training should be organised and funded through the Department of Health.

It is the HBC aspect of the EPWP which is taken up by the NCHWPF.

1.1.2 The National Community Health Workers Policy Framework

In October 2003 a national Lekgotla on CHWs was held at which the Minister of Health and the national DoH encouraged provincial departments to rapidly establish generalist CHW programmes in disadvantaged communities throughout the country. Following input from a wide range of stakeholders such as municipalities NGOs, academic institutions and other structures in civil society during the Lekgotla, the DoH in collaboration with the Health and Welfare Sector Education and Training Authority (HWSETA) and the South African Qualifications Authority (SAQA) put this NCHWPF in place. An implementation framework outlining the essential elements of CHW programmes (See Figure 2) was launched in February 2004 (DoH, 2004).

Figure 2: Overview of the Community Health Workers Policy Framework

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

- The State President's articulation of the commitment 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.

Source: Friedman, 2005.

1.2 The challenge of policy implementation

Smit (2003) pointed out that in the past research focused mostly on the generation or production of policy, while little attention was paid to what happens on the ground, at the micro levels where policy text translates into practice. It is precisely at this level where the policy implementation or non-implementation decisions are taken. At the same time, emphasis is placed on outcomes evaluation to determine whether a health programme was successful. Process evaluation involving assessment of programme implementation, which is viewed by Saunders, Evans & Joshi, (2005) and Lips & Grant (1990) as particularly important in providing accountability information to policy makers, is mostly neglected. Data

from these evaluations may be used to indicate whether key components of a programme have been altered or not implemented.

South Africa is no exception to the above scenarios. Around the issue of policies, the country is characrerised by what Hernandez & Hodges, 2003) in Fixsen, et.al. (2005) calls more paper implementation and less process implementation, meaning that more emphasis is placed on putting into place new policies and procedures whilst less emphasis is placed into putting new operating procedures in place. As pointed out by Klugman & McIntyre (2000), after 1994 the country went into a frenzy of new policy generation. Because these were not well thought through or no comprehensive consultations took place between the policy makers and programme implementers on the ground, most of these were partially implemented and others never took off at all. Pieterse (1998) in Schneider & Stein, (2001) referred to this gap between policy intentions and implementation as "a general institutional logjam in reorienting the South African public service towards new social goals".

A key observation by Gilson (1989) was that national CHW programmes, especially in developing countries, suffered from many implementation problems. Noted by Mazmanian and Sabatier (1983) in deLeon, (2002), these problems might emanate from lack of knowledge about the basic policy that identifies the issues to be addressed, stipulates the objective(s) to be pursued, and, in a variety of ways, "structures" the implementation process. Emphasised by Bhattacharyya et al. (2001) and Gilson et al. (1989), CHWs should be carefully selected, appropriately trained and, very importantly, adequately and continuously supported, in order for them to make an effective contribution.

1.3 Study Background

The School of Public Health has been working in the Eastern Cape Province for a number of years, conducting research on staff retention, the impact of the HIV/AIDS pandemic on personnel in primary care clinics and staffing arrangements for HIV care. In the context of this research we encountered the implementation of the new CHW programme from a health services perspective. Although implementation of this programme commenced in approximately mid 2004 across the province, there still seemed to be confusion and uncertainty among the programme implementers, regarding the processes to be followed in early 2006. An observation of proceedings in a meeting held by managers (district and health facility) and the NGO tasked with the employment of CHWs, revealed a lack of uniformity in implementing the programme especially at community level. There was no clarity around issues like how much time the CHWs should work, what specific duties should they perform, who and how their work should be monitored/evaluated. The NGO tasked to manage the CHWs' stipend denied being an employer to the CHWs, and instead regarded itself as a conduit through which the provincial department paid stipends to the CHWs. Clinic managers reported that CHWs wanted to know what benefits they were entitled to. A decision was taken to find out the CHWs' service conditions from the provincial office.

Under the above mentioned circumstances, it was certainly difficult to understand whether the CHW programme was operating as planned and was achieving its intended goals. Currently, there is no formal documentation of the implementation process from the inception of the new CHW programme. It was therefore decided to conduct an in-depth investigation of the implementation of the programme in one local service area, focusing on the roles of the key actors in the implementation process, The study will hopefully contribute to the

evaluation of the CHW programme's impacts. Werner (2004) asserts that this kind of research is relevant in this situation as it focuses on the questions "What is happening?" and "Is it what is expected or desired?" among other issues, in the implementation of social programmes. Unlike impact studies which often require several years of follow-up to track changes caused by a programme, implementation research studies can be designed and fielded quickly, therefore can feed timely information back to managers and policymakers.

1.4 Aim

The aim of this study was to assess the implementation of the new government funded CHW programme in selected facilities of the Eastern Cape Province.

1.5 Objectives

The aim of this study was achieved through following objectives:

- To investigate how the CHWs were recruited and selected
- To assess the (content and duration of) training undergone by CHWs
- To describe the activities carried out by the CHWs
- To identify the support and supervision given to CHWs
- To describe the nature of incentives provided for the CHWs
- To describe the arrangements of governance of CHWs
- To identify the gap between the actual implementation and the expected processes laid down in relevant CHW programme and policy documents.
- To make recommendations for changes in the implementation of the CHW programme in the CHDM.

Chapter outline

Chapter 1: Overview of the study

Chapter 2: Literature review

Chapter 3: Methodology

Chapter 4: Findings

Chapter 5: Discussion

Chapter 6: Conclusions and recommendations

The following chapter will be a review of literature in relation to this study.

Chapter Two: Literature Review

2. Introduction

The main objective of this chapter is to examine the literature on implementation of CHW programmes locally and in other countries, the intended focus being on large scale programmes.

2.1 CHWs as a resource for health care delivery

In the face of increasing morbidity it is clear that there is a need for more health workers especially in the remotest rural areas that are hard to reach. Efforts are made to increase the numbers of doctors, nurses, midwives, pharmacists and technicians who are entering the workforce. But recruitment and training of these professionals takes time, four to six years, training is often insufficient, and many countries are experiencing an accelerating brain drain of health care professionals (JLI, 2004). Therefore, it is essential to find alternative and simplified models that can quickly expand the current health workforce.

Task shifting is one such alternative recommended by the WHO (2006). Task-shifting, a process of moving appropriate tasks to less specialized workers is one of the alternative strategies to provide human resources where and when needed. For example, community workers can potentially deliver a wide range of HIV services, thus freeing the time of nurses and other professionals. This process expands the human resource pool and has the added advantage of building bridges between the health facility and the community.

It is a fact that CHWs represent an important health resource world over. Lehmann and Sanders (2007) reviewed the literature on the role of community health workers in low

income countries. Similar to other studies (Gilson, et.al., 1989; Friedman, 2002; Lehmann et.al., 2003; Friedman et al., 2007), they fully acknowledge the CHWs potential in extending coverage and providing a reasonable level of care to otherwise underserved populations. While scientific studies of impact are rare, there is evidence that suggests dramatic improvements can be achieved with well-designed and run community-based health volunteer programmes (Haines et al., 2007). The UNICEF conducted a review of large-scale national programmes in five countries of South Asia (UNICEF, 2004). The five countries were Bangladesh, Bhutan, India, Nepal and Sri Lanka. Most of these countries piloted CHW programmes in late 1970s. Based on the successful experiments in small-scale programmes, these countries scaled up the programme to national level by late 1980s.

CHWs have become a distinguishing feature of many PHC initiatives. In South Africa they play 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 primary health care.

2.2 Defining CHWs

With the varying demands and differing levels of health within countries, regions, districts, and villages, each community has its own version of the CHW. A widely accepted definition was proposed by a WHO Study Group (WHO, 1989, quoted in Lehmann & Sanders, 2007): "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers". Their role in the health care delivery

system, according to the Health Resources and Services Administration (2007), reflects the following all embracing definition of CHWs: "Community health workers are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments and usually share ethnicity, language, socioeconomic status, and life experiences with the community members they serve. They have been identified by many titles such as community health advisors, lay health advocates, "promotores(as)," outreach educators, community health representatives, peer health promoters, and peer health educators. CHWs offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counselling and guidance on health behaviours, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening". Walt (1989) also gives a similar definition, but goes further to say that "They are generally not, however, civil servants or professional employees of Ministry of Health". The latter part also applies to the South African CHW as envisaged in the National Community Health Worker Policy Framework (2004). Here in South Africa, a policy guiding the government funded CHW programme –the National Community Health Workers Policy Framework (2004), also stipulates that CHWs will not be government employees, but an NGO funded through conditional grants (by the government) will employ the CHWs and pay them stipends.

2.3 Challenges of CHW programme implementation

In recent years, many countries including South Africa have expanded their health systems by training CHWs on a large scale. These CHWs are either paid or voluntary workers. The success and effectiveness of small, well-managed CHW projects has been documented. The

same cannot be said about national large scale programmes' effectiveness. Gilson et al.. (1989) reported that there was concern in relation to the quality of their work, the amount of work they do, attrition rates, the precedence curative or facility work takes over preventive or community work etc. Lehmann and Sanders (2007) illustrate that the fate of human resources management programmes is determined not only by a single isolated factor, but by a "combination of these factors". These authors found that lack of supplies, poor selection criteria, poor or non existent supervision were some of the factors that led to failure of large scale programmes in many countries. Walt's opinion on this is that most large scale CHW programmes were expansions of previous vertical approaches. On scaling up of the small programmes, not all aspects of the system are up graded. Most commonly, only the numbers of volunteers were increased as well as their roles and functions, while resources for up skilling, supervision and support remained unchanged (Walt, 1988).

Friedman, et.al (2007) conducted a study in South Africa 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 and lessons learned to improve practice. They concluded that CHW programmes were particularly important in the comprehensive home-based response to the HIV/AIDS and TB pandemics, as well as in other more traditional areas of PHC. For successful strengthening of the CHW programme, they recommended that the following be addressed: policy related issues, leadership, accountability, participation, tasks and functions, recruitment, support, training and remuneration. Another study by Slatsha (2005) looked at organisations and institutions that provide HIV and AIDS services at sub district level in all provinces in South Africa. Findings

of this study highlighted a shortage or non availability of lay counsellors in some Voluntary Counselling and Testing (VCT) sites. Both these studies did not include government funded facility based CHWs, the main focus of this study.

2.4 Developing models of good practice

There have been several attempts over the years to define good practice and develop guidelines for good and sustainable CHW programmes (e.g. WHO, 1987; WHO, 1989). Recently the WHO South-East Asia Region "developed a generic model for comprehensive community- and home-based health care to provide information to Member States on how they could strengthen community health services to meet the changing health needs and to provide holistic, integrated and continuous care that is patient/client-centred, with the active involvement of communities" (WHO, 2004). This model was then field-tested in Bhutan, Myanmar, Nepal and Thailand in 2002-2003 and was found to be a useful tool in assisting countries to better organise and manage their community health services (WHO, 2004). The guidelines for implementing this model are similar to the stipulations of the Social Sector EPWP Plan which guides the implementation of the CHW programme in South Africa, and therefore will form the basis for the rest of this chapter. Furthermore, lessons learnt from the South Asia reviews will be discussed in conjunction with the WHO guidelines, South Africa's Social Sector EPWP Plan and other literature.

WHO (2004) suggests that, to be successful, the implementation of a HCBC programme (a foundation for the roll out of a CHW programme in South Africa) needs to be undertaken in a careful and phased manner. It should be carried out over the following two well-defined phases: Phase 1: Preparing for the implementation. Phase 2: Implementing community- and

home-based health care (See Table 1). However, it is not necessary to carry the following activities in a linear and sequential manner. A number of activities take place at the same time, depending on the local situation. This framework embodies all issues around the implementation of HCBC/CHW programmes starting from the moment a need for such a programme is identified to the roll out stage. In the following, particular focus will be on Phase 2 since the programme (that the researcher is assessing) is already running.

2.5 Implementing comprehensive community and home based care

Table 1 below presents a summary of the activities performed for successful implementation of a comprehensive community and home based care (CCHBHC) programme. In this model, CCHBHC is defined as "an integrated system of care designed to meet the health needs of individuals, families and communities in their local settings. It includes primary prevention, i.e. prevention of health problems and/or diseases before they occur (health promotion and disease prevention); secondary prevention, i.e. early detection of problems or diseases and intervention (curative care and support); and tertiary prevention, i.e. correction and prevention of deterioration, rehabilitation and terminal care (rehabilitative care). It is underpinned by the partnership between health workers, clients/patients and members of the local community. CCHBHC can be provided in numerous settings in the community, by various people including health professionals, care assistants, and nonformal caregivers such as volunteers and family members. This model does not isolate the CHW as an independent provider, but places him/her within a PHC team. In simpler terms, the model utilises the settings approach to health care.

Table 1: A summary of activities in comprehensive community and home based care.

Phase 1	Phase 2
Activities to prepare for implementation	Activities to implement community- and home-based health care
1. Advocate widely for the need to implement the model. 2. Mobilize support from the local administration. 3. Form a leading team at the district level. 4. Select a health centre as demonstration site. 5. Define/redefine the catchment area for the provision of CCHBHC. 6. Forge strong partnerships and linkages. 7. Interact and negotiate with the defined population to be served. 8. Identify health care activities to be provided at the health centre, community and home. 9. Strengthen support systems at the health centre. 10. Orient health personnel. 11. Formulate a plan of action.	1. Determine and mobilize human resources to ensure an adequate number of care providers for the services. 2. Skills development of health personnel and volunteers. 3. Identify and mobilize financial and material resources. 4. Provide holistic, integrated and continuous care. 5. Supervise the provision of care to ensure continuing quality improvement of service provision. 6. Monitor the implementation of the model. 7. Evaluate the implementation of the model. 8. Review lessons learned from demonstration sites. 9. Consider further expansion of the use of the model. 10. Disseminate the results of the evaluation and future action plans to advocate for the wider implementation of the model.

Source: WHO, 2004.

2.5.1 Governance and ownership

The WHO makes it clear that the first and foremost step in programme implementation is the ownership of the plan by policymakers, planners, managers, health personnel and other stakeholders, particularly the community. Everyone involved in the implementation of the model should be aware of the total picture, and what action will be taken by whom and when. Where practical, they should be involved in the formulation of the plan, otherwise they should be given an opportunity to comment on the plan (WHO, 2004). In agreement with the above statement from the WHO, Khanya (2007) says that CHWs are accountable to the community who are also the clients and also to the facilitating agent as they provide support and resources to them. Accountability is achieved by means of contracts which lay down the

responsibilities and duties of CBWs in a clear job description and by reporting processes. Poor accountability systems were reported by organisations without contracts or regular reporting systems with their CBWs. To enable meaningful accountability communities would have to be properly briefed about what they should expect of the CBWs and trained in straightforward and simple mechanisms for monitoring performance. It was generally agreed that communities will need to be capacitated to take on such roles. Bhattacharyya, et.al (2001), the Social Sector EPWP Plan (2004) and the NCHWF (2004) all concur that communities and agents implementing the CHW programme should be part of governance structures in CHW programmes.

2.5.2 Determining and mobilizing human resources to ensure an adequate number of care providers for the services

The staff and skills mix ratio should depend on the local health needs and priorities, and the level of human resources available in the communities, including the services of volunteers and national human resource for health policies. The WHO guidelines suggest that, based on the agreed services, an analysis of human resource requirements needs to be made (WHO, 2004). This should take into account the available human resources for care within the community such as health volunteers, community groups and NGOs. Health volunteers should be identified early in close collaboration with the community. In addition, roles of health volunteers and other non formal caregivers for providing CCHBHC, particularly in home care and health promotion, will need to be clearly defined and supported.

Friedman et.al (2007) points out that recruitment of CHWs 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. Khanya (2006) recommends that to ensure accountability, communities must play a major role in the identification and selection of CBWs, who should have a passion for the work that they will be doing. The community should draw up the terms of reference and the memorandum of understanding with the CBW. Clients must be aware of the service that the CBW has to provide so that they are able to monitor the services they receive. Also the two policies guiding CHW programmes in South Africa, put communities, specifically clinic or community health committees, at the center in the selection of CHWs. Final selection is the responsibility of the panel formed of the clinic committee, the clinic manager and the facilitating agent (e.g. NGO or government representative).

In the review by the UNICEF (2004) all five countries have had standard criteria for selecting CHWs that included involvement of community members in the selection process. But in practice most often the volunteers were appointed by local elites, political leaders and health workers and were related to these people. Though the criteria for selecting CHWs could vary depending upon the local and national context, based on the successful examples, the generic selection criteria could include the following: selection by the community members equitably, married female (so the CHW would not leave the community) of 20 to 35 years from the same community, socially acceptable, preferably literate (so that they can record health information and use written materials), demonstrated involvement in and willing to work for the community (UNICEF, 2004).

Perold, Carapinha and Mohamed (2006) in a recent five-country study of community-based civic service programmes found that the majority of volunteers were females as men tended to look for salaried jobs. Their age ranged between 36-55 years, reason being that home based care especially in the field of HIV and AIDS is sensitive and requires a certain level of maturity and resilience. Also, beneficiaries of the CHW programmes (clients) were reported to prefer being looked after by older rather than younger volunteers (Perold, Carapinha and Mohamed, 2006).

In SA the policy as it stands now stipulates a total of 10 CHWs per site irrespective of the workload. For one to qualify for selection in the stipend programme, it is stipulated that: 1) one should have been a volunteer for a minimum of one year (since there is a very large pool of volunteers); 2.) one must not be in receipt of and government grant; 3) must reside in the catchment area served by the clinic where on is employed; 4) People living with HIV/AIDS (not getting a grant) and their adult dependents are targeted; as well as 5) persons from households with a total income of less than R1 500.00 (Social Sector EPWP Plan, 2004). Literacy was proved by the UNICEF not to be a barrier to being a CHW. It contends that once empowered, the poorest illiterate women can become leaders (UNICEF, 2004). The South African government also includes the illiterate in its CHW programme. This it does by stipulating educational qualifications as criteria for entry at different levels on the NQF. For example candidates with very little or no education should be accepted at Level 1, whilst Grade 11 candidates are targeted for the most senior category, a CHW at Level 4. This document and the NCHWPF emphasise the involvement of the community structures, a clinic committee in this case, in collaboration with the facilitating agent (government or NGO) in the selection of the CHWs.

2.5.3 Developing skills of health personnel and volunteers

WHO suggests that, following a training needs assessment, appropriate skills should be developed in health personnel as well as health volunteers and nonformal caregivers. The quality, regularity and relevance of the training is critical to CBW retention (WHO, 2004). Countries reviewed by UNICEF had provisions of basic foundation training that ranged from five days to three months, and refresher training (one to five days) at regular intervals (UNICEF, 2004). Training emerged as a strong motivating factor for CBWs who value the fact that training provides them with specialist skills that enable them to perform a service to their community, and that raises their status in the community; and at the same time it increases their future employment prospects. The staff (health professionals) needs to be equipped with the requisite knowledge, skills and attitudes to work with the community and other sectors as well as to train and support volunteers and other non formal caregivers in addition to their clinical skills. As a considerable part of care will be home-based, special efforts should be made to develop home visit skills in the staff. Hands-on experience and training is required for skills development. Training should be provided systematically and continuously according to needs, to ensure competency. In the South African context, Friedman (2005:178) comments that "the HASA 59- day training course for HBC workers.... has provided a standardised form of training, which has greatly accelerated the provision of quality community-based palliative care.... Training is based on a curriculum and materials developed by HASA and approved by the DOH. 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." Unit standards and qualifications have also been developed by the South African Qualifications Authority for ancillary and community health workers. But Friedman further comments that of the more than 60 000 community health

related volunteers linked to the Department of Health, "few of these have had the opportunity to receive standardised training and a variable quality of delivery has been the outcome" (Friedman, 2005).

2.5.4 Identifying and mobilizing financial and material resources to ensure the provision of quality care.

The level and type of financial and material resources required depends on the services to be provided. Finances are needed for the organisation of training and supplies needed for service provision. Also, provision should be made for incentives, whether financial or in kind to motivate the CHW. Although, according to the South Asia review report, service to the community was the primary motivation factor for volunteering, training, stipends, earning an income through selling medicines and possibility of future employment opportunities were the motivational factors for many CHWs (UNICEF, 2004). The concept of voluntarism is associated with altruism, but Dick et.al. (2005) questioned the expectation that people living in poverty should dedicate their energies to assist the health services achieve their objectives without compensation. They reiterated Bhattacharyya et al. (2001) suggestion that rewarding volunteers for their role may occur in a number of ways, either financially and or otherwise. Findings from a recent five-country (Botswana, Malawi, South Africa, Zambia and Zimbabwe) cross national study into the prevalence and form of national, international and local community-based civic service programmes emphasise the constraints of poverty and high unemployment as well as perceptions (among men) that volunteering is for women. The study established that volunteering, specifically in South Africa, is thus not the preserve of the middle class. Among its concluding statements was that the absence of a comprehensive policy, underdeveloped infrastructure and insufficient funding might constrain the

implementing community based programmes (Perold, Carapinha and Mohamed, 2006). Khanya (2005) and Dick, et al. (2005) contend that it is unfair "to expect poor people to give even more of their time without some recompense", and importantly ask the question, "When does community solidarity become exploitation?". The NCHWF and the Social Sector EPWP in South Africa are also firmly based on volunteerism. But they also provide additional resources to fund the programme nationally in the form of tiered stipends ranging from R500.00 to R1 000.00, based on levels of the CHWs.

2.5.5 Providing holistic, integrated and continuous care to improve the health of the population.

According to WHO, the roles and functions of each health worker in the provision of CCHBHC should be clearly defined and suitable training provided to them. Health personnel provide care in the community and home in accordance with the criteria agreed upon with the community. They (health workers) must ensure the use of a systematic approach to maintain close and continuous interaction with the community, and continuing support to non-formal caregivers. Whilst they should have a single or multiple focus, the UNICEF contends that CHWs are best able to carry out clearly defined, concrete tasks over a short and specific time period such as national health campaigns (e.g. Vitamin A distribution, polio campaigns etc) rather than carrying out broad-based activities such as health education, protecting CHWs from being over whelmed by increased burden of work and excessive time commitment for multiple task (UNICEF, 2004). Contrary to the UNICEF's model, the NCHWF, although it accepts the use of single focus care workers for specialist community needs, promotes a generalist approach to CHWs.

Lehmann and Sanders (2007) commented on the tension between generalist and specialized service delivery. They argue that "While developmental and educational activities are considered important, curative services are demanded by communities that do not have access to these services. There is substantial evidence in several countries that CHW programmes floundered due to disappointment among the community about the range of health services the CHWs could provide. Sanders argues that "equipping VHWs with curative skills does not simply provide health care to more people, more quickly and more cheaply, but it also gives the VHW greater credibility in the eyes of the community" . This needs to be weighed up against other stakeholder expectations and a realistic assessment of CHWs' capacity, given their training, other commitments and the size of the population they are expected to serve".

2.5.6 Supervising the provision of care to ensure continuing quality improvement of service provision.

Supervision should be carried out in a systematic way to support and develop workers in providing care, and identify and meet training needs. Health volunteers need to be appropriately trained and supervised by the health workers. WHO suggests that at least two health workers, who may be nurses, nurse midwives, or other primary health care workers with the necessary knowledge and skills, should be available for this role WHO, 2004). This view reinforces Nemcek and Sabatier (2003) in endorsing the use of nurse-supervised CHWs, especially for expanded health access to the underserved, assuming that health care professionals better understand the goals for using CHWs, the quality indicators, and CHW duties. The supervision process, according to WHO (2004), also provides a formal opportunity to acknowledge achievements and developments as well as to identify and

address obstacles encountered in the delivery of community- and home-based health care. An important component for successful community-based interventions is sustaining high morale by caring for the caregivers. It appears from the research conducted by Dick, et.al. (2005) that where DOTS supporters are well prepared for their role, effectively supervised and monitored, acknowledged in some form (not necessarily monetary) for their contribution, and well integrated into the formal health sector's management process, there is a stronger possibility of sustaining the intervention.

The following is a detailed account which summarises supervision practices in several projects (Khanya, 2005): "Most CBWs meet their supervisor on a monthly basis which involves a debriefing on what work they have done, and planning for the next month. Several use a standard reporting format for the CBW to record what they have done. The FA (e.g. the NGO) usually identifies training needs, organises training and also assists in proposal writing for the organisation. Professional backup is usually provided, e.g. a nurse giving HBC workers feedback and guidance on client care. Hospice's experience is that nurses need to meet with CBWs on a weekly basis because of the nature of work CBWs are involved in. Some community supervision and accountability is also important, if the community is to be empowered in the process". The NCHWPF is silent on mentoring, support and supervision of CHWs.

2.5.7 Monitoring the implementation of the model to ensure continuous feedback on progress

Monitoring mechanisms should be in place to ensure that activities are carried out according to the plan, and in case deviations occur, corrective actions are taken immediately. Feedback

loops need to be established so that lessons can be learned and acted upon without delay and waiting for the final evaluation. Mohammad& Gikonyo (2001) reported a lack of technical expertise in key areas of monitoring and evaluation, programme management, and implementation of activities/services in CHBC programmes. Such expertise is required to strengthen measurement of programme outcomes, quality and coverage. The purpose of monitoring and evaluating the CHBC programme is to ensure an on-going and sustainable improvement of the programme, hence Mohammad& Gikonyo (2001) recommend that implementing agent and clinic staff (including the CHWs) should be involved in monitoring progress by jointly measuring outcomes. The first step to monitoring any programme is to conduct baseline assessment which helps in appreciating any changes in the programme. However, it is common practice for large social programmes to be launched without pilots (Social Sector EPWP Plan, 2005). The data gathered during the preparation and assessment phase will serve as a baseline towards which the monitoring and evaluation will be done. The social sector EPWP Plan (2004) identified the need to compile baseline data on the identified pilot areas against which the impact of the programme can be measured. However, the programme is looking predominantly at its national training outputs, which then leaves the local implementing agents to monitor the progress on the ground.

2.6 Conclusion

WHO (2006) warns countries that wish to implement task-shifting strategies, like the CHW programme, on a large scale to be very vigilant not to compromise quality of services. The evidence from the literature (WHO, 2004; Khanya, 2007; Dick et. al.,2005; UNAIDS, 2006; and Mohammad & Gikonyo, 2005) shows that from the very beginning stages of programmes clarity on community role, selection criteria, CHWs' role, mechanisms for

compensating CHWs' time involvement and incentives, sound management support and supervision helps to enhance the effectiveness of the CHW programme.

Chapter 5 of this study will explore to what extent these principles have been applied in the implementation of the CHW programme in the studied LSA.

Chapter Three: Methodology

3. Introduction

The previous chapter examined the literature on how CHW programmes were implemented in different countries. This study aims to assess how the new government funded CHW programme is implemented one Local Service Area in the Eastern Cape Province. Following will be a thick description of the methodology that was used to realize this aim.

3.1 Research design

A cross sectional, qualitative, explorative and descriptive design was used to conduct this study.

3.1.1 Cross-sectional design

A cross-sectional study will capture the implementation of the CHW policies and relationship between actors at a specific point in time and will provide information that will contribute to the evaluation of the programme's impacts. This involves a sharp focus on the actors and agencies, in this case CHWs, the NGO, The Eastern Cape DoH and clinic committees. It was chosen here for practical purposes, as the scope a Masters mini-thesis would not have allowed for a longitudinal study.

3.1.2 Qualitative design

Smit (2003) argued that qualitative research for social policy offers substance and a deeper nuanced understanding of the complexities at the level of policy implementation, presenting empirical data through the reflections of among others, service providers themselves. She (the author) also contends that the narrative style of qualitative research reports can be more

accessible to a wider range of potential readers; and in predominantly oral (African) cultures the advantages of personal fieldwork, in-depth interviews and observation are most significant. This sentiment is shared by Green and Thorogood (1998) who concur that some health policy issues can only be addressed through examining the talk of key actors, on the assumption that it is through talk that the social world is constructed.

3.1.3 Exploratory and descriptive design

Although Polit and Hungler (1991) explain that exploratory research does not only focus on a phenomenon of interest but also identifies important relationships, this study did not go that far. It only described the status quo and compared it to programme definitions. Due to the contextual nature of exploratory studies, the purposefulness in sample selection and the smaller sample size, generalisability of the findings to the entire province is impossible, but applicable only to the selected district's clinic based programmes. However, the same methodology can be applied to assess the same programme in another setting (Lincoln and Guba, 1985 in De Vos, 1998).

3.2 Study setting

The Eastern Cape measuring about 169 580 square kilometres is South Africa's 2nd largest province after Northern Cape. Its population estimates mid-2007 was 6.9 million people. Port Elizabeth and East London are the only two cities with urban concentration, whilst the bigger portion of the province is predominantly rural. IsiXhosa is the main language spoken by about 83.4% of the population, followed by 9.3% Afrikaans and 3.6% English. The province is divided into one Metropole and six district municipalities which are further divided into 25 health sub districts or local service areas (LSAs). Four of the six district municipalities have

been designated rural nodes meaning that they have been identified as priority areas characterised by endemic poverty, for rural development and investment (ISRDS, 2000). Some of the common characteristics of the rural nodes is high levels of unemployment, illiteracy and poverty, all these impacting negatively on the population's health status. Three types of primary health care (PHC) facilities namely fixed clinics, mobile clinics and district hospitals, cater for the health needs of the population in each LSA.

One LSA was chosen from one of the rural districts of the Eastern Cape Province. The proximity to the supervising authority (LSA office) served as a yardstick in selecting three clinics, ensuring that both easy and hard to reach facilities were included in the sample. The clinics were coded according to the sequence of the CHW interviews. The first clinic where CHWs were interviewed was labeled A and so on. All the three clinics are relatively close to the LSA office, the nearest (Clinic B) within a walking distance of not more than 2km. The two other clinics are on opposite sides of the LSA office, clinic A about 20km from the LSA office, clinic C about 25km. The connecting road between Clinic A and the LSA is very good and tarred, whilst a very poorly maintained gravel road links the LSA to clinic C. The time taken to get to this clinic was exactly three times the time the researchers took visiting Clinic A. All three clinics are serving nine and more catchment areas with most of them far flung from the clinics serving them. It was common knowledge that during the rainy season, clinic C becomes inaccessible even to some of the villagers served by this clinic. Hence the LSA was keen for the interviews to take place before the wet season began.

A total of six (6) focus group discussions were conducted with three groups of CHWs, one group of provincial health promotion managers and two groups of clinic committees (CCs),

seven (7) in-depth interviews were conducted with the three facility mangers (two face to face and one telephone interviews), a representative from the facilitating NGO, two (2) LSA programme managers and one interview with two CLOs.

3.3 Population and sampling

This study represents the execution of one objective 'To trace the policy implementation process through engagement with key actors and documents' from a broader project that explored the concept of power in the implementation of South Africa's new CHW policy in the Eastern Cape Province. To give this study a meaningful title, the above mentioned objective was rephrased to read 'Assessing the implementation of the government funded CHW programme'. Key actors identified in the policy implementation process were: (a) Eastern Cape Department of Health (EC DoH) (b) NGO tasked with policy implementation (c) LSA programme managers (d) Facility managers (e) Community Health Committees, and (f) CHWs receiving stipends under the auspices of the government funded programme in the district.

A non-probability sampling strategy, utilizing a combination of a judgement and snowball or chain sampling was employed in achieving a suitable sample for this study. In line with an explanation by Patton (1990) on judgement and snowball samples, this study sample was obtained according to the discretion of the researchers who were familiar with the relevant characteristics of the population. Furthermore, each study participant was asked whether they knew of other key informants on this particular topic. Three clinics, well known to the researcher, were purposefully selected. The distance to the supervising authority (LSA office) served as a yardstick in selecting appropriate clinics to ensure the inclusion of both easy and

hard to reach facilities. Also, the prospective participants, being key actors in the CHW programme implementation, were purposefully selected. However, a chain of additional participants were identified and recommended by those already interviewed as the most appropriate informants for this study, thus developing a network of key informants.

3.4 Data collection

The researcher analysed the Social Sector Plan EPWP and the National CHW Policy Framework, the two policy documents that form the basis for the new government funded CHW programme, before doing the field study. This exercise set the stage for process analysis, identifying pertinent issues for exploration in the interviews (for all the stake holders), thus facilitating and guiding the interview process. Data from participants was collected using in-depth and focus group interviews. In-depth interviews are invaluable in that participants may be more prepared to discuss matters which they would not otherwise talk about in front of other people (Liamputtong and Ezzy, 2005). However, Liamputtong and Ezzy also recognize that an advantage for using focus group interviews is the ability for many people to be interviewed in very little time (one to two hours). De Vos (1998) contends that homogeneity be aimed at for successful focus groups. However, Liamputtong and Ezzy (2005) believe that heterogeneous groups sometimes work in favorable ways. This strategy was more appropriate especially when interviewing CHWs, some on the new programme with stipends, some still volunteering without stipends, and others no more volunteering. This enabled the exploration of the same issues from different perspectives. Critical issues that were explored with all participants included recruitment and selection, training, activities that CHWs carried out, support and supervision as well as incentives available.

A brief questionnaire was developed to record the personal characteristics of the CHWs on stipends, these being the target population of this study. Participants were required to fill in these questionnaires on the day of the focus group, before interviewing began.

3.4.1 Preparing for interviews

Prospective study participants were contacted either in writing or telephonically. The researchers were informed that the Health Promotion (HP) Programme at provincial level was responsible for the CHWs, and subsequently made an appointment to meet to introduce the study. Management was highly enthusiastic about this study, seeing it as an opportunity for them to gain more insight into the community level implementation of the programme. As a result, they appointed the HP programme manager at the selected LSA, not only to be interviewed as a participant, but also to be actively involved in the study process till its completion, with the intention to replicate the study in all LSAs in the selected district. The programme manager was also tasked (by the province) to assist in recruiting participants from selected clinics. The researcher wrote a letter to the LSA manager informing her and requesting her permission to proceed with the study in the LSA. After a positive response from the LSA manager, the researcher personally contacted the facility managers informing them about the study, as well as requesting them, their clinic committees and those CHWs working in their clinics and receiving stipends, to participate in this study. The NGO was also very interested and eager to participate.

Plans were put in place to conduct the first round of interviews with the NGO, provincial and LSA managers, as well as two (of the three) facility managers from selected clinics. The face

to face interviews took place over three days between the 1st and 3rd August 2007, whilst the telephone interview with one facility manager was conducted a week later.

The in-depth interviews took place at participants' work places, including the unplanned focus group at the provincial office, at times agreed to between them and the two researchers, whilst focus interviews with CHWs and CHCs were conducted at clinics which they served. Interviews with CHWs and CHCs were conducted in Xhosa, the local and first language spoken by all CHWs in the sample, the clinic committee members as well as the researcher herself. The NGO representative, a non- Xhosa speaker, was interviewed in English, whilst a medley of English and Xhosa was used in interviews with the managers (at provincial, LSA and facility levels).

Gate keeping was a serious issue around this study. Entry to research sites had to be negotiated at all levels of service delivery. While the province, LSA and clinics were fully aware, the district manager was not informed about the study, an unfortunate oversight by the researchers. Although interviewing was already underway, arrangements were made to see the district manager to smooth things over. Alluded to by the district manager whilst giving the researchers a discreet tongue lashing, this happened simply because of established relationships with the previous LSA manager who used to take the responsibility of communicating with the district office out of the researchers' hands. She clearly pointed out that, every time someone visits any of the LSAs, for the initial or follow up processes, the district should always be notified in writing. After the air had been cleared, this encounter proved to be an eye opener concerning the uneasiness from some intended participants to

participate. About the project, she explained some issues that came out or were not clear from previous interviews.

3.4.2 Conducting interviews

All the interviews were preceded by appropriate personal introductions. These were followed by explanations of the purpose and objectives of the study, as well as requesting permission to interview the participants. All participants in the first round of interviewing gave verbal consent to voice recorded interviews to allow the researcher to pay full attention to what the participants said. For this purpose, digital and audio tape recorders were used. This enhanced the quality recording of the group sessions, as the two recorders were simultaneously used to guard against data loss due to inaudibility of recordings. The use of the digital voice recorder helped control the interview process especially during the focus group discussions, in that it had to be held closer to individual speakers, thus preventing participants from talking all at once. An interview guide was used to ensure coverage of all the necessary areas for exploration. The researcher posed open-ended questions and probed topics as they arose. New lines of questioning were pursued as the interviews developed. As focus group discussions were conducted in Xhosa, and the other field researcher did not speak the language, the CLOs probed or clarified areas of concern and interest from participants. Immediately after the group interviews, discussions took place among the moderators to clarify issues and to debrief the non Xhosa speaking moderator. Both researchers wrote reflective notes (individual) everyday on reaching their place of residence, compare them and come to a consensus, while the day's events were still vivid in their minds. These notes included feelings, observations and relevant informal conversations.

3.4.2.1 Interview with participant from the NGO

The first interview was conducted with the informant from the NGO. She volunteered the information with very minimal probing and encouragement. Their area of involvement with CHWs was related to disbursing of stipends. She furnished the researchers with names of persons in the HIV/AIDS directorate who could give more information. The interview lasted for about 90 minutes.

3.4.2.2 Interview with provincial managers

On completion of the interview with the NGO, the researchers proceeded to the provincial manager's workplace. But on arrival it was found that she had invited other two managers who in her opinion would shed more light in the CHW issue, as well as someone to take notes for them. Therefore instead of the one-on-one interview this turned out to be a small group discussion. Like the NGO informant, the small group suggested that the HIV/AIDS programme managers both at provincial and LSA levels were best informed regarding the distribution and utilisastion of CHWs, and would be a worthwhile gesture to speak to them. They even offered to contact the HIV directorate. But due to time constraints, no additional interviews could be scheduled for that time, therefore these would be planned for the next round of data collection. It was further suggested that Community liaison officers (CLOs) at the selected LSA be also interviewed as they were the ones responsible for training, mentoring, supervision and support of the CHWs. The interview took about an hour.

The following day interviews were planned for the LSA HP programme manager and one facility manager.

3.4.2.3 Informal conversation with the LSA manager

On arrival at the LSA office the researchers were introduced to the LSA manager. At that moment the programme manager to be interviewed was still busy with some office matters. Whilst waiting on her, the researchers engaged the LSA manager in a conversation related to the study. She gave information regarding the CHWs such as numbers and categories available in the LSA, as well as the staff members responsible for the CHWs. At that stage the programme manager for HIV/AIDS (prevention) came to meet the researchers.

3.4.2.4 Interview with HIV/AIDS (prevention) programme manager

She voluntarily shared valuable information about this programme, since, before the appointment of another manager for HIV/AIDS Treatment, Care and Support, she was responsible for the CHWs. She echoed the provincial interviewee's suggestion that the other HIV/AIDS manager would be one of the most valuable and appropriate respondents in this study. Unfortunately this manager was away from the office during that week. Consequently arrangements were made to seek her consent to an interview at a later date. This unplanned session was not taped, but notes were written later in the day. Eventually the HP manager was free to be interviewed in the LSA manager's office, the only venue where one could get some privacy, besides the boardroom.

3.4.2.5 Interview with LSA HP programme manager

This interview did not take long since the manager was relatively new in this position, and therefore had no knowledge of the programme on its inception. However she provided very useful information on CHW training and activities, including the role of the CLOs in this

regard. This strengthened the need to also speak to these officers. After the interview she accompanied the researchers to Clinic A for the facility manager's interview.

3.4.2.6 Interview with Clinic A manager

The facility manager agreed to be interviewed in the presence of the LSA manager which proved to be beneficial in clarifying issues both for the researchers and the facility manager in relation to the CHWs. According to the facility manager, implementation of the CHW programme, apart from a few glitches, occurred as reasonably smooth as expected. The interview came to an end after about one and a half hours. After this plans to interview the clinic committee and CHWs were discussed, but the researchers could not confirm the dates yet.

3.4.2.7 Interview with Clinic C manager

The last interview of the first round was with facility manager from Clinic C. Like in Clinic A, the facility manager allowed the LSA manager's presence. Although programme installation was reported not to have been smooth compared to Clinic A, with certain aspects of implementation compromised, the programme was viewed as beneficial. Also, after the interview which took about an hour, plans were made for the other stakeholders' interviews – the CHC and CHWs.

3.4.2.8 Telephone interview with clinic B manager

The facility manager from Clinic B was attending a course off site during the first round of interviewing, and would be on holiday during the second round. Apparently, she had not been properly informed about the study, hence she asked the researcher to write a letter to the LSA

manager requesting her participation. With that done, she agreed to a telephone interview, a variation of a one-on-one interview, to be conducted from 07h00 on a Sunday of the following week. Although some useful data was obtained, it became clear from the interview that she was not well informed about the programme at her facility simply because a dedicated staff member leading the facility HIV/AIDS programme was in charge of the CHWs. She promised to arrange the interviews with CHWs and a couple of available CHC members. The interview ended in less than an hour.

The second and final data collection took place between the 3rd and 8th of September 2007. Plans had been put in place to interview the HIV/AIDS programme manager on a Tuesday morning. But she had to attend an urgent meeting at the district office the whole day. However, all was not lost as the CLOs agreed to fast forward their appointment to be interviewed in place of the manager.

3.4.2.9 Interview with CLOs

The two CLOs were interviewed simultaneously. They confirmed their involvement with CHWs, reported by previous participants, to be training and job related only, giving detailed accounts of their involvement.

3.4.2.10 Interviews in Clinic A

The CLOs were delegated by the HP programme manager to assist in coordinating the focus group discussions in the three clinics. On arrival in Clinic A, there was a new manager who had no idea about the interviews to be conducted. Fortunately the CHWs were present, because every Wednesday they came to submit their reports. Further, they knew about the

interviews, having been informed by the previous facility manager before she went on leave. Then the facility manager allowed the interviews to go ahead.

3.4.2.10 (a) Interviews with CHWs

The group of nine CHWs included six volunteers receiving stipends, one volunteer not receiving a stipend but getting an old age pension and two others designated 'care givers'. The latter felt confused as they had been informed that they were not CHWs, and did not have any job descriptions. They came to the focus group with the hope of getting clarification of their position. The CLOs were a great help in this regard. All issues planned for exploration were discussed for about two hours. The next discussion was with the CHC.

3.4.2.10 (b) Interviews with clinic committee (CC) members

We discovered during the previous interview that several CHWs were in fact members of the CC and found that all but one of the convened CC members were participants in the CHW group interview. Hence this interview took far less than an hour. Except for this one non volunteer CHC member, all the participants in this group were fairly literate (with Grade 10-Grade 12). This one member was one of the previous volunteers who apparently did not qualify for the new programme.

3.4.2.11 Combined interview with CHWs and CC members in Clinic B

More than 30 participants turned out for the discussions at clinic B. Of these, seven (7) were active and received stipends, 10 reported to be still volunteering though not receiving stipends, and the rest had stopped volunteering since the installation of the new programme. This became a very sticky and sensitive situation because: 1) the room prepared for the

interviews was small and could not accommodate all these people; 2) No one could be turned away as this would have aggravated the tension surrounding the implementation of this programme in clinic B; 3) Obviously many had high hopes that this could lead to them reconsidered for the programme. Although it is highly advisable and desirable for focus groups, homogeneity was out of the question in that situation. However, it was not entirely disastrous to have a heterogeneous group like that. Liamputtong and Ezzy (2005) believe that heterogeneous groups sometimes work in favorable ways, more appropriately when exploring the same issues from different perspectives. For example the 'parent study' looked at previous CHW arrangements before the regular stipend, exploring similar issues as this study. Consequently the discussions were held outside, thanks to very warm weather on that day. The digital voice recorder became very handy under those circumstances as it could be handed from one person to the other. Again, the CLOs played a very crucial role at this juncture. A number of participants arrived late, with the discussion already in progress. A couple of these turned out to be the only remaining members of Clinic B CHC. As a result their responses, in relation to their roles with CHWs, were invited. Although this meeting, theoretically, did not qualify to be called a focus group, it produced very rich information, some of which was immediately usable to the participants; for example, sharing of experiences and identification of available resources. The discussion went well, apart from one expected draw-back of a heterogeneous group: participants declined to discuss one of the touchy issues around the programme: payment and incentives.

3.4.2.12 Interview with HIV/AIDS programme manager (treatment, care & support)

The interview with the HIV/AIDS programme manager took place after many delays. She reported that the new changes were implemented before her employment in her current

position, therefore had no idea how the process unfolded. However she addressed relevant issues in relation to additional CHWs that came during her time. One of her greatest concerns was that she never set eyes on the policy documents that determine the foundations of this programme. It seemed that communication between the province and the LSA was predominantly through verbal directives, apart from a few irregular memos. The researchers promised to furnish her with the relevant documents. The interview lasted for less than two hours.

3.4.2.13 Observation of workshop proceedings

On the same day, we had the opportunity to observe one of the regular monthly meetings of all CHWs in the LSA, established and convened by the HP programme co-ordinator. These meetings are used as information, report-back and continuing education session. TB, HP, and HIV/AIDS programme managers took turns addressing the CHWs in relation to respective programme areas. Reports on work related issues were shared, CHWs asked for advice from managers and their peers from other clinics. Over 100 CHWs attended this particular meeting. While the meeting's proceedings were not part of our data collection, they provided invaluable contextual insights and background information to us.

3.4.2.14 Interviews in Clinic C

The last focus group discussions were held in Clinic C on a Saturday, a day on which CHWs brought their reports.

3.4.2.14 (a) Interviews with CC members

The chairperson and two other CC members turned up for the interview. Although they were disgruntled with certain issues in the programme, they appeared to be interested and concerned in the well being of their community. They saw the programme as very useful and beneficial, and therefore eager for improvements to make it even more effective. Very useful and innovative ideas came out of the vibrant interview. The interview carried on for about an hour.

3.4.2.14 (b) Interviews with CHWs

Lastly, a heterogeneous sample of CHWs were interviewed. The group was composed of twelve (12) participants of whom six (6) were current volunteers on stipend; two (2) volunteers were not on stipend but still rendering their services and four were no longer doing volunteer work. This was the only clinic with young male volunteers. Issues raised were similar to other clinics.

Efforts to engage managers from the HIV/AIDS directorate in interviews were unsuccessful. This was mainly because the data collection period coincided with incidents between the media and the province that had negative impacts on the DoH. This resulted in reluctance and cautiousness with regard to interviews with outsiders.

3.5 Data analysis

Interim data analysis occurred concurrently with data collection. During the interviews, for example, probing questions were asked following on participants' statements. These statements allow for further refinement of questions and pursuing of emerging avenues of

inquiry in subsequent interviews (Pope, Ziebland and Mays, 2000). The discussions researchers had after each interview (verbal analysis) and tape based analysis through repeated listening to recordings of the interviews contributed to continuous analysis. This helped to identify gaps in data for further exploration and or clarification from concerned participants before leaving the setting completely. A week after completion of data collection, a couple of programme managers' comments during the interviews were followed up telephonically. On completion of data collection, the taped focus groups and individual interviews were transcribed verbatim and translated in to English to facilitate coding by multiple researchers. Field notes were written in full to render them meaningful for final analysis. Descriptive analysis of the personal identification data was done to characterize the profile of the participating CHWs.

Two researchers carried out transcript based analysis of data, thus achieving researcher triangulation which in turn contributes to the credibility of this study' findings. The five stage framework approach recommended by Pope, et.al, (2000) for analysing applied or policy relevant qualitative data was used to get to the findings of this study. This approach is informed by the aims and objectives of this study in comparison to specifications of the CHW policy framework and EPWP (DoH, 2004; Social Sector Plan, 2004). The five stages of the framework are: 1) familiarization; 2) identifying a thematic framework; 3) indexing; 4) charting; and 5) mapping and interpretation. Descriptive statistics have been calculated to characterize the sample and specific correlations.

3.6 Data quality assurance

The following techniques recommended by Lincoln and Guba, (1985) and Sandelowski (1986), were applicable in conducting this study:

- Authority of the researcher: the researcher has both theoretical and practical experience of focus group and in-depth interviewing, has taught these methods to post graduate students at the School of Public Health, as well as utilised them in several field studies.
- Prolonged and varied field experience: the researcher is well conversant with the study setting. In the past three years she worked in different projects in the same LSA, and interviewed the nursing staff in several clinics.
- Triangulation, a convergence of multiple perspectives for mutual confirmation, strengthened the credibility of the findings of this study. Two forms of this strategy were applied, namely (a) data triangulation involving focus group discussions, in-depth interviews, field notes and document analysis; and (b) researcher triangulation where two researchers did independent data analysis of the same interview transcripts and notes.
- Member validation, a technique for establishing the validity of researchers' interpretations of data collected from research participants, took place during the interviews by asking for clarification. Follow up telephone conversations were held with some informants after completion of data collection to verify certain issues.

3.7 Ethical considerations

This study proposal was submitted to and approved by the UWC Higher Degrees Research Ethics Committee. Meetings were held with the provincial, district and LSA Programme coordinators, as well as the facility managers, who in turn recruited community representatives and the CHWs at their clinics, in order to secure permission to conduct the assessment. An informed written consent for participating was sought from all the focus group participants, whilst verbal consent was obtained from all the other interviewed informants. Consent forms for focus groups were written in both Xhosa and English; and the explanation of the purpose of the study was done in Xhosa. Participants were assured that confidentiality would be maintained such that no data would be associated with any particular person. Only the researcher and supervisor have access to the audiotapes in which interviews have been recorded. The interview transcripts were shared between the researcher and her supervisor. Names of people and places mentioned during the interviews, were erased and replaced with codes, for example sampled clinics have been referred to as Clinics A, B or C. On completion of the study, that is after the full report has been published, the audiotapes will be erased. Participants were informed of their right to withdraw from taking part at any stage of the study, as well as freedom of answering only questions that they were comfortable with. Focus group participants in Clinic B exercised this right. All participants were informed about possible research reports and publications that will emanate from this project. Anonymity of managers and community representatives cannot be completely guaranteed in this study due to the very small size of the sample. However, permission will be sort from particular participants, should there be an inescapable need to use information, the source of which can easily be traced. Apart from the province where this study took place, the names of the specific municipality, LSA and selected clinics have been kept confidential.

3.8 Limitations

This study was conducted under very severe time constraints. As a result of this predicament, it was impossible to assess two very important aspects in the implementation of any social programme, namely determining the perceptions of the consumers (clients receiving services of the CHWs); and CHWs' competency in performing tasks. Both these aspects require a considerable time to follow up and observe the CHWs' interaction with clients.

The following chapter will describe the findings of this research.

Chapter Four: Findings

4. Introduction

In this chapter the findings of the study will be presented, including the demographic characteristics of the CHW sample. The findings will be presented according to the first six objectives of this study (the framework approach), the manner in which the data from documents and interviews were analysed, and finally organised in themes that will emerge. First, excerpts from the National Community Health Worker Policy Framework (NCHWPF) and Social Sector EPWP Plan (2004) representing each objective will be described. The Social Sector Plan operationalises the broad prescriptions of the NCHWPF (2004), thus providing programme level guidelines for implementation of the CHW programme. Then data from programme documents and interviews will provide supportive evidence of compliance or non compliance to these two documents' prescriptions and guidelines.

4.1. Characteristics of the CHW sample

Nineteen (19) CHWs were interviewed during the three focus groups. Only 10.5% (n = 2) of the CHWs were males. The mother tongue of all participants was Xhosa. Except for two (2), all could understand, read and write English. One could also speak Afrikaans and Sesotho. 37% (n = 7) were married and 63% (n = 12) were single (single included: never married, divorced and widowed), with 2 - 10 dependants. All of them were Christians. Their ages ranged between 27-58 years. Of these, 10.5% (n = 2) were in the age range of 20-29 years, 79% (n =15) in the 30-49 years range, and another 10.5% (n = 2) were between 50 - 59years of age (see table 1).

Table 2: Age stratification of CHWs by clinic, in years.

Code of Clinic	20-29 years	30-39 years	40-49 years	50-59 years	Total no. of CHWs
A	-	3	2	1	6
B	2	2	3	-	7
C	-	2	3	1	6
Total	2	7	8	2	19

The highest levels of schooling attained by participants in ascending order were:

- two with Grade 8 or the former Standard 6 certificate, these being the two oldest in the sample (56 and 58 years old);
- one with Grade 10;
- ten with Grade 11;
- and six with Grade 12.

They were all previous volunteers before the regular stipend arrangement, some of them since as early as 1995.

All clinics had seven CHWs in three different categories on stipends: three home-based carers (HBCs), two lay counsellors (LCs) and two TB DOTS supporters. This is in line with provincial policy stipulations. Table 2 shows the number of CHWs present in each clinic on the days of the interviews. Two were absent (a LC and a DOTS supporter) were absent during the interviews.

Table 3: Number of different categories CHWs per clinic on the days of interviews.

Name of Clinic	HBC	DOTS supporter	LCs	Total
A	3	1	2	6
B	3	2	2	7
C	3	2	1	6
Total	9	5	5	19

4. 2 Classification of CHWs

The NCHWPF (2004), whilst acknowledging the availability of single focus care givers such as DOTS supporter and LCs based on community needs, has the generalist CHW as its main concern, and therefore reserves this title for this particular group. Over and above this senior category of care workers, the Social Sector EPWP has two lower qualified categories, the Community Care Workers (CCWs) and Community Health Support Workers (CHSWs), the latter being not available in the study LSA. The NGO representative referred to the CCW as

"... the umbrella under which the volunteers for the department of health fall",

of which the home based carers (also referred to as "the original CCWs"), LCs and DOTS supporter are subgroups available in the sampled LSA. As with the NGO, similar names for the subcategories are used at provincial, LSA and clinic levels, but CHW being the common umbrella name. In the communities all these workers are called "*Oonompilo*', a Xhosa translation for 'health workers.

4. 3 How CHWs were recruited and selected

It is an internationally accepted principle in CHW programmes that CHWs should be selected from and by the communities in which they reside. This principle is upheld in the NCHWPF and the Social Sector Plan EPWP which stipulate that all recruits should be selected from a pool of existing volunteers residing in the communities in which they work. Only people who had volunteered for a minimum of one year should be considered. The Social Cluster (National Departments of Health, Education and Social Development) decided to fast track the recruitment and selection of prospective generalist CHWs targeted as work seekers with either an NQF level 3 qualification, Grade 11 or an equivalent since the majority of existing volunteers often had either none or very little schooling, and therefore would take years to be trained until they reached the required entry level for this grade of worker. The policy states that an advertisement of the available work opportunity should be circulated to all volunteers and advertised in at least one newspaper or at a public meeting in the area. Selection should target volunteers who are unemployed adult dependants of the terminally ill and people living with HIV/AIDS who are not in receipt of a state grant. Community structures in the form of clinic committees (CCs in this study) should be involved in the recruitment and selection process. The final selection should be made by the NGO, facility managers and committees of the clinics at which the CHWS are to be employed.

Before the arrival of the regular stipend, all three selected clinics had volunteers working with them from as early as 1995. During that time the DoH encouraged the clinics to mobilise communities into volunteering their time in community work. People came of their own free will to work as unpaid volunteers. Most of these volunteers were mature women with little or no educational qualifications. They were trained in particular by NGOs on different aspects,

most commonly on TB, first aid etc. Generally speaking there was no formal training for them. There were no specified hours or days that a volunteer was forced to work, but they had to give reports of what they did in the communities at specified periods. They mostly did home visits, educating families on different aspects of health, such as nutrition, sanitation and others. Once in a while a lump some of money would come from the DoH or other funders for a group of volunteers to share. They were loosely supervised by the health professionals at the clinics they were attached to.

At the time when the regular stipend was introduced, Clinics A, B and C had about 36, 42 and 12 volunteers respectively. Out of these, each clinic had to select initially five CHWS and later an additional two to come to a total of seven.

4. 3. 1 Selection process at clinics

The three facility managers reported that all the CHWs getting stipends had been volunteering before. Clinic A manager reported to have involved the CC in selecting CHWs. This was confirmed by CHWs themselves as most of them were members of the CC and had therefore been involved in their own selection.

In Clinic B, the facility manager reported that due to the short notice for the submission of names for stipends to the LSA, the clinic staff had to take executive decisions regarding who to be selected for what. This was confirmed by the CHWs in the same clinic who said that the sister in charge of the clinic HIV/AIDS programme single handedly chose them to be in the programme. The manager reported that although two members were still active in clinic related matters, the CC in general was defunct, and therefore was never involved in CHW

selections. The two CC members confirmed that they did not take part in selecting CHWs. In fact, they had never been involved in any matters concerning the CHWs.

In Clinic C the manager did not report any involvement of the CC in selecting CHWs for stipends. Instead she reported that they (presumably the clinic staff) had no problems in selecting volunteers for the regular stipend. She mentioned, though, that the community submitted names of volunteers who were interested to be trained in home based care. CHWs confirmed that they were selected by the sisters (clinic staff). The facility manager complained that the LSA had interfered with the selection of CHWs in that instead of the list of names the clinic submitted to the LSA for stipends, another list perceived to have been compiled by the LSA was forwarded to the province. As a result some of the volunteers chosen by the clinic did not get selected. But, despite these allegations, LSA managers reported not to have actively participated in the selection of CHWs, but only advised on the processes to be followed.

"We (programme managers) said to them (facility managers) that you have to invite the clinic committee and all the community care workers must be there; the ones who are getting the stipend and the ones who are not getting the stipend. ... Make it a point that you don't take anyone who is not a volunteer here in a particular facility. Take within our whole of volunteers...So we were not involved as the managers" (LSA programme manager).

On the other hand, the CC of clinic C had a similar grievance against the facility staff for not involving them in selecting CHWs, such that they could not identify some individuals as CHWs.

"The committee does not get involved when it is time to choose health workers [i.e. CHWs – 'onompilo'] .*We just see health workers around, and that is the firs problem. ... This meeting is full to capacity but we (the CC) do not know half the people (CHWs) who are here"* (CC).

They also reported that the volunteers whose names were on the initial list but did not appear on the final list at the LSA were disgruntled.

"... w*hen the time came to elect other health workers, they were not on the list, hence their dissatisfaction about the whole process today" (CC).*

Another factor reported to have excluded many previous volunteers from being eligible for the stipend was the educational qualifications required. This was reported to have caused tensions between the volunteers and the facility managers who were the bearers of this bad news, as well as among the CHWs themselves. According to the Social Sector Plan EPWP, educational qualifications are applicable for entry at different levels. For example, very little or no education is required for the CCW or home based carer at NQF level 1. Both the province and the NGO representatives concurred with these stipulations.

"...*depending on the categories; like home-based carers, somebody with only a Standard 3 can be a home based carer, it is a hands on thing. You just need to have a kind heart, have a pair of eyes to check out, are there any children running around that have got no mom and dad at home, you know that sort of thing*".(NGO representative)

However, the NGO representative also felt that specific qualities should be looked for when choosing LCs due to the perceived sensitive nature of their job.

"But when it comes to something more involved with a bit more skill, like lay counselling, yes then I agree, you definitely need specific criteria"(NGO representative).

Language was identified as a key issue in the debate around qualifications requirements. One programme manager explained,

"I think since the training, the language which is used is English so they don't understand English, some of the things they don't understand even if you are trying to explain it in Xhosa, some of the things are not easy to explain in Xhosa, I think that is the main problem" (LSA manager).

An argument by the CLOs supporting their use of the Xhosa language when training the CHWs was that,

"...some of them are not well educated, so to accommodate everybody we use Xhosa because even in the community they are going to serve speak Xhosa" (CLO).

CHWs that had been to off site training shared their experiences on the difficulties encountered by those participants with low literacy levels. Two major problems were that at times the trainers were non-Xhosa speakers and therefore only able to communicate in

English; and also none of the teaching and learning materials were in Xhosa; hence all trainees were expected to understand the English language.

4. 4 Training undergone by CHWs

According to the Social Sector Plan, volunteers with no schooling or little formal schooling should be trained at National Qualifications Framework (NQF) level 1. Care workers with NQF level1/Grade 9 or an equivalent qualification should be trained at NQF level 3 in order to qualify as CHSWs. On completion of accredited training and required work placements, a care worker can or may progress to the next level. Training in the above two levels is the primary responsibility of the government whilst the CHW at NQF level 4, for workers with Grade 11 or equivalent qualification should be put through learnerships under the Health and Welfare Sector Education and Training Authority, hosted by the NGO. The national 59 day HCBC programme forms the basis of all the training. This implies that CHWs at all levels should have completed this course and any other training should build on this foundation programme.

Contrary to the above policy stipulations: (a) The NGO played no part in training.
(b) All the "uneducated" previous volunteers were excluded from the programme because they were "untrainable" which seemed to mean that they could not understand English. (c) None of the home based carers had completed the basic 59 day programme. One LC in each of the three clinics had completed the basic HCBC programme. This was one of the LSA programme manager's deepest concerns.

"...another problem that we are faced with is the trainings, especially with the home based care. At this LSA you'll find that home based carers are not trained. Some have done 2 weeks. You see the home based care is 59 days to finish up... So you will find that most of them are having 2 weeks of home base care, another group, a week, most of them, they haven't been started. ...Only 14 out of 158 completed" (LSA HIV programme manager).

The HIV manager in charge of training and generally responsible for the utilization of CHWs neither received orientation nor documentation regarding this programme when she got into the post. To familiarize herself with what had to happen in the programme, she made a photocopy of the relevant materials (borrowed from the trainer). This situation is compounded by insufficient funds and trainers.

Yes, from when I was employed, I wasn't given that package, no policy and no curriculum. I've just said to someone who was trained as a trainer, just give me the books so that I know".

" ...they gave us R40 000 to train the lay counselors on PMTCT. So with that R40 000; accommodation and then now another problem which we are facing is that we don't have the trainers, PMTCT trainers. So we have to look for an NGO, who is going to train. So the R40 000 is not enough" (LSA HIV programme manager).

CHWS, LSA and facility managers reported that all LCs had gone through most aspects related to HIV/AIDS training, amongst them the 5 days basic HIV/AIDS course, the 10 day

Voluntary Counselling and Testing and Prevention of Mother to Child Transmission (PMTCT) of the HIV.

The LSA conducts informal training in the form of monthly meetings. Work related issues are discussed based on the needs of both the CHWs and their clients). This is helpful for CHWsCHWs not formally trained yet, in addition to learning from observing their experienced colleagues as well as clinic-based training by clinic staff.

4. 5 Status, activities and workloads of CHWs

While the Social Sector EPWP Plan describes the jobs of CHWs in fairly broad terms according to their levels on the NQF (See Table 3 below), the NGO listed, in a document (Appendix), the specific activities for two out of three groups in its classification, the CCWs and LCs. The activities of these two categories are in line with those of workers at NQF levels 1-3 of the EPWP. During the interview the NGO representative also mentioned that the roles and functions of the DOTS supporter were similar to those of CCWs, but with a specific focus on TB.

Table 4: Job descriptions of different categories of CHWs according to the NQF.

Level	Category	Job description
1	CCW	- Early identification of families in need. - Early identification of orphans and vulnerable children. - Provision of food parcels. - Patient care and support related to /HIVAIDS and other terminal conditions. - Referrals.
3	CHSW	- Patient care and support related to HIV/AIDS and other chronic conditions - Information and education

		- Patient and family counselling and support - Referrals
4	CHW	- Mobilise community members to determine health needs, take responsibility for health and mobilise health resources. - Act as an advocate to improve health - Coordinate the access of other health workers into households and communities in order to ensure the efficacy of service against community consulted needs. - Provide specific 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 other community members - should be able to provide referrals to other sectors beyond the scope of their work to maximise efficiency.

Source: Social Sector EPWP Plan, 2004.

The NGO representative had a few negative perceptions regarding the interaction between the CHWs and the clinics. Firstly she felt that

"... in some areas these volunteers are abused, abused in the sense that they are not doing pure volunteer work as in being the extended arms of the clinic Sisters. Sometimes they are being expected to cook the clinic Sisters food or clean the halls/walls or mop the floors or whatever. Basically being, in inverted commas a 'skivvy', ..." (NGO representative).

But this perception was not shared by the CHWs, instead they reported the clinic staff to be very supportive. Secondly, the NGO representative perceived some of the clinic sisters to be less interested in CHWs, seeing the volunteers *"as a burden"*. However, comments from all the facility managers interviewed were to the contrary. The role of CHWS was highly

appreciated to such an extent that there was a strong need expressed for more CHWs to be employed. Another motivation for more people on stipends, though from a different angle, came from CLOs. They perceived the unpaid volunteers to be unreliable:

"*because one leaves anytime they feel like...it gets worse when there are new (qualifying) people taken in every now and then*" (CLO).

On the issue of employment, the NGO representative felt that the community health workers were disillusioned,

"looking at themselves as 'employees' in inverted commas, rather than volunteers in the true nature of volunteers" (NGO representative).

Like the CHWs, the researcher became confused about the status of these volunteers when the NGO representative mentioned that R6.00 was deducted from the R600.00 stipend for the UIF contribution, which the researcher assumed to apply to paid workers.
CHWs knew that they were expected to work for a minimum of four (4) hours a day or 20 hours a week, and definitely not less than 60 hours per month in order to get their stipend. Failure to do so resulted in forfeiture of payment.

In most interviews the question of what constitutes appropriate workloads generated lively discussion. Respondents had different responses and suggestions regarding the number of households that CHWs should be expected to visit per month. The policy recommends that in rural areas each CHW should cover 80 -100 households. The province was

"... *expecting at least 1-20 households per month"*(Provincial programme manager), while the *LSA* managers suggested allocation of CHWs by size of catchment areas, using one CHW per 50 households as the norm. Clinic B CHWs had been told by their supervisor that, " *we should visit at least 100 homes per month in your designated village" (CHW).*

The reality is that CHWs at present are not allocated according to catchment area, but allocated to facilities.

4. 6 Support and supervision given to CHWs

The NCHWPF is not explicit regarding the supervision of CHWs. It only states that CHWs must have a support system e.g. Non- Profit Organisation or Community Based Organisation, as well as access to an efficient referral system. The NGO representative reported to be providing support to CHWs whenever there is a need via their 24h00 call center.

The provincial managers informed the researchers that

"... actual management and supervision of community health workers is better understood at this moment by the local service area manager, and HIV/AIDS programme manager at that level"(Provincial programme manager).

The provincial manager reported that the role of the Community Liaison Officers (CLOs) located at the LSA in relation to CHWs was to

"... support them. They mentor them, they advise them, they guide them, and they conduct training. They go out with them for home visits" (Provincial manager).

CLOs and their LSA supervisor reported that due to transport problems it was impossible to go out to the villages. The only regular method of communicating was through the weekly reports submitted at the clinics by the CHWs.

Supervision of CHWs in clinics, reported by both CHWs and managers, was the role of facility managers, who in turn are supported by the clinic supervisors and programme managers at LSA level. Facility managers acknowledged, however, that their supervision was limited to receiving reports from CHWs and answering questions CHWs might bring to them, as they had no time to go out and conduct home visits with CHWs.

Assisting the professional supervisors in this task were the so-called 'super DOTS', correctly TB coordinators, who are comprehensively trained. Clinic C committee members vouched for the village leaders full support to CHWs at community level provided that they were appropriately introduced to these leaders.

4. 7 Incentives provided for the CHWs

National policy recommends a minimum monthly stipend of R1000.00 for the generalist CHW referred to by the EPWP as HCBC Level 4 worker. While the national policy does not specify stipends for the lower level CW categories, the EPWP recommends a sum of no less than R500.00. At the LSA or facilities nobody could explain different levels of remuneration,

and facility managers pointed out that they neither had input nor were they informed about remuneration practices. The provincial HP manager explained it as follows,

"*There is a national CHWs policy which operates in all the provinces ... it says... if as person has been trained comprehensively, she shall be getting a stipend of R1500.00, ...but it doesn't say if the person is not comprehensively trained, what is it that we should be giving to them. ...HIV/AIDS is giving those people... a sum of R600.00 and those that have got the training a sum of R1500.00"* (Provincial Manager.)

This comment linked training directly to levels of remuneration. It was a pity that the provincial HIV/AIDS programme managers were not available to be interviewed. Maybe they could have shed some light on the criteria they used to decide on the amount to give to the workers, in view of the fact that home based carers, like LCs were paid more than the DOTS supporters. This issue was reported by both the LSA and facility managers to be causing tensions and dissatisfaction among the CHWs. CHWs in Clinic B declined to discuss the issue of stipends.

Pretty much against the stipulations of the two documents guiding the CHW programme implementation LSA programme and facility managers led those that were not on stipend to believe that one day their luck might turn, in an effort to encourage people to continue with voluntary work,.

"I used to tell them that ...we don't know when, but if there is an opportunity that is coming, ...those who were getting stipend, others are having std 10, they can get

training or other jobs, we are going to take out of them to replace those (who left)" (LSA programme manager).

A professional nurse in charge of CHWs in Clinic B was reported to have also told the volunteers that,

"*A message had arrived saying only five people were to be chosen for the programme. We do not know at this moment what the government will decide in the future, they could ask for more people. You will join in small groups at a time"* (CHW).

4. 8 Governance and ownership of CHW programme

A tripartite structure prescribed by the policy for the management of CHWs includes the NGO, the government and the CC. The employment of CHWs should be through NGO funded by the ECDoH, specifically by the HIV/AIDS directorate in this case. In line with the policy stipulations, the NGO representative reported to be responsible for signing employment contracts with the CCWs, reporting on the employment and training opportunities, record keeping and exit counselling. Despite the fulfillment of these roles expected of implementing agents, the NGO representative denied being the employer to the CHWsCHWs, claiming to be only a conduit through which the provincial department of health disbursed the stipends to their volunteers. She said

"We do the stipends for the Department of Health, and our role in that is as a paymaster on behalf of the Department of Health for the payment of stipends in the Eastern Cape. Okay, so that is our role ..." (NGO representative).

While the HP programme regarded itself as the rightful coordinator of the CHW programme, it agreed with the NGO and the LSA that the HIV/AIDS directorate, having been involved even in the planning stages of the programme, ran the programme through the NGO. When directly asked if the CHWs were under their control, the (HP) provincial managers replied

"Yes and no..., ... the actual management and ownership has not yet been handed over to us ...officially. ... so we are not in full control as health promotion as we are supposed to be on the ground ...".

The researchers sensed some tension around this topic, as if people are treading cautiously around the ownership of this programme. Even senior management was perceived to be leading them on, but not speaking out about the matter, giving the HP programme manager

"*... the general impression ... health promotion should be managing community health workers but nobody actually sits down and gives us the mandate*"

Sounding very concerned, the provincial manager continued to say

"...I'm just asking for the mandate,... to start the management of community health workers in the Eastern Cape. What I want at the moment ... services evenly must go to the people. Then maybe next year we can now talk about transferring funds and all that or the other year, but at the moment I would like to make sure that the people of the Eastern Cape get services from community health workers. Then we continue to pay them, if they can just give me the authority to supervise" (Provincial programme manager).

The tension around the ownership of CHWs between programmes had also cascaded down to the LSA. We were told that among the manifestations of these silent conflicts was the tendency by one LSA programme manager to discourage the CHWs from attending meetings convened by another programme manager. The CCs at Clinics claimed not to having been aware of their role regarding the CHWs at all.

4. 9 Concluding remarks

The following themes emerging from the above study findings will be discussed in chapter 5:

- Involvement of communities in CHW issues;
- Educational and language requirements for volunteers to be selected in the stipend programme;
- Availability and organisation of initial and continuing training;
- Roles and status of different categories of CHWs;
- Communication between different service levels and interpretation of policies;
- Ownership of the new programme among stake holders.

Chapter Five: Discussion

5. Introduction

A number of themes identified as challenges in the implementation of the CHW programme emerged from the findings of this study. These include: 1) Deficient involvement of communities in CHW programme; 2) Tension around the ownership of the new programme among stake holders; 3) Inappropriate educational and language requirements for volunteers to be selected in the stipend programme; 4) Limited accredited training as well as uneven non formal training given to CHWs; 5) Tension between volunteer and employee status of CHWs; 6) Poor communication between service delivery levels and poor interpretation of policies. These issues are interrelated and have a chain effect on one another, for example literacy of selected CHWs determines the manner in which training must be conducted, and training is directly linked to the stipends received. In this chapter, addressing Objective 7 of this study, the above themes will be discussed in relation to relevant literature and findings from interview data.

5.1 Deficient involvement of communities in CHW issues

Communities are supposed to be the primary beneficiaries, implementers and managers of the CHW system. According to Bhattacharyya, et al.., (2001), working with the community gives CHWs both a platform from which to strengthen their relationship with the community and receive community feedback, and a structure for regular interaction with health facility staff. Without their involvement, communities loose interest leaving CHWs without a support base. However, we found that similar to findings by Friedman (2007) and many international studies, there was little evidence of active involvement of communities in this study, apart

from their involvement as CHWs. Except in one clinic, clinic committee (CC) members never took part in any CHW matters and none of them had been involved in the selection and recruitment of CHWs, a requirement emphasized in the international literature (Lehmann and Sanders, 2007).

Furthermore, although the NCHWPF (2004) is a bit vague about how communities can be involved, the Social Sector EPWP Plan (2004) stipulates that PLWHA or their grown up dependants should participate as CHWs; and clinic committees should be involved when CHWs are selected. None of the CHWs were in the study reported or were known to be either infected or affected with HIV/AIDS.

5.2 Tension around the ownership of the new programme among stake holders.

The NGO shunned its responsibility towards CHWs saying that they did not employ them, but only paid them on behalf of the ECDoH. However, according to both the NCHWPF and the Social Sector EPWP Plan, the NGO is the employer, supported by the government, not the other way round. Despite denying the status of being the employer, the NGO complied with all the prescriptions of the Social Sector EPWP Plan in relation to roles and responsibilities, for example preparing all the documentation necessary for employment for the CHW, signing service agreements with them and so on (See Appendices). On follow up for clarification of certain issues with the NGO, the representative mentioned that she also had to report regularly to the EPWP. The researchers were not previously aware of this accountability relationship between the two, as a result it was not pursued during the interviews. But the researcher has interpreted this as a deliberate oversight on the part of the NGO, for reasons best known to them.

Like the provincial managers, the NGO felt that support and supervision of CHWs was the LSA's responsibility through the clinics in which they are allocated. Facility managers by default took this responsibility as their own, although as a rule they already carried very heavy workloads. At the clinics it was mostly the facility managers who looked after the CHWs. This appears to defeat the task shifting rationale which is meant to free the professionals from jobs that can be done by lesser qualified staff. For example, all the three clinics had one enrolled nursing auxiliary (ENA), a semi skilled category in the nursing profession, in their employ. Previous studies conducted at these clinics by the researcher found this category under utilised. This is the kind of person, supported by more senior staff, who could be supervising the CHWs (personal experience and WHO, 2006). However, a tricky situation exists in the NQF between the two health worker categories. The ENA is on level 3 while the fully fledged CHW is on level 4 (although none of this group is available yet at the sampled clinics).

Another support issue was identified around the provision of kits for home based care (i.e. gloves, swabs, antiseptics, etc.). These were reported to have been out of stock for almost a year. The LSA programme managers reported to have requisitioned these from the province to no avail.

The issue of the control of programme funds appeared to be causing some tension between the HIV/AIDS directorate and the HP programme. The HIV/AIDS programme controls the funds and is therefore responsible for the utilisation of CHWs. However, the HP programme manager, by virtue of the HP programme cutting across all programmes, perceived themselves as the rightful custodians of the CHW programme. The major concern was that

the HIV /AIDS programme seemed to be running as a vertical programme, against the government commitment to integration and provision of comprehensive services at primary care level (DoH, 1997). This, reported by the provincial managers, crippled effective use of CHWs in other programmes. This tension was reported to have previously filtered down to the LSA level programme managers. However, during data collection these programmes were working collaboratively in relation to CHW management.

5.3 Inappropriate educational and language requirements for volunteers to be selected in the stipend programme

Findings from interviews revealed uncertainty around qualification required for volunteers to be eligible for selection in the new programme. The facility managers and some LSA programme managers explained that the directive came from the province stipulating certain qualifications for particular groups of CHWs. Despite the fact that these CHWs had been volunteering for years and successfully trained in several aspects by different NGOs, for the new programme they were said to be "untrainable". This term appeared to be meaning that CHWs should be able to read, write and understand English. This resulted in the exclusion of many volunteers who were mature women with little or no education. But despite this, practices on the ground were variable. Due to unavailability of 'qualifying' candidates, Clinic C, for example, had mature women holding Grade 8 certificates. CHWs and managers at all levels concurred that there was no difference between how the new and old CHWs performed their jobs.

Contrary to what is happening in practice, the Social Sector EPWP does not hold illiteracy as a barrier for selection as a CHW. Instead it prescribes different entry criteria at different levels at the NQF, a concept none of the interviewees appeared to be familiar with. It actually specifies that all those with little or no education who were previous volunteers, will be trained at NQF level one. Definitely these people mostly communicate in the local language. Even other literature is in agreement that the ability of a CHW to read had never been shown to be necessary in a properly designed system (Khanya, 2006 and Imva, undated). Instead, in line with UNICEF/WHO (2006), they emphasise that one of the criteria for selecting CBWs should be their ability to understand the language and culture of the community that they will serve. On a general level, this situation seems to perpetuate what is happening in the very province between foreign health care providers and the patients especially in the remotest rural areas, where language is a huge barrier between clients and the doctors. It is common knowledge that language barriers between patients and healthcare providers result in longer consultations, more medical errors and lower patient satisfaction. While interpreters are a necessary solution to the problem of language barriers in healthcare, they are likely to be an imperfect one.

5.4 Limited accredited training as well as uneven non formal training

All the countries reviewed by UNICEF had provisions of basic foundation training that ranged from five days to three months, and refresher training (one to five days) at regular intervals (UNICEF, 2004). In South Africa, pilot CBW programmes raised the issues around standardization and accreditation of CBWs, monitoring for quality and impact as a concern (Khanya, 2005). Lack of post-training support was also identified. One of the major constraints reported in relation to training of CHWs and confirmed in the EPWP report is the

scarcity of accredited training providers to provide and manage NQF level accredited training (EPWP, 2006).

In this study, there were variations in training among CHWs. LCs received more training than other categories. But very few of the courses were accredited. In South Africa, a 59- day training course for home based care has provided a standardised and holistic form of training. Although this programme is not accredited, it has been adopted by the DoH as the basis for HBC. The situation in each of the selected clinics was that only one CHW had completed the 59 day programme. Some had done two to four weeks whilst others had not been to the course at all. Major constraints reported by the LSA programme manager included lack of or inaccessibility of funds, with training budget still centralized at provincial level; and lack of trainers to conduct the training. Ideally, CHWs can only start practicing after they have completed the 59-day HCBC programme. But in real terms it was reported to be impossible to achieve. Firstly, no one CHW can be away for such a long time, considering that they are few. Secondly the training budget at LSA level was reported to be extremely limited, if it ever came.

The NGO, according to the Social Sector EPWP Plan and also in line with WHO (2004), should conduct training needs so that appropriate skills are developed. Once again, contrary to its denial to be the employer of CHWs in the Eastern Cape, the NGO has developed a training audit (see appendices) as a way of doing training needs assessment.

5.5 Tension between volunteer and employee status of CHWs

CHWs reported to be aware that they were not employees per se, but still volunteers. However, they were not happy about the designation 'volunteer' appearing on their pay slips. They reported this as preventing them for acquiring any credit facility from merchants. But then, although they are not regarded as paid workers, the NGO reported that a small amount of money was deducted from the stipends as a contribution towards Unemployment Insurance Fund, which the researcher assumed to apply to paid workers. Confusion arises when the CHWs have not worked the minimum hours required and as result forfeits their stipend. The Social Sector EPWP Plan is explicit in that once people are trained they should be encouraged to find paid work.

5.6 Poor communication between service delivery levels leading to poor interpretation of policies

Communication amongst the four levels (province, district, LSA and facility) of health service delivery was found to be erratic and predominantly consisting of verbal directives. By the time communication gets to the CHWs, the message has often lost some of its aspects and gained different interpretations along the way. This oral culture impacts negatively on policy implementation. This could be eliminated if a culture of written communication were to be adopted.

Regarding the two policies guiding the CHW programme, none of the interviewees had any knowledge about them. A programme manager at the LSA tasked with managing of the CHWs felt overwhelmed by running a programme on hearsay, without any guidelines. Lack of active and clear distribution of guidelines and policies, reported by Khanya (2006), was a

common feature of large scale programmes. People, especially programme implementers, are often unaware of policies and plans.

Also, as evidence of poor communication, facilities had two newly appointed care givers. Neither the facility managers nor the LSA programme managers understood what their roles were supposed to be at the clinics or how they had been appointed. They were just known to be the province's responsibility, some speculating that they were additional home based cares and others counting them as DOTS supporters. Another factor causing confusion and misinterpretation reported by HIV/AIDS manager at LSA level was that she had to report to several managers at provincial level who run single sub programmes. Yet, at the LSA she was expected to be responsible for the entire programme. This manager was of the opinion that the CHW programme was very broad on its own, therefore needed to be separated from HIV/AIDS programme, which also is very wide.

5.7 Conclusion

These findings have identified a number of implementation gaps in the CHW programme. Recommendations for improvement or correction of these fallacies will be dealt with in the next Chapter.

Chapter Six: Conclusions and recommendations

6. Introduction

It was evident from the findings of this study that the implementation of the new government funded CHW programme in the Eastern Cape province did not completely reflect the stipulations of the relevant policies. This means that there are discrepancies between the intention of the policy and its practical implementation.

For the issues found to be challenges during the implementation of the CHW programme, the following is recommended:

6.1 Deficient involvement of communities in CHW issues

Meaningful involvement of communities in health issues should be encouraged. Close cooperation and collaboration between health facility staff and the communities should be improved. This can happen through open dialogue. Clinic committees should be involved in identifying the right candidates from their communities to serve as CHWs. They can only know what to do if they are oriented or trained in their roles and responsibilities after election. Also, they are the best people to support the CHWs in their work at the villages, whilst also acting as a bridge between the CHWS and the health facilities.

6.2 Inappropriate educational and language requirements for volunteers to be selected

There appears to have been some message distortion around criteria for selecting CHWs. It should be explicitly communicated to communities what educational qualifications are required for which levels of CHWs. Even illiterate persons can volunteer, but then means should be put in place to improve their literacy, for example through adult basic education

and training. The issue of the medium of instruction in CHW training was explained in terms of unavailability of trainers speaking the local language, and training materials not translated into Xhosa. To mitigate against this, trainers who can speak the local language must be recruited for short term, whilst for the longer term people should be trained as trainers in the local language.

6.3 Limited accredited training as well as uneven non formal training given to CHWs

Lack of trainers and a limited training budget were two major obstacles identified. The management can minimize off site training which seemed to be a common approach. Instead of taking participants for training, a trainer could be organised to come to the LSA to minimize traveling, accommodation and subsistence costs. On-going and on the job training should be provided regularly. This kind of training is normally provided by health professional at clinics who unfortunately are in short supply. One of the senior CHW should be given this role of training and supervising the less qualified CHWs.

6.4 Tension between volunteer and employee status of CHWs

It should be clarified when people are appointed as CHWs that although they are remunerated, they are not government employees. The clinic committees should also be oriented about this so as to assist the CHWs to comprehend their situation. Actively encouraging the CHWs to find other paying jobs could assist CHWs to realise their status.

6.5 Poor communication between service delivery levels and interpretation of policies:

Managers at all levels of service delivery should be reoriented to make more use of written rather than verbal communication to ensure that there is evidence or a paper trail to which one can turn to in times of uncertainty. Even when initial contact has been verbal or telephonically, at the earliest convenience a written follow up should take place. Stakeholder meetings can also minimise the communication breakdown as everybody gets the same message at the same time. Policies should be distributed to all persons and facilities to be affected by such policies, not only managers, but also the implementers.

6.6 Tension around the ownership of the new programme among stake holders

Stakeholders need to understand that collaboration among them can benefit the programme. Open communication is very important so that each partner understands his or her roles in the programme.

6.7 Research recommendations

Due to the small sample of this study, its findings cannot be generalized to the whole province. It is recommended therefore that similar small scale studies be conducted in all LSAs and then a comparison of findings will lead to common recommendations.

Reference List

Abbatt, F. (2005). *Scaling Up Health and Education Workers: Community Health Workers.* London: DFID.

A. S. De Vos (ed). (1998). *Research at Grass Roots. A Primer for the Caring Professions.* Pretoria: J.L. van Schaik Publishers.

Bhattacharyya, K., Winch, P., Leban, K. & Tien, M. (2001). *Community Health Worker Incentives and Disincentives: How they Affect Motivation, Retention and Sustainability.* Arlington, Virginia: Basic Support for Institutionalizing Child Survival Project (BASICS II) for the United States Agency for International Development.

de Leon, L. (2002). What Ever Happened to Policy Implementation? An Alternative Approach. *Journal of Public Administration Research and Theory,* 12(4): 467-492.

Department of Health, South Africa. (1997). *White Paper for the Transformation of the Health System in South Africa.* Pretoria: Government Printer.

Department of Health, South Africa. (2000). *HIV and AIDS/STD Strategic Plan for South Africa 2000-2005.* Pretoria: Department of Health.

Department of Health, South Africa. (2001). *National Guidelines on Home-Based Care and Community-Based Care.* Pretoria: Department of Health.

Department of Health, South Africa. (2003). *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa.* Pretoria: Department of Health.

Department of Health, South Africa. (2004). *Strategic Priorities for the National Health System 2004-2009.* Pretoria: Department of Health.

Department of Health, South Africa. (2004). *National Community Health Worker Policy Framework.* Pretoria: Department of Health.

Department of Health, South Africa. (2007). *A Policy on Quality in Health Care for South Africa.* Pretoria: Department of Health.

Department of Public Works (DoPW). (2006). EPWP, SA (Expanded Public Works Programme, South Africa).. *4ih Quarterly Report – Year 2 (Containing Data and Information for the Period 1 April to 31 March 2006).* Pretoria: Department of Public Works (DoPW).

Department of Social Development, Department of Education & Department of Health. (24.02.2004). *Social Sector EPWP Plan – Version 5* (24.02.2004). Pretoria: Expanded Public Works Programme.

Dick, J., Murray, E. and Botha, E. (2005). *The Effectiveness of TB DOTS Supporters in South Africa. Operations Research Results.* Bethesda, MD: Published for the U.S. Agency for International Development (USAID) by the Quality Assurance Project (QAP).

Eastern Cape Department of Health, South Africa. (nd). *Annual Performance Plan 2007/08 – 2009/10.* Bisho: Eastern Cape Department of Health.

Friedman, I. (2002). Community Based Health Workers. *South African Health Review 2002.* Durban: Health Systems Trust.

Friedman, I. (2003). Community Based Health Workers. *South African Health Review 2003.* Durban: Health Systems Trust.

Friedman, I. (2005). Community Health Workers and Community Caregivers. Towards a Unified Model of Practice. *South African Health Review 2005.* Durban: Health Systems Trust.

Friedman, I., Ramalepe, M., Matjuis, F., Bhengu, L., Lloyd, B., Mafuleka, A., Ndaba, L. and Baloyi, B. (2007). *Moving Towards Best Practice: Documenting and Learning from Existing Community Health/Care Worker Programmes.* Durban: Health Systems Trust.

Gilson, L., Walt, G., Heggenhougen, K., Owuor-Omondi, L., Perera, M., Ross, D., & Salazar, L. (Winter, 1989). National Community Health Worker Programmes: How Can They Be Strengthened? *Journal of Public Health Policy*, 10 (4): 518-532.

Green, J. & Thorogood, N. (1998). *Analysing Health Policy: Sociological Approaches.* London: Longman.

Green, J. & Thorogood, N. (2004). *Qualitative Methods for Health Research.* London: Sage Publications.

Haines, A., Sanders, D., Lehmann, U., Rowe, A. K., Lawn, J.E., Jan, S., Walker, D.G. and Bhutta, Z. (2007). Achieving Child Survival Goals: Potential Contribution of Community Health Workers. *Lancet*, 369 (9579): 2121-2131.

Health Resources and Services Administration, U.S. (2007). *Community Health Worker National Workforce Study.* Washington, D.C.: Bureau of Health Professions, U.S. Department of Health and Human Services.

JLI (Joint Learning Initiative). (2004). *Human Resources for Health. Overcoming the Crisis: Global Health Initiative.* Cambridge, Massachusetts: Harvard University Press.

Khanya - AICDD. (2005). *Guidelines for Implementation of CBW Pilots.* Bloemfontein: Khanya - African Institute for Community Driven Development.

Khanya - AICDD. (2006). *CBW National Workshop Report South Africa.* Bloemfontein: Khanya - African Institute for Community Driven Development.

Khanya - AICDD. (2007). *Experiences with Community Based Worker Systems in Kenya, Lesotho, South Africa and Uganda: Final Report of the Four Country CBW Project.* Khanya - African Institute for Community Driven Development.

Klugman, B. & McIntyre, D. (2000). *From Policy, through Budgets, to Implementation: Delivering Quality Health Care Services.* Cape Town: Women's Budget Initiative.

Lehmann, U., Friedman, I. and Sanders, D. (February 2004). *Review of the Utilisation and Effectiveness of Community-Based Health Workers in Afric. JLI Working Paper 4-1.* [Online], Available: http://www.hrhresourcecenter.org/node/284 [9/7/06].

Lehmann, U. and Sanders, D. (2007). *Community Health Workers: What do we know about them?* Geneva: WHO. [Online], Available: http://www.who.int/hrh/documents/whr06_background_papers/en/index.html [6/5/07].

Liamputtong, P. & Ezzy, D. (2005). *Qualitative Research Methods.* Sydney: Oxford University Press: 54-99.

Lincoln, Y. S. & Guba, E.G. (1985). *Naturalistic Enquiry.* Beverley Hills: Sage.

Lips, G. & Grant, P.R. (1990). A Participatory Method of Assessing Programme Implementation. *Evaluation Review,* 14 (4): 427-434.

Mohammad, N. & Gikonyo, J. (2005). *Operational Challenges: Community Home Based Care (CHBC) for PLWHA in Multi-Country HIV/AIDS Programmes (MAP) for Sub-Saharan Africa: Working Paper Series No. 88.* AIDS Campaign Team for Africa (ACTafrica) Africa Region for World Bank, Washington, D.C.

Myanmar Nurses Association in collaboration with National AIDS Programme, Division of Nursing, Department of Health, UNOPS/UNDP, UNICEF and UNAIDS. (2001). *Strengthening of Home Based Care in Myanmar Implementation Guide for Establishment of Community Home Based Care in Pilot areas in Myanmar.* Geneva: UNICEF.

Nemcek, M. A. & Sabatier, R. S. (2003). State of Evaluation: Community Health Workers. *Public Health Nursing,* 20 (4): 260-270.

Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods.* (2nd ed.). Newbury Park, CA: Sage.

Perold, H., Carapinha, R. and Mohamed, S. E. (2006). *Five-Country Study on Service and Volunteering in Southern Africa. South Africa Country Report.* Johannesburg: Volunteer and Service Enquiry, Southern Africa.

Polit, D. F. & Hungler, B. P. (1991). *Nursing Research: Principles and Methods.* Philadelphia: Lippincott.

Pope, C., Ziebland, S. and Mays, N. (Jan 2000). Analysing Qualitative Data. *British Medical Journal*, 320: 114-116.

Sandelowski, M. (1986). The Problem of Rigour in Qualitative Research. *Advances in Nursing Science*, 8(3). 27-37.

Saunders, R. P., Evans, M. H. and Joshi, P. (2005). Developing a Process-evaluation Plan for Assessing Health Promotion Programme Implementation: A How To Guide. *Health Promotion Practice.* [Online], Available: http://hpp.sagepub.com [10/9/07].

Schneider, H. & Stein, J. (2001). Implementing AIDS Policy in Post-Apartheid South Africa. *Social Science and Medicine,* 52: 723-731.

Slatsha, N. (2005). Mapping of HIV and AIDS Services and Resources in South Africa. Durban: Health Systems Trust.

Smit, B. (June 2003). Can Qualitative Research Inform Policy Implementation? Evidence and Arguments from a Developing Country Context. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research* [On-line Journal], *4*(3), Art. 6. Available at: http://www.qualitative-research.net/fqs-texte/3-03/3-03smit-e.htm [15/06/07].

The Integrated Sustainable Rural Development (ISRDS). (November 2000). [Online], Available: http://www.info.gov.za/otherdocs/2000/isrds.pdf [18/08/2007].

UNAIDS. (2006). *A Faith-Based Response to HIV in Southern Africa: The Choose to Care Initiative.* Geneva: UNAIDS.

UNICEF. (2004). *What Works for Children in South Asia. Community Health Workers.* Nepal: UNICEF.

UNICEF and WHO. (2006). *Management of Sick Children by Community Health Workers. Intervention Models and Programme Examples.* Geneva: UNICEF/WHO.

Van Wyk, B. E., Strebel, A., Skinner, D. & Peltzer, K. (2006). *Community-based Interventions for HIV Prevention. OVC Occasional Paper 3.* Cape Town: Human Sciences Research Council Press.

Walt, G. (1988). CHWs: Are National Programmes in Crisis? *Health Policy and Planning*; 3 (1): 1-21.

Werner, A. (2004). *A Guide to Implementation Research.* Washington: Urban Institute Press. [Online], Available: http://www.urban.org/pubs/implementationresearch/index.html [7/20/2007].

WHO (World Health Organisation). (1987). *Draft working document for the WHO Study Group on Community Health Workers.* Geneva: Division of Strengthening of Health Services, World Health Organisation.

WHO. (1989). *Strengthening the Performance of Community Health Workers in Primary Health Care: Report of a WHO Study Group. WHO Technical Report Series No 780.* Geneva: World Health Organisation.

WHO. (2003). A Public Health Approach to Antiretroviral Therapy: Overcoming Constraints. Geneva: World Health Organisation.

WHO. (2004). *Comprehensive Community- and Home-based Health Care Model.* New Delhi: World Health Organisation.

WHO.(2006). *Taking Stock: Health Worker Shortages and the Response to AIDS.* Geneva: World Health Organisation.

WHO. (2006).*Working Together for Health. The World Health Report.* Geneva: World Health Organisation.

Appendix 1: Permission letter

UNIVERSITY OF THE WESTERN CAPE
School of Public Health

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-9592872

http://www.soph.uwc.ac.za

The Superintendent General - Health
Eastern Cape Department of Health
P/B X0038
Bisho
Mr L Boya

Fax: 040-6093505

22 August 2007

Dear Mr Boya

Re: Research in Chris Hani District

I hope this letter finds you well. I am writing to you to update you on research presently being conducted by the University of the Western Cape in Chris Hani District and specifically to request permission to interact with your provincial staff regarding the implementation of the Community Health Worker Policy Framework.

As you may be aware, UWC, in conjunction with the Health Systems Trust, has been engaged in research in Chris Hani District over the past couple of years, focusing on the strengthening of programme information systems and developing tools to evaluate the impact of HIV/AIDS on human resources in the district. At the request of the District we have been working particularly with Emalahleni and Intsika Yethu Local Service Areas.

In early 2006 a meeting was held between the joint UWC/HST research team, the Chris Hani District Manager, Mrs Njaba and the two LSA managers aimed updating all role players on progress regarding the research and to chart the way forward. The meeting was held at Dr Mjekevu's office and was chaired by Mrs Matebese, as Dr Mjekevu had to render apologies at the last minute.

At the meeting it was mentioned that the implementation of the new Community Health Worker Policy Framework was an important human resource intervention in the District and that little is presently known about the implementation of the policy at service delivery level. UWC agreed to pursue this topic and we have now asked one of our colleagues, Ms Princess Matwa, to conduct research into the implementation of the CHW Policy Framework, using Emalahleni LSA as a case study as part of her Masters studies. I am supervising and assisting her, also exploring the linkages between old and new community health worker practices.

As part of this research we would like to engage with key role players in the provincial Department of Health to learn from them how the policy is being implemented. In particular we would like to talk to staff in the HIV/AIDS and Health Promotion directorates as we understand that they have primary responsibility for policy implementation.

We would be very grateful if you could grant us permission to do so. Please do not hesitate to contact me, should you have any further queries. My contact details are:

E-mail: ulehmann@uwc.ac.za
Tel: 021-9592633 (office)
082-2-23189 (mobile)

With best regards,

Uta Lehmann, PhD
Ass. Prof., School of Public Health
University of the Western Cape

cc: **HIV/AIDS Directorate**
Health Promotion Directorate

Appendix 2: Interview Guide

CHW Programme interview guide (adaptable to all participants including CHWs)

1. **CHW recruitment and selection**
   - What do you call your CHWs?
   - What entry requirements or criteria are used for selection?
   - What is their motivation and to what extent is this motivation maintained?
   - To what extent and how are they remunerated?

2. **CHW training**
   - To what extent was there recognition of prior learning?
   - How are they trained?
   - Who is responsible for training?
   - Is the training programme certified (SAQA/ NQF etc)?
   - How is the training funded?
   - How long is the training period?
   - What is covered in the training period?
   - Are there different levels of training?
   - How is their competence assessed?
   - What is the rationale for their deployment?

3. **CHW work**
   - What is a typical work routine?
   - What is the role of each level of CHWs?
   - What difficulties do they encounter?
   - In which way have they been successful?
   - What is the relationship with other health workers- both traditional and conventional? And from other sectors?
   - What referral system is in place (why, how, when and where to)?

4. **CHW support**
   - What support systems are available for CHWs?
   - To what extent are they mentored and ongoing training provided?

5. **Management, monitoring and evaluation**
   - How are they supervised and by whom?

- To what extent is the quality of care or work performance evaluated?
- How is this information recorded, stored and used?
- Who is responsible for assessment?
- How effective have the CHWs been in their role?

Appendix 3: English Participant Information Sheet

UNIVERSITY OF THE WESTERN CAPE

School of Public Health
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-9592872
http://www.soph.uwc.ac.za

Project Title: Assessing the implementation of the government run Community Health Worker Programme in selected clinics of the Eastern Cape Province, South Africa.

Sir / Madam

I, Princess Nonzame Matwa, am studying towards a Masters Degree in Public Health with the University of the Western Cape. I am interested in conducting a research study on the implementation of the new Community Health Worker (CHW) programme in the Eastern Cape Province.

You are invited to participate in this study because you are one of the beneficiaries of the new programme, receiving a stipend from the government. You will be interviewed in a group with the other CHWs in your clinic. The discussion will be conducted either in Xhosa or English, depending on the group's preferred language, and also because these are the only languages I can speak fluently. You will be asked to furnish your biographic details and these will be written down. You will then be asked to share information on:

- How you were selected to the programme;
- What training you received;
- What activities you perform;
- How you are rewarded for the tasks you perform; as well as
- What kind of support and supervision you are afforded.

An audiotape will be used to record the interview so as to capture accurately all the information that will be given. The interview will not be longer than two hours. The information that you give during a group session will help us to write a report that will be

published, as well as contribute towards the fulfilment of the requirements for my degree. At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name, erasing the taped material on completion of the study; and limiting access to the interview transcripts to my supervisor, and one other researcher who will assist in analysis of the collected information.

If you do not wish to participate in this study, you have the right to say no, and that will not influence your benefits within the CHW programme. You may also stop participating in the group discussion whenever you feel that you do not want to talk. You can also choose not to answer some of the questions if you do not feel comfortable answering them.

You will not be paid for participation in this study. However, the information that you give us will help us make recommendations that will enhance future implementation of the CHW programme.

Findings of this study will be communicated to you as soon as they are available. Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator -

Princess Nonzame Matwa at the following address
University of the Western Cape
Private Bag X17,
Belville
7535
Telephone: (021)959-2809
Cell: 0828708689
Fax: (021)959-2872 **Email:** pmatwa@uwc.ac.za

Thank you for your cooperation

Appendix 4: Xhosa Participant Information Sheet

UNIVERSITY OF THE WESTERN CAPE

School of Public Health
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-9592872
http://www.soph.uwc.ac.za

Project Title: Assessing the implementation of the government run Community Health Worker Programme in selected clinics of the Eastern Cape Province, South Africa.

Mhlekazi / Nkosikazi

Ndingu Princess Nonzame Matwa. Ndifundela isidanga sempilo yoluntu jikelele kwi dyunivesity yase Ntshona Koloni. Ndinomnqweno wokuphanda ngofakelo-nkqubo entsha yoonompilo kwiphondo leMpuma Koloni.

Uyacelwa, wena neqela labanye oonompilo bale kliniki abaxhamla kule nkqubo enntsha ngokuthi bafumane isibonelelo kurhulumente, ukuba uthabathe inxaxheba kwingxoxo emalunga nolu phando. Le ngxoxo iya kuqhutywa ngesiXhosa okanye ngesiNgesi ngokwesigqibo seqela lenu boonompilo, yaye ezi ikukuphela kweelwimi endikwaziyo ukuzithetha gqibi. Uyakucelwa ukuba unikele ngeencukacha zakho eziyakuthi zibhalwe phantsi. Emva koko koobanjwa ingxoxo nani malunga:

- Nendlela enakhethwa ngayo ukuba nibe kule nkqubo intsha;
- Noqeqesho enilufumeneyo;
- Nemisebenzi eniyenzayo;
- Nembuyekezo eniyifumana ngomsebenzi eniwenzayo; kwa
- Nenkxaso eniyifumana kubaphathi benu.

Le ngxoxo iya kushicilelwa kwiteyiphu-rekhoda khonukuze sicholachole yonke ingxelo ngobunjalo bayo. Le ngxoxo iyakuthatha ithuba elingaphantsi kweeyure ezimbini. Izimvo zakho ziya kusetyenziswa ukubhala ingxelo epapashiweyo, yaye ibeluncedo ekuphumeleleni

izifundo zam. Ngalo lonke ixesha ndiyakuqinisekisa ukuba umthombo weengxelo zoluphando uyimfihlo ngokuthi ndikubize ngagamalimbi elingelolakho, ndicime iiteyiphu ezishicilelweyo lwakugqitywa uphando, ize ibengumphathi wam kunye nomnye umphandi ozakuncedisa ekucaluleni zonke ingxelo zoluphando oyakufikelela kumaxwebhu akhutshelweyo eengxoxo eziqhutyiweyo.

Ukuba awuthandi ukuthatha inxaxheba kolu phando, unelungelo lokwala ukwenza njalo, yaye oku akusayi kuchaphazela izibonelelo ozifumana kule nkqubo yoonompilo. Unokuyeka ukuba yinxalenye yeengxoxo nanini na ufuna. Unelungelo lokungayiphenduli imibuzo ongathandi kuyiphendula.

Awusayi kufumana ntlawulo ngenxaxheba yakho kolu phado. Koko ulwazi oyakusinika lona luyakusetyenziswa ukuphucula le nkqubo yoonompilo.

Uyakwaziswa ngeziphumo lwakuqosheliswa olu phando. Ukuba unemibuzo okanye unqwenela ukwenza ingxelo ngeengxaki ohlangabezene nazo ngokunxulumene nolu phando, nceda qhagamshelana nomququzeleli wolu phando u Princess Nonzame Matwa, kule dilesi:

University of the Western Cape
Private Bag X17,
Belville
7535
Telephone: (021)959-2809
Cell: 0828708689
Fax: (021)959-2872 **Email:** pmatwa@uwc.ac.za

Enkosi ngentsebenziswano yakho.

Appendix 5: English Consent Form

UNIVERSITY OF THE WESTERN CAPE

School of Public Health
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-9592872
http://www.soph.uwc.ac.za

Title of Research Project: Assessing the implementation of the government funded Community Health Worker Programme in selected clinics of the Eastern Cape Province, South Africa.

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name .....

Participant's signature.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator

Princess Nonzame Matwa
University of the Western Cape
Private Bag X17,
Belville
7535
Telephone: (021)959-2809 **Fax:** (021)959-2872
Cell: 0828708689
Email: pmatwa@uwc.ac.za

Appendix 6: Xhosa Consent Form

UNIVERSITY OF THE WESTERN CAPE

School of Public Health
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592809, Fax: 27 21-9592872
http://www.soph.uwc.ac.za

Title of Research Project: Assessing the implementation of the government funded Community Health Worker Programme in selected clinics of the Eastern Cape Province, South Africa.

Iphepha-mvume

Olu phando luchaziwe kum ngolwimi endilwaziyo, yaye ndiyavuma, ndinganyanzelekanga, ukuthabatha inxaxheba. Imibuzo yam malunga nolu phando iphendulwe. Ndiyaqonda ukuba igama lam alisayi kudandalaziswa yaye ndingarhoxa nangaliphi na ixesha koluphando ngaphandle kokunika izizathu zoko yaye oku akusayi kuba nafuthe libi kum nangaluphi na uhlobo.

Igama lomthathi nxaxheba.....

Intsayino-gana yomthathi nxaxheba.....

Umhla.....

Ukuba unemibuzo okanye unqwenela ukwenza ingxelo ngeengxaki ohlangabezene nazo ngokunxulumene nolu phando, nceda qhagamshelana nomququzeleli wolu phando u Princess Nonzame Matwa, kule dilesi:

University of the Western Cape
Private Bag X17, Belville 7535
Telephone: (021)959-2809
Cell: 0828708689
Fax: (021)959-2872 **Email:** pmatwa@uwc.ac.za

Appendix 7: SPF Documents 1-7

SPF Document 1 : Volunteer Community care worker service agreement

ANNEXURE 1

Volunteer Community care worker service agreement

I..... community care worker/lay counsellor/peer educator/personal seller, agree that I understand what is written below.

1. **I am not employed by the municipality, Small Projects Foundation, or the Department of Health and do not receive an income/stipend from any other source.**
2. **I agree to inform the municipality and Small Projects Foundation of any change to my employment status.**
3. **I realise that I am a volunteer (a person who agrees to provide a service without an expectation of being paid) with rights and responsibilities as attached in ANNEXURE THREE.**
4. **I want to provide a volunteer health service and I will perform the tasks assigned and explained to me to the best of my ability and within the Code of Conduct as per ANNEXURE TWO.**
5. **I agree to work under the direct medical supervision of clinic staff who will act as medical supervisors and as a resource and referral point for clients in my care.**
6. **I accept that during my association with the municipality and Small Projects Foundation I shall have access to information that in respect of people with HIV/AIDS that must remain both confidential and private.**
7. **In upholding the principles of confidentiality, I will at all times respect matters of confidentiality and will not divulge any information whatsoever unless with the express consent of such person/s concerned**
8. **I agree to keep complete records of volunteered services and submit these to Small Projects Foundation by the dates agreed upon.**
9. **I understand that any equipment or consumables issued to me will remain the property of the Department of Health and is available for my use as long as I remain an active volunteer.**
10. **I understand that I will be held legally liable for the negligent loss of any equipment or consumables issued to me.**
11. **I agree not to use any equipment or consumables issued to me for use other than that for which it was intended or explained to me. I understand further that such use will be interpreted as theft/fraud and as such I will be liable to prosecution.**
12. **I agree to undergo further training as deemed appropriate to update my skills to help improve the quality of my volunteer service.**
13. **I understand that I will not hold Small Projects Foundation, Department of Health and the municipality responsible for any injury or loss during the normal course of volunteer duties.**
14. **I will wear suitable identification to assist both Clinic staff and clients in identifying me as a volunteer worker assisting in the community.**

The contents of this agreement have been explained to me in a language that I understand.

Completed and signed in Nelson Mandela Metro/Alfred Nzo/Cacadu/Chris Hani/O.R. Tambo/Ukhahlamba/Amatole Municipality on the.....of.....in the year.....

Signature: **Volunteer:.....**
Witness:1. .....
2. .....

ANNEXURE TWO

Code of Conduct for volunteer Community Care Workers

1) Proposed service times: (guideline)
   a) The starting time for the voluntary community care worker is 08h00 unless otherwise agreed to by the sister-in-charge
   b) The duration of the volunteer community care worker's service will be 4 hours per working day or an equivalent of 20 hours per week
   c) The voluntary community care worker will forfeit their stipend if absent for more than 5 working days or more a month

2) Dress code:
   a) A community care worker should be neat, tidily dressed and presentable while performing their tasks
   b) A community care worker should be identifiable as a volunteer and should dress accordingly

3) Behaviour:

3.1 Towards clients and the community
   a) All clients should be treated with respect
   b) All clients should be spoken to in a polite manner
   c) The client is entitled to have their own opinion and this should be respected
   d) All clients should be treated in the same way and the community care worker is expected to remain impartial

3.2 Towards health providers
   a) There should be mutual respect for all members of the health team – professional and non-professional
   b) Lines of communication should be restricted to the relevant community health nurse in charge

3.3 Clients and the community
   a) The client and the community should not abuse the community care worker, either physically, emotionally, or verbally
   b) The client should understand that they are ultimately responsible for their own care and the care of any family member that is a patient
   c) The community care worker will not be held accountable for any act or omission during the care of the patient and during their presence in the client's home
   d) The client needs to understand that the community care worker may withdraw at any time

3.4 Clinic Supervisors/Clinic Sisters
   a) The community care worker may only be utilised for volunteer work as highlighted in point 4. administration – community care worker activities (fields for which the CCW needs to report on) they may not be utilised for personal use – running of errands, gardening and mopping of floors
   b) The CCW will be treated with respect as they are providing a valuable service on behalf of the Clinic Supervisors and Clinic Sisters
   c) They assist with supervision of patients
   d) The Clinic Supervisors and Clinic Sisters undertake to ensure that the logsheets/attendance registers/tick registers are signed and submitted with their reports to the Local Service Area office.

3.5 General
   a) Any intoxication (alcohol or drugs) is not permitted while performing volunteer tasks
   b) Only emergency telephone calls will be allowed at the facility, this is in consultation with the sister in charge
   c) The list of duties must be adhered to; all other issues should be referred to the Sister-in-charge
   d) Personal cellular phones need to be switched off when consulting with clients

SPF Document 2: Certification letter

SMALL PROJECTS FOUNDATION

Certification letter

Town: _____

Local service area: _____

Clinic/hospital/fixed site: _____

Clinic sister's name: _____

Community care worker's full name: _____

Community care worker's ID: _____

Designation: _____

I hereby declare that _____(name of volunteer has been working at the above Clinic/hospital/fixed site since date: _____
I further declare that the information contained above is accurate and true. (If back-pay is required, this will need a separate letter from the clinic sister)

(This is important) Please circle the appropriate designation

community care worker **lay counsellor** **TB dots worker**

Peer educator **Personal seller**

Signature of volunteer: _____

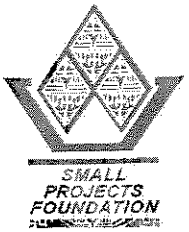
Signature of manager/sister:_____

Date: _____

Clinic stamp

Please attach a **certified copy of your identity document** to the back of the bank verification form

SPF Document 3: Bank Verification Form



Bank verification form

Town: _____

Local service area: _____

Community care workers FULL name: _____

Community care workers ID number: _____

I hereby declare that _____ (name of community care worker) ID number _____ confirm that my bank details are as follows:
Bank name: _____
Account number: _____
Branch code: _____
*If you have a Post Bank account - my ACB number is (this is not the number on your card) _____

To Whom It May Concern, this is to certify that this bank account is held by the above person and it is open and activated.

Signature of Community care worker:

_____

Date: _____

Bank stamp

SPF Document 4: Fields of different CCWs

The activities undertaken by each type of community care worker and for which they need to report on (fields) are as follows:

Community care workers
Fields divided up into:

1. date of visit

(name of CCW and clinic + kit bag number)

2. Number of:
   - Home visits conducted (total amount)
   - Dependent patients (bed ridden)
   - Semi-dependent (wheel chair, assisted walking)
   - Independent
   - Orphans served by HBC carers
   - Child headed families served
   - Families served (excluding child headed families)
   - Food parcels distributed (if applicable)
3. Self care assistance
   - Bed bathing
   - Feeding
   - Wound care
   - Pressure cleaning and positioning
4. Medical supervision
   - TB
   - ART
   - VCT awareness
   - Other
5. Referrals:
   - Clinic
   - Hospital
   - Nutrition programme
   - Social services
6. HBC Kits
   - Amount of kits initially issued
   - Stock replenished

Lay counsellors
Fields divided up into:

1. date of visit

(name of CCW + clinic)

2. Number of:
   - Home visits conducted (total amount)
   - Dependent patients (bed ridden)
   - Semi-dependent (wheel chair, assisted walking)
   - Independent
   - Orphans served by HBC carers
   - Child headed families served

Families served (excluding child headed families

3. Clinic
   - Pre-counselling

Post-counselling
ART adherence
VCT awareness
Other

4. Home visit
   Wound care
   Pressure cleaning and positioning
   ART adherence
   VCT awareness
5. Referrals:
   Clinic
   Hospital
   Nutrition programme
   Social services

The following is advised for lay counsellors:
Guideline:
10 clients per volunteer (more is not manageable)
60 visits per month (no more than)
3 home visits per day (no more than, unless homes visited are close together)
15 visits per week
A weekly debriefing session with clinic sister – group debriefing is equally effective
No more than 6 hours counselling is completed each day (based on 1 hour per client and time in between for counsellor to take a break to debrief him/herself)
Confidentiality (needs to be emphasised)

Personal sellers

1. date of visit

(name of CCW + clinic)

2. Type of discussion held:
   Voluntary counselling and testing
   (Number of persons attended, amount of referrals cards handed out)
   Prevention of mother to child transmission
   (Number of persons attended, amount of referrals cards handed out)
   Home based care awareness
   (Number of persons attended, amount of referrals cards handed out)
   Wellness management (healthy life-style living0
   (Number of persons attended, amount of referrals cards handed out)
   Condom usage and identification of distribution points
   (Number of persons attended, amount of referrals cards handed out)
   Education, advice and promotion on VCT
   (Number of persons attended, amount of referrals cards handed out)
3. Referrals:
   Clinic
   Hospital
   Nutrition programme
   Social services

SPF Document 5: Community Health Worker Training Information Survey

Surname	
First Name	
Local Service Area (LSA)	
Clinic/Hospital/Fixed Site	
CBO name	

Identity Number

Date of Birth

Day		Month		Year	

Sex:

Male		Female	

Race:

African		Indian		Coloured		White		Other Specify	

Do you have a disability, as contemplated by the Employment Equity Act 55 of 1998? (Employment Equity Act defines a disability as a long-tern or recurring physical or mental impairment which substantially limits prospects of entry into, or advancement in, employment)

Yes	Specify	No	

What language /s do you speak at home?

Your address

Postal code:

Cellphone Number

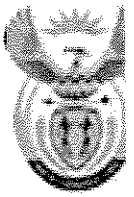
Highest Level Qualification: *(for example, Std 7, Grade 10 etc)*

Which training have you received? Please also say who offered you this training, and how long the training course was (how many days or weeks)

Training	Training Provider	Duration	Training	Training Provider	Duration
Home based care			DOTS supporter		
First aid			Counselling		
HIV/AIDS Literacy			Immunization		
VCT			Peer Education		
Food Gardening			Victim empowerment		
Nutrition			Breastfeeding		
STI Education			PMTCT		
TB Education			Palliative Care		

If you had the opportunity for further training in the fields of home based care, health, community development and HIV/AIDS, what training would you be interested in? Please explain why you say this.

SPF Document 6: Monthly Log Sheet



MONTHLY LOG SHEET
FOR COMMUNITY CARE WORKERS

(For SPF administrator only) Volunteer cost centre number

_____

M	F	D

FOR THE MONTH OF: _____

CH Worker: First Name(s) _____ Surname:

_____

(Print Your Names CLEARLY)

ID Number: _____ Sister in Charge:

_____

Name of Clinic: _____ District:

_____

Day	Date	Month	Year	Time Arrived	Time Departed
WEEK 1					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
WEEK 2					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
WEEK 3					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
WEEK 4					
Monday					

Official
Clinic Stamp
HERE
(1 per page)

Tuesday					
Wednesday					
Thursday					
Friday					
WEEK 5					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					

Signed by: _____ Signed by: _____

Sister in Charge Healthcare Worker

SPF Document 7: Termination Letter

Termination letter

Town: _____

Local service area: _____

Clinic/hospital/fixed site: _____

Clinic sister's name: _____

Community care worker's full name: _____

Community care worker's ID: _____

Designation: _____

I hereby declare that _____(name of volunteer) has been working at the above Clinic/hospital/fixed site up until date:_____ and needs to be removed from your system as he / she is no longer an active volunteer and is being replaced by _____(name of volunteer) starting date:_____

Signature of manager:

_____

Date: _____

Clinic stamp

NB Please attach a letter from the volunteer / or the clinic sister (if a letter cannot be obtained from the volunteer) to the back of this form stating the reason why he / she is no longer performing volunteer services.