

**Community Participation in the Recruitment of Community
Health Workers:
A Case Study of Three Community Health Worker Programmes
in South Africa**

BY

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2. Community Health Workers
3. Public Health
4. Health Policy
5. Primary Health Care
6. SA Community Health Workers Policy Framework
7. Department of Health
8. Alma Ata Declaration
9. Recruitment
10. Selection



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DECLARATION

I declare that *Community Participation in the Recruitment of Community Health Workers: A Case Study of Three Community Health Worker Programmes in South Africa* is my own unaided work and that all the sources I have consulted and referred to have been indicated and acknowledged through complete referencing as shown in the text. I declare that this mini-thesis has not been submitted at any other university, college or institution of higher education for any degree or academic qualification.

Yanga Zembe



May 2008

DEDICATION

I dedicate this mini-thesis to my late parents Sibusisiwe Zembe and Lungiswa Jozela: for modelling hard work, for laying the foundations and for fostering and nurturing my love for reading. Lalani ngoxolo Ngwane no Mandaba, inga ndinganivusa nibone ukuchuma kwembewu yenu kunye nobuhle bukaBawo.



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TABLE OF ABBREVIATIONS

ANC	African National Congress
DoH	Department of Health
CHC	Community Health Committee
CHW	Community Health Workers
COSATU	Congress of South African Trade Unions
CSO	Civil Society Organization
CBO	Community Based Organization
EPWP	Expanded Public Works Programme
FBO	Faith Based Organization
NDoH	National Department of Health
NGO	Non-Government Organization
NPPHCN	National Progressive Primary Health Care Network
PHC	Primary Health Care
PHHC	Pholela Health Centre
SANCO	South African National Civic Organisation
SAHSSO	South African Health and Social Services Organisation
UNICEF	United Nation's Children's Fund
VHC	Village Health Committee
WHO	World Health Organization

ABSTRACT

This research investigates the nature and extent of community participation and involvement in the recruitment and selection processes for Community Health Workers (CHWs), primarily through detailed case studies of three CHW programmes, one in the Western Cape, another in KwaZulu-Natal, and a third which operates in the Western Cape and KwaZulu-Natal. The first utilizes CHWs in health education and home-based care in Khayelitsha and Nyanga. The second specializes in the training, management and supervision of home-based care CHWs in the rural areas of KwaZulu-Natal. The third utilizes CHWs in addressing maternal and child health issues in targeted peri-urban and rural areas in the three provinces.

The International Conference on Primary Health Care in Alma Ata, 1978 redefined public health discourse and practice with its emphasis on community participation through primary health care, in particular as a way of achieving wide coverage of basic health services in low and middle income settings. Prior to this important declaration, CHW programmes, where they existed, had become relatively marginalized from mainstream health systems. Since the 1980s, there has been a mushrooming of CHW programmes in different parts of the world. In South Africa in the period before 1994, this took the form of the expansion of CHW programmes in the non-governmental sector, with support from international donors but not from the apartheid state. Since 1994 the Government has demonstrated an increasing emphasis on community participation and CHWs in its health service reforms. Yet it was only in 2005 that the Department of Health (DoH) introduced a systematic approach to the role and work of CHWs through its national Community Health Workers Policy. Although the global and South African research evidence suggests that the increasing emphasis on the use of CHWs has had a generally positive effect in improving general health outcomes, it also reveals a number of challenges that have impeded the effectiveness of CHWs (see for example the work by Lehmann and Sanders (2007), and Stekelenburg et al. (2003) in particular. Chief amongst these have been the lack of financial resources; difficulties in measuring the performance of CHWs; poor monitoring (including supervision) and evaluation; high attrition rates of CHWs; lack of community acceptance; and lack of community ownership of the programmes. It is the latter two challenges that form a key basis for the present study, premised on the assumption that the nature of the selection and recruitment processes for CHWs, and in particular whether these are 'top-down' or 'bottom-up' in focus, will have a significant influence on the degree of community acceptance and ownership of the programmes.

Whilst there has been a growing literature, both globally and in South Africa, on the performance and effectiveness of CHW programmes, relatively little specific attention has been focused on the recruitment and selection processes as possible determinants of community acceptance and ownership of such programmes. At the same time, whilst the national Community Health Workers Policy Framework (NDoH, 2004b) emphasizes the selection of CHWs through community involvement, it fails to provide clear direction on what form community participation is to take and the extent thereof. It is the intention of the present study to assist in addressing both of these gaps, thereby contributing to the existing, albeit quite limited, literature on the selection models used for the

recruitment of CHWs, as well as to the development of improved national policy with respect to the recruitment and utilization of CHWs.

Key research questions that were pursued by the study included the following: (i) how do the CHW programmes recruit and select their CHWs?; (ii) are uniform methods used in the 3 case study programmes, or do they follow different procedures?; (iii) are there differences in approach in urban and rural communities?; (iv) are the recruitment and selection methods employed essentially 'top-down,' 'bottom-up,' or a combination of these two approaches?; (v) what factors determine the choice of a selection model?; (vi) are the actual procedures in line with or at variance with government policy and the declared policy of the 3 organizations concerned?; (vii) what is the actual nature and extent of community participation in the selection processes for the recruitment of community health workers?; (viii) is there an optimal selection model for the recruitment and selection CHWs and, if so, what would be the key elements of such a model?; and what are the main lessons that can be learned about the dynamics involved in the institutionalization of community participation in CHW programmes?

The research was largely qualitative and relied in part on desk research. The latter took the form of a detailed comparative literature review of contemporary issues and theoretical debates surrounding the issue of community participation in health care, to contextualize the research themes and questions that will form the basis of the present study. It also includes a detailed description and analysis of key documentary sources from the South African Department of Health and from the 3 individual organizations concerned. Important qualitative information was derived from detailed semi-structured interviews with the programme managers of the three organizations surveyed in the study, as well as a representative sample of programme staff and, in particular, of the community health workers on the three programmes. In total 7 CHWs were interviewed. Informal discussions were also held with key professionals and officials in the CHW sector to deepen the researcher's understanding of the key findings of the mini-thesis.

Written permission has been obtained from the 3 organizations to carry out the study, with the proviso that the confidentiality of data gathered and anonymity of respondents must be ensured. The organizations also requested that their own identity should remain anonymous. The researcher has indicated in writing that these conditions will be fully respected. Although the protection of the anonymity of the three programmes (by using general titles such as Programme A, Programme B etc) poses some limitations for the research, in particular by excluding the possibility of other researchers confirming the research findings, the researcher felt that the detailed narrative richness derived from the interviews would still be relevant and significant, providing the data is handled with sensitivity, integrity and objectivity. In line with the above conditions, the sole purpose of using the data gathered for research was communicated to all respondents, together with assurances concerning confidentiality and anonymity. The choice of not answering questions raised was also respected.

The mini-thesis yielded the following key results: (i) The current processes of selecting CHWs in South Africa are different from the ones prior to South Africa's political independence and prior to government's involvement in CHW programmes; (ii) The negative experiences of community participation-led selection processes such as nepotism, selective community participation; the perception of low community activism/community disorganization; and the perception of illegitimate community leadership structures are cited as reasons for the lack of community participation in most

of the selection processes that the case study CHW programmes engaged in; (iii) The perceived lack of government guidelines on how CHW Programmes are to select CHWs is another impediment that case study CHW programme respondents cited and which they said makes it difficult for them to conduct community participation-led selection processes; (iv) The evidence from CHW Programme WCB suggests that community acceptance of newly appointed CHWs is constrained when there has been no community involvement in the selection of the cadres. However, the case studies also reveal evidence that suggests that community rejection of newly appointed non-community selected CHWs is minimized in community settings where the size of the community is small, not transient in nature and where CHWs are introduced to community gatherings at the start of the programme; (v) Determinants of selection are: community dynamics; organizational priorities and the extent and nature of provincial and national government involvement in CHW programmes; (vi) Finally, the NGO-government partnership arrangement evident in two of the case studies has had negative consequences for community participation in the case of CHW Programme KZNA.

The mini-thesis is organized into five chapters: the first chapter provides the introduction and background as well as the methodological design of the mini-thesis; the second chapter focuses on providing a detailed literature review of relevant materials that cover the subject matter; the third chapter provides the descriptive background of the history of CHWs, CHW policies and community participation in South Africa, as well as a description of the three case study organizations; the fourth chapter describes and discusses the findings and the last and fifth chapter provides a summary of the findings as well as recommendations and conclusions.

CHAPTER 1

INTRODUCTION AND BACKGROUND

INTRODUCTION

Community participation is a very elusive, complex but popular ‘buzz’ term in development and health discourse. The elusiveness and complexity of the term lies in the definitional and operational disputes amongst many of the disciplines that employ the use of the term to refer to community involvement in health and development (Morgan, 2001). What constitutes community participation in primary health care is debatable, but a review of the literature indicates that there is a continuum of utilitarian, top-down approaches expressing community participation as the means by which to carry out health projects more effectively; and empowerment driven, bottom-up approaches, expressing community participation as not just a means but an end in itself in efforts to achieve primary health care for the poor (Oakley, 1989; Morgan, 2001; Adato et al, 2005).

This mini-thesis entails a description, analysis and discussion of community participation in the context of community health worker (CHW) programmes. The purpose of this chapter is to outline the mini-thesis’s main subject of study. The outline begins with a broad introduction of the topic of community participation and CHW programmes, followed by a description of the nature of the research problem as well as the rationale and the significance of conducting this enquiry at the present time in South Africa. The purpose and objectives of the study are also detailed in this chapter. The methodology section provides a detailed description of the data collection and data analysis processes. The chapter ends by providing the organisational structure of the mini-thesis.

BACKGROUND

The International Conference on Primary Health Care (PHC) in Alma Ata in 1978, organized by the World Health Organisation (WHO) and UNICEF, redefined public health discourse and practice with its introduction and heavy emphasis on

community participation through PHC (Oakley, 1989). The Alma Ata Declaration contains 7 principles of PHC, namely: economic and human resource feasibility at the country level; acceptability of the type of PHC health workers; community participation in PHC; appropriate technology; intersectoral coordination; comprehensiveness of PHC programmes; and health equity (Roemer, 1991). Through the Alma Ata Declaration, community participation was no longer to be on the periphery of programme planning, implementation and management of primary health care, but was to be the very heart of all intentions and activities of the health system at the community level. The Alma Ata Declaration envisaged a primary health care model that would have the formal health system with its professional and paraprofessional base working side by side with a community health worker driven base. Thus the central element of the Alma Ata Declaration's primary health care strategy was unveiled as being the roll out of national CHW programmes (Ofosu-Amaah, 1983).

In this way, the Declaration formalized and entrenched CHW programmes into mainstream public health discourse and practice, even though the concept dates back to more than 50 years ago (Lehmann & Sanders, 2007). China had their first CHWs in 1965 in the form of the aptly named "barefoot doctors" who were lay health workers administering basic primary health care services to villages that were otherwise impossible to reach (Walt, 1988). More locally, South Africa's history of formalized CHW programmes began in the early 1940's with Drs Sidney and Emily Kark's government sponsored Pholela Health Centre (PHHC) programme (Tollman & Pick 2002; Tollman, 1994). However, due to the political climate in the late 1940's-1950's, government led CHW programmes in the country never managed to sustain a strong presence within the health system and in fact soon disappeared completely from government policy and planning (Tollman & Pick 2002)

CHW programmes became relatively marginalized from the health system in the country until the Declaration redeemed their obscurity by reviving emphasis on

the importance of community based strategies in efforts to achieve wide coverage of basic health services in low-middle income settings. In the wake of world wide enthusiastic implementation of national CHW programmes, the 1980's saw the mushrooming of CHW programmes taking place in different parts of the South Africa (Walt, 1988). Indeed, at a time when health care in apartheid South Africa was highly segregated and thus inequitable, non-government (NGO) driven CHW programmes were the pillar of health care service delivery that was otherwise impossible to achieve for many of the marginalized and poverty stricken areas in the country. Today South Africa exists under different and liberated political conditions. However the socio-economic inequities that inform the health system continue to persist, making CHW programmes as relevant as they ever were.

In terms of what constitutes a CHW, international consensus is that CHW refers to any lay health worker who is selected, trained and works in the community from which s/he comes and that "who and what CHWs are has to respond to local societal and cultural norms and customs to ensure community acceptance and ownership" (Lehmann & Sanders, 2007: v).

Furthermore, there is a plethora of evidence that supports the effectiveness of CHWs in improving general health outcomes and especially child health related ones (Lehmann & Sanders, 2007). However there are also a number of challenges that impede the effectiveness of CHWs, in particular the lack of financial resources, difficulties in measuring the performance of CHWs, poor monitoring (including supervision) and evaluation, high attrition rates of CHWs, lack of community acceptance, and lack of community ownership of the programmes (Stekelenburg et al., 2003).

The two latter mentioned challenges bring us to the main consideration of this mini thesis, namely community participation in the selection of CHWs.

RESEARCH PROBLEM

Whilst there is general consensus that community participation is indispensable to relevant CHW programmes, top down and paternalistic approaches in the establishment and management of CHWs is what we see most evident in many CHW programmes (Lehmann & Sanders, 2007). Most CHW programmes are largely founded on centralized bureaucratic mechanisms that may have the adverse effect of alienating the community (Lehmann & Sanders, 2007). This calls for the examination of the nature and the extent of community participation in CHW programmes, because as the call for community participation to be entrenched in CHW programme continues, we need to know what kind of community participation we are referring to and whether it enhances or inhibits community involvement in health and development issues.

RATIONALE & SIGNIFICANCE

According to Dr Manto-Msimang Tshabalala, as expressed during her speech at the launch of the CHW Programme in 2004, (NDoH, 2004a) the concept of using CHWs to expand health services, is driven by five imperatives:

- The President's articulation of a people's contract to create work and fight poverty
- Government's commitment to improve service delivery
- The national human resource and skills development strategies
- The increasing complexity of the burden of diseases and poverty-related challenges
- The increasing need for health promotion activities, community and home based care

The National Policy on Community Health Workers (NDoH, 2004b), released a few months after the Minister's launch of the CHW Programme, eloquently communicates these imperatives, particularly in its integration with the Extended

Public Works Programme (EPWP) Social Sector Plan 2004/5-2008/9¹. There is anticipation that this renewed interest in CHWs will result in a major roll-out of generalist CHW programmes in the country and the field of research in public health needs to keep up and parallel these strides with scientific evidence that is able to provide further guidance on the development and implementation of community health worker policies.

There may be several ways to interrogate the nature and extent of community participation in CHW programmes, but the selection processes followed in the recruitment of CHWs are key indicators of community involvement in CHW programmes. However, selection models for the recruitment of CHWs have rarely been examined for their association to community participation and their impact on effectiveness (Lehmann and Sanders, 2007). Thus, in describing and analyzing the selection processes followed in the recruitment of CHWs we are able to examine the nature and extent of community participation in primary health care. Furthermore, selection processes may determine community acceptability of community health workers and ownership of CHW programmes. Thus, the shape and form that community participation takes in the selection of CHWs may be an indicator of the quality of CHWs recruited as well as their retention and performance (Ofosu-Amaah, 1983).

The national Community Health Workers Policy Framework (NDoH, 2004b) emphasizes the selection of CHWs through community involvement but it fails to provide clear direction on what form community participation is to take and the extent thereof. Critical examination of the various ways in which communities can be involved in the selection of CHWs will provide evidence based recommendations on how the policy should guide effective community participation in CHW programmes. The nature and the extent of community participation in CHW programmes in South Africa also needs to be examined in

¹ Chapter 2 and Chapter 3 provides a detailed discussion of these two policy documents

order to establish whether the macro political ideals of citizen participation in development are being met.

This study seeks to focus on one aspect of community participation in CHW programmes by analyzing and reporting on the selection models used for the recruitment of CHWs through the review of the literature as well as through the description of selection processes followed by three CHW programmes in South Africa. The major focus of the study will be on analyzing the nature and extent of community participation in CHW programmes; the determinants of the selection model applied in each of the case study CHW programmes; and the benefits and limitations experienced when applying different levels of community participation. The lessons learnt from this analysis will be used to recommend policy directives on the recruitment of CHWs.

KEY RESEARCH QUESTIONS

Some of the key research questions that will be investigated by the study include:

- How do CHW programmes select their CHWs?
- What factors determine the choice of a selection model?
- What is the nature and extent of community participation in the selection processes for the recruitment of community health workers?

PURPOSE AND OBJECTIVES

The overall purpose of this study is to examine the nature and the extent of community participation in the selection and recruitment processes for CHWs through a case study approach of 3 CHW programmes. More specifically, the objectives are:

- To explore current debates and theoretical considerations in the literature for community participation in CHW programmes;
- To describe the selection processes followed by 3 CHW programmes in the recruitment of CHWs in South Africa;

- To explore the ways in which community participation is expressed in CHW programmes;
- To describe the factors that determine the choice of a selection model for the recruitment of CHWs;
- To draw on the lessons learnt from the 3 CHW programmes and the implications for the CHW policy on the recruitment of CHWs in South Africa.

The study will also fill a knowledge gap by contributing to the limited literature on the selection models used for the recruitment of CHWs.

LITERATURE REVIEW

A detailed literature review and conceptual framework for the study is provided in Chapter 2. The major themes explored include the community participation continuum that sees community participation as a utilitarian tool to achieve project aims on the one hand and community participation as an empowerment driven process to ensure that beneficiaries have decision making power on the other hand. In the review, community participation is further explored within the South African context by looking at how community participation has been expressed in the country over the years. Finally, community participation is explored within the context of CHW programmes with a particular focus on the expression of community participation in the selection and recruitment of these cadres. The literature reviewed is made derived from research papers, opinion papers, systematic reviews, policy frameworks and conference papers.

RESEARCH METHODOLOGY

Study Design

The study follows a comparative case study approach that is largely qualitative in nature. Three CHW programmes, herein referred to as CHW Programme WCA (Western Cape), CHW Programme WCB (Western Cape), and CHW Programme KZNA (Kwazulu Natal) were selected for the study and sampled through semi-

structured interviews on the subject of CHW selection. In each of these organisations one-on-one interviews were conducted with one senior manager and the organisation's CHWs. The number of CHWs selected for interviews in each CHW Programme depended on the availability and willingness of the CHWs to be interviewed. In CHW Programme WCA, four CHWs were sampled during in-depth qualitative interviews; two were sampled from CHW Programme WCB and 1 from CHW Programme KZNC. An additional group of four CHWs from different CHW programmes in the Western Cape were also sampled through a focus group discussion (FGD) for additional and comparative insights. Thus the total number of participants was 14 individuals. The information derived from the interviews was triangulated, wherever, possible with official documents from the relevant programmes.

Data Collection

Informed Consent

Informed consent forms were drawn up and signed by each of the programme managers. Verbal informed consent was sought from all of the CHWs before the interviews commenced.

Interviewing Methodology

All interviews as well as the focus group discussion were conducted by the researcher using interviewing schedules that were drawn up beforehand. An interviewing schedule containing 4 broad questions was used to direct interviews with the senior managers (*see Appendix A for Interviewing Schedule used for interviews with CHW Programme Managers*). The senior managers of CHW Programmes WCA and WCB were interviewed in face-to-face interviews, whilst the senior manager of CHW Programme KZNA was interviewed telephonically due to travelling constraints posed by the geographical location of the programme in Kwazulu-Natal.

For triangulation and as a formative research strategy, a focus group discussion (FGD) was held with four CHWs from the Western Cape. This helped to illuminate the kind of issues to explore and probe during one-on-one interviews with CHWs from the case study CHW programmes. The FGD was facilitated through open ended questions that sought to understand the CHWs' experiences of selection and recruitment; their perceptions on the selection of CHWs pre- and post-1994 and their thoughts on how CHWs should be selected. The findings of the FGD are not reported in the mini-thesis as they were only conducted to inform the development of in-depth interviewing schedules.

Three weeks after the FGD was held and analysed, one-on-one in depth qualitative interviews were conducted with CHWs from each of the CHW programmes as described above. These interviews lasted for 30 to 45 minutes each. An open ended interviewing schedule was also used to guide the exploration of issues during the interview (*see Appendix B for the interviewing schedule used to interview CHWs*).

Data Analysis

The data was analyzed using content analysis research methods. Content analysis refers to “a research tool that is used to determine the presence of certain words or concepts within texts or sets of texts” (The Colorado State University Writing Centre, 2007). The meanings and relationships between words and concepts are analyzed and inferences are drawn about what the text is trying to communicate. The text being examined is referred to as a unit of analysis which may be an entire text (e.g. an entire interview) or a part of a whole text (e.g. a paragraph).

Furthermore, content analysis is broken down into two different kinds, namely manifest content analysis and latent content analysis. The former is used to code the *explicit* presence of particular words, terms or phrases. These are then coded into sub-categories which may generate larger categories when analyzed in

conjunction with other texts. Latent content analysis is used to code the *implicit* presence of words, terms of phrases.

Description of the Process of Analysis

The data was analyzed using manifest content analysis methods. Each of the transcripts was regarded as a unit of analysis. This following process of coding and forming categories was employed in the analysis. Each transcript was read through 3 times. The first time it was read through without any attempt at analysis to become familiar with the content; then it was read a second time still focusing on 'hearing' what the overall unit of analysis is saying and not coding it yet, (though thoughts that arose when reading certain parts were written down); the transcript was then read for a third time, slowly, paying attention to every word and beginning to code texts of the transcript. The coded transcript was read through again to confirm or reject the codes derived from the unit of analysis.

For the first transcript, all the codes generated were used as categories, then the codes generated from transcripts that followed were fitted into these categories as sub-categories where appropriate, otherwise they became a new category. This became a cause for major interrogation of the reliability of the process of coding seeing that the process of creating and fitting codes into existing categories was largely an outcome of subjective thinking. It was decided that though analysis of qualitative data requires rigour that is often maintained through observing rigid standard methods of analysis, flexibility is also necessary. Also, what was most important was to be transparent about the analysis process and to be able to justify every step taken.

Every code generated and identified as being appropriate was placed under a subcategory which belonged to a larger category.

ETHICAL CONSIDERATIONS

There are several considerations that have been observed to ensure that the mini-thesis was conducted in an ethical manner that respects and upholds the rights of participants. These are as follows:

Participants' rights to privacy and anonymity

To ensure the upholding of the participants rights to privacy, the researcher conducting the study agreed to the participant organisations' request for anonymity. As such, all participants are referred to either by their professional titles or by pseudo names. In line with the requirement laid down by the three programmes, the names of the organisations have also been withheld. As such, the three organisations are referred to as CHW Programme WCA, CHW Programme WCB and CHW Programme KZNA. Data collection included documentary analysis of the organisations' published documents. However, only CHW Programme WCA and CHW Programme WCB agreed to have their documents perused on condition that their organisational identity would remain anonymous. CHW Programme KZNA refused access to their organisational documents and only allowed access to the web documents of their parent international organisation based in the United States of America and whose name has also not been disclosed in the writing of the mini-thesis.

Benefits to participants:

CHW participants were compensated with refreshments for their participation. At a broader level, CHW participants, CHW programme managers and the CHW sector and community members receiving CHW services may benefit in the future from information learned from this study.

Voluntary participation:

All participants were informed that their participation in the study was strictly voluntary and that they were free to withdraw from the interviews at any time.

Informed Consent

Information on the study purpose and details about what would happen to the information collected was provided prior to each interview. All three of the programme managers gave written consent and all 7 CHW participants and the 4 focus group participants all gave verbal consent prior to participation in the discussions.

LIMITATIONS

The study has several limitations. The first of these is the fact that the respondents' names and organisational identities are kept confidential. This limitation has been especially constraining in the discussion of the documents accessed to complement qualitative analysis of the interviews. However, this was a strict condition for the research to be conducted, and was therefore respected by the researcher. The second limitation is the uneven extent of data collection between the three case studies. Due to logistical challenges only the nearest and most readily accessible organisation had the largest number of CHW participants (4) interviewed for the study and this was CHW Programme WCA. CHW Programme WCB could not meet the request for 4 CHW participants as their CHW Programme ended at the beginning of 2008 and thus it was difficult to find CHWs who were reachable to invite for interviews. Only two former CHWs could be accessed from CHW Programme WCB. CHW Programme KZNA is in Kwazulu-Natal which is a different province to that of the researcher who is based in the Western Cape. This meant that the researcher had to rely on the programme manager of CHW KZNA to recruit CHWs and only two were said to be available. Of these two only one CHW could be reached for a telephonic interview. Efforts to contact the other proved impossible.

The data for the documentary analysis was also unevenly collected between the three organisations. With respect to CHW Programme WCA the researcher was referred to the organisation's website and had to rely on this rather than hard copies of official documents. CHW Programme WCB did provide organisational

documents in the form of reports and published research papers on the outcomes of their CHW programme. CHW Programme KZNA refused to provide organisational documents, citing that they did not have the documents that were asked of them, and referred the researcher to the website of the parent NGO in the United States which proved to have very little information on CHW KZNA.

Attempts have been made to minimize the impact of these limitations on the quality of the mini-thesis. This has been done through thorough description of the limitations themselves, as well optimum use of the data through thorough description and analysis of the data made available for the mini-thesis.

ORGANISATION OF THE STUDY

The mini-thesis is organized into five chapters as shown below:

- CHAPTER 1: Provides an introduction and background to the study, including the research problem and questions, purpose and objectives and research methodology.
- CHAPTER 2: Provides a detailed literature review and theoretical framework on issues with respect to community participation and community health work.
- CHAPTER 3: Provides descriptive context and background on the history and development of CHW programmes in South Africa, on the policy and legislative framework for community participation in the public health field; and on the three organisations selected for the case studies.
- CHAPTER 4: Provides a detailed description and analysis of the findings and lessons learned.
- CHAPTER 5: Provides conclusions and policy recommendations.

CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

This chapter provides the theoretical framework that underpins the main theme of the mini thesis through a review of the literature and a discussion of the major debates informing the subject.

Since the Alma Ata Declaration of 1978 there has been widespread consensus that the concept of community health worker (CHW) programmes is the linchpin and the most appropriate community based expression of community participation in primary health care (Ofosu-Amaah, 1983; Oakley, 1989; Walt, 1988; Lehmann & Sanders, 2007). The debates regarding CHWs and community participation are so intertwined and interlinked that it becomes difficult to determine whether CHW programmes are taken to be synonymous with community participation or simply a handmaiden of the latter. As such, attempts to decipher the relationship and the dynamics between the CHW concept and community participation (both of which are very broad and complex issues) requires that we abandon ambitions to tackle all the questions surrounding the relationship between the two and rather focus on examining one aspect of CHW programmes, namely the recruitment and selection of these cadres. Thus, this review examines the selection and recruitment of CHWs in the context of community participation. Thus, although the literature review covers community participation in general, it is community participation in the context of CHW programmes that will be extensively explored through the interrogation of selection processes followed for the recruitment of CHWs.

The scope of this study is meant to be generalisable to any low to middle income country that makes use of community health workers. However, there is particular significance in studying CHW programmes in South Africa, especially in the era of HIV/AIDS, unemployment and poverty in the country. These are all

factors that have been considered in the drawing up of the national Community Health Workers Policy Framework (NDoH, 2004b) as well as the Extended Public Works Programmes (EPWP) Social Sector Plan 2004/5-2008/9, both of which are the policy mechanisms by which government hopes to engage communities in their own social and health development in the country. As such, a particular South African focus on literature regarding community participation and CHW programmes is also provided. This focus is applied by providing a brief discussion on the two aforementioned policies and their link to issues of community participation in CHW programmes in South Africa.

The literature review comprises the following key sections: definitions of community participation concepts; the conceptualization and operationalisation of community participation; motivations for community participation in health and development discourse; the experience of community participation in South Africa; the experience of community participation in CHW programmes internationally and in South Africa; and the selection of CHW and community participation internationally and locally. The review ends with a summary of the key issues and debates emanating from each of the afore-mentioned sections.

COMMUNITY PARTICIPATION: DEFINITIONS, THEORIES AND PRACTICAL APPLICATIONS OF COMMUNITY PARTICIPATION

To unpack and understand community participation it is necessary to first define the most basic meaning of the term. The dictionary definition of the term 'community' is taken to refer to a group of people, a society, an area or a neighbourhood, (Oxford Dictionary Online, 1998). In socio-political terms it is interchangeably referred to as 'the people'; and 'the public'. The simplicity of these definitions betrays the complexity that underlies the use of the term, particularly in health development discourse which often uses it very specifically to refer to not just any group of people but specifically those groups that are poor; not just any neighbourhood but those whose geographical boundaries serve to

perpetuate their marginalization from mainstream public health services; and not just any society, but the underserved whose socio-economic status sees them struggling to access even the most basic promotive, preventive and curative services.

It is often assumed that community implies homogeneity, but Oakley (1989) argues that the understanding of community as comprising a homogenous people with common needs and common problems is a mere assumption. The diversity of individuals and households in communities consequently stratifies them into different levels of poverty, access to proper health care, and power. In the same community there will be differences in terms of such factors as age, gender, culture and social status. This spells out the social as well as economic differentiation in spite of the geographical communality, and Oakley (1989) argues this differentiation needs to be taken into account when determining community participation in health development. This is because the nature and extent of the community's involvement in health and development programmes is often determined by these factors. This differentiation also adds to the complexity of defining and understanding community as according to Botes and Van Rensburg (2000: 48) "The stratified and heterogeneous nature of communities is a thorny obstacle to promoting participatory development". This is so because the more heterogeneous a community, the greater the variety of needs may be and consequently conflicting interests may arise. Adato et al., (2005: 41) also problematise the definition of community citing that

...community signals inclusion and solidarity, but it is simultaneously exclusionary... ...reference to the 'community' can obscure divisions of race, class, gender, political affiliation and other differences

If the concept of community is complex to define, then participation is even more elusive in its apparent simplicity. The dictionary definitions of participation are that it refers to a contribution, an input, sharing, partaking, chipping in, involvement and membership (Morgan, 2001). Whilst these definitions do

contribute to the many existing interpretations of the concept of participation in health and development, it is widely agreed that there are definitional disputes that divide pragmatists from activists, the bureaucrat from the scientist, and the anthropological perspectives from epidemiological ones (Oakley, 1989; Adato et al., 2005; Morgan, 2001). But there is also consensus that what community participation boils down to are two broad categories on two extreme ends of a continuum, namely, participation as a means and participation as an end (Oakley, 1989; Botes & Van Rensburg, 2000; Adato et al., 2005; Nelson & Wright, 1995).

The Participation Continuum

Participation as a means utilizes a utilitarian approach that seeks to involve communities in health development merely as a way of achieving programmatic aims for efficiency and affordability (Oakley, 1989; Morgan, 2001). Within the utilitarian approach, community participation is seen as

...a temporary feature, an input required if objectives are to be achieved...inevitably the emphasis is on rapid mobilization, direct involvement in the task on hand and the abandonment of participation once the task has been completed (Oakley, 1989: 10).

Furthermore, participation as a means reflects a product and hard-issues driven interpretation of community involvement in development initiatives (Botes and Van Rensburg, 2000). According to this theory, when participation is product driven the main emphasis is on outcomes and efficiency (the 'hard' issues), as such considerations for what is often a comprehensive, time-consuming and often complex community participation process is not prioritized. The main priority is getting the work done and the community may participate only as far as their involvement meets the project objectives for outcomes and efficiency. This is also referred to as "community-renting" (Botes & van Rensburg, 2000:46). With community renting, communities are invited to participate as a means to get them to buy into the idea of the project, but they are consulted merely to "...legitimize

existing decisions i.e. to tell people what is going to happen by asking them what they think about it" (Botes et al., 2000: 43)

The inverse of this is community participation that is process driven where the priority is not just on *getting there* but on *how* we get there. As such ensuring maximum and in-depth involvement ('soft issues') of the target communities in their own development is emphasized. In this regard community participation is seen as an end to all efforts of people-centred community development (Oakley, 1989). It is seen as an empowerment driven approach occurring in order to allow for disenfranchised and marginalized communities to act as co-authors and co-directors over the health development processes aimed at improving their health status. As Oakley (1989:11) says:

...participation [becomes]...a process [that] is a dynamic, unquantifiable and essentially unpredictable element. It is created and moulded by the participants...it will not only last the life of the project, but more important, will extend beyond the project's end in the shape of a permanent dynamic involvement

Paul (1987) also sees community participation as occurring along a continuum with four phases, namely: 1) information sharing; 2) consultation; 3) decision-making; and 4) initiating action. In the first phase, bureaucrats and development agencies merely inform communities about development programmes that are planned for the future or that are already underway. The information sharing phase can be either in-depth or superficial. In the second phase communities are consulted for advice and opinions on all or certain aspects of the development programmes. The third and fourth phases are about the transference and sharing of power and create an opportunity for communities to go beyond listening and advising, to making decisions and enacting what they want to happen regarding their development. Furthermore these four phases can also be further stratified into the two extremes of the aforementioned community participation continuum. Where phases one and two are implemented in product-driven, top-down health initiatives, they would belong to the utilitarian end of the community participation

continuum. If phases three and four are implemented in people-centred, process driven health initiatives, they would reflect community participation as an end in itself.

Conceptualisation and Operationalisation of Community Participation

The above definitions of community participation present distinct, though broad categories of interpreting community involvement in health. However, in reality the conceptualization and operationalisation of community participation in health is not always so clear cut and neatly packaged into utilitarian versus empowerment approaches. The World Bank, arguably one of the most influential [and somewhat controversial] role player in development, sees community participation as being a process through which stakeholders share decision making and control over the Bank's development initiatives (World Bank, 1996).

On the surface this definition seems to allude to an empowerment driven approach, however upon closer interrogation the Bank seems to lean more towards the utilitarian approach. This is seen in the Bank's definition of the term "stakeholders" which very broadly comprises those who "could affect the Bank's proposed outcome or be affected by it" (Morgan 2001:222). This group includes "elected officials, line managers, government officials, indirectly affected groups such as NGOs, the private sector, and so forth...as well as Bank management, staff and shareholders" (Morgan, 2001:222). There is no mention of the beneficiaries of the Bank's initiatives, i.e. the largely marginalized poor communities that are the target groups. As such the network of stakeholders at the decision making level enables all kinds of development actors (governments, NGOs, private sector) to come together to the exclusion of the beneficiary communities. This apparent incongruence between what is said and what is meant about community participation suggests that the use of the concept in health and development theory and practice is only used as a popular term to imply compliance with contemporary development discourse

Furthermore, there are others whose definition of community participation in health also reflects a dynamic that is pursued through mechanisms that are neither deliberate nor rigorous, but merely hopeful. This is seen in the oft existing narrow conceptualization of community participation in health as beginning and ending with creating access to health information for communities in the hope that, as they grow in knowledge they will become more involved and committed in their own health, and as such ensure the success of the programme (Oakley, 1989).

Problematizing Community Participation

Thus, whilst there is general consensus that community participation in health needs to be comprehensive in nature (in line with the people-centred notion of community participation outlined above), reality suggests a more complex scenario. It would seem the kind of community participation that is empowerment and process driven is ideal. However is idealism ever compatible with realism? Can it really happen that communities become stewards of their own health development processes, not just passively receiving but dictating, directing and owning the terms and the conditions of such service delivery? Most importantly, is comprehensive community participation always appropriate for all settings? These are the questions to be asked, especially as community participation unless in the sanitized version of the World Bank's definition, is a radical, time-consuming and sometimes highly politicised process. (Lehmann & Sanders, 2007; Botes & Van Rensburg, 2000; Korten, 1980 in Lund 1987)

Adato et al., (2005: xi) conducted a study on community participation in South Africa which also revealed that “community participation introduces politics, conflict, and lengthier decision-making processes”. With respect to the political nature of community participation, the WHO states:

...community participation is a political process in so far as community members acquire a say in decision-making about health and health care issues that affect them, and a measure of control over the persons that

are supposed to serve their needs. Community participation in this sense raises the most serious organisational problems, and even dilemmas, for ministries of health. (WHO, 1984:88)

All of these insights point to the complex and conflicting nature of community participation, and further point to the challenges that the state and health agencies are faced with when trying to implement community participation based interventions. It may be that it is not just the attitudes and traditions of the public health institutions involved in health development that determine the nature and extent of community participation. The nature of the community intervention as well as the availability of resources (time and human resources in this instance) have a determining role to play as well. Not every intervention can afford the time-consuming and complex dictates of community participation as an end in itself. Limited time and human resources as well as the scope of the intervention may place a greater emphasis on approaches that prioritize efficiency, affordability and as a consequence a more limited involvement of community members. The study conducted by Adato et al., (2005) revealed that at times communities are not patient with the more people-centred and empowerment based models of community participation. Often they tire of the lengthy discussions and processes to establish common ground and reach consensus, elements that are pivotal to comprehensively participative processes. Instead, communities often put pressure on implementing agencies to hasten the onset of service delivery. On the other hand there are just as many community interventions that flounder unless the beneficiaries are comprehensively involved in the design, planning and implementation of the project (Adato et al., 2005).

The paradox in the theory and practice of community participation

To add to the definitional and operational complexities of community participation, the nature of our understanding of community participation, both in discourse and in practice suggests a paradox in the application of the concept. Most definitions of community participation in health seem to imply reliance on an external agent for the facilitation of community participation, rather than

communities being the very agents that mobilize, initiate and facilitate their involvement in health (Morgan, 2001). Uphoff et al., (1998 in Morgan, 2001: 222) state that “encouraging participation is something that practically by definition comes from above or outside”. Thus we see that often community participation is not endogenous, instead it tends to be an externally mediated process and all the actors - both the facilitators (including funders, and managers) and the beneficiaries - bring different perspectives and expectations of what community participation means and how it is to be manifested. In trying to explain the reasons that inform this reality, Morgan (2001) narrows it down to power dynamics and argues that communities cannot escape external agency because they do not have power. This argument is arguably simplistic, because communities do have power and it was in fact that very recognition that gave rise to contemporary theories on development such as people-centred development approaches (Thomas & Allen, 2000). The problem is that the power of disadvantaged communities is not recognized and often finds itself a muted foreigner in the bureaucracy-led context under which we expect it to operate. As such self-generated conscientisation is hindered (Morgan, 2001). If we just consider the way in which rural communities have managed to initiate, manage and sustain age-old, complex and multi-organisational social customs of celebration, of providing support and of resolving conflict, then it becomes clear that outside the pre-defined and bureaucratic contexts as imposed by the formal health system, communities are able to initiate, maintain and sustain their own participation. Even within the health context, we find that communities have their own indigenous health systems with which they interact, within which they participate and which they themselves sustain. An example is the way in which rural communities deal with an outbreak of disease or virus that affects their livestock. During such times, we would probably witness the most rapid and effective form of public mobilization and collective action. The problem is that the modernized government/agency run health system solely determines the rules of engagement, often enters communities with its own culture of discourse and operation, and yet expresses the desire for integration between the bureaucracy

and the community, but in reality facilitates little more than mere assimilation of community norms into its institutional arrangements. And so whilst indeed an outside catalyst or facilitator is often required in the initiation of community participation in health, it is not to come and say “here is the power take it” but to say “think about the power you have, that you possess, how can you use it to improve your circumstances and reach your aspirations?” External agents of community participation come to enable power that already exists, not to give it; hence the very definition of empowerment is that it is an enabling process (Thomas & Allen, 2000).

The above discussion highlights the importance of interrogating whether the fact that community participation in health almost always relies on external agency facilitation compromises the nature and extent of the people’s involvement in their health development. There are existing arguments that suggest that it does. The Director General of the WHO remarks that “health is not a commodity that must be given, it must be generated from within” (Ofosu-Amaah, 1983: 2).

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Botes & Van Rensburg (2000: 43) are concerned that the initiation of community programmes by external agencies is always bound to be paternalistic in its nature. They go on to argue that:

...this has often contributed to professionals (consciously or unconsciously) regarding themselves as the sole owners of [health] development wisdom and having the monopoly of solutions which consistently undermine and under-value the capacities of local people to make their own decisions as to determine their own priorities.

Werner (1981: 4) in his keynote address on CHWs at an international congress concurred that “The political/economic powers-that-be assume an increasingly paternalistic stand, under which the rural poor become the politically voiceless recipients of both aid and exploitation”.

There are concerns that are raised about the integrity of the process of participation in light of the possibilities that an external agent may not be able to

divorce him/herself from a preset and not-necessarily-people-centred agenda of the institution on whose behalf s/he comes. In addition to the myriad of issues already mentioned, there is also the question of how applicable is the notion of community participation in community health programmes. It has been suggested that when it comes to community participation in health, “theory is ahead of practice” (Oakley, 1989: 27). For whilst the term is well entrenched in public health discourse (Morgan, 2001) it is not as equally institutionalized in practice (Lehmann & Sanders, 2007). Pragmatists are frustrated that community participation has been “talked to death” (Morgan, 2001:228). Dudley (1993: 159) maintains that:

..the challenge is now to get beyond the general principle and determine the practicalities of how participation fits into a larger picture of effective aid for just and sustainable development.

THE SIGNIFICANCE OF COMMUNITY PARTICIPATION IN HEALTH PROGRAMMES

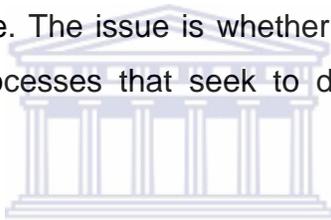
Most of the proponents of community participation cite issues of ownership and programme utilization as the main reasons why community participation needs to be entrenched in primary health care (Ofosu-Amaah, 1983; Walt, 1988; Oakley, 1989; Lehmann & Sanders, 2007). Evidence suggests that community participation increases community ownership of health programmes as well as their safeguarding and accountability of CHWs to the communities they are serving. Oakley² (1989: 4) sees five fundamental reasons for community participation, one of them being that:

A community participation approach is a cost-effective way of extending a health care system to the geographical and social periphery of the country...[secondly]... communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures

² The other four fundamental reasons for community participation in CHW programmes that Oakley (1989) mentions are: knowledge empowerment about health problems results in action on preventive measures; communities investing their resources in health programmes have a greater sense of ownership and as such responsibility towards such programmes; health education that is integrated into local community activities is more effective; community health workers gain the community’s confidence.

Adato et al., (2005: 50) also attest that "...aside from instilling pride, a sense of local ownership has instrumental benefits such as increasing cooperation [and] improving maintenance..."

This suggests that community participation is largely good for its health-outcomes enhancing properties. In contexts where there is low uptake of health care services, it is reasonable that the concern for increasing cooperation and utilization should be key in the consideration of community participation in health. However, community participation should not be considered only for its ability to enhance health outcomes and the increase of health services uptake. It is also primarily an issue of social justice, and when taken from that perspective, whether its promotion results in community ownership and thus utilization of programmes is not the issue. The issue is whether it is merely for people to be excluded from the very processes that seek to determine the life and death aspects of their lives.



COMMUNITY PARTICIPATION IN SOUTH AFRICA

The interrogation of factors that shape the current culture of community interaction with the health system in South Africa has sometimes led to the conclusion that it is the apartheid era and its arms-length culture of interacting with communities that has resulted in the current apathy of communities. The Policy Proposal on Community Participation in the Health Sector submitted at the National Progressive Primary Health Care Network (NPPHCN)/ South African Health and Social Services Organisation (SAHSSO) Health Policy Conference in December 1992 (NPPHCN, 1993b: 87), observed that

The apartheid system has militated against community participation in health development...has alienated communities from their own health and from the health workers who are supposed to serve them... lead[ing] to...services [that] are imposed without consultation, representation and accountability; and government support for discredited local authorities at the expense of popular community representative structures...These problems have made the community apathetic...

This statement may be a valid argument when considering that the culture of dealing with the health system during the apartheid era was distant and top-down and may have conditioned communities to believe that this is what characterizes interactions with government. However, it is now close to 15 years of democracy in South Africa, and yet the present emancipatory system has also not seen the entrenching of comprehensive community participation in health and development. Though policies have been altered to 'talk' participation, the way in which government health initiatives for communities have been implemented has been no less top-down and hierarchical than was the case during the apartheid government era (Mathekga & Buccus, 2006). The tune may have been changed, proving to be rather eloquent in participation discourse, but at the implementation level it is still in many ways business as usual.

Forms of Community Participation in South Africa

Selective Community Participation

Theoretical discussions aside, Adato et al., (2005) conducted a multi-fold study of community participation in public works programmes in South Africa and found that the urban culture of community participation in South Africa is informed by historical forms of activism and mobilization whereby communities participated in development through civic organisations such as street committees, the South African National Civic Organisation (SANCO) and development forums. This form of community participation does not rely on the individual participation of every member in the community, but rather on the representation of the communities by elected members who participate on behalf of the entire community. It makes sense that when it comes to participation, South Africa should borrow from tried and tested approaches of community engagement with the bureaucracy. This particular method of participation saves time, and simplifies the process of participation as there are fewer people and thus fewer opinions and differences therein to deal with. Moreover, if the selection of these community members occurs along comprehensively participative norms that involve the entire community, then this approach remains preferable.

However, in reality this kind of community participation opens itself up to unintended impediments to true community participation. One of these impediments would be selective participation, one of the “nine plagues”³ that Botes & Van Rensburg (2000) mention regarding community participation. Selective participation refers to the participation of only a select few in development, usually the most vocal, wealthier, more eloquent members of the community (Botes & Van Rensburg, 2000; Skok, 1974). This becomes problematic because the participation of a select few is often to the exclusion of the majority who are often the most in need of the community intervention. Add to this the possibility that the very selection processes of these members may have been far removed from the real community and possibly manipulated by the officials, managers and planners, the result could well be a group of unrepresentative community members resulting in marginal, unrepresentative and elitist community participation.

Another reality that frames community participation in South Africa is the fact that at times local community leadership structures such as development forums and street committees are monopolized by one dominant political party which, if there are heterogeneous political party affiliations, impacts on the representation of the diverse interests of the community. At times these one-party leadership structures manipulate and control the development agenda, to the exclusion of all other interests except its own (Botes & Van Rensburg, 2000).

Non-Governmental Organisation (NGO) involvement as a proxy for community participation

There is another type of community participation that has gained popularity in South Africa. This type of community participation is expressed by the

³ The other eight “plagues” that are mentioned by Botes & Van Rensburg (2000) are: the paternalistic role of development professionals; the inhibiting and prescriptive role of the state in development programmes; the over-reporting of development successes; hard-issues bias; conflicting interests between end beneficiary groups; gate-keeping by local elites; excessive pressures for immediate results and the lack of public interest in becoming involved.

involvement of NGOs on behalf of the communities where they run development programmes. Botes and Van Rensburg (2000) propose that the representation of the community by NGOs and Community-Based Organisations (CBOs) is inappropriate because they are often made up of individuals who are not democratically or participatively elected by the community. These authors add that at times such NGOs may not even be geographically based in the community, increasing possibilities of not being in concert with the needs and interests of the community they are representing.

This observation is especially significant in light of the way in which public policy in South Africa on community participation has been framed to suggest a rather heavy reliance on NGOs and CBOs as facilitators and the means of community participation. The national Community Health Workers Policy Framework (2004b) delegates the responsibility of the selection of community health workers to NGOs and CBOs who are to ensure (albeit in a rather vague, undefined manner) community participation in the recruitment of this cadre of workers. The Extended Public Works Programme (EPWP) Social Sector Plan 2004/5-2008/9 is divided into two main components, i.e. the Home Community Based Care Plan as well as the Early Childhood Development Plan. It lays out government's strategy to use CHWs to address poverty alleviation and unemployment; to meet the need for community based health care strategies for HIV/AIDS and other chronic diseases; and to increase the involvement of communities in their own health and social development. Interestingly, the entire document reflects an understanding of community participation that is limited to NGOs and CBOs as participating actors.

Community Health Committees as a proxy for Community Participation

Another proposed remedy for the lack of involvement of communities in CHW programmes as designers, implementers and managers instead of just as beneficiaries, has been the creation of community/village health committees (CHCs/VHCs) (Ofosu-Amaah, 1983; Oakley, 1989; Lehmann & Sanders, 2007;

Lund, 1987). Korten (1980 in Lund, 1987) sees committees in development projects as being pivotal in the building of problem-solving capacity of communities. The South African National Policy on Community Health Workers (2004b) also supports the notion of CHCs as the channel by which community participation in health is to be achieved.

These CHCs are thought to be the means by which the formal health system could interact with the community. As such these committees would be a body made up of community representatives participating in health development on behalf of the community. It has already been mentioned that representative participation saves time and simplifies participation and some have even pointed out that in some CHW case studies “no committee has meant no concrete community involvement at all” (Lund, 1987: 132). However, this model of community participation carries with it the danger of unintended consequences such as selective participation, unrepresentative and limited community participation. Lund’s case study of three CHW programmes in South Africa (1987) also revealed that in one of the rural community health projects surveyed, the health committee only comprised of senior hospital personnel (including the hospital superintendent), the project trainer and a local businessman with interests in the project. When staff of the project requested the inclusion and representation of the project CHWs in the committee, the committee dissolved, (Lund, 1987).

Lehmann and Sanders (2006: 28) also warn that these committees may prove to play an ambiguous role within CHW initiatives, adding that:

The position of VHCs within village hierarchies is not always clear and often contested, leading to tensions between VHC members and other community leaders or becoming the site of political contestation.

Thus, whilst it is historical for South Africa to define community participation as being largely made up of the involvement of community representatives that vary

from local community members to CBOs and NGOs, the definition of community representatives in this context needs to be examined. Depending on how the community is involved in selecting their CHW (minimally vs. comprehensively) in actual fact these 'representative' bodies may not be representative of the community and its interests and may result in selective participation. Furthermore, the well documented internal politics within the individual as well as collective arena of NGOs and CBOs (Workshop Report: *The Future Role of NGOs in Health Care Delivery*, 1994) may contaminate the process of community participation in health and further drive the agenda away from the involvement of ordinary people in their own health development.

In conclusion, whilst the difficulties that challenge community participation are well appreciated, in a democratic context such as South Africa, it is inappropriate and unethical for communities to be excluded from their own health and development matters.

Having provided the discussion on community participation locally and internationally as the overarching framework under which to consider issues of community based health care, the researcher will now look at what the literature has to say about CHWs, in terms of their origins, definitions, roles and their link to community participation in health as discussed in the following section.

COMMUNITY PARTICIPATION IN CHW PROGRAMMES

The History of CHW Programmes

The concept of using local community members for the delivery of basic health services dates back to more than 50 years ago (Lehmann & Sanders, 2007; Kahssay et al., 1998; Walt, 1990). However, the endorsement of CHWs as the pillar of primary health care was first affirmed in the declaration made by the International Conference on Primary Health Care in Alma Ata in 1978 (Kahssay et al., 1998; Walt, 1990). This Declaration sought to use primary health care as the engine to address not just health needs but the underlying socio-economic

and political dynamics that inform the health status of especially the marginalized poor in our societies (Morgan, 2001).

The Alma Ata Declaration was hailed by many as the dawn of new beginnings in public health which would eradicate elitist, centralized and alienating traditional practices of the health system (Oakley, 1989; Morgan, 2001). It meant that communities would have a direct say in health development and practice with this concept finding its highest expression in CHW programmes. Such programmes would make use of indigenous community capacity, namely: community resources (human, knowledge and financial resources); community structures and norms including cultural beliefs and practices that are related to health; and community opinions and ideas about health interventions. (Ofosu-Amaah, 1983). The response to the Declaration's call for national CHW programmes was both eager and hurried as the beginning of the 1980's saw countries rolling out rushed CHW policies and programmes. By the mid to late 1980's public health discourse was already beginning to highlight the hastiness of the roll-out as having been one of the major causes underlying the failure of many of the national CHW programmes that were initiated during the era of the Declaration (WHO, 1989; Gilson et al., 1989). Decades later hastiness in policy implementation continues to be an occurrence (Friedman, 2002) and a major problem in health. Development processes such as community involvement in health are the most adversely affected when the meeting of specific time-frames is the main priority during the planning and implementation of health programmes. This is because processes such as community participation which are complex and time-consuming are often compromised and/or even completely ignored.

In the history of CHW programmes there have been many areas of dissonance about who and what CHWs are. However there are also areas of consensus namely that CHWs are selected by and work in the community in which they reside, and receive forms of training, support and supervision (Ofosu-Amaah,

1983; Walt, 1988; Friedman, 2005; WHO, 1989; Gilson et al., 1989). There is also consensus that “who and what CHWs are has to respond to local societal and cultural norms and customs to ensure community acceptance and ownership” (Lehmann & Sanders, 2007: VI).

The Role of Community Participation

The implications of the above suggest a central role of the community and as such the integral role of community participation within CHW programmes. The link between CHW programmes and community participation is a very close one since the former was conceived as a means of giving expression to the ideals of the latter as voiced in the Alma Ata Declaration of 1978 mentioned earlier.

Kahssay et al (1998: 18) emphasize that:

By their very nature, CHW programs would encompass and promote the key principles of equity, inter-sectoral collaboration, community involvement, prevention and use of appropriate technologies.

Ofosu-Amaah (1983: 35) also attests to the consensus that community participation in CHW programmes is indispensable, health matters being “...personal to the individual and yet basic to the general development of the community”. However, when she conducted a review of CHW programmes in 13 countries, she found that, when it came to participation, the involvement of communities was often limited to their contribution of labour, material and financial resources, but featured minimal involvement in the training, selection and role definition of their CHWs.

The reviews conducted by Walt, (1990) of national CHW programmes; by Gilson et al., (1989) of 3 countries (Botswana, Colombia and Sri Lanka); and by Ofosu-Amaah (1983) indeed suggest that the interpretation of community participation in CHW programmes has been limited to the way in which CHWs facilitate community mobilization for health and development planning. The early conceptualisation of CHWs (see Werner, 1981), saw them as change-agents that

would awaken communities to concepts of self-generated health interventions and self-reliance. However, there seems to be a lack of thinking about the involvement of communities in the very conceptualization, design and implementation of CHW programmes, save a mention that they would select their own CHWs and keep them accountable for service delivery. These reviews further reveal that the lack of involvement of communities in the design, initiation and implementation of community health worker programmes, has often resulted in a divergent view between what the health system understands to be the role of CHWs and community expectations. In some areas communities expressed the need for comprehensive curative services, but their local health systems prioritized the curing of basic ailments and a health promotion and prevention focus (Ofosu-Amaah, 1983; Walt, 1990; Lehmann & Sanders, 2007)

There is also acknowledgement that the facilitation and success of community participation has a better chance of success in small-scale programmes which are initiated within and by communities (Lehmann & Sanders, 2007). This is especially the case where:

time-consuming investments were made in (a) securing participation of communities and (b) involving them in all aspects of the program, including the identification of priorities and project planning... (Lehmann & Sanders, 2007:27)

In such instances, community participation in CHW programmes thrives and thus “community mobilization precedes and accompanies the establishment of CHW programmes” (Lehmann & Sanders, 2007:27).

Lehmann and Sanders (2007: 28) caution that community participation in CHW programmes should not be viewed as “a magic bullet to solve problems rooted in both health and political power” but rather “as an iterative learning exercise allowing for a more eclectic approach to be taken”.

Selection of CHWs and Community Participation

Participative vs. Bureaucratic Processes

The literature on CHWs reveals that one of the most telling manifestation of community participation in CHW programmes is found in the selection processes followed for the recruitment of this cadre of workers. In theory it is widely established and accepted that CHWs should be selected in and by their communities of residence (Ofosu-Amaah, 1983; Walt, 1988; Lehmann & Sanders, 2007; Kahssay et al., 1998; Walt, 1989; WHO, 1989; Gilson et al., 1989). However, all the reviews on CHWs consulted for this study suggest that in practice they are often not selected by the communities in which they reside, but that instead they are selected by officials (Ofosu-Amaah, 1983; Walt, 1988; Sanders & Lehmann, 2007; Gilson et al., 1989).

The desktop review of published and unpublished literature on CHW programmes that David Sanders and Utah Lehmann (2007) conducted in 2006, suggests that CHWs are rarely ever selected by the communities which they later serve. Adato et al., (2005) found an interesting dynamic in examining the lack of community participation in the selection of many CHWs. This dynamic is found in the fact that generally the selector becomes the employer who pays the salary/wage/honorarium of the recruited. So in CHW programmes where the community selects the CHW but the payment and supervision lies with bureaucracy, the CHW finds herself/himself in the interesting dilemma of being selected and made accountable to the one whilst being controlled and paid by the other. In times of conflicting interests between what the community wants versus what the bureaucracy supplies and demands, should the loyalties of a CHW lie with the hand that selects or the one that remunerates him or her? In fact, it could be suggested that such a situation presents a conflicting role for the kind of CHW that Werner (1981) speaks of, who is seen as an advocate and change agent who mobilizes his/her majority lot for protests and demands against the powers-that-be for inclusion in decision-making around health. Furthermore, in South Africa, COSATU (NPPHCN, 1993b) warned against the

selection of CHWs by the community if they are going to be salaried government employed CHWs, citing issues of patronage and nepotism as likely consequences of such selection processes.

A study conducted in Kalabo district in Zambia (Stekelenburg et al., 2003) to evaluate the performance of CHWs found a link between the selection process followed to recruit CHWs and their performance. The study found the CHWs of the district to have performed poorly whilst also reporting superficial participation of the community in their selection. General views on the link between the selection of CHWs and their subsequent performance in their jobs suggests that selection processes that are community participation oriented tend to produce a cadre of workers that are accepted and accountable to the community they serve, whilst more top-down bureaucracy led selection processes tend to produce a cadre that are unaccountable, culturally and socially inappropriate and not accepted by the community in their communities of practice (Ofosu-Amaah, 1983; Walt, 1988; Lehmann & Sanders, 2007; Lund, 1987). The Zambian study reveals a more complex picture when it comes to community participation in the selection of CHWs. The Kalabo district communities in Zambia were reported by officials to have selected their CHWs, but when a survey was conducted amongst the residents of the district to assess community knowledge about how the CHWs were selected, it was found that very few community members seemed to have been personally involved in the selection process. This suggests that sometimes community participation may be reported to have taken place, but in reality this may have been a superficial exercise.

Selection of CHWs in South Africa

To help us shed light on community participation in selection processes for CHWs in South Africa, we now look at a case study conducted by Lund (1987) among three CHW programmes in South Africa.

Lund (1987) conducted a study of three rural community health projects measuring amongst other variables, community participation and especially the recruitment processes of CHWs. Her findings revealed that community participation in the selection of CHWs is a complex rather than clear cut process. In two of the projects the process of recruitment was often taken to be participative by virtue of the headman of the village being involved in the decision-making process. At times a community meeting would be called to nominate but where nominations by the ordinary majority conflicted with the headman/chief's choice, the latter's candidate would be selected. The findings of Lund's study also revealed that during the beginning stages of the community projects, selection processes were found to be more transparent, democratic and community-led, but as the projects expanded the bureaucrats would take over selection, usually training and hiring whoever presented herself to the clinic/hospital, with a headman's letter of reference. The study also revealed a difference in recruitment processes based on whether or not CHWs were paid or were volunteers as was the case for one of the projects. One of the three projects had unpaid volunteers and experienced "less accountability of the mass of members to the project" (Lund, 1987: 68) and as such there were no strict criteria followed and the recruitment process relied more on who presented herself for training.

Whilst community participation in the selection of CHWs is often romanticized as clear cut and simple, in reality it is a far more complex process and not without pitfalls. In another paper Lund (1993) discusses four paradoxes that CHW programmes have to contend with, namely the paradox of prevention, the paradox of professionalization, the paradox of community participation, and the paradox of policy⁴. In the paradox of participation, she discusses the fact that though it is popularized that communities should participate in the selection of their CHWs to ensure acceptance and ownership of the programmes, in reality "local elections get rigged and controlled by those [community members] in

⁴ It is not relevant to the topic under discussion to elaborate on the other 3 paradoxes.

positions of power, and there is little real participation in a free and fair way” (Lund, 1993: 62)

All of the above reveals the need to go beyond simply examining community participation per se in selection processes for CHWs, but rather the *nature* and *extent* of whatever community participation is said to be occurring in CHW selection processes.

SUMMARY OF THE ISSUES AND DEBATES

In summary of the issues discussed around community participation in health and in CHW programmes internationally and specific to South Africa, it can be said that there is contention with regard to the definition of the concept of community participation. It is also clear that issues of conceptualisation and operationalisation dominate discussion on community participation, with anthropological studies more interested in the former and epidemiologists, policy makers and officials more concerned with the latter. Theory and practice suggest an existence of a continuum along which community participation in health programmes occurs and this continuum consists of the two extreme ends where participation is more of a top-down, hierarchical and bureaucracy-led superficial process on the one hand, and a bottom-up, comprehensive and people-centred process on the other hand.

Though the literature would seem to suggest that the empowerment approach is the most theoretically favoured of the two, closer examination raises the question of whether it is always appropriate in all contexts especially at its most extreme. In the context of time-constraints and efficiency driven community based programmes, applying community participation approaches that are “unquantifiable [and] essentially unpredictable...” (Oakley, 1989:11) may prove inappropriate as they may be too long-winded and complex to contain. The utilitarian approaches on the other end of the continuum may be inappropriate in the most extreme cases because the nature and the extent of the involvement of

the community becomes minimal and superficial. However, practical realities of some community projects may benefit from the emphasis on outcomes and efficiency.

As such the key questions to answer do not concern whether community participation features in CHW programmes, but rather should seek to interrogate what should be the nature and extent of community participation in health and specifically in CHW programmes. Should we try to arrive at an all or nothing answer, or should community participation be defined according to the context in which it is to be implemented, and in particular the nature and objectives of the health project? We wonder if we should be discussing only one particular extreme of the continuum or if we should start considering a middle ground that combines aspects of each extreme of the continuum.

Though not extensively analyzed in the literature reviewed for this paper, a middle ground in the continuum, that combines both approaches may be more suitable to our understanding and application of community participation in health, especially in instances where community participation is neither spontaneous nor self-generated. Adato et al., (2005: xi) point out that "...participation does not have to be all or nothing, and its best forms are likely to vary under different conditions". Furthermore Adato et al., (2005) also point that the two extreme ends of the continuum can be combined by settling on community participation approaches that allow for top-down approaches during certain phases of the programme being implemented and applying comprehensive bottom-up approaches in other phases. However, the authors also warn that their study revealed a tension between the two extremes of the continuum.

With reference to the subject of community participation in the selection of CHWs, it is clear that a few established norms in instituting community participation in CHW programmes need close scrutiny. By these we are referring

to the role of such age old structures as community/village health committees, whose role, though seemingly clear cut, seems to contain possibilities for selective community participation leading to elitist, nepotism-driven recruitment processes. The question to be asked in the scrutiny of these structures is how they can be constituted in such a way that they reflect community participation that is empowering, comprehensive and resulting in community acceptance, ownership and sustainability of a programme.

The literature review also reveals the need to re-examine the participation of NGOs/CBOs as proxy for community involvement in development and health programme planning and implementation. NGOs/CBO interests and views are not always synonymous with those of the community, and as such the entrusting of the selection of CHWs to NGOs/CBOs may result in selective participation. The selector vs. employer dynamic that is likely to ensue when CHWs are selected by communities though employed and paid directly by government or indirectly via NGOs/CBOs is another factor that calls for closer examination in South African Health Policy for CHWs.

Lastly, this review suggests that if the theory of community participation is not operationalised into actual community involvement of the masses who are the beneficiaries of development and health initiatives, then the concept is indeed 'only good for its 'cosmetic value...[and] its ability to make whatever is proposed sound good' (Chambers, 1995 in Morgan, 2001:222)

GAPS IN THE LITERATURE

There is a plethora of literature on various aspects of CHW programmes, yet very little has been written regarding the selection processes of CHWs and how these processes enable or disable community participation. Exploring the link between selection processes for CHWs and community participation is useful in helping us to determine whether theory is ahead of practice. At a time when there is a renewed interest in the use of CHWs to reach underserved communities in South

Africa and abroad, opportunities to enhance public participation should be pursued both in discourse and in practice.



CHAPTER 3

DESCRIPTIVE BACKGROUND AND CONTEXT

INTRODUCTION

The following section focuses on describing the background and context of community health worker (CHW) programmes in South Africa. Particular emphasis is placed on examining and detailing the policies and practice of CHW programmes in the country. The first section describes the history of CHWs in South Africa; the second section discusses the current policies that guide the implementation of CHW programmes in the country; the third is a descriptive background of each of the 3 CHW organisations sampled as case studies for the mini-thesis; and lastly a conclusion that summarizes the chapter is provided.

THE HISTORY OF COMMUNITY HEALTH WORKERS IN SOUTH AFRICA

South Africa's history of formalized primary health care started in the early 1940's prior to the official legislation of apartheid (Tollman & Pick, 2002) with Drs Sidney and Emily Kark who were tasked with implementing a government sponsored Pholela Health Centre (PHHC) programme (Tollman & Pick, 2002; Tollman, 1994; Tollman, 1994). The PHHC programme was developed as a response to the need to reach the communities marginalized and consequently underserved as a consequence of racially segregated health care practice in South Africa at the time. The work of the PHHC was based on a framework known as Community Oriented Primary Health Care (Tollman & Pick 2002) which sought to make basic health care community based.

In analyzing the operations of the PHHC program it becomes clear that its community orientation lay primarily in its geographical proximity to the community it was serving; in its emphasis on community based versus individual-based epidemiology and through its introduction of CHWs (Tollman,1994).

In the way the programme was implemented it took off pretty much like other government initiated programmes, i.e. it followed a top-down and expert driven approach by the two doctors charged with the programme. But soon after it began to operate, the programme changed its structural arrangements in response to protests by the community against their exclusion from the planning and implementation of the programme. In particular, there was resistance against the employment of CHWs from other regions who were not known to the community (Tollman, 1994). The Pholela Health Center management team responded by including community elected representatives in its governing body and by employing additional CHWs selected from (and not by) the community. However, it is difficult to assess the nature and extent of the community's involvement in the decision making processes of the programme. This is because there are no details provided about the way in which these community representatives were elected or selected into the governing body, nor are there details about who they were (and as such how representative they were of their community) and what their participation in the governing body entailed.

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Despite the programmes' top-down beginnings, it soon gained popularity amongst health planners and researchers in South Africa and abroad and its successes were documented widely. Tollman (1994) even goes so far as to suggest that the successes and the lessons learnt from the programme were instrumental in the theorization of the Primary Health Care approach that was adopted by the Alma Ata Declaration in 1978.

In 1948, apartheid was officially legislated and the new government led by the National Party did away with the PHHC programme as the prioritization of community oriented primary health care did not feature in the agenda of the apartheid government (Tollman & Pick, 1994). However, CHW programmes did not cease to exist in the country. Informal, non-governmental or faith-based CHW programmes were noted to have been in existence in various communities in

South Africa as early as the 1970's (SA Alma Ata Conference Report, 24-26 August, 2003).

That said, it is the 1980's that saw the revival and mushrooming of CHW programmes in the health system in different parts of South Africa. Indeed, at a time when health care was highly segregated and thus inequitable, non-governmental CHW programmes were the pillar of primary health care service delivery that was otherwise impossible to achieve for many of the marginalized, underserved and poverty stricken areas in the country. For a while CHW programmes under the auspices of non-governmental organisations (NGO), faith based organisations (FBOs) and community based organisations (CBOs) as well as some 'homeland' governments within South Africa (such as the former Transkei government), flourished with international donor support being the main source of funding (Friedman, 2002; Tollman, 2002). However, by the late 1980's and the early 1990's, the experience of dwindling international donor support for national CHW programmes was increasingly evident across beneficiary countries (Schneider et al, 2008). The main reasons that were cited for this decreased level of enthusiasm for CHW programmes were: the lack of strong evidence for the effectiveness of nationalized CHW programmes; difficulties in up-scaling small local CHW programmes into national projects; difficulties in measuring the effectiveness of CHW programmes and the supervision and training inadequacies in many CHW programmes (Schneider et al, 2008).

Locally, in the early 1990's, international funding for CHWs also started dwindling as the Alma Ata Declaration vision for CHWs had always been to nationalize CHW programmes and as such government funding was meant to sustain the support of the programmes (Walt, 1990).

During this time, South Africa also saw the thawing of political repression and plans for democratic governance of the country began in earnest. The ANC's emerging health policies and plans demonstrated enthusiasm and commitment

for the use of CHWs as the means of expanding health services and realizing people-centred notions of development (Makan & Bachman, 1997). However after the elections in 1994, the national government seemed to demonstrate less interest in CHW programmes and especially less interest in nationalizing them. In fact only one very broad reference was made to them in the ANC Health Plan (1994:5) stating that:

...local CHW programmes will be encouraged, provided that they are integrated into local health services, but no national programme will be launched at this point

By the late 1990's, the HIV/AIDS epidemic in South Africa was spiralling out of control, putting a major strain on an already over-burdened health system. The AIDS 'crisis' thus put CHW programmes on the development and health agenda again with government fully embracing the concept of using CHW to deliver primary health care and much needed HIV/AIDS treatment and home based palliative care support (Schneider et al, 2008)

In 2003 the National Department of Health (NDoH) began the policy development process that would see the unveiling of a national policy on CHWs in August 2004 (Friedman, 2005). According to Helen Schneider, a public health policy expert in South Africa, the development of the policy followed an organic and incremental process. As such the process of developing the policy enjoyed the involvement of multiple stakeholders in the sector of CHWs.

CURRENT POLICY ON CHWS

In 2004 the National Policy on Community Health Workers was released (NDoH, 2004b). The policy envisioned a widespread use of CHWs and extended their purpose beyond improving and expanding health care services in South Africa, to meeting the objectives of the Expanded Public Works Programme (EPWP) Social Sector Plan 2004/5-2008/9 for massive job-creation for the unskilled and semi-skilled to alleviate poverty. According to the Minister of Health at the time,

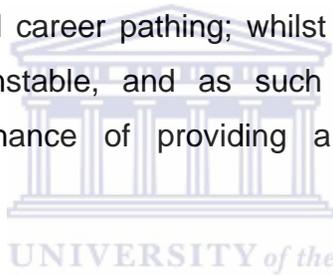
Dr Manto-Msimang Tshabalala, as expressed during her speech at the launch of the CHW Programme in 2004, (NDoH, 2004a) there are five imperatives that underpin the concept of this policy:

- The President's articulation of a people's contract to create work and fight poverty
- Government's commitment to improve service delivery
- The national human resource and skills development strategies
- The increasing complexity of the burden of diseases and poverty-related challenges
- The increasing need for health promotion activities, community and home based care

The national policy on CHWs reflects the government's major shift in government thinking away from traditional CHW concepts which have been historically confined to offering basic primary health care services to prevent disease, promote health and palliate the sick in the confines of their homes. According to Scheineder et al., (2008) the shift in the CHW policy has not occurred as an isolated event in the health and development sector in South Africa. It has rather occurred as part of the government's response to the HIV pandemic, the human resource shortage of nurses as well as the high levels of unemployment of unskilled and semi-skilled labour in the country. Thus, in the first instance the policy tries to hit two birds with one stone: introducing national CHW programmes to address health sector problems whilst simultaneously creating employment opportunities for those otherwise unskilled and semi-skilled in the population. The EPWP Social Sector Plan, 2004-5/2008-9 articulates the poverty alleviation and job creation imperatives of the CHW programme in South Africa, by mapping out a plan of mass recruitment, training and employment of CHWs to provide work opportunities and further career pathways for the masses of the unemployed and unemployable members of the South African community (EPWP, 2005). This represents a major shift in the way CHWs programmes are conceptualized internationally, where they are largely regarded as "barefoot doctors" (Kahssay et

al, 1998) and deliverers of basic primary health care services with no particular intentions to increase their skills beyond the basic level.

The second major shift that this policy makes is the move from single purpose CHWs to generalist CHWs (NDoH, 2004b). Specialist CHWs perform specific tasks, e.g. Home Based Care CHWs; TB Directly Observed Treatment (DOT) Supporters; ARV Patient Advocates; Infant Feeding Peer Supporters. Generalist CHWs on the other hand are those whose functions comprise a combination of all of the other ones, (Friedman, 2005; NDoH, 2004b). This variety also means that CHWs are employed by a wide variety of non-government organisations (NGOs) such as CBOs and FBOs. Some of these organisations are well established and well resourced and as such better employers in terms of workload, remuneration and career pathing; whilst others are under-resourced, newly established, and unstable, and as such with unclear targets, poor remuneration and little chance of providing a ladder to greater career opportunities.



Another significant policy feature is that government although providing the infrastructure for CHW programmes, has steered clear of becoming an employer of CHWs. The CHW policy makes this apparent in its statement that “CHWs may receive a stipend but will not be government employees” (NDoH, 2004b: 6). This means that CHWs are not provided for by the government regulatory systems that secure and protect the employment of civil servants. Because of this, the employment of CHWs has become highly casualized and thus insecure.

The major shifts articulated in these policies bring to bear many changes on how CHW programmes are operationalized, including the aspects of how these cadres are selected and recruited into their jobs. For instance, career pathing as a key aim of the new policy on CHWs brings with it new rules on the selection criteria to be used when selecting CHWs. The policy stipulates Grade 7 as the minimum education qualification required (NDoH, 2004b). This is a major shift in

criteria as in the past CHWs just had to be able to read and write, and since selection criteria determine the process to be followed when selecting, they have an exclusionary effect.

Lastly, it is important to keep these policy shifts in mind when we look at the findings in chapters 4 and 5.

Public Policy and Community Participation In Health In South Africa

There is evidence that community participation in CHW programmes was high in apartheid South Africa (Tollman, 2002) when the programmes were largely run by NGOs/CBOs/FBOs without much government intervention. The onset of democracy brought about liberation, a more unified health system, and public endorsement of community participation in health as a development approach. However, with that also came greater government regulation, and an efficiency driven bureaucracy, was not structured effectively to deal with the dynamic, complex, and unpredictable nature of comprehensive community participation.

The national government's intention to prioritize and uphold community participation in health policy and practice is well versed in the RDP statement about the restructuring of the health system (NDoH, 1997). In the RDP statement, it is envisioned that the restructured health system, founded on a strong district health system to achieve the goals of primary health care would emphasize:

...community participation and empowerment, inter-sectoral collaboration and cost-effective care as well as integration of preventive, promotive, curative and rehabilitation services. (NDoH, 1997: 45)

The White Paper for the Transformation of the Health System in South Africa, (notice 667 of 1997, Government Gazette no. 17910), has seven goals that it set out to enable it to deliver equitable, accessible, effective and unified health

services in the country. The policy placed community participation in health as the sixth of the seven goals (NDoH, 1997), aiming to:

- i. involve communities in various aspects of the planning and provision of health services;
- ii. establish mechanisms to improve public accountability and promote dialogue and feedback between the public and health providers; and
- iii. encourage communities to take greater responsibility for their own health promotion and care. (goal number 7, NDoH, 1997: chapter 1)

The national policy on CHWs (2004b) also recognizes community participation in CHW programmes as one of its main policy mandates.

Lastly, as it has already been demonstrated, the climatic political environment of the country has affected for better and for worse the current context of community participation in CHW programmes discourse and practice in South Africa. Pre apartheid and post apartheid South Africa's political agenda has played a role that has had a determining effect on the shape and size of CHW programmes. As the situation stands today, CHW programmes are in the threshold of major transformation, hence the need to parallel these strides with evidence-based research on how best to make them effective.

DESCRIPTION OF CHW PROGRAMMES IN THE STUDY

The study focuses on three organisations that were selected for the study. Due to the confidentiality requirements that were insisted upon as a condition by the three organisations, they are herein referred to as CHW Programme KZNA, CHW Programme WCA and CHW Programme WCB.

CHW Programme KZNA is an organisation in Kwazulu Natal that specializes in training, managing and supervising Home Based Care CHWs in the rural areas of the province. The organisation has been in existence since the late 1980's and is affiliated to a larger international development organisation based in Maine in the United States of America. The larger parent organisation has eight key areas of intervention, namely: child survival; HIV/AIDS, malaria treatment; architecture

and engineering; orthopaedic and rehabilitation services; health sector reform; water supply and sanitation and health care financing. CHW Programme KZNA falls under the HIV/AIDS category through its work with CHWs who are Home Based Carers (HBC) for those bed-ridden with AIDS. The historical work of CHW Programme KZNA has been primary health care as well as HIV/AIDS research and intervention development. For many years until about two years ago, the organisation operated a home-based care (HBC) project for which they employed CHWs. However, in the last two years, due to policy changes in the National and provincial Department of Health (DoH) in Kwazulu-Natal regarding CHWs, the organisation has since narrowed its operations to only include training and preparation of CHW candidates for HBC posts. The provincial Department of Health in Kwazulu-Natal adopted a CHW strategy in 2004, whereby they started funding specific NGOs to run CHW programmes and in the process CHW Programme KZNA was relegated to the role of recruiting, training and referring CHWs in their database for employment by the government funded CHW NGOs. By 2004 there were 4000 CHWs in the province with an additional 1000 CHWs targeted for recruitment for the year 2005 (www.kznhealth.gov.za/chw.htm). In the last year, CHW Programme KZNA has trained and deployed 150 CHWs as Home Based Carers in their district.

CHW Programme WCA is a non-governmental organisation (NGO) that was formed in 2002 through the amalgamation of three Community Health Worker (CHW)⁵ programmes in Phillipi, Khayelitsha and Nyanga in the Western Cape. CHW Programme WCA provides primary health care services to various communities in the Western Cape. These communities include 12 designated areas within the Cape Metropole, most of which are within the Khayelitsha and Nyanga townships. The NGO also services rural communities in Zolani, and Ashton /Montagu. The services of the organisation are delivered through Community Health Workers (CHWs), Community Rehabilitation Workers (CRWs) and HIV Lay Counselors. To date the organisation has employed 116 CHWs who

⁵ The ethical obligation to keep the identity of CHW Program WCA anonymous means that I am not able to reveal the names of the three organisations that merged to form the current organisation.

provide basic curative services, health education as well home based care (HBC) for palliative patients who are recuperating in their homes.

CHW Programme WCB is not a CHW programme per se, but rather a research project that existed as a large randomised control trial in two provinces in South Africa (Western Cape and Kwazulu-Natal) between 2004 and 2007. However, for the purposes of uniformity and coherence of the reporting on case studies, the research project will be referred to as CHW Programme WCB. The programme was implemented as a research intervention to address maternal and child health issues. The type of CHWs that the programme employed were Infant Feeding Peer Supporters for Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) and operated in one peri-urban area in the Western Cape, namely Paarl; one peri-urban area in Kwazulu Natal, namely Umlazi and one rural area also in Kwazulu-Natal, namely Umzimkhulu. During the two and half years of the programme's existence, 38 CHWs were recruited and employed across all of the study sites. The province of the Western Cape had 10 CHWs; and the province of Kwazulu-Natal had 28 (14 each at the two sites).



The three organisations are similar in some ways and different in others. The first two organisations, CHW Programme WCA and CHW Programme KZNA have both seen major changes in their work with CHWs both in policy as well as in practice as they have existed in both the pre- and post apartheid era. The last organisation, CHW Programme WCB, has only existed in the post apartheid era as such does not have changes that the organisation has gone through.

CONCLUSION

This chapter has sought to describe CHW programmes in policy and in practice. This has been done by detailing the history as well as the current synopsis of what governs the programmes at a policy level, as well as by illustrating their various compositions as reflected by the brief description of the CHW programmes interviewed for this study.

The following chapter focuses on providing a description of the findings by outlining the themes and sub-themes that emerged from the process of data analysis.



CHAPTER 4

FINDINGS

INTRODUCTION

The findings outlined in this chapter are drawn from documents and interviews conducted with various actors of the three CHW organisations. Due to ethical considerations for anonymity, the CHW organisations are not referred to by their real names, instead they are named according to their provincial location and thus herein referred to as: CHW Programme WCA, CHW Programme KZNA and CHW Programme WCB.

The chapter provides a detailed description and discussion of the key themes and sub-themes that emerged from the qualitative data analysis from each of the three case studies that constitute the mini-thesis. Two of the case studies, CHW Programme WCA and CHW Programme WCB, are based on data from two sources, namely organisational documents and qualitative interviews. The third case study, CHW Programme KZNA is based solely on the interview findings, as the organisation provided unwilling to provide any documents.⁶

Key themes that are discussed are include the selection of CHWs; the determinants of selection processes; the challenges in the selection of CHWs and the role of government policy and involvement in CHW programmes.

CASE STUDY 1: CHW PROGRAMME WCA

Brief descriptive background of the organisation

CHW Programme WCA is a non-governmental organisation (NGO) that was formed in 2002 through the amalgamation of three Community Health Worker

⁶ See Chapter 1: Limitations for details of efforts made to acquire documents from CHW Program KZNA.

(CHW)⁷programmes in Phillipi, Khayelitsha and Nyanga in the Western Cape. CHW Programme WCA provides primary health care services to various communities in the Western Cape. These communities include 12 designated areas within the Cape Metropole, most of which are within the Khayelitsha and Nyanga townships. The NGO also services rural communities in Zolani, and Ashton /Montagu. The services of the organisation are delivered through Community Health Workers (CHWs), Community Rehabilitation Workers (CRWs) and HIV Lay Counselors. To date the organisation has employed 116 CHWs who provide basic curative services, health education as well home based care (HBC) for palliative patients who are recuperating in their homes.

Main Findings From The Documentary Analysis Of CHW Programme WCA

CHW Programme WCA has various documents that detail the history as well as current programmes of the organisation. These documents were accessed to complement the qualitative data.

Four key findings emerged from the analysis of these documents, namely: the organisation's CHWs are residents of the communities they serve; the CHWs are trained and salaried employees of the organisation; the community selects the CHWs; and the organisation's ethos is underpinned by principles of community participation.

The organisation's CHWs are residents of the communities they serve

The organisational documents state that their CHWs are all residents of the communities they serve. According to these documents:

Community Health Workers provide health education and basic curative services within their resident communities... Each CHW is assigned a zone of between 300 to 500 houses within their residential area.

⁷ The ethical obligation to keep the identity of CHW Program WCA anonymous means that the researcher was unable to reveal the names of the three organisations that merged to form the current organisation.

The CHWS are trained and salaried employees of the organisation

The organisation's document on CHWs states that the CHWs are salaried workers though there are no details provided about who pays them or what their salaries / salary ranges are. It also states that the CHWs undergo a number of training sessions upon entry into the organisation as well as refresher training workshops during the course of their work as CHWs. The training that CHWs receive is not only meant to equip them for the work that they do but also to lend credibility to their work.

The CHWs are selected by the communities they serve

The organisational documents state that their CHWs:

are elected by, and answerable to their communities...CHWs and CRWs are elected by the communities within which they reside through Community Health Committees, which are part of organized community structures. This election process is entirely consultative...This process ensures that CHWs are respected and accepted by and are accountable to their community.

The organisation provides a detailed description of how the communities they serve become involved in the selection of CHWs. First a need for a CHW is identified by either CHW Programme WCA or the community. Then the community's local health committees and the organisation engage in a consultative process that culminates in a community meeting where potential CHW candidates are nominated. After the community nominations, candidates undergo an interview process involving both CHW Programme WCA and the community. Finally, those candidates who meet the selection criteria are then employed by CHW Programme WCA. The website does not provide details of what the selection criteria are, nor does it provide details of the community's further involvement once the CHWs are appointed.

The organisation's ethos is underpinned by principles of community participation

CHW Programme WCA prides itself in being a non governmental organisation that is rooted in community participation. The organisational documents describe how the organisation delivers all of its primary programmes through community involvement , where the community is both benefactor and beneficiary of CHW Programme WCA's programmes. According to the documents:

Our philosophy is to develop community participation in preventive, promotive, rehabilitative and limited curative health care through developing coordinated advocacy programmes, disseminating information, conducting research and mobilising communities.

Findings From The In-depth Interviews

For the in-depth qualitative interviews, 1 senior programme manager and 4 CHWs were interviewed. The 4 CHWs were stratified by time period of employment : those who were employed prior to government's involvement in CHW programs (2) and those who were employed in the current era of government's involvement in CHW programs (2). The first two CHWs (pre-government involvement) will be referred to as Mrs M and Miss T and the second two CHWs (current era) will be referred to as Ms A and Ms H.

There are four main themes that emerged from the analysis of the in-depth qualitative interviews with the senior programme manager and the four CHWs. The four themes are: Selection of CHWs; Determinants of Selection Process; Challenges to Selection; and the Role of Government Policy and Involvement.

The following section outlines the findings under the main themes and sub-themes without engaging in an interpretive discussion of their meanings and implications. It is only after all of the themes and sub-themes have been outlined that a discussion on the various findings will ensue.

Selection of CHWs

Historical Experience of Selecting CHWs

According to the senior programme manager of CHW Programme WCA, the organisation's historical experience of selecting CHWs is defined by two time periods. The first period was prior to 1994, and to the post-1994 Government's direct involvement in CHW programmes in 2002, during which the CHW organisations that were later amalgamated to form CHW Program WCA received funding directly from the European Union. The second period was after government involvement when the European Union stopped direct funding of the organisation, preferring instead to channel its funds through the National Department of Health (DoH) for dispersion to those CHW programmes adhering to DoH policy and guidelines for CHW programmes.

Past Norms of Selection: Consultative Community Involvement Driven Selection

According to the senior programme manager, in the period prior to government's involvement, CHW Programme WCA selected CHWs through informal processes that prioritised the involvement of communities who were beneficiaries of the organisation's primary health care services. According to the senior programme manager

...in the past... they were using that process of calling a community meeting, and the community would raise hands and say who it is they are selecting and then from that pool the organisation would conduct interviews and then whoever that person is would be appointed as a CHW

Interviews with the two CHWs Mrs M and Miss T confirmed the above selection process. These two CHWs started working for CHW Programme WCA prior to government's involvement in CHW programmes (Mrs M started early in 1994 and Miss T in 1999). Mrs M reports that during her selection process, a community meeting was called, whereby nominations for CHWs were carried out by the raising of hands. At a later date the nominated community members then went to

CHW Programme WCA for an interview that was conducted by the management of CHW Programme WCA and observed by the community's political structures (such as SANCO and the African National Congress), as well as community leaders. According to both the senior programme manager and Mrs M, the selection criteria included being able to read and write; being a member of the community; and being prepared to volunteer.

Current Selection: Partial Community Involvement in Selection

The programme manager of CHW Programme WCA reported a somewhat different approach to selection that her organisation employs in the current post independence/government involvement era. CHW Programme WCA no longer involves communities in the selection of CHWs as a matter of course, but only when it is convenient and feasible. Due to the change in the political landscape of post apartheid South Africa, ward councillors very often now form the representation of political and developmental community leadership in many communities. The programme manager mentioned that the organisation involves communities only through ward councillors and even then ward councillors are involved only if they indicate an interest in primary health care and are perceived to be functional. The senior programme manager reported that:

...in communities where there are councillors who show interest, like with the people that I have employed from Makhaza, I employed them through councillors... So what I do is to just call and say I need CHWs and then during their Development Forum meetings they announce that so many people are needed from this organisation and then when they come to us they must bring their certificates or CVs if they have them, or certificates from their committees

The other two CHWs interviewed were those of the government involvement era (both employed in 2005) and they both reported not having been employed through any process that involved their communities. However, after being appointed they were taken to the communities where they would practice and introduced to the ward councillors.

Current Selection: NGO Led Selection of CHWs

The programme manager of CHW Programme WCA mentioned that for the most part selection and recruitment processes are an organisational affair in her organisation. This process involves only herself, the organisation's area coordinator and sometimes one of the organisation's CHWs. According to the senior programme manager:

It would be myself and then the area coordinator, and then in the past whilst- when I didn't have an area coordinator I would use one of the CHWs to select, the intention then was to empower them so that they can know what to look for from a [prospective] employee...

The two CHWs employed since 2005 also narrated their stories of how they were selected and recruited to become CHWs and indicated that there was no community involvement at all. Both Ms A and Ms H came to know about CHW Programme WCA after completing a 3 month course on Home Based Care at a school for nursing and were looking for CHW work. They then applied by submitting their curriculum vitae and academic certificates. Interviews were conducted with both of the CHWs and only involved the management of CHW Programme WCA.

Current Selection: Merit Driven Selection

One of the differences that the programme manager of CHW Programme WCA drew between the past and current forms of selection concerned the selection criteria. Currently, the selection of a CHW is largely dependant on his/her educational qualifications and work experience more than anything else. As she explained it:

...we want people who have grade 9, we want people with a certificate in home-based cae, we want people with experience in health and welfare or whatever work experience they have...

Both of the respondents employed by CHW Programme WCA from 2005 cited their training qualifications and educational background as having been what earned them their positions as CHWs in the organisation.

The new emphasis on educational qualifications has caused divisions within the body of CHWs. Those CHWs employed prior to government's involvement and as such with less or no educational qualifications feel threatened and undermined by those of the current era who have between grade 9 and grade 12 and other kinds of CHW certificates. On the other hand while feeling superior because of higher educational qualifications, those from the current era feel undermined by the CHWs of old who claim greater community credibility because of the participation of the community in their selection and recruitment. The programme manager of CHW Programme WCA put it this way:

...And now since there are those from that era and these ones, there is that division between these CHWs because those ones from the old era are illiterate whilst these ones have some education at least and so now there is always that conflict. These ones maintain that "we are more community oriented", whilst these ones maintain that "we are a bit educated", you see...

Determinants of the Selection Approach

There are various determining factors that inform the selection process that CHW Programme WCA ultimately chooses when recruiting a CHW. These are: community dynamics; programme needs; and government's involvement in matters of selection and employment of CHWs.

Community Dynamics

According to the programme manager of CHW Programme WCA, the extent to which communities are organized into vibrant, involved and credible leadership structures determines the likelihood of the organisation following a community participation led selection approach. As she put it

...But in communities where there are councillors who show interest, like with the people that I have employed from Makhaza, I employed them through councillors, and as I say these councillors showed interest in health and development issues...

One of the CHW respondents also confirmed this saying that CHW Programme WCA no longer selected CHWs through community meetings because nowadays few people turned up for community meetings.

Programme Needs

The CHW respondents of CHW Programme WCA indicated that the selection process followed for the recruitment of a CHW is sometimes guided by the urgent need to fill a vacant CHW post. CHW respondent Miss T is an example of how programme needs can determine selection processes for the recruitment of CHWs. Miss T was employed by CHW Programme WCA at a time when the organisation needed to fill a vacant CHW post urgently. As such Miss T's selection process did not involve her community or any other community for that matter. She was recruited based on a recommendation by a CHW that was employed at CHW Programme WCA at the time and who was living in the same community as Miss T.

Government's Involvement

The programme manager of CHW Programme WCA indicated that one of the key factors that has changed the way in which CHWs are selected has been the introduction of the Department of Health's (DOH) selection criteria. These criteria seem to have formalised the selection process with the requirement for submission of curriculum vitae and references to confirm previous work experience when applying for a CHW position. The programme manager of CHW Programme WCA put it this way

...now DoH is saying at least grade 9, or standard 7 education, so now we look at such educational levels, so that it's at least grade 9 ...but to a certain extent, you see we measure (balance) the criteria that DoH sets

with trying not to lose the points on community participation wherever possible...

When asked about who they consider to be their employer, all four CHW respondents cited the DoH, though they also reported to not have had direct interactions with the Department. The reasoning behind this understanding was reported to be due to fact that the DoH pays the CHW's monthly stipends of R400.00 per month. Another reason given for this understanding was that the senior programme manager is always referring to the DoH as the determiner over the CHW's remuneration, over how long the employment contract is and whether they will be employed the following year.

Challenges in the selection processes of CHWs

There are a number of factors that both the CHWs and CHW Programme WCA cited as obstacles that stand in the way of following the principles of selection that the organisation embraces. These challenges included the legitimacy of community structures; lack of community organisation; and competition, scarcity of jobs and poverty.

Legitimacy of community structures

The programme manager of CHW Programme WCA cited that one of the first steps when involving the community in the selection of CHWs is to identify the community's leadership structures that can mobilise the community for participation. However, she also added that nowadays it has become difficult to establish the legitimacy of community leadership structures due to their large number as well as competition between political parties. She further reported that whilst there are community leadership structures that are consulted at the start of the process, soon after their involvement it is then revealed that the said community leadership structure is not considered a legitimate or representative voice in the community. The programme manager put it this way:

...there are also issues such as rivalries and jealousies about whatever structure is in existence, so that you end up not knowing who is legitimate and who isn't and who you should go to if you are looking for CHWs...

This ends up discouraging the organisation from pursuing community involvement processes during selection.

Lack of community organisation

According to the experiences of CHW Programme WCA, in the post apartheid era most of the communities that the organisation operates in are not organized in collective action groups. As the senior programme manager of CHW Programme WCA said:

....now we no longer go to community structures as such because they do not exist...those structures that were used during the apartheid era were organized but now these community structures are not organized at all...

All of the CHW respondents confirmed the organisation's perception of an unorganised community in the post apartheid era. They also perceived the nature of community leadership structures as highly politicised and disorganised. The CHW respondents also reported that they have not participated in nor observed any mass community meetings mobilised for the purpose of selecting CHWs in recent years.

Competition, scarcity of jobs and poverty

The CHW programmes that are run by CHW Programme WCA are delivered in poor communities with high rates of unemployment. The programme manager cited this contextual background as being the cause for major competition among the community members for every kind of employment opportunity that is brought to the community. According to the programme manager, whenever the organisation tries to involve the community leadership structures, they find that the leaders themselves or their families want to be employed as CHWs and as such do not extend the opportunity to apply for CHW posts beyond themselves and their families. At the general community level, the programme manager of CHW Program WCA reported that the situational context of high unemployment

in the community invariably meant that unemployed community members were reluctant to nominate others besides themselves for CHW positions. According to the programme manager:

...and those [community structures] that exist also want to be employed, you see, they are also unemployed and so they want to grab these opportunities... the community- these are poverty stricken areas, so everyone wants a piece of this small bread, so you are not able to discern when a person is genuine or when there are ulterior motives, you are not able to discern...and there is this tendency of choosing family members, because even during that time it was a problem because people always prioritized their families and relatives and homies...

The CHW respondents also confirmed this, with Mrs M adding that when she was first employed as a CHW pre-1994, the community selected her without knowing that she would be a salaried worker. According to Mrs. M, at the time CHW Programme WCA described CHW work as voluntary and altruistic. As such even Mrs. M was shocked when she started earning a salary within a month of commencing her work as a CHW. Mrs. M claims that nowadays the work of CHWs attracts a lot of interest and jealousies in the community as everyone is now aware of the financial incentives attached to the work. Ms H and Ms A also attested to this, saying that they did not believe that communities should be involved in the selection of CHWs because every community member would want to have the jobs for themselves.

Discussion of Findings

The following section will discuss the findings outlined in both the documentary analysis as well as the analysis of the in depth qualitative interviews. Four main themes in the form of questions will guide the discussion: How does CHW Programme WCA select CHWs; what are the contextual factors that influence the choice of one selection process over another; what are the implications of the role played by government policy in the determination of selection processes; and lastly, what are the lessons learnt from CHW Programme WCA's experience of selecting CHWs?

How does CHW Programme WCA select CHWs?

There are a number of issues that emerge from both the documentary analysis and the qualitative findings about the way in which CHW Programme WCA selects CHWs. Firstly, the two sources of data do not present the same information about how CHWs are selected by the organisation; secondly, there seems to be a disparity between the organisation's theory of how CHWs should be selected and actual practice; and thirdly, the organisation has applied a different type of selection approach during different time periods.

Differing accounts of selection processes

The documentary analysis suggests a textbook account of how selection is conducted in the organisation. The community is extensively involved in the selection of fellow residents as CHWs - from nominations to interviews/assessments, to appointments. However, the verbal account given by both the programme manager and the CHWs suggests that this community involvement centered type of selection is something of the past. Currently, for the most part, the organisation no longer involves communities when recruiting CHWs. Instead they recruit CHWs through local media advertisements and through referrals. In the instances where the community is involved, only the community leadership is involved. As Lund (1987) has argued, this type of community involvement has tended to result in selective or elitist community participation.

Furthermore, the documentary analysis reveals that CHW Programme WCA embraces the principle of selecting CHWs from their local communities, however in practice the organisation seems to apply different rules. Through its city-wide selection approach the organisation does not necessarily employ candidates from the local communities of practice. Interviews conducted by the researcher with the organisation's programme manager and CHWs suggests that the

organisation sometimes employs CHWs from communities outside the ones they are serving.

Lehmann & Sanders (2007) conducted a review of CHW programmes in South Africa, where they found a similar contradiction between theory and practice. Many programmes embrace the principles of community participation in the selection of CHWs but in reality scarcely apply them.

The evidence borne by these findings suggests that indeed as Lynn Morgan (2001:224) has suggested, when it comes to community participation in health, theory is ahead of practice and perhaps the principle of this concept is only good for its “cosmetic value...[and] its ability to make whatever is proposed sound good”.

The disparity between what CHW Programme WCA says versus what they do when selecting CHWs, also points to the important role that contextual factors play in determining the selection process that is ultimately applied regardless of what the organisation’s theoretical beliefs are. An organisation may start off with noble intentions to implement a community participation based CHW programme, but practical issues and/or contextual factors that act as impediments to fully fledged community involvement, may deter the organisation.

Botes and van Rensburg (2000) conducted a review of the impediments to community participation in South Africa and noted that there are several “plagues” that prevent community participation in development: from institutional to socio-cultural, and technical and operational obstacles. CHW Programme WCA seems to have encountered a number of contextual factors some of which have acted as impediments to community participation in the selection of CHWs by the organisation. The findings from the interviews reveal a number of these determining factors: socio-political time periods; community dynamics and programme needs.

Contextual factors that determine the choice of a selection process

Changes in the social and political landscape

The selection processes for the employment of CHWs followed by CHW Programme WCA have been strongly influenced by the changes in the social and political landscape in the country after South Africa gained independence from the apartheid rule. Prior to 1994, a time when South Africa had a racially segregated health system that favoured the White minority population and disregarded the Black majority population, CHW organisations were the pillar of primary health care service delivery (Tollman, 2002). Also, there was no government involvement in CHW organisations as they were exclusively funded by international donor organisations (Tollman, 2002). According to the senior programme manager and the CHWs interviewed, the European Union was the main funder of many of the CHW organisations existing at the time in the Western Cape. Organisations were funded independently granting them sufficient autonomy and a degree of self-rule in terms of organisational guidelines and had no government policy to abide by.

In addition, according to CHW Programme WCA, the level of community activism was strong due to the political activism marking that era. As such, mobilising and organising the community for participation in the selection of CHWs was easy. Furthermore, because there were no government-stipulated criteria for the selection of CHWs, the organisation could follow selection processes that were more informal thus providing the opportunity to be a CHW candidate to a larger number of community members. The selection criteria that the organisation applied only required that CHW candidates should be from the local community and should be able to read and write. Thus, pre-1994, due to the absence of stringent government selection criteria and the widespread nature of political/community activism, CHW Programme WCA had an enabling

environmental context for extensive community involvement in the selection of CHWs.

The findings also reveal a strong working relationship between the organisation and local community leadership structures during this time. According to the senior programme manager and CHW respondents of CHW Programme WCA, during the apartheid era these leadership structures were well defined (as health committees or street committees). This made it easy for the organisation to collaborate with local community structures in the selection of CHWs. This kind of community participation that involves community leadership structures is lauded in reviews and reports on CHW programmes as being one of the best mechanisms by which to facilitate community involvement in CHW programmes (Lund, 1987; Ofosu-Amaah, 1983; Oakley, 1989; Lehmann & Sanders, 2007). However, the perception amongst the respondents from CHW Program WCA is that in the post apartheid era, community leadership structures have taken on a new form that raise questions of legitimacy and reliability. According to the respondents these leadership structures are said to be a lot more politicised and divisive and that they are often aligned to particular political parties which may not be agreeable to all community members. The discussion on the use of community leadership structures to facilitate community participation in the selection of CHWs will be pursued when looking at the community dynamics that have influenced the selection processes of the organisation.

Post-1994, the organisation went through a major transformation as it was amalgamated with other smaller CHW programmes in the Western Cape. During the same period of amalgamation, the new democratic government began to take a keen interest in CHW programmes. By 2002-2003 the new government had taken over the funding of CHW programmes as the European Union began to channel donor funding away from individual CHW organisations and through the National DoH (Personal Communication with Melanie Alpestein CHW expert, UCT (April 2007) and by 2004 a national policy on CHWs had been released.

The National South African Community Health Workers Policy (NDoH, 2004b) spells out the definition of who CHWs are; what their functions entail; how they are to be selected (including selection criteria) and recruited; their remuneration; training; and the preferred model of managing them.

There are two issues in the policy that pertain to the selection and recruitment of CHWs, i.e. how they are to be selected and the selection criteria. The policy states that CHWs are to be selected through community participation processes facilitated by NGOs who are running CHW programs (NDoH, 2004b). This issue is dealt with in more at a later stage when the impact of government policy and involvement in CHW programs is discussed. The second issue is the selection criteria required by the national policy. The selection criteria (minimum Grade 9 education and previous work experience in a community health related field) are rather formal, strict and with a heavy emphasis on the level of education (minimum Grade 9). This has meant that CHW candidates cannot be selected based on their community merit only, but must be selected on their educational merit and previous work experience. Whilst understanding the government's rationale for establishing the selection criteria, the findings suggest that their existence has narrowed the pool of those community members who can apply for CHW positions. Furthermore, the existence of these criteria has had a somewhat negative impact on the involvement of communities in the selection of their CHWs. Previously communities only had to be sure of their community members' social standing in the community to be able to "raise hands" and nominate them. Now however, they require a lot more information about their candidates. They have to be acquainted with their level of education and relevant work experience, making it more complex than just raising hands and saying "I nominate Mrs. So and So".

During these two time periods, socio-political changes have brought about a redefinition of community in South Africa, and as such a redefinition of community participation in the selection of CHWs. In the era of apartheid,

community participation in the selection of CHWs flourished because the context within which CHW programmes were implemented was conducive to such a process. Community activism, an accessible selection process and robust leadership structures meant that CHW Programme WCA could choose selection processes that involved communities with simplicity and depth. In the new era of democratic rule, community participation is limited and disabled by socio-political changes that have made it difficult for CHW Programme WCA to practice community involvement in the selection of CHWs. Community apathy in the context of low political activism, stringent selection processes due to government prescription and politicised community leadership structures are some of the factors that have influenced the choices of selection processes that are devoid of community involvement in the communities where CHW Programme WCA operates. There is also an argument that the apartheid government and the way in which they interacted with communities has created the present community apathy that CHW Program WCA has observed in the communities where they practice. The Policy Proposal on Community Participation in the Health Sector submitted at the National Progressive Primary Health Care Network (NPPHCN)/ South African Health and Social Services Organisation (SAHSSO) Health Policy Conference in December 1992, made the following statement with regards to community apathy in post apartheid South Africa:

The apartheid system has militated against community participation in health development...has alienated communities from their own health and from the health workers who are supposed to serve them... lead[ing] to...services [that] are imposed without consultation, representation and accountability; and government support for discredited local authorities at the expense of popular community representative structures...These problems have made the community apathetic... (NPPHCN, 1993b)

Thus, it can be said that in the presence of an enabling local community context (i.e. with a vibrant, cohesive community and community leadership structure) accompanied with organisational willingness (i.e. the organisation must be willing to facilitate community involvement even in the presence of obstacles) ,

conforming the practice of CHW programmes to the theory of community participation in the selection of CHWs is realizable.

Community Dynamics

The findings reveal a range of community dynamics, some of which have been touched on briefly above, i.e. community apathy and questionable leadership structures which have influenced the choice of selection processes undertaken by CHW Programme WCA. The interviews revealed other community dynamics such as selective community participation and competition in the context of poverty and job scarcity. All of these community dynamics are going to be explored to determine the way they influence the choice of a selection processes when recruiting CHWs in CHW Programme WCA.

CHW Programme WCA claims to have experienced difficulties when trying to involve the community in their selection processes with both the senior programme manager and CHWs respondents complaining that it is difficult to mobilize people to get together for mass community meetings. As such, the two CHW respondents from the current era (post-1994) claim to never having witnessed a community gathering for the selection of CHWs in their communities.

What is of interest to note is the fact that currently in South Africa there are constant reports of large turn-outs of the public for various public participatory meetings. Just recently, there was a report in the local news of a public turnout of 80 000 people in the rural Eastern Cape province in support of the country's ruling party (www.mg.co.za). This is one case that clearly contradicts the findings of this case study. So, what is the explanation when community members do not turn up for participation in development and health programmes? It is possible that the lack of interest in participating in health and development programmes is because people know that their presence will not be meaningfully appreciated or utilised (Botes & Van Rensburg, 2000).

In the case of CHW Programme WCA, it can be speculated that perhaps community members in the areas where the organisation is in operation are aware of the dominant role of local councillors and as such know that their voices as ordinary community members do not count for much during the selection of CHWs. It may also be that community members, whilst desiring the benefits of the programme, do not have the time that is demanded by community participation processes which are often lengthy and at inconvenient times, often after hours (Mngxali, 2006).

Selective community participation is that dynamic occurring when involvement of the community in a development project is only limited to the involvement of the special select few in the community (Botes & Van Rensburg, 2000). According to the programme manager of CHW Programme WCA, selective participation occurs whenever they try to initiate community involvement through the local ward (political) councillors. The councillors tend to limit community participation to themselves and their family members and thus prevent true community participation from occurring. An example of this is provided by the programme manager when she narrates an incident whereby councillors in Makhaza (Khayelitsha) nominated relatives for CHW posts, but the program manager then had to apply a stringent selection process that ultimately disqualified all of the relatives. Having noted this dynamic, the management of CHW Programme WCA claim to have been deterred from pursuing community participation processes when selecting CHWs.

This brings to bear questions about the appropriateness of the national policy for Community Health Workers' guideline on how CHWs should be selected. The policy on CHWs (NDoH, 2004b) states that CHWs should be selected through community participation to be enacted by the involvement of community leadership structures. These leadership structures would include politically formed leadership structures as well such structures as Community Health Committees (CHC) or Health Committees. The idea of using these community

leadership structures as the vehicle for community participation rests on the assumption that these community structures are representative of the community's diverse profile; are democratically elected by community members to represent them and represent as well as stand to benefit the interests of the community at large and not just their own. Adato et al's multi-fold study on community participation in public works programmes (Adato et al., 2005) established that working through such community leadership structures is preferred by most development programmes because the culture of collaborating with them is historical. As such facilitating community participation is more like a tried and tested approach. However, according to Botes and Van Rensburg (2000:49):

There is always the danger that decision-making at community-level may fall into the hands of a small and self-perpetuating clique, which may act in its own interests with disregard for the wider community

If current community leadership structures consist of politicised groups who are self-serving and preventing wider-reaching forms of participation in health and development, then the exercise of community involvement through such structures is wasted. The evidence suggests that in the case of CHW Programme WCA this is what has happened, further discouraging the organisation from pursuing community participation processes when selecting CHWs. It can thus be said that unless community leadership structures are screened for representativity of their communities and are further monitored to ensure that they open the participation process to the wider community, the involvement of such structures should not be taken to mean that community participation has taken place.

The other dynamic that CHW Programme WCA has been faced with is the reality of working in communities that are ravaged by poverty and high rates of unemployment. The organisation claims a lot of competition exists for CHW vacancies making it difficult to have community members who are willing to nominate others for the CHW posts other than themselves or their families. These communities have always been poor, even during the apartheid era when

community participation in CHW programmes was the order of the day, yet there were no problems of high competition for CHW vacancies. So what could be different between now and then? The difference lies in the way in which CHW work was regarded by communities in the past. According to the CHW respondents, pre-1994 CHW work was considered to be completely voluntary and altruistic. There was no expectation created for remuneration and as such community members happily nominated those they thought would best do the work. Currently, the emphasis of government stipends (at minimum R500-R1000 per month) in CHW programmes has created the understanding of CHW work as being *paid* voluntary work. In the context of poverty and unemployment, community leaders and general members alike all want the CHW positions for themselves or their unemployed family members. South African organisations such as COSATU have warned that if CHWs are remunerated by government, then it would be impossible not to have occurrences of nepotism and patronage during the selection process (NPPHCN, 1993b). Considerations for the socio-economic context under which the most extensive forms of community participation are expected to operate need to be made as poverty and unemployment challenge the notion of community participation processes that are free and fair during the selection of paid CHWs.

Programme Needs

Selection processes for the recruitment of CHWs also have to contend with programme needs. According to Adato et al., (2005) it is sometimes not feasible for organisations to involve their communities in the conceptualisation, planning and logistical implementation of their development programmes. This is often due to time constraints, prioritisation of technical (hard issues) rather than the process (soft issues) aspects of the programme and resource limitations. The programmatic needs such as immediate replacement of a CHW, have also meant that CHW Programme WCA sometimes does not have time to engage in a lengthy community participation process to select a CHW, leading to an organisation led, top-down type of selection process. In an era of donor pressure

to deliver on outcome indicators, sometimes compromising quality for quantity, the prioritisation of technical programme needs over laborious community participation processes is likely to become the reality.

The community dynamics and the programme needs that influence the choice of a selection model regardless of what organisational stance there is have now been discussed. There is now need to explore the role that government involvement in CHW programmes has played in the type of selection model that CHW Programme WCA applies when recruiting CHWs.

The Role of Government Policy and Involvement

It has already been established that post 1994 the South African government has gone from no involvement in CHW programmes to extensive involvement that comes complete with a national policy that provides policy directives for the implementation and management of CHW programmes.

Box 1 Key elements of the National South African CHW Policy (NDoH, 2004b)

- It allows for both generalist and single-purpose CHWs
- CHWs to 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 CHWs
- Although voluntarism will continue to be encouraged, volunteers should not be employed more than a few hours a week without remuneration. Volunteers should also not be misled into believing that they will necessarily get paid work.
- Training should be accredited, through appropriate learnerships.
- Trainees should be residents of communities where they will work and selected by those communities.
- CHWs should have a support system, e.g. be part of an NGO/CBO and have access to a referral system.
- Targets on households covered set for generalist CHWs

The findings from CHW Programme WCA reveal that the government's involvement in CHW programmes is found in the prescriptive selection criteria and in the stipends that government pays to CHWs. In the opinion of the CHWs, both the selection criteria as well as the stipends effectively make the national DoH their employer. According to the respondents, the perception that the DoH is their employer is informed by their experience that their year-to-year employment

is only possible when the DoH is willing to fund their stipends. To add to the dynamics, the CHWs also perceive the DoH to be aloof and distant. When asked about the DoH, the CHW respondents did not seem to have a grasp of what the DoH functions are (apart from the local community health centres) and reported that interactions between themselves and the DoH have never taken place.

According to Schneider et al., (2008) one of the central features that emerge from the national South African CHW Policy (NDoH, 2004b) and which is important to consider when discussing the status of CHWs in South Africa is their employment status. Although the government provides the infrastructure for CHW programmes, it has steered clear of becoming an employer of CHWs, as the CHW Policy Framework states that “CHWs are to receive a stipend but will not be government employees” (NDoH, 2004b: 6). This means that CHWs are not provided for by government regulatory systems that secure and protect the employment of civil servants. Because of this, the employment of CHWs has become highly casualised and thus insecure. This is quite a shift from the past norms of CHW employment in CHW Programme WCA as according to those CHW respondents employed prior to the government’s involvement, their employment was secure and stable. The practical implications of this relationship between the national DoH and CHWs is that CHWs are selected and recruited by one hand (CHW Programme WCA) and in their perception being paid by another.

Thus, it would seem that the relationship that the DoH has with CHWs is not without tension. What seems clear is that the existence of the merit driven selection criteria and the stipends make it difficult for CHW Programme WCA to facilitate community involvement during the selection of CHWs.

A provincial policy and planning review of CHWs in South Africa recommended that in the instance that CHWs are salaried workers, their salaries should be paid through Health Committees (Cruse, 1997) rather than directly by government or through non governmental organisations. This would promote community involvement in CHW programmes as well as the CHWs’ answerability to the

community that selected them and whom they serve. This would be minimise the perception of the dual accountability of CHWs as the appointer/selector would be perceived as one and the same as the remunerator.

It is thus necessary for government to examine their role in CHW programmes and where the relationship disables community participation in the selection of CHWs, then government should readjust their position.

Lessons learnt from the selection processes of CHW Programme WCA

There are several key lessons that emerge from the selection processes that CHW Programme WCA has followed over time, which can hopefully be used to understand the issue of selection better.

Community Participation: Challenges to the practical application of theory

The findings make a clear statement that when it comes to community participation, theory is very different from practice. The findings, rather than providing a simple narrative of how CHWs are selected reveal a more complex process, one that is unlike the straightforward textbook explanation that sees the selection of CHWs process as either a means or an end; bottom-up or top-down; utilitarian or empowerment driven. Rather, depending on the context that is informing the work of CHWs, what we see is some of each of the forms of community involvement in the top-down/bottom up participation continuum. Within CHW Program WCA, at times we see community participation that was once very comprehensive and community centred (bottom-up end). Currently, however, CHW Program WCA either recruits CHWs without any community involvement whatsoever (top-down end), or engages in a compromise that includes a bit of both ends of the participation continuum.

Lastly, we see that at times the intention to place community participation at the heart of all CHW organisational operations is there, but real life contexts marked by poverty, job scarcity and as such high job competitiveness challenge the

noble intentions, making it near impossible to involve the community in a way that stays true to the ideals of community participation.

Community Participation in the context of changing social and political landscapes

The findings reveal that at other times, community participation in the selection of CHWs may have been the only method of selection, until macro socio-political changes brought about change on the ground, challenging and redefining meanings attached to the understanding of community. Government stepped in to support with all the best intentions and perhaps misguided assumptions about what is needed to make CHW programmes community oriented. However, the unintended consequences of policy guidelines add rather than reduce the challenges to a community participation entrenched from of selection.

In conclusion, the selection of CHWs through community participation requires an enabling environment that takes into consideration the changes in socio-political landscapes of South Africa, the socio-economic realities within which CHW programmes operate and the consequences of government involvement. To this end, government guidelines on how CHWs should be selected need to be better refined and more specific than the current national Community Health Workers Policy Framework. More research needs to be conducted to better understand what is needed to facilitate community participation that is comprehensive and all inclusive.

CASE STUDY 2: CHW PROGRAMME KZNA

Brief descriptive background of the organisation

CHW Programme KZNA is a large community based health care organisation serving the rural regions of Kwazulu-Natal. The organisation has been in existence since the late 1980's and is affiliated to a larger international development organisation based in Maine in the United States. The larger parent organisation has eight key areas of intervention, namely: child survival;

HIV/AIDS, malaria treatment; architecture and engineering; orthopaedic and rehabilitation services; health sector reform; water supply and sanitation and health care financing. CHW Programme KZNA falls under the HIV/AIDS category through its work with CHWs who are Home Based Carers (HBC) for those bed-ridden with AIDS. The historical work of CHW Programme KZNA has been primary health care as well as HIV/AIDS research and intervention development. Until about 2 years ago, the organisation operated a home-based care (HBC) project for which they employed CHWs. However, in the last two years, due to policy changes by the National and KwaZulu-Natal Provincial Department of Health (DoH) regarding CHWs, the organisation has since narrowed its operations to only include training and preparation of CHW candidates for HBC posts. The provincial Department of Health in Kwazulu-Natal adopted a CHW strategy in 2004, whereby they started funding specific NGOs to run CHW programmes and in the process CHW Programme KZNA was relegated to the role of recruiting, training and referring CHWs in their database for employment by the government funded CHW NGOs. According to the respondents interviewed from the case study organisation, currently only community based organisations that are approved, funded and recognized by the KwaZulu-Natal Provincial DoH can run CHW programmes. By 2004 there were 4000 CHWs in the province with an additional 1000 CHWs targeted for recruitment for the year 2005 (www.kznhealth.gov.za/chw.htm). In the last year, CHW Programme KZNA has trained and deployed 150 CHWs as Home Based Carers in their district.

Outline of the Main Findings from the Documentary Analysis

CHW Programme KZNA declined to provide the researcher with organisational documents to review, citing that the organisation does not have updated informative documents. The organisation is part of an international community health and development NGO which has documents available online but there is not much mentioned in these about CHW Programme KZNA.

Main Findings from the In-depth Interviews

There are four main themes that emerged from the analysis of the in-depth qualitative interviews with the senior programme manager of CHW Programme KZNA and the organisation's one CHW⁸ referred to here as Mr H to ensure his anonymity (see Chapter 1 on ethical considerations for anonymity of respondents). The following section is going to outline these findings, stating the main themes as well as sub-themes. The four broad themes of the findings are: The selection of CHWs; Determinants of Selection Process; Challenges to Selection; and the Role of Government Involvement and Policy

Selection of CHWs: Historical and Current Selection Process

The culture around the selection of CHWs in CHW Programme KZNA is marked by two periods in the life of the organisation: pre-1994 when there was no government involvement in the selection of CHWs and the current era of government involvement in CHW programmes. These two periods informed the selection of CHWs in different but also very similar ways.

The Historical Selection of CHWs

During the period prior to the National and provincial DoH's involvement in CHW Programmes, CHW Programme KZNA selected CHWs according to three factors: the voluntary status of CHWs; involvement of tribal councils and health committees; and pre-defined selection criteria.

Voluntary status of CHWs

CHW Programme KZNA selected, trained and conducted their work with CHWs on the basis of their voluntary status. According to the senior programme manager of the organisation, these volunteers were not remunerated for their work. Thus, when the organisation went out to solicit the counsel of tribal

⁸ Attempts to get hold of the second CHW who had agreed to be interviewed failed as there was no reply to the calls made to her. There were logistical challenges to arranging a replacement CHW as the researcher is not based in Kwazulu Natal but based in the Western Cape.

authorities on whom to recruit, it was clearly explained that this was for a caliber of people who would work as volunteers.

Involvement of Tribal Councils

Tribal councils were consulted through a process that would see NGO staff advising the councils of their CHW programme and their need for people in the community to train as CHWs fulfilling particular criteria. The tribal councils would then select whomever they thought would make a good candidate.

... at that point...it was left to the tribal councils to select who they thought were good candidates

According to the programme manager, the consultation and use of tribal councils seemed to be the culture at the time as even other CBOs working with CHWs would approach the councils, understanding them to be opinion leaders in the community. The popularity of the use of tribal councils should not however signal an inclusive flawless community involvement process. According to the programme manager, the organisation made use of the councils but soon realized the tribal authorities were not opening up the process of selection to the whole community for participation, but instead made the process exclusive and non-transparent. The program manager's experience is that under these circumstances, nepotism flourished with tribal councillors choosing friends and family as CHW candidates.

Here is how she put it:

...Now what is happening is in the communities the local councils were making decisions without consulting the rest of the communities...They were choosing friends and family so that you ended up with people who were not suitable for the job or didn't know how to do the job, and the people that we'd been working who'd been trained would be overlooked because of ...that was the situation there...

Defined Selection Criteria

The organisation recruited CHWs based on NGO established selection criteria. However, the interview did not reveal much about what these criteria were; suffice to say the organisation used criteria that they themselves had established. The tribal councils would be mandated with selecting CHWs using these criteria.

The Current Selection of CHWs

Post 1994, when government gradually began formulating policies and programmes for CHWs, CHW Programme KZNA also changed their approach to selection. According to the programme manager, factors that largely stem from the DoH policy on CHWs, meant that:

- (1) CHWs are remunerated by the DoH through the stipends that are paid to CWH organisations;
- (2) DoH sets the selection criteria that CHWs have to fulfil to be eligible for employment for the stipend programme;
- (3) CHW Programme KZNA no longer makes use of volunteers but instead trains prospective CHWs, keeps them on their database and readies them for entry into the DoH stipend employment programme;

...we are especially preparing people who are obviously volunteers to be selected for the DoH stipend programme through these CBOs

- (4) CHW Programme KZNA acts as a middle-man in the selection of CHWs for CBOs that DoH has appointed to employ CHWs through the stipend programme. CHW Programme KZNA selects, trains and then recommends their CHWs for employment by these DoH commissioned CBOs.

...in our district there are now 3 CBOs who have been selected and are being funded, who are now administering stipends for 20 home based care volunteers each. So we are working with them to help them select people...

(5) CHW programme KZNA has more CHWs that are trained and ready for entry into the DoH stipend programme than the DoH is currently able to absorb. This means that at any one time there is always a pool of trained CHWs that are in CHW Programme KZNAs database from which CHWs can be selected. Thus, the opportunity to go and search for CHWs through the community is minimised.

An in-depth interview was conducted with one CHW who had received training from programme KZNA during the current era. He is referred to as Mr H. The interview revealed the following:

Mr H is in his mid twenties and has been working as a CHW since 2006. Mr H claims to have been drawn to the work of Home-Based Care since he was a high school student. After he had finished his matric studies, an aunt informed him about a local organisation, CHW Programme KZNA that was taking on volunteers and training them on HBC work. Mr H formally joined the organisation and received training. His selection as a volunteer involved only the organisation, whereby he presented himself at their offices and was promptly offered a voluntary position. After a year with CHW Programme KZNA, the organisation then found him a CHW post in a government appointed HBC organisation. Mr H then began working for this organisation and has continued working for them until now. Mr H also mentioned that he is paid a government stipend of R500 per month.

When asked about what he thought of the way in which he was selected, Mr H expressed satisfaction claiming that he knew of no other way to select and employ CHWs. He claimed to have never witnessed any other method of selection for CHWs. Mr H also considered himself as more of a DoH employee, and claimed this perception was due to the fact that DoH are paying his stipend and the organisation that is managing him is funded by the DoH. However, Mr H also confirmed that he was not certain about his employment status with DoH due to the department's aloofness in its interaction with CHWs. Mr H claimed to

have never personally interacted with the DoH, hence the perceived aloofness. Mr H also reported to work in the same community where he was born and grew up in.

Involvement of Tribal Councils and Local Councilors

According to the programme manager, CHW Programme KZNA continues to consult local tribal councils when selecting CHWs but to a lesser extent and in a more cautious rather than the unrestrained manner of earlier times.

...we still use tribal councils but we try not to overly politicise it...so we do it quietly...

According to her, this new way of relating to the tribal councils is informed by the organisation's past experience of nepotism and limited community involvement in tribal council led selection processes. The involvement of tribal councils is now limited to having the already selected CHWs introduced in their council meetings. Mr H also confirmed that, whilst there was no community involvement of any kind in his selection as a CHW, upon employment he was formally introduced to the community by old generation CHWs from CHW Program KZNA during a community meeting. Mr H claims the introduction eased his entry into the community as a result.

Challenges to the Selection of CHWs

The findings revealed a number of impediments and challenges that CHW Programme KZNA has experienced in the selection of CHWs through community participation processes. These are: lack of selection guidelines; community dynamics; selective community participation; and the context of poverty and unemployment in which CHWs are selected.

Lack of Selection Guidelines

In the current CHW era, where the DoH is playing the critical role of employer, the programme manager claims that there are no clear guidelines on how CHW organisations should select their CHWs. Whilst in the past CHW Programme KZNA followed selection processes that they had determined themselves as an organisation, the DoH which is perceived to have assumed regulatory powers over CHW programmes in the province, have not provided any blueprint of how selection should be done under their leadership. According to the programme manager, CHW Programme KZNA has consequently moved away from the use of tribal councils as their main selection mechanism, and have themselves become the selectors of CHWs for DoH stipend programmes. The programme manager reports that they now select CHWs through word of mouth, or by going through their established database of unemployed CHWs that they have trained and who are available for the work. Mr H also reported a similar experience of selection. Having been referred to the organisation by a relative, he received training and after volunteering for some time was placed with one of the NGOs running CHW programmes under the DoH programme as a paid CHW.

Community Dynamics

Working with communities in the selection of CHWs revealed a few things for CHW Programme KZNA namely: the lack of organised community structures; nepotism; and selective community participation.

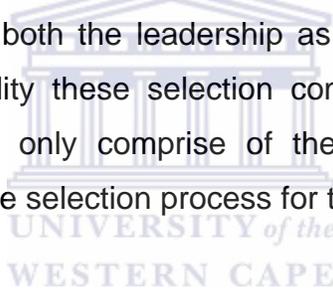
With respect to the lack of organised community structures, CHW Programme KZNA reported that they sometimes encountered difficulties in involving communities in the selection of CHWs due to the lack of organised community structures. The programme manager did not elaborate on this challenge other than to say:

...The community doesn't always galvanise to get together in a decision making process...

With respect to nepotism, the programme manager claimed to have had experiences whereby tribal councils would nominate CHWs through nepotistic processes. The organisation found that sometimes tribal councils would favour friends and family members in the selection of CHWs. According to the programme manager tribal councils:

... were choosing friends and family so that you ended up with people who were not suitable for the job or didn't know how to do the job, and the people that we'd been working who'd been trained would be overlooked because of eh...that was the situation there...

With respect to selective community participation, the programme manager of CHW Programme KZNA also reported that tribal councils would be tasked with ensuring that the community is well represented in the selection committees through the involvement of both the leadership as well as ordinary community members. However, in reality these selection committees became elitist and exclusive clubs that would only comprise of the councils and thus limiting community involvement in the selection process for the recruitment of CHWs.



Context of Poverty and Unemployment

Of the difficulties cited by the programme manager of CHW Programme KZNA, the poverty and unemployment context within which the CHW programme works was cited as being the most challenging. The programme manager claimed that the CHW programme goes to great lengths to ensure that all of their candidates are aware that the organization only offers training and preparation for possible but not guaranteed selection by the DoH's stipend programme as a CHW. However, she also reported that a lot of the community members who report for training as prospective CHWs remain expectant that the organization is going to remunerate them during the time that they are awaiting referral to and employment through the DoH stipend programme. The programme manager reported that the unmet expectations for remuneration result in high attrition rates from the training programme as soon as CHW trainees become aware that there

is no remuneration from the project. This is how the programme manager detailed the challenge:

The only difficulties are that people come along expecting to be paid and we have no...we don't offer a stipend and we don't guarantee that there'll be in line to receive a stipend from the DoH... whether we expect it or not...people who are barely scraping by, I don't blame them. But sometimes it is not clear to those people that they are not in line to get a stipend out of this... It's very difficult...we have [high] attrition in that way

Furthermore, according to the programme manager, the high attrition experienced as a consequence of the trainees' inability to stay with a programme that offers no remuneration has made it difficult for the organization to select for training everyone who shows up at the organization applying for training. As such the organization prefers to first ascertain that the applicant is willing to participate in the training programme and in CHW programmes for altruistic purposes rather than income.

Government Involvement

According to the programme manager, the Kwazulu-Natal provincial DoH pays stipends to CHWs through commissioned CBOs and NGOs.

...in our district there are now three CBOs who have been selected and are being funded by the DoH, who are now administering stipends for 20 home based care volunteers each. So we are working with them to help them select people...

The role and function of CHW Program KZNA then becomes that of selecting, training and referring CHWs to these NGOs that the programme manager claims are selected and funded by government to run CHW programs. According to the programme manager:

...we are especially preparing people who are obviously our volunteers to be selected for the DoH stipend programme through these CBOs...that's a new relationship, we are working on that now...

This has influenced so many aspects of CHW Programme KZNA and CHW programmes in the region including the aspects of selection and recruitment of this calibre of lay health workers. The different ways in which the provincial DoH's involvement in CHW programmes has affected selection processes will be covered in more detail in the discussion section which follows.

Discussion of Findings

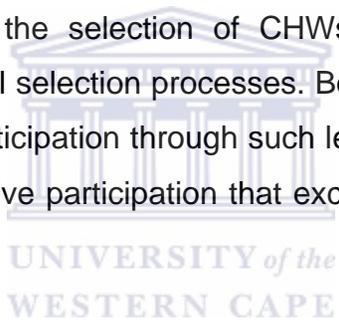
The following discussion is going to largely focus on those themes in the analysis of CHW Programme KZNA that are different from those discussed in the analysis of CHW Programme WCA. The themes that describe the selection of CHWs in the organisation are the historical versus the current selection norms of CHWs, and the challenges to the selection process of CHWs and government policy. The first theme contains findings similar to those of CHW Programme WCA and as such will only be discussed briefly. The second theme on government policy, brings with it slightly different findings as it reflects a DoH-NGO partnership that has not been seen in CHW Programme WCA. The structure of the discussion is thus going to be as follows: first the discussion of the historical versus the current selection norms of CHWs; followed by the discussion of the challenges to the selection process of CHWs and ending with the discussion of the role of government involvement in CHW programmes, with particular attention to the government-civil society partnership that is portrayed by CHW Programme KZNA's selection of CHWs.

The Historical vs. Current Selection Norms for the Recruitment of CHWs

The evidence gathered from interviews with CHW Programme KZNA respondents suggests that there is a difference in the current way in which CHWs are selected by the programme when compared to the selection process of the past. The defining time periods are marked by two historical changes in South Africa and in CHW programmes: the political independence of South Africa in 1994 and the subsequent involvement of the new government in CHW

programmes which culminated in the nationalisation of CHW programmes and the release of the national policy on CHWs in South Africa.

The evidence suggests that historically CHW Programme KZNA selected CHWs through community participation driven processes that involved local leaders in the form of tribal councils. The tribal councils engaged in the selection processes of recruiting CHWs by proposing names of those community members that the community would have nominated to stand as CHWs. According to the programme manager, currently, the involvement of the community in the selection of CHWs is limited to tribal councils being informed of CHWs that have already been recruited by CHW Program KZNA independent of community participation. The reasons given by the programme manager for the diminished community involvement in the selection of CHWs were nepotism and non-transparency of tribal council selection processes. Botes & Van Rensburg (2000) confirm that community participation through such leadership structures as tribal councils are prone to selective participation that excludes the ordinary members of the community.



The programme manager also reported that the communities where CHW Programme KZNA operate do not “galvanise to get together in a decision making process anymore”. This is likely to be one of the deterrents that has reduced the level of community participation in the selection of CHWs for programs run by CHW Program KZNA. According to Lehmann & Sanders (2007: 27):

...community mobilization precedes and accompanies the establishment of CHW programs..

Interestingly, traditional concepts of CHWs see these cadres as more than just functionaries of the health system, but as liberators and community mobilisers (Weiner, 1981). However, the evidence from this case study suggests that in the communities where CHW Programme KZNA operates, CHWs do not mobilise communities for action. Perhaps the role and functions of CHWs should be

revisited in the context of communities that are transient and as such difficult to organise for participation without a catalyst or facilitator.

The other key feature in the case study findings is the role played by the changes in the political landscape of South Africa post independence. The DoH in KwaZulu-Natal classifies CHWs into two categories: those employed prior to 1994 and those employed after the restructuring of Health Services (www.kznhealth.gov.za). The DoH makes this categorisation because of the impact that the political changes had on CHW programs. Firstly, according to the official documents of the DoH in KwaZulu-Natal, the DoH pays different stipend scales depending on which side of history CHWs fall: those employed pre-1994 (termed Ex-KwaZulu group by the department (www.kznhealth.gov.za) earn the highest amount at R2046.88 per month; those contracted to the NGOs are paid R1448,00 per month; and those employed after August 2004 are paid R1000.00 per month⁹.

According to the programme manager of CHW Program KZNA, the provincial DoH implemented their “stipend program”¹⁰ by selecting certain NGOs in the province to run CHW programs. The selection of CHWs in the province has changed since then because CHW Programme KZNA now selects CHWs for all government contracted NGOs.

The following section on government involvement in CHW programmes will continue this discussion more robustly.

Government Involvement in CHW Programmes

The provincial DoH in KZN assumed involvement in CHW programmes in 2004 when they began funding the stipends of CHWs. According to the programme

⁹ The official website of the DoH in KwaZulu-Natal does not provide reasons for the different stipend scales.

¹⁰ According to the policy on CHWs (NDoH, 2004b) and the programme manager, government funded NGOs are paid monthly stipends of a minimum R1000 per CHW per month, which are then paid as monthly remuneration to CHWs. However, according to the CHW interviewed for the case study, he earns R500 per month.

manager of CHW Programme KZNA, until then, the organisation selected CHWs through extensive community involvement strategies. CHW Programme KZNA determined the selection criteria, determined the selection approach and agenda and ran CHW programmes in KZN. The DoH stepped in, revised the selection criteria, selected and started funding specific NGOs in the province to run CHW programmes. CHW Programme KZNA became the government approved NGO recruitment agency for CHWs.

Thus, the modus operandi of CHW Programme KZNA shifted in 2005. Previously the organisation's main function was to run CHW programmes and that meant their work was centred on selecting CHWs, training them and managing their CHW day to day work. Currently the organisation's function is to train new CHWs, keep them and those previously employed by the organisation on their database of unemployed but skilled CHWs. According to the programme manager of CHW Programme KZNA, they then refer those CHWs who are in their database of the unemployed to the government approved and funded NGOs which run CHW programmes in the province. This means that NGOs which run CHW programmes in the province no longer have to go to the individual communities and involve them in the selection of their CHWs, instead they have a convenient 'CHW recruitment agency', namely CHW Programme KZNA at their disposal which they refer to when employing CHWs. Furthermore, this arrangement relegates the position and function of CHW Programme KZNA to that of middle-man in the DoH-NGO partnership and effectively eliminates the involvement of communities in the selection of CHWs.

This mini-thesis thus argues that government involvement in CHW programmes in Kwazulu-Natal has had the unintended consequences of undermining and effectively eliminating all opportunities for community participation in the selection of CHWs. Interestingly, government-civil society partnerships are often conceived as the much needed bridge between the government and grass-roots communities. This assumption is based on the premise that the government has

a broad mandate which cause for their interactions with civil society to be limited to the broader, macro level, whilst civil society organisations often have their foundations in the local community as well as easier access to community trust and knowledge of community norms (Howell, 2007). It is thus imagined that civil society organisations are able to complement the work of government by facilitating people-centred and participatory service delivery. However in this case study, in the selection of CHWs, the NGO-government partnership in Kwazulu-Natal has not delivered on these assumptions. There is evidence that suggests that these promises of participatory development that are attached to the concept of NGO-government partnerships are emerging as undelivered in other parts of the world as well. Howell et al., (2007:7) of the London School of Economics, authored a Civil Society Working Paper which examines the nature of civil society in the contemporary global development arena, and assert that:

The claims of NGOs to representativeness, comparative effectiveness, to operating democratically and their proximity to their constituencies/clients are being challenged...

In this case study we find that community participation has been replaced by prescriptive government participation in CHW programs. Adato et al., (2005) argue that prescriptive government involvement in development programmes sometimes becomes a “plague” to community participation, because it limits rather than broadens the scope for the community’s involvement. Furthermore, although the national policy for Community Health Workers (NDoH, 2004b) states that the selection of CHWs is to be undertaken through community participation, the policy limits the facilitation of community participation to NGOs and CBOs. The policy does not mention anything further about community participation in the selection of CHWs and according to the programme manager of CHW Programme KZNA, the DoH does not provide any explicit guidelines on how organisations are to select CHWs. As such, CHW Programme KZNA select CHWs in the way that is most convenient for them and currently that means with little to no community involvement.

Another interesting side to the government-civil society partnership is the fact that according to government legislation, non-government organisations are meant to maintain an existence that is completely separate from government. However, in the case of the KwaZulu-Natal Provincial DoH, government's involvement in CHW programmes extends to contracting CHW NGOs to implement CHW programmes (www.kznhealth.gov.za). The evidence and the KZNA DoH documentation on CHWs (www.kznhealth.gov.za), suggest that the relationship between the DoH, CHW organisations and the community is a hierarchical one, with the DoH as the head of the hierarchy selecting, contracting and paying NGOs to implement CHW programmes. Government contracted CHW NGOs then refer to CHW Programme KZNA to select CHWs; CHW Programme KZNA then refers to their database of CHWs whom they then recruit for the government contracted CHW organisations and the community gets informed of the CHWs appointed by CHW organisations. In this sense the role and the involvement of the community in the selection of CHWs in Kwazulu-Natal, has been compromised and minimised to only being informed of CHWs that the organisation has hired. In the words of Botes and Van Rensburg (2000: 5) in this case study community involvement is limited to "telling people what you are going to do by asking them what they think about it"

Lessons learnt from the selection processes of CHW Programme KZNA

There are two key findings from the KZN case study: CHW Programme KZNA used to involve the community in the selection of their CHWs, but they no longer practice community participation and at the heart of this shift is the Provincial Government's involvement in CHW programs and with it the civil society-government partnership that now characterises CHW programme funding and implementation. Through this partnership, a previously well established CHW implementation programme (CHW Programme KZNA) has been turned into a CHW training and recruitment agency, thus eliminating the opportunity for CHW NGOs to approach communities for the selection of their CHWs.

Thus, in conclusion, government involvement in CHW programmes in Kwazulu Natal has eliminated rather than enhanced community participation in the selection of CHWs. Whilst government-civil society collaborations are clearly desirable, in this context they have redefined the function and processes of CHW organisations at the cost of the very community participation principles that are emphasised by government policy on CHW programmes. Furthermore, the lack of clear protocol on how organisations are to select CHWs in the context of this new government-civil society partnership undermines the CHW policy's emphasis on selection processes that are facilitated through community participation.

CASE STUDY 3: CHW PROGRAMME WCB

Brief descriptive background of the organisation

CHW Programme WCB is not a CHW programme per se, but rather a research project that existed as a large randomised control trial in 2 provinces in South Africa (the Western Cape and KwaZulu-Natal) between 2004 and 2007. However, for the purposes of uniformity and coherence of the reporting on case studies, the research project will be referred to as CHW Programme WCB. The project conducted research in the area of maternal and child health through the use of CHWs who acted as peer supporters to pregnant women and mothers of infants. The project is no longer in operation but the former project manager and 2 CHWs in the Western Cape province were available for qualitative interviews.

Main Findings From The Documentary Analysis Of CHW Programme WCB

CHW Programme WCB provided published papers and excel spreadsheets with programme statistics on numbers of CHWs employed; number of CHW trainings provided and numbers of participants recruited in each of the three research sites. However, the published material does not report on the selection processes of CHWs in each of the 3 provinces, it only reports on numbers of

CHWs, participants and research methods, analysis and results. The documents report that there were 38 CHWs recruited and employed across all of the study sites, 10 in the Western Cape and 14 each at the two sites in KwaZulu-Natal. A 40 hours long training workshop was provided over one week along with one observation of each of the CHWs during home visits and on going supervision. According to the documents, the work of the CHWs entailed recruiting local pregnant mothers for a maximum of 5 home visits (1 prenatal visit; 4 postnatal visits) during which they supported and counselled mothers on how to maintain exclusive infant feeding.

Main Findings From The Qualitative Interviews

There are three main themes that emerge from the analysis of interviews conducted with the senior management and CHWs of CHW Programme WCB. The themes are: the selection and recruitment of CHWs; determinants of selection; and community acceptance. These themes are going to be outlined below and following this a discussion of their implications for CHW programmes will then ensue.



Selection and recruitment of CHWs

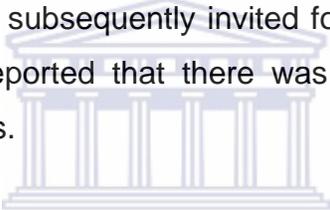
The project manager interviewed for this case study reported that CHW Programme WCB selected their CHWs by inserting advertisements in local newspapers, and local health centers. The advertisements invited candidates with Grade 12, who were interested in child health, who were women residing in the community, and who had a good reputation, to apply for positions as CHWs in the organisation. According to the project manager:

...the women had to reside in the cluster that they were going to do their interviews in...we wanted women who were interested in child health, and eh women who were respected within their communities...people had to have Matric...

The project manager reported that after issuing the call for applications, the organisation then waited for all applications to come through, after which

applicants were short-listed and invited to come for interviews. The interviewing process consisted of reading and written assessment tests, role plays and detailed questioning. The panel would then score candidates during each exercise and the highest scorers were chosen as CHWs. Thus, performance during interviews ultimately decided who became a CHW and who did not.

The interviews conducted with two former CHWs of CHW Programme WCB, one a Black African middle aged woman and another a Coloured young woman in her mid-twenties, confirmed these findings. These two CHWs were based in the Paarl (Western Cape) study site of the research intervention. They reported to have been recruited by the organisation in 2005, after having come across CHW vacancy advertisements in the local newspaper as well as clinics and hospitals. They both applied and were subsequently invited for interviews which they both passed. The CHWs also reported that there was no community participation during their selection process.



Determinants of Selection UNIVERSITY of the

According to the project manager, CHW Programme WCB, which belongs to a research organisation, has strict organisational procedures that are generally followed in the selection and recruitment of staff. The project manager stressed that the selection process was thus largely determined by organisational protocol rather than theoretical guidelines on the selection and recruitment of CHWs. The organisation held internal meetings to discuss what their selection criteria would be and how they would go about recruiting the CHW candidates. The end result was that the selection process remained wholly confined to the organisation and the research team and never involved outsiders, be it community members or any other community stakeholders.

Organisational priorities also seemed to play a determinant role in the choosing of selection methods for the recruitment of CHWs. According to the project manager, CHW Programme WCB was guided by their organisational priority to

ensure that the process of selection was executed efficiently and in the shortest time possible. Thus they chose a selection approach (advertising CHW vacancies) that could be implemented without too many hassles (as opposed to those approaches that involve community mobilisation for instance). The project manager reported that organisation's other priority was to ensure that they were seen as being a credible institution by the communities in which they were going to be working in. To this end, they ensured that in their selection teams they combined local staff members with those from outside the geographic area (from other provinces). They also ensured that they remained consistent in the way they conducted the interviews, to ensure that the candidates ultimately selected would never be thought to have been selected in a biased manner.

Community Acceptance of CHWs

One of the issues explored in the interviews with CHWs was the one regarding their reception and acceptance by the communities where they were working. The one CHW reported to have gone to all the local clinics in her township and introduced herself and her work to pregnant mothers sitting in the waiting rooms (her client group). The CHW also reports that when she started conducting her visits to pregnant mothers' homes in the community, whilst she found that most homes were welcoming, a few were suspicious and wary of her. The CHW put their suspicion down to the fact that lay health worker home visits in the community had come to be associated with HIV, i.e. those who were visited by lay health workers were assumed to be HIV positive with the risk of being stigmatized. After a few months the CHW managed to establish her role in the community as a maternal and child health lay health worker and thus disproved suspicions that she was an HIV patient advocate.

The second CHW that was interviewed also reported to have started out in her job by visiting hospitals and clinics in her local community. She claims to have experienced only warmth and positive regard from the homes that she visited. The CHW put the community's warm reception and acceptance of her to the fact

that she was working in the same community where she grew up and was still a member. She also claimed that hers is a small community where everybody knows everybody else and as such all of her clients were familiar faces that she did not have to introduce herself to.

Discussion of Findings

The discussion entails an in-depth exploration of the themes identified in the outline of the findings above. The main themes that are discussed are organisational type and community acceptance.

Organisational Type

The one key factor that has informed the selection of CHWs in CHW Programme WCB is the type of organisation that the programme exists as. The CHW programme was implemented by a research organisation that operates within strict organisational boundaries. This in turn has informed the kinds of priorities that the organisation concerns itself with and these are efficiency, execution of organisational tasks within limited time-frames, and the pursuit of research outcomes rather than process. As such, CHW Programme WCB did not concern themselves with observing community participation norms of selection when recruiting CHWs. Instead they applied the norms of recruitment that the organisation normally follows when employing new staff. Community participation was not part of the agenda as the concept and practice did not fit in with their organisational priorities. Adato et al (2005) have argued that community participation is not always seen as ideal in the implementation of development programmes. In fact, due to the iterative, unpredictable, dynamic and time consuming nature of community participation, it is sometimes a real challenge to implement it in the context of deadlines and technical rather than process oriented priorities (Oakley, 1989). The evidence suggests that CHW Programme WCB prioritised efficiency and the meeting of their research outcomes rather than embarking on time consuming processes such as community participation. In this sense, the implementation of the CHW programme by CHW Programme

WCB reflects a product and hard-issues driven implementation approach (Botes and Van Rensburg, 2000). According to Botes & Van Rensburg (2000), when implementation is product driven the main emphasis is on outcomes and efficiency (the 'hard' issues), as such considerations for what is often a comprehensive, time-consuming and often complex community participation process is not prioritised. The main priority is getting the work done and the community may participate only as far as their involvement meets the project objectives for outcomes and efficiency. In the case of CHW Program WCB, community participation went only as far as involving the purposefully selected community members as beneficiaries of the programme. This is also referred to as "community-renting" (Botes & van Rensburg, 2000:46). The inverse of this is community participation that is process driven where the priority is not just on *getting there* but on *how* we get there. As such ensuring maximum and in-depth involvement ('soft issues') of the target communities in their own development is emphasised.



The question to ask in such situations as presented by CHW Programme WCB is whether they lost anything by not involving the community in their selection of CHWs. This is because, according to the theory of CHW programmes, community participation involves more than just giving communities the right to select CHWs. It also enables community acceptance and buy in of CHW programmes without which they may flounder. To explore this dynamic, we are going to look at community acceptance of the CWH programmes that CHW Programme WCB implemented in their research sites.

Community Acceptance

According to the 2 CHWs that were interviewed and who were based in the Western Cape province, their communities did not reject them or become unwelcoming when they began to practice as CHWs even though the communities did not have any involvement in their selection. The findings suggest that their acceptance was enabled by two factors: the small size of their communities which meant that the CHWs were known by everyone in their

community, and the CHWs introduction of their work to target client groups in hospitals and clinics prior to commencing their work. This suggests a middle ground in community participation, whereby the process is largely inclined to the top down end of the selection continuum and yet community buy-in of the community is achieved because of the community make-up (small size) and because of the introduction of the programme to the community in a group context.

The above suggests that community acceptance was enjoyed by CHW Programme WCB in the Western Cape province despite their top down approach which goes against conventional theory on CHW programmes and community participation. However, further interactions with the organisation outside the thesis data collection phase have suggested that the programme was not accepted at all research sites where it was implemented (Personal Communication with research team, 2008; Barni et al, 2009, paper submitted for publication). A sub-study (process evaluation) that was conducted in 2006 by the research organisation when the programme came to an end, revealed that in the two research sites located in bigger communities in Kwazulu-Natal (one a large township of more than 1 million population, and the other a large rural settlement) the programme faced challenges in terms of community buy-in and acceptance. The CHWs reported difficulties in entering households due to mistrust by residents as well as superstitions involving witchcraft and jealousy. Further exploration of these findings revealed that the cultural context of these communities is such that there are superstitions around pregnancy as there are perceptions that pregnant women are vulnerable to witchcraft. Hence pregnancy is often hidden until it is showing and even then the details about it such as the number of months are kept as a closely guarded family secret. These dynamics manifested in the form of community members either refusing to participate in the CHW programme or accepting invitation to participate but then giving wrongful information on home addresses and times of availability. These factors acted as impediments to the successful implementation of the programme in these two

sites with the result that the programme in the end showed no effect on key research outcomes.

Lesson's learnt from the selection processes of CHW Programme WCB

The main lesson learnt from this case study is that community participation in CHW programmes is confirmed to be relevant and necessary to ensure programme acceptance and uptake. However, perhaps the assumptions that all programmes are suited to comprehensive community participation need to be re-examined to take into consideration contextual factors that may challenge the approach when implemented in certain forms that do not take into account organisational type, organisational priorities and local community dynamics. The evidence suggests that a middle ground is reached when, having failed to involve the community comprehensively at the selection stage, efforts are made to introduce CHWs and the programmes they are running to community groups from the onset.

Thus, the argument is made once again that community participation should not be seen as an either/or type of process; as a top down versus bottom up approach, but rather as an iterative process to be implemented according to contextual realities that cater for all priorities of the organisation. This means that the pursuit of community participation requires compromises to be made whilst upholding the ideals for citizen involvement in their own development.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

INTRODUCTION

This chapter will first provide a summary of the key findings that have emerged from the three case studies conducted to describe community participation in the selection processes that are followed in the recruitment of Community Health Workers (CHWs) in South Africa. It then provides an exploratory discussion of recommendations as a response to the findings discussed in Chapter 4, and finally provides conclusions.

SUMMARY OF KEY FINDINGS

The three case studies have yielded a wide range of findings about the way in which CHW programmes select CHWs in South Africa. The main findings suggest the following:

- The selection of CHWs in South Africa has a past and present nature to it: the period prior to the country's political independence and government involvement in CHW programmes, and the period post the country's political independence
- The current processes of selecting CHWs in South Africa are different from the ones prior to SA's political independence and prior to government's involvement in CHW programmes.
- The past saw the selection of CHWs conducted through community participation-driven selection processes, albeit not without weaknesses such as nepotism and selective participation.
- Currently, the selection of CHWs has inconsistent patterns of community participation as selection processes are sometimes bottom-up and sometimes top-down, though in the case studies there is more evidence of the latter than the former.
- The negative experiences of community participation-led selection processes such as nepotism, selective community participation; the

perception of low community activism/community disorganisation; and the perception of illegitimate community leadership structures are cited as reasons for the lack of community participation in most of the selection processes that the case study CHW programmes engage in.

- The lack of government guidelines on how CHW Programmes are to select CHWs is another cited impediment to community participation led selection processes.
- The selection processes of some CHW programmes, i.e. in the CHW Programme KZNA and in the CHW Programme WCB case studies, have settled for a middle ground in the community participation continuum, which is neither bottom-up nor top-down but a compromise of both ends of the continuum. This middle ground is expressed by the introduction of non-community selected CHWs to communities where they are meant to practice at the beginning of their work.
- The evidence from CHW Programme WCB suggests that community acceptance of newly appointed CHWs is constrained when there has been no community involvement in the selection of the cadres. However, the same case study as well as CHW Programme KZNA also suggest that community acceptance of newly appointed non-community selected CHWs is possible in community settings where the size of the community is small, not transient in nature and where CHWs are introduced to the community at the start of the programme.
- Key determinants of selection include community dynamics; organisational priorities and the extent and nature of provincial and national government involvement in CHW programmes
- The NGO-government partnership that is evident in CHW Programme WCA and CHW Programme KZNA suggests that the arrangement has had negative consequences for community participation in the case of CHW Programme KZNA. According to the case study findings, through the provincial DoH-NGO working arrangement in Kwazulu-Natal, CHW Programme KZNA went from being an implementer of CHW programmes

to being a recruiter and trainer of CHWs for government selected and approved NGOs in the province. The result has been that CHW NGOs in the region no longer have to select CHWs themselves- thus missing the opportunity to involve the communities which they serve- but simply refer to CHW Programme KZNA who select CHWs from their pool/database of unemployed and trained candidates that they largely selected by word-of-mouth.

POLICY AND PROGRAMME RECOMMENDATIONS

Public policies are known for their “jelly-like nature.....like seashells with no apparent beginning and end” (Cloete & Wissink, 2000: 25) and their processes for being iterative rather than linear. Furthermore, public policies are known to be hypothetical statements of intent, which are not cast in stone as truths that cannot be contested, but are rather evolutionary ideals subject to alteration in response to an ever changing policy environment (De Coning & Cloete, 2000). The same can be said about the development of the national CHW policy in South Africa. According to Schneider et al., (2008), the development of the national CHW policy that was released in 2004 followed a fluid, incremental and organic process rather than a straight forward one, which saw the coming together of various actors in the lay health worker sector who then participated in the development process of the policy. The development process of the policy experienced fits and starts as the African National Congress vied between expressing a keen commitment to establish national CHW programmes as part of their strategy for the transformation of what was a highly inequitable and fragmented public health sector but later expressed a relative disinterest in CHW programmes after the democratic elections in 1994 (Mark & Bachanan, 1997). This changed over time, however, and 2004 saw the eventual release of the country’s first national policy for CHW programmes.

The national policy on CHWs emphasises the role of community participation in the selection of CHWs through three statements that are made in the policy.

First, the policy recommends that where CHW services are integrated into provincial health system activities, government chosen NGOs should ensure the involvement of the community in the selection of CHWs (NDoH, 2004b). Second, the importance of community participation is stressed again when the policy states that mechanisms¹¹ will be put in place to ensure that CHWs are selected through community participation processes. The third pronouncement about community participation is made when the policy states the selection criteria for CHWs and adds that community representatives should be involved in the selection of CHWs (NDoH, 2004b). However, there is little in the policy about how community participation is going to be facilitated and manifested in the selection of CHWs. Furthermore, the evidence gathered from the three case studies that have been examined shows that there are many challenges that have made it difficult to “translate progressive national policy into effective provincial and local practice” (Tollman, 2002: 1726). In particular, the evidence suggests that the NGO-government partnership model does not necessarily lead to the community participation-driven selection processes that the policy envisaged.

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In light of the findings of the three case studies, the following recommendations are suggested:

- The NGO-government partnership model applied in the implementation of CHW programmes in South Africa should be revisited to take into consideration deliberate and strategic ways of applying the model in such a way that community participation in the selection of CHWs will be realized. One such way could involve setting community participation in the selection of CHWs as part of the criteria for NGO approval for government funding. Another way could be setting the involvement of communities in the selection of CHWs as one of the key outcome indicators upon which the service delivery of government funded NGOs is assessed.

¹¹ These mechanisms are not elaborated by the policy.

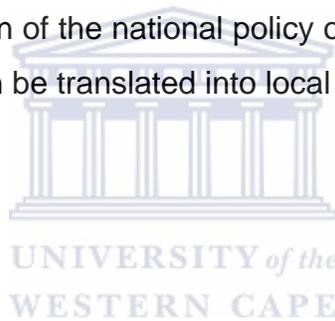
- A set of selection guidelines should be developed by a joint stakeholder group comprising the government, civil society (NGOs and communities with CHW programmes) and a representative body of CHW cadres, to ensure that all CHW stakeholders establish and implement a commonly developed practice of selecting CHWs in post apartheid South Africa.
- In instances where the facilitation of community participation in the selection of CHWs is challenged by disorganized community structures, perceptions of fragmented and questionable leadership structures, a low rate of collective effort activities and a history of poor community mobilization, then CHW programmes should be encouraged to set up CHW selection committees made up of community leaders, interested members of the community, local NGOs operating in the community and the CHW programme staff.
- In instances where even the above is difficult to attain, CHW programmes should make an effort to formally introduce their NGO selected CHWs to the communities where they are deployed to practice and get the community's approval prior to the commencement of the CHW contract.
- In addition, as reported by the CHW interviewed from CHW Programme KZNA, the community entry of newly appointed non-community selected CHWs should be assisted by community-selected CHWs who have an established working history with the community through accompanying them on their initial home visits.

CONCLUSION

In conclusion, the three case studies have illustrated the dynamic face of community participation in the selection of CHWs in South Africa. There is a history to the selection processes of CHWs and whilst the post apartheid liberated, unified and transformed public health sector has afforded many opportunities for citizen participation in health and development, some government-civil society partnerships have yielded practices that unintentionally undermine the ideals of community involvement. The findings of the case studies

have also problematized our notions of community participation as being ideal and doable in every development context, as contextual impediments to community involvement have been exposed (e.g. organisational type and priorities that do not cater for complex processes; community dynamics such as disorganized, competitive community leadership structures and low community activism). Lastly, the three case studies have shown that unless there are deliberate strategies put in place to translate policy into practice, community participation will remain good only for its “cosmetic nature...and its ability to make everything it proposes sound good” (Chambers, 1995 in Morgan, 2001: 222).

The set of recommendations provided in this chapter seek to provide alternatives to the current implementation of the national policy on CHW programmes, so that what the policy idealises can be translated into local and provincial practice.



REFERENCES

1. Adato, M, Hoddinott, J, & Haddad, L. (2005). Power Politics and Performance: Community Participation in South African Public Works Programs. *International Food Policy Research Institute. Research Report 143*. Washington, D.C.
2. Botes, L, & Van Rensburg, D. (2000). Community Participation in Development: Nine Plagues and Twelve Commandments. *Community Development Journal*, Vol 35, No. 1, 41-58.
3. Celebrating Alma Ata 1978-2003. (2003). *Strengthening Primary Health Care in South Africa*. Conference Report.
4. Dalpoz, M. (2003). *Changes in the hiring of health personnel*. Geneva, Switzerland: World Health Organisation.
5. Dennill, K. (2005). *The Integrated Health Professional: Resource Pack for Becoming a Health Professional: International Views on Primary Health Care*. Cape Town: Faculty of Health Sciences, University of Cape Town.
6. Department of Health. (2000). *A synopsis of health policies & legislation: 1994-2000*. Pretoria: National Department of Health.
7. Dudley, E. (1993). *The critical villager: beyond community participation*. London and New York: Routledge.
8. Expanded Public Works Program Social Sector Plan 2004/5-2008/9. [Online]. Available www.epwp.gov.za.
9. Friedman, I. (2005). Chapter 13: *CHWs and Community Caregivers: towards a unified model of practice*. South Africa. South African Health Review, Health Systems Trust.
10. Friedman I. (2002). Community Based Health Workers. In Ijumba, P, Ntuli, A, & Barron, P (eds). *South African Health Review 2002*. Durban: Health Systems Trust.
11. Friedman, I, Bhengu, L, Matjjs, F, Ramalepe, M, Baloyi, B, Mohammed, T, Lee, S, Mafuleka, A, Ndaba, L, & and Lloyd, B. (2007). *Community Health Workers And Community Caregivers: towards best practice in home &*

- community based care*. Presentation at Health Systems Trust Conference, 2007.
12. Friedman, I. (1994). Chapter 9: Community Based Health Workers. South Africa. *Health System Trust Publication*.
 13. Gilson, L, Walt, G, Heggenhougen, K, Owuor-Omondi, L, Perera, M, Ross, D, & Salazar, L. (1989). Community Health Workers: How can they be strengthened? *Journal of Public Health Policy*, Vol. 10, No. 4, 518-532.
 14. Howell, J, Ishkanian, A, Obadare, E, Seckinelgin, H & Glasius, M. (2007). *The Backlash against Civil Society in the Wake of the Long War on Terror*. Civil Society Working Paper 26. London: London School of Economics. [Online]. Available www.lse.ac.uk/collections/CCS/publications
 15. Kahssay, H.M, Taylor, M.E, & Berman, P.A. (1998). *Community Health Workers: The way forward*. Geneva: World Health Organisation.
 16. Kahssay, H.M & Oakley, P. (1999). *Community Involvement in Health Development: A review of the concept and practice*. Geneva: World Health Organisation.
 17. Kwazulu-Natal Department of Health. (No date provided). *Community Health Workers*. [Online]. Available www.kznhealth.gov.za/chw.htm
 18. Lehmann, U & Sanders, D. (2007). *Community Health Workers: What do we know about them?*. Geneva: World Health Organisation.
 19. Lund, F.J. (1993). Paradox and Policy: Some lessons from CHW projects. *Critical Health*, Vol. 42.
 20. Lund, F.J. (1987). *The Community Based Approach To Development: A description and analysis of three community health projects*. Unpublished Thesis. Durban: Centre for Social and Development Studies, University of Natal.
 21. Mathews, C, Van der Walt, H & Barron, P. (1994). A shotgun marriage-Community Health Workers and government health services. A Qualitative evaluation of a CHW project in Khayelitsha. *South African Medical Journal*, Vol. 84, No. 10, 659-663.

22. Mathekga, R & Buccus, I. (2006). The challenge of local government structures in South Africa: Securing Community Participation. *Critical Dialogue: Journal of Public Participation in Governance*, Vol.2, No2.
23. Mngxali, N. (2006). *Obstacles to Meaningful Public Participation in Local Government in South Africa: A critical analysis of Integrated Development Planning (IDPs)*. Unpublished Thesis. University of Cape Town
24. Morgan, L. (2001). Community Participation in Health: Perpetual Allure, Persistent Challenge. *Health and Policy and Planning*, Vol 16, No. 3, 221-230
25. Morgan, LM. (1989). Political Will and Community Participation in Costa Rican Primary Health Care. *Medical Anthropology Quarterly*. Vol. 3, No. 3.
26. Mwombeki, F. (no date provided). *Civil Society/Government Partnerships: Presentation on Government/Civil Society Organisations Partnerships in Monitoring Poverty/PRSP*. [Online]. Available www.hakikazi.org/tcdd/newpage6.htm
27. National Department of Health. (2004a). *Speech by Minister of Health, Dr Manto Tshabalala-Msimang, at the launch of the Community Health Worker Programme, 26 February 2004*. [Online]. Available www.doh.gov.za
28. National Department of Health. (2004b). *Community Health Workers Policy Framework*. Pretoria: Department of Health.
29. National Department of Health). (1997). *The White Paper for the Transformation of the Health System in South Africa*. Pretoria: Government Gazette no. 17910
30. NPPHCN. (1993a). The Rock, "Health Workers: CHWs in Perspective". Johannesburg.
31. NPPHCN. (1993b). *Policy in Transition*. NPPHCN/SAHSSO Health Policy Conference Dec. '92. Johannesburg.
32. Oakley, P. (1989). *Community Involvement in Health Development: An examination of the critical issues*. Geneva: World Health Organisation.

33. Ofosu-Amaah V. (1983). *National Experience in the Use of Community Health Workers: A review of Current Issues and Problems*. Geneva: World Health Organisation.
34. Skok, J.E. (1974). Participation in Decision-making: The Bureaucracy and the Community. *Western Political Quarterly*, Vol. 27, No. 1, 60-79.
35. Statistics South Africa. (2006). Mid-year population estimates, South Africa, 2006. *Statistical Release P0302*.
36. Stekelenburg, J, Kyanamina, S & and Wolffers, I (2003). Poor performance of community health workers in Kalabo District, Zambia. *Health Policy*, Vol. 65, 109-118.
37. Thomas, A & Allen, T. (2000). *Poverty and Development in the 21st Century*. New York: Oxford University Press.
38. Tollman, SM. (1994). The Pholela Health Centre: The origins of Community Oriented Primary Care (COPC): An appreciation of the work of Sidney and Emily Kark. *South African Medical Journal*, Vol. 84, 653-58.
39. Tollman, S.M & Pick, W.M. (2002). Roots, Shoots, but too little fruit: Assessing the contribution of Community Oriented Primary Care (COPC) in South Africa. *American Journal of Public Health*, Vol. 92, No. 11.
40. Walt, G. (1988). *Community Health Workers: Policy and Practice in National Programs: A review with selected annotations*. London. *EPC Publication 16. LSHTM*.
41. Walt, G. (1990). *Community Health Workers in National Programs: Just another pair of hands?* Philadelphia, Pa: Open University Press.
42. Werner, D. (1981). The Village Health Worker-Lackey or Liberator? *World Health Forum*, Vol 2: 46-54
43. World Health Organization. (1984). *Strengthening Ministries of Health for Primary Health Care*. Geneva: World Health Organisation.

APPENDICES

Appendix A

Individual Interviews with CHW Programme Managers: Interviewing Schedule¹²

- Describe for me (in detail) the selection processes that your organization followed for the recruitment of your CHWs
- Why did you follow your particular approach to selection?
- What are the strengths and weaknesses that you can identify from the selection process that you followed?
- What are the programmatic effects (whether successes or challenges) that you can attribute to the selection processes that you followed?
- What are the programmatic effects (whether successes or challenges) that you can attribute to the selection processes that you followed?

Appendix B

Open ended Individual Interviews with CHWs: Interviewing Schedule

- Please tell me in detail about the way in which you came to be a CHW, including the year in which you started, the organization you started with, the selection and recruitment processes that you went through and the persons involved in the selection process
- What do you think of the way in which you were selected and recruited to be a CHW?
- How did the community that you are serving react to your appointment as a CHW? How were you received by your community that you serve when you first started out as a CHW?
- Who do you consider to be your employer?
- Who are you accountable to?
- What role does your community play in your work as a CHW?

¹² The interviewing schedules (Appendices A and B) were constructed to guide the interviews but were not rigorously adhered to. The responses to individual questions frequently provided opportunities to probe for the other questions as well.

- How do you relate to CHWs selected/appointed differently to the way in which you were selected?
- How would you describe your relationship and experiences with your community that you serve? How do they see you?
- What do you think of the way in which CHWs are selected and recruited currently? What do you think of the way in which they were selected and recruited in the past?
- How do you feel about your work as a CHW?

