Community Health Workers in South Africa

A Scoping Review

Prepared for DGMT

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Table of Contents

Terminology

Community Care Workers (CCW) or **Community Care Givers** (CCG) are generic, umbrella terms for the cadre of caregivers who support the health and social services at community level, without professional or accredited training and sometimes on a volunteer basis. These broad terms include not only those performing the function of lay health workers but also those providing social support for orphans and vulnerable children (OVC), home-based caregivers, and those assisting with social grants and psychosocial support. Some CCWs might perform all of the above roles.

Community Health Workers (CHWs) are a category of CCW or CCG, offering lay community-based health services, usually within the areas in which they live. They **"**screen, map, educate, link and extend primary health care services".[1] This cadre of caregivers might include lay counsellors, DOTS supporters, health promoters, adherence counselors, PMTCT counsellors and support group facilitators (to name a few). They can be specialist or generalist in their scope and include both volunteers and those earning a stipend. Other terms for community health workers include *Nompilo, village health worker, patient advocate, 'change agent', treatment literacy practitioner and more.*

Home-Based Care/givers (HBC) are often treated separately from CHWs, although this delineation is contested. These care workers provide time-consuming and often intimate care within the home. Their patients may be bed-ridden, constrained in their mobility, or vulnerable children. The work of home-based caregivers includes preventative, promotive and palliative functions. HBC's are more prevalent, and in many ways more needed, in rural areas. Their work is more likely to be voluntary. Currently, they are employed exclusively by NGOs with some financial support from the DSD and DOH.

[1] White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.

Acronyms

AIDS — Acquired Immune Deficiency Syndrome
ARV — Antiretrovirals
CBO — Community-based Organization
CCW — Community Care Worker
CCG — Community Care Giver
CHBC — Community Home-Based Care
CHW — Community Health Worker
DOH — Department of Health
DOTS — Directly Observed Treatment Short-Course
DSD — Department of Social Development
EC — Eastern Cape
EPWP — Extended Public works Programme
HBC — Home-based Care(worker)
HIV — Human Immuno-Deficiency Virus
KZN — KwaZulu-Natal
LP — Limpopo Province
NGO — Non-government Organisation
NHI — National Health Insurance
NPO — Non-profit Organisation
NQF — National Qualifications Framework
PHC — Primary Health Care
SANAC — South African National AIDS Council
TB — Tuberculosis
VCT — Voluntary Testing and Counselling
WBOT — Ward-based Outreach Team
WC — Western Cape
WHO — World Health Organisation

A History of Community Health Workers in South Africa

1920's	Malaria assistants are trained in KwaZulu-Natal, forming some of the first community health worker cadres in South Africa.[2]
1940s	In 1944, **The Gluckman Report** is released, advocating a holistic, preventative and community-based approach to healthcare in The Union. The report is never implemented.[3] Doctors Sydney and Emily Kark establish over 40 primary health care centres across South Africa, starting with the **Pholela Centre** in KwaZulu-Natal.[4] These state-sponsored primary health care (PHC) programmes are later thwarted by the National Party,[5] who institute a racially-fragmented health service focused on hospital care for the white minority.[6]
1970s	During the 1970s, NGO-initiated CHW programmes respond to an inequitable apartheid healthcare system, offering comprehensive, innovative and empowering support to communities and health providers alike.[7]
1978	**The Alma Ata Declaration** puts the World Health Organisation's (WHO) *Health for All* principles into action, stating that: • Health is not just the absence of disease, but concerns the over-all wellbeing of a person and their community. • Health should be equally distributed, accessible and affordable. • Socio-economic and environmental factors, like housing, employment and sanitation, are central to good health, which makes health a key issue for development. • PHC is the way to put these principles into practice and should encourage holistic, preventative and promotive care. • Community health workers(CHWs) are central to delivering PHC. Despite South Africa being banned from Alma Ata, the principles of PHC have already taken root among researchers and CHW programme leaders in the country.[8] Alma Ata gives local CHW programmes motivation to become examples of PHC in action.
During the 1980s	Although the WHO is pushing for PHC globally, the apartheid government does not take interest. NGO-lead CHW programmes run very successfully with support from international funders. The growth of these programmes is founded on the struggle against Apartheid. CHWs work as agents of community empowerment rather than narrowly-defined technical health officers.[9]
	Maputo AIDS Conference

Late 1980s	The progressive movement in South Africa gather in Maputo to design and implement an AIDS program. The Maputo statement on HIV/AIDS says "*Any program must be community- based*".
1990	During the period of democratic transition, progressive thinkers establish community initiatives that they hope will inform new government's policy.
After 1994	The DOH neglects CHW programmes in favour of a health system driven by professionals. The idea turns out to be over-ambitious and does not take into account the lack of human and other resources. Many CHW programmes shut down as international funders re-direct their funding to the new democratic government. Organised CHW programmes are replaced by a range of small, unregulated community-based projects with hundreds of volunteers filling many different roles.[10] The CHWs working in these programmes are predominantly older women, with little formal education, usually filling task-specific roles in response to HIV/TB. As hospitals, clinics and hospices became increasingly overburdened by the HIV/AIDS epidemic, tasks are shifted to home-based caregivers.
Mid-Late 1990s	The impact of the AIDS epidemic leads to a call for community home based care (CHBC). While the state does not seek to integrate CHWs into the health system, it does begin to offer support to NGO-lead CHW programmes, as well as the training of lay caregivers for

[2] Van Ginneken, N., Lewin, S., and Berridge, V (2010) 'The emergence of community health worker programmes in the late apartheid era in South Africa: an historical analysis' *Social Science & Medicine* 71, pp. 1113.
[3] Marks, S. (2013) 'Social justice or grandiose scheme? the 1944 National Health Services commission revisited', presentation at WISER, Johannesburg, 30 September 2013.
[4] Gofin, J. and Gofin, R. (2005) Community oriented primary care and primary health care', American Journal of Public Health 95(5), pp. 757-757.
[5] Kautsky, K. and Tollman, S. (2008) 'A perspective on primary health care in South Africa', South African Health Review. Heath Systems Trust, Durban, pp. 19.
[6] Gilbert, T. and Gilbert, L. (2003) 'Globalisation and local power: influence on health matters in South Africa', Health Policy 67, pp.248.
[7] Languza, N., Lushaba, T., Magingxa, N., Masuku, M. and Ngubo, T. (2011) Community health workers: a brief description of the HST experience' Health Systems Trust.
[8] Clarke, M., Lewin, S. and Dick, J (2008) 'Community health workers in South Africa: where in the maze do we find ourselves?' SAMJ 98(8), pp. 680
[9] Van Ginneken, N., Lewin, S., and Berridge, V (2010) 'The emergence of community health worker programmes in the late apartheid era in South Africa: an historical analysis' *Social Science & Medicine* 71, pp. 1113.
[10] Friedman, I. (2005) 'CHWs and community caregivers: towards a unified model of practice', *South African Health Review*, pp. 176—188.; Friedman, I., Ramphele, M., Matijus, F., Bhengu, L., Lloyd, B., Mafuleka, A., Ndaba, L. and Baloyi, B. (2007) 'Moving towards best practice: documenting and learning from existing community healthcare worker programmes'. Health Systems Trust, Durban.

	VCT and DOTS.[11] Funders start to make AIDS-specific donations to CHW initiatives, narrowing their focus.
2003	Increased funding, along with the growing impact of the HIV/AIDS epidemic, leads the DOH to reverse its previous policy and support CHW programmes. Government encourages provincial departments to establish generalist CHW programmes and commits to paying stipends between R500 - R1000 per month.[12] Lay workers are part of the DOH's **Comprehensive Care, Management & Treatment Programme** for antiretroviral access. National government implements a large-scale job-creation programme, which works across departments. The **'Extended Public Works Programme'** (EPWP) aims to reduce unemployment through basic skills training, including the training of lay health workers.
2004	By 2004, there are an estimated 40 000 lay health workers in South Africa.[13] Rapid, informal growth of CHW programmes has produced fragmented, vertical and duplicated programmes in which many CHWs are poorly trained and badly supervised.[14] **ARVs are introduced into the public health sector. CHWs become essential for the scale-up of ART.** DOH adopts a **National CHW Policy Framework**, which aims to harmonise existing CHW programmes and establishes civil society organisations as intermediaries between CHWs and the government.[15] According to the National Policy Framework 2004: • CHWs will receive a stipend but will not be government employees. • Government will provide grants to NGOs who will employ CHWs. • CHW training will be accredited through learnerships. • CHWs must be residents of the communities where they work and have access to a referral system.

[11] Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.

[12] Friedman, I. (2005) 'CHWs and community caregivers: towards a unified model of practice', *South African Health Review*, pp. 176—188

[13] Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.

[14] Swarts, A. and Colvin C. 'It's in our veins': caring natures and material motivations of community health workers in contexts of economic marginalisation, Critical Public Health, 25:2, 139-152

[15] Friedman, I. (2005) 'CHWs and community caregivers: towards a unified model of practice', *South African Health Review*, pp. 176—188.; Friedman, I., Ramphele, M., Matijus, F., Bhengu, L., Lloyd, B., Mafuleka, A., Ndaba, L. and Baloyi, B. (2007) 'Moving towards best practice: documenting and learning from existing community healthcare worker programmes'. Health Systems Trust, Durban.

	While the National Policy Framework promotes generalist CHWs, the majority of CHWs at the time are limited-purpose HIV/TB workers.[16] The EPWP further encourages single-purpose workers, working alongside and in contradiction to the National Framework.[17]
2006	The WHO proposes 'task-shifting' and the training of CHWs as core ideas in its **AIDS Health Workforce Plan**. The DOH registers four community worker qualifications in terms of the **National Qualifications Framework**, creating the possibility of career pathways for CHWs as mid-level health workers[18] (L1 Ancillary Health Worker; L2&3 Community Care Worker; L4 Community Health Worker). The L4 qualification demands a matric.
2010	Health Minister, Aaron Motsoaledi, visits Brazil and returns with a broad vision to integrate CHWs into the PHC system. Government estimates that there are 65000 lay health workers operating in the public health sector, mostly HIV and TB centred. DOH launches plan to **Re-engineer Primary Healthcare,** as part of a broader set of reforms around the National Health Insurance. It aims to strengthen health promotion, prevention and disease detection through community-based outreach teams, known as Ward-Based Outreach Teams (WBOT) WBOT to be staffed by **6 generalist CHWs** and supervised by a professional nurse. CHWs will responsible for 250 households each. CHW's **scope of work to be comprehensive**: extending beyond HIV/TB to include maternal-child health and chronic non-communicable diseases; they will have a preventive and promotive orientation, and work with other sectors and community based providers. Draft policy documents suggest that there will be more regulation and training, higher entrance requirements, and an overall decrease in the number of CHWS operating.
2011	DOH release **Provincial Guidelines** for the Implementation of Three Streams of PHC Re-engineering. One of these streams are the WBPHOTs.

[16] Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.
[17] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET).
[18] Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.

	DOH now estimates 72000 CHWs operating but not being used optimally (particularly for maternal & child health).[19] DOH identifies the following reasons for poor performance of CHW programmes: • Poor support, training and supervision • Poor coverage • Poor linkages between facilities and communities • Inadequate accountability of NGOs • Limited or no targets While PHC re-engineering is a national mandate, provinces have a fair degree of independence in adopting and adapting national policy, especially if they are required to mobilise their own funding for implementation.
2012	In the DOH's **Human Resources for Health Strategy**, government articulates the need for 'a large workforce of CHWs' whose employment is standardised. Promotion of maternal and child health is highlighted as central to the role of CHWs.[20]
2014	A year after the proposed deadline, only four of the eight provinces are implementing the ward-based system. There are large provincial discrepancies in how "ward-based" community health workers are recruited, what they are paid, who pays them, the kind of work benefits they get and how many households they should cover. These discrepancies can be attributed to a lack of national policy and the fact that the country's community health worker strategy remains an unfunded mandate. [21]
2017/2018	Despite ongoing discussions and some implementation of a CHW programme, we remain very far from a standardised CHW policy, never mind one that is able to meet our healthcare demands.[22]

[19] Pillay, Y. and Barron, P. (2012) 'The implementation of PHC re-engineering in South Africa', https://www.phasa.org.za/wp-content/.../11/Pillay-The-implementation-of-PHC.pdf
[20] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za
[21] Malan, M. (12 September 2014) ' Community health workers shafted by SA's policy shambles', *Bhekisisa*
[22] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za

Significant Shifts in the Positioning of Community Health Workers

In response to an escalating AIDS-epidemic, immense health worker shortages, and the massive rollout of antiretrovirals (ARVs), community health workers have, over the past 15 years-or-so, been increasingly incorporated into South African social policy. This formalisation of community health work has resulted in the occupation taking on a newly **ambiguous form**: somewhere between volunteerism and formal labour, homes and health facilities, non-state and state, traditionalist conceptions of communal care and the job-creating impetus of a remunerated, upwardly-mobile sector. On one level, care has been progressively de-professionalised through taskshifting to lay workers, while at the same time, there is a formalisation of lay health work through increased standardisation, accreditation and remuneration. Consequently, the profile of our caregivers is slowly diversifying — from the charity of grandmothers caring for sick relatives and orphaned children, to the improvisations of young aspiring professionals seeking skills and opportunity.

Care as Decentralised and De-Professionalised

This review is located in a global policy context in which care is increasingly viewed as a community responsibility, thereby transporting care from centralised hospitals to communities and their cadres of caregivers. The formulation of primary healthcare in the 'Alma Ata Declaration' (1978) and 'Health for All' policy (WHO, 1981) cemented this worldwide trend, advocating for community participation and the shifting of specified tasks from professionals to lay workers.[23] Community-based primary healthcare has been a key strategy for countries highly affected by HIV, whose under-resourced health systems have struggled to cope with the burden of illness.

In line with these international trends, South Africa has, since the early 2000s, seen increased state support for community-based primary healthcare programmes, and community health workers in particular. Since 2010, government has been in the process of reforming its health system in order to strengthen primary healthcare implementation and shift from an individualized, passive, curative, vertical system to a population-based, proactive, community-based model.[24]

[23] WHO (2007) *Task shifting: global recommendations and guidelines*. Geneva.
[24] Naledi, T., Barron, P and Schneider, H. (2011) Primary healthcare in SA since 1994 and implications for the new vision for PHC Re-engineering, in Padarath, A., English, R. (eds.) South African Health Review. Durban: Health Systems Trust, pp. 17-28

Care as Remunerated Work

Volunteers have historically played a significant role in the delivery of community-based care in South Africa. The more-recent state reliance on community health workers to shoulder the burden of HIV/AIDS, along with the move to formalise lay health work, have been attended by a growing call for proper remuneration and employment benefits for community health workers. At the level of incentives, remunerated caregivers are thought to be more committed to their jobs and better able to perform. But beyond this is an advocacy push to recognise care work as legitimate, skilled labour. This advocacy has sought to protect caregivers (who are predominantly poor, black women) from exploitation, but has also positioned care work as a means to alleviate unemployment, upskill the jobless, and create future career pathways for caregivers.

The recent positioning of community health workers as semi-formal, paid workers on the borderlines between health facilities and communities has had implications for the profile of workers. There is a younger cohort of CHWs entering the workforce, who are often better educated than their older, but also more experienced, counterparts. Many hope their CHW position will serve as a stepping stone to other careers within the health profession. The arrival of this younger cadre has produced significant tensions and insecurities surrounding CHW entrance requirements, altruistic versus instrumental motivations to care, and job security.

Care as Generalist

While state guidelines on the 'Re-engineering of Primary Healthcare' suggest a shift towards more generalist community health workers, who will serve as both treatment supporters and health promoters, dealing with a broad spectrum of health concerns, the current CHW programme in South Africa remains disease-focused. Most attention has been given to HIV, AIDS and TB care.[25] Disease-specific programmes have contributed to the fragmentation of the CHW landscape, where coverage is patchy, uneven, and driven by the differing agendas of particular provinces, NGOs or funders. This situation has produced a growing interest in

[25] Languza, N., Lushaba, T., Magingxa, N., Masuku, M. and Ngubo, T. (2011) 'Community health workers: a brief description of the HST experience', Health Systems Trust: Durban.

standardising CHW portfolios and incorporating them into the national health system.[26] With this in mind, PHC Re-engineering will focus initially on HIV, TB and (importantly) maternal and child health. It will then expand to other chronic illnesses as well as conditions resulting from injury and violence.[27] In this context, questions around CHWs scope of work have become highly contentious.

Care as Integrated into the State PHC System

The 'Re-engineering of Primary Healthcare' aims to integrate CHWs into the formal health system as part of Ward-based Outreach Teams. By locating CHWs in facility-based teams, supervised by a professional nurse, the new strategy seeks to improve relationships and referral networks between CHWs and the healthcare system. While this is believed to invest CHWs with more official authority, it can also threaten their 'community-based' orientation and their role as community advocates. PHC re-engineering hopes that CHWs will be employed directly by government. However, due to budgetary constraints and differing forms of provincial implementation, most CHWs in South Africa continue to work for NGOs, who are contracted by the state.

Key Policy Debates

'Liberators' vs 'Lackeys'

Are CHWs community advocates, mobilising their neighbours around the social determinants of health? Or are they technical extensions of the health system performing an outreach role?[28] In the 1980s, David Werner, famously termed this tension 'lackeys' versus 'liberators'.

Indeed, one of the central ambiguities in how CHWs are conceptualised is their dual position as representatives of both the health facility and the community. This tension also reflects in

[26] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863.
[27] Van Pletzen, E. and McGregor, H. (2013) 'Community caregivers: the backbone for accessible care and support: multi-country research: South Africa report', The Caregivers Action Network.
[28] Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436); Colvin, C. and Swartz, A. (2015) 'Extension agents or agents of change: community health workers and the politics of care work in postapartheid South Africa', *Annals of Anthropological Practice* 39(1).

CHWs understanding of their own position. While many see themselves as custodians of the community, who have extensive community knowledge and are able to translate the technical language of the clinic into local parlance; they also wanted to signal their official status through uniforms, badges and other markers of authority.[29]

On the one hand, CHWs are expected to seek improved and expanded health services on behalf of their patients, which can require that they take on a dissenting role. On the other hand, they must also strive to maintain good relationships with health professionals, since the trust and legitimacy bestowed on them by communities depends on their ability to broker power within facilities[30]. Meanwhile, this power is inevitably precarious: CHWs are expected to show deference as subordinates in the health system, whose function is to lessen the burden on health professionals.

While CHWs are expected to 'bridge' and 'link' communities to the formal health system, occupying this 'middle-ground' can produce tensions in the assumed identity and allegiances of community health workers. The roles most valued by clinics and government departments might be different from those appreciated by families and patients.[31]

Generalist vs Specialist

Many of South Africa's current CHW programmes arose in response to the HIV/AIDS and TB epidemics, often supported by HIV and TB-targeted funding as well as the limited-scope training of the EPWP. As a result, the broader, more comprehensive functions of CHWs have been sidelined.[32] Our national CHW programme remains disease-oriented and many programmes require quite fundamental recasting in order to perform the more generalist roles envisioned in PHC Re-engineering. Donors tend to favour specialist CHWs in order to maximize the effectiveness of short-term interventions. State policymakers, however, prefer

[29] Vale, E. (2012) 'I know this person, why must I go to him?' techniques of authority among community health workers in Cape Town. Centre for Social Science Research Paper, University of Cape Town.
[30] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[31] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[32] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand, pp. 75.

generalist approaches as one way of addressing healthcare's human resource crisis and shifting a variety of tasks away from nurses and doctors.[33]

A 'generalist' cadre of community health workers, as is currently recommended for South Africa, is believed to provide more comprehensive, cost-effective care. However, some programme leaders worry this makes CHWs' scope of work unmanageable and exploitative, expecting lay health workers to serve as the magic bullet for all health problems.[34] There is also significantly less robust evidence for the efficacy of generalist as opposed to targeted CHWs.[35] Indeed, a Cochrane systematic review of CHW interventions showed that CHWs had benefits when they operated within a limited scope of practice (e.g. immunization uptake and breastfeeding). Evidence of the effectiveness of 'generalist programmes', in which CHWs deliver a wide range of primary care services, remains sparse.

Volunteers vs Employees

Across the country, CHWs occupy an ambiguous position between 'volunteers' and 'employees'. Many CHWs continue to self-define as 'volunteers' earning a 'stipend', rather than employees earning a 'salary'. Given that the vast majority of stipended CHWs earn below the 2017 minimum wage, some remain unpaid, and most go without the rights and benefits of employment; this unfortunately remains an apt characterisation.[36] Yet the working hours, reporting demands and structures of accountability demanded of CHWs imply employee obligations.[37] Since many provinces continue to contract CHWs through NGOs (in a system akin to outsourcing), they are able to side-step key obligations associated with employment. As a result, most CHWs are employed through fixed-term contracts, with insecure, poor pay, little to no benefits and working conditions that are frequently hazardous. CHWs lack of proper employment or professional status creates precarious relationships

[33] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[34] Grimwood, Ashraf (08.01.2018) Personal communication.
[35] Clarke, M., Lewin, S. and Dick, J. (2008) 'Community health workers in South Africa: where in this maze do we find ourselves?' *South African Medical Journal* 98(9).
[36] Schneider, H., Hlengiwe, H. and van Rensburg, D. (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects', *Health Policy & Planning* 23, pp. 179–187; White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.
[37] Trafford, Z., Swartz, A., and Colvin, C. (2017) '"Contract to volunteer": South African community health worker mobilisation for better labour protection', New Solutions 0()), pp. 1-19.

both with other health workers and with patients. Given their position as informal lay workers, it is often the case that neither communities nor facilities recognise and respect their role.

While worries over the exploitation of volunteers persist, the introduction of a stipend for CHWs has also come with some unintended consequences. Given budgetary constraints, some provinces have only been able to offer stipends to a small number of their community volunteers. The process of selecting who should be among this paid cohort has caused immense tension. In some instances, this has resulted in large numbers of volunteers resigning in the wake of being excluded.

The increased formalisation, remuneration and career-pathing of CHWs has given rise to new questions around CHW motivation. In a study by Swartz,[38] many CHWs framed their motivations through discourses of altruism, linked to their gender, religion or 'African values'. Many programmes rely on CHW's altruism as a primary source of motivation, given that monetary incentives are so small. But research shows that CHWs are also interested in the material benefits of care work.[39]

In the South African context, unpaid volunteers have often responded to the urgent care needs brought by HIV/AIDS and TB. But these dual epidemics have also been accompanied by increased funding, opening up rare access to resource and opportunity. In a context of widespread joblessness, where CHWs often struggle as much as their patients with illness and income, material incentives play a significant role in their decisions to take up care work. Although altruism is highly valued both by CHWs and communities, it is rarely sufficient to retain CHWs in care work. Some CHWs worry that these instrumental motivations — for a decent, paid job — exist in tension with their more socially-acceptable altruistic intentions.[40]

[38] Swartz, A. and Colvin, C. (2014) "It's in our veins": caring natures and material motivations of community health workers in contexts of economic marginalisation', *International Journal of Integrated Care* 14(8).
[39] Swartz, A. and Colvin, C. (2014) "It's in our veins": caring natures and material motivations of community health workers in contexts of economic marginalisation', *International Journal of Integrated Care* 14(8); Akintola, O. (2011) 'What motivates people to volunteer? The case of volunteer AIDS caregivers in faith-based organisations in KwaZulu-Natal South Africa', Health Policy & Planning 26, pp. 53-62
[40] Swartz, A. and Colvin, C. (2014) "It's in our veins": caring natures and material motivations of community health workers in contexts of economic marginalisation', *International Journal of Integrated Care* 14(8).

Some NGO representatives lament "the spirit of volunteerism being lost"[41], while activists argue that the lauding of self-sacrificial altruism has been used to justify CHWs' exploitation.[42]

Education vs Experience

With the move to formalise CHWs, more attention has been given to the question of entrance requirements. At minimum, CHWs are expected to have basic literacy and numeracy as well as an understanding of English. In some areas, CHWs are now required to have a Grade 10, or in some instances a matric. This has served not only as a way to limit the number of CHWs eligible for stipend, but also to ensure the possibility of career pathing through the NQF. The positioning of community health work as a career has meant than many older, highly experienced CHWs, without formal education, now feel that their jobs are under threat. They have struggled to get their experience recognised.

While it is possible to employ people who have matric *and* suitable experience, the consequence will be to exclude experienced and competent people who do not have this level of formal education. One Community Health Council Member in Lehmann and Matwa's 2008 study[43] said**: "the volunteer who has worked for 10 years is a good example and yet the one who has volunteered for just one year or a few months gets first preference because she is educated".**

NPOs vs State

National policy proposals have favoured the integration of CHWs into the civil service, where salaries and working conditions would likely be improved. This mandate has not, however, been funded, making it difficult to implement in the short term. Affordability is just one of the considerations of full state incorporation, which poses a number of costs and benefits.[44]

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[41] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET).

[42] Trafford, Z., Swartz, A., and Colvin, C. (2017) '"Contract to volunteer": South African community health worker mobilisation for better labour protection', New Solutions 0()), pp. 1-19.

[43] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET).

[44] Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436).

For many years, the DOH has relied on NGOs to deliver community-based services with some financial support from the state. Because of this, these NGOs have gained significant experience and expertise. Overseeing community-based health initiatives is difficult and intensive work that requires continuous training, supervision and mentorship. Some feel that in order for CHW programmes to be effective, we need to draw on these existing skills and foster partnerships between NPOs and the state.

There is a feeling that those NGOs that are too dependent on government might lose their autonomy and flexibility, thus hampering their ability to deliver responsive, efficient care to their communities.[45] To add to this, researchers have found that government-run programmes are generally less well resourced, creating competition between state and NGO-employed CHWs.[46] Research from the Eastern Cape has shown that some state-employed, generalist CHWs feel unable to meet the high expectations set by better-resourced CHWs, employed by disease-specific NGO programmes.[47]

Those in favour of absorbing CHWs into state PHC programmes raise concerns about the ongoing role of NGOs, who are believed to be unaccountable, highly fragmented, and not necessarily aligned with health department agendas. Supervision and resources vary greatly from one NGO to the next. To add to this, 'outsourcing' CHW programmes to NGOs has meant that some NGOs effectively function as 'labour brokers', exempting government from having to meet basic standards of employment for CHWs.[48] State employment will mean standardised conditions of employment, more job security, and a greater likelihood of career pathways for CHWs. Although it will be costlier, a state-run CHW programme will also be better integrated and easier to manage. We will be more likely to see a continuum of care and CHWs will be embedded within formal networks and resources.

[45] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand.

[46] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.

[47] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863.

[48] Trafford, Z., Swartz, A., and Colvin, C. (2017) '"Contract to volunteer": South African community health worker mobilisation for better labour protection', New Solutions 0()), pp. 1-19.

There is, however, a worry that CHWs within a fully state-run programme would sit at the lowest rungs of the civil service, would be predominantly facility-based, and would lose their community identity. This approach would also likely set standardised entry requirements, which would create barriers to entry for many existing care workers. Given limited budgets and a generalist approach, the number of care workers overall is likely to decrease under a purely state-run model.

Scope of Work

Considerations related to CHW training, recruitment and employment all pivot around their intended scope of work, which has also been a key area for debate among policy makers and practitioners.

The WBPHCOT Policy provides for 'generalist' tasks to be completed by CHWs in the following 'broad areas':

Health promotion and disease prevention:

- Conduct community, household- and individual-level health assessments.
- Identify potential and actual health risks and assist the household or individual to seek appropriate care.
- Screen and refer individuals for further assessment and testing, where appropriate.
- **Identify pregnant women and conduct home visits during pregnancy and the postnatal period to promote healthy and safe births and identify danger signs needing extra care.**
- **Provide extra support for healthy behaviours during early childhood, including exclusive breastfeeding.**
- Provide screening and health promotion programmes in schools and Early Childhood Development centres.
- Work in partnership with the School Health Team and other healthcare workers, such as Health Promoters.
- Counsel on and provide support for family planning choices.
- Provide follow-up and assistance to persons with health problems, including distribution of medicines according to the Integrated Chronic Disease Model, and help with adherence to treatment and treatment defaulter tracing.

- Promote and work with other sectors and undertake collaborative community-based interventions, such as Early Childhood Development, palliative care, geriatric care.

There is some evidence to suggest that CHWs are more effective when they perform some curative functions beyond their preventative role. This leads patients to take CHWs more seriously, and gives CHWs enhanced self-efficacy.

Curative services as their scope and training allow:

- Rehabilitative care
- Palliative care
- Psychosocial support, including support groups,
- Administrative tasks: i.e. reporting requirements and supervisor meetings

Many would argue that this list of roles is far too long. Particularly in under-resourced communities, there is a risk that CHWs might be treated as a panacea for a sea of problems, taking on more than they are able to deliver.[49]

Some CHW supervisors have expressed concern that the growing list of tasks allocated to CHWs undermines their ability to dedicate proper time to the physical and psychosocial needs of their patients. Supervisors also worried at the increased biomedicalisation of these tasks in contexts where clients needed intimate, social and often emotional care.[50]

More so, while policy might specify a particular set of CHW roles, in practice, their work often extends beyond what is required, including house cooking, cleaning, bathing the patient, laundry and even gardening.[51] Many CHWs also assist in the collection of grants, call ambulances and make referrals to social services. They take calls from patients after hours and often find themselves working on weekends.[52]

[49] Clarke, M., Lewin, S. and Dick, J (2008) 'Community health workers in South Africa: where in the maze do we find ourselves?' SAMJ 98(8), pp. 680.
[50] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[51] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand, pp. 191.
[52] White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.

The number of households CHWs are expected to be covered is also of concern. Proposals for the 'Re-engineering of Primary Healthcare' envision that CHWs will work an 8-hour day, with each CHW being responsible for 250 households. It remains unclear how often CHWs are expected to visit each household. There is also no differentiation between rural and urban areas in terms of the number of visits expected, or the number of households in a CHW's charge.

There is widespread consensus that the number of households charged to each CHW is too high. Locally, in KwaZulu-Natal, one CHW serves 50 or 80 households, depending on poverty levels. In Thailand, only 8-15 households are served by one CHW and in Brazil the ratio is 1:150 households.[53]

CHW vs HBC

Another key debate in the wake of moves towards a more generalist CHW policy is the future of home-based care, particularly for bedridden and disabled patients. Some feel that home-based care should be part of the CHW role. The nationally-proposed model, however, is for home-based caregivers to be positioned as a separate cadre of worker, employed by NGOs. The rationalisation for two cadres is that home-based care is time-consuming and therefore extends the work of CHWs too far. More so, if CHWs were to perform HBC roles, one would need far more of them (particularly in rural areas), making the national CHW programme more expensive. Retaining HBC as a separate type of care worker, with lower entrance requirements, also means that these caregivers will not be excluded from care work entirely.

The worry with two cadres of workers, however, is that patients may become frustrated at the number of different caregivers invading their home. Home-based caregivers will also be excluded from proper remuneration, employment benefits and career pathing. The current PHC Re-engineering plan therefore relegates HBCs to a more precarious position, even though the lines between CHW and HBC are often blurred.[54] Friction between non-state (largely volunteer HBCs) and government-employed CHWs will likely affect the continuum of care and produce conflict in communities.

[53] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za
[54] SANAC (2011) 'Notes from ad hoc meeting of SANAC-convened task team', 19 & 20 April 2011, University of the Western Cape

Provincial Profiles

	Kwazulu-Natal	Eastern Cape	Limpopo
Employment Conditions	Employed directly by **DOH.**	Employed by both the **DOH and NGOs.** There are just over 50 NGOs contracted by government to provide CHW services (CHW audit 2011). Reportedly WBOTs are not clinic based but linked to facilities.[57]	All CHWs employed by **NGO's**. Limpopo has the highest number of NGOs contracted to provincial government.[58] Some challenges with state/NGO cooperation.
	CHWs are paid **R1800** and supervisors R2300.[55]	Each CHW is paid **R2000** per month, and their supervisors R2500 (plus airtime). Hospitals & clinics provide CHWs are equipped with kitbags.	CHWs paid between **R1500-R1800**.
	No cellphone or transport allowance is paid and CHWs are mandated to buy their own uniforms.	**Supervisor gets airtime.**	**No airtime or travel allowance**. Provided **kitbags** with essential equipment.
	Sick leave, annual leave and unpaid maternity leave are granted. [56]	Informal sick leave and maternity leave is granted.	Sick leave, annual leave and maternity leave granted.
Demographics		A recent study of 91 CHWs in the Eastern	Case studies seem to suggest similar

[55] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za
[56] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za
[57] Marcus T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.
[58] Department of Health (2011) CHW Audit Report. Tshwane

	A recent study[59] of 53 CHWs in peri-urban KZN reflected only women. These CHWs spanned a large age range, but had a mean age of 40. KZN had a pre-94 CHW programme, associated with the former homeland, that has survived into the post-democratic period.	Cape[60] showed that 90% were female with a mean age of 41.5 years (age range of 22—57). EC has a long history of mostly disease-specific CHW programmes run by NGOs.	demographics to the rest of the country.
Recruitment	All single purpose care workers will be trained and absorbed into the system. WBPHOT recruited from **existing pool** of CHWs.	Only lay counsellors and home-based caregivers in the EC will continue to perform single-purpose roles, while CHWs will move towards more generalist roles.[61] According to one source,[62] WBPHOT are recruited from the **existing pool** of CHWs, but another[63] says this is not necessarily the case.	Single-purpose CHWs will continue to exist. CHWs recruited from the **existing pool** of CHWs.
Education		In a recent study of 91 CHWs in the	Case studies suggest limited formal

[59] White, M., Govender, P. and Lister, H. (2017) Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal, African Journal of Disability 6(1), e294

[60] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T and El-Dasr, W. (2017) Community health worker perspectives on a new primary healthcare initiative in the Eastern Cape of South Africa, PLOS One 12(3): e0173863

[61] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za

[62] Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za

[63] Malan, M. (12 September 2014) 'Community health workers shafted by SA's policy shambles', *Bhekisisa.*

	In a recent study[64] of 53 CHWs in peri-urban KZN, the majority of CHWs had **not completed formal schooling**, although almost all had above a Grade 10. All had completed the National Certificate in HBC (NQF Level 1). Most had volunteered for an average of 4 years prior to being employed by the DOH.	Eastern Cape[65], one third had completed secondary school and 10% had university education. Eighty-two percent had worked as a CHW in this district for more than five years. Most were recruited by a local chief or leader	education, particularly among older cohorts.
Coverage	According to a 2011 CHW audit, KZN had a ratio of **1 CHW for every 507**uninsured people. Reports of coverage, however, vary greatly. A 2017 KwaZulu-Natal study[66] reported the ratio of CHW to population in their research area as 1:4074. As of April 2014, 846 CHWs trained	According to a 2011 CHW audit, the Eastern Cape has a ratio of **1 CHW for every 1000** uninsured people. As per April 2014, there were reportedly 428 CHWs trained for PHC re-engineering.	According to a 2011 audit, Limpopo has a ratio of **1 CHW for every 568** uninsured people. Only 546 CHWs trained for PHC re-engineering (as of April 2014).

[64] White, M., Govender, P. and Lister, H. (2017) Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal, African Journal of Disability 6(1), e294
[65] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T and El-Dasr, W. (2017) Community health worker perspectives on a new primary healthcare initiative in the Eastern Cape of South Africa, PLOS One 12(3): e0173863
[66] White, M., Govender, P. and Lister, H. (2017) Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal, African Journal of Disability 6(1), e294

	for PHC Re-engineering.		
HBC	**13%** of national HBC organisations based in KZN (2010 audit): NGO-driven and mostly rural, with some state funding.	**12%** of national HBC organisations based in the EC (as of 2010 audit): NGO-driven and mostly rural, with some state funding. The Eastern Cape was reported to be especially reliant on volunteers to provide services and a large number of HBC organisations were unregistered.	**20%** of national HBC organisations based in Limpopo (as of 2010 audit): NGO-driven and NGO-driven and mostly rural, with some state funding

Each of these provinces has a sizeable rural population. Home-based care is reportedly twice as common in rural areas. Travel time is longer in these areas as are the length of home visits.

Who are community health workers in South Africa?

A 2011 government audit counted more than 72 000 CHWs linked to health departments across South Africa. Nearly 3000 NGO and CBO organisations were involved in their employment. The vast majority of South Africa's community health workers (90-95%) are poor, black women.[67] Given their meagre stipends, most of these women (like their patients) qualify as social grant recipients, either for child support or pension pay-outs. Most CHWs have a history of informal caring, whether as mothers of children, or as caregivers for sick, elderly and disabled relatives. Those supervising CHWs have often been CHWs in the past and are themselves also poor women.[68] Annual attrition rates among South African health

[67] SANAC (2011) 'Notes from ad hoc meeting of SANAC-convened task team', 19 & 20 April 2011, University of the Western Cape

[68] Akintola, O. and Chikoko, G. (2016) 'Factors influencing motivation and job satisfaction among supervisors of community health workers in marginalized communities in South Africa', *Human Resources for Health* 14, pp. 54.

workers are reported to be as high as 25%[69], and estimated to be much higher among CHWs, particularly those who are young.

According to SANAC,[70] CHWs range in age from 20 to 72. This is a vast age range, signaling different eras in the response to community-based care in South Africa. Increasingly, researchers have encountered two distinct groups of CHWs. One group is made up of mature women, with many years of caregiving experience but little formal schooling. The other, emerging group, is comprised of younger women in their early twenties. Most of these CHWs have a matric qualification. Many enter community health work as a potential career path, in lieu of being able to afford nursing or another tertiary qualification.[71] The presence of these better educated younger women in CHW work is starting to complicate previous conceptions of lay health work as a calling for older, respected women with little formal qualifications. Changes in the age and educational profile of CHWs have come with new ways of viewing care work — as a technical intervention by trained staff rather than a charitable service offered by lay volunteers.[72] Unsurprisingly, there are marked difference between the profile and motivations of CHWs in these different age groups.[73]

CHWs under 30 years	• Most have a matric • View a CHW position as a career path or skills-building opportunity • Greater likelihood of attrition • Many are single mothers[74] • Young mothers, in particular, appreciate being able to work close to where they live.
CHWs Age 30–50	• Often have experience in care work.

[69] Besada, D (2017) 'One or two-tier community health worker cadres? Resource implications for South Africa', *Institutionalising Community Health Conference*, Johannesburg, 27-30 March 2017

[70] SANAC (2011) 'Notes from ad hoc meeting of SANAC-convened task team', 19 & 20 April 2011, University of the Western Cape

[71] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET).

[72] Van Pletzen, E. and McGregor, H. (2013) 'Community caregivers: the backbone for accessible care and support: multi-country research: South Africa report', The Caregivers Action Network.

[73] Swartz, A. (2012) 'Community health workers in Khayelitsha: motivations and challenges as providers of care and players within the health system', Masters' Thesis, School of Public Health, University of Cape Town.

[74] Vale (2012) and GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

	• Previous, insecure employment (including domestic work, factory work, farm work, shop assistants, hawkers etc.) • Some are grandparents and many cohabit.[75]
CHWs older than 50	• Most do not have a matric. • Very limited schooling, but many years of experience in care work. • Some feel trapped (as a result of their age and limited qualifications).[76]

How are they governed?

With no official CHW policy in place, implementation of CHW programmes has been haphazard and ad hoc. While some CHWs have been integrated into ward-based teams, most continue to work for NGOs. These organisations enroll, supervise, manage and pay CHWs. The state offers funding, policy guidelines, resources as well as some skills development and training. Government also coordinates monitoring and evaluation, ensuring that targets and protocols are adhered to. The Department of Social Development (DSD) and The Department of Health (DOH) are involved in funding and supporting CHWs. CHWs linked to the DSD often prioritise home-based care and support for orphans and vulnerable children. These CHWs tend to have poorer resources than those operating under DOH, but offer more holistic care. The DOH is known to offer support through larger tenders, focusing on DOTS, adherence counselling and other, more biomedical, functions. There is deemed to be lack of integration between DSD and DOH,[77] which makes it especially difficult for organisations receiving funding from both departments.

Regardless of their links to government departments, most CHWs are deployed from NPO offices and conduct their work primarily in homes and communities. Some organisations

[75] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.
[76] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

[77] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.

employ nurses or retired nurses as supervisors, but many employ non-professional managers (including former CHWs).[78]

How are they recruited?

Entrance requirements for becoming a CHW vary greatly across the country and tend to be flexible. Often, these requirements are waived to cater for experienced care workers with little formal education. In general, CHWs are required to be literate and numerate with competency in English. They are also expected to live in the communities in which they will work and be over the age of 18. Some employers give preference to those with home-based care training.

In many cases, official recruitment criteria operate alongside informal practices. Many organisations will have a number of CHWs from the same family. In a study by Vale, CHW positions were broadcast at the clinic, resulting in many existing volunteers or model patients being recruited. Some CHWs are alerted of the posts through their churches, speaking to a longer history of the involvement of faith-based organisations and community-based work.

In some areas, there are reports of CHWs being informed that they will not receive stipends unless they have a matric qualification. **"When they have a post, they don't take us, but someone off the street"**, said one CHW in a nationwide study by Van Pletzen et al.[79] In the same study, other CHWs had received the message that they would have to leave their NGO unless they acquired a matric within 3-4 years.

New policy towards Ward-Based Outreach Teams suggests that CHWs minimum entry requirements will be raised and that fewer CHWs will be operating throughout the country. Many health activists are concerned about job losses among CHWs currently working, particularly those with little formal qualification but extensive experience.[80]

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[78] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town; Akintola, O. and Chikoko, G. (2016) 'Factors influencing motivation and job satisfaction among supervisors of community health workers in marginalized communities in South Africa', *Human Resources for Health* 14(54).

[79] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.

[80] Trafford, Z., Swartz, A. and Colvin, C. (2017) '"Contract to volunteer": South African community health worker mobilisation for better labour protection', New Solutions 0(0), pp. 1—19.

In the process of forming new Ward-Based outreach teams, there has been no guarantee that government will recruit from the existing pool of CHWs.[81] In the Free State, this has resulted in many CHWs losing their jobs. Gauteng and Eastern Cape Provinces also do not necessarily recruit from within the existing pool of CHWs. In the North-West, where NGOs are responsible for recruitment, this is often from outside the existing pool. To add to this, while some provinces have decided to absorb and upskill single-purpose CHWs as generalists, in other provinces, these workers are likely to lose their jobs.[82] Even in those areas where WBOTs are drawn from CHWs already in operation, it is often not possible to hire all CHWs, creating tensions between those stipended and those working unpaid, and forcing recruiters to implement arbitrary entrance requirements in order to justify their decisions.[83]

In some provinces, Ward-Based Outreach teams are now recruited directly by the state, but more often it is NGO governance structures making the call. Policy proposes that 'the community' be involved in the recruitment of CHWs. In some areas, CHWs are appointed by, or even from within, Community Health Councils. Sometimes traditional leaders are involved in their appointment.

What are their motivations?

Care

Research indicates that CHWs' often have multiple motivations to care. Many CHWs will refer to a desire to 'help others' and 'support their community'. These altruistic imperatives are sometimes located within a particular understanding of what it means to be a woman, a Christian, a good neighbor, or even an African.[84]

Often, CHWs have a long experience of caregiving in their own homes, whether for their own children, or disabled, sick and elderly family.

> **'I lost my younger sister to HIV and eventually had to take care of her two kids. When I see kids like them, I feel the need to love and help them. So I help by educating them to help stop the pandemic (CHW, GP).** [85]

[81] Malan, M. (12 September 2014) ' Community health workers shafted by SA's policy shambles', *Bhekisisa*
[82] Malan, M. (12 September 2014) ' Community health workers shafted by SA's policy shambles', *Bhekisisa*
[83] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET).
[84] Swartz, A. and Colvin, C. (2015) "It's in our veins": caring natures and material motivations of community health workers in contexts of economic marginalisation', *Critical Public Health* 25(2), pp. 139-152.
[85] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

'I had the love to look after sick people. Someone told me about the training...and I decided to become a volunteer' (CHW volunteer, KZN)[86]

Past experience of family caregiving has given many CHWs a sense of self-efficacy and purpose — that they have a 'calling' to care. Some CHWs are living with HIV or other chronic conditions themselves. In these cases, their experience (whether good or bad) as patients often motivates them to enter care work.

I see the people that are living with this [virus] and I was like, "How can I be like them?" And then it's where I started motivating people, speaking to the people, telling the people about my status. So it goes on […] until I accepted that I'm living with disease and then I will go far with it' (CHW, WC).[87]

Developing links to the formal health system as a CHW means that both CHWs and their families have smoother access to information, medication and expertise.

Dignity

In addition to their altruistic 'will to care', many are also drawn to a CHW position for its (volatile) social currency. The literature suggests that non-monetary signifiers of official status — like uniforms, certificates or name tags — can provide important incentives for CHWs.[88] CHWs often make an effort to dress formally or fashionably to work, valuing the professional prestige of a job in the health sector.[89] These aesthetic markers form part of CHWs attempts to manufacture social distance between themselves and their patients. As lay health workers,

[86] Akintola, O. (2011) 'What motivates people to volunteer? The case of volunteer AIDS caregivers in KwaZulu-Natal, South Africa', Health Policy and Planning 26, pp. 57.
[87] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 15.
[88] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863.
[89] Vale, E. (2012) '"I know this person, why must I go to him?': techniques of authority among community health workers in Cape Town", Centre for Social Science Research Working Paper No: 314 , University of Cape Town; Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.

whose authority is precarious both in the professional setting and in communities, symbolic indicators of authority help CHWs to be taken more seriously in their daily practice.[90]

Employment

Given the extent of South Africa's unemployment, particularly among poor, black women with limited access to tertiary education, many will be interested in a CHW post. Not only are these jobs increasingly likely to be remunerated, they are also close to home. As already noted, CHWs are often mothers who value the ability to live close to their children.

Among the cohort of CHWs in contemporary South Africa are those younger CHWs who enter care work as part of an improvised, ad hoc search for work.

> **I kept telling myself that I'm going to get a job. I was submitting my CV everywhere but nothing was coming. So when I see here – and really it was just something so that I could have something. I won't lie saying that [it was] just because I have a passion or something. No there was no passion. I just needed the money' (CHW, WC).[91]**

> **So, because I was not working that is why I came to [the NGO]. Just to get a job. It was not about knowing exactly what is the job, what it's all about, what is being a PA [patient advocate]. So it was just a job for me' (CHW, WC).[92]**

While CHWs might be motivated by a desire to 'help people', many also feel trapped in their positions and unable to access alternative opportunities. Some older CHWs reportedly feel limited by their age, while many are also constrained by their lack of qualifications.[93]

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[90] Vale, E. (2012) "'I know this person, why must I go to him?': techniques of authority among community health workers in Cape Town". Centre for Social Science Research Working Paper No: 314, University of Cape Town.
[91] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 13.
[92] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 14.
[93] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

Upward mobility

Research suggests that even among volunteer CHWs, whose altruism is regularly lauded, there are also instrumental motivations to care.

> **'I can't say that there's something that attracts me to work for [the HIV/AIDS NGO], but I said, 'let me volunteer first'. Maybe by the time I will be volunteering at clinic I [will] see some posters [for jobs]. That is what has happened.' (CHW, WC)[94]**

> **'The volunteering will turn into a job. We are getting more skills and are therefore going forward' (CHW, WC).[95]**

Hopes of finding secure employment are among the key reasons that CHWs volunteer, but many also develop professional identities and aspire to careers as counsellors or nurses.[96]

> **"[After just] a few months, I am already acting as a community health counsellor. But I'm not here to stay in this field forever because I want to see myself as a nurse one day... that's my dream" (CHW, GP). [97]**

> **'I'm working here [and] I'm using it as a learning curve for me. The experience that I'm getting here I want to use it in future […] Of course I don't wanna be a PA [patient advocate] for the rest of my life!' (CHW, WC).[98]**

For young CHWs in particular, entering care work was an opportunistic ad hoc move to 'get by' and hopefully 'move up' in post-apartheid South Africa.

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[94] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 12.
[95] Swartz, A. (2012) 'Community health workers in Khayelitsha: motivations and challenges as providers of care and players within the health system', Masters' Thesis, School of Public Health, University of Cape Town, pp. 48.
[96] Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.
[97] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.
[98] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 20.

> **'It's only because you see you can be here, working here, but […] you didn't get an income that will satisfy you. We always think about – if I can get this and that and that then it will be better. So that's why even if are at your own job, you have to be looking for the others. We [are] are looking for the green pastures' (CHW, WC).[99]**

Because CHWs are often on the look-out for better pay, more skills and potential career pathways, rates of attrition are high. In a study by Vale (2012), one highly committed CHW (who used her experience on HIV-treatment to motivate patients) quit her job to earn R1000 more per month at MacDonalds. Another young CHW left because he felt the opportunities for career progression were limited:

> **I hate being in a position whereby you notice that there is not progress at all, you understand. You realise that, I mean, you could be here for fifty years, or for twenty years, or for many years, but there would be no progress in your life. I think that is junk! It's totally – I don't know how to describe it, but it's not right. Some people who are still there, I sometimes wonder, what's going on with them? (CHW, WC)[100]**

Research has either positioned care workers as under-resourced and over-burdened, or as models of empowered self-reliance. This neglects the role of care workers as tactical operators, constantly re-inventing their practice under immense pressure.

How are CHWs trained?

The types of training offered to CHWs, as well as the training providers themselves, seem to vary immensely across cases and provinces. The Departments of Labour, Health and Social Development appear to contract trainers rather than doing training themselves. The most regularly mentioned training course is the 69 day HBC course. This includes 20 days of theoretical work, with the remainder being supervised practical work. Beyond this there are

[99] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 13.
[100] Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 19.

a wide variety of courses, including specialist and refresher courses, some accredited and others not.[101] In a 2009 review of CHW programmes in South Africa,[102] CHWs reported receiving patchy and incomplete training. The absence of refresher courses is a particular problem,[103] especially since studies suggest a fall-off of knowledge over time.[104]

CHWs interested in developing a career pathway often find that their training does not properly equip them.[105] Many CHWs have not had the opportunity to access the nationally-accredited, laddered training, for community caregivers. This training is funded by the EPWP and provided through contracted trainers. Some NGOs resent sending much-needed staff away to be trained. Many in the NGO and state system felt this training was poorly aligned to contemporary and future needs, unrealistically structured, and limited in its ability to create real career pathways.[106] In organisations with clear career ladders (to mentor, supervisor or other positions), CHWs are shown to perform better and be better retained.[107]

Current national policy proposals for CHWs suggest training in two phases over 20 days, with further changes for refresher and specialist training. There has been some criticism that the first phase does not include first aid or basic counselling.

[101] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[102] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[103] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town; Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand.
[104] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863.
[105] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand; Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[106] Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436).
[107] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand; White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.

How Are CHWs remunerated?

Many CHWs are still unpaid and unprotected. For those who receive stipends, remuneration varies greatly, depending on employers and funders. In general, CHWs earn up to R3000 per month, with most receiving between R1000-R2000. A recent study[108] of CHWs in KZN showed that CHWs' monthly stipend contravened South African labour laws, blurring boundaries between 'volunteer' and 'employee'.

Although CHWs in the newly-recruited Ward-Based Outreach teams perform the same work, undergo the same training and work the same hours, in 2014 they would have been paid R1000 in Mpumalanga, R2263 in Gauteng and R1500 in the Northwest.[109] Some were paid directly through the provincial DOH which meant fewer payment interruptions. Others, however, were paid by their NPO employers. These CHWs could experience significant delays in payment if NPOs were paid late by government.

Even with their meagre stipends, many CHWs supplement work-related costs (transport, airtime, food for patients etc.) with their own money.

What is a CHWs scope of work?

In light of the history of CHW programmes in South Africa, CHW functions have continued to revolve predominantly around HIV/TB activities. These have included lay VCT and adherence counselling, DOTS, OVC, home-based care and peer education. Roles are often shaped by particular funding schemes; whose funding is regularly ring-fenced.[110] Around these core sets of activities are a range of other functions that vary greatly between provinces and different NGOs. In Limpopo, KZN and EC, there are more generalist CHW programmes that pre-date HIV and seem to exist in parallel with these HIV initiatives. Across the country, CHWs are involved predominantly in care work, rather than preventative work (which has been more emphasised in recent policy proposals). [111] In a recent study from KZN, CHWs

[108] White, M., Govender, P. and Lister, H. (2017) Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal, African Journal of Disability 6(1), e294
[109] Malan, M. (12 September 2014) ' Community health workers shafted by SA's policy shambles', *Bhekisisa*
[110] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.
[111] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.

identified home-based care as their most frequent task, and the weighing of infants and babies as the least performed task.[112]

The plans to re-engineer primary healthcare suggest that each CHW will spend part of their day on facility-based tasks, with the rest in communities and homes. In urban areas, CHWs are expected to conduct about 8 visits per day, 6 in rural areas and 4 in deep rural areas. While PHC re-engineering suggests an in-principle commitment to the centrality of CHWs, no policy outlining scope of work has been finalised.

How are CHWs organised?

> **"Despite more than a decade of rhetorical political commitment to the enhancement, formalization, and upskilling of this cadre of health worker, CHWs continue to occupy a deeply uncertain place in the South African health system and labor market".[113]**

In recent years, there has been increased mobilisation around the labour rights of CHWs. Section27, The Rural Health Advocacy Project, TAC and others have been involved. In 2016, the National Union of Care Workers of South Africa (NUCWOSA) was inaugurated. NEHAWU and Hospersa have, for some time, provided opportunity for representation for community health workers, but given what is often a fraught relationship with other health providers and their specific grievances, the need for an independent union emerged. The union has faced some struggles uniting CHWs given the immense diversification of roles, employment structures, geographic location etc.

Given the extent of CHW burden and exploitation, a number of NGOs have also, for some years, been involved in offering care, support and advocacy assistance for community health workers.

[112] White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.
[113] Trafford, Z., Swartz, A. and Colvin, C. (2017) '"Contract to volunteer": South African community health worker mobilisation for better labour protection', New Solutions 0(0), pp. 4.

CHWs' Biggest Challenges

CHWs feel ill-equipped to meet the needs of their patients

Across case studies and reports, community health workers voiced frustration over the limited care they were able to provide, given a lack of resources and the scale of need. Many felt unable to meet patients' expectations or needs.

Most CHWs cannot deliver medication to patients' homes, have no access to transport, do not carry health monitoring equipment, and lack even basic tools.

> **"We don't have medication for our clients. They expect us to bring them medication. It is hard when you reach a household you talk and talk but don't provide anything" (CHW, EC).[114]**

> **"It would be better if government could equip us with wheelchairs, blood pressure machines, etc. Since we have none of these tools we do not deliver according to our promises, as a result communities lose hope in us" (CHW, EC).[115]**

This lack of resources extends to a lack of space in which to complete paperwork, store documents and report to supervisors.[116]

With many patients struggling to afford public transport, living far from the clinic, and/or being limited in their mobility, a lack of transport creates a significant barrier to care, which CHWs cannot solve on their own.[117] CHWs become frustrated that they cannot bring patients closer to the health services. Not only is it difficult for CHWs to reach their patients, but referrals

[114] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863, pp. 6.
[115] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863, pp. 7; Munshi, S. (2017) 'Exploring the municipal ward based primary health care outreach teams implementation in the context of primary health care re-engineering in Gauteng', Masters' Thesis, Public Health, University of the Witwatersrand.
[116] Marcus T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.
[117] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand; Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.

become effectively impossible[118] Given that a primary role of a CHW is to link patients and facilities, this can lead to many CHWs feeling demotivated. An inability to deliver meaningful care also affects trust between CHWs and communities.[119] At times, this trust has depreciated to the extent that CHWs are accused of profiting off the care needs of others.[120]

At times, CHWs registered to different programmes find themselves in competition, with varying resources to care. While some NGOs, for example, offer food parcels, state-employed CHWs are usually unable to offer such assistance. **"They do not even want to listen to what we have to say",** said one CHW in the Eastern Cape, **"as we have brought nothing".**[121]

Households visited by CHWs often have multiple social and physical needs. Most of these will require referrals or linkages to health facilities, social services, home affairs or other NGOs. Referral channels between CHWs, health facilities, social services and NGOs are often weak. In instances where the referral system fails, CHWs are left feeling redundant, unable to provide the holistic care that is both needed by their patients and prescribed by policy.[122]

In some studies, CHWs report feeling overwhelmed by their patients' expectations (which are often beyond their scope). Patients are said to request meals, electricity, massages, as well as assistance of pregnant women in labour.[123]

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[118] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863; Nxumalo, N., Goudge, J. and Manderson, L. (2016) 'Community health workers, recipients' experiences and constraints to care in South Africa — a pathway to trust', AIDS Care 28(4), pp. 61–71.

[119] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand

[120] Swartz, A. (2012) 'Community health workers in Khayelitsha: motivations and challenges as providers of care and players within the health system', Masters' Thesis, School of Public Health, University of Cape Town, pp. 23.

[121] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863

[122] Hlengwa, W. (2010) 'The burden of care: a study of perceived stress factors and social capital among volunteer caregivers of people living with HIV/AIDS in KwaZulu-Natal', Masters' Thesis, Psychology, University of KwaZulu-Natal

[123] White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.

"What makes CHWs to appear unwelcomed is the fact that when you visit these homes you teach them about health issues. In return, they expect you to have a solution on every problem they bring" (CHW, EC).[124]

In some respects, this reflects the idealism of primary healthcare as a broad vision, which expects radical socio-economic change as well as political reform. It also points to the anomalies of a system in which care providers and those cared-for are equally in need.[125] Their remuneration is insecure, often below minimum wage, and qualifies them for social grants.

Speaking of those instances in which he is unable to attend to the needs of patients, one CHW from Cape Town said:

'It's sad, but take it from me, […] we can turn the tables: I also don't have! So, I don't get too attached to that kind of stuff, because I also don't have. If I had I would have provided' (CHW, WC).[126]

It is reported that some CHWs will often use their own limited resources to support patients, funding work-related costs like transport and airtime. They are also known to give their own food to encourage treatment adherence.[127]

'It's hard because some of us are using the small money they give us to take transport to the area we are working. That makes it very hard because there is little money left sometimes' (CHW, KZN).[128]

[124] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863, pp. 6.
[125] Nxumalo, N. (17.08.2015) 'What it takes to make community health workers better at servicing the poor', The Conversation, http://theconversation.com/what-it-takes-to-make-community-health-workers-better-at-servicing-the-poor-45856; Vale, E. (2012) '"You must make a plan or some story": community health workers and the reappropriation of the care manual', Centre for Social Science Research, Working Paper No. 312, University of Cape Town.
[126] Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper 312, University of Cape Town, pp. 16.
[127] Sips, I., Mazanderani, A., Schneider, H., Greeff, M., Barten, F., Moshabela, M. (2014) 'Community care workers, poor referral networks and consumption of personal resources in rural South Africa', PLOSOne 9(4): e95324.
[128] White, M., Govender, P. and Lister, H. (2017) Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal, African Journal of Disability 6(1), e294, pp. 10.

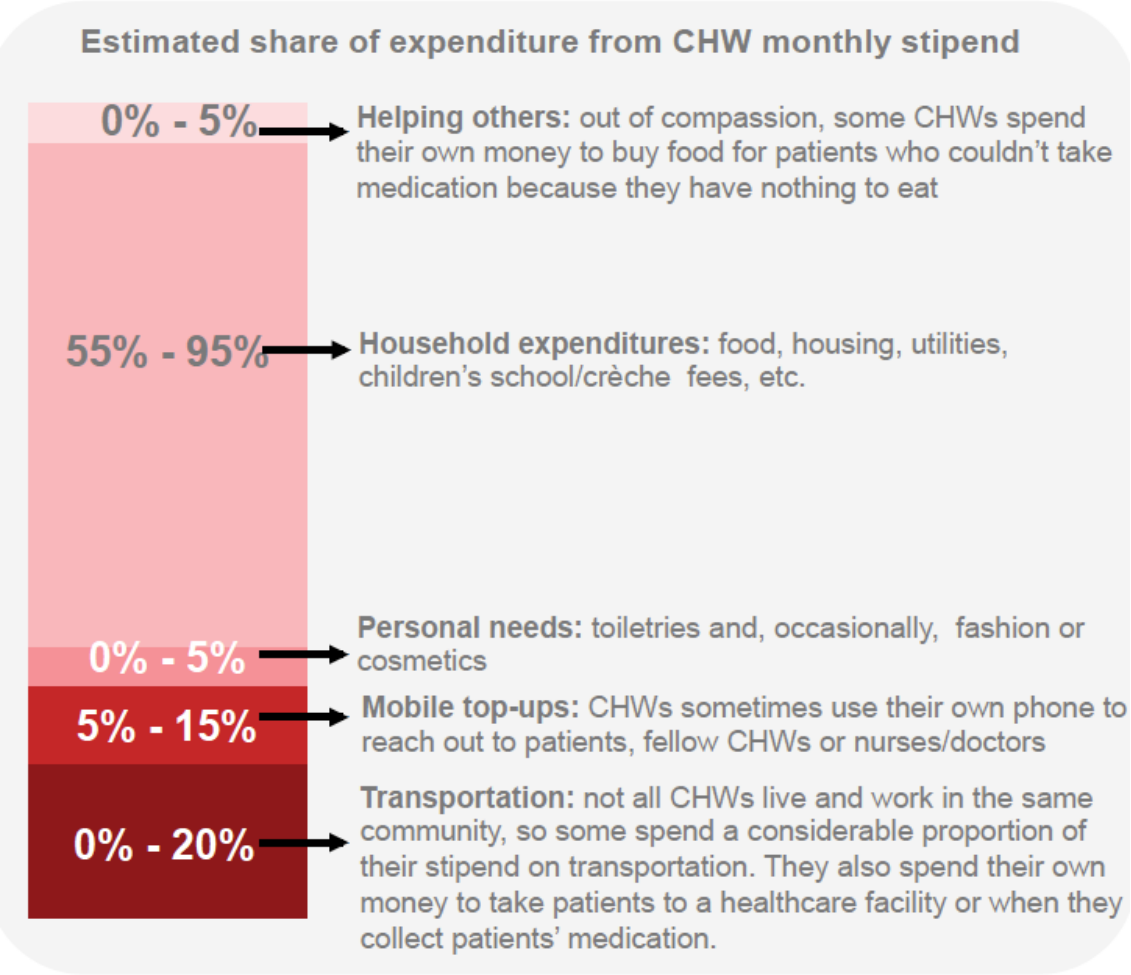

Figure 1 GSMA (2014) 'MHealth: understanding the needs and wants of community healthcare workers'

CHWs are not readily accepted in people's homes

In order to create locally-relevant, accessible health services, primary healthcare encourages not only that care is *community-driven*, with lay workers at the forefront, but also that it is *community-based*. This means situating clinics closer to where people live, but also extending clinic services into homes.

Home-based consultations are the primary role of CHWs across the country, whose performance is often measured by number of visits completed. Home-based consultations are also key to holistic care, since it is often on the basis of these visits that referrals are made to social workers, counsellors, or social grants offices.

Although many CHWs and CHW organisations champion home visits in their rhetoric, in reality, CHWs encounter a multitude of difficulties in and around the home. Home spaces are

often fiercely guarded by family gatekeepers, who police established boundaries of private life. **"Sometimes they [the household members] don't want you",** said on CHW in a study by Vale. **"Others they chase you [away]".**[129]

The norms of the home space view strangers with suspicion, requiring that guests be invited in. CHWs ask to enter a place of intimacy, often arriving unannounced. **"Sometimes it feels like you are invading someone else's space"**, said one Cape Town-based CHW.[130]

The strategy of deploying CHWs into people's homes is intended to make health services more amenable to patients: infiltrating care into their social environment and bringing caregivers closer to them. The assumption is that bringing a care worker into the home will somehow normalize and integrate care into patients' everyday lives. In practice, however, home visits are utterly abnormal, putting additional stress on families and communities, who must attempt to construct a level of normalcy in the face of crippling poverty and a stigmatized HIV/AIDS epidemic. The extent of surveillance and intrusion which these households are expected to accept would most likely not be tolerated in a middle-class setting.

> **"The work was difficult at first because they told us you are going to visit […] this house - doing this, be there, and monitor and everything. And I was so scared. How can I just go to that house and knock? It's so strange, you see. The thing is, I never saw you! [Maybe] I saw you once at the clinic or once somewhere else, but the thing is now it's strange [to] knock at the door looking for this person […] And I ask myself what am I going to do about this?" (CHW, WC)**[131]

While patients sometimes chase CHWs away from their homes or fiercely interrogate them, they are also known to hurriedly clean their houses or find a place for care workers to sit, humbling themselves before their guests. Similarly, while in some instances CHWs behave

[129] Vale, E. (2012) '" You must make a plan or some story": community health workers reappropriation of the care manual', Centre for Social Science Research Working Paper No. 312, Centre for Social Science Research, University of Cape Town.
[130] Vale, E. (2012) '" You must make a plan or some story": community health workers reappropriation of the care manual', Centre for Social Science Research Working Paper No. 312, Centre for Social Science Research, University of Cape Town.
[131] Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper 312, University of Cape Town, pp. 9.

as respectful guests, at other times they report immediately asserting their authority, instructing patients on how to clean and order their home.

Home-based visitations are also built on the assumption that patients are at home during CHWs' working hours. Given that CHWs will be performing more preventative and promotive functions, and not only caring for sick patients, this might not always be the case. Some patients work during the day, while others might attend school.[132]

Age and gender can also be important determinants of the extent to which CHWs are readily accepted in the home. When young, female CHWs provide intimate care or sexual health education for older (particularly male) patients, they flout pre-established social norms, creating tension, discomfort and humiliation in the consultation. Some facility managers have reported problems with the acceptability of young CHWs by their communities. At times, younger care workers have been viewed as unreliable, inexperienced and untrustworthy, particularly with respect to patient confidentiality.[133]

CHWs dual position as community member and facility worker is particularly fraught in the home as the systematised, technical and efficiency-driven procedures of the clinic collide with the domesticity of the home. Some CHWs speak of deviating from their prescribed checklists in order to have more informal conversations with their patients, building comfort and trust.[134]

Indeed, CHWs employ many improvisatory tactics to make care order amenable to the home space. In order to protect their patients from the stigmatizing speculations of neighbours, some CHWs have reported pretending to be friends 'just passing', or salespeople selling insurance. Paradoxically here, care workers remain professional and aloof by fabricating closeness. "You have to do by all means to protect - or to hide what you are going for. You have to tell another story", says one CHW.[135] In cases where care workers do in fact know

[132] Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.
[133] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET).
[134] Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper 312, University of Cape Town.
[135] Vale (2012) '"You have make a plan or tell some story": community health workers' re-appropriation of the care manual', Centre for Social Science Research Working Paper No. 313, University of Cape Town.

their patients on a personal level - whether they are family or friends - the opposite occurs. CHWs must maintain an air of distance and professionalism to mask the genuine intimacy of their relationships. Hence, to provide community-based care successfully is to adopt improvisatory strategies that disguise and fabricate relationships, negotiating the lines between public and private, proximity and distance.

CHWs feel unsafe

CHWs often work in unsafe environments, in which violence, theft and sexual assault are a major concern. Women, who make up the vast majority of South Africa's CHW cohort, are particularly vulnerable.[136] Working in the home space means that CHWs often find themselves in private quarters, in which their power is limited, and in which there is little recourse should they feel threatened.

> **'When you visit, what if this person rape[s] you to this house? Because sometimes you walk alone. You go to the man's house alone. I was very scared. I was not comfortable' (CHW, WC).[137]**

The current model for PHC Re-engineering proposes that each CHW be allocated responsibility for 250 households. In addition to this being an unmanageable workload, working alone may also not be desirable. CHWs operating alone are more likely to have their personal safety compromised, less likely to receive support in difficult situations, do not experience on-the-job mentorship and are less likely to benefit from a complementary pairing of skills.[138]

In addition to fear of crime, CHWs also feel unsafe caring for patients with infectious conditions, particularly since many do not have protective equipment like masks or gloves.[139]

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[136] Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.
[137] Vale (2012) '" I know this person, why must I go to him?": techniques of authority among community health workers in Cape Town', Centre for Social Science Research Working Paper No: 314, University of Cape Town, pp. 16.
[138] SANAC (2011) 'Notes from ad hoc meeting of SANAC-convened task team', 19 & 20 April 2011, University of the Western Cape.
[139] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

CHWs are overburdened

CHWs regularly describe being stressed, overworked, exhausted or burnt out.[140] This is attributed to high workload, poor supervision, a lack of career pathways within CHW programmes, insufficient remuneration, poor debriefing and a dangerous work environment.[141]

"After listening to painful stories, you feel the stress too. You yourself need some counselling because of all those emotional stuff" (CHW, WC)[142]

There is a lack of supervision and support for CHWs

Across almost all existing studies of CHW programmes in South Africa, there are reports of poor supervision. Many CHWs feel that supervisors do not value their contributions and that they are being treated as clerks or messengers, rather than a cadre of workers with important insights into their patients.[143] Despite their extensive knowledge about their patients' lives and communities, health professionals rarely asked their opinion on cases.[144]

The lack of on-the-job supervision for CHWs is of particular concern.[145] Rather than retrospective, clinic-based reviews by nurses, CHWs in a recent Eastern Cape study, for example, advocated for field-based training and supervision.

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[140] Hlengwa, W. (2010) 'The burden of care: a study of perceived stress factors and social capital among volunteer caregivers of people living with HIV/AIDS in KwaZulu-Natal', Masters' Thesis, Psychology, University of KwaZulu-Natal; White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294; Akintola, O. (2006). Gendered home-based care in South Africa: More trouble for the troubled. *African Journal of AIDS Research, 5*(3), 237-247; Akintola, O. (2008a). Defying the odds: Coping with the challenges of volunteer caregiving for AIDS patients in South Africa. *Journal of Advanced Nursing,* 63(4), 357-365; Akintola, O. (2008b). Unpaid HIV/AIDS Care in South Africa: Forms, Context, and Implications. *Feminist Economics,* 14(4), 117-147.

[141] White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.

[142] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

[143] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf; Munshi, S. (2017) 'Exploring the municipal ward based primary health care outreach teams implementation in the context of primary health care re-engineering in Gauteng', Masters' Thesis, Public Health, University of the Witwatersrand.

[144] Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436).

[145] Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional

"We need a team leader who will do home visits with us. The supervisor that we have has never done any home visits with us. We only see her at the end of the month to check on our books. We have incidents that we tell her that need her attention but she tells us that she is busy…and she sometimes tells us that she does not have transport to come. We do not know whether we are doing things correctly because there is no one to guide us" (CHW, EC).[146]

Many facilities struggle to find time and staff to properly supervise CHWs.[147] Overstretched, facility-based supervisors are likely to prioritise facility over community-based work. CHWs are also reported to waste significant time reporting to catchment clinics before and after work.

'[*It is*] difficult for them to report weekly to the team leader at the facility because of the distance and [*it is*] difficult for team leader to do supervision because of transport' (CHW supervisor, Eastern Cape).[148]

Coordination between government clinics and employer-NGOs also creates challenges for supervision. CHWs work *under* health facilities but *for* NGO, creating conflicts over jurisdiction and authority.[149]

The advantages of good supervision are that CHWs feel more supported, are better networked within NGOs and government, and are better able to problem solve around their

Network for Equity in Health in East and Southern Africa (EQUINET); Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863.

[146] Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863, pp. 5.

[147] Munshi, S. (2017) 'Exploring the municipal ward based primary health care outreach teams implementation in the context of primary health care re-engineering in Gauteng', Masters' Thesis, Public Health, University of the Witwatersrand; Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.

[148] Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.

[149] Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.

cases.[150] Effective supervision can be an important motivator for CHWs, but it is widely recognised that supervisors are not equipped with the time or training to supervise effectively.

Generally, CHWs who are facility-based seem to receive better supervision. Here, nurses often play a supervisory role but their effectiveness depends on the individual nurse or the facility management. Supervision in rural areas is especially difficult and may come down to monthly meetings. Home-based care workers are also particularly badly supported.

CHWs report being exploited by professional health workers

Within facilities, CHWs enter as subordinates to clinic nurses, who are often able to dictate their activities and working hours. Indeed, nurses can determine whether CHWs are accepted or marginalised by clinic teams.[151] Some CHWs felt their roles were not recognised or valued by nurses. This lack of recognition affected continuity of care, since professional staff did not report back to CHWs on their referred cases. Exploitation by nurses was regularly reported. CHWs complained of being assigned medial tasks like translation, buying nurses lunch, or cleaning.[152] Where professional staff validated and supported CHWs, this played a crucial role in cementing community trust. In instances where professional staff seemed to doubt the competency and trustworthiness of CHWs, this significantly affected their acceptability by patients.[153]

[150] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand

[151] Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.

[152] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town; Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436); Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET); Vale, E. (2012) '"I know this person, why must I go to him?": techniques of authority among community health workers in Cape Town, Center for Social Science Research Working Paper No: 314, University of Cape Town, pp. 5.

[153] Grant, M., Wilford, A., Haskins, L., Phakati, S., Mntambo, N., Horwood, C. (2017) 'Trust of community health workers influences the acceptance of community-based maternal and child health services', African Journal of Primary Health Care & Family Medicine 9(1).

CHWs struggle to occupy the dual roles of community member and facility staff

One of the few areas of uniformity among CHWs across the country is that they are selected from the communities in which they will work. The benefits of this are that they know the local geography, culture and dialects. The hope is that familiarity will breed CHW confidence and patient comfort. There is an assumption that patients will see CHWs as 'one of them', which will promote trust. In practice, however, there are numerous challenges in occupying the dual role of clinic worker and community member.

Ironically, trust is of particular concern. Once it becomes clear that there are community members who now have access to confidential patient information held at the clinic, this information is made significantly more dangerous. There is a worry that having a community member, rather than an anonymous professional, involved in your case threatens confidentiality. It is precisely because CHWs straddle clinic and community that they become a threat. Ironically, it is sometimes those CHWs who are least sociable, and therefore least embedded in communities, who are also most trusted.[154]

It has been reported that some patients view CHWs as clinic 'informants', who report patients' 'bad behaviour' back to health authorities.

> **'[The patient will say] "No don't tell the sisters!" Me I just say, "I'm watching you". I just say that: "I'm watching you" ... I don't have a right to come to Sister and say I saw him [drinking], because they are going to hate me because of that. They say I'm impimpi [informer – also used as the term for a police informer during apartheid] and I don't want to be impimpi. I just say "Watch out!" (CHW, WC)[155]**

> **'And then when you meet with her [it is] as if you are police or something. [She is] running [from] you and avoiding you...' (CHW WC).[156]**

[154] Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper No: 313, University of Cape Town, pp. 7.
[155] Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper No: 313, University of Cape Town, pp. 19.
[156] Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper No: 313, University of Cape Town, pp. 19.

Being 'just another neighbour' also creates a problem for CHWs ability to assert authority. One CHW reported that when patients are sent to them, in the clinic, for lay counselling, some will say:

> **"Ag I mean I know this person! They stay here. Why must I go to them?' (CHW, WC).** [157]

The problem of authority is made particularly difficult since CHWs lack often lack accreditation or signifiers of their official status (whether uniforms, badges etc.). Indeed, many CHWs have mixed feelings towards these official symbols, which on the one hand would invest them with a greater sense of legitimacy and authority, but on the other hand would draw unwanted attention to them as they go about their community work. Some patients will not want others to know they are being visited by a CHW, as this is often attended by stigma.

CHWs struggle with reporting demands

As community health work becomes increasingly formalised, programmes need to be monitored and evaluated. This often places particular reporting demands and performance indicators on CHWs. Increasingly, CHWs are spending many hours of their day completing paperwork. Beyond this, the fact that performance is often measured by 'number of visits' (as opposed to patient progress) can affect the quality of care.

> **'The most important part [of my job], they say it's the visitation. But the most important part to me is not about the visits. It's about are they doing well? Are they taking their medication correctly?' (CHW, WC).**[158]

CHWs across the country report that the introduction of patient quotas has made it difficult to respond flexibly to the needs of their patients.[159] In a 2009 report of nine country-wide case

[157] Vale, E. (2012) 'I know this person, why must I go to him?' techniques of authority among community health workers in Cape Town', Centre for Social Science Research Working Paper No. 314, University of Cape Town, pp. 5.
[158] Vale, E. (2012) Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper No: 313, University of Cape Town, pp. 23.
[159] Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436); Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town; Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral

studies,[160] some CHWs were expected to visit 15 homes per day, which meant they had little time to spend with each patient or family. In some areas, lay counsellors, too, reported feeling pressed for time now that they had to meet clinic targets, and worried about their ability to offer thorough psychosocial counselling.[161]

If CHWs reported on activities and progress for each household, this seemed to promote a more holistic approach to care. Reporting on the number of households visited, with monthly quotas, has meant that CHWs are not able to meet the care demands of households, nor the targets of their funders/employers.[162]

Challenges and Opportunities for DGMT

Opportunities

Mobile health technologies: recent studies suggest that CHWs do, in general, have access to smartphones and a particular affinity to Whatsapp-style platforms. Many CHWs already use their cellphones to check in with households, receive patients' questions, communicate with other CHWs, and remind patients of appointments and treatment times. Some CHWs are using **Mobile Health technologies** to communicate with their teams and collect patient data. These tools can decrease the time spent on administrative tasks, help garner respect from supervisors and patients, and improve in-field support and training for CHWs.[163] That being said, carrying gadgets is also perceived as a safety risk by some CHWs, as they might attract muggers with the added risk of patient information falling into the wrong hands.[164]

actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand.

[160] Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town.

[161] Van Pletzen, E. and McGregor, H. (2013) 'Multi-country research on community caregivers: the backbone of accessible care and support' — South Africa Report. *The Caregivers Action Network*, pp. 20.

[162] Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand.

[163] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

[164] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

Offering supervision, care and support: CHWs are notoriously under-supported. Better supervision, mentorship and networks of care have been shown to enhance performance and self-efficacy, and reduce attrition rates. Feedback on performance and ongoing mentorship can give CHWs a sense of accomplishment and belonging, making them feel as though their work is valued.[165] DGMT's CHW club and virtual hub could offer important support and affirmation to CHWs. If these clubs were able to offer a physical space for CHWs to gather on occasion, this would also be highly valued.

Building on renewed emphasis on MCH: since MCH is a major priority in the new PHC re-engineering strategy, but also noted as a weakness in current CHW programmes, there is an opportunity for DGMT to respond to an identified gap in existing community health approaches and upskill CHWs to more generalist roles.

> **In the area of reproductive, maternal, newborn and child health) specifically, CHWs provide support not only in the identification of pregnant women but also in the collection of vital patient information. Their role is crucial in providing care and driving demand for early and continual antenatal care, as well as for postnatal care. Besides providing ANC and advocating for a healthy mom and baby, CHWs provide social support and a critical communication channel between the health facility and the pregnant woman and her family.[166]**

Many CHWs are single mothers themselves: this will likely help motivate them to care for pregnant women and new mothers. More so, they are less likely to face the age and gender-based tensions experienced in other settings.

Offering important skills: many CHWs are attracted to opportunities to enhance their skills and value certified training. Being trained as 'champions for children' may make some specialist CHWs more employable under the ward-based system.

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[165] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

[166] GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

Offering resources that allow CHWs to measure patient progress: by equipping CHWs with the tools to weigh infants and track their progress, CHWs will be able to monitor their patients' progress which greatly enhances their own motivation as well as their patients' trust.

Challenges

Delivering care in the home: both CHWs and patients struggle with intrusions on the home space. While pregnancy is perhaps a less stigmatised reason for visiting than HIV/AIDS or TB, it remains fraught, particularly in instances of teenage pregnancy. More so, CHW interferences around appropriate 'motherhood', which has well-established norms and family practices attached, will not necessarily be well received.

A recent study from KZN[167] showed that poor confidentiality and a lack of trust made it difficult for CHWs to be accepted by patients in the delivery of maternal and child health services. Community members believed CHWs should not be trusted, partly because of their lack of professional status but also their familiarity.

Contributing to local tensions around CHW policy and practice: DGMT will likely be contributing to a terrain in which some CHWs are better connected and better resourced than others. This may generate tensions between different organisations and different CHWs. There may be resentment around how DGMT's project impacts CHWs scope of work, depending on whether CHWs in the given area are already involved in maternal and child health services.

A need for training: since most CHWs have been fulfilling HIV and TB-specific roles, they will need to be upskilled to provide maternal, child and nutritional services.

The role of NPOs and donors: there is concern about the role of NGOs and funders in driving particular task-specific agendas in particular areas. Some worry that this detracts from a more generalist approach to CHW work and contributes to a fragmented and poorly coordinated CHW landscape.

[167] Grant, M., Wilford, A., Haskins, L., Phakati, S., Mntambo, N., Horwood, C. (2017) 'Trust of community health workers influences the acceptance of community-based maternal and child health services', African Journal of Primary Health Care & Family Medicine 9(1).

Bibliography

Akintola, O. (2008a). Defying the odds: Coping with the challenges of volunteer caregiving for AIDS patients in South Africa. *Journal of Advanced Nursing,* 63(4), 357-365

Akintola, O. (2006). Gendered home-based care in South Africa: More trouble for the troubled. *African Journal of AIDS Research, 5*(3), 237-247

Akintola, O. (2008b). Unpaid HIV/AIDS Care in South Africa: Forms, Context, and Implications. *Feminist Economics,* 14(4), 117-147.

Akintola, O. (2011) 'What motivates people to volunteer? The case of volunteer AIDS caregivers in KwaZulu-Natal, South Africa', Health Policy and Planning 26, pp. 57.

Akintola, O. and Chikoko, G. (2016) 'Factors influencing motivation and job satisfaction among supervisors of community health workers in marginalized communities in South Africa', *Human Resources for Health* 14, pp. 54.

Austin-Evelyn, K., Rabkin, M., Macheka, T., Mutiti, A., Mwansa-Kambafwile, J., Dlamini, T. and Wafaa, E. (2017) 'Community health worker perspectives on a new primary health care initiative in the Eastern Cape of South Africa', PLOSOne 12(3): e0173863, pp. 5.

Besada, D (2017) 'One or two-tier community health worker cadres? Resource implications for South Africa', *Institutionalising Community Health Conference*, Johannesburg, 27-30 March 2017

Clarke, M., Lewin, S. and Dick, J (2008) 'Community health workers in South Africa: where in the maze do we find ourselves?' SAMJ 98(8), pp. 680.

Colvin, C. and Swartz, A. (2015) 'Extension agents or agents of change: community health workers and the politics of care work in postapartheid South Africa', *Annals of Anthropological Practice* 39(1).

Daviaud, E., Besada, D., Budlender, D., Kerber, K. And Sanders, D. (2017) 'Investment case for community health workers in South Africa', Medical Research Council.

Department of Health (2011) CHW Audit Report. Tshwane

Gilbert, T. and Gilbert, L. (2003) 'Globalisation and local power: influence on health matters in South Africa', Health Policy 67, pp.248.

Gofin, J. and Gofin, R. (2005) Community oriented primary care and primary health care', American Journal of Public Health 95(5),

Grant, M., Wilford, A., Haskins, L., Phakati, S., Mntambo, N., Horwood, C. (2017) 'Trust of community health workers influences the acceptance of community-based maternal and child health services', African Journal of Primary Health Care & Family Medicine 9(1).

Grimwood, Ashraf (08.01.2018) Personal communication.

GSMA (August 2014) 'MHealth: understanding the needs and wants of community health workers', https://www.gsma.com/mobilefordevelopment/wp.../CHW-Research-Report-V16.pdf.

Hlengwa, W. (2010) 'The burden of care: a study of perceived stress factors and social capital among volunteer caregivers of people living with HIV/AIDS in KwaZulu-Natal', Masters' Thesis, Psychology, University of KwaZulu-Natal

Kautsky, K. and Tollman, S. (2008) 'A perspective on primary health care in South Africa', South African Health Review. Heath Systems Trust, Durban.

Languza, N., Lushaba, T., Magingxa, N., Masuku, M. and Ngubo, T. (2011) 'Community health workers: a brief description of the HST experience', Health Systems Trust: Durban.

Lehmann, U. and Matwa, P. (2008) Exploring the concept of power in the implementation of South Africa's new community health worker policies: a case study from a rural sub-district', Discussion Paper 64, Regional Network for Equity in Health in East and Southern Africa (EQUINET)

Malan, M. (12 September 2014) ' Community health workers shafted by SA's policy shambles', *Bhekisisa*

Marcus, T., Hugo, J. and Jinabai, C. (2017) 'Which primary care model? A qualitative analysis of ward-based outreach teams in South Africa', African Journal of Primary Health Care & Family Medicine 9(1), a1252.

Marks, S. (2013) 'Social justice or grandiose scheme?: the 1944 National Health Services commission revisited', presentation at WISER, Johannesburg, 30 September 2013.

Munshi, S. (2017) 'Exploring the municipal ward based primary health care outreach teams implementation in the context of primary health care re-engineering in Gauteng', Masters' Thesis, Public Health, University of the Witwatersrand.

Nxumalo, N. (2013) 'Community health workers, community participation and community level inter-sectoral actin: the challenges of implementing primary health care outreach services', PHD Thesis, University of the Witwatersrand.

Nxumalo, N. (17.08.2015) 'What it takes to make community health workers better at servicing the poor', The Conversation, http://theconversation.com/what-it-takes-to-make-community-health-workers-better-at-servicing-the-poor-45856

SANAC (2011) 'Notes from ad hoc meeting of SANAC-convened task team', 19 & 20 April 2011, University of the Western Cape.

Schneider, S. and Nxumalo, N. (2017) 'Leadership and governance of community health worker programmes: a cross-case analysis of provincial implementation in South Africa', *International Journal of Equity in Health* 17(72).

Schneider, H (2008) 'Community health workers and the response to HIV/AIDS in South Africa: tensions & prospects' *Health Policy & Planning* 23, pp. 179–187.

Schneider, H., Schaay, N., Dudley, L., Goliath, C. and Qukula, T. (2015) 'The challenges of reshaping disease specific and care oriented community based services towards comprehensive goals: a situation appraisal in the Western Cape Province, south Africa' *BMC Health Services Research* 15 (436)

Sips, I., Mazanderani, A., Schneider, H., Greeff, M., Barten, F., Moshabela, M. (2014) 'Community care workers, poor referral networks and consumption of personal resources in rural South Africa', PLOSOne 9(4): e95324.

Stevenson, S. (2016) Community health workers: a Spotlight in-depth feature, www.spotlight.co.za

Swartz, A. (2012) 'Community health workers in Khayelitsha: motivations and challenges as providers of care and players within the health system', Masters' Thesis, School of Public Health, University of Cape Town, pp. 23.

Swartz, A. and Colvin, C. (2015) "It's in our veins": caring natures and material motivations of community health workers in contexts of economic marginalisation', *Critical Public Health* 25(2), pp. 139-152.

Trafford, Z., Swartz, A. and Colvin, C. (2017) '"Contract to volunteer": South African community health worker mobilisation for better labour protection', New Solutions 0(0), pp. 4.

Vale, E. (2012) 'I know this person, why must I go to him?' techniques of authority among community health workers in Cape Town', Centre for Social Science Research Working Paper No. 314, University of Cape Town

Vale, E. (2012) '"Looking for greener pastures": locating care in the life histories of community health workers', Centre for Social Science Research Working Paper No. 313, University of Cape Town, pp. 19.

Vale, E. (2012) Vale, E. (2012) '"You must make a plan or some story": community health workers' reappropriation of the care manual', Centre for Social Science Research Working Paper No: 313, University of Cape Town

Van Ginneken, N., Lewin, S., and Berridge, V (2010) 'The emergence of community health worker programmes in the late apartheid era in South Africa: an historical analysis' *Social Science & Medicine* 71

Van Pletzen, E., Colvin, C., Schneider, H. (2009) 'Community care workers in South Africa: local practices: case studies from nine provinces', Cape Town: School of Public Health and Family Medicine, University of Cape Town

Van Pletzen, E. and McGregor, H. (2013) 'Multi-country research on community caregivers: the backbone of accessible care and support' — South Africa Report. *The Caregivers Action Network*, pp. 20.

White, M., Govender, P. and Lister, H. (2016) 'Community health workers lensed through a South African backdrop of two peri-urban communities in KwaZulu-Natal', African Journal of Disability 6 (0), a294.