Community Health Workers in Gauteng - Context and Policy

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Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal care
CBOs	Community-Based Organisations
CHC	Community Health centres
CHW	Community Health workers
DHMT	District Health management Teams
DOTS	Direct Observation Therapy – Short course
EPI	Expanded Programme on Immunisation
ETQA	Education Training Quality Assurance
FP	Family Planning
GDOH	Gauteng Department of Health
HBC	Home-Based Care
HIV	Human Immune Virus
HWSETA	Health and Welfare Sector Education and Training Authority
IDHAC	Interim District Health Advisory Committee
MCH	Maternal and Child Health
NGOs	Non-governmental Organisations
NQF	National Qualification Framework
PFMA	Public Finance Management Act
PHAC	Provincial Health Advisory Committee
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PWAs	People Living With AIDS
RCHWC	Regional Community Health Workers Committee
SAQA	South African Qualifications Authority
STIs	Sexual Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counselling and Testing

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Executive Summary

Community health workers (CHWs) serve as a bridge between community members and the health care and social services systems. They are found to be most appropriate to assist in responding appropriately to community needs. The formal health sector has also increasingly used community health workers to provide services, especially in dealing with the HIV epidemic, nutrition, child abuse, etc.

Community health workers are important to the health and social services for various reasons, especially, in developing countries. Community health workers should not be seen as an alternative to formal health care services but rather as complementary to the formal health care setting.

The Gauteng Department of Health like most provincial Departments in the country has been using NGO's and community volunteers to provide a range of community based health services. There is a range of community workers that exists in the province including HIV counsellors and home-based carers, DOTS supporters, community workers providing mental health services, rehabilitation services, home deliveries and those providing health promotion activities. The HWSETA is awaiting the development of an SGB and the development of standards for this category of worker. The guidelines for NGO funding are not explicit on how CHWs should be paid by NGOs.

The 2003 budget for all HIV related NGOs/CBOs funded by the province indicates that the province was to spend R33, 193,290.00 on funding NGOs and CBOs and the type of services to be funded ranged from home-based care, support of PWAs, youths cultural groups etc. Funding for organisations working in prevention programmes seems to be minimal. However, other programmes, like mental health and physical disability, have a less formal relationship with NGOs, and thus we do not have information on whether or not there are alliances between volunteers and NGOs nor if there are CHW's in these areas working in our communities.

Gauteng is estimated to have about 2 million households and 30% of these households were made of informal houses. If these households are targeted for CHW activities, the province has to cover 648,849. Using the Kwazulu Natal norm for CHWs workload of 200 households per CHW in urban areas, the province would need 3,244 community health workers and this will cost the province R19, 465,461 on stipends per year.

A framework for assisting the province in implementing the programme is outlined. It deals with procedures for selection, monitoring and reporting systems of community health work. Its aim is to provide guidelines, policy context and assist programme managers in setting up systems that will promote the use of community health workers in the province.

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Background

Community health workers (CHWs) serve as a bridge between community members and health care and social services systems. Their duties centre on preventing disease and minimizing the impact of existing disease through providing health information, social service care coordination, client intake and orientation, and outreach.

CHWs are usually indigenous to the communities in which they work. Ethnically, culturally, linguistically, socio-economically, and experientially they are able to bridge gaps in language, culture, economic status and education and are able to connect diverse communities with the health and social services they need. [1] CHWs also advocate on behalf of individuals and communities for improvements in health and social conditions.

CHWs carry out enabling services to help families navigate, sometimes, fragmented health care systems and create a bridge between the medical regime and the contexts of the community members. [2] Activities include screening of individuals who come in for care, locating and coordinating both medical and social service resources, educating families, and lending emotional and practical support for management of care in home settings. [3] This role is needed in all communities.

As the importance of behavioural factors in health and illness is becoming more widely recognized, there is increasing interest in the role CHWs can play at an institutional level in the overall health care system. [4] This enabling role is essential for isolated or low-income families that are not in a position to access formal services due to socio-economic reasons and related contextual factors.

International experience suggests that CHWs should have "very specific roles, be responsive to the needs of communities and be well supported by the rest of the health services and any non-governmental organisations (NGO's) working with them". [5]

Although the formal health sector has increasingly used CHWs to provide services, especially in dealing with the HIV epidemic, nutrition, child abuse, NGOs and community-based organisation (CBOs) have played a pivotal role in bringing health services closer to the people through CHWs.

In line with public demand to see government responding swiftly to promises of improved service delivery, NGOs and CBOs have been and remain in and important position to complement government's service expansion. NGOs and CBOs are however also faced with management and operational problems. These include defining their roles in the developmental efforts, ensuring sustainability through reliable funding sources, and building internal management and logistical capacity. It is to the benefit of government service delivery to understand the needs, efficiencies and potentials of NGOs and CBOs

[1] Cesar J A, Cavaletti M A, de Lima S G, Houthausen R S. (1998) Can community health workers reduce the utilisation of health services for children under five years?. Takemi program in International Health, Boston, MA.
[2] Quijano V. (1996) A job task analysis for community health workers. Department of Health education, San Francisco State University, San Francisco, CA.
[3] Ochola P. (1992) The role of community health worker. In Ochola P and Kisubi W K. (Eds) Primary health care: Experiences in Eastern and Southern Africa. African Medical Research Foundation, Nairobi, Kenya.
[4] Malaria- A manual for community health workers. (1996) World Health Organisation, Geneva.
[5] Cruse D (1997) Community Health Workers in South Africa, Health Systems Trust, Durban

and to ensure that such structures are appropriately supported. It is also important to note that amongst NGOs and CBOs which utilise community health workers to render community level health care services, there are differences in the activities and functions of CHWs.

It is acknowledged that CHW programmes do not necessarily cost less than the provision of formal health care services,[6] and planners need to explore ways of enhancing cost-effectiveness and service efficiency to ensure a complementary relationship between CHW programmes and formal health care systems.

With the demand created by the HIV/AIDS epidemic coupled with critical issues such as child and women abuse, the need for CHWs has become a central consideration for effective service delivery. The Presidential call on speeding up service delivery to the community and ensuring community participation has also influenced the health sector to rethink and formalise CHW programmes.

Community health work should not be seen simply as an extension of the formal health care sector. Roles and responsibilities need to be clearly defined, and to provide guidance on monitoring and evaluation systems. There is a need to develop a systematic framework for understanding the inter-relation between the two approaches.

Methods

The Health Systems Trust, on behalf of the Gauteng Department of Health commissioned the Centre for AIDS, Development, Research and Evaluation (CADRE) to formulate a draft policy to guide the implementation of community health workers in the province.

A review was conducted of the current context of community health workers operations in Gauteng. This included in-depth discussions with provincial staff working in the NGO funding unit, Regional HIV managers and HIV coordinators.

Reports and business plans from regions were also reviewed, including a review of monthly reports submitted to province, budgets and financial plans. Documents including draft policies and guidelines on NGOs and community health care from the province were also reviewed.

The context of community health workers in Gauteng

The Gauteng Department of Health, like most provinces in the country, have been supporting and has been depending on NGOs, CBOs and community volunteers to provide a range of community based health services. This has centred on the provision of services such as home based-care for terminal ill people (including HIV/AIDS), voluntary counselling and testing (VCT) for HIV, day care centres, counselling and support for women and children who have been subject to abuse and violence, Directly Observed Therapy Short Course (DOTS) for Tuberculosis (TB) patients, amongst other services. [7]

[6] Cruise D. (1997) Community health workers in South Africa: Information for provincial policy makers. Health Systems Trust, Durban, South Africa.

[7] Gauteng Department of Health. Relationship between Gauteng Department of Health and non-governmental/community-based organisations (NGO/CBOs) – Discussion paper: towards a NGO/CBO health policy, May/June 1999.

The challenges faced by the province includes many responsibilities, and there is increasing pressure as a result of increased demand for services at community level. With regard to CHWs, the challenges include ensuring that services rendered by NGOs and CBOs contracted by the province are in line with policies and strategic plans.

Issues

Systems

The majority of CHWs in the province are employed by NGOs and CBOs. There are however some CHWs, especially those providing HIV counselling, who are directly linked to province and seconded to NGOs and CBOs. Apart from HIV counsellors and home-based carers, there a range of CHWs that are active in the province.

The GDOH has attempted to define community health work in the province in its draft memorandum on implementation of a policy to train, utilise, support and reimburse CHWs. This has been defined as: "… people who represent, and are chosen by, the community in which they work. They respond to the health needs of their communities, thereby becoming an extension of, and a link to the health services. On behalf of their communities, they network with health teams and other sectors. They identify with their communities, and are accountable to them, and are committed to the health and uplifting of their communities. They must undergo a basic training in health".[8]

In Gauteng the regional personnel expressed the feeling that NGOs are at least complying with the spirit of the definition of CHWs. The experience is that most of the home-based care carers and DOTS supporters are selected from the communities they are serving. However, NGOs are faced with a challenge of capacitating them, as many are illiterate, thus posing a challenge during training and reporting, as a regional co-ordinator noted:

> *"For these NGOs it is encouraging to note that all their workers are from the community and known by the communities. As we speak now we are training a number of HBC carers and they belong to those communities … many of them have been TB supporters. The problem we have is that most of them cannot read and write and we have a real challenge… we are not sure how to help the NGOs and trainers to deal with that problem".*

Population coverage

From the 2003 mid-year population estimates, Gauteng has a population of over eight million people, and over two million households. The national household survey on health inequalities[9] estimated that about 30% of the houses in the province were informal settlements. These are critical households to be covered by community health workers. Based on these numbers, in the province has an estimated 648 849 households that would need to be covered by CHWs. However, with the decline in

[8]Gauteng Provincial Government, Draft Memorandum. Implementation of a policy to train, utilise, support and reimburse community health workers in areas of need in the communities of Gauteng. **22 August 2003**

[8] Hirschowitz R and Orkin M. (1995) A national household survey of health inequalities in South Africa. The Henry J Kaiser Family Foundation, Washington DC.

economy and the constant migration of people, a number of informal settlements are mushrooming around Gauteng. The demand for CHWs will also increase, requiring the province to also increase the numbers of CHWs in the province.

Table 1: Population in Gauteng – Mid year estimates for 2003

Districts	**Population**	**Household**
Johannesburg Metro	2,871,192	755,577
Ekurhuleni Metro	2,205,043	580,274
Tswane Metro*	1,830,677	481,757
West Rand	825,895	217,341
Sedibeng	485,943	127,880
Total	**8,218,750**	**2,162,829**

* Tswane population and household include Metsweding district

Funding for service provision

The funding of NGOs and CBOs in Gauteng has been largely determined by each directorate within the Department of Health. This has resulted in different practices, procedures and different interpretations of the legal, administrative and treasury requirements. The absence of guidelines for funding NGOs and CBOS has resulted in the fragmentation and duplication of relationships and resources provided to these organisations.

To arrive at a single system for dealing with NGOs and CBOs, the health department in Gauteng commissioned Gobodo Inc. to assist in developing guidelines for funding such funding. These guidelines[10] deal with a range of procedures and administrative requirements that need to be adhered to when funding NGOs and CBOs in the province.

The guidelines gave rise to a framework that takes into account relationships that exist between the GDOH and NGOs and CBOs in relation to the legislative requirements of accounting for use of public funds. The guidelines set out formal processes at regional and provincial levels, to ensure a uniform process across the province, incorporating criteria for selecting organisations for funding, and systems for overseeing such funding.

Although the guidelines are clear, there have been practical problems experienced by both NGOs, CBOs and government officials in implementation. Problems raised include insufficient clarity of processes and procedures. For example, as a provincial official noted:

> *"The fact that NGO's are funded on an annual basis made it difficult and cumbersome for the unit to ensure good performance for NGOs, or to establish a good relationship with NGOs. The period for funding needs to be reviewed toward a*

[10] Gauteng Department of Health. Recommended guidelines NGO funding. Gobodo Inc. 20th March 2003

> *two to three year funding cycle, with proper monitoring systems. This will allow the creation of good rapport and trust between the province and NGOs. When you start to create that relationship the funding cycle stops and you have to ask an NGO to submit a proposal for the next cycle of funding. Many NGOs are learning the systems and adjusting and this does not give them time to settle and master the necessary requirements. I find it very disruptive… This happens to NGOs that we are very satisfied with… when they ask for rationale – we just have to tell them that this is a requirement that needs to be followed regardless of their performance. I guess it is there for transparency and to ensure that all NGOs have an equal opportunity to access funding".*

Apart from the duration of the funding cycle for NGOs and CBOs, there is a sense of discontent from government officials at all levels about the lack of efficiency in paying NGOs timeously. This is seen as a major contributing factor to poor performance and lack of commitment by these organisations.

There is clearly an over-reliance on government funding for NGOs. When the government has not been able to pay NGOs in time, it is extremely disruptive as there is no alternate source of funding. "They are complaining. We cannot do anything until the province releases money," said a District co-ordinator. In relation to reporting and funding, another District co-ordinator observed:

> *Reporting is very poor. But many of them do not comply with reporting requirements. Some just take advantage of the fact that there are loopholes in the systems and we have very little we can do to deal with those loopholes. There is a need for NGOs to diversify their funding to enable to sustain these programmes and retain CHWs as they leave if they are not paid.*

Although there are payment systems and guidelines for dealing with NGOs and CBOs in the province, these seem only to be largely followed by the directorate dealing with HIV/AIDS. It was noted by managers at both provincial and district level that presently there are no systems in place that can track and link activities of funded NGOs – even more so community health workers employed by these NGOs. The absence of such systems makes it difficult for managers at provincial level to coordinate NGO and CBO efforts. As a District HIV/AIDS manger noted:

> *"There seems to be a duplication of some work if each programme has to deal with the same NGO requesting funding on different programme. There is no system presently that can track that. We do not know which NGOs are also funded by the Department outside the HIV programme.*

A provincial official made a similar observation:

> *"Different committees from the programmes are dealing with funding the same NGOs and there is no formal communication structure. It would be useful to have one committee that deals with all NGOs funded through the Department. Officials from the different units can continue to be responsible for the NGOs funded through their programme".*

Remuneration of CHWs

There are presently no standardised remuneration packages for CHWs working within NGOs and CBOs. Remuneration rates also vary depending on the services provided. This creates problems of migration of these workers between programmes, resentment for others on rationale why are they not paid. As a district manager noted:

> *"The major concern is that there is no uniform payment system for workers in this type of work. Counsellors for both VCT and PMTCT are paid (R800) higher than HBC providers (R500), and worse DOTS supporters are not paid at all. This has caused a huge migration of DOTS supporters to join HBC programmes in the province".*

There is a specific need for guidelines to address this issue. As a provincial official noted:

> *"There is a need for guidelines on payment of such workers in the province. Though there is a policy for NGO funding in general, the Gobodo guidelines do not address the payment of workers."*

The draft memo to the Gauteng provincial legislature on the establishment of community health workers acknowledges that this problem exists. It states that there is no uniform payment system, and that some groups working in the health area are less formalised than others.

Training

Training is a critical component of the CHW programme. There is still a debate in relation to the full content of the curriculum, the name of the qualification, and the NQF level for such workers. However, it has been deemed urgent that the health sector formalise this type of health worker in all provinces in the country. The Health and Welfare Sector Education and Training Authority (HWSETA) has proposed a qualification for community based health workers where they would be known as Ancillary Health Workers. In the consultation process with stakeholders, a scope of practice was proposed. This was to be guided by the level of competence, and the regulations and policies pertaining to the context in which the worker should operate. The following tasks were proposed to be part of the scope of practice.

- Promote and assist with the maintenance of the health of a client, a family and a community.
- Disseminate information on health including STIs, HIV/AIDS, TB and MCH to individuals and groups.
- Assist the community to identify health related issues including, but not limited to, social and health related needs, and to formulate a plan of action to address identified needs.

- Participate in drawing up a simple care plan to guide the family of a person who is receiving home-based care.
- Promote and assist with maintenance of the environmental hygiene of families and communities.
- Promote and maintain the comfort, rest sleep and exercise of a client
- Participate in preventing deformity and other complications in a client
- Assist in the activities of daily living
- Assist with the mobility of a client
- Participate in the activities of the dying
- Promote communication with clients, families and communities
- Use basic listening skills to provide support for clients, families and communities
- Refer community members appropriately and timeously
- Care for clients during transfer to hospitals and clinics
- Take responsibility for the possession and valuables of a client during transfer to hospital or clinic
- Assist the family to administer and provide palliative care principles when caring for a client.
- Assist and support the bereaved including orphans.

Based on the proposed scope of work, there are several questions that need to be answered – these include:

- what would the selection criteria be for CHWs?
- what would the level of education requirement be for this type of work? What would happen to existing CHWs who do not meet the educational criteria? What would the plan be for upgrading them?
- Who will provide their training? How would trainers be selected?
- What methods would be acceptable for training CHWs and how would these training methods be monitored?
- What would be the career path of these workers?
- Who will carry the cost of training CHWs?

The accreditation process for these workers is already underway. This process will ensure that there is a uniform training across provinces, that standardised competencies exist, and that there is a uniform qualification that has career paths for those undergoing the training. This will also guide remuneration for the qualification.

Budgetary issues

It is difficult to establish the total number of NGOs with CHWs currently working with the present programmes of the GDOH. Programmes like mental health have a less formal relationship with the NGOs, and thus they do not have detailed information on these organisations and cannot quantify them. However, the 2003 budget for all HIV related NGOs funded by the province indicated that the province was to spend R33, 193,290 on funding of NGOs and CBOs. The type of services provided range from home-based care, support of PWAs, youth and cultural groups etc – see Table 2 below.

Almost half of the budget was to be spent on NGOs and CBOs conducting home-based care. In fact, about 70% of the budget for HIV/AIDS related NGO and CBO funding is shared by organisations working on HBC and hospice. Funding for organisations working in prevention programmes seems to be minimal. It seems that organisations working on the educational aspect of HIV/AIDS receive the least of the funding. Organisations targeting specific groups like youth, cultural activities and education for special risk groups combined in all the three regions in the province had a funding of less than 15% of the total funding.

Table 2: Types of activities funded through NGOs

	Region A		**Region B**		**Region C**	
Type of activity	**Total (Rs)**	**%**	**Total (Rs)**	**%**	**Total (Rs)**	**%**
Home-Based care	7428450	48.4	5820000	44.9	2350000	48.0
PWA support	1514000	9.9	990000	7.6	600000	12.3
Local NGO's	934600	6.1	1150000	8.9	100000	2.0
Special Risks	936000	6.1	880000	6.8	310000	6.3
Youth	585000	3.8	400000	3.1	360000	7.4
Cultural	476000	3.1	795000	6.1	80000	1.6
Hospice	3467240	22.6	2922000	22.6	1095000	22.4
Total	**15,341,290**	**100**	**12,957,000**	**100**	**4,895,000**	**100**

The majority of NGOs and CBOs were classified as working with PLWAs and the community. The definition of community encompasses a wide range of community initiatives and the bulk of those were found to be home-based care activities. However, one can note that of youth organisations, there are 20% in region A, 13% in region B and 14% in Region C, their funding share in the regions was 7% in Region C, 3.8% in Region A and 3.1% in region B. Sedibeng in Region B, did not fund any organisation focusing on youth activities only.

Table 3: Community groupings serviced by funded NGOs[11]

	Region A		Region B		Region C	
Target group	**Total**	**%**	**Total**	**%**	**Total**	**%**
Women	2	2.2	3	3.9	0	0.0
Youth & children	19	20.4	10	13.0	4	14.3
PLWA	32	34.4	36	46.8	18	64.3
Community	34	36.6	28	36.4	6	21.4
Other	6	6.5	0	0.0	0	0.0
Total	**93**	**100**	**77**	**100**	**28**	**100**

It is very difficult to determine the number of people providing CHW services in the communities in Gauteng. The numbers of known workers are those attached to NGOs, who are often working in a set environment providing counselling for HIV and Home-based care. In most instances these workers do not conduct home visits, especially those who are counsellors. If a primary role for CHWs is to conduct home visits and provide services at home, there is a need to shift from the present status quo in terms of the operation of CHWs.

To determine the numbers of CHWs that would be required for Gauteng, it is necessary to determine a norm for each CHW as the basis for coverage. In this instance, the number of households were used for determining a unit for coverage.

In Kwazulu Natal, it has been proposed that coverage of 200 households per CHW is appropriate for urban areas. [12] Gauteng is mostly an urban area, and households are in close proximity to each other. From this assumption, 200 homesteads per year are used to calculate workload for each CHW.

To determine cost for CHWs, three different scenarios are explored: low, medium and high coverage. In each scenario the number of CHWs required to cover a certain number of households and related personnel costs were calculated.

The low scenario allows for CHWs to only cover households in the low-income group. This is mainly in informal settlements and townships. The medium coverage is expanded to also include inner city households, whilst the high coverage scenario also includes suburbs that are populated by people from disadvantaged backgrounds. The projection assumes a workload of 200 households per CHW and a subsidy of R500 per month. See Table 5.

The low coverage will require a total of 3,244 CHWs for the entire province and will cost R19, 465,461 for stipends only annually. This covers 648,849 households in the

[11] The NGO/CBO audit report. (Undated) Gauteng Provincial Government.
[12] Kwazulu Natal Policy Document for Community Health Workers, Draft October 2002.

province. High coverage will require the services of 7,029 CHWs covering 1,405,839 households and will cost annually R42, 175,164 for stipends only.

Table 5: Coverage and cost scenarios for CHWs

		High Coverage			**Medium Coverage**			**Low Coverage**		
Area	Household	65% cov.	# CHWs	Cost (Rs)	45% cov.	# CHWs	Cost (Rs)	30% cov.	# CHWs	Cost (Rs)
Johannesburg Metro	755577	491125	2456	14733748	340010	1700	10200287	226673	1133	6800192
Ekurhuleni Metro	580274	377178	1886	11315352	261124	1306	7833705	174082	870	5222470
Tshwane Metro*	481757	313142	1566	9394264	216791	1084	6503721	144527	723	4335814
West Rand	217341	141272	706	4238145	97803	489	2934101	65202	326	1956067
Sedibeng	127880	83122	416	2493655	57546	288	1726376	38364	192	1150918
Total	**2162829**	**1405839**	**7029**	**42175164**	**973273**	**4866**	**29198191**	**648849**	**3244**	**19465461**

* Tswane Metro estimates include Metsweding district

Planned in an incremental fashion, the low coverage might be the best starting point for the CHW programme in the province. This would allow the province to consolidate what exist at current cost or budgets. Once consolidation has been completed, the province can start to expand the programme. However, if the programme is implemented, it will require a shift from the present operation and management systems utilised in managing both NGO's and the CHWs attached to them. A proposed framework for the programme is outlined below.

Operational framework

This framework provides guidelines for the operation of CHWs in the province. It includes procedures on selection, monitoring and reporting systems for health community work in the province. It also standardises the remuneration of community workers and provide guidance in managing service level agreements between the province and NGO's/CBOs funded by the GDOH.

The framework seeks to:

- Provide an operational frame for implementing CHW programmes in the province
- Provide guidelines for developing a policy on community health work for the province
- Assist programme managers in setting up systems that will promote the use of community health workers in the province.

There are fundamental tenets of the framework that need to be established in order to provide guidance to implementors and to protect both managers and NGOs/CBOs whilst implementing the programme.

The **definition** of community health workers (CHW): CHWs , ideally, would be members of a community who serve and respond to health needs of the community on a day-to-day basis. They will not be unpaid volunteers. The will have a well-defined job description and will be expected to perform functions that promote the health status of the community.

Selection: CHWs should ideally be chosen with full participation of the community and be people who are committed to development of the health status of the community. Responsibility should lie with the institution(s) where they are placed in collaboration with community leadership structures.

The **role of CHWs:** Whether they are assigned to a specific programme or operate on general services at community level, their role will include the following: -

- Linking communities with resources and services - referrals
- Providing health information to their communities
- Mobilising communities to determine their health needs - advocacy
- Raising awareness about diseases and carrying preventive activities
- Carrying out specialist activities such as DOTS, counselling, home-based care, rehabilitative care, etc.

Scope of work: Their scope of work will be at community level and also involve linking the community with the formal health sector. Their activities will be a combination of the following:

- Home visits, to determine health needs, support individuals and families including providing help to solve problems and where applicable, to refer to appropriate health services
- Health education and promotion of public health issues
- Prevention and facilitation of control of communicable diseases
- Follow-ups on chronic diseases (hypertension, psychiatric illness, disability conditions, Tuberculosis, HIV/AIDS etc.)
- Data collection and evaluation (for self-evaluation and for use by the health service)
- Acting as a link between community and local health services in the district (assisting home-based care teams, DOTS, Psychiatric teams, etc.)
- Community organization and development that promotes involvement of communities in promoting health status of the population.

Management

A management structure to monitor and support this programme should be build in the existing structures at Provincial, District level, Sub-District and Ward levels. These structures will be responsible for the following:

- Accountability
- Reporting to the Provincial Health Authority Committee
- Co-ordinating of community health workers programme in the province including training
- Monitoring and evaluation
- Budgeting
- Receiving and screening applications for participation in the CHW programme

Supervision

Supervisory systems should be build in the existing supervisory structures at provincial, District and Sub-district levels. These systems will ensure that there is a mentorship programme, support structures and capacity building activities for community health workers.

At all level, a person should be tasked to coordinate all community health workers activities. This person will coordinate training for CHWs, provide supervision, support and mentoring to NGOs/CBOs and other programmes that are utilizing CHWs in their operations.

Funding

The budget for this activity will come from GDOH. Each district will be allocated funds to implement this programme, based on local needs and approved NGO's/CBOs that have presented business plans according to the NGO's funding guidelines.

The budget will provide subsidies for activities related directly to the programme. This includes training of CHWs, stipends and operational activities for the programme.

Approval of business plans and funds to NGOs/CBOs will be the responsibility of the Provincial Head of Department, through recommendations from both provincial and District committees responsible for selection of NGOs/CBOs. This process will be guided by the provincial NGO/CBO funding guidelines.

Incentives

All community health workers in the province will be paid a stipend of not less than R500. This will discourage the high turn over of community health workers from programmes that are unable to pay their volunteers. It will be the responsibility of NGOs/CBOs to ensure that CHW are paid their stipends

Training

Training plans and programmes need to set up for CHWs. These plans should include:

- Determination of NQF level for CHW training
- Determine existing training providers
- Standardisation of training and accreditation with relevant ETQA and SAQA where applicable.
- Recognition of prior learning for training that has already occurred.

APPENDIX A: PROPOSED POLICY ON CHWS IN GAUTENG PROVINCE. [13]

1. PREAMBLE

The proposed policy provides provincial guidelines on working with CHWs in the province. It guides government, NGOs and CBOs on the selection, training and payment of CHWs as a basis for standardising the utilisation of CHWs in the promotion of health and delivery of health related services. The policy also seeks to ensure that a standardized subsidy system is in place and that standardized provincial management of the CHW programmes takes place.

2. DEFINITION OF COMMUNITY HEALTH WORKERS.

The working definition of CHWs is as follows:

CHWs should ideally be people who come from the community they are serving. They respond to the health needs of their communities, thereby becoming an extension of, and a link to health services. On behalf of their communities, they network with health teams and other sectors. They identify with their communities and are committed to the health and uplifting of their communities. They are trained and are paid.

3. AIMS AND OBJECTIVES

The aim is to ensure that there are uniform principles, procedures and processes for implementing and managing CHWs in the province and to provide guidelines for government officials, NGOs and CBOs working with CHWs.

The Objectives are:

- To establish an operational framework for CHWs in the province
- To promote the utilisation of community-based individuals in the delivery of health services
- To guide NGOs and CBOs in the utilisation of CHWs in the areas they are operating
- To establish uniform operational and management systems for CHW programmes in the province – including supervision, training, payment and support
- To provide a guide for community members, NGOs and CBOs when selecting community health workers
- To provide a guide on liaising and building partnership with other sectors also working toward community development and poverty relief

[13] The proposed policy is based on the contextual analysis of the operations of community health workers in Gauteng province and has been modelled along the lines of KZN community health workers policy.

- To set up principles on monitoring and evaluating CHW programmes in the province.

4. PRINCIPLES

4.1 Who should be a CHW

- A CHW should ideally be a member of the community in which she/he provides community-based health services.
- A CHW should play a unique role as part of the health team, and network with other sectors and development teams, such as welfare.
- They should be committed to uplifting the health of their community, be trusted by, and identify with their community.
- Should have a basic level of literacy, those who already exist without basic literacy, must be trained as a matter of priority.

4.2 The need for CHWs

- CHWs are an important component of community level health interventions e.g. health promotion etc.
- Health services in poor communities are inadequate and in need of extension workers who can provide easy access to information, support and referral to the formal health system.
- Home visiting makes CHWs accessible to the communities and households
- Where CHWs are part of the community, their experiences and understanding of similar health problems can facilitate community organization to confront the root causes of ill health.

4.4 The role of CHWs

The basic role of CHWs is to make primary health care more accessible to their community and to promote the use of health facilities in the communities. To achieve this they may perform some or all of the following roles:

- Linking communities with resources and services
- Distributing health information
- Monitoring community health
- Mobilizing people to determine health needs, to take greater responsibility for their health, which includes advocating for appropriate resources and services.
- Raising awareness about disease and disability, and carrying out health promotion activities.
- Rendering basic fist aid
- Identifying acute and chronic illnesses and facilitating appropriate treatment, care and referral.

- Facilitating change for health development
- Carrying out delegated health driven activities in areas such as MCH, FP, ANC, EPI, HIV/AIDS, TB control, rehabilitation, chronic conditions etc.

5. SCOPE OF ACTIVITIES OF CHWs

5.1 Areas of service delivery

There are a number of areas within the programmes of the Department where CHWs should be utilized. These include the following:

- Voluntary counselling and testing sites, both in Primary Health Care centres and in "One-stop" centres for victims of rape and abuse
- Post exposure prophylaxis (PEP) sites and medico-legal services for victims of rape
- Prevention of mother-to-child transmission programmes
- Support for people living with HIV/AIDS (PWAs or PLWHAS)
- Home based care, assisting families and caring for the terminally ill
- DOTS support for people with TB
- Community mental health services
- Assisting people with disability
- Nutrition education
- Promotion of preventive and curative services, including environmental health and sanitation

5.2 Functions of CHWs

- Home visiting to find the health needs and problems of the families and to help them solve or refer these to the health service deliverers.
- Health education and motivation (maternal and child health, immunization, nutrition, spacing child birth, sanitation, water supply, prevention of home accidents)
- Prevention and facilitation of control of endemic diseases (e.g. TB, Diarrhoea) and epidemics (e.g. HIV/AIDS)
- Follow-ups on chronic diseases (hypertension, psychiatric illness, disability conditions, diabetes etc.)
- Basic management of common diseases and injuries (increasing families' self-sufficiency in the area)
- Data collection and evaluation (for self-evaluation and for use by the health service)
- Acting as a link between community and local health services in the district (assisting home-based care teams, DOTS, Psychiatric teams, etc.)
- Community organization and development (for water supply, clinics, community gardens, forming women and youth groups etc.)
- Counselling for HIV and AIDS

6. INDICATORS FOR MONITORING CHW ACTIVITIES

6.1 Possible output indicators

- Number of house visits carried out
- Number of cases/defaulters/defaulters traced
- Number of meetings held with community, local Health services and other organizations.
- Number of at risk children and adults identified
- Numbers of mobile and fixed clinics attended
- Number of community projects initiated e.g. support groups, community gardens
- Number of VCT cases

6.2 Possible impact indicators

- % rise in under fives with Road to Health charts
- % rise in under fives with Immunization up to date
- % decrease in under fives presenting with diarrhoea
- % rise in homes with toilets (Pit plus structure)
- % drop in homes with potentially fatal toxins accessible to under fives and the mentally ill
- % rise in hospital deliveries
- % drop in un-booked clinic / hospital deliveries
- % drop in diarrhoeal admissions in under five children in out of season months
- Increase in the numbers of community Projects (Gardens, sewing, etc.)

7. MANAGEMENT

- A register of all Community Health Workers will be kept in each district
- Task teams at Provincial, District and Sub-district levels will ensure the implementation of Policy Guidelines
- Organisations will follow the Funding Procedure of the Department in order to be considered for funding
- A Memorandum of Agreement will be signed between the Department and the Organisation.
- Funding, if granted, will be paid in quarterly ‘tranches’ of equal amounts with the first amount being paid in advance.
- A basic minimum stipend will be part of the funding allocated, and NGO/CBOs will give an undertaking in the Memorandum of Agreement to

pay this amount to the CHWs. This amount will be decided upon from time to time by the Department, and will be based on available resources.

- A percentage of the total NGO/CBO allocated funding will be paid to each NGO/CBO for administration costs. This will be reviewed by the department from time to time as funds permit.
- Standardised workloads will be defined.
- Training for CHWs will be standardised according to the curriculum developed by the National Department of Health, and will, as far as possible, be generic in content so that CHWs are equally skilled.
- Training courses will be accredited with the HWSETA. NGO/CBO staff will be trained as assessors by the SETA, and will carry out assessments for recognition of prior learning.
- The National Qualification Framework level will be finalized with the HWSETA.
- Training in supervision, management and finance will be provided by the Department for administrators of organisations who require this.
- A member of staff in each sub-district will be delegated to supervise and coordinate the CHW programme, with the organisations in that sub-district. This person will also manage the register.
- Regular meetings will be held between the Departmental CHW supervisor and the relevant NGO/CBOs.
- Regular meetings between NGOs/CBOs and CHWs will be held in order to offer them support and monitor their progress.
- Regular reports will be submitted to the supervisor in each sub-district on changes in the status of the CHWs, needs, health problems identified and other matters of relevance that may be decided upon from time to time.
- A system of monitoring and evaluation of the work of the CHWs will be developed by the Department and implemented by responsible organisations.
- Accountability for the actions and omissions of CHWs will lie with the NGO/CBO.

7.1 Management structures

- The Provincial Health Advisory Committee (PHAC) will be responsible for policy development, development of guidelines, leadership, support and monitoring of the NGOs/CBOs program in the province.
- The Interim District Health Advisory Committee (IDHAC) will be responsible for planning, co-ordinating and managing all aspects of NGOs/CBOs funding and activities in the district. This can also include collaboration with other government departments and NGOs/CBOs to deliver agreed upon core services.

- The Sub-district Health Committee, working in collaboration with the Ward Health Sub-Committees will be responsible for selection and screening of NGOs/CBOs for funding and monitoring, supporting and supervision of NGOs/CBOs. It will be also responsible for reporting to the district about progress in the NGO/CBO funding programme.

7.2 NORMS

Using available information taking into account district populations and number of household crude estimates will be developed for workloads and coverage.

7.3 FINANCING

The district structures will be allocated funding for the NGO/CBO programme.

Funding of CHWCs

- Each District Committee should be funded through the Provincial Health Authority Committee (PHAC) by annual contracts.
- Funded contracts should be in line with the NGOs/CBOs funding guidelines and adhere to the Public Finance Management Act (PFMA).
- Provincial financial allocations should be divided between districts on an equitable basis.

8. TRAINING

- The PHAC committee will liase with the Standards Generating Accrediting Body (HWSETA) and ensure that it is inline with the national policy.
- The Core training of CHWs will be comprehensive, with additional special training given according to the specific community health programme and district needs.
- Training of CHWs will be needs- and practice-based. The approach is people-centred and discovery-based adult education, with the aim of empowering development.

9. MONITORING AND EVALUATION

- A monitoring system should be established and maintained. Monitoring should be ongoing and all stakeholders must agree upon the monitoring and reporting cycles.
- There should be an annual evaluation carried out by an appropriate organisation or group. This evaluation should be carried out such that there is a community based review as well as a district-based review that can assist with the compilation of district and ultimately Provincial evaluation reports. Continuous monitoring of CHW activities should take place; proposed indicators will be used for monitoring the programme.

FIGURE 1. Model for supervision of CHW in the District Health Systems