

Community health workers and the response to HIV/AIDS in South Africa: tensions and prospects

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After a decline in enthusiasm for national community health worker (CHW) programmes in the 1980s, these have re-emerged globally, particularly in the context of HIV. This paper examines the case of South Africa, where there has been rapid growth of a range of lay workers (home-based carers, lay counsellors, DOT supporters etc.) principally in response to an expansion in budgets and programmes for HIV, most recently the rollout of antiretroviral therapy (ART). In 2004, the term community health worker was introduced as the umbrella concept for all the community/lay workers in the health sector, and a national CHW Policy Framework was adopted. We summarize the key features of the emerging national CHW programme in South Africa, which include amongst others, their integration into a national public works programme and the use of non-governmental organizations as intermediaries. We then report on experiences in one Province, Free State. Over a period of 2 years (2004–06), we made serial visits on three occasions to the first 16 primary health care facilities in this Province providing comprehensive HIV services, including ART. At each of these visits, we did inventories of CHW numbers and training, and on two occasions conducted facility-based group interviews with CHWs (involving a total of 231 and 182 participants, respectively). We also interviewed clinic nurses tasked with supervising CHWs. From this evaluation we concluded that there is a significant CHW presence in the South African health system. This infrastructure, however, shares many of the managerial challenges (stability, recognition, volunteer vs. worker, relationships with professionals) associated with previous national CHW programmes, and we discuss prospects for sustainability in the light of the new policy context.

Keywords CHW, HIV/AIDS, South Africa

KEY MESSAGES

- The response to HIV has given rise to a large lay health worker presence in South Africa's health system.
- CHWs are fulfilling important and new service needs, but can only play meaningful roles in the context of strategies to improve the supply, management and deployment of human resources for health more generally.
- Strengthened systems are needed for the appropriate support and management of CHWs.

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Introduction

Over the last decade in South Africa, a rapid growth in programme activities and budgetary allocations for the comprehensive response to HIV/AIDS has been responsible for the emergence of a large lay health worker infrastructure. It began in the mid-1990s with state support for non-governmental organizations (NGOs) employing home and community-based carers (Russel and Schneider 2000), and the training of lay counsellors to promote voluntary HIV testing and of DOTS supporters for the parallel epidemic of TB. Lay workers are also part of the Comprehensive Care, Management and Treatment Programme governing antiretroviral access (NDoH 2003), where they have been described 'as an indispensable extension of the reach and strength of professional involvement in ART services' (Steyn *et al.* 2006: 113). By 2004, there were an estimated 40 000 such lay workers in South Africa (NDoH 2004a), nearly equal to the number of professional nurses (43 660) working in the public sector (Day and Gray 2005). In that year, the government introduced the umbrella term 'Community Health Worker'¹ for these and all other community workers in the health sector, and adopted a policy framework for their training and remuneration (NDoH 2004b; Friedman 2005). While this framework is oriented to the notion of a generalist CHW, a wide array of more limited purpose HIV/TB workers currently constitute the majority of CHWs in South Africa and are driving developments in what has become a de facto national CHW programme. Expansion and regulation of the CHW infrastructure now features in both the National Strategic Plan for HIV/AIDS (NDoH 2007) and medium-term human resource plans for the health sector (NDoH 2006a).

The deployment of lay or community health workers is by no means a new phenomenon, in South Africa or internationally. In the years following the 1978 Alma Ata Declaration on Primary Health Care (PHC), CHWs were promoted and became a part of many developing country health systems (Walt 1988). While there was enormous variation in the types of CHWs and the forms taken by CHW programmes, these international experiences gave rise to a set of core debates on the role of CHWs in health systems and highlighted common problems associated with their management. Influenced by the development principles underpinning the Alma Ata Declaration, a central debate concerned the technical versus social roles of CHWs, and whether they were to be viewed as agents of community empowerment or narrow functionaries of the health system. It led Werner, following a review of Latin American CHW programmes in the late 1970s, to make the famous distinction between CHWs as 'lackeys' or 'liberators' (Werner 1981). There were overlapping debates on where CHWs were best placed (within facilities or communities), by whom they should be selected and to whom they should be accountable (professionals or communities), and the balance between prevention and care, and generalist and specialist roles (Lehmann *et al.* 2004).

While successful experiments across a variety of contexts provided the inspiration for CHW programmes, numerous difficulties arose in the process of shifting from effective and small-scale local projects to national CHW schemes. Common problems included the lack of integration and conflict with health professionals, unrealistic expectations, unsupportive

environments, poor supervision, lack of appropriate incentives, high turnover and ultimately poor quality and cost-effectiveness (Berman *et al.* 1987; Walt 1988; Walt 1990; Gilson *et al.* 1989). In many countries, CHW programmes were introduced in an overly hasty and top-down manner with little planning. Rather than being the leading edge of a transformed approach to health care, CHWs often ended up becoming a poorly resourced and undervalued extension of the existing health service—'just another pair of hands' (Walt 1990). In the face of these difficulties and of severe economic crises, enthusiasm for national CHW programmes declined internationally in the 1980s and 1990s (Abbatt 2005).

Although national governments tended to steer clear of CHW programmes in the 1990s, CHWs did not disappear from health systems. There is extensive evidence of use of lay or community health workers at sub-national or local level, even in the first world (Witmer *et al.* 1995; Abbat 2005; Lewin *et al.* 2005; Haines *et al.* 2007; Lehmann and Sanders 2007). Rather than the generalist CHWs of the previous generation, these workers have tended to be associated with specific programmes, for example Maternal-Child Health, or disease interventions, for example Directly Observed Therapy, Short Course (DOTS) for tuberculosis (TB) and malaria treatment.

In recent years, a rapid expansion in HIV/AIDS funding and programmes and renewed interest in child survival have provided the impulse for a significant shift in international thinking back towards large-scale deployment of lay or community health workers (WHO 2006; Haines *et al.* 2007). The reasons for this appear to be more pragmatic than ideological: the need to address the crippling health worker shortages in many countries hampering 'national scale-up' of new initiatives, such as access to antiretroviral therapy (ART). Thus in 2006, the World Health Organization proposed 'task shifting' and the training of community health workers, as core ideas in its 'AIDS and health workforce plan' (WHO 2006). The 'massive training of community-based workers' was identified as a quick win for achieving the Millennium Development Goals (UN Millennium Project 2005, cited in Abbatt 2005).

More recent reviews of CHW experiences suggest that under the right conditions scaled up CHW programmes are feasible, can lead to health gains and do produce wider social benefits over sustained periods of time (Haines *et al.* 2007; Lehmann and Sanders 2007). Examples of successful contemporary programmes are the *Programa Agente Comunitário de Saúde* of Ceará State in Brazil and the *Mitanin* programme of Chhattisgarh State in India (Sundararaman 2007). The right conditions include political support, community embeddedness, appropriate training, strong supervision and support, and remuneration and incentive systems (Bhattacharyya *et al.* 2001; Lehmann and Sanders 2007).

International experiences and debates no doubt influenced views on CHWs in South Africa as it entered a period of major political and health sector change in the early 1990s (see for example, Mathews *et al.* 1994). At the time there were a number of generalist CHW programmes in the country, some linked to NGOs and others to regional governments (Kuhn and Zwarenstein 1990; Mathews *et al.* 1991; Mathews *et al.* 1994; Friedman 2005). Despite considerable political support for the concept of PHC, a national CHW programme was not part

of the health reforms instituted by the new democratic government immediately after 1994 and many of the existing initiatives folded (Friedman 2005). One CHW programme, associated with the former Kwazulu homeland, survived the transition post-1994, keeping alive these earlier models of CHWs and later helping to shape the CHW policy which emerged in 2004 (<http://www.kznhealth.gov.za/chw.htm>).

This paper examines the current generation of CHWs in South Africa in the light of the history and international experience with CHWs, with a focus on their central role in the response to HIV/AIDS. It analyses the national policy context and then reports on the empirical reality of CHWs in the primary health care system of one of the nine provinces (Free State) of the country, studied over a period of 2 years. It concludes by discussing the effectiveness, tensions and prospects of sustainability of CHWs in the South African health system, which may be relevant to developments elsewhere, especially in countries involved in the scaling up of massive new programmes.

For the purposes of this paper, our definition of CHWs includes all those 'local inhabitants given a limited amount of training to provide specific basic health and nutrition services to the members of their surrounding communities. They are expected to remain in their home village or neighbourhood and usually work part-time as health workers. They may be volunteers or receive a salary. They are generally not, however, civil servants or professional employees of the Ministry of Health' (Berman *et al.* 1987).²

Methods

The research for this paper forms part of a larger, longitudinal project to document and evaluate the implementation of ART roll-out in the Free State Province,³ with an emphasis on assessing health system impacts. The CHW component involved, firstly, a search for and analysis of national and provincial (Free State) policy documents, ministerial speeches, government commissioned audits and published literature on care-givers and lay and community health workers in South Africa. Secondly, between April 2004 and July 2006, the first 16 primary health care facilities providing ART in the Free State were visited on three occasions: a month prior to inception of the programme (baseline), 7 months after the initiation of the programme (follow-up 1, F1) and then again 13 months later (follow-up 2, F2). At each of these visits a full inventory was made of CHW numbers and training. At the two follow-up occasions, semi-structured group interviews were conducted with CHWs in each of the 16 facilities, involving 231 (89% of total) and 182 (76% of total) CHWs, respectively. Group interviews were conducted in the main language of the group and covered various aspects of work experiences (motivations, roles, relationships, supervision etc.). Opportunities were also provided for participants to raise themes they deemed relevant. Separate group interviews were also conducted with nurses working in the 16 facilities, in which they were asked to give their opinions on CHWs. Consent was obtained to tape-record the sessions and the interviews were transcribed and translated into English. They were then coded by two of the authors (HS and HH), first independently, and then together. The analysis involved an iterative process of identifying themes and

grouping data into categories based on both a grounded approach to the data as well as established frameworks in the CHW literature (Miles and Huberman 1994). The research was approved by the Ethics Committee of the Faculty of the Humanities, Free State University.

National CHW policy context

There are several features of current policy on CHWs in South Africa that have a bearing on considerations of sustainability. In the first instance, lay or community-based workers have not been an isolated phenomenon of the health sector and have emerged as part of broader cross-sectoral responses to HIV as well as employment creation strategies. The Department of Social Development, in particular, has developed its own category of community caregivers addressing the needs of orphaned and vulnerable children. By 2006, the combined number of community caregivers in health and social development sectors was estimated at 62 445 (NDoH 2006b).

At the same time as community workers were emerging to service new HIV initiatives, the national government declared 2002 the 'year of the volunteer', running campaigns to mobilize community volunteers across all sectors. The notion of volunteerism influenced the discourse on community caregivers in the health sector,⁴ while conversely, the presence of lay health workers provided a ready model for organizing the volunteers emerging in other sectors. A recent census counted nine social sector community worker categories: Community Development Workers, Community Development Practitioners, Mid-level Worker, Community Caregivers, Community Health Workers, Child and Youth Care Workers, Youth Worker, Probation Officers/Community Service Officers and Early Childhood Development Practitioners (NDoH 2006b). In 2003, these workers were all brought under the banner of an Expanded Public Works Programme (EPWP), currently one of government's poverty alleviation strategies for the country. The EPWP is itself tied to the Department of Labour's National Skills Development Strategy which includes accreditation of community-based training through structured learnerships. Steps have been taken to standardize and accredit CHW training; by 2006 the Department of Health had registered four community worker qualifications in terms of the National Qualifications Framework, creating the possibility of career pathways for CHWs as mid-level health workers (NDoH 2006c).

The evolution of CHWs has thus been an integral part of the general economic and social policy platforms of the South African government. In her speech at the launch of the CHW Programme in 2004, the Minister of Health (NDoH 2004a) reflected this when she reiterated the following 'imperatives' for the Programme:

- The President's articulation of a people's contract to create work and fight poverty;
- Government's commitment to improve service delivery;
- The national human resource and skills development strategies;
- The increasing complexity of the burden of diseases and poverty-related challenges;

Box 1 Key elements of national South African CHW Policy 2004 (from NDoH 2004b)

- It allows for both generalist and single-purpose CHWs (proposing better coordination of the latter at community level).
- CHWs to receive a stipend but will not be government employees and will be employed through civil society initiatives.*
- The preferred model is a government–NGO partnership where government provides grants to NGOs which employ the CHWs.
- Although voluntarism will continue to be encouraged, volunteers should not be employed more than a few hours a week without remuneration. Volunteers should also not be misled into believing that they will necessarily get paid work.
- Training should be accredited, through appropriate learnerships.
- Trainees should be residents of communities where they will work and selected by those communities.
- CHWs should have a support system, e.g. be part of an NGO/CBO and have access to a referral system.
- Targets on households covered set for generalist CHWs.

*In 2004, monthly stipend levels were set nationally at R1000 (US\$143).

- The increasing need for health promotion activities, community and home-based care.

A second important policy feature is that although the CHW infrastructure is a direct consequence of state investment, the government has avoided becoming an employer of CHWs. The CHW Policy Framework (Box 1) is clear on this: ‘The employment of CHWs would be through NGOs funded by government’ (NDoH 2004b: 6). CHWs thus fall outside of the public service and the regulatory processes governing employment in South Africa. In the 2005/6 financial year, the national Department of Health allocated R68 million (US\$10 million) for provincial funding of NGOs involved in HIV/AIDS and TB care and support activities (Ndlovu 2005), a large proportion of whom act as intermediaries for employment of CHWs. A significant amount of donor funding is also oriented to funding and building the capacity of NGOs and community-based organizations (CBOs). The European Union, for example, committed R250 million (US\$35.7 million) over 5 years (2002–07) to support the development of partnerships between government and NGOs in the health sector, with a specific emphasis on HIV/AIDS (Ndlovu 2006).

A third feature of CHWs is that national policy has developed incrementally and organically over time, rather than constituting a tightly formulated strategy from the top. By the time the national CHW Policy Framework was agreed upon and the programme launched, funding of NGOs and the involvement of lay and community workers in the health sector was already well established across the country. It was also a highly diverse and fluid terrain with multiple NGO/CBO initiatives and single-purpose cadres deployed at local or provincial level. They included lay counsellors, home-based carers, DOTS supporters, prevention of mother-to-child transmission (PMTCT) counsellors, adherence counsellors, support group facilitators, to name a few (Friedman 2006). The national policy framework provides an overarching concept, some standardization, and possibilities for alignment with central government initiatives such as the Expanded Public Works Programme. At the same time it is sufficiently loose to allow for a degree of ambiguity and interpretation, such as proposing remuneration of CHWs while not precluding ongoing recruitment of volunteers; being oriented to more traditional notions of CHWs (community-based generalist workers) whilst acknowledging the reality of more limited purpose CHWs.

Finally, it is important to point out that CHWs in South Africa represent the most formalized end of a continuum of community participation around HIV/AIDS, from treatment literacy training programmes for people living with HIV, to members of their social networks volunteering to be TB or ART ‘treatment buddies’, and participation in rights-based activist networks. The *Médecins sans Frontières* programme in Lusikisiki, Eastern Cape, for example, identified seven different forms of community participation in their sub-district HIV programme, including amongst others, the informal activities of knowledgeable people with HIV/AIDS, support groups, adherence committees, and links with the AIDS activist organization, the Treatment Action Campaign (MSF 2006).

CHWs in the Free State Province

The Free State’s CHW programme has its origins in contracts signed in 2001 with two large NGOs (Hospice and Cancer Association of South Africa) to provide a province-wide system of home-based care based on volunteers. It was followed in 2002 by a ‘Free State Policy on Voluntary Work’ outlining roles and responsibilities of volunteers, amongst others, requiring them to be linked to a local health facility and to report to the facility manager (Hlophe 2006). In its 2003 Health Strategic Plan, the Free State Department of Health outlined further plans to develop and implement strategies for the deployment of community workers to assist in HIV/AIDS interventions (FSDoH 2003). This was followed in 2004 by a policy on ‘Relationships with NGOs’ to cater for expanding activities and a growing number of NGO contracts (Hlophe 2006).

In this section we report on findings on the presence and impact of CHWs in the PHC system of the Free State, including how CHWs themselves described this reality. The findings are based on facility assessments and interviews conducted in the first PHC facilities implicated in the ART roll-out in the Province.

Roles

In mid-2004, when the first inventories were made in the 16 PHC facilities earmarked for the ART programme, there was an average of just over 14 CHWs linked to each facility. The vast majority were trained as single purpose workers, namely as lay counsellors, home-based carers or DOTS supporters (Table 1).

Table 1 Characteristics of CHWs in 16 primary health care facilities in the Free State Province at baseline and follow-up

	Baseline	Follow-up 1	Follow-up 2
Results from inventory			
Lay counsellors (%)	28 (12)	10 (4)	13 (5)
Home-based carers (%)	74 (32)	29 (11)	0 (0)
DOT supporters (%)	72 (31)	21 (8)	22 (9)
ART supporters (%)	0 (0)	5 (2)	1 (1)
Some combination of the above (%)	57 (25)	195 (75)	202 (85)
Total CHW numbers (%)	231 (100)	260 (100)	238 (100)
Profile of participants in group interviews			
Numbers of participants (% total CHWs)	–	231 (89)	182 (76)
Female (%)	–	213 (92)	168 (92)
Age in years:			
• Mean (1SD)	–	41 (11.2)	42 (11.8)
• Median	–	39	42

The age and sex profiles of the CHWs (obtained from participants in the group interviews) indicate an overwhelmingly (92%) female infrastructure, predominantly between the ages of 30 and 50 years (Table 1). Recruitment and selection occurred mostly through calls for volunteers, sometimes via community-based organizations and often with the involvement of local health facility staff. Those assessed as suitable were then sent for training through provincially contracted NGOs. Although not explicitly probed, it was evident that facilities sought to recruit people living with HIV/AIDS as CHWs, reflecting a national trend promoting the involvement of people living with HIV/AIDS in government programmes. Of the 182 CHWs who participated in the second wave of interviews (follow-up 2), 97 (53%) had been present a year earlier in the first wave of interviews, suggesting a more-or-less stable core with a high turnover around this core.

Over the course of the 2 years, total numbers of CHWs in facilities did not change substantially. However, there was a clear investment in training of CHWs with a shift towards to more multi-skilled and multi-purpose HIV/TB workers, even if not generalist CHWs. At baseline only 25% of CHWs had training in more than one area; by follow-up 2 this had increased to 85% (Table 1).

The combination of further training, the new tasks of the ART programme and the reduced need for care of home-bound terminally ill patients effectively created the impetus for a reorganization and expansion of job descriptions for CHWs. As one put it:

“The thing is we now have patients on ARVs, so we do follow-ups for those who miss return dates. We also do counselling, home-based care and drug readiness [training]. We rotate, for example if I do home-based care today, I do counselling tomorrow, just like that.” (N2, F2)⁵

Associated with a more multi-faceted CHW role was the shifting of tasks from professionals to CHWs. For example, responsibility for tracking drop-outs and drug readiness training in the ART programme was initially conducted almost exclusively by nurses, but as patient numbers increased, this gradually became delegated to CHWs, who also began to be

deployed for more general tasks such as providing health talks in facilities and communities. Role confusion, a major theme in the first round of CHW interviews (Hlophe 2006), appeared to have diminished by the second round of interviews.

Over the 27-month period of observation, a distinct division of labour emerged in the clinics, with CHWs increasingly relied upon to fulfil the communication tasks linked to HIV and TB, and nurses limiting their roles to tasks perceived as technical. One of these technical tasks, frequently commented upon by the CHWs, was that of ‘pricking’ (finger pricking for HIV testing). While relatively mundane from a skills point of view (no more complex than a diabetic learning to test their own blood sugar and less complex than communicating the actual test result), it served to mark the boundary between professional and lay roles.

Although the home-based care component of the work was seen as physically and emotionally demanding, CHWs mostly described themselves as skilled and effective players, especially in tasks related to counselling and ART.

“...our patients are alive because of counselling. We tell them about ARV [antiretroviral] drugs and now we have patients that were on wheelchairs but not anymore. Patients love us and appreciate what we do; they tell and refer other patients to us.” (N4, F2)

For some, the more specific facility roles provided a base for enabling access to broader community networks of support.

“Sometimes they come and present with social problems, some will tell me about conflict in the house at home. I am a member of the community policing forum so I do assist where I can, but sometimes the problem will be food, we sometimes get food parcels because I am part of the municipality committee, so I help people where I can.” (N10, F2)

The majority of professional nurses interviewed were positive about the contribution made by CHWs in their clinics, referring not only to their counselling and educational functions but also to their roles as mediators between the facility and the community. Although nurses did not see CHWs as encroaching

on their own professional roles, fears were expressed about delegating sensitive tasks such as HIV counselling to relatively untrained and inexperienced CHWs, who may not remain in the facility for long. This was the source of some tension between nurses and CHWs (see below), and was also raised as a problem by some of the more established lay counsellors.

Another significant development during the period of follow-up, as national policy started filtering down to provincial level, was some regularization of stipend payments and formalization of CHWs as employees. In the initial assessments, payments were still uncommon and the model of 'volunteers' still prevalent in many facilities (Hlophe 2006). By follow-up 2 the vast majority of interviewees had been promised or were receiving the R1000 recommended monthly stipends, even though there were still problems with inconsistent and unreliable processes of payment. In return, CHWs were expected to work half days (20 hours per week), although many claimed to work longer hours. During the period of follow-up, CHWs also reported improvements in supplies such as gloves and kits for home-based care.

Workers versus volunteers

Despite the positive changes in the environment and a growing sense of self-efficacy, interviews with CHWs remained marked by high levels of dissatisfaction. This stemmed from the overriding perception that their contribution, however skilled, fundamentally lacked recognition in the eyes of health care authorities, facilities or communities.

"We are working so hard, we make sure we do our work perfect but no one sees that. Yes, we are volunteers but we need someone to say thank you for what we are doing. We need to be appreciated, that alone will mean a lot to us." (N12, F1)

CHWs universally referred to themselves as 'volunteers' (rather than CHWs) and as an undervalued, flexible and exploited labour force without normal rights or benefits such as leave, maternity benefits and pensions.

"People look down on you when you are a volunteer, when you die you get nothing from the Department. That I still don't understand: how can I work for more than 10 years and get nothing at the end of the day?" (N8, F2)

The precariousness of employment as a CHW was highlighted when in one facility the manager summarily dismissed the lay counsellors following rumours that patient confidentiality had been broken, only for some to be later reinstated by the same facility manager.

Although CHWs were officially employed by NGOs in the province, the real employer was widely perceived to be government, with the employing NGOs portrayed as insignificant players who were merely a conduit for payment of stipends. Not surprisingly, therefore, government officials were a key target of resentment. In one district CHWs went on a two-week strike following the postponement of debriefing and training sessions promised by the Department of Health.

Referring to the Minister of Health in the Province, they indicated that:

"... he should bring police officers with and body guards the day he decides to visit us, because he might not survive on his own. People are very dissatisfied with the way he does things." (N12, F2)

CHWs reported to and were accountable to clinic staff, either the facility manager or the TB or ART programme manager, who was designated as the CHW supporter/supervisor. CHWs thus were in a hierarchical relationship to clinic nurses, who were clearly able to exercise considerable control over their activities, working hours and degree of integration or marginalization in facility teams.

"There are rooms we are not allowed to enter into, we are not even allowed to use the phone, we are treated as if we don't belong here... they [the nurses] call staff meetings and when we attend we are told 'not you volunteers'." (N2, F2)

Nurses also worked to demarcate and maintain their territory as professionals, not only defining the allocation of roles referred to earlier, but also resisting suggestions that CHWs should wear uniforms and monitoring how the community related to CHWs.

"Because I help them [patients], all of them call me 'sister'. Even when they come again they say 'sister, sister' but I tell them that I'm not a sister, but it's difficult for them to stop calling me. Nurses become very angry when patients say that." (N1, F2)

However, the latitude given to facilities also generated positive models of collaboration between CHWs and nurses, which in some instances compensated for a broader lack of recognition.

"We are satisfied with the support, they [nurses] are very supportive and we have a good relationship with them. They are very encouraging especially when we feel as if we are not appreciated by the Department for the work we are doing." (N8, F2)

Motivations

Given these experiences, it is not surprising that being a CHW was not held in high esteem. Most saw it as a way to occupy time, or as a stepping-stone to formal employment.

"Lay counselling is a voluntary work. We want to be employed permanently, because as volunteers, we do not enjoy benefits. We are doing this because we are still looking for job opportunities." (N9, F2)

It is significant, however, that half of the CHWs interviewed had been associated with their facility for at least a year; some reported doing the work for up to 5 years. It is worth considering what motivated those who decided to stay in the health system. In the face of large-scale unemployment, the introduction of regular stipends, however small, no doubt played a key role in attracting and retaining CHWs. The stipend

amounts were set above the state disability grant level, which has been one alternative source of income for those CHWs living with HIV/AIDS, thus providing an incentive to continue as CHWs. They also saw the environment as dynamic, where opportunities might open up.

"When you think of leaving the clinic you again think what if I leave and things change? You think what if I leave and hear that volunteers are getting the money and have been registered." (N10, F2)

One of the most frequently cited opportunities was the possibility of entry into formal health worker training. Contrary to the first round of interviews, by follow-up 2, there was widespread awareness amongst CHWs of policies to create career paths through learnerships, which the province had begun to implement. Many CHWs had direct experience of colleagues being given places to train as nursing assistants. Perceptions of the opportunities, while concrete, however, were also qualified by considerable uncertainty and mistrust. Selection criteria were experienced as opaque or, in some instances, as unfair.

"I volunteered myself for almost 5 years now. When there is a post, they take somebody from outside, not you, because you are a volunteer. Does it make sense? Now we are applying for learnerships, they say: 'we are going to give volunteers first priority'. Unfortunately, they take somebody with standard 2 or 8 sitting in the township doing nothing and you find out that her/his mother is head or something in the Department of Health." (N6, F2)

While hopes of finding stable employment were a key reason for volunteering, this was not the sole motivation of CHWs. Over the course of time, some CHWs had developed professional identities, especially those working as counsellors, and expressed desires to advance in that role.

"You know we want to continue with counselling, but employed permanently as counsellors. Doing counselling is in our blood now." (N4, F2)

For people living with HIV, working as a CHW may also have represented an opportunity to create positive new and non-stigmatized personal identities by using their knowledge and experience of being HIV-infected to the community's benefit.

"It has changed because I can now tell people that when they have tested positive, it does not mean they are going to die, look at me, I drink ARVs but I am still alive, if you can have support, your families and not think that this is the end, you will be fine. I share my experiences with them and tell them how the treatment has helped me." (N3, F2)

For one or two respondents, being a volunteer allowed them to express religious identities of altruism and caring.

"I like what I'm doing and the community understand me as well. Maybe this is a calling, because I am a Christian. So I believe for

me this is a calling from God. You have to love this to do it. I don't want to leave this work; I have been here since 2000. I just want them to use me because I'm available." (N10, F2)

Discussion

Within a relatively short space of time, CHWs have become important players in public health care in South Africa. While this study did not evaluate the quality of CHW provided services, it is clear that several generations of AIDS interventions would not have been possible without their presence. CHWs are generally seen to be adding value and meeting new needs, rather than simply substituting for professionals. However, contrary to the normative view of CHWs as community-based generalists, the dominant health service reality observed in the Free State Province is of limited purpose CHWs, increasingly based in facilities as support structures to professionals, selected by and answerable to the health service. Although their roles have broadened with time, they are oriented towards care rather than prevention or promotion. Despite these features, it would be wrong to characterize the CHWs as mere 'lackeys' of the health system, stuck in a particular mould. There is evidence to suggest that CHWs have had an empowering role, serving as a bridge between patients/communities and the health system, creating a voice for people living with HIV, fulfilling identity-related needs, institutionalizing notions of volunteering and building lay knowledge and expertise on health issues. They are often community-oriented if not always community-based.

Perhaps a more fundamental problem relates to the fact that CHWs are effectively a large and flexible, state-generated and supported labour force on the margins of the health system, in which they occupy a profoundly ambiguous position as volunteers/workers. While the state has been the motor for the funding and development of CHWs, it has deliberately avoided incorporating them into the civil service as formal employees. This has been made possible by the use of NGO intermediaries, whose role, at least in the Free State, is seen as little more than disbursing stipends. CHWs do not have the employment rights of other health workers while being expected to work regular hours. Their status is considered intrinsically inferior by both themselves and other health workers, and relationships with professionals are generally precarious. Not surprisingly, most CHWs express intentions to exit, even though the reality of few alternatives may limit this in the short-term. There is also the danger that the public health system increasingly relies on a semi-formal and semi-integrated health workforce as a way to avoid confronting the larger crisis in the supply of health professionals. These problems are at the heart of difficulties experienced in other national CHW programmes (Walt 1990) and raise questions as to the long-term viability of the CHW as a cadre in South Africa.

However, there are signs that the current generation of CHWs in South Africa is more than a human resource flash-in-the-pan. Firstly, as long as they are aligned to core social policy, the state will continue to fund, support and develop CHWs. This is reflected in the Free State in the provision of ongoing training and steps to standardize remuneration and create career pathways for CHWs. Secondly, CHWs have not been a once-off,

top-down solution to the human resource crisis but have evolved incrementally to fulfil specific needs in service provision. Roles and processes, such as lay counselling and the involvement of people living with HIV, have become embedded in the health system over time. National policy has tended to be reactive, creating some coherence in what had become a chaotic field while allowing for provincial flexibility in approaches. Thirdly, expectations of CHWs have been limited and realistic, and they do not threaten the position or roles of other health workers.

It is also not clear that the solution to the difficulties associated with CHWs lies in incorporating them wholesale into the civil service. Relatively loose processes surrounding the selection and deployment of CHWs, and the blurring of boundaries between CHWs, volunteers and other forms of participation are not without their advantages. The open-ended and dynamic nature of the infrastructure allows for inclusiveness, local flexibility and the expression of a range of different motivations. It may be useful to view participation in the health system as a continuum, from patient experts, to volunteers, stipended CHWs, mid-level workers and professionals. Permeable boundaries and opportunities for movement through the various categories in the continuum could provide the necessary incentives to sustain the CHW infrastructure as presently configured.

This vision of CHWs is only possible if it is located within a broader strategy that seeks to strengthen the supply, management and deployment of human resources for health more generally. In such a context, building a sustained and effective CHW presence in the South African health system would require the following types of actions:

- Improving the working conditions and basic entitlements (such as leave and complaints mechanisms) of CHWs beyond the provision of stipends;
- Training professionals to better engage with and support CHWs;
- Developing the roles of NGO intermediaries in the ongoing training and support of CHWs and professionals;
- Viewing the CHW position not as an end point but as a means to an end, accepting a high degree of turnover;
- Creating formal sector mid-level categories, such as counsellors, into which CHWs with skills and experience in specific domains can progress, and ensuring a perceived fairness in the distribution of opportunities for entry into the formal health sector;
- Developing expanded models of CHW involvement in HIV/AIDS and other programmatic areas, such as integrating prevention with care and promoting community-based roles, while at the same time not fixing a single identity or job description for CHWs;
- Maintaining an appropriate balance between regulation of the CHW infrastructure and provincial and local flexibility.

As Lehmann and Sanders (2007: vi) point out, CHWs are a good investment but they are 'neither the panacea for weak health systems nor a cheap option to provide access to health care for underserved populations'. A lot more empirical evidence is required on national CHW programmes, the

problems they are facing and their contribution to addressing health needs and the scaling up of new programmes.

Endnotes

- ¹ The official title 'Community Health Worker' is yet to become institutionalized in the health system. Terms such as lay and community workers, home-based carers, community caregivers and volunteers are still frequently used as generic descriptors of the category.
- ² This loose definition comes closest to capturing the wide range of CHW roles in South Africa, rather than the more normative and specific definitions proposed by WHO (1989) and in the CHW Framework (NDoH 2004b).
- ³ The Free State has a population of 3 million and a mixed economy based on a combination of gold mining, agriculture and small industries. Population HIV prevalence is 12.6% (Shisana *et al.* 2005) and per capita spending on health care and access to basic infrastructure is average by national standards (Blecher 2006).
- ⁴ In a speech to CHWs in 2002, the then MEC for Health in the Free State spoke of volunteerism as "something that comes from the heart, that one is doing completely out of love with no expectation of any reward in whatever form The African spirit of Ubuntu calls upon us to do this" (Office of the MEC for Health 2002).
- ⁵ Refers to the facility number (N) and when the interview was conducted (F1 or F2).

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