THE ROLE OF COMMUNITY HEALTH WORKERS IN THE HIV/AIDS PROGRAMME

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DECLARATION

By submitting this thesis electronically, I declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualifications.

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ABSTRACT

The role of Community Health Workers (CHWs) in the HIV/AIDS Programme is directly dependent on the support systems provided by nurses, NGOs, the community, institutional frameworks, and government funding and stress management institutions. The Home-based caregivers that work in the HIV/AIDS Programme are CHWs who need maximum support from the above- mentioned institutions.

The community is also reeling with the aggravating consequences of HIV/AIDS. CHWs play a role in trying to take care of the HIV patients within the home environment. People are cared for by the people they associate with and people who live with them.

In order for CHWs to maximise their contribution to the HIV/AIDS Programme, there should be commitment from all stakeholders involved in the programme. Forty-one people from formal and non-formal structures took part in the study. The formal structures refer to clinics and hospitals, whereas informal structures refer to Home-based care (HBC) groups, volunteers, NGOs and international donor agencies. The study was conducted over a period of eight weeks. The study was conducted at Cork, Calcutta and Mkhuhlu clinics, and Mkhuhlu Home-based care and on USAID field officers.

The results of the study suggested that with support systems from the relevant institutions, CHWs are able to carry their community obligations in an effective and efficient manner. These findings have positive relationship implications towards the reduction of HIV infections in the community. Hospitals that are faced with overcrowding also benefit in a way, when terminally ill patients are cared for at HBC centres.

OPSOMMING

Die rol van gemeenskapgesondheidswerkers in die HIV/VIGS Program leun sterk op die ondersteuningstelsels verskaf deur verpleegsters, privaatmaatskappye, die gemeenskap, insitusionale raamwerke, regeringshulp en instellings vir spanningsbeheer. Die tuisversorgers werksaam in die HIV/VIGS Program, is G.G.W en behoort die maksimum ondersteuning van bogenoemde stelsels te geniet.

Die gemeenskap gaan swaar gebuk onder die verswarende gevolge van HIV/VIGS. Die G.G.Ws speel hier ‘n belangrike rol deurdat hulle H.G.V. pasiente binne hul tuisomgewing probeer versorg. Hierdie pasiente word versorg deur mense met wie hulle kan assosieer en tussen hulle woon.

Vir die gemeenskapsgesondheidswerkerkers om hul bydrae tot die HIV/VIGS Program te versterk, benodig hulle die hulp van al die betrokke partye in die program. Een-en-veertig persone van formele en nie-formele instansies het aan die studieprojek deelgeneem. Die formele instansies verwys na klinieke en hospitale, terwyl die informele instansies verwys na tuisgebaseerde groepe, vrywilligers, nie-regesingsorganisasies en internasionale hulpverslenings-agenttskappe. Die studie projek het oor ‘n tydperk van agt weke gestrek en het plaasgevind by die Cork, Calcutta en Mkhuhlu klinieke, asook die Mkhuhlu tuissorgeenheid en onder USAID veldwerkers.

Die resultate van bogenoemde studie het getoon dat met die ondersteuningstelsels van die betrokke instansies, die G.G.Ws heeltemal daartoe in staat is om hul gemeenskapsdiens effektief en op ‘n bekwame manier te doen. Hierdie uitslae toon ook ‘n postiewe gevolg ten opsigte van die vermindering van H.G.V. infeksies onder die gemeenskap. Hospitale wat gebuk gaan onder oorvol toestande, sal ook hierby baat, deurdat terminale pasiente deur die tuissorgeenhede versorg word.

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ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
CBD	Community Based Development
CBO	Community Based Organisation
CDF	Community Development Forums
CHWS	Community Health Workers
DOH	Department of Health
EU	European Union
HBC	Home-based care
HIV	Human Immuno Virus
ICHC	Integrated Community Based Home Care
NACOSA	National Aids Co-ordinating Committee of South Africa
NGOs	Non-Governmental Organisation
PHSSP	Public Health Sector Support Programme
PPASA	Planned Parenthood Association of South Africa
STD	Sexual Transmitted Diseases
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation

Chapter 1

Introduction

1.1. The scope of the study

The first chapter of this research study looks at the problem statement, the aims of the study, the hypothesis, background, research design and the international perspective of support systems in the Primary Health Care sector.

Chapter two outlines the South African institutional perspective in respect to health. The third chapter is the literature review, in which the origin of the Community Health Workers' concept and other related aspects are described. Chapter four is the case study that focuses on the methodology of the research project, and presentation and interpretation of results. The last chapter is the conclusions and recommendations of the study.

1.2. PROBLEM STATEMENT

Despite the fact that it is estimated that there are approximately 5.6 million people in South Africa who are HIV positive, there are no meaningful structures to support the HIV/AIDS Programme. The AIDS pandemic is a challenge to the National Health Department. The South African government has to come up with strategies to care for people who suffer as a result of AIDS related ailments.

At Mkhuhlu village, there are various groups who serve as CHWS. The groups are Home-based care (HBC) workers, Primary Health Care workers and USAID field officers. The CHWs conduct home visits on daily bases to take care of the elderly and the sick. HIV patients are bathed, counselled, given emotional support, assisted to take medication and also referred to hospital when their condition become worse.

The door to door campaign conducted by CHWs is not an easy task. It needs support from various stakeholders. The support systems come from NGOs, grants from the government and international donor agencies such as USAID. The success of the support systems is noted when community members and HIV patients start to understand and embrace CHWs who come from different stakeholders.

CHWs face challenges in their day-to-day activities. They face challenges such as travelling long distances and community members refusing them access to their homes where HIV patients are kept. Other challenges include failure to get stipends which help them cover travelling costs. Some CHWs are also HIV positive and they need support from their colleagues and NGOs they are working for.

Maximum support is needed from all stakeholders who are engaged in the HIV/AIDS Programme in order to facilitate the expansion of the CHWs' Programme in the community.

1.2.1. AIM OF THE STUDY

The aim of the study is to explore and confirm the influence of support systems on the role of CHWs. Support to the HIV/AIDS Programme is provided by the National Department of Health, NGOs and USAID.

1.2.2. HYPOTHESIS

The role of Community Health Workers in the HIV/AIDS Programme is directly related to the presence of support systems and the availability of funds.

1.2.3. Key Concepts

Financial support
Community
HIV/AIDS Programme
Community Health Workers' Programme
Support Systems
Community Health Workers
Stipend
Volunteer
Nurses (Primary Health Care workers)
NGOs

1.2.4. Background

Based on Werner's (1984) definition of a Community Health Worker, in Hammond & Buch (1984:2), a Community Health Worker is an integral change agent, who is not only concentrating his/her energies to health issues, but he/she also arouses human potential to HIV/AIDS patients and the community at large.

Their loved ones shun some of the patients. And they are left alone to die without anyone to look after them. In some cases, it becomes the burden of the CHWs to see where to get a coffin to bury them.

It is in situations like these that the Social development officers come in to assist by donating the coffin to bury such people. Without the contribution of these CHWs, there could be much suffering from the poor HIV/AIDS patients who solely depend on the CHWs. It is one of the CHWs' job descriptions to visit families and identify sick people. The terminally ill ones who are unable to help themselves, are fed, given motivational talks and sometimes assisted to go to hospital when their condition deteriorates dramatically.

The CHWs endeavour to establish links between community members, health services, NGOs and social development services. The CHWs continue to educate community members on the dangers of HIV/AIDS.

The strict code of ethics that apply to HIV/AIDS patients should be adhered to in every respect in order to protect the names of the patients, the good names of all stakeholders. HIV/AIDS patients have a right not to disclose their status to anyone. If they do disclose their status as is the case with CHWs, the information is considered to be very confidential.

1.3. International Perspective of support systems in the Primary Health Care sector

Two African countries, Senegal and Uganda were able to use formal and informal institutions as support systems in their HIV/AIDS Programmes. An overview of the Australian Policy on the health of Aborigines and the Health Action Zone model in Britain also present the effectiveness of support systems in the Primary Health Care sector.

1.3.1. Senegal's institutional initiative in the HIV/AIDS Programme

According to Kauffman & Linduer (2004:25) the President of Senegal became an advocate of directing government resources, faith organisations and civil society to effect a change in behaviour towards AIDS. The President used a multisectoral approach to promote practices that would reduce the spread of HIV. He enlisted the support initiatives of religious groups to help promote safe sex.

During prayer meetings, the Senegalese people included messages, which promoted safe sex. The school and the media also played an important role in spreading the message of safe sex. The formal institutional side required the Segalese sex workers to be registered and undergo regular health checks.

1.3.2. Uganda's institutional change in the HIV/AIDS Programme

Uganda's institutional change was aimed at reducing HIV infection rates (Kauffman & Lindeur, 2004:27). Kauffman & Linduer indicate that the President of Uganda engaged many sectors of civil society to effect change in the informal institutions surrounding sexual relations. Kauffman & Linduer further indicate that the Ugandan government changed regulations and laws dealing with the scale of medicine to treat Sexually Transmitted Infections (STIs).

1.3.3. The National Aboriginal Health Strategy (1989)

According to Hennesy & Spurgeon (200:59) the Australian government introduced a national system for education and registration of Aboriginal health workers. They assert that the health workers are members of the community and are trained in health issues to serve their communities.

These health workers were selected by the community health council to be CHWs. The CHWs were responsible for the health of the community and played a caring role to the sick.

1.3.4. Health Action Zone model in Britain

According to McDonald (1999:142) the Health Action Zone in Britain was presented as an example of partnership in action. This model works in partnership with the health department, community groups, volunteers and the business sectors. It encourages health organisations to work together in order to reduce health inequalities and promote sustainable development.

The National Strategy for Sexual Health and HIV in the UK supports links between social support and the health sector to care for the HIV- positive people (McDonald, 1999:185). McDonald asserts that voluntary agencies need to be engaged in order to care for people with HIV/AIDS.

1.4. Methodology of the study

The unit of analysis for the study was the CHWs who work at Mkhuhlu village. The sample size was 70 CHWs, who were grouped as follows: Primary Health Care Workers (nurses), Home-based caregivers and USAID field workers. The study is a quantitative empirical type of research.

1.4.1. Subjects

A stratified probability sample was used in the study. Participation to the study was voluntary, and this was indicated by a written informed consent. The target groups for the research study are Primary Health Care workers; USAIDS field workers and volunteers from the Mkhuhlu Home-based care facility.

1.4.2. Measuring instrument

A 30-minute Likert-scale questionnaire was designed. The questionnaire contained 25 items. The 25-item scale was testing the influence of support systems on the role of CHWs in the HIV/AIDS Programme.

1.4.3. Procedure

The questionnaire was handed over to the prospective subjects in their workstations. A total of 80 questionnaires were distributed. Participants to the study were encouraged to answer the questions as honest as they can. Questionnaires were collected at an agreed date with the subjects.

1.4.4. Data Analysis

Statistical analysis was done using Moonstats software in Windows XP operating system. The Pearson's correlation coefficient was used to establish the relationships between variables.

1.5. Summary

The foregoing discussion represents the aim of the research study, which is to assess the role of CHWs in the HIV/AIDS Programme. The community of Mkhuhlu is one of those that experience the ravages of HIV/AIDS. The government's partnerships between departments, NGOs and other stakeholders are also in existence at Mkhuhlu village.

A summary of key concepts and acronyms help to guide and give the meanings of abbreviations used in the entire study. A tentative research methodology explains how the research study is to be conducted. An international perspective on support systems in respect to health sheds light on how other countries fight diseases in their communities.

Chapter two of the study looks at the South African Institutional Context of health.

Chapter 2

The South African Institutional Context of Health

2.1. Introduction

The aim of chapter two is to explore South Africa's policy establishments and models, which guide the functions of CHWs. The origin of some strategies to fight AIDS will be looked at. The policy review looks at various aspects within strategies to fight HIV/AIDS in South Africa. Some of the policy guidelines include the following:

- The development of strategies to fight HIV/AIDS in South Africa;
- HIV prevalence in South Africa;
- Constitutional perspective in respect to health;
- The National Health Act;
- The HIV/AIDS/STD Strategic Plan for South Africa 2000 - 2005;
- The Community Health Workers' Programme; and
- Integrated Community based Home Care.

2.2. Development of strategies to fight HIV/AIDS in South Africa

In 1990, the former government started an initiative called "National AIDS Co-ordinating Committee of South Africa (NACOSA)" (van Rensburg, 2004:304). Van Rensburg further points out that a system of networking was put in place to negotiate widely with Non Governmental Organisations (NGOs) to try to find, develop and implement a strategy to fight the escalating HIV/AIDS epidemic in South Africa. When the government of National Unity came into power, it adopted NACOSA's AIDS plan and renamed it HIV/AIDS and STD Programme 1995 - 1996 of the Department of Health (DoH) 1995. This HIV/AIDS and STD programme fell within the National Framework of the Reconstruction and Development Programme.

The programme itself was given to the DoH as its leading department. The programme's main area of focus was to secure a high level of commitment from DoH and initiate partnerships with other departments and NGOs to combat the epidemic. The HIV prevalence in South Africa serves as a yardstick to determine the degree with which the epidemic has affected families.

The South African Department of Health has its focus on the introduction of different types of initiatives and programmes to assist CHWs. The legislative frameworks and programmes have been implemented to fight the epidemic. A few examples of these policies and programmes are:

- The Constitution of the Republic of South Africa, Act 108 of 1996;
- The National Health Act no. 61 of 2003;
- The HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005;
- CHWs Programme (2004); and
- Integrated Community -based Home Care (ICHC) in South Africa (2002).

All the programmes mentioned above complement each other in the fight against the epidemic. The duties of CHWs who are also called Community Health Caregivers are to conduct home visits, offer support in the form of counselling, administering medication and offer financial support to terminally ill patients.
Hospitals are unable to cope with the influx of HIV/AIDS patients. Hospital beds become fewer and fewer, hence programmes to care for the sick are introduced to try to treat them in their homes. These programmes reduce the burden, which is often carried by hospitals who are supposed to accommodate a large number of patients who need long-term or continuous care.

2.3. HIV Prevalence in 2004

Noble (2006:1) provides a statistical overview of the HIV prevalence among antenatal clinic attendees, by province for the year 2004 as follows:

Province	2004 Prevalence %
KZN	40.7
Gauteng	33.1
Mpumalanga	30.8
Free State	29.5
Eastern Cape	28.0
North West	26.7
Limpopo	19.3
Northern Cape	17.6
Western Cape	15.4
National	**29.5**

The 2006 prevalence statistics as provided by the South African Broadcasting Corporation (SABC) News (2006) stand as follows:-

Worldwide	65 million infections
SADC countries	25 million infections
South Africa	5.5 million infections

The statistics serve as indicators for the rate at which HIV infections are growing in South Africa and internationally.

2.4. The Constitutional perspective in respect to health in South Africa

The Constitution of the Republic of South Africa, Act 108 of 1996 acts as a supreme law of the country that provides guidelines on health issues.

2.4.1. The Bill of Rights in respect to health care, water and social security

According to section 27 (1) (a) (b) (c) of the Constitution Act 108 of 1996 everyone has a right to have access to;

- Appropriate health care services;
- Sufficient food and water; and
- Social security even when they are unable to support themselves and their families.

HIV/AIDS patients as citizens of the country South Africa have a right to be protected from any form of discrimination.

2.4.2. Provision of resources by the state to HIV/AIDS care programmes

Section 27 (1) of the Constitution Act 108 of 1996 provides that the government needs to develop legislative measures to realise the rights of every citizen, provided there are available resources. The resources mentioned in the above section include, medicine, transport to hospital, support, food, shelter and other resources that may be of help to the poor and infected patients and their families who are affected by the epidemic.

2.4.3. Emergency medical treatment

HIV/AIDS patients are always in and out of hospital when the HI-virus has developed into full-blown AIDS. The patients may not be denied emergency treatment at a time when they need it most (Section 27 (3) of the Constitution Act 108 of 1996).

2.4.4. Patients and Health Caregivers to be treated with dignity

Patients and health caregivers are entitled to be treated with dignity and their dignity needs to be respected and protected (Section 10 of the Constitution Act 108 of 1996)

2.5. National Health Act no. 61 of 2003

The National Health Act is not clear on the role of CHWs within the South African context. The Act only sheds some guidelines on how health aspects should be carried forward.

2.5.1. Consent User

Section 7 (2) of the National Health Act no. 61 of 2003 provides that health care providers have to obtain the patient's consent before treatment and care can begin. The above section holds true for CHWs who also have to ask for permission from their patient's relatives before the commencement of the home care programme. The patients also need to agree and understand the role of CHWs as home - based caregivers.

2.5.2. Maximising Services of Health Care Providers

Section 49 of the National Health Act 61 of 2003 encourages district health counsels to "implement programmes for the appropriate distribution of health care providers and health workers." The above section also supports the creation and implementation of health care programmes, which are aimed at providing health care for all.

2.5.3. Provision of free health services in public health institutions

All state health establishments such as clinics and community health centres, which are funded by the state, need to provide all persons without medical aid with free primary health care services. (Section 4 (3) (b) National Health Act 61 of 2003)

2.5.4. Promotion of community participation

According to Section 21 (2) (b) of the National Health Act no. 61 of 2003 the Director General must engage the community in planning, provision and evaluation of the health services. Communities who are encouraged to take part in health matters comply easily with hygienic needs. Communities start to understand how the sick should be taken care of in their communities.

2.6. HIV/AIDS/STD Strategic Plan for South Africa 2000 - 2005

Due to the escalating rate of HIV infections in South Africa, the government came up with a strategic plan to fight the epidemic.

2.6.1. Purpose of the Strategic Plan

The document is a broad based national plan to guide the country's response towards the epidemic. The document states that no single department is responsible for addressing the HIV pandemic. The plan seeks to form partnerships with stakeholders within and outside government. It is also aimed at maximising efficiency and effectiveness in the fight against HIV/AIDS. (HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005, 2000:5).

2.6.2. Primary goals of the plan

The primary goals of the plan were set as follows-

- Reduce the number of new HIV infections;
- Reduce the impact of HIV/AIDS on individuals, families and communities; and
- Improve the care and treatment of HIV positive persons living with AIDS to promote access to better quality of life and limit the need for hospital care.(HIV/AIDS/STD Strategic Plan for South Africa 2000 - 2005, 2000:16).

The last primary goal supports the role of CHWs who look after the sick from their homes. Care provided by CHWs help to reduce the numbers of patients who seek continuous care from the overcrowded hospitals. The aims and objectives of the strategic plan are laid out in the form of two priority areas.

Priority area no. 1

- Conducting regular in-service training for CHWs;
- Developing, printing and distribution of training manuals in all eleven official languages;
- Conducting capacity building workshops; and
- Developing guidelines for counselling patients (HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005, 2000: 20).

Priority area no. 2

- Developing guidelines for treating and caring of HIV/AIDS patients in state and private hospitals;
- Build appropriate capacity of health professionals to provide comprehensive HIV/AIDS/STD/TB treatment, care and support;

- Develop strong partnerships between health facilities and community-based support programmes;
- Involve relevant public and private sector in poverty alleviation projects ;
- Introduce a maximum package for treatment and care for HIV/AIDS patients in public and private sector health establishment;
- Develop and implement proper home-based care guidelines;
- Establish intersectoral and multisectoral task teams to develop community home-based care in the community; and
- Come up with a plan for welfare benefits to assist children and families of HIV/AIDS patients (HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005, 2000: 22).

2.6.3. Provision of financial resources

The CHWs programme cannot function properly without financial support. Adequate funding needs to be made available at national, provincial and local government level within the healthcare sector to enhance service delivery (HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005, 2000: 37).

The Strategic Plan further proposes that a standard resource provision needs to be established for all provinces to finance the HIV/AIDS Programme. The standard resource provision for the year 1999/2000 was set as R10 per person per year. The total amount for the whole country stood at R400 million per year.

Denise (1997:2) asserts that funds need to be allocated through community structures to cater for CHWs' salaries and other support costs that will help sustain community-healthcare programmes. He further asserts that a national salary structure has to be set up for salaried CHWs.

According to the Status Report on HIV/AIDS in the Social Development sector (2001:3) funds made available for Community-based care were as follows:-

Financial year	Community-based Care
2000/2001	R13 million
2001/2002	R28 million
2002/2003	R68 million
Total	**109 million**

More funds were to be channelled to community-based care and support programmes which are run by CHWs in the community.

2.6.4. Multisectoral approach to address HIV/AIDS

The HIV/AIDS/STD Strategic Plan for South Africa 2000 - 2005 (2000:12) puts more emphasis on encouraging government sectors, parastatals, NGOs, private sector, community based and faith-based organisations to take part in the fight against HIV/AIDS. The Strategic Plan also presents a brief overview of South African structures that help to combat the epidemic:

- Government departments (DoH, Social Development, Education, Transport and others);
- Interdepartmental Committee on AIDS (IDC);
- Donor Agencies such as the European Union (EU), Joint United Nations Programme on HIV/AIDS (UNAIDS), Global Fund, United States Agency for International Development (USAID) and many others which are not mentioned in the study; and
- World Health Organisation (WHO) (HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005, 2000:12).

Given time and enough support from everyone in South Africa, the structures could make significant gains in the fight against AIDS.

2.7. The Community Health Workers' Programme

The South African CHWs' Programme was launched on the 26th February 2004 at Odi Stadium, Mabopane. The CHWs' Programme's main objective is to improve health services and promote health (Tshabalala-Msimang: 2004:1). She further asserts that the CHWs' Programme can be made possible if there are effective support and referral structures. More emphasis in this regard is placed on on-going training for CHWs by government and NGOs.

2.7.1. Goals for the CHWs' Programme

The CHWs' primary goals are set out as follows:

- To create work and fight poverty by the people;
- The government's prerogative to improve service delivery;
- Resource and skills development strategies;
- Addressing the complexities brought about by the burden of diseases and poverty-related challenges; and
- The need to promote healthcare activities, community and home-based care (Tshabalala-Msimang, 2004:2).

2.7.2. CHWs as cadres or foot soldiers to fight diseases

According to Tshabalala-Msimang (2004:2) for the effective and efficient implementation of the CHWs' Programme, combinations of competencies in "health promotion, primary health care and health-resource networking as well as co-ordination" need to be put in place. She further states that CHWs are expected to work within their communities and be able to visit households.

2.7.3. CHWs working as volunteers

Tshabalala-Msimang (2004:3) defines volunteers as people who render a service to the community without expecting a reward or payment. She indicates that due to the scarcity of health resources in poverty-stricken communities, the DoH relies on the support of volunteers to render health services.

In order to encourage volunteers to work with determination, the South African government has recommended that all of the estimated 40 000 volunteers in the healthcare service should be given a minimum stipend of R1000 a month (Tshabalala-Msimang, 2004: 3).

2.7.4. The CHWs' Programme Declaration

The Declaration state that: "Primary Health Care requires and promotes community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care making fullest use of local, national and other available resources and to this end develops through appropriate education and the ability of communities to participate" (Tshabalala-Msimang, 2004:3)

In support of the above declaration, the White Paper for The Transformation of The Health System in South Africa (1997:32) states that primary health care's main focus is on training and development of skills, experiences and expertise of health personnel who support CHWs to ensure optimal use of resources in a cost-effective manner.

2.8. Integrated Community-based Home Care (ICHC) in South Africa

The DoH introduced an ICHC model which is a strong tool to fight AIDS in South Africa. The ICHC model in South Africa works closely with clinics and hospitals (Fox, 2002:2).

2.8.1. Training of CHWs

According to Fox (2002:15) caregivers attend a three-month course on basic skills of home-based care and palliative care. The training is based on DoH's curriculum for home-based care, basic information on STIs, HIV/AIDS and TB. Other skills covered during the training include communication and teaching skills, spiritual and cultural issues, social support and infection control.
Training hours are divided as follows:

- 70 hours theory in the classroom; and
- 160 hours practical work in the clinics, hospices and hospitals (Fox, 2002: 12).

Once qualified, caregivers in a hospice work between six and eight hours a day (Fox, 2002: 15)

2.8.2. Cost implications of the ICHC model

The cost for caring for patients in a hospital in South Africa is R650 per patient per day (Fox, 2002: 34). She asserts that home-based care costs are between R30 and R35 per patient per day. A patient in a hospice between 2001 and 2002 costs R1015 per annum (Fox, 2002: 35). She further indicates that many hospices in South Africa depend on fundraising to increase their annual grants from government.

2.8.3. The purpose of conducting home visits

According to Fox (2002:18) home visits by CHWs help provide the following services to patients:

- administering medication and vitamin supplements;
- educating family members on how to care for the patient;
- cooking for the patient;
- distribution of food parcels;

- making transport arrangements for the patient from home to hospital for medical check ups; and
- providing spiritual and moral support.

2.8.4. Remuneration of the hospice staff

Based on the research conducted by Fox (2002:14) the hospice staff work on contract bases. The contract is signed for only one year. She asserts that salaries of hospice staff vary from hospice to hospice. She further indicates that in one hospice the staff was paid as follows:

- Caregivers are paid R1 200 per month;
- After three months of employment, the salary increases from R1 200 to R1 500 per month; and
- Other hospices pay caregivers R1 750 per month with a R250 travel allowance.

2.9. Summary

In light of the above discussion, the institutional context of health in South Africa provides very clear guidelines on how to assist HIV/AIDS patients and CHWs. The Constitution Act 108 of 1996 shows that the rights of patients should be protected. The prevalence of HIV in South Africa as highlighted gives an overview of the impact of the disease in communities. The National Health Act promotes community participation and it puts more emphasis on seeking consent from the patient before CHWs can counsel or administer medication. The HIV/AIDS/STD Strategic Plan for South Africa 2000 – 2005 provides the aims and objectives of the plan.

The plan also gives an overview of how financial resources should be made available to fight the disease. The CHWs' Programme that was launched by the Minister of health in 2004, gives guidelines on working conditions for CHWs.

The remuneration of CHWs who work as volunteers is also discussed. The ICHC model, which focuses on caring for the sick in a home environment, gives guidelines on training of CHWs, cost implications of the model, how home visits should be conducted and the remuneration of hospice staff.

Chapter three is the theoretical framework that defines the CHW concept, discusses its origins and many important aspects, which make the work of CHW easier.

Chapter 3

Primary Health Care: The Community Health Worker Approach

3.1. Introduction

The aim of the theoretical framework is to define the concept CHW, discuss relevant and appropriate theories and models, which are applicable in the role played by CHWs in the HIV/AIDS Programme. There are a number of aspects, which play a significant role on the activities of CHWs. Some of the aspects are;

- The origin of the Primary Health Care concept;
- The role of CHWs in the HIV/AIDS Programme;
- The economic component of running the HIV/AIDS Programme;
- Contribution by NGOs;
- Skills development on CHWs;
- Support networks;
- Support by Department of Social Development; and
- Challenges experienced by CHWs.

3.2. The origin of the CHWs concept

The introduction of the Primary Health Care concept, led to the development of the CHW in many countries (Walt, 1990:17). The Alma Ata Conference, organised by the World Health Organisation (WHO) and UNICEF in 1978, where 137 states accepted the primary health care approach as the most effective way of achieving health for all by the year 2000 (WHO,1987:9). The agreements reached at this conference became the building blocks of the CHW concept.

According to Freire (1972) in Walt (1990:20), a CHW is an agent of change who strives to empower communities through the educational process. His concept of "conscientisation" arouses the potential of community members for their own development. WHO (1987:13) came up with a job description of a CHW, which is to provide housing and basic equipment used only for health. Other services rendered by CHWs in the community are described as follows:-

- Provision of heath care in the community; and
- To help local authorities and the public to take initiatives that are aimed at improving people's living conditions.

Walt (1990:19) describes the duties of CHWs as follows;-

- They are seen as people who extend services to the poor and neglected people in the disadvantaged communities; and
- They offer health care to people who are unable to help themselves.

Walker, Reid & Cornell (2004:117) see community-based care as the only viable form available in Sub-Saharan Africa to improve public health facilities, which are at best very inadequate and some times unavailable. According to WHO (1987:10) CHWs are described as chosen community members who are comprised by men and women, trained to work closely with the health services.

Home-based care (HBC)'s main objective is to "provide effective and affordable community-based care and support" (van Rensburg, 2004:426). He further suggests that terminally ill patients are moving from hospitals to people's homes and community members. There is co-operation between the DoH and Social Development. The Social Development sector focuses mainly on social relief (food parcels), social grants, foster placement and training of volunteers on care and support. The DoH focuses on provision of medicines, training of volunteers and CHWs and providing care kits.

A home-based care programme tries to meet three basic needs of patients and their families.

- psycho-social and spiritual support;
- material support; and
- physical support (Muchiru & Fröhlich, 1999: 2).

3.3. The role of CHWs in the HIV/AIDS Programme

Care giving for the AIDS patients involves quite a number of factors. Some of the factors that are to be considered in the caring for the patients are; provision of emotional support; financial support; mediating with health and social service organisations. Other tasks that are performed by the CHWs include tasks such as bathing, toileting, shop keeping, preparing food, feeding, maintaining a household budget and housekeeping (Hunt, 2001: 344).

3.3.1. Home visits

CHWs conduct home visits to identify and provide home-based care to terminally ill patients (WHO, 1987: 335). The purpose of home visits is:

- To help family members who are sick to become healthier or to see whether patients do follow health advice;
- To help the family learn new skills that are important in improving their health;
- To collect relevant information regarding the patient's health; and
- Encourage patients to take medication and do many other relevant duties.

Karim & Karim (2005:359), assert that home visits provide CHWs with an opportunity to render life-prolonging care and support services, through administering antiretrovirals in the home environment.

They further indicate that home visits provide day-to-day care for the sick or in short provide home-based palliative care. Community-based care allows patients to be treated in an environment, which is near their homes or in their homes. Although home-based care is an informal type of care, it is worthwhile in improving the health of citizens (Boaden & Bligh, 1999: 15 - 16).

3.3.2. CHWs as Counsellors

According to Evian (2000:270) health care workers can play a significant counselling role if they are thoroughly trained. She asserts that people with complex problems receive psychological assistance through counselling. Care workers need to be professional, non-judgemental and confidential. As teachers, the CHWs need to clearly understand how HIV spreads and how moral approaches need to be used in the process of caring for the patients. CHWs need to accept all patients with utmost respect, dignity, sensitivity and kindness.

3.3.3. CHWs serving as mini doctors

According to Walt (1990:34), CHWs are not trained to give injections to patients as this may create a dangerous situation. They are not professionally trained nurses or doctors, but they are community members who are trained to help patients take their medication properly and follow instructions to safeguard overdose. They also give guidance to patients and family members on health issues. From Walt's (1990:35) point of view, a balance needs to be sustained between treatment and prevention of the disease. CHWs spend much of their time, bathing patients and teaching families prevention measures.

3.3.4. CHWs as extra-pair of hands

Walt (1990:35) regards CHWs as contributing positively in sharing the load of patient care and relieving hospitals of overcrowding.

He asserts that, in Thailand, CHWs conduct routine health activities such as weighing babies, assisting in immunisation, recording and providing information relating to sanitation, educational campaigns and conducting first aid where necessary.

3.4. The financial economic component in the HIV/AIDS programme

The financial economic component refers to the manner in which financial and economic matters are organised and regulated (van Rensburg, 2004: 4). This includes payments for services, remuneration for care providers, recovering costs and other expenditures. In the case of CHWs' Programme, costs are incurred in several categories: cost of training, CHWs' salaries, medicine supplies, travelling costs and supervision (Walt, 1990: 70).

Cost implications for training village health workers per week, in Tanzania in terms of South African currency (rands) are as follows.

Activity	Regional level	Local level
Transport	R11, 10	R2, 40
Food and allowances	R103, 25	R13, 85
Salaries	R5, 45	R7, 95
Materials	R2, 35	R1, 60
Total	**R121, 75**	**R25, 80**

Source: de Savingy et al (1988) in Walt (1990: 70).

The above figures indicate costs that were applicable during the year 1988. The present situation presents a huge challenge in terms of financial budgets. Medicines have become expensive over years and inflation has become a major problem in many countries.

3.4.1. Preparing Training Manuals

According to Walt (1990:73 - 74), health worker programme manuals are expensive. He highlights that the number of village teams or CHWs who are to be trained mostly determines costs. The expansion of the CHWs' Programme to more rural areas requires that more people need to be trained as CHWs. The training of large numbers of people needs money for training manuals and other costs. He also asserts that costs for home visits are more expensive than outpatient contact with a doctor in a health centre or hospital. Costs need to be calculated by looking at expanding the HIV/AIDS Programme or increasing the number of CHWs in rural areas, where home-based care is highly needed. When preparing national programmes, it is essential to calculate costs based on real cost supervision, salaries, drugs and other related costs. These programmes need to be funded to ensure their successful implementation and sustainability.

3.4.2. Travelling costs

According to Fox (2002:22), caregivers from Zululand are able to reach their patients on foot. This often makes them reach the patients' homes an hour or more late. The home-based care programme needs transport to enable CHWs to fulfil their roles well. Transporting CHWs from village to village or home to home requires financial support from funders. Travelling on foot is a setback or waste of time for the CHWs.

3.4.3. Health Care funding by government

A huge proportion of health care funds come from the government (van Rensburg, 2004: 380). The South African government has allocated funds for health care with an intention of catering for each household. The cost of health care continues to escalate as a result of the increasing numbers of patients affected by the epidemic.

Foster (2004) in Pharoah (2004: 77-79) argues that the success of community-based support initiatives in Africa needs extensive facilitation and financial support. He asserts that most donors make short-term grants to CBOs, which are not enough to address the growing population of poor and destitute people. According to McDonald (1999: 123 - 124), the cost of health care is always of great concern to policy planners and senior managers. She further asserts that market related care, which is value for money needs to be employed in order to minimise costs. Minimising costs is a real contradiction, because as the patient numbers increase, the costs for care need to increase. Based on the infection figures in 2.3 chapter two, it becomes clear that there are many sick people in South Africa.

The Social Development Sector incurs costs in the form of direct payments to needy patients (social grants) who suffer from HIV/AIDS. Orphaned kids also receive grants in the form of Child Welfare grants. These are direct payments as mentioned by McDonald (1999:125 - 126).

In order to make the work of CHWs easier and effective, financial support needs to be available. Hennessy & Spurgeon (2000:45), assert that the "lifeblood of health care institutions and systems of care is financial viability." They further indicate that health care programmes should not be planned on short-term basis but it should be for the long-term. They assert that "cost, quality and value can coexist in the same context." Financial support to the HIV/AIDS Programme cannot be ignored, as it is the backbone of the programme.

3.4.4. Medical Costs

Looking after HIV/AIDS patients is very costly because of continued escalation of drug prices. Mankell (2004:109 - 110) calls the treatment of HIV/AIDS patients as "The price of life". AIDS treatment drugs are expensive. In 1989, the cost of AZT was US$ 7000 per year. By the year 1995 a year's treatment of HIV/AIDS patients in UK was found to be in excess of £12,000 (US$ 18, 000) (Mankell: 2004, 10).

Developing countries like South Africa find it hard to cope with the high costs of drugs (medication). These high costs of drugs, lead to AIDS activists springing into action to try to force pharmaceutical companies and governments to reduce medicine costs. According to Mankell (2004: 110), generic drugs were found to be an option.

The government needs to be prepared to spend money on the HIV/AIDS Programme if it is serious about empowering CHWs. All the government initiatives discussed in chapter two, need money in order to be effectively and efficiently implemented. The Child Health Policy Institute (2001: 11) reports that the estimated cost for treating an HIV positive individual per year was R1700 for stage 4 of the disease, R6200 for stage 3 and R1300 for stage 1 and 2. With the fast increasing number of infections, the costs are set to increase even further. To cope with the epidemic, the government is required to increase expenditure on the care of HIV patients.

3.5. Remuneration of CHWs

CHWs in the HIV/AIDS Programme render a humanitarian service, which is often considered voluntary. The international and South African trends on remunerating CHWs support the view of giving stipends to CHWs.

3.5.1. International Perspective of paying CHWs

According to Popple (1995:75), community workers in the United Kingdom (UK) were recruited on full or part-time for 12 months contract or more. He highlights that a survey conducted counted 5,365 community workers. The National Government in the UK fund local authorities who then channel the money to community organisations who work with community workers (Popple, 1995:95). He indicates that community organisations then decide the amount of salary or stipend for each community worker under their control.

The community was responsible for paying for the services of CHWs in some countries such as Philippines, Papua New Guinea, India and Brazil (Walt: 1990, 78).

These forms of payments have gross setbacks because poor communities would not have enough funds to sustain the payments over a long period of time.

Walt (1990:79) draws an example of a community that supports its CHWs from Somalia. He highlights that in Somalia, UNICEF supports the CHWs' Programme. UNICEF supplies the programme with drugs. The community is given a choice to decide the best method of remunerating their CHWs. He further indicates that communities impose taxes on the village water pump in order to collect revenue to pay the CHWs.

3.5.2. South African perspective on paying CHWs

The policy framework on CHWs suggests that the CHW needs to be given a stipend of R1000 per month. This is aimed at encouraging the CHWs to do their work with much determination. Kobue (2006: 6) reported that 300 community workers or caregivers were to go on strike in May 2006 as a result of the North West Health Department's failure to pay them. This suggests that provincial health departments also take initiatives to issue grants to NGOs, which work with home-based caregivers. The NGOs become responsible for paying stipends to CHWs who render a service in the community.

3.5.3. Compensating volunteers in the HIV/AIDS Programme

Wandberg (2002:21) describes a volunteer as a person who invests his energy in "assisting someone dealing with a disease or other personal crisis." He also states that volunteering: "It's About People." The statement holds true for all people who have an interest in helping other people who are unable to help themselves. In many instances, a volunteer is not paid, but receives compensation for the service rendered. In other countries volunteers are paid, but in others a volunteer is not paid. Volunteers sacrifice their time and skills to assist community members who are sick and who experience poverty related problems.

3.5.4. Funds generated through NGOs

South African NGOs who work in the HIV/AIDS Programme receive funds from developed countries, such as European Union (EU) and the United States of America (USA). These rich countries donate money to local NGOs who provide a caring service to HIV/AIDS patients. The Planned Parenthood Association of South Africa (PPASA) receives its funds from the EU. The funds help to conduct HIV/AIDS awareness campaigns and train caregivers.

Soul City Workbook (2001:148) has this to say about the assistance given by the EU:
˝The EU identifies the health sector as a key focus and is funding a range of different health programmes. One of these is the Public Health Sector Support Programme (PHSSP) that provides financial resources to the public health service in order to support government reforms. This includes the prevention of HIV and AIDS and support for people living with HIV and AIDS. In addition to government health programmes, the PHSSP also supports NGOs working to fight HIV and AIDS˝.

The PPASA's Community Based Distribution Programme offers contraception provision and reproductive health (including HIV/AIDS) education on a door-to-door basis in underserved communities. CBD programmes have been successful in more than 40 developing countries and the PPASA has pioneered this programme in South Africa with effective success (PPASA, 1998: xiii). The EU sponsors PPASA as a South African NGOs.

3.6. Skills that CHWs should have

CHWs need to have certain qualities and skills in order to do their community-based activities effectively and efficiently.

3.6.1. The Qualities of CHWs

According to the ABE Development Services Trust (2003: 10) a CHW needs to:

- Be kind to the people they serve;
- Share his/her knowledge with the community;
- Encourage people to look ahead in terms of shaping their health;
- Empower people to participate in their health aspects;
- To use Western and traditional healing methods which are best;
- They need to work within set limits;
- They need to be lifelong learners in the trade of care giving; and
- They need to act as exemplary to the patients they treat or people they serve.

The Trust further states that CHWs:-

- Work as part of a team to promote good health;
- Are trained to see and prevent ill health; and
- Support people who need health care (ABE Development Trust Services, 2003: 8).

Based on the study conducted in one of the villages in Bushbuckridge in 1984, Hammond & Buch (1984:3 - 7) assert that CHWs need to:

- Need to have experience of community work;
- Need to have experience in primary health care;
- Need to first discover his/her own potential so that he may be able to assist the villagers to realise their potential;
- Work in their communities so that they are nearby and can be reached by anyone; and
- Participate fully in developing their communities.

3.6.2. Appropriate skills of CHWs

According to Bryant & Bryant in Popple (1995:90), a good community worker should have the following skills:

- relationship skills;
- community skills;
- organisational skills;
- mediating skills;
- entrepreneurial skills;
- political and analytical skills; and
- tactical skills.

Based on Wandberg (2002:12), a volunteer who serves as a CHW needs to have good listening skills, non-judgemental attitude, supporting skills and be computer literate. During home visits, some of the duties which need to be done are:-

- administering medication and vitamin supplements to patients;
- educating family members on how to look after the patient. For example, bed-baths, how to lift the patient, mouth care and other basic skills;
- preparing food for the patient;
- distributing and providing food parcels;
- making transport arrangements for patients to the hospital; and
- educating the community, family members and neighbours about HIV/AIDS.

3.6.3. Training CHWs

The WHO (1987:13) suggests that training of CHW in rural areas take six to eight weeks or longer. The training is supposed to be practical and focus on the conditions of the environment. CHWs do not just start working with communities without first receiving proper training. They first attend training sessions aimed at developing their health care skills.

Training of CHWs differs from country to country (Walt: 1990, 72 - 73). Walt asserts that some CHWs are trained in days; others take six months and others a third of a year.

The training often takes place near the communities, for example, the nearest health centre. As mentioned by Walt (1990:75 - 77), the training programmes are hands-on learning programmes. The programmes are designed to teach the CHW practical work on how to handle patients as caregivers. Popple (1995:77) describes the training programmes for CHWs as "Field-based training." He refers to the programmes as community work learning programmes, which emphasises "teaching and doing." He asserts that the criteria for selecting CHW depend on the previous experience of individuals on community work, rather than academic qualifications.

In South Africa, some caregivers attend three months basic skills of home care and palliative care training (Fox, 2002: 15). The training programme, which is based on DoH's curriculum, includes: -

- role of care givers;
- basic information on STD, HIV/AIDS and TB;
- teaching and community skills;
- spiritual and cultural issues;
- infection control;
- social support;
- principles of palliative care and basic nursing;
- nutrition; and
- care of the care givers.

3.6.4. The success of CHWs

The success of the CHWs concept is attributed to the following guidelines:

- extension of health care services to the community;
- encourage communities to identify their health needs; and
- encourage people to solve their own health problems (WHO, 1987: 9).

The success of the CHWs concept was first observed in China, where the health of many Chinese people dramatically improved due to the implementation of the primary health care programme (WHO, 1987: 9). Based on research findings from Botswana on CHWs, Walt (1990:118) states that health officials and community members were unanimous in agreeing that CHWs should continue to work in their villages and conduct home visits.
The report further indicates that there was much improvement on hygiene issues when CHWs moved from home to home educating people about health issues.

3.7. Support networks for CHWs in the HIV/AIDS Programme

Karim & Karim (2005:359) assert that as the epidemic grows, the burden of caring for the sick becomes great and a network of support groups such as Community Based Organisations (CBOs), NGOs and community care workers need to be formed. According to Willis (2002: 69), for the CHW to execute his or her duties well, there should be an existing support network. He describes support networks as:

- families, friends, work colleagues;
- medical and paramedical staff;
- professional counsellors/psychologist;
- social services/charitable organisations;
- faith communities; and
- special organisations working specifically with HIV/AIDS infected people and their families.

This kind of support, which is given by people and organisations concerned, should be easily accessible, consistent, genuine, caring, subtle and confidential (Willis, 2002: 70).

3.7.1. Support by the Department of Social Development

The government through the National Social Development Department assist families affected by the epidemic by providing foster care grants, food parcels and other interventions (Report on HIV/AIDS in South Africa, 2000: 5). In South Africa, social workers are responsible for facilitating housing provision, processing social grants for poverty-stricken people and the sick, distribution of food parcels as well as solving social problems. Based on the report by the Child Health Policy Institute (2001: 8), households with terminally ill patients survive on the Adult Disability Grant or pension, which is granted by the Department of Social Development.

The Department of Social Development works hand in hand with CHWs in the community, to identify households who qualify for food parcels. Some households are solely dependent on the food parcels due to the level of their poverty. Terminally ill patients need food and vitamin supplements in order to survive. The Status Report on HIV/AIDS in the Social Development Sector (2001:17) states that families affected HIV/AIDS need material assistance in the form of shelter, food and social relief.

3.7.2. Support by the Department of Health

According to Walt (1990:46), the Department of Health carries a responsibility to support the CHW by assigning nursing staff to communities. These nurses are employed in the community clinics and health centres. The nearest clinics are the ones, which receive daily information on the success or failure of the HIV/AIDS Programme in communities.
The Provincial Health Department continues to supply medicines to CHWs who then distribute to bedridden patients. The budget for the National and Provincial Department of Health continue to expand yearly due to the increasing number of HIV patients who need home-based care.

Walt (1990:49) states that the link between CHWs with the health services is important because specialised treatment and care come from nurses and medical doctors. The specialist knowledge is transferred to the CHW who work directly with the community.

3.7.3. Support by NGOs

NGOs support the caregivers by engaging in research, advocacy, education, welfare and health service provision, managing orphan care, and counselling and other activities (Aids Foundation South Africa, 2005: 3). The foundation also indicates that various donors channel huge sums of money to NGOs. NGOs are also driving campaigns to lower drug prices, improve care and formulation and implementation of effective HIV/AIDS policies. Whiteside & Sunter (2000:114) assert that there should be a coalition involving NGOs, business, trade unions, and civil society to fight the epidemic.

3.7.4. Support by the community structures

Walt (1990: 60 - 61) asserts that CHWs will not be successful in rendering their service to the community if there is no support from the community. He further highlights community organisations such as Village Development Committees or VDC (in South Africa, Community Development Forums (CDF), trade unions and farmers' associations that should be part of the CHWs' Programme. The community needs to know and understand the impact of HIV/AIDS in their area. They are expected to assist the community home-based care programme.

Governments give mandates to communities to control their CHWs' Programme (Walt, 1990: 61). He indicates that the common form of community support for CHWs comes in the form of voluntary labour. CDFs have a task of galvanising community support for the CHWs' Programme. They encourage home visits to care for the sick and conduct counselling sessions to patients.

The ABE Development Services Trust (2003:32) suggests the following guidelines to increase community participation:

- Involving as many people as possible in the planning and decision making process;
- Everyone need to be given a chance to participate;
- Focus on smaller health committees; and
- Help the community plan activities.

The above facts suggest that community health care needs maximum support from the community. According to Granich & Mermin (1999:153), community theatres and puppets can be used successfully to educate and empower communities to take responsibility of their health.

3.8. Challenges faced by CHWs

The work of CHWs is challenging and needs patience and confidence in order to succeed. There is quite a number of challenges encountered by CHWs.

3.8.1. Stress

Hunt (2001:345) asserts that the strain on lay caregivers sometimes becomes great as a result of depression and illness. She further mentions that caregivers are at risk from suffering psychological problems.

Nkosi (2006: 4) observes that many home-based care workers (HBCW) do not get paid but volunteer their services to the community. He points out that research conducted in Mpumalanga and Limpopo indicates that approximately 89% of HBCW suffer from depression. He further asserts that one caregiver reports that she had to go for counselling after watching some of her patients die of ill health and hunger. Patients are often alone at home and have no one to feed, bath and help them take medication.

The research also highlights that many caregivers are unable to cope with the increasing numbers of patients who need continued care. The South African Depression and Anxiety Group (Sadag) has records of treatment given to CHWs for stress related problems.

Granich & Mermin (1999:123) mentions three reasons why CHWs should be supported.

- CHWs suffer burnout as a result of insufficient resting time;
- Loss and frustrations; and
- Morale becoming low or reach a stage of hopelessness.

3.8.2. Risk of infection

According to Sim & Moss (1995:35) CHWs are subject to the following risks;

- Risk of contracting HIV/AIDS through needle stick injury;
- Risk of contracting hepatitis B which is 20%; and
- Frank contamination of skin and mucous membrane with blood and other body fluids.

These risks are precipitated by the fact that CHWs are assigned to patients who need to be monitored and assisted to take medication and also respond to patient and family concerns and to offer support (Nattrass: 2004, 143).

Healthlink Worldwide (1987 – 2004: 5) indicates that health workers are always at risk of coming into contact with blood or other fluids through:

- open sores on their skins;
- accidents such as needle pricks or blood splashes;
- carelessness such as dangerously discarded needles or blades; and
- lack of gloves and other protective barriers.

3.8.3. Working without compensation

Based on Popple (1995:55 – 58) the community workers' model is an initiative that empowers community members to be engaged in voluntary services. He asserts that community members become concerned with the welfare of residents, more especially old people, children and the sick.

These caregivers work without payment. They give care to HIV/AIDS patients who are receiving treatment at home. He further cautions of the exploitation of volunteers in the form of free labour.

3.8.4. Uncooperative community and families

The caring and prevention of HIV patients is to a great deal hampered by stigma and denial in South Africa (Mankell, 2004: 112). During the World Aids Day in 1995, Nelson Mandela encouraged all South Africans to "speak out against the stigma, blame, shame and denial that have thus far been associated with this epidemic" (Mankell, 2004: 112).

Some families often deny CHWs access to their sick relatives. And this puts a lot of strain on CHWs who have to spend a long time negotiating with the affected families. Fox (2002:22-23) asserts that some families do not want to mention that they have HIV/AIDS patients in their homes. They deny the existence of such sick people in their homes. Patients are locked away in isolated rooms, where they get no assistance from the family. It is in situations like these, where CHWs take an efficient and effective role in caring for the sick.

According to Hunt (2001:333) one disadvantage of home-based care is that family members sometimes express concerns about their privacy, interruption of family environments and conflicts with home care staff.

3.9. Summary

From the discussion above, it follows that CHWs need a lot of support from different sectors. The definition of a CHW gives an indication that he or she is a change agent in his or her community. A change agent needs to have appropriate skills, which are required to execute his duties well.

There are different roles, which are played by CHWs in the community. Some of these roles are as follows; act as mini doctors, counsellors and as extra pair of hands.

The CHW is usually a volunteer who gets stipends at the end of the month. Professional CHWs such as nurses are paid by the state. The CHWs' Programme cannot function in isolation from other sectors. A network of support systems is needed to sustain the role of CHWs. Support systems usually come from DoH, community, government funding and NGOs. The DoH provides support by training CHWs and providing medication to patients. The Department of Social Development provides support by supplying destitute patients with food parcels. NGOs fund Home-based care groups, train CHWs and also establish hospices for the sick.

Chapter four is a case study that explores the effects of support systems on the role of CHWs in the HIV/AIDS Programme at Mkhuhlu village.

Chapter 4

The Community Health Workers' Programme at Mkhuhlu

4.1. Introduction

Mkhuhlu village is a rural settlement with a population of approximately 29 000 people (Department of Water Affairs and Forestry: 2000). This community is serviced by three health facilities, namely; Mkhuhlu, Calcutta and Cork clinics. People living with HIV get health assistance from these three clinics.

The Mkhuhlu Home-based care centre assists HIV patients by paying them visits at their respective homes. The USAID, although an international governmental aid agency, fulfils the role of an NGO in this community. This aid agency assists HIV patients in their homes. The following aspects were dealt with in this chapter;

- methodology of the study;
- subjects involved in the study;
- measuring instrument;
- procedure;
- data analysis; and
- the presentation and interpretation of results.

4.2. Methodology of the study

The unit of analysis for the study is CHWs who work at Mkhuhlu village. There are seventy CHWs who work at Mkhuhlu. Thirty of them are professional CHWs (Primary Health Care Workers or nurses) and forty volunteer CHWs who are working at the Home-based care centre and the USAID field workers.

The research was a quantitative empirical type of study. The study looked at how support systems influence the role of CHWs in the HIV/AIDS Programme.

The reliability of the research instrument was tested by calculating the alpha between the component variables. The value of alpha was calculated and found to be 0.9. This shows the reliability of the research instrument. If the same instrument was to be used in another rural village in another province similar results could be obtained.

A stratified random sample was used on the 41 cases selected from the total sample of 70 that represent 59% of respondents. This was made possible because a homogenous population was chosen. The support systems will still come from the same stakeholders.

There is a relationship between the role of CHWs and the support systems, which are provided by a number of stakeholders such as, provincial and regional health department, NGOs, the community, USAID, government funding and nurses.

The sampling frame was as follows;

Primary Health Care Workers (Nurses)	=	30
Home-based care givers	=	20
USAID field workers	=	20
Total	**=**	**70**

4.2.1. Subjects

A probability sample that was purposefully drawn was used in the study. The Mkhuhlu Home-based care workers, Primary Health Care Workers and USAID field officers agreed to take part in the research study. The participation in the research study was voluntary, and this was indicated in a written informed consent (see letter in Annexure A).

The participants were informed that their names or particulars would not appear on any of the records of the study. Subjects who agreed to take part in the study indicated that by putting their signatures on the consent letter.

Questionnaires were administered to each participant at their work centres (Mkhuhlu, Cork and Calcutta clinics), Mkhuhlu Home-based care centre and USAID office. Permission was obtained from the Mpumalanga Health and Social Services Department to conduct research in the three clinics (see Annexure B)

4.2.2. Measuring instrument

The measuring instrument consisted of a 30-minute questionnaire (see Annexure C). The questionnaire contained 25 items. Twenty-three items were on a 5 – point Likert scale. Item number 24 was a dichotomous question. Item number 25 contained six roles of CHWs.

The purpose of the 5-point Likert scale was to measure the degree of support offered to CHWs by different stakeholders. The 5-point Likert scale was designed as follows;

1 = strongly disagree
2 = disagree
3 = uncertain
4 = agree
5 = strongly agree

Scores 1, 2 and 3 were classified as negative responses and scores 4 and 5 were classified positive responses. The Yes and No responses on item 24 were coded as follows;

1 = Yes
2 = No

Responses on item 25 were coded as; Q1 = most important role, Q2 = 2nd most important role and Q3 = 3rd most important role. The questionnaire was dropped off at the chosen centres in a single day. They were collected from the centres after three days.

4.2.3. Procedure

Prospective subjects were addressed during lunch time at their work environment. The aim of the study was clearly explained to them. Participants who agreed to take part in the study were given consent letters to sign as a confirmation of their participation. Questionnaires were handed over to them for completion. They were requested to complete the questionnaires as honest as possible. Only subjects who had signed the consent letter were allowed to complete the questionnaire.

A total of 80 questionnaires were distributed to the subjects. Of the 80 questionnaires distributed, only 41 were completed and returned. A few questionnaires had one or two questions not answered. The questionnaires were analysed after collection.

4.2.4. Data analysis

The Pearson correlation coefficient was used to determine relationships between variables testing support and variables testing the role of CHWs. Statistical analysis was performed by Moonstats software on a Windows XP operating system. Inferential statistics was used to determine the influence of support systems on the role of CHWs. The inferential statistics was based on univariates (frequencies) and bivariates (correlation relationships between variables X and Y).

4.3. Presentation and interpretation of results

4.3.1. Summary of frequency for all variables

The findings on the frequency table (see Annexure D) were analysed through checking negative responses against positive responses.

Table 4.1: Negative versus positive responses

Number of Negative responses (1 – 3)	%	Number of Positive responses (4 – 5)	%
20	48	21	52

The percentages of the responses showed a very small difference.

4.3.2. Characteristics of respondents

There are three categories of CHWs as mentioned in the sampling frame (4.2). The numbers and percentages of the CHWs who took part in the study are described in table 4.2.

Table 4.2: Demographic characteristics of respondents

The CHWs were drawn from Primary Health Care workers, volunteers from Mkhuhlu Home-based care workers and USAID field officers.

CHWs	Number	%
Primary Health Care Workers	16	39
Home-based care workers	15	36.6
USAID field workers	10	24.4
TOTAL	41	100

4.3.3. Correlation matrix

The correlation relationships of variables as presented from Moonstats software states that the p value indicates if the correlation is statistically significant or not. The level of statistical significance has been set at 0.01 (99%) and 0.05 (95%) unless otherwise stated. If the p value is 0.01 ($p < 0.01$) it shows a 99% or better probability of a statistically significant relationship. If $p < 0.05$ it indicates a 95% or better probability of a statistically significant relationship.

The statistical report focused on moderately strong relationships ($r = 0.35$) to strong correlation relationships (0.5). According to the Moonstats software $r = 0.35$ indicates a moderately strong significant statistical relationship. The strength of the relationship increases with the increase in the value of r.

The independent and dependent variables are represented by X and Y respectively. The tables below show the correlation matrix between variables.

Table 4.3: Community support systems (X) variables by role variables (Y)

The role variables are few problems, good service and home visits. The community support variables are community leaders' support, ward council support, community members' support, and community support initiatives, community support for HIV/AIDS Programme and municipal support.

(X : Y)	role Few problems	role good service	role home visits
Community leaders support	-0.13	0.30	-0.11
Ward council support	0.13	0.11	-0.29
Community members' support	-0.36	-0.11	0.31
Community support initiatives	-0.18	0.21	0.10
Community's support for HIV/AIDS Programme	0.07	-0.01	0.17
Municipal support	-0.05	-0.23	0.02

From the above table, the variable *few problems* showed a negative relationship with community members' support ($r = -0.36$; $p < 0.05$). The less community members support CHWs, the more problems encountered by a CHWs.

All the other role variables did not show any statistical significant relationship with the community support variables. No statistically significant correlation exists between them.

Table 4.4: Community support (X) variables by role variables (Y)

The role variables are home-based care, primary health care and CHWs' Programme expansion.

(X:Y)	role home based care	role primary health care	role CHWs programme expansion
community leaders' support	-0.30	-0.62	-0.14
ward council support	-0.07	-0.15	-0.50
community members' support	0.31	0.25	0.40
community support initiatives	0.21	-0.40	0.43
community support for HIV/AIDS Programme	0.20	-0.07	0.38
Municipal support	0.16	0.19	0.17

Home-based care did not show any statistical significant relationship with the all the *community support* variables. Role *Primary Health Care* showed a negative relationship with *community leaders support* ($r = -0.62$; $p < 0.01$) and *community support initiatives* ($r = -0.40$; $p < 0.05$). The more *community leaders* withdraw support, the less *Primary Health Care* workers play their role in the HIV/AIDS Programme. The more *community support initiatives* lag behind, the less Primary Health Care workers engage in health services.

Role *CHWs programme expansion* indicated a relationship with *ward council support* ($r = -0.50$; $p < 0.01$), *community members' support* ($r = 0.40$; $p < 0.05$), *community support initiatives* ($r = 0.43$; $p < 0.05$) and *community support* for HIV/AIDS Programme ($r = -0.50$; $p < 0.01$).

Table 4.5: Support systems variables by role variables

The correlation matrix between support variables and role variables was done. The support variables represented independent variables (X) and the role variables were dependent variables (Y).

(X:Y)	role few problems	role good service	role home visits
transport 1	-0.27	-0.03	0.23
transport 2	0.19	-0.27	0.20
social workers	-0.39	-0.01	0.31
work shops	0.17	0.13	0.05
NGO support	0.20	-0.12	0.49
health department support	-0.30	0.25	-0.35
government funds	-0.33	-0.28	0.30
stipend	0.06	-0.16	0.52
stress management	0.24	-0.16	0.52
policy support	0.26	-0.15	0.24

Few problems did not show any correlation with the other X variables except support from *social workers* ($r = -0.39$; $p < 0.05$). The more *social workers* support CHWs, the fewer problems experienced by the CHWs in the HIV/AIDS Programme.

The role *good service* did not show any correlation relationship with all the independent variables. *Home visits* showed a significant relationship with *NGO support* ($r = 0.49$: $p < 0.01$) and *stress management* ($r = 0.52$; $p < 0.01$). The more the DoH withdraws support for CHWs, the less *home visits* they will conduct in the community ($r = -0.35$; $p < 0.05$).

The role *home visits* was also correlated with *stipend* ($r = 0.52$; $p < 0.01$) and *stress management* ($r = 0.52$; $p < 0.01$).

Table 4.6: Support systems variables by role variables continued

(X:Y)	role home-based care	role primary health care	role CHWs programme expansion
transport 1	-0.11	-0.26	0.29
transport 2	0.66	0.49	0.09
social workers	-0.03	-0.15	-0.06
work shops	0.01	-0.44	0.05
NGO support	0.54	0.20	0.32
health department support	-0.61	-0.36	0.06
government funds	0.23	0.27	0.43
stipend	0.49	0.25	0.47
stress management	0.49	0.25	0.47
policy support	0.33	0.44	-0.28

The role *home-based care* was significantly correlated with *transport 2* ($r = 0.66$; $p < 0.01$), *NGO support* ($r = 0.54$; $p < 0.01$), *health department support* ($r = -0.61$; $p < 0.01$), stipend ($r = 0.49$; $p < 0.01$) and *stress management* ($r = 0.49$; $p < 0.01$). The provision of transport makes the work of CHWs who work as volunteers in the HBC environment easier. NGOs play a measure supporting role by providing training and guidance to HBC workers. HBC givers suffer from stress from time to time and they need stress management support.

The more the health departmental support lags behind, the less home-based care givers provide care for the patients. Stipends make HBC givers work with determination and it also enables them conduct home visits with ease.

The role *Primary Health Care* was positively correlated with *transport 2* ($r = 0.49$; $p < 0.01$) and *policy support* ($r = 44$; $p < 0.01$). The provision of transport to Primary Health Care workers enables them to cover a vast area when doing routine visits to HBC centres and ICHC. The policy frameworks provide guidance on how CHWS should conduct their services in the community. Policy frameworks also offer protection for CHWs from exploitation.

The role *Primary Health Care* also showed a negative correlation with *workshops* ($r = 0.44$; $p < 0.01$) and *health department support* ($r = -0.36$; $p < 0.05$). The more workshops to train CHWs are not conducted, the less they become capacitated to perform their caring duties in the community. The health department provides a supervisory role to CHWs. The more the health department withdraws support for Primary Health Care workers, the less role they play in the community.

The CHWs' Programme expansion was positively correlated with *government funds* ($r = 0.43$; $p < 0.05$), *stipend* ($r = 0.47$; $p < 0.01$) and *stress management* ($r = 0.47$; $p < 0.01$). The provision of funds by government makes the CHWs' Programme to expand well in the community. Stipends have a potential to draw many young people to the CHWs Programme. If many people join, the programme expands in the community. CHWs are human beings who experience stress like anyone else. Appropriate stress management support systems enable CHWs to feel assured that if they experience stress there is assistance from the CHWs' Programme.

Table 4.7: Analysis of dichotomous questions

The question on AB 24 only needed a Yes and No responses. The responses were analysed based on their percentages.

Is there enough support from DoH, the, community, NGOs and Social Services department?	Number of responses	%
Yes	16	39
No	25	61

The above results showed that the support given by the District Health Department officials, the community, the NGOs and the District Department of Social Services is not enough in the community of Mkhuhlu. There is a need for the institutions listed above to provide more support to the CHWs.

Table 4.8: Respondents' rating of the roles of CHWs

The ratings showed how respondents ranked the six roles of CHWs. The three most important roles were identified. The table below presented all the ratings of the roles and identified three most important roles.

Role	Number of responses	N	%
Mini doctor	5	41	12
Helping hand	15	41	37
Bath patients	13	41	32
Give emotional support	21	41	51
Counselling HIV/AIDS patients	36	41	88
Referring patients to hospital	27	41	66

The most important roles played by CHWs at Mkhuhlu are rated as follows:

Q1 = most important role is counselling HIV/AIDS patients (88%)
Q2 = second most important role is referring patients to hospital (66%)
Q3 = third most important role is emotional support (51%)

When CHWs conduct home visits they mostly do counselling, refer critically ill patients to the hospital and give emotional support to the sick. This is a daunting task considering the findings that showed the importance of transport, stipends and government support. A rural community like Mkhuhlu does not have professional counsellors and the CHWs provide a valuable service to the HIV patients.

The findings of this research study are consistent with the previous research findings conducted in Botswana, Columbia and Sri Lanka (see Walt, 1990: 118 – 173). The findings for the research projects conducted in the above countries showed the following;

The roles of CHWs. The roles of CHWs were identified as follows; to assist in vaccinations, conduct home visits and assist in maternal and child health. During home visits, CHWs do counselling, give emotional support to HIV patients and do referrals for critically ill patients.

Community support. CHWS received various levels of support from local community and its structures.

Transport support. Transport was found to be problematic to CHWs, because they had to travel long distances. Transport costs were very difficult to cope with and this hindered the progress on home visits. Lack of vehicles to make trips to rural health posts restricted CHWs from doing their work in the community.

Primary Health Care support. CHWs used to get support and encouragement from nurses, district and regional level staff.

Workshops. Workshops were funded by the World Bank to train CHWs. Government also funded training of CHWs and facilitate the provision for incentives.

Stipends. The lack of incentives in the form of stipends effectively made CHWs to be demoralised and thus yield negative results.

NGO support. NGOs in the three countries were found to be useful in the CHWs Programme, because they were able to meet the training and travelling costs of CHWs. International donor agencies were also identified to be useful because they assisted in the training of CHWs.

Policies on work schedule. Clear policies on work scheduling helped to guide and support CHWs. The policies were able to boost the morale of CHWs because they were protective towards their cause of caring for patients in the community.

4.3.4. Limitations of the study

- The limitation of the methodology is that the study was biased in favour of stakeholders in the HIV/AIDS Programme only;

- Patients who are beneficiaries of the services provided by the CHWs were not interviewed;

- The questionnaire was designed in English and therefore there is a possibility that the findings may have been influenced in a specific direction;

- Stakeholders such as traditional healers, spiritual leaders and pastors were not consulted;

- The views of family members who look after the sick were not given an opportunity to make a contribution to the study; and

- No other study of this nature was found to have been conducted at Mkhuhlu could provide comparable data relevant to the present study.

4.3.5. Interpretation of findings

The findings confirm study's hypothesis that says, "The role of CHWs in the HIV/AIDS Programme is related to the available support systems that are provided by the community, NGOs, international donor agencies and the DoH.˝ Without community support, there could be no meaningful contribution by CHWs in the HIV/AIDS Programme. With enough support from all stakeholders, the CHWs' Programme is set to expand well in the community.

Appropriate policies protect CHWs from exploitation by NGOs and health officials. Policies are also made to guide CHWs to play their role within the parameters of human rights. Walt (1990: 95-96)) states that the conceptualization of the CHWs policy, its formulation and implementation assist CHWs to remain protected from exploitation by authorities.

There are NGOs, which commit funds to the HIV/AIDS Programme. These funds enable volunteer CHWs to get stipends at the end of the month. The stipends help volunteer CHWs to travel to work everyday. The little money also helps CHWs to conduct home visits with ease. The involvement of NGOs in the CHWs' Programme is supported by the SA Yearbook (2006/2007:512), which states that government encourages the establishment of Home and Community-Based Care Programmes, the formation of partnerships with NGOs, CBOs and government departments to fight HIV/AIDS in South Africa. According to Walt (1990:75) international donors such as UNICEF meet the training costs of CHWs in other countries.

In the case of this research study, the Mpumalanga Health Department and the international donor agency USAID meet the training costs of CHWs at Mkhuhlu.

Walt further indicates that NGOs who support CHWs' Programme incur extremely high costs in trying to run the programme. Government incurs costs as a result of supplying medication to the HIV patients, training of CHWs and paying stipends to volunteer CHWs (Walt, 1990:75). The US president's emergency plan for AIDS relief in South Africa, has committed more than R10 billion in the form of grants from 2004 to 2008 to fight HIV/AIDS in South Africa (Cassinga, 2007:1). Cassinga further states that many NGOs from around South Africa received a portion of this amount to assist CHWs in the HIV/AIDS Programme. At Mkhuhlu, the Enhleleto Support Group received an amount of R70 000. This amount is aimed at supporting caregivers with stipends, training, office supplies and transportation fees.

Primary health care workers and volunteer CHWs experience a lot of stress in their day-to-day activities in the community. They both need stress management support systems in order to play their role more effectively. With less stress, CHWs are able to discharge their responsibilities more effectively. From these results it could be assumed that the role of CHWs is related to the support systems offered by all stakeholders in HIV/AIDS Programme.

4.4. Implications of the findings

The research findings suggest that CHWs play a very important role in the HIV/AIDS Programme at Mkhuhlu. This is supported by the responses that show that the most important roles of CHWs are emotional support (51%), referral of patients to hospital (66%) and counselling (88%).

Government funding is one of the major mechanisms, which encourages CHWs to play their role with ease and determination.

The above view is supported by the strike action, which was undertaken by CHWs in Mpumalanga – Nelspruit in June 2007 (Moatshe, 2007:7).

Moatshe also indicates that about 530 CHWs who receive a monthly stipend of R1 000 each, from the Department of Health and Social Services staged a sit in because they did not receive their monthly stipend for three months. As a result of the failure by the department to pay them, they were struggling to reach their work places.

The findings show that there is a need for strong government support to the HIV/AIDS Programme. Without government support, the programme cannot function to its full potential. Appropriate policies need to be established in order to guide both authorities and CHWs in their community responsibilities.

The Foundation for Education, Science and Technology (2001: 41) indicates that a collective approach is needed to fight HIV/AIDS. The Foundation suggests that co-orperation with the community and its structures play a very important role in the HIV/AIDS Programme. The Foundation further asserts that money should be made available to the HIV/AIDS Programme. The programme is able to provide invaluable service to the community if there is support from all relevant stakeholders. The National Treasury, local authorities, NGOs and international donor agencies need to make it a priority to commit funds to the HIV/AIDS Programme.

The Nelson Mandela Foundation (2005: 26-27) asserts that there are important roles and functions that CHWs should do in the community. The roles are identified as follows:

- Give emotional support during bereavement occasions;
- Receive training in order to execute their duties well;
- Receive financial support in the form of volunteer incentives;
- Give home-based care to AIDS patients;
- Give counselling to HIV patients; and
- Receive AIDS training.

The expansion of the CHWs' Programme is a very important factor in getting access to all HIV patients in the community. These can be made possible by community support. Looking after terminally ill patients in their own environment alleviates overcrowding in hospitals. It is therefore imperative for all stakeholders in the community to work together so that maximum benefits by HIV patients could be achieved.

4.5. SUMMARY

The research design was carried within the working environment of CHWs at Mkhuhlu village. The identified subjects completed questionnaires and returned it. The findings of the study showed that there is a relationship between the role of CHWs in the HIV/AIDS Programme and the support systems. The variables showed a statistically significant relationship that was set at $p < 0.01$ and $p < 0.05$ levels. Despite the fact that some variables did not show a correlative relationship, the regression of major variables presented both a positive and negative relationship.

The most important roles of CHWs at Mkhuhlu were ranked as follows:- counselling, referring patients to hospital and giving emotional support.

Limitations of the study were considered as well as the implications. The fact that English was used in the questionnaire could have influenced the findings. The implications are both positive and negative. If enough support is provided to CHWs, their contribution in the HIV/AIDS Programme becomes significant. In the case where there is no meaningful support from stakeholders, the patients who are beneficiaries of the CHWs Programme suffer.

Chapter 5 presents a conclusion and recommendations based on the findings of the study. Suggested further study is also presented in chapter 5.

Chapter 5

Conclusions and Recommendations

The major issue raised in this research concerns the relationship between the role of CHWs in the HIV/AIDS Programme and support systems as well as the availability of funds. The aim of the study which was to explore and confirm the influence of support systems on the role of CHWs was confirmed by the findings. The analysis reported here was based on the sample of sixteen Primary Health Care workers, fifteen home-based care givers and ten USAID field workers.

The institutional context of health discussed in chapter two, was preceded by a discussion on the international perspective of support systems in the Primary Health Care sector. The international perspective of support systems was based on four countries namely; Senegal, Uganda, Australia and Britain. The approaches used by the four countries to support their CHWs, linked well with the theory on existing literature and the South African Institutional Context of Health. The approaches are consistent with the theory that says, CHWs can be successful if they receive maximum support from government, NGOs and other agencies that work towards the reduction and management of HIV infections in the community.

The methodological design of the study as described in chapter 1 was able to provide evidence of the findings, which were obtained in chapter 4. The unit of analysis proved to be appropriate for the study because statistical significant correlation relationships were obtained from variables that were tested.

The development of the South African Institutional Context of Health was a direct consequence of the escalating rate of HIV infections in South Africa. The government initiatives and strategies give guidelines on how a multisectoral approach could be used to fight HIV/AIDS in South Africa.

The Constitution of the Republic of South Africa, Act 108 of 1996, National Health Act and other related policy frameworks were developed to guide and protect both patients and CHWs from exploitation. The chapter on the Institutional Context of Health gave insight on the extent to which HIV infections have affected communities in South Africa.

The Community Health Worker's Approach in chapter three describes the origins of the Primary Health Care concept and the roles of CHWs in the HIV/AIDS Programme. The existing theory on the role of CHWs showed that CHWs depended on a number of support networks such as;

- The economic component to run the HIV/AIDS Programme;
- NGOs provide funds and training of CHWs;
- Training of CHWs through workshops;
- To a lesser extent, the Department of Social Development; and
- The community that provides volunteer CHWs.

The Community Health Workers' Approach further described the challenges faced by CHWs in their day-to-day activities in the community. The CHWs face challenges such as stress, the risk of infections, working without financial compensation, unco-operative family members and many others. The analysis reported here was based on the correlation relationships between variables, which reflect the influence of support systems on the role of CHWs.

In the light of the findings, the following conclusions were made;
With support from the community members, the CHWs experienced few problems in their day-to-day undertakings. Support from the social workers reduced problems that affected CHWs in the community. From the literature review, it was revealed that social workers provided assistance in the form of social grants and food parcels to the terminally ill HIV patients.

For CHWs to render their services well, support from NGOs and Department of Health was imperative. Offering stipends to CHWs at the end of the month enabled them to cover transport costs when conducting home visits from area to area. It was also revealed that home visits needed support from stress management systems. CHWs become stressed as a result of watching the suffering of the people they are trying to help.

The Home-based care workers needed transport to enable them to visit their patients. Without transport, CHWs find it difficult to visit their patients. The Home-based care workers also needed support from NGOs, Department of Health and stress management systems. Stipends also played an important role in boosting the morale of CHWs.

The role of Primary Health Care workers in the community could be played well if support in the form of transport is provided. This made it possible for them to visit Home-based care centres and USAID officers. Workshops played an important role by imparting new skills that made CHWs to carry out their duties in a proper manner. Primary Health Care workers needed support from the Provincial and Regional Department of Health.

Without appropriate policy establishments Primary Health Care workers could not render their services well because they would not have proper guidelines. Appropriate policy frameworks and Acts protect Primary Health Care workers from abuse by employers.

The expansion of the CHWs' Programme in the community required funds from the government. Without financial support from government, the programme could not expand well in the community. Stress management systems helped CHWs to get emotional support. The findings also showed that stipends enabled CHWs to feel rewarded for the services they render to the community. This facilitated the expansion of the CHWs' Programme in the community.

The conclusions made above, were consistent with the aim of the research study and the theoretical framework discussed in chapter three.

The importance of the role of CHWs in the HIV/AIDS Programme is summarised by ranking responses on the roles of CHWs. The responses (see table 8) were ranked as follows;

- Counselling HIV/AIDS patients;
- Referring patients to hospital; and
- Giving emotional support to patients.

In the light of the findings of the research study, the following recommendations could be made;

- There is a need to expand the CHWs' Programme at Mkhuhlu, because HIV/AIDS patients could benefit a lot in the improvement of their well-being;
- The government should provide enough budgets to train CHWs. The provision of funds enables volunteer CHWs to receive stipends at the end of the month;
- Counselling centres should be established to help CHWs who are stressed as a result of stress related to their work;
- Common transport should be provided to assist CHWs travel from one area to another;
- Workshops need to be conducted from time to time to equip CHWs with appropriate skills that will help them do their work with confidence;
- Primary Health Care workers should always provide assistance to CHWs;
- Appropriate policies need to be developed to protect CHWs and patients from exploitation; and
- Home-based care centres need to be encouraged to open more centres to assist the community because only one centre is servicing a population of 29 000.

There was a positive relationship between support systems and the role played by CHWs in the HIV/AIDS Programme. From the research results it seems clear that support systems have an influence on the role of CHWs.

Suggestions for further study

In light of the above limitations, the study should not be viewed as conclusive. It is therefore, imperative to replicate the research study with a larger and wider sample. In spite of the above limitations, the role of the CHWs in the HIV/AIDS Programme remains an important one in the community. The CHWs' role brings change into the lives of HIV patients.

Further research will therefore help to determine how best HIV patients can be assisted within their home environment. The policies, which guide the implementation of the CHWs' Programme, should be examined to find appropriate institutional framework, which will assist both CHWs and patients. The government's contribution to the CHWs' Programme should also be looked at to see if they are really committed to assist CHWs.

Based on the above discussion, further research should focus on the training of CHWs. The involvement of stakeholders in the HIV/AIDS Programme and the formation of partnerships between government departments, NGOs, international donors and CBOs should be a priority in the further research studies.

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ANNEXURE A

DIVISION POST GRADUATE PROGRAMMES IN
PUBLIC AND DEVELOPMENT MANAGEMENT

Learning for Sustainable African Futures

To Whom It May Concern:

On behalf of Prof Kobus Müller of the School of Public Management and Planning (SOPMP) of Stellenbosch University, I hereby request you to take part in the research project entitled "The Role of Community Health Workers in the HIV and AIDS Programme."

The purpose of the study is to explore the effects of support systems on the role of Community Health Workers in the HIV and AIDS Programme at Mkhuhlu Village in the Bushbuckridge Municipality. Your name will not be included on any documents. We do not believe that you can be identified from any of this information. This informed consent will not be kept with any of the other documents completed with this project.

Your participation in this study is entirely voluntary. You may choose not to participate without any consequences to you. Should you choose to participate and later wish to withdraw from the study, you may discontinue your participation any time without incurring consequences.

This study has been reviewed and approved by a panel of academics selected and appointed by the University of Stellenbosch. The panel has determined that this study meets the ethical obligations required by the university.

Researcher: Johan Sondlane
Cell: 073 350 1216
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Administrator: Riana Moore
Tel: 021 918 4400
E-mail: djam@belpark.sun.ac.za

If you wish to participate in this study, you should sign below.

Date :…….. Subject's Signature for consent:…….

Thank you for participating in the study.

_____Researcher (JS Sondlane)

ANNEXURE B

MPUMALANGA PROVINCIAL GOVERNME.

Number 7
Government Boulevard
Riverside Park
Extension 2
Nelspruit
1200
South Africa

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Department of Health and Social Services

Litiko Letemphilo Namakhanti Yenhlalakahle Yesive | Umnyango WezePilo neZehlalakuhle | Departement van Gesond en Maatskaplike Die

Enquiries: Martha Mokoena 013 766 3297

MR JOHAN S SONDLANE
P. O. BOX 184
MKHUHLU 1246

07 FEBRUARY 2007

APPLICATION FOR RESEARCH AND ETHICS APPROVAL FOR PROPOSED RESEARCH PROJECT: ROLE OF COMMUNITY HEALTH WORKERS IN THE HIV/AIDS PROGRAMME

Your research proposal has been reviewed by the Provincial Research Ethics reviewers.

No ethical concerns have been detected.

Your proposal has been approved. Kindly ensure that you provide us with the report after your study has been completed.

M G MOKOENA
For: RESEARCH ETHICS REVIEWERS
HEALTH INFORMATION & RESEARCH UNIT

We care. Do you?

SAMPLE GROUP: …… **ANNEXURE C**

This scale tests the influence of support systems to the role played by Community Health Workers in the HIV/AIDS Programme. The CHWs are ranked into Professional CHWs (Nurses) and Volunteer CHWs (Home-based care givers and USAID field officers)

The CHW is asked to indicate his or her choice of answer to the question by marking his or her preferred box.

SECTION A: SUPPORT INITIATIVES FOR CHWS

Rating Scale: 1 – strongly disagree 2 – disagree 3 – uncertain 4 – agree 5 – strongly agree

		1	2	3	4	5
AB1	Community leaders (indunas, pastors, chiefs) support CHWs.					
AB2	Ward Councillors support CHWs in their day to day activities					
AB3	There are few problems in the CHWs programme					
AB4	Support in the form of transport is always provided for the CHWs' home visits					
AB5	Community members support CHWs who are deployed in their village					
AB6	Some community members have their own support initiatives to assist people who live with HIV and AIDS					
AB7	Community members fully support HIV and AIDS programmes in their area					
AB8	Health Workers (volunteers and professionals) always meet and conduct workshops as a form of support to CHWs					
AB9	Local Social Workers are very supportive to CHWs					
AB10	Your organisation makes a meaningful contribution to the CHWs programme					
AB11	CHWs who work as volunteers are fully supported by the Health Department					

		1	2	3	4	5
AB12	The stipend (remuneration, wages) given to CHWs at the end of the month is enough for a living					
AB13	CHWs render a very good service to the community					
AB14	During rainy or sunny days, CHWs conduct their community support duties without difficulties					
AB15	Home visits by CHWs are important support mechanisms to HIV and AIDS patients					
AB16	Municipalities offer maximum support to CHWs					
AB17	Home-based care is another form of support structure offered to HIV and AIDS patients by NGOs					
AB18	CHWs help Primary Health Care workers to reduce patients' default on medication					
AB19	CHWs support programmes are expanding well at Mkhuhlu Village					
AB20	The government provides enough support in the form of grants (funds) to help CHWs carry out their duties in the community with success					
AB21	NGOs who work with CHWs offer valuable support to HIV and AIDS patients who live in the community.					
AB22	The Health Department offer support to CHWs who suffer from stress levels as a result of the stressful community work					
AB23	The CHWs programme has good policies which help to protect CHWs from exploitation by the Health Department and NGOs					

SECTION B

COMMENTS AND OTHER INPUTS REGARDING THE ROLE OF CHWS

AB24. Do you think CHWs get enough support from the community, regional Health and Social Services Department and NGOs who work in the HIV/AIDS Programme in the village? Yes = 1 No = 2 Yes…… NO ……. If answer is NO, state reasons why CHWs are not supported. …… …… …… …… …… …… …… …… …… …… ……	
AB25. CHWs play a number of roles in the community. Some of the roles are listed below. Choose three most important roles which are applicable in your community. Write the number in the column on the right. 1. Act as mini doctors 2. Offer a helping hand to the sick 3. Bath patients 4. Support patients emotionally 5. Give counseling to the sick 6. Refer critically ill patients to hospital	

ANNEXURE D

Frequency table for all variables

Frequency table for **COMMUNITY LEADERS**

Value	N	%	Cum. %
2	1	2.50	2.50
3	3	7.50	10.00
4	19	47.50	57.50
5	17	42.50	100.00
TOTAL	40	100.00	

Missing or invalid cases: 2

Frequency table for **WARD COUNCIL**

Value	N	%	Cum. %
1	7	17.07	17.07
2	8	19.51	36.59
3	6	14.63	51.22
4	10	24.39	75.61
5	10	24.39	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **FEW PROBLEMS**

Value	N	%	Cum. %
1	4	9.76	9.76
2	13	31.71	41.46
3	2	4.88	46.34
4	21	51.22	97.56
5	1	2.44	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **TRANSPORT$_1$**

Value	N	%	Cum. %
1	19	47.50	47.50
2	11	27.50	75.00
3	1	2.50	77.50
4	9	22.50	100.00
TOTAL	40	100.00	

Missing or invalid cases: 2

Frequency table for **COMMUNITY MEMBERS**

Value	N	%	Cum. %
1	2	5.00	5.00
2	10	25.00	30.00
3	6	15.00	45.00
4	13	32.50	77.50
5	9	22.50	100.00
TOTAL	40	100.00	

Missing or invalid cases: 2

Frequency table for **COMMUNITY SUPPORT INITIATIVES**

Value	N	%	Cum. %
1	2	4.88	4.88
2	7	17.07	21.95
3	8	19.51	41.46
4	13	31.71	73.17
5	11	26.83	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **COMMUNITY SUPPORT FOR HIVAIDS PROGRAMME**

Value	N	%	Cum. %
2	5	12.82	12.82
3	14	35.90	48.72
4	14	35.90	84.62
5	6	15.38	100.00
TOTAL	39	100.00	

Missing or invalid cases: 3

Frequency table for **WORKSHOPS**

Value	N	%	Cum. %
2	4	9.76	9.76
3	17	41.46	51.22
4	11	26.83	78.05
5	9	21.95	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **SOCIAL WORK**

Value	N	%	Cum. %
1	5	12.20	12.20
2	5	12.20	24.39
3	6	14.63	39.02
4	10	24.39	63.41
5	15	36.59	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **MEANINGFUL CONTRIBUTION**

Value	N	%	Cum. %
1	1	2.50	2.50
2	2	5.00	7.50
3	6	15.00	22.50
4	16	40.00	62.50
5	15	37.50	100.00
TOTAL	40	100.00	

Missing or invalid cases: 2

Frequency table for **HEALTH DEPARTMENT SUPPORT**

Value	N	%	Cum. %
1	4	9.76	9.76
2	3	7.32	17.07
3	14	34.15	51.22
4	18	43.90	95.12
5	2	4.88	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **STIPEND**

Value	N	%	Cum. %
1	31	75.61	75.61
2	9	21.95	97.56
3	1	2.44	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **GOOD SERVICE**

Value	N	%	Cum. %
2	3	7.50	7.50
3	3	7.50	15.00
4	6	15.00	30.00
5	28	70.00	100.00
TOTAL	40	100.00	

Missing or invalid cases: 2

Frequency table for **TRANSPORT$_2$**

Value	N	%	Cum. %
1	16	39.02	39.02
2	12	29.27	68.29
3	8	19.51	87.80
4	1	2.44	90.24
5	4	9.76	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **HOME VISITS**

Value	N	%	Cum. %
1	2	4.88	4.88
3	4	9.76	14.63
4	15	36.59	51.22
5	20	48.78	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **MUNICIPAL SUPPORT**

Value	N	%	Cum. %
1	6	15.38	15.38
3	19	48.72	64.10
4	11	28.21	92.31
5	3	7.69	100.00
TOTAL	39	100.00	

Missing or invalid cases: 3

Frequency table for **HOME-BASED CARE**

Value	N	%	Cum. %
1	1	2.44	2.44
3	2	4.88	7.32
4	17	41.46	48.78
5	21	51.22	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **PRIMARY HEALTH CARE WORKERS**

Value	N	%	Cum. %
2	2	4.88	4.88
3	4	9.76	14.63
4	10	24.39	39.02
5	25	60.98	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **CHWS PROGRAMME EXPANSION**

Value	N	%	Cum. %
1	1	2.44	2.44
2	7	17.07	19.51
3	4	9.76	29.27
4	20	48.78	78.05
5	9	21.95	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **GOVERNMENT FUNDS**

Value	N	%	Cum. %
1	19	46.34	46.34
2	6	14.63	60.98
3	6	14.63	75.61
4	8	19.51	95.12
5	2	4.88	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **NGO SUPPORT**

Value	N	%	Cum. %
1	2	4.88	4.88
2	11	26.83	31.71
3	8	19.51	51.22
4	9	21.95	73.17
5	11	26.83	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **STRESS MANAGEMENT**

Value	N	%	Cum. %
1	7	17.07	17.07
2	5	12.20	29.27
3	23	56.10	85.37
4	2	4.88	90.24
5	4	9.76	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **POLICY**

Value	N	%	Cum. %
1	6	15.00	15.00
2	2	5.00	20.00
3	23	57.50	77.50
4	3	7.50	85.00
5	6	15.00	100.00
TOTAL	40	100.00	

Missing or invalid cases: 2

Frequency table for **HEALTH DEPARTMENT, COMMUNITY, NGO SUPPORT**

Value	N	%	Cum. %
1	16	39.02	39.02
2	25	60.98	100.00
TOTAL	41	100.00	

Missing or invalid cases: 1

Frequency table for **MINI DOCTOR**

Value	N	%	Cum. %
1	5	100.00	100.00
TOTAL	5	100.00	

Missing or invalid cases: 37

Frequency table for **HELPING HAND**

Value	N	%	Cum. %
2	15	100.00	100.00
TOTAL	15	100.00	

Missing or invalid cases: 27

Frequency table for **BATH PATIENTS**

Value	N	%	Cum. %
3	13	100.00	100.00
TOTAL	13	100.00	

Missing or invalid cases: 29

Frequency table for **EMOTIONAL SUPPORT**

Value	N	%	Cum. %
4	21	100.00	100.00
TOTAL	21	100.00	

Missing or invalid cases: 21

Frequency table for **COUNSELLING PATIENTS**

Value	N	%	Cum. %
5	36	100.00	100.00
TOTAL	36	100.00	

Missing or invalid cases: 6

Frequency table for **REFER PATIENTS TO HOSPITAL**

Value	N	%	Cum. %
6	27	100.00	100.00
TOTAL	27	100.00	

Missing or invalid cases: 15