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AT THE CROSSROADS OF CARE AND RIGHTS:

THE FUTURE OF COMMUNITY HEALTH WORKERS IN SOUTH AFRICA

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CONTENTS

EXECUTIVE SUMMARY

This report is published at a time when the government, in the face of the Minister of Health, made a commitment to formalise and employ 27,000 community health workers who were working for the Department of Health for more than twenty years. The Minister's pledge represents a significant win for community health workers and organised labour, which has been fighting for formalisation for many decades. While this positive development requires acknowledging, the Minister's promise still leaves nearly 20,000 community health workers precariously employed. This means that the trade union's work needs to continue.

This report focuses on the daily issues and challenges faced by community health workers (CHWs) in South Africa. It has four goals:

1. Describe the past and current context in which community health workers operate.
2. Analyse the key community health workers' challenges.
3. Review existing policies to ensure compliance with fundamental ILO rights and WHO guidelines.
4. Offer suggestions for better CHW alignment with international best practices.

Community health workers perform important duties and have a key role in the country's present and future. Yet they face numerous challenges. They form a vital part of primary healthcare in South Africa, but they are frequently not employed by the Department of Health directly. Instead, they are often forced to rely on short-term, recurrent contracts, receiving a stipend instead of a salary and benefits. They are routinely underpaid and under resourced. They face high levels of violence, harassment and abuse on the line of their jobs. They often have limited freedom of association and cannot freely and without fear of retaliation join the trade unions of their choice.

A lot of the challenges that CHWs face are rooted in the policies from many decades ago. At least part of the problem lies in the fact that, from the beginning, the community healthcare sector was envisioned as a relatively cheap solution to the limited medical access of the population in "developing" countries. Initially, many decades ago, when the very first community health projects were rolled out, community health workers were expected to volunteer within the community they lived in for a small stipend.

However, in the years since the original community healthcare work was developed, the economy, community living, and medical science have undergone significant changes. Communities are no longer semi-sufficient and relatively isolated from one another, and urban areas have sprawled massively. Community roles and expectations changed significantly. Medical science has advanced, offering a wealth of knowledge and interventions, as well as numerous diagnostic tools to support individuals.

The current way community health programmes operate - the overreliance on non-government providers to hire and manage community workers, the poor integration of community workers into the broader healthcare system, and the volunteer nature of community work - is a result of the legacy of the past. This is the outcome of apartheid, which limited healthcare to the majority of the population and forced healthcare projects to rely on donors and volunteers. It is the outcome of the early days of democracy, with its views of community work as "sub-par" versus primary care delivered by nurses and doctors. It is the outcome of the financial austerity of the last decade, which claims that South Africa never has enough resources to ensure fundamental working rights for numerous groups.

The current system, however, is not practical, efficient, or humane. It does not deliver the best quality of care to the patients. It falls significantly short of providing affordable primary healthcare to all those living in South Africa. And the benefits that it does manage to deliver, it does so at the

expense of the workers, leaving many in unsafe working conditions, without benefits or access to pensions, living in poverty after many years of service. In other words, tradition, rather than evidence or justice, has shaped much of what we now accept as the standard approach.

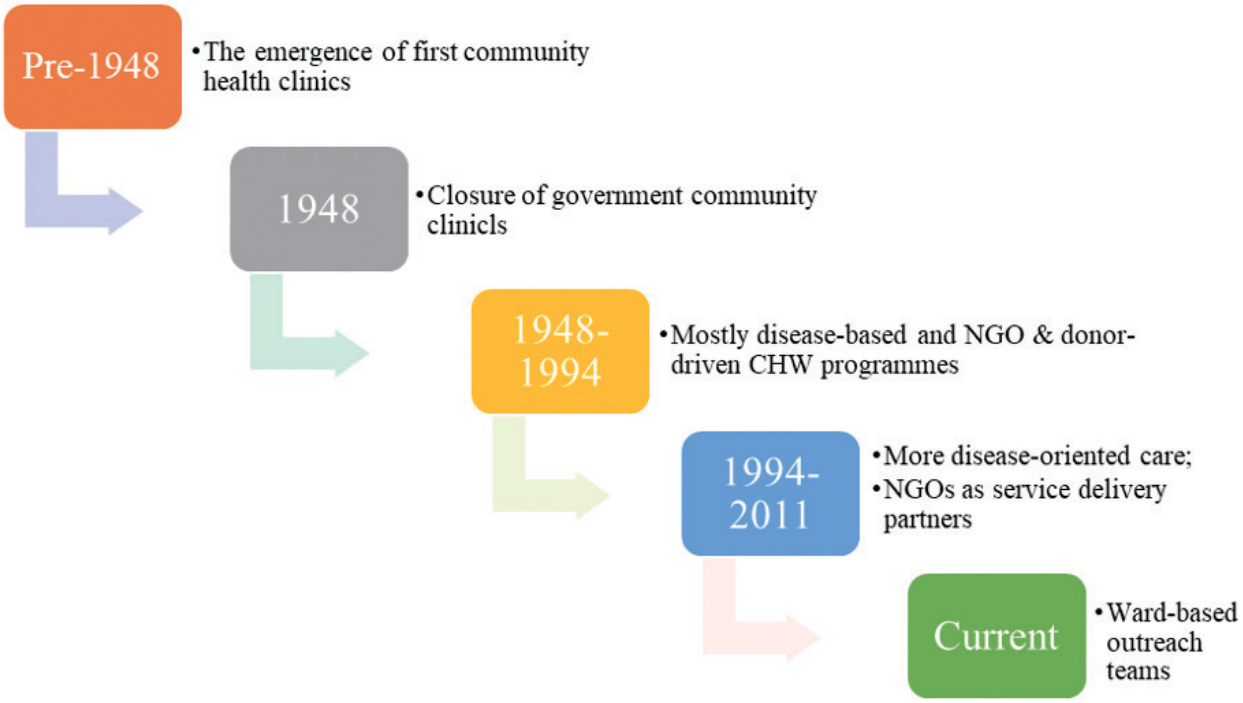
This system can be changed, and the transition towards the National Health Insurance (NHI) provides a good opportunity to restructure the community health programmes. The current NHI provisions suggest that community health programs will remain unchanged as they are today. However, instead of keeping the status quo, the community health programmes need to be changed based on the following principles:

- Insourcing of all the community health workers who work in the public primary healthcare provision into the Department of Health (DoH);
- Standardising job roles, responsibilities, and conditions of employment for CHWs across the provinces;
- Separating the roles of nurses, auxiliary nurses and community health workers;
- Improving CHW supervision;
- Improving the current under-resourcing situation;
- Standardising and formalising the training for community health workers;
- Increasing community engagement in the rollouts of community health programmes;
- Aligning laws and regulations with the ILO and WHO guides and conventions through expanding the scope of the Occupational Health and Safety laws to include violence, abuse, and harassment and improving enforcement mechanisms of the Code of Good Practice.

1. COMMUNITY HEALTH WORK THROUGH THE CHANGING HEALTHCARE SYSTEMS

A historical overview of community health projects in South Africa is important for several reasons. First of all, it shows the continuity of community health projects despite and, at times, against government directives. It highlights the ultimate importance and value that community health workers deliver to their communities and how cherished community health projects are to survive through many years of limited resources. Secondly, this brief overview highlights the origins of many of today's CHWs' challenges. Understanding the root causes of these challenges may help create new solutions for the future.

Chart 1.1 History of community health projects



South Africa has been operating a dual healthcare system for many decades. The apartheid healthcare system created segregated and unequal facilities, where the non-white population was subject to higher rates of disease and worse quality of care. In the 1940s, community Health Workers were a vital part of closing the healthcare gap. The work of the CHWs was described as "innovative, responsive, comprehensive and empowering for staff and communities". [1] The government built and financed forty dedicated rural health centres where CHWs, who back then were called health assistants or health educators, worked. Their primary responsibilities included conducting home visits, providing health education, collecting data, and promoting community participation. [2] Health assistants educated people about preventative care and provided some curative care at people's homes when necessary. These initiatives were popular and successful, setting the foundation for future CHW programmes.

[1] Ginneken, N., Lewin., S., Berridge, V., 2010. The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Soc Sci Med*, 71(6).
[2] People's Health Movement (PHM), 2018. *Contextualising the struggle of health workers in South Africa*.

Even though the number of rural health centres - 45 by 1948 - was ten times less than the estimated necessary amount, after the 1948 general election, in which the National Party won, the governing party stopped funding rural health centres. [3] Most of the existing rural health clinics where health assistants worked closed down. The few that remained had to change their source of funding and relied on civil society and NGOs. Those years, from the 1950s to the beginning of democracy, were at the roots of the community health systems that exist in South Africa to this day.

The funding for CHW programmes and the employment of community health workers during that time was sporadic, driven by donor priorities, fragmented and precarious. There were no national CHW programmes. Instead, the areas where community health workers worked and the projects they worked on were determined by funding organisations, and the coverage was patchy.

There is little reliable statistical data on the number of the community health workforce during that time, or the various ways those workers were employed. Some of the CHW programmes were true to the original mission and offered general-level community support. The more notable initiatives in the field included the Health Care Trust (also known as the Brown's Farm Project) and the South African Christian Leadership Assembly. These projects were also more formalised than many of their counterparts and offered a salary and permanent employment to their community health workers.

Other programmes, such as the Elim Care Group Project or the Village Health Worker Project, while providing generic care, relied predominantly on either unpaid volunteers or on volunteers receiving only a small stipend. The expectations of community health workers in these projects varied - many often didn't have a specified set of hours to work. Instead, they were community members equipped with knowledge and some resources, offering help on a need basis when members of their communities required it.

Most of the CHW programmes were initially devoted to a particular topic and then scaled up to provide more general support. The Elim Care project, for instance, was dedicated to treating trachoma. The Zibonele health project was meant for women and young children. There were other projects aimed at combating malnutrition, supporting maternal health, or treating specific diseases. By the 1980s, community health work had become prominent enough for several networks of community organisations to be established. The Progressive Primary Health Care Network (PPHCN), for instance, was built to share best practices and knowledge among various community healthcare projects.

The evaluation of the community health work, however, was mixed. On the one hand, there were some perceptions that community health centres provided lower-quality care. On the other hand, the medical professionals were also far from embracing the community-oriented approach. Nurses often viewed community health workers as subordinates within health centres, and the entire CHW system began to become increasingly hierarchical.

By the dawn of democracy, CHWs in South Africa were a formidable force, offering support to their communities and providing care where the apartheid government wouldn't. The whole system of delivering community-oriented healthcare, however, was mostly absent. Civil society, NGOs, and individual donors funded a range of community-level projects, employing or enrolling several workers, either formally or informally, to achieve their goals.

These goals were often well-intentioned and addressed urgent local needs, such as HIV prevention, maternal health, or basic home-based care. However, they often followed the goals and ideas of the NGOs or donors who paid for them, rather than aligning with a broader national health plan. As a result, community health efforts were often scattered and inconsistent, shaped more by outside funders than by the actual needs of the public health system.

[3] Philips, H., 2014. The return of the Pholela experiment: medical history and primary health care in post-Apartheid South Africa. *Am J Public Health*, 104(10).

This also gave rise to a patchwork of community employment models—some offering stipends, others nothing at all. In many cases, CHWs were classified as volunteers, blurring the lines between care work and formal employment, and leaving many without labour protections or long-term security.

There were expectations that community health care projects would flourish under democracy, but the post-1994 healthcare plan did not dedicate a significant role to community health workers. Instead, it was proposing a healthcare system that was expected to be run by doctors, nurses, and nursing assistants. There was a dedicated level of healthcare that should have been provided at the community level, yet community health workers were not expected to run it. The policy document states: "*Community Health Workers can play a unique role in promoting health and in expanding and improving health services, provided they have effective support structures and referral systems and they receive ongoing training. They can also be catalysts for community development, mobilising people around health issues. Local programmes will be encouraged, provided they are integrated into the local health services, but no national programme will be launched at this stage*."[4]

The proposed theory for the abandonment of the numerous CHW activities was that they were viewed as providing "second-rate care". [5] The National Plan also altered expectations regarding primary care by offering free healthcare to all pregnant women, the elderly, children under six years of age, and individuals with certain chronic illnesses. The large volume of interventions conducted by community health workers was now part of a government-sponsored initiative and had a lower value in the eyes of the community.

Numerous community health initiatives disappeared in the next two decades, and the existing community health workforce moved even further towards disease-oriented care and volunteer-type work. Instead of providing a wide range of community initiatives, which were admittedly variable by region and donor priorities, most post-1994 community health projects focused on HIV and TB prevention and support.

The South African healthcare system envisioned in the 1994 document has not materialised in the expected way, and rural and distant communities have not received adequate access to healthcare. The gaps in coverage grew, and by 2004, the Government realised that its primary healthcare provision was impossible without a dedicated community healthcare workforce.

In 2004, the Government hosted a meeting on the matter and eventually established a Community Health Worker Policy Framework (2004). By that time, the Department of Social Development provided a stipend to 5,988 community health volunteers across 892 sites. An additional 13.6 thousand volunteers were reported as being unpaid. The Department of Health offered stipends to nearly 20,000 volunteers, who were primarily engaged in HIV education and prevention programmes. There was information about an additional 40,000 community health workers who worked on this topic and were linked to the Department of Health, but did not receive direct remuneration for their work. [6]

Oftentimes, the Department of Health would subcontract an NGO to work on the HIV or TB-related project, and the NGO would hire community health workers and provide them with a small stipend. International organisations and local donors financed some other NGOs. The NGOs would then be responsible for hiring and training the community health workers, as well as supervising their work.

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[4] ANC, 1994. *A National Health Plan for South Africa.*

[5] Ginneken, N., Lewin., S., Berridge, V., 2010. The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. Soc Sci Med, 71 (6).

[6] Friedman, I., 2005. Community health workers and community caregivers. *South African Health Review*, (01).

So by 2004, when the government unveiled its new community health framework, there were several emerging trends:

- The 1994 primary healthcare plan, which featured doctors and nurses as primary care providers, has not been successful.
- The community health workforce was disjointed.
- The community workforce was not well coordinated into the national healthcare system at any level and operated as a separate entity.

The Framework, however, was hardly an answer to the looming community healthcare crisis. On the one hand, the Framework detailed the roles and responsibilities of community health workers. These roles mainly were around defining CHWs as a "*worker whose primary function at the adoption of this policy framework is to promote basic health or the delivery of basic health services within the home or primary health care facility*". [7]

The Framework outlined a list of expectations for communities, CHWs, NGOs responsible for CHW management, District and Regional health and social development authorities, and plans for CHW training and retention. It mentioned that full-time CHWs should be earning R1500 per month in the first year of employment (taking inflation into account, this amount is equivalent to approximately R4500 in 2025 Rand). However, it made provisions for NGOs and provincial departments to deviate from the recommended framework and remunerate CHWs differently.

Importantly, however, the new Framework did not shift the status quo. Provincial departments were not required to employ community health workers directly; instead, they could finance non-government organisations, which would be fully responsible for hiring, employing, remunerating, and supervising community health workers.

As a result of this Framework, the number of issues that community health workers faced continued to grow. CHWs were still not meaningfully integrated into the health provision in the country. CHWs were still part of NGOs and were often unpaid or low-paid volunteers on a small stipend, rather than formal workers who could enjoy all occupational health and safety benefits and annual leave. Equally, because NGOs retained the overall control over the community health sector, CHWs were still mostly single-disease specialists. The sector remained uncoordinated. As Friedman (2005) shows, there were over 23 different categories of community health workers, each focusing on a distinct aspect of care (Chart 1.2). [8]

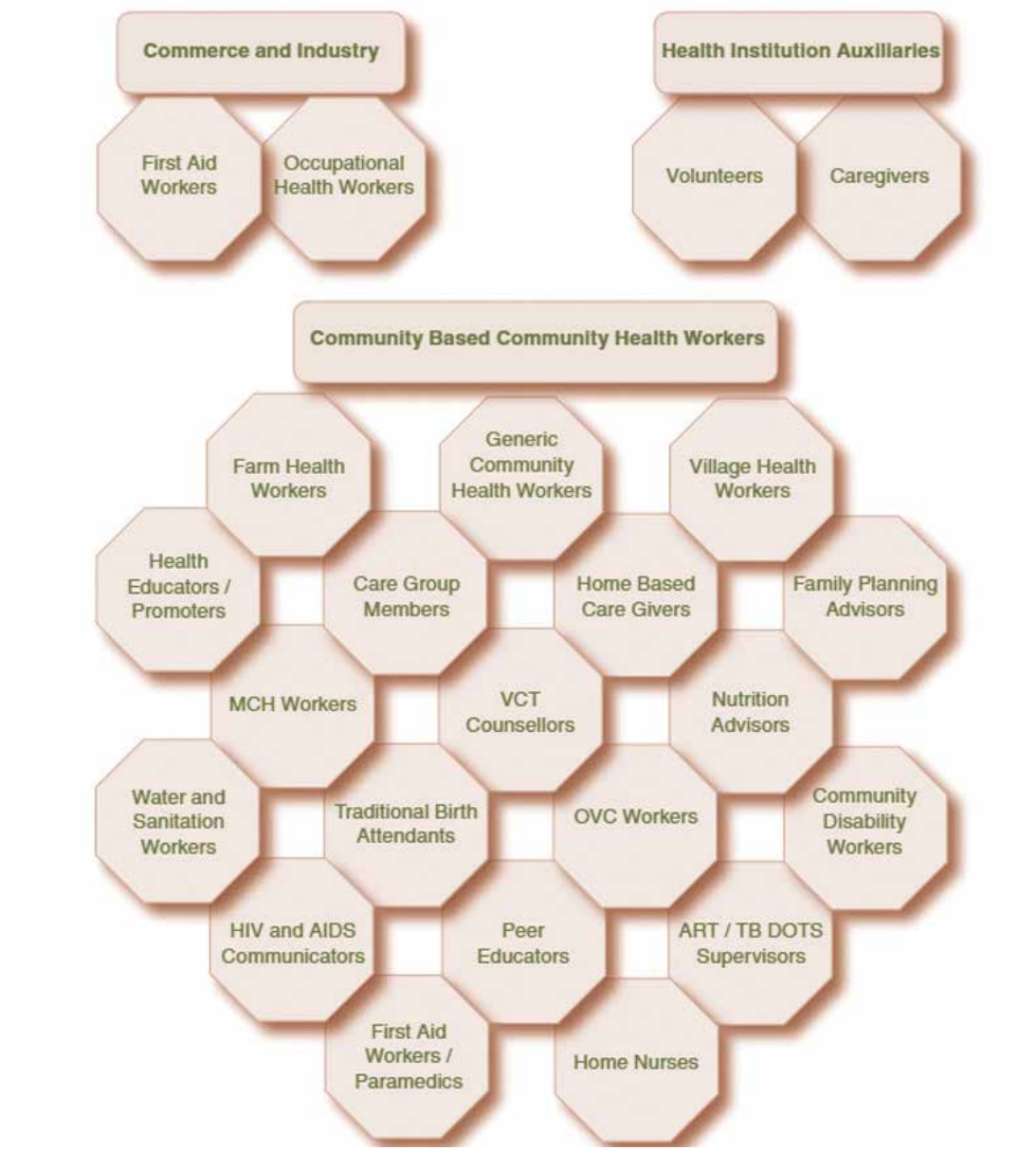
While the Framework encouraged NGOs and provincial departments to adopt a more comprehensive approach to community healthcare, moving away from reliance on multiple specialists, it failed to address the challenges that community health workers faced in a meaningful manner.

This history of community health worker programmes matters. This historical account shows how CHW initiatives have persisted over time, changing as politics, funding, and health priorities shifted. This history reveals how South Africa has arrived at its current state. It is crucial to recognise that there is nothing inherently logical about the way CHW programmes are currently functioning. The NGO-run and donor-dependent model dominating today is not necessarily superior to other potential frameworks, such as fully integrated public-sector employment. In fact, this model frequently exposes its weaknesses, especially in protecting CHWs' labour rights and ensuring consistent, high-quality care for patients. Nonetheless, it has been maintained more by inertia and precedent than by careful policy design.

[7] Department of Health (DoH), 2004. *Community Health Worker Policy Framework*

[8] Friedman, I., 2005. Community health workers and community caregivers. *South African Health Review*, (01).

Chart 1.2. Various types of community health workers
Data Source: Friedman, I., 2005. *Community health workers and community caregivers*



[8] Friedman, I., 2005. Community health workers and community caregivers. *South African Health Review, (01).*

2. CURRENT LEGISLATIVE CONTEXT

2.1 WBPHCOTs and employment

As the previous section of this report shows, most of the community health workers' issues are institutional and part of the broader legacy of slow and uneven community health adoption. The over-reliance on NGOs, poor remuneration, the sporadic nature of organising community health workers, and the numerous expectations from the CHWs workforce, combined with limited to no training, all stem from the history of CHW development in South Africa.
Several significant developments over the last decade and a half have contributed to the current state of community healthcare workers. These are:

- Re-engineering of the primary healthcare provision.
- Insourcing of community health workers during COVID in some provinces.

By 2010-2011, it was clear that neither the 1994-envisioned model nor the 2004 Framework were functioning as the government had designed, and that the healthcare access gap, especially in remote and rural communities, was not being reduced. The government made another attempt to redefine primary healthcare provision, introducing the Ward-Based Primary Health Care Outreach Teams (WBPHCOTs). The first policy document came in 2011. Its 2018/19 review is the most up-to-date regulation of community health workers.

WBPHCOTs introduced at least three key differences for the community health work:

1. Community health workers were expected to provide general health and education services rather than focusing on a single disease.
2. Community health workers were now attached to primary healthcare facilities.
3. Community health workers were now supervised by either professional or enrolled nurses.

The net result of these changes was that community health workers were fully vertically integrated into the primary healthcare provision. WBPHCOTs estimated that South Africa required 54,956 community health workers to be based across 9,159 wards. Each of the wards was expected to cover 1500 households (which is approximately 6000 people), with each community worker being responsible for 1000 patients. There were supposed to be six to ten community workers per team, accompanied by a professional nurse, or, at a later stage, an enrolled nurse, who would serve as a supervisor.

This structure meant that for policy and healthcare delivery purposes, community healthcare workers were at the bottom of the medical hierarchy. They were, oftentimes, no longer accountable to the communities where they were supposed to live and serve, but instead were salaried or stipend-based employees, delivering general advice and healthcare assistance and providing referrals in case of need. However, a key component of community-oriented and primary healthcare remained missing: the questions of CHW working conditions and remuneration were deliberately omitted from the policy documents.

Several of the challenges that community health workers currently face stem from this deliberate omission. Under the current regime, community health workers are still often employed by NGOs in most provinces, while being managed and supervised by nurses from the healthcare facilities to which they are attached. This system establishes a dual supervision and accountability system, effectively preventing the Department of Health from having a fully functional and operational community-level care system.

Data estimates that by 2010, there were over 3,000 NGOs jointly employing more than 70,000 community health workers. How many of those workers fell under the broad Department of Health umbrella, meaning that those projects received approval or financing from the DoH, is uncertain; however, some estimates put the number at close to 50,000. [9]

The 2025 community-level healthcare still looks disjointed. There are over 54,000 officially registered community workers working with NGOs or provincial health departments [10]. In reality, the number is much higher, as some non-government organisations employ community health workers in their private capacity [11]. Yet, there are still no reliable estimates. Each province has its unique pattern of CHW employment and supervision, as seen in Chart 2.1.

Chart 2.1. Current employment arrangement of CHWs among provinces

Data Source: Murphy et al., 2021. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework [12]

Various arrangements range from being fully employed by the government as Level 2 employees in Gauteng, to having several key NGOs coordinate the employment and stipend for most community health workers, to having multiple NGOs in the province. The number of NGOs has significantly decreased since 2010, as there have been consolidation efforts in some provinces to streamline the recruitment and supervision of community health workers. Today, Limpopo is being serviced by two NGOs, compared to nearly 300 NGOs in 2014, for example. Mpumalanga, however, has over 114 NGOs working on behalf of the DoH, and the Western Cape has allocated approximately one NGO per sub-district.

The most recent update on CHW employment came from the Minister of Health during his Budget Speech in July 2025. In his speech, the Minister announced that 27,000 community health workers, most of whom were working as CHWs for close to two decades, would be insourced in the coming financial year. [13] This is a welcome development. At the time of writing this report, there was still no official guidance on how the insourcing process would take place and who, among the community health workers in the provinces, would end up with permanent employment.

[9] Tshitangano, T.G., Olaniyi, F.C., 2018. Sustaining the National Health Insurance scheme in South Africa: the roles and challenges of community health workers. *The Open Public Health Journal*, 11(494)

[10] Ludolph, N., 2023. 'They fail us, year in and year out': why community health workers are ditching unions. Bhekisisa, January 23, 2023

[11] International organisations such as PEPFAR were employing close to 8,000 community health workers to distribute ARVs and provide other HIV-related medications and screenings. In 2025, the organisation closed down and it is unclear whether the government will replace PEPFAR and fund these activities itself.

[12] Murphy, J.P., Moolla, A., Kgowedi, S., Mongwenyana, C., Mngadi, S., Ngcobo, N., Miot, J., Evans, D., Pascoe, S., 2021. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework. *Health Policy Plan*, 36(4).

[13] Motsoaledi, A., 2025. Policy debate on budget Vote 18.

2.2 Community health budgets

It is impossible to determine how much money the Department of Health or various provincial legislatures are spending on community health strengthening. The community health aspect remains disorganised, even at the national budget level. The analysis of the annual budget shows that there is no single line that shows the DoH spent on various community health initiatives. Instead, there are various outreach programmes against HIV, TB, malaria, oncology, non-communicable and communicable diseases and towards better mental health and nutrition. There is also a budget allocated to the Primary Care Health facilities, which often includes community health teams as well.[14]

Provincial legislations are less ambiguous about their community healthcare spending. Table 2.1 presents the budget allocations for general-purpose community health. Under the community-based services category, approximately 80% of the payments recorded in the table are allocated towards compensation for community health workers and their supervisors.

Table 2.1. Budget spending on community health initiatives
Data Source: National Treasury, 2023. Provincial Budgets

Province	Community-based service budget	Population, 2023	Rand spent per person per year on CBS
Eastern Cape	0.8 bln	6.5 mln	123
Free State	0.7 bln	3.0 mln	233
Gauteng	2.7 bln	16.6 mln	162
KwaZulu-Natal	1.1 bln	11.9 mln	92
Limpopo	0.78 bln	6.2 mln	125
Mpumalanga	Unspecified	4.9 mln	-
North West	Unspecified	4.3 mln	-
Northern Cape	Unspecified	1.3 mln	-
Western Cape	0.48 bln	7.4 mln	65

Analysis shows that, in absolute numbers, Gauteng devotes the largest amount of money to community health services, while the Western Cape spends the least. However, considering the population size of each province reveals that Gauteng is no longer the leader. The data show, however, that KZN and Western Cape are severely underinvesting in community health workers on a per capita basis.

These numbers can be compared with the National Treasury's estimates on the national per capita spending. In 2023/24, the National Treasury spent approximately R5180 per person per year on health spending. [15] In contrast, community-based services - the foundation of public health - received no more than R233 per year per person. That means that less than 4.4% of national health spending goes towards supporting community health workers. This number is on par with the government spending on paramedic services (4%), and is severely behind the governmental spending on hospital services (61%) and on public health services in general (33%). [16]

[14] National Treasury, 2023. Estimates of National Expenditure, Vote 18, Health
[15] Section 27, 2024. South Africa will spend up to R320 less per learner and R200 less per health service user in the coming year. Media Report, 22 February.
[16] Statistics South Africa, 2021. Healthcare and education spending: Gauteng and Western Cape the odd ones out. Media Release. coming year. Media Report, 22 February.

3. CHW CHALLENGES

A brief history of current and past approaches to community healthcare in South Africa reveals a range of challenges that community health workers face. These challenges can be categorised into four broad categories:

- Fundamental, or policy and governance-related challenges;
- Systemic challenges that are shaped by the design of the healthcare system;
- Societal challenges;
- Job-related or nature-of-work challenges.

The table below details some of the key challenges that community health workers face.

Table 3.1. Community health workers' challenges

Fundamental or governance-related	Systemic challenges	Societal challenges	Job-related challenges
• Difficulty setting the CHW role appropriately; • Lack of political support for CHW programmes; • Inconsistent funding; • Donor reliance.	• Lack of integration with the rest of healthcare; • Poor or sporadic training; • Lack of promotion; • Unpaid or low-paid work; • Resource shortages; • Inadequate supervision; • Lack of clear policies and guidelines; • Job insecurity.	• Lack of community trust or support; • Violence or threats in communities; • Cultural barriers.	• Emotional or physical demands; • High exposure to risk (violence, harassment, abuse, health risks); • Travel to remote or unsafe areas; • Long hours.

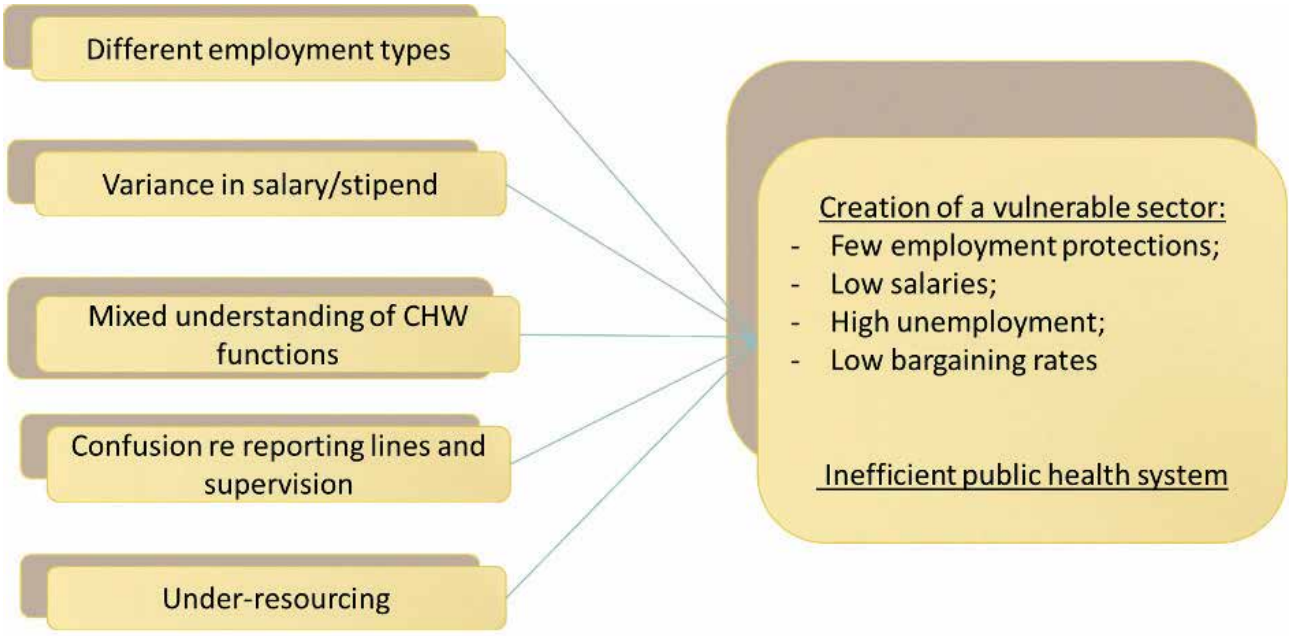
The crux of the fundamental challenges is related to how community healthcare is organised in South Africa (and, often, beyond). There is a common misconception that community healthcare should be reserved for low- or middle-income countries without an extensive network of healthcare professionals. The expectation almost always is that a community healthcare system would be cheaper than alternatives.

In reality, however, and this has been the case for many other countries, building a comprehensive, well-resourced, and professionalised network of community health practitioners is never cheap. It requires a significant amount of resources, including planning, setting up wards, teaching students, and providing medical and other essential resources (such as uniforms, medical devices, test strips, medications, bicycles, or transportation to reach distant communities) to ensure that the community health level provides the best quality of care for patients.

Many of the fundamental challenges stem from this disconnect between the perceived and actual costs of running a sound community-level healthcare system. When confronted with this discrepancy, various governments adopted different strategies to reduce the cost of community-level care. Some of the most common options include relying on a network of volunteers instead of paid community health workers, limiting the work of CHWs to specific diseases rather than providing comprehensive services, restricting the outreach of CHWs, or reducing training and resources.

All of this has been trialled in South Africa with limited success. While these measures ensured that the community health work budget could be much smaller than required, they also created a community health structure that ultimately led to large-scale inefficiencies at the governmental level, poor service delivery to the public, and unhealthy working conditions for the workers. Thus, the fundamental misconceptions about what community healthcare is led to a multitude of structural challenges, the biggest one of which is the incoherent and disintegrated nature of the SA community level of healthcare. The final outcome of these challenges is the inefficient healthcare system for patients and a precarious and vulnerable sector of workers, who find themselves at the intersection of structural, societal and job-related pressures.

Chart 3.1. Challenges in the CHWs programmes



3.1 Policy design and implementation

One of the primary issues related to CHWs is the inadequate design and implementation of policies regulating the sector. Although a national WBPHCOT policy exists, provinces interpret and implement it variably. A 2020 implementation study found that CHW models vary significantly across districts due to unclear operational guidance, inconsistent role definitions, and inadequate coordination with facility-based staff. [17] Moreover, health promoter cadre roles remain ambiguous alongside CHW roles, with no standardised operating procedures to resolve overlap or define collaborative responsibilities at the facility and community levels.

[17] Murphy, J.P., Moolla, A., Kgowedi, S., Mongwenyana, C., Mngadi, S., Ngcobo, N., Miot, J., Evans, D., Pascoe, S., 2021. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework. *Health Policy Plan*, 36(4).

This policy ambiguity contributes to a mixed understanding of CHW functions, referral responsibilities, data reporting lines, and performance assessment criteria, undermining accountability and creating confusion among supervisors, CHWs, and facility managers alike. It is inconceivable that the conditions of community health workers differ so drastically across provinces. No other medical professional in the public sector is employed under such conditions, and no other level of care is organised in a way that directly inhibits success.

Another issue that is a direct result of the lack of vision for community-level care and the inconsistent approach to policy development and implementation is the disconnect between community outreach and clinic-based care. These issues are especially pertinent when it comes to referrals, supervision, promotions, and training.

Despite WBPHCOTs being the government policy for more than fourteen years, many CHWs still describe themselves as working "on the fringes" of primary care teams, with poor intersectional coordination, limited continuity, and continuous issues related to referrals and patient follow-ups. The 2014 study of Cape Town's CHWs found that "inter-sectoral collaboration was weak and hindered CHWs from addressing social issues". [18]

3.2. Working conditions and salaries

Each province has considerable leeway in determining how community-based services are run. While some provinces employ community health workers directly, others rely on a myriad of NGOs. As a result, the workforce is split between two extremes: those employed full-time as public sector employees with benefits, and those on short-term or recurrent contracts with a stipend.

Due to the predominant employment of community health workers through NGOs, their salaries differ significantly both between and within provinces. Gauteng has formally insourced the CHWs as Level 2 public sector workers. Thus, Gauteng CHWs earn between R9,000 and R10,000 monthly. In contrast, many of the workers in the rest of the country are employed for a stipend of between R2500 and R4500. The responsibilities of community health workers also vary - some work non-set hours or part-time, while others work full-time on recurring contracts that are extended either quarterly or yearly.

Such an employment difference is a gross injustice to community health workers in South Africa. The current system leaves workers vulnerable - workers on recurrent contracts do not earn any benefits and have no job stability or security. It is undoubtedly difficult working conditions for community health workers to operate in, and numerous research studies have found that CHWs are struggling under the current job provisions. This situation persists despite Resolution 1 of 2018 by the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC) and the most recent January 2025 Labour Court decision regarding the contract duration of CHWs.

The earlier 2018 Resolution of the PHSDSBC bargaining council was a breakthrough agreement hard-fought for by the community health workers and their trade unions. The agreement aimed to standardise remuneration for CHWs and set their salaries at R3500 for those with a matric or Recognised Prior Learning. These CHWs were intended to be paid through the personnel system, and provincial heads of the Department of Health were responsible for recruiting CHWs. [19]

[18] Doresha, L.M., Mash, W., Mash, R., 2024. The role of community health workers in non-communicable diseases in Cape Town, South Africa: descriptive exploratory qualitative study. *BMV Primary Care*, 25 (176).

[19] DPHSDSBC, 2018. Resolution 1 of 2018. *Agreement on the standardisation of remuneration for community health workers in the Department of Health.*

This Resolution was an important step in CHW insourcing, but the Department of Health did not enforce it. Six years after the Resolution, the Labour Court issued a decision that workers on continuous recurrent contracts should be treated as permanent employees. This is a landmark decision that was hailed by all the major trade unions organising in the field. However, by mid-2025, there had still been no changes to CHW employment nationwide. Instead, in July 2025, the Minister of Health stated that 27,000 community health workers are about to be insourced, presumably, leaving the rest of the CHWs who are not yet public sector workers on short-term contracts.

3.3. Training

Despite the 2011 re-engineering of the primary care provision, there is still no unified training for community health workers. Department of Higher Education and Training (DHET) attempted to introduce the CHW standardised Level 4 qualification between 2013 and 2017. It offered a standard curriculum in several TVET colleges nationwide. Approximately 1,000 people obtained the original pre-2018 qualification, a number significantly lower than the number of employed community health workers in the country. For unspecified reasons, the DHET stopped the roll-out of the programme in 2017. Some private colleges, however, still offer the programme.

Instead, in 2018, several new courses were registered with SAQA:

- Further Education and Training Certificate: Community Health Work (Level 4);
- National Certificate: Community Health Work (Level 2);
- National Certificate: Community Health Work (Level 3);
- General Education and Training Certificate: Ancillary Health Care (Level 1);
- Occupational Certificate: Health Promotion Officer (Level 3);

The most standard qualification is the Level 4 Further Education and Training Certificate: Community Health Work. It is accredited by the HWSETA (Health and Welfare SETA) and is a one-year, full-time course offered by twenty-one colleges. The yearly tuition ranges between R14,000 and R28,500.

However, having the certificate is not a requirement for the CHW work. Neither is it a guarantee of full-time employment that could offset the relatively high education costs. There are currently no statistics available on the number of graduates holding the Level 4 HWSETA certificate. What is known, however, is that the vast majority of community health workers received an NGO-run or DoH-approved on-the-job training that usually lasts 6 weeks, and can occasionally be as long as 6 months. Participants get a certificate of attendance, and these courses are generally not accredited.

These courses are usually based on the government-updated CHW curriculum from 2011 (updated in 2024) and consist of the following modules:

- The National Health System and the Role of the Community Health Worker;
- The Basics of Health, Environmental Health, Basic Signs of Health, and Basic Primary Health Care;
- Understanding HIV;
- Tuberculosis;
- Non-Communicable Diseases;
- Maternal health;
- Child health and nutrition;
- Adolescents and Youth Health;
- Treatment adherence;
- Covid-19. [20]

[20] Department of Health, 2024. *Ward-Based Primary Healthcare Outreach Team. Community Health Worker Training: Foundation phase.*

A 2024 study in Cape Town highlighted a common thread: many CHWs reported receiving only minimal or outdated instruction, leaving gaps in competencies such as palliative care, data collection, or rehabilitation support.[21] The cumulative effect is the uneven service delivery across wards and weak disease-specific care.

3.4. Lack of career growth

Narrow training, coupled with blurred supervision lines and difficulties coordinating between primary facilities and community outreach work, also leads to community health workers feeling "trapped" in their jobs without any promotion opportunities on the one hand, and frequent resentment from assistant nurses.[22] Broader career pathways for community health workers remain limited: the role of the CHW supervisor in clinic facilities is often reserved for professional nurses. This means that for CHWs attached to primary care facilities, there are few opportunities for career growth. They are forced to work in the same role with the same compensation until they retire or change career paths.

CHWs in Gauteng and Sedibeng districts voiced frustration that after attending training courses, they were not elevated or formally recognised. One CHW noted, "*We remain the same... same level, same stipend*" despite upskilling.[23] This frustrating experience is detrimental to both community health workers, who constantly feel undermined, and the government-run healthcare system.

3.5. Resources

Another systemic challenge that warrants extensive discussion is the inadequate allocation of resources to community health workers. This subject has been touched on elsewhere, but it needs repetition. The current system allocates insufficient resources to community health workers, hindering their ability to perform their duties effectively. This shows in the lack of training (which is a vital resource on its own), in the lack of wages and job security, and also in the consistent lack of key medicines, measuring tools and devices that CHWs need to perform their duties. Under resourcing also means lack of access to proper monitoring databases, travel allowances and many other resources that would ensure that the community health level of care is best equipped to deal with community health needs.

There is considerable evidence of a lack of resources. One rural team described sharing just one or two blood pressure devices among 20 CHWs, with consumables like glucose strips rarely replenished.[24] Basic materials, such as stationery, uniforms, or name badges, are often purchased by CHWs with their own stipends. The 2024 Eastern Cape supervision intervention emphasised the transformative impact of logistical support. CHWs receiving transport support, mobile phones, and supplies, along with training, showed greater motivation and higher community credibility.[25] But resource gaps remain systemic: national-level studies and provincial reports continue to flag missing resources as one of the key problems in the sector.

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[21] Doresha, L.M., Mash, W., Mash, R., 2024. The role of community health workers in non-communicable diseases in Cape Town, South Africa: descriptive exploratory qualitative study. *BMV Primary Care*, 25 (176).

[22, 23] Doresha, L.M., Mash, W., Mash, R., 2024. The role of community health workers in non-communicable diseases in Cape Town, South Africa: descriptive exploratory qualitative study. *BMV Primary Care*, 25 (176).

[24] Tseng, Y.H., Griffiths, F., de Kadt, J., Nxumalo, N., Rwafa, T., Malatji, H., Goudge, J., 2019. Integrating community health workers into the formal health system to improve performance: a qualitative study on the role of on-site supervision in the South African programme. *BMJ Open*, 9(2).

[25] Katzen, S., Skeen, L., Dippenaar, S., 2024. Community health workers' experiences of an intervention to provide them with increased support and supervision: a qualitative study of a home visiting model in rural South Africa. *Discovery Health Systems*, 3(4).

3.6. On-the-job violence, harassment and abuse

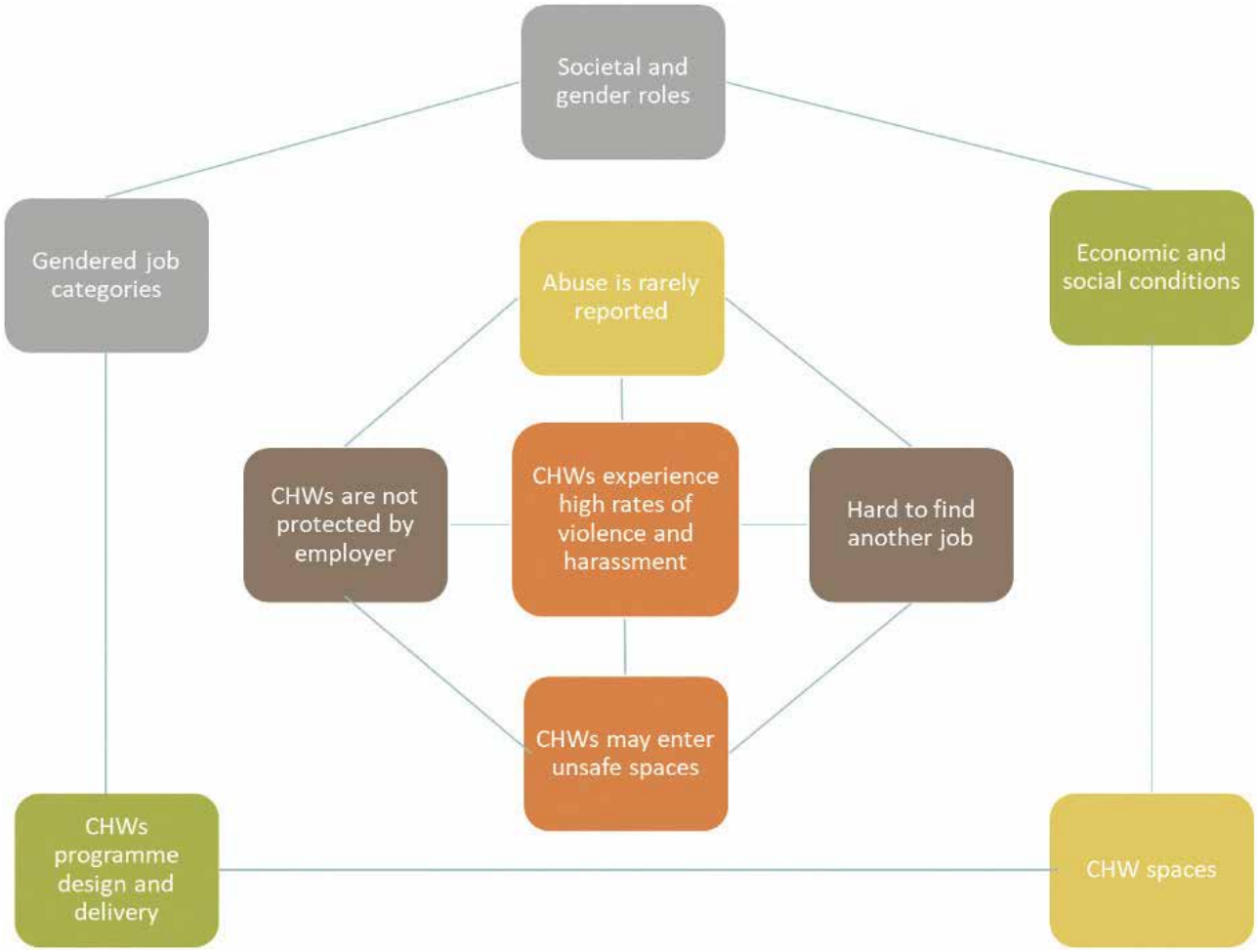
All of the challenges discussed above largely stem from the government's lack of political will and subsequent policy direction regarding community-level healthcare. Despite the 2011 idea of re-engineering primary healthcare, which aimed to build on Brazil's comprehensive community health provision as its goal, the actual South African new policy was ambiguous in its wording and dismal in its implementation.

There is no doubt that the current CHW provision is perilous for both workers and the government. The current system creates no beneficiaries, except perhaps for those managing government budgets. The system ultimately creates a low-wage, limited-skills workforce that remains in precarious employment for the remainder of their careers in the sector. This current system fails to upskill people and resource them appropriately, thus limiting the effectiveness of the community health system as a whole.

Moreover, systemic problems intersect with the challenges that many community workers face due to the nature of the job itself. The latter key challenges include high exposure to risk, such as violence, harassment, abuse or various health risks, in addition to extended hours, emotional or physical demands and generally unsafe working conditions.

Chart 3.2. The impact of societal, gender, and work-related expectations on community health workers' safety

Data Source: Re-worked based on the material of Closser et al., 2023



In South Africa, over 80% of community health workers are female.[26] These workers start their shifts early, by 7 or 8 am, and often finish their work after 6 pm. They are not paid enough to own a car, so they travel to their workplaces on foot or via public transportation, often in the dark during early morning or late evening hours. Even the community workers assigned to a facility spend half of their workweek visiting patients at their homes, going inside flats and houses. All of these factors exponentially increase the risks to community health workers.

A large body of research, dating back to 2003, has shown the prevalence of safety concerns that plague the public primary healthcare system in South Africa. The earlier data estimated that 61.9% of all healthcare workers were subject to violence and sexual abuse.[27] This level of abuse was significantly more prevalent in public hospitals and clinics. Nurses, midwives, and ancillary health professionals suffered from much higher rates of all types of violence than many other professions, except for ambulance workers.

Back then:

- ☞ 52% of all healthcare professionals reported getting verbally abused. Most reported that it had happened more than once in their career;
- ☞ 20.6% reported bullying incidents;
- ☞ 22.5% stated they were the victims of racial harassment; and
- ☞ 4.6% stated they were the victims of sexual abuse.

Similarly, many recent studies found evidence of widespread physical and sexual violence against community health workers.[28] Although there are no specific publicly available statistics on recent violence against healthcare workers, there is a body of anecdotal evidence. Workers report being sometimes attacked by family members of the patients they are visiting or by the patients themselves.[29] Many report unsafe working conditions when travelling, with no safety measures provided by the government.

An international study of community health workers showed that most of the CHWs in the developing countries face higher rates of harassment and abuse due to the combination of economic, political, social and cultural conditions.[30] It also shows that some of the reasons that CHW face higher burden of violence and harassment lies within the SA healthcare organisation: short-term contracts, coupled with the high SA unemployment rate, provide little protection from reporting harassment that happened at the patients' place or inside the primary care facility, and offer even less protection against the harassment potentially taking place at the NGO.

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[26] Murphy, J.P., Moolla, A., Kgowedi, S., Mongwenyana, C., Mngadi, S., Ngcobo, N., Miot, J., Evans, D., Pascoe, S., 2021. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework. *Health Policy Plan*, 36(4).

[27] Steinman, S., 2003. *Workplace violence in the health sector. Country case study: South Africa*. ILO: Geneva.

[28] Murphy, J.P., Moolla, A., Kgowedi, S., Mongwenyana, C., Mngadi, S., Ngcobo, N., Miot, J., Evans, D., Pascoe, S., 2021. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework. *Health Policy Plan*, 36(4).

[29] Johnson, L.J., Schopp, L.H., Waggie, F., Frantz, J.M., 2022. Challenges experiences by community health workers and their motivation to attend a self-management programme. *Afr J Prim Health Care Fam Med*, 14(1).

[30] Closser, S., Sultan, M., Tikkanen, R., Singh, S., Majidulla, A., Maes, K., Gerber, S., Rosenthal, A., Palazuelos, D., Tesfaye, Y., Finely, E., Abesha, R., Keeling, A., Justice, J., 2023. Breaking the silence on gendered harassment and assault of community health workers: an analysis of ethnographic studies. *BMJ Global Health*, 8(5).

3.7. Low collective bargaining rates

One of the last issues that needs discussing is the low collective bargaining rates among community health workers. Collective bargaining gives workers a united voice against injustices at the workplace and helps workers receive better salaries and working conditions. In South Africa, public sector workers who are part of a trade union and are covered by a bargaining council agreement tend to earn close to 7 to 11% more than their colleagues without such protections.[31]

However, few community health workers are unionised, and the CHW policy design makes it difficult for them to join the unions of their choice. The design of the CHW policy ensures that many workers are kept on rolling short-term contracts with low salaries. In these conditions, joining (or forming) a union is objectively difficult: sacrificing even a small portion of an already low wage is a significant ask. Not having stable employment is a massive hindrance to unionising, as many CHWs fear employer retaliation.

There are also few choices available to the community health workers. Due to the precarious nature of their employment, few trade unions organise in the field. To date, NUPSAW has the most significant presence in the field. Other unions that engage with CHWs include DENOSA, NEHAWU, and HOSPERSA; however, their joint presence is not significant.

As a result, many of the community health workers chose to join various alliances or forums. These forums are often local, aiming to connect workers within the same region. At times, community health workers organise around civil society and NGOs that have been supporting their work for years, such as the Treatment Action Campaign (TAC). These forums can be powerful. The Gauteng CHW forum, for instance, spearheaded one of the more successful campaigns and advocated for the insourcing of Gauteng CHWs into the formal health sector. At the same time, many of these forums are only able to address local or regional issues and do not have a seat at the bargaining council or during discussions with the Department of Health, thus limiting their overall influence.

In summary, the right to unionise is part of the core ILO rights. Unionisation has multiple positive effects for workers, including better wages, improved working conditions, and having a voice during stakeholder discussions on a range of topics. While CHWs are not explicitly denied this right, their access to it is severely limited by the way that CHWs work is organised. This impediment, in turn, limits the abilities of community health workers to safely fight for their working rights.

[31] Ntlhola, M.A., Kwenda, P., Ntuli, M., 2019. A distributional analysis of union-wage effects in South Africa. *Development Southern Africa*, 36 (3).

4. ALIGNMENT WITH INTERNATIONAL BEST PRACTICES

The WHO and the ILO have developed several international conventions, recommendations, and best practices that can be applied to community health workers, thereby improving their status, working conditions, and employment, while also benefiting the overall primary healthcare system. These are:

- WHO CHW Guidelines;
- ILO Decent Care Work Agenda;
- ILO Convention C190.

Jointly, they form a comprehensive set of international documents designed to protect the most vulnerable workers. As this chapter demonstrates, however, these documents are not aligned with South African legal practice or the prevailing situation on the ground. Better alignment with these guidelines and policies can significantly improve the conditions of community health workers.

4.1. WHO CHWs Guideline

In 2018, the World Health Organisation (WHO) published a guide titled "WHO Guideline on Health Policy and System Support to Optimise Community Health Worker Programmes." [32] To this day, this remains one of the most comprehensive documents with recommendations on the structure of CHW programs worldwide. Chart 4.1 illustrates the key recommendations and the extent to which South African programmes align with them. Green indicates areas of full compliance, orange indicates areas requiring improvement to achieve full compliance, and red indicates missing components.

Chart 4.1. The degree of alignment between the WHO Guidelines and the South African community health worker programmes

Appropriate selection criteria	**Appropriate training**, incl. - Pre-service training; - Wide curriculum; - Certification.	**Appropriate remuneration**
Appropriate supervision		**Creating general-purpose CHWs rather than disease-focused**
Providing adequate resources	**Appropriately determining the target population**	**Active community engagement:** - During the planning of CHW programmes - When selecting CHWs; - In other decisions re budgets and the content of the programme
Ensuring CHWs have written contracts	**Documenting CHW services**	

Even a quick glance shows that out of the key WHO recommendations, South African CHW programmes only fully conform to three: selecting CHWs using the proper criteria, ensuring that CHWs have written contracts, and designing an appropriate system to determine the target population size.

[32] WHO, 2018. *WHO Guideline on Health Policy and System Support to Optimise Community Health Worker Programmes.* WHO: Geneva.

There are four further areas where the SA government can improve its programmes. They are denoted in orange. That means that the existing South African programmes conform to some of the WHO standards, but require some additional work. Regarding these areas, firstly, SA needs to strengthen its CHW supervision and career development. WHO recognises that CHWs should have a career ladder, which is currently almost non-existent in South Africa. CHWs should also be supervised professionally.

Secondly, WHO recommends focusing on the general-level CHWs who work within the health system and address a broad range of concerns, rather than developing a body of specialised or disease-driven workers. The South African system only partially conforms to this recommendation, as there is a significant body of community health workers who still focus only on specific diseases, such as HIV or TB.

Thirdly, the WHO recommends that CHWs document their work and the services they provide. They should collect, collate and use health data on routine activities and have access, where possible, to a mobile health application. This area of CHWs programmes requires some revision in South Africa, as not all of the CHWs have access to databases or mobile applications to record the correct information.

Finally, compared to the WHO recommendations, SA can institute stronger and much more comprehensive training provisions. Training for the CHWs should not be optional and should include a standardised enhanced curriculum and certification. The training should also be a combination of on-the-job practical training coupled with theoretical knowledge, as the WHO suggests. Finally, the training should be facilitated in several languages.

The building blocks in red indicate the areas that are least conforming to the WHO guidelines and require revision as soon as possible. In particular, CHW programmes and community health workers need to be adequately remunerated and resourced. These are the two key challenges facing community workers in South Africa, and the WHO recommends allocating sufficient funds for CHWs to earn a living based on their skills and the services they provide. CHWs should also be technically and medically capacitated and resourced.

The final building block currently missing from the SA CHW programmes is an appropriate level of community engagement. Currently, community engagement is limited, despite WHO recommendations and various studies that demonstrate the importance of securing community buy-in for the success of CHW interventions. Communities and community management are often treated as an afterthought in the current implementation of the CHW programmes. In turn, the WHO recommends that communities be engaged in pre-programme consultations, monitoring of CHWs, selecting CHWs, and in other relevant planning, budgeting, decision-making, and problem-solving processes.

Chart 4.2. How to align the South African CHWs provision with the WHO guidelines

4.2. CHWs and ILO Decent Care Work Agenda

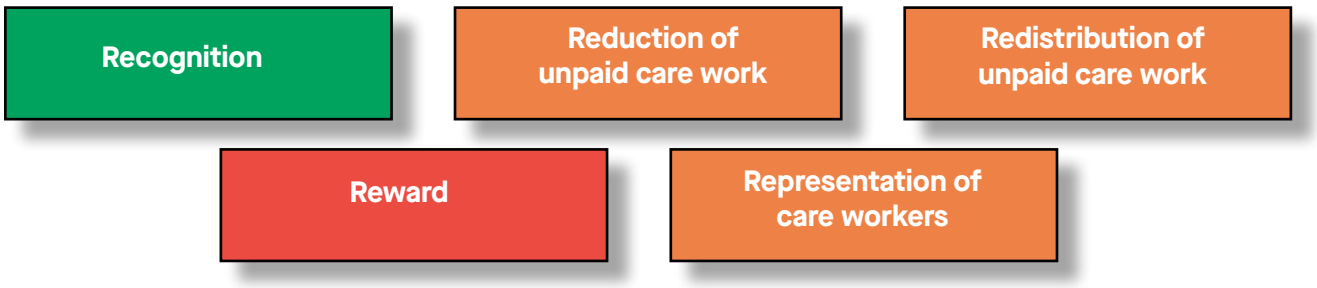
The ILO Decent Care Work Agenda comprises a second set of international resolutions aimed at advancing the rights of community health workers. While, on principle, care economy is different from community health work, there is a significant overlap between the two. Often, community health workers are asked to perform some of the roles and responsibilities typically assigned to caregivers, such as assisting patients with hygiene or helping mothers with new-borns. They deliver the medications or ensure that patients take their medicine daily at the right time.

Due to this overlap, the Decent Care Work Resolutions present another opportunity to analyse the community health workers' rights and what is currently missing. The ILO Resolution states the following: "*All care workers should enjoy decent work. .. All members have an obligation to respect, promote and realise fundamental principles and rights at work in respect of care workers, namely: freedom of association and the effective recognition of the right to collective bargaining; the elimination of all forms of forced or compulsory labour; the effective abolition of child labour; the elimination of discrimination in respect of employment and occupation; and a safe and healthy working environment.*" [33]

The ILO Resolution on Decent Work and Care Economy also advocates for stronger labour protections and social security, as well as for better working conditions for those working in the care economy. It specifies the need to limit the working hours, improve occupational safety, prevent violence and harassment and ensure that workers are paid accordingly.

Decent Care Work is also often framed around the 5Rs: recognition, reduction and redistribution of unpaid care work, reward and representation of care workers. The chart below shows the progress of the 5Rs in South Africa regarding community health workers.

Chart 4.3. The degree of implementation of the ILO-suggested 5Rs among South African community health workers



The only area of CHW work that is fully compliant with the ILO Resolution is recognition. The government recognises community health workers as vital providers of primary healthcare. The remaining 5Rs indicators are not sufficiently implemented or enforced. Community health workers often do not get a salary, let alone a sufficient reward. Relying on a stipend after providing essential skills to communities and healthcare systems contradicts the ILO recommendations.

The representation of workers is also an area that needs improvement. The nature of CHW work limits the freedom of association: trade unions have little to no negotiating power when it comes to workers employed by NGOs on short-term contracts. Under this scenario, the NGOs or the Department of Health have a lot of power to retaliate towards the unionising workers and that in itself means that the rights of CHWs are routinely trampled on.

The last two elements that need to be addressed are the reduction and redistribution of unpaid care. For community health workers, this means that their own care work needs to be recognised and rewarded. CHWs should be able to take leave for family illness or childcare purposes without losing income or position. Such opportunities are rarely afforded to the majority of community health workers, especially those not formally and fully employed by the Department of Health.

The redistribution of the burden of care means that the government needs to stop its austerity politics and must assume greater responsibility for community-based care rather than relying on CHWs' informal labour. This can be achieved by insourcing the existing community health workers and hiring additional staff to fully staff the Wards-based Outreach Teams.

Chart 4.4. How to align the South African CHWs' work with the ILO 5R recommendations

4.3. CHWs and the ILO C190 Convention

The final international guideline directly applicable to community health workers in South Africa is the ILO Convention No. 190 on Violence and Harassment (2019). The Convention aims to protect all workers in every industry from harassment, abuse, violence, and bullying. The Convention equally applies to public, private, and non-profit organisations, as well as to formal, informal, part-time, full-time, apprentice, or any other type of worker.

The Convention was ratified by South Africa in 2021. After the ratification, South Africa was expected to update its laws and regulations to conform to the Convention in the area of worker protection from harassment and violence. In response, it published the *Code of Good Practice on the Prevention and Elimination of Violence and Harassment in the Workplace* in 2022, and later in 2024, a *Policy on the Prevention and Elimination of Harassment in the Public Service World of Work*.

Both documents represent a significant step in the government's effort to eliminate workplace violence and harassment. The stated goal of those documents is the following: "*Zero tolerance shall be upheld against any form of violence and harassment in the world of work. … Harrassment is a form of discrimination that violates the rights of individuals and undermines the integrity of the employment relationship*". [34]

These documents are fairly similar in content. Both focus on the issues of violence and harassment of employees, with the second policy concentrating exclusively on the public service workers. Both apply broad definitions of harassment and include verbal, physical, sexual and psychological violence against workers. The Code and the Policy provide extensive definitions of different types of abuse against workers and also recognise the problems of gender-based violence. The two documents also heavily emphasise the need for employers' training programmes to prevent harassment and encourage employers to develop internal policies and reporting mechanisms that address these issues.

[34] Department of Public Service and Administration (DPSA), 2024. *Policy on the prevention and elimination of harassment in the public service world of work.*

The differences between the documents are minimal. The Code has a broader application than the internal Policy, which focuses only on public sector employees. As such, the Policy is less comprehensive and is less aligned with the C190 Convention. On the other hand, while the Code only recommends the inclusion of various monitoring structures, policies, and disciplinary procedures, the Policy specifies who is expected to be accountable for anti-harassment policies and outlines the internal steps for disciplinary action.

Despite being in broad alignment with the C190 policies and, at times, being hailed as "ground-breaking" documents, both the Code and the Policy fall short of delivering a meaningful and enforceable change for workers in general and community health workers in particular.

First of all, despite working in public healthcare, most community health workers are not employed directly by the provincial or national Department of Health. They are thus excluded from the Policy document altogether. Therefore, the benefits of the Policy, such as arbitration procedures and other actions and trainings outlined in the Policy, do not apply to those workers.

This, on its own, is a significant hindrance, as the C190 Convention explicitly requires states to protect sectors, occupations, or work arrangements that are the most vulnerable. The statistics on the prevalence of violence towards community health workers are staggering. Yet, since they are excluded from the public sector, they are also excluded from the specific sectoral policies that can assist them.

In turn, this means that the available mechanisms for community health workers to protect themselves against violence and harassment are severely limited. The Code of Good Practice covers the majority of the community health workers. A brief summary of what the C190 Convention entails and the degree to which the Code of Good Practice Complies with it can be found in Table 4.1. [35]

Table 4.1. The degree of alignment between Convention C190 and the South African Code of Good Practice with respect to community health workers.

C190 Provisions	Code of Good Practice (with respect to CHWs)
Monitor and enforce national laws against violence and harassment.	✓
Ensure access to remedies, fair and effective reporting, and dispute resolution mechanisms.	✗
Privacy protection of involved individuals.	✓
Appropriate sanctions.	✗
Access to gender-responsive, safe and effective complaint and dispute resolution mechanisms, support and remedies.	✗
Recognise the effect of domestic violence and mitigate its impact.	✗
Ensure that workers have the right to remove themselves from a work situation which puts them in danger without suffering retaliation.	✓
Ensure that labour inspectorates and other relevant authorities are empowered to deal with violence and harassment.	✗

[35] ILO, 2019. C190 - *Violence and Harassment Convention*, No 190.

The biggest problem with the Code of Good Practice is the complete absence of enforcement and consequences for harassment. The Code prescribes that employers are supposed to devise anti-harassment policies, training, as well as arbitration procedures and sanctions, yet offers no enforcement policy.

There are no mechanisms or checks to ensure that every employer is compliant with the Code. For instance, no one collects data on internal complaints that employees log and their outcomes. There are no mechanisms in place that create incentives for employers to fully comply with the Code, such as penalties or fines for non-compliance. Equally, no other government office is equipped to deal with workplace violence and harassment. For instance, labour inspectors are not given an explicit mandate to request compliance with the Code either.

This means that despite numerous good points that the Code of Good Practice raises, community health workers are not being more protected from violence, harassment and abuse than before. Those workers who fall under the Department of Health will be protected by the DPSA's Policy, discussed above. The majority of the rest of the community health workers, outside of the few employers with a goodwill to comply with the Code, can report violence or abuse through traditional channels:

- CCMA under the Labour Relations Act or Employment Equity Act;
- PEPUDA, in the cases of discrimination;
- Police, in cases of physical or sexual violence;
- The Occupational Health and Safety Act.

Part of the reason ratification of the C190 convention led to the Code of Good Practice is that these traditional channels were not up to the task. The Labour Relations and Employment Equity Act limits its application to those employed, thus excluding a significant portion of community health workers who are technically volunteers. PEPUDA predominantly focuses on discrimination, which is only one aspect of violence and harassment that community health workers experience. The Occupational Health and Safety Act does not explicitly mention violence or harassment, and, thus, has limited applicability. Finally, internal harassment or unwanted attention by the employer is rarely reported to the police, as law enforcement agencies often have limited options for resolving these issues.

In essence, community health workers are only marginally more protected since the ratification of the ILO Convention 190 than they were prior to it. Most community health workers have precisely the same functional protection from violence and harassment that they had pre-2021/22. That level of protection was insufficient then, and it is not enough now.

Chart 4.5. Necessary steps to align the South African CHWs programmes with the ILO C190 Convention

5. SOLUTIONS TO THE STRUCTURAL CHALLENGES

The current community health sector provision is neither practical nor efficient. It primarily relies on the low-wage labour of women, who are routinely under-resourced, undertrained, not capacitated, and are subject to a high level of occupational risks. This is not an ideal situation, and the community healthcare sector in South Africa can be improved. It can provide more to the communities, alleviate some of the burden from other primary care facilities, and ensure the dignity of workers.

The path towards this future is enshrined in the policy documents' visions and is fought for by trade unions and community workers' associations. The ideal community healthcare system should be guided by national priorities and should centre on the needs of communities and workers. Some of the key tenets of this system would be:

- Ensuring the hiring of the required number of community workers to perform their duties.
- Ensuring that CHW teams are fully resourced with uniforms, badges, medicines, medical equipment, and other required resources.
- Insourcing the CHW workforce and ensuring that CHWs are employed as public sector employees.
- Removing the intermediary level of NGOs for facility-based community health workers. (It is not the intention of this report to demonise the NGOs. There is a deep understanding that NGOs have filled the massive void left by the government's inability to provide community-level care. NGOs in South Africa, traditionally, were the first ones to respond to the HIV crisis, for example. However, NGOs should not be partners in delivering community health as part of public primary care provision.)
- Creating a national CHW certificate that is accessible for new and existing workers (with the Recognition of Prior Learning being a part of it).

Achieving this long-term vision of the future is not a straightforward task. It requires a significant amount of political will to reform the current healthcare provision, in addition to the dedication of numerous policy workers across different departments, and the coordination of efforts among all stakeholders. It will also require time.

At present, there is neither the political will nor the time. Partially, this can be explained through the power relations theory. Although community health workers form the bulk of primary healthcare provision, they are not seen as the key element of the healthcare system by either the government or the communities. Equally, the working conditions of CHWs, such as irregular hours, fixed-term contracts that can be renewed or not at the employer's discretion, employment through NGOs rather than direct employment by the DoH, and low wages, ensure that community health workers have limited bargaining power. It is difficult for them to self-organise or join existing unions due to job insecurity and the potential costs associated with unionisation.

The unionising costs are both direct and indirect. Firstly, CHWs would have to pay a union fee from their already-low wages. Secondly, and perhaps more importantly, CHWs fear retaliation from their managers for joining a trade union. Their job insecurity lands them directly at the mercy of their managers, who can always not extend the contract for another term, leaving CHWs unemployed.

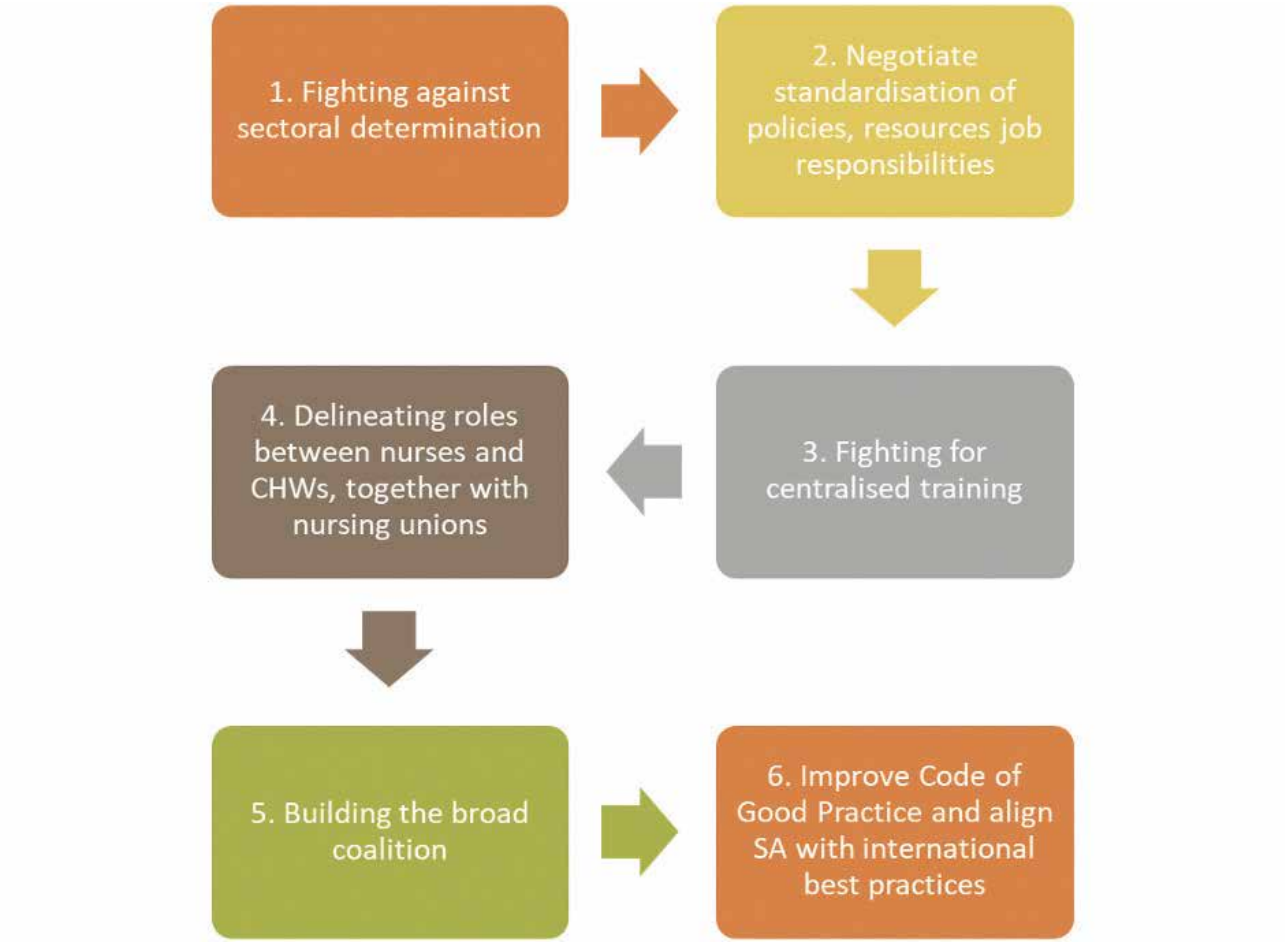
Partially, this lack of political will to change the healthcare sector stems from the current timing. The National Health Insurance (NHI) is a policy that is currently the subject of intense debate. The NHI bill was passed in 2014, and it is unclear how long it will take for the current system to be restructured in the NHI framework. In these circumstances, there is a general unwillingness to change the current status quo too much, because the healthcare system might be unrecognisable in the several years to follow.

Finally, there are always budget concerns. By some modest estimates, the Department of Health and provincial departments would need to allocate approximately R7-10 billion towards CHW programmes. This amount is based on the following calculations:

- The total number of CHWs needs to be increased from the current 55-56 thousand workers to 63,500 to reflect the WBPHCOT estimates that 1 CHW should focus on 1,000 individuals or 250 households.
- Employing 63,500 workers permanently at minimum wage would require a budget of at least R3.8 billion annually.
- Employing 63,500 workers as Level 1 or Level 2 public workers would cost approximately R6.8 billion annually alone.
- Providing training, resources, and medicines would cost another R1.2-1.5 billion per annum.
- Providing communication devices or mobile data, travelling allowances, and all other relevant allowances for each CHW would cost R0.5 billion.
- Hiring additional supervision and more DoH employees to monitor the CHWs, allocate resources and respond to issues and complaints might cost an additional R1-2 billion per year.

In total, the budget for the capacitated CHW provision should be between R7-10 billion, about double the current allocation. Although this may seem expensive, it can bring numerous benefits and significantly improve primary healthcare delivery.

While the vision of a truly comprehensive community health care system that takes care of both communities and workers may seem distant due to the reasons mentioned above, some steps can bring this vision closer. These are:



5.1. Fight against sectoral determinations for CHWs

The recently reopened conversation on whether community health workers need to be under sectoral determination is against the best interests of the workers, the industry, and the SA healthcare system. Ministerial or sectoral determinations are traditionally reserved for jobs that have little bargaining protection or uncommon working conditions. Some examples include security guards, agricultural workers, and domestic workers.

While it is true that the current bargaining provisions for CHWs are limited, this is largely a result of the government's failure to address the issue. There are no exceptional employment circumstances that hinder the full-time public employment of CHWs, other than the Department of Health's unwillingness. The CHWs do not work uncommon hours (unlike security guards or domestic workers, for instance). Neither do they enjoy any work privileges such as employers' accommodation or food (as is the case with agricultural and domestic workers). CHWs can work part-time, full-time, or in a shift pattern, and they are typically members of the communities they serve.

Hence, while CHWs are vulnerable workers, this vulnerability has been manufactured by the government, and the government has every opportunity to correct it. Furthermore, there is also no social or economic reason for the community health workers to receive a salary below the national minimum wage.

Suppose the DoH intended to increase the CHW wage determination above the national minimum wage, which can happen with specific categories under the sectoral determination. In that case, there are better platforms to do so. Bargaining councils, particularly the Public Health and Social Development Sectoral Bargaining Council (PHSDSBC), are the best platforms for determining CHW wages.

The bargaining council provides workers with the opportunity to be unionised and represented by their associations, thereby giving them a voice. Sectoral determinations give no such opportunity. While the Commission that determines sectoral determinations may occasionally collect reports from those interested in contributing to a topic, this exercise is significantly different from direct negotiations over not only the wage, but also numerous non-wage working conditions. Finally, the (PHSDSBC) has already been involved in the process of negotiating CHWs' working conditions in 2018 and continues to be the platform where the DoH and all the unions representing the health workers meet. There are no objective reasons to change the current procedure.

5.2. Negotiate the standardisation of CHWs' policies across provinces

A significant part of the CHWs' challenges deals with the lack of standardisation of practices among provinces and DoH departments. There is an array of practices regarding employment, contract management, salaries, and job conditions that differ between provinces and even among various facilities.

Such a wide discrepancy in employment conditions, workplace resources and roles and responsibilities poses many challenges both for the workers and for the public healthcare as well. One of the ways to significantly improve CHWs' conditions is the fight towards the standardisation of all aspects of CHWs' work across provinces and facilities. In principle, CHWs employed for the purposes of public healthcare delivery should have:

- Standardised working conditions: employment contracts, employment duration and other contractual matters;
- Standardised pay: all employees should receive at the Level 2 or 3 as public sector workers;
- Standardised resource package: name tags, uniforms;
- Standardised roles and responsibilities;

As trade unions and CHWs themselves have been fighting for recognition and better working conditions and wages for many years, many of these actions are familiar. What is rarely discussed is the need to have standardised roles and responsibilities. While the WBPHCOT policy initiated this conversation by assigning CHWs to facilities and placing them under the supervision of professional nurses, the implementation of the rest of the policy was left to the provinces, District Health managers, and managers of each particular facility. This created a divided workforce, whose roles and responsibilities change depending on who is in charge of the facility.

Community health workers, in their interviews and through various research, reported that their roles and those of nursing assistants are often confused. While some CHWs work as peer educators or disease counsellors, others spend their days facilitating, helping nurses, tracing patients, and taking vital signs. Yet, many of the workers never had aspirations to become nurses. In various interviews with CHWs, many workers reported that they chose their job so that they could give back to their communities and work within them to improve health outcomes. The fact that the actual role that CHWs end up performing differs so drastically from policy expectations calls for a more standardised approach to roles and responsibilities.

5.3. Collaborate with nursing unions

Following the previous point, there is a need to engage nursing unions in the delineation of jobs and responsibilities among community nurses, auxiliary nurses, student nurses, and community health workers. The relationship between nurses and community health workers in South Africa has long been shaped by structural inequalities, role ambiguities, and a legacy of apartheid-era health policies. A core source of tension is the unclear delineation of roles and responsibilities.

Currently, there are several groups of workers whose jobs and responsibilities overlap:

- Community nurses: nurses who received a degree or diploma in community nursing after 3-4 years of studying. They are registered with the South African Nursing Council (SANC). They are allowed to provide clinical care, diagnosis, patient management and supervision. They are also allowed to administer immunisations, provide antenatal care, perform midwife duties if trained as midwives, and treat chronic diseases and minor ailments.
- Auxiliary nurses or assistant nurses (sometimes called Enrolled Nursing Auxiliary): assistant nurses who are working under the supervision of registered nurses. They can assist with medication provision and some clinical tasks, such as recording vital signs, but do not have the authority to diagnose or prescribe medications independently.
- Community health workers: workers who usually operate under the supervision of a registered nurse. They are not registered with any of the bodies, and there are no formal certification requirements. They have no authority to diagnose or prescribe medication and must refer patients to clinics. Their jobs and responsibilities vary widely, ranging from providing home-based care to patients, delivering medications, offering health promotion and education services, referring patients to clinics, and collecting and reporting data.

Even the brief summary reveals that the roles of nurses, especially assistant nurses, often overlap with those of community health workers. In practice, however, since the government was not able to hire enough professional community nurses at the beginning of the CHW rollout, it often relied on enrolled and assistant nurses to supervise community health workers.[36] This created a tense situation in which professional nurses perceived that they were being side-lined, and community health workers were unhappy with the hierarchy that often delegated only supplementary tasks to them without offering meaningful promotions or opportunities for growth.

[36] Schneider, H., Besada, D., Sanders, D., Daviaud, E., Rohde, S., 2018. Ward-based primary health care outreach teams in South Africa; development, challenges and future directions in HST (2018) *Annual South African health review.* HST: Durban

Research highlights that nurses often question the competence and reliability of CHWs, particularly due to the lack of standardised training and formal accreditation. Meanwhile, CHWs reported feeling excluded from decision-making, poorly treated by clinic staff, and dismissed as "helpers" rather than recognised health workers.[37] This adversarial relationship weakened collaboration and affected patient care, as communication between clinics and communities often broke down, and the potential of CHWs to extend the reach of healthcare services was undermined.

A potential solution to this situation might lie in creating a partnership and/or a working group between trade unions representing nurses and community health workers to discuss the delineation of responsibilities between the two groups. Once worker representatives can find a tangible solution that prevents CHWs from being used as nursing assistants and vice versa, they may opt to jointly present and lobby their findings to the Department of Health.

5.4. Negotiate CHWs' centralised training

The current training provision is challenging and sporadic for many of the reasons outlined in the section on CHW challenges. For the CHWs programmes to reach their full potential, however, the training needs to be updated.

There are two possible approaches to CHWs' training. Option one is to formalise the current provision. Since the government has already developed official training materials for community health workers, it can make this training obligatory. This training also deserves a certificate of completion. If this path is followed, then every CHW should be required to pass this initial training and receive a certificate that will be recognised across all NGOs working with the DoH. Alternatively, if the CHW has work experience, they should pass the test based on the training materials and also receive the certificate. This will ensure that CHWs have uniform information that the DoH approved.

A second, more comprehensive option for CHW training would be to pursue full-time, one- to three-year courses at TVETs, which offer a Level 4 or Level 6 certificate upon completion. This approach is more complex: it either requires significantly more financing to support students during the courses or necessitates an overhaul of CHW employment and work, so that students who receive the full qualification can expect to be employed full-time with an appropriate wage. However, this approach also creates a professionalised cadre of workers who can be employed in numerous communities and can provide universal care.

Once community health workers have clearly defined job responsibilities, qualification requirements, and training, they can decide whether registration with a professional body is something worth pursuing. At the moment, the too broad range of responsibilities of CHWs and the lack of centralised training make it impossible for the workers to organise and become part of any regulatory body. If those issues were addressed, CHWs, like many other health professionals, could form a board under the Health Professions Council of South Africa (HPCSA). This could enable community health workers to become more professionalised on the one hand, and to be more in control of the profession on the other.

5.5. Engage provinces on insourcing CHWs

Trade unions have been vocal supporters of community health workers' rights and have been engaging with provincial and national departments of health regarding the insourcing of community health workers. This is a challenging work that should continue.

[37] Ginneken, N., Lewin., S., Berridge, V., 2010. The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Soc Sci Med*, 71 (6).

This work is challenging in light of both the power imbalance between community health workers and the DoH, as well as the impending policy changes towards the NHI. However, the full implementation of the NHI is still approximately a decade away, which is a long time for the CHWs to continue working without adequate salaries or employment protections. Hence, the work with each provincial government on improving CHW working conditions should continue.

5.6. Continue building the coalition

The concept of trade union solidarity is key to solving many of the challenges that CHWs face. Due to the nature of the CHW contracts, however, few CHWs are currently unionised. Instead, many CHWs form associations and/or forums that serve as venues to discuss their grievances. Such forums are often localised, which makes them difficult to access both for CHWs across the country and the trade unions. Understanding all these challenges, it remains of key importance to maintain these relationships and engage with CHW forums as much as possible. Building a broader coalition of health and allied professionals, NGOs, and civil society organisations can also help with campaigns and put pressure on the Department of Health to improve the working conditions of CHWs.

5.7. Align South African laws with the WHO Guidelines and ILO Conventions

There are substantial gaps between the ILO C190 Convention, the ILO Decent Work in the Care Economy Recommendation, the WHO Guidelines on Community Health Work Programmes and the South African reality. Several steps must be taken to ensure better compliance.

To align with the **WHO Guidelines** on CHW programmes, South Africa needs to:

- ☞ Implement national pay scales for community health workers.
- ☞ Formally employ all of the community health workers.
- ☞ Introduce formal training for community health workers.
- ☞ Amend the supervision of community health workers to provide CHWs with opportunities for career progression and growth.
- ☞ Provide adequate resources to the workers.
- ☞ Engage community representatives in the establishment and operation of the CHW programmes.

To comply with the **ILO Decent Care Work Recommendation**, the South African government needs to:

- ☞ Ensure that all those working in the care economy, including community health workers, are employed and receiving a salary.
- ☞ Enhance social dialogue and ensure freedom of association.
- ☞ Strengthen collective bargaining.
- ☞ Improve care provisions towards community health workers (provide allowances for childcare leave or paid leave due to family illness).

To fully comply with the **ILO C190 Convention**, the South African government needs to:

- Insource community health workers and ensure they become public health employees.
- Widen the definition of violence and harassment to include domestic violence spill-overs.
- Establish national-level compliance and enforcement mechanisms to address harassment and violence.
- Expand the scope of the Occupational Health and Safety Act to explicitly include the prevention of a hostile work environment and the protection of employees from violence and harassment.
- Ensure better coordination between different legal provisions and the C190 requirements, as well as alignment with criminal law.
- Ensure that all legal standards are applied not only to full-time employees, but also to contract workers, stipend volunteers, unpaid volunteers, and other work relations.
- Embed C190 into collective bargaining agreements.

6. THE FUTURE OF THE CHWS UNDER THE NHI

The final aspect of this report that needs discussion is the future of community health under the proposed NHI system. There are several caveats to this conversation. Firstly, it is unclear when the NHI will be implemented. Secondly, it is impossible to predict whether the NHI will be implemented in its entirety or what kind of changes can be anticipated.

Keeping those caveats in mind, the community health provision under the NHI is not expected to differ from the current status quo. Community health workers are included in the NHI in the following way: "*The Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs) form a pivotal part of South Africa's PHC re-engineering strategy. The outreach team will be led by a nurse and linked to a PHC facility. The CHWs will assess the health status of individuals in the households. They will also provide health promotion education, identify those in need of preventive, curative or rehabilitative services, and refer those in need of services to the relevant PHC facility.*" [38] The NHI Act (2014) does not expand on the roles and responsibilities of CHWs.

This quote suggests that the NHI system is expected to operate similarly to the WBPHCOTs, with all the subsequent issues and challenges that arise. There are no mentions of insourcing CHWs into the Department of Health under the NHI. Equally, there are no mentions of any other CHW-related reforms.

The most recent analysis of the NHI pilot projects indicates that, barring some changes in responsibilities, CHWs are performing in a similar context under the NHI pilots as they do under the general WBPHCOTs in the rest of the country. The only significant change is that CHW responsibilities under the NHI pilots shifted towards health promotion and away from home-based care. Under the NHI pilots, most CHWs screened households, counselled community members, and referred them to clinics. [39]

The challenges that CHWs face under the NHI pilot schemes are similar to today's:

- Little integration with the Department of Health;
- Tense relationships with nurses, facilities, and, at times, communities;
- Unclear roles and responsibilities;
- No formal full-time employment;
- Low salaries.

In summary, there are no indications that the NHI system will bring significant changes to the role of community health workers. The current NHI pilots are based on the PHC re-engineering policies and WBPHCOTs, and thus differ little from the rest of the country's community healthcare provision. Hence, the best time to reform the community health programmes to ensure workers' dignity and rights is now, before the NHI gets fully implemented.

[38] Department of Health, 2015. *White paper on National Health Insurance*.

[39] Van Vuuren, C.J., Lowe, Z., Bodenstein, K., 2025. Moving towards a South African NHI system of excellence: recommendations based on the insider perspectives of CHWs as key role-players. *International Journal of Environmental Research and Public Health*, 22(807).

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