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29 June 2009

The Honourable Minister of Health  
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The Honourable Minister of Social Development  
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The Honourable Minister of Economic Development  
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The Honourable Minister of Labour  
Mr Membathisi Mdladlana  
Private Bag X499 Pretoria 0001

Fax: 012 320 1942 (012 392 9620/22)

Dear Ministers Motsoaledi, Molewa, Patel and Mdladlana

## **RE- DECENT WORK AND CONDITIONS FOR COMMUNITY HEALTH AND CARE WORKERS**

1. We are writing to you to express our concerns about the joint and several policy processes that have been run by the Departments of Health and Social Development to try to develop a new policy on community health and social development care workers (hereinafter "community health care workers").
2. We have a number of interests in this matter:
  - a. We have received numerous complaints about the conditions of work from community health care workers who have asked us to make representations concerning their position;
  - b. We are involved in health systems research that has revealed the challenges facing community health care workers;

**Board of Directors:** Ms V. Dubula (Chairperson), Justice J. Kriegler (Deputy Chairperson), Mr N. Ndlovu (Treasurer), Prof. Q. Abdool-Karim, Dr B. Brink, Prof. S. Fonn (ex-officio), Mr M. Heywood (Executive Director), Prof M Pieterse (ex-officio), Ms T. Steele

AIDS Law Project, a section 21 company (2006/021659/08) and a registered law clinic,  
is formally associated with the School of Law at the University of the Witwatersrand, Johannesburg.

Income Tax Exemption Reference Number: PBO 930022549  
Nonprofit Organisation Registration Number: 055-382-NPO

- c. We are involved in work on HIV and TB prevention and care, which is heavily dependent upon motivated and trained community health care workers; and
  - d. We are concerned about the human resource crisis within the Department of Health, including unfilled posts and inadequate remuneration and terms of employment, and feel community health workers are a vital link to address these through forms of task-shifting.
3. At the outset we would like to say that we have been part of the process at various levels and we appreciate the spirit in which it has been conducted.
4. We welcome the attempts by the Departments of Health and Social Development respectively to devise both a "Community Care Giver Policy Framework" (version 4 June 2009) and a "Policy Framework for Home and Community Based Care and Support Programme" (revised draft September 2008). We agree with both draft frameworks' attempts to provide a uniform approach to formalizing the work of community health care workers through necessary improvements in the definitions and conditions of service of both remunerated community health care workers and those described as "volunteers".
5. Between us we have made a number of detailed submissions on the draft policies, or more particularly on the Community Care Giver Policy Framework, which we will not repeat here. We attach a more detailed list of our concerns in **Annexure A** hereto.
6. However we have three major concerns:
  - a. That the policy chooses not to formalize the employment of community health care workers with the state with appropriate and standardized rates of remuneration and employment benefits, but to continue their employment through more than 1600 non-profit organizations – in effect making essential health services reliant on volunteers receiving stipends. Whilst these non-profit organizations and other organizations should be further capacitated to form part of the support network for the community health care workers, the community health care workers' employment should be formalized and standardized within the health sector. The policy needs to take into account a sustainable role for NPOs in training, monitoring, evaluation and support of the community health care worker workforce, and not to use NPOs, to all intents and purposes, as labour brokers for the employment of community health care workers on behalf of the government;

- b. That the policy chooses not to recognise the different tasks, functions, forms of training and management required by community health care workers who are facility-based and those who are home-based; or those 68,5% who specialize in HIV/TB-related care, as opposed to the 32% who are more generalized home and community based carers; and
  - c. That the policy chooses not to establish career paths and skills development benchmarked against the National Qualifications Framework. Setting up such career paths would not only provide job opportunities but structured and systematic development opportunities for existing and future community health care workers as envisaged in the EPWP policy.
- 7. If this draft Community Care Giver Policy Framework is "accepted" at the end of June 2009 as it stands, it is a missed opportunity but also it means that the current poor system is further entrenched (with slight modifications) for a number of years.
- 8. We are deeply concerned at this approach of rejecting direct employment through the departments, because we fear that the result will be chronic underfunding of community health care worker programmes at the provincial level.
- 9. On the other hand, we believe that this policy could be an opportunity to meet several of the priorities that have been set by this government, in relation to health specifically, but also in relation to its broad economic and development policy.
- 10. In his State of the Nation address the President prioritized "decent work" where he said *"the creation of decent work will be at the centre of our economic policies"* and that *"... between now and December 2009, we plan to create about 500 000 job opportunities"* and about four million job opportunities by 2014, through "transform[ing] the economy to create decent work and sustainable livelihoods". We believe that in keeping with this, the proper formal employment and training of community health care workers and setting up of structured skills development and career paths is an opportunity to create decent, permanent and necessary jobs, not just limited-duration public works programme or one-year opportunities. Some unique advantages that exist include:
  - a. Some of the infrastructure is already there;
  - b. There is a need for a cadre of community health care workers created by policies such as the National Strategic Plan on HIV/AIDS and STIs

2007-2011 (NSP), and the draft Tuberculosis Strategic Plan for 2007-2011 (TBSP); and

- c. The workers are already available. It is estimated that there are nearly 65 000 such workers in the health and social sectors in informal employment relations, (of whom around at least 38,500 are employed through provincial health sector initiatives), the vast majority of whom are women.

11. However what is needed are:

- a. better managerial systems and support to community health care workers, especially given the frequent reports of non-payment of stipends or wages, and poor disbursement of funds to NPOs employing community health care workers, and
- b. better access to training and appropriate career pathways into the formal health and social development systems.

12. We are aware of the financial constraints faced by the government and the Department of Health in particular. However we would like to point out that the current expenditure on community health care workers is massively inefficient because of poor morale, high turnover due to funding and payment instability, lack of training and lack of technical and psycho-social support to these workers. A larger investment would not only yield better health outcomes, but would have cost savings in the prevention of TB, HIV infection and better adherence to antiretroviral therapies.

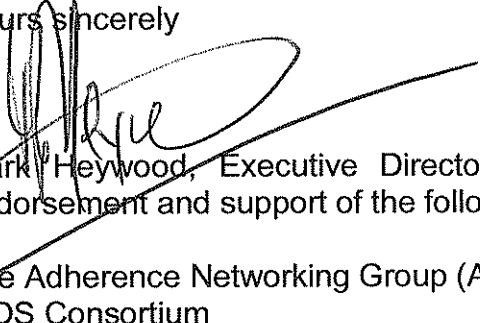
13. In addition, it is important to note that the targets of the NSP, TBSP etc, are all dependent on properly trained and supported community health care workers. Without them we will fail in the national priorities identified by the President, including his commitment to "... *strengthen the skills and human resource base ... [and] improve the health profile of all South Africans*".

14. In conclusion, we would like to say that South Africa's unique health challenges require a new vision of the health workforce, based on our population and disease demographics. In this regard community health care workers should be seen not as auxiliary "volunteer" workers under the Expanded Public Works Programme, but as a vital first and essential tier of the health workforce, tasked with prevention, health education, elements of home-based care, access to social grants and services and so on.

15. We appeal to you for an opportunity to discuss these issues with you. In the light of the above we ask for an urgent meeting before the end of June 2009

when the Departments of Health and Social Development propose to finalize their draft Community Care Giver Policy Framework for “staggered” national and provincial implementation.

Yours sincerely



Mark Heywood, Executive Director of the AIDS Law Project (ALP), with the endorsement and support of the following individuals and organisations:

The Adherence Networking Group (ANG)

AIDS Consortium

Children's HIV/AIDS Network (CHAIN)

Children's Sector HIV/AIDS National Network (CATCH)

Professor Ashraf Coovadia, Head of Paediatric HIV Services, Rahima Moosa Mother & Child Hospital

Sidumo Dlamini, President of the Congress of South African Congress of Trade Unions (COSATU)

Enhancing Children's HIV Outcomes (ECHO)

Professor Uta Lehmann, Director, School of Public Health, University of the Western Cape (UWC)

Jack Lewis, Director of Siyayinqoba Beat It! at the Community Media Trust (CMT)

Networking AIDS Community of South Africa (NACOSA)

Reproductive Health and HIV Research Unit (RHRU), University of the Witwatersrand

Professor Helen Schneider, Infectious Disease Epidemiology Unit, School of Public Health and Family Medicine, University of Cape Town (UCT)

Southern African HIV Clinicians Society

Treatment Action Campaign (TAC)

Dr Gilles van Cutsem, acting Head of Mission, Medicins Sans Frontieres (MSF)

Cati Vawda, Director, Children's Rights Centre – South Africa (CRC)

## ANNEXURE A

### CONCERNS REGARDING THE DRAFT COMMUNITY CARE GIVER POLICY FRAMEWORK FOR HOME COMMUNITY-BASED CARE

1. At the recent workshop in Boksburg, on 4 and 5 June 2009, a number of us were invited. It became clear from the proceedings of the workshop and in the draft framework itself, that the departments are concerned about the financial implications of directly employing the "community care givers" (CCGs, as described by the Department of Health) themselves. While we understand the department may be suffering from financial constraints, we are deeply concerned at this approach of rejecting direct employment through the departments, because we fear the result will be a continued chronic underfunding of CCG programmes at the provincial level.
2. If the departments decide to continue to use non-profit organisations (NPOs) or non-governmental organisations (NGOs) based in communities and provinces to employ community health care workers (CHWs) and CCGs, at least the departments must ensure through their funding contracts with NPOs that all the standardised conditions of employment contained in the policy framework are a mandatory part of all tenders for funding these NPOs, and that there is a functional grievance procedure for CHWs and CCGs from the NPOs to the departments in the provinces. Whilst the support of the larger NGO sector is vital in maintaining this layer of workers, the Department of Health needs to play the role of custodians and formalise the community health care workers' (including CCGs) employment as a bonafide layer of the health sector. NGOs should be capacitated in their role to further support and mentor CCGs and CHWS as far as a mentorship/support network.
3. There are several other flaws or omissions in the draft framework which reinforce this concern. Some of the major ones are highlighted below.
4. The draft framework brings welcome changes to the vision of CCGs. But ultimately the success of the policy framework will depend on effective management, funding and secure employment of CCGs. Our concern in this regard is that while the draft framework attempts to address many of the issues, there is very little which is sufficiently detailed to ensure the policy framework's implementation will follow in a manner which will fully resolve the concerns we have previously raised with the departments.
5. CCGs should not be excluded from further career opportunities as a result of their lack of qualifications. In its present form, the draft framework will bring this undesirable outcome into being. This stems from the fact that the draft framework does not require minimum qualifications to be achieved by those who want to serve their communities as CCGs, during the course of their employment. This has the potential of excluding thousands of young people from career opportunities. We do not see any reasonable justification for this approach, especially because a holistic absorption of CCGs into the healthcare system over time will assist government in creating a lot of employment opportunities for the unemployed. Over and above this, some of the human resource problems which

are crippling our primary healthcare system could be significantly reduced, through the absorption of facility-based CHWs directly into the departments after they achieve a standardised level of training.

6. It is important to note that the draft framework confuses rather than clarifies the issue of different cadres. It is absurd to pretend that there is and will be only one cadre of CCG. CCGs, in the view of the current health department policy drafters, currently comprise all non-professional workers in health and social welfare linked to the provision of “home community-based care”. This conflates the more skilled and literate lay counsellor based in a facility who works a full 40 hour working week, with a person who visits and offers some assistance to those with chronic diseases in their own homes for a few hours in a week. The social welfare department view is not the same. Our view is that there should be further research to determine the different types of CCGs, how many there are of each type, where they are located nationally, and this should be used as the basis for a more informed and nuanced policy.
7. The draft framework fails to discuss the current status of CCGs in the country, such as how many CCGs are currently being utilised by the provinces and districts, what tasks they have been made responsible for, and the current level of training amongst the workforce. These are critical areas that need urgent attention.
8. We also cannot talk about CCGs without any goals and targets, as the draft framework does. Those targets related to CCGs and currently located in the NSP, the TB Strategic Plan, the draft policy on Maternal and Child Health, the Department of Health’s Strategic Plan for 2009-2012 etc, should be listed in the policy to enable effective monitoring and evaluation.
9. The ways of categorising responsibilities of CCGs in the draft framework also do not clearly correspond to any of the tasks contained in the NSP or the TB Strategic Plan. The draft framework task formulations are primarily oriented to health care and not social development. The separate Social Development and Health Department “Policy Framework for Home and Community-Based Care and Support Programme”, which appears to have been drafted primarily by the Department of Social Development in September 2008, contains a more specific list of tasks; but these are mainly oriented towards social development work and do not relate directly to any of the Health Department’s abovementioned policies or strategies either. This is a serious problem because, in the absence of clear, detailed and specific tasks or categories of CCGs, it is not possible to monitor the achievement of the two strategic plans to counter South Africa’s twin pandemics. The blurring of these tasks also prevents coherent budgeting and management to accomplish these goals.
10. The draft framework fails to distinguish between facility and home based CCGs and there is not enough in it to adequately or conceptually address facility-based CCGs.
11. The policy proposals on both wages for CCGs and stipends for volunteers seem unjustifiably low. One of the major problems facing CCGs has been inappropriate

budgeting for CCG programmes. The draft framework has not indicated how this problem is to be resolved. We note that the departments explicitly dissociate themselves from CCGs in the draft framework by stating that the recruitment, management and support of CCGs falls within the domain of NPOs. We submit that this is not in the best interest of our health care system as it fails to address the underlying budgetary and proper planning concerns.

12. The CCG policy framework must ultimately be seen in the light of the responsibility of the departments to progressively realise the constitutional goals of access to health care services, social security and social assistance in a manner which respects human dignity. Given that volunteers and CCGs perform health care tasks which are necessary for saving and prolonging the lives of those they serve, their remuneration and conditions of service should be bettered without further delays.
13. Real career paths are necessary if the skills and training of these workers are to be retained in the health care system, and the most job opportunities will be within the two departments. This means making learnerships and access to training available for the CCGs to acquire the necessary training to become full-time departmental employees.
14. CCGs are potentially a huge resource, particularly for the Department of Health with its shrinking and ageing staff. There is an urgent necessity for the departments to conduct a full investigation to determine the number of CCGs that are currently being utilised and how they have been successfully (or unsuccessfully) deployed in certain districts.
15. CCGs are responsible for delivering a large portion of necessary health interventions, particularly at the primary health care level. CCGs are envisaged as a cornerstone of health care delivery. Despite this, through the latest draft of the framework, the departments seem to be proposing to continue to offer these services to the bulk of the population through an "informalised" corps of "volunteers" and employees with little job security, under the control of NPOs functioning like labour brokers, with no directly accountable link to the departments in the provinces. We believe that it is important for government to recognise CCGs as formal employees with stable permanent careers over the long term, without delay. Our health system cannot rely on volunteers from the most impoverished sections of our population to make available essential services.
16. To create a properly trained CCG their role needs to be understood in relation to the rest of the primary health care team, as well as current thinking on task-shifting and task-management that seeks to maximise the efficient allocation of activities in service. Failing to do so, will ultimately undermine the ability for provinces and districts to adequately plan their CCG programmes as they are being rolled out.
17. The draft framework does not contemplate proper budgeting and planning as a way of resolving the problems faced by CCGs. In particular, we are concerned that the main problems relating to regular remuneration of CCGs will not be

addressed immediately due to “budgetary constraints” without any approach to progressively realising any improvements. In light of the President's drive to create millions of job opportunities and the government's intention to ensure the creation of decent job opportunities, we are of the opinion the benefit of improving the working conditions of CCGs and their absorption into the departments as a trained, experienced and provenly willing and committed workforce will far outweigh the financial revisions of existing budgets required, in the long run.

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 Nonprofit Organisation Registration Number: 055-383-6199