# Better care, closer to home

## The case for community health workers

Lessons from Cape Town and Boston for the UK's Neighbourhood Health Service

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2025 Churchill Fellow






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## About the Author

Alice Vodden is a Transformation Lead at DrDoctor - a health technology organisation working with the National Health Service (NHS) to improve patient engagement, streamline care delivery and support the transition towards more efficient, digitally enabled healthcare.

She holds a Masters in Public Health from the University of Cambridge and has multiple peer-reviewed publications spanning digital health, health inequalities and epidemiology. Her work has been cited by the British Medical Journal and The Lancet, and presented at national and international conferences. She has held positions as a Digital Health Steering Committee Member at the European Public Health Association, a Fellow at One Healthtech and a Research Fellow at the Health Equity Evidence Centre.

Alice spent several years working in the NHS across operational and strategy roles, including as General Manager for the Emergency Department at University College London Hospitals NHS Foundation Trust. That experience — seeing daily the pressure on hospitals, the consequences of an underfunded preventive health system, and the urgent need to keep people well in the community — shaped her conviction that the UK must invest seriously in community-based care. She moved into health technology to explore how digital tools could support this shift, and pursued this Churchill Fellowship to learn from countries that have been building community health worker programmes at scale for decades to inform the UK's emerging neighbourhood health programme.

# Executive Summary

## What Was Researched

This Churchill Fellowship explored how Cape Town, South Africa, is delivering community healthcare at scale with a particular focus on the role of technology — and what the UK can learn as it seeks to build a new Neighbourhood Health Service. The central questions driving the research were: How do community health worker (CHW) programmes function in the Western Cape, and what makes them effective? How are digital tools and data being used to enable proactive, preventive care at community level? And what specific, transferable lessons can the UK draw from this context?

Three weeks of field research were conducted in Cape Town in February 2026, involving visits to university research programmes, government health departments, non-profit organisations (NPOs), digital health companies and primary care settings, alongside meetings with healthcare managers, community health workers, researchers, and policymakers.

A shorter visit to Boston, Massachusetts, USA, in November 2026 provided a complementary perspective on community health worker programmes in a high-income healthcare system. Discussions with individuals working in community health and CHW advocacy highlighted similar challenges around community trust, workforce security, funding and incentives for prevention. Given the limited scope of the Boston visit, these insights are used to provide additional context rather than form a substantive part of the research findings.

## Major Findings

The National Health Service (NHS) is under profound strain. Lord Darzi's 2024 independent investigation concluded that the NHS is in a "critical condition" and called for care to shift away from hospitals and closer to home. The 10 Year Health Plan published in July 2025 responds with a commitment to a new Neighbourhood Health Service, alongside an expansion of Community Health Worker programmes following successful pilots. The ambition is right. The question now is how to deliver it.

South Africa has been grappling with these same questions for decades. It formalised community health workers into its national health system in 2011, built around Ward-Based Primary Healthcare Outreach Teams. The Western Cape has gone furthest — integrating this workforce with a world-class data infrastructure, the Provincial Health Data Centre (PHDC), and a dynamic ecosystem of NPO-delivered innovation.

The five major findings from this Fellowship are as follows. First, community-embeddedness is the mechanism, not just the method: CHWs rooted in the communities they serve can build trusted relationships and reach people whom clinic-based services may struggle to engage. Second, a linked data infrastructure is the foundation for proactive care: the PHDC demonstrates what is possible when person-level clinical data is made actionable at community level. Third, technology works when it serves the CHW, not the system: the most effective digital tools are mobile-first, low-cost and designed around CHW workflow. Fourth, workforce precarity is a defining vulnerability of every CHW programme: in South Africa and the UK alike, CHWs often operate on precarious contracts with poor pay and no career pathway. Fifth, the NPO model is a strength, but

only with the right governance: Cape Town's NPOs can draw on established community relationships, but the model requires robust accountability to work at scale.

### Recommendations

The following recommendations for the UK are expanded in Section 7:

- establish a nationally defined CHW role within NHS neighbourhood health teams;
- invest in community-level data infrastructure;
- develop a mobile-first digital strategy for neighbourhood health;
- align neighbourhood health outcomes and financial incentives;
- and strengthen the voluntary, community and social enterprise (VCSE) sector as a long-term delivery partner.

# 1. Introduction to the Project

## 1.1 Background to the Project

In July 2024, Wes Streeting commissioned Lord Darzi to conduct an independent investigation into the National Health Service (NHS) in England. It concluded that the NHS was in a critical condition: the elective waiting list had grown from 2.4 million in 2010 to over 7 million by June 2024, and health inequalities had widened significantly over the same period. Darzi also identified a structural imbalance in how NHS resources are allocated — too much flowing into hospitals, too little into community services (Darzi, 2024).

The government's 10 Year Health Plan, published in July 2025, responds with three strategic shifts: hospital to community, analogue to digital, sickness to prevention (DHSC, 2025). The centrepiece is a new Neighbourhood Health Service: integrated, population-focused teams at neighbourhood level. From September 2025, 43 areas began operating as test sites under the National Neighbourhood Health Implementation Programme (NHS Confederation, 2025).

This is not the first time the NHS has articulated this ambition. The NHS Long Term Plan (NHS England, 2019) and the Fuller Stocktake (Fuller, 2022) pointed in the same direction. The difference now is the scale of political commitment. But questions about how to deliver the vision — particularly around workforce, data and the voluntary sector — remain largely unanswered.

This Fellowship was designed to interrogate those questions by looking at a context that has been grappling with them for decades. South Africa formalised a national community health worker (CHW) programme in 2011. The Western Cape has developed a world-class health data infrastructure and a diverse ecosystem of non-profit organisation (NPO)-delivered community health innovation. It is a system that has been forced to innovate out of necessity, and some of the lessons from that innovation can be applied in a UK context.

I was inspired to pursue this Fellowship in part by the work of Professor Matthew Harris and colleagues, whose research on Brazil's Family Health Strategy and the successful community health worker pilot in Westminster demonstrated that structured CHW models can work in a UK context. South Africa offered an opportunity to study another system that had successfully implemented community healthcare delivery models at a national scale — and to understand both the achievements and the challenges of doing so.

## 1.2 Aims and Objectives

This Fellowship had two overarching aims. First, to understand how community health worker programmes are designed, deployed and sustained in Cape Town, including their scope of practice, training, supervision, digital integration, and relationship to formal health services. Second, to identify specific, transferable lessons from Cape Town's community healthcare ecosystem that can inform the UK's neighbourhood health programme.

The specific objectives were: to observe and analyse the Ward-Based Primary Healthcare Outreach Team model in operation; to explore how the Provincial Health Data Centre and other digital tools enable proactive, data-driven community care; to

examine the governance model of NPO-delivered community health, including the distinctive Western Cape approach of embedding CHWs within NPOs rather than government; and to draw out grounded, actionable recommendations for policymakers and health system leaders in the UK.

## 1.3 Purpose of This Report

This report is intended primarily as a contribution to the emerging evidence base and policy debate around the UK's neighbourhood health programme. It aims to inform and prompt discussion, particularly among NHS leaders, integrated care boards, voluntary, community and social enterprise (VCSE) organisations and policymakers working on the design and implementation of the Neighbourhood Health Service. It is written to be accessible to a non-specialist reader while remaining grounded in the published evidence. The findings are intentionally summarised — this is not designed to be an exhaustive account, but rather to convey the main themes emerging from this Fellowship and what they might mean for the UK context.

## 1.4 Approach and Methods

I conducted the majority of my research over a three-week period in Cape Town in February 2026.

I visited and met with people from several organisations: the University of Cape Town Faculty of Health Sciences, including the Cape Town Systematic Healthcare Action Research Project (C-SHARP) programme, the School of Public Health and Students' Health and Welfare Centres Organisation (SHAWCO); the Western Cape Department of Health and Wellness, including Cape Town Metro Health Services; Masincedane Community Service, a long-established NPO delivering CHW services in the Nomzamo township; Touching Nations, an NPO providing CHW and wellness services in Delft; Dimagi, the health technology organisation that developed the CommCare platform; and REACH Digital Health, developers of digital communication tools including MomConnect.

Over three weeks I met with and interviewed programme managers, CHW supervisors, community health workers, academic researchers, government health officials, digital health developers and NPO leaders. I spent a day in Nomzamo, visiting the local Wellness Centre and observing operations at Nomzamo Community Day Centre. I attended a presentation on the C-SHARP research programme, and received briefings on the Provincial Health Data Centre, the Community Health Action Mobile Platform (CHAMP) digital tool, and the Western Cape's Community-Oriented Primary Care (COPC) framework.

Academic and policy literature was reviewed to contextualise findings, covering the UK neighbourhood health agenda, South Africa's national CHW policy and the Western Cape's digital health infrastructure.

While the findings in this report are drawn primarily from the research undertaken in South Africa, I also spent several days in Boston, Massachusetts, USA, in November 2026, meeting with individuals involved in CHW advocacy and research, including through the Massachusetts Association of Community Health Workers and Harvard Medical School. Given its limited scope, the Boston visit provides a complementary perspective from a high-income healthcare system rather than a separate body of substantive fieldwork.

# 2. The UK Context: A System in Urgent Need of Change

## 2.1 The problem

The scale of pressure on the National Health Service (NHS) is well documented. By June 2024, over seven million people were on the elective waiting list, of whom around 309,000 had been waiting more than a year for treatment — in 2019, that figure stood at just 1,600 (Darzi, 2024; NHS England, 2024). The 18-week treatment standard, which requires that 92% of patients begin treatment within 18 weeks of referral, has not been met since 2016 (House of Commons Library, 2024). More than one million people were also waiting for community services by the same point (Darzi, 2024). In 2023/24, only 72% of patients were seen within four hours in accident and emergency (A&E) — well below the 95% constitutional standard — and over 1.75 million attendances lasted more than 12 hours from arrival (NHS Digital, 2024). The Royal College of Emergency Medicine has estimated that corridor care affects hundreds of thousands of patients annually, with associated risks to patient safety (RCEM, 2023). Mental health services face similar pressures: by April 2024, one in ten adults waiting for community mental health services had been waiting more than two years simply for a second contact with services (NHS England, 2024). Access to general practitioner (GP) services has also deteriorated sharply, with only 23% of people reporting satisfaction with GP waiting times in 2024 (Nuffield Trust and King's Fund, 2025). Against this backdrop, public satisfaction with the NHS has fallen to its lowest level since records began in 1983, with just one in five people satisfied with the way the NHS runs — a fall of 39 percentage points since 2019 (Nuffield Trust and King's Fund, 2025).

Beyond these headline statistics, the Darzi investigation identified structural weaknesses in NHS financing and delivery. It highlighted a £37 billion capital spending shortfall, the effects of the 2012 Health and Social Care Act, and the sustained pressure on community nursing and general practice, particularly in deprived areas. Underinvestment in care outside hospital has contributed to greater reliance on hospital services, reinforcing the challenge of shifting towards prevention (Darzi, 2024).

## 2.2 The Neighbourhood Health Agenda

Shifting care from hospitals into communities has been a recurring theme in English health policy, articulated in strategies including the NHS Long Term Plan (NHS England, 2019) and the Marmot Review on health inequalities (Marmot et al., 2010). The Fuller Stocktake, an independent review commissioned by NHS England, developed this further, setting out a vision for integrated neighbourhood teams serving populations of 30,000 to 50,000 people and was co-signed by the chief executives of all 42 Integrated Care Systems in England (Fuller, 2022). The Neighbourhood Health Service as a formal policy commitment, however, was first introduced in the 10 Year Health Plan, published in July 2025, which placed it at the centre of its ambition to shift care from hospitals into communities — directly responding to the structural diagnosis set out by Darzi (DHSC, 2025).

The 10 Year Health Plan positions neighbourhood health centres as accessible, multidisciplinary hubs prioritising areas with the lowest healthy life expectancy (DHSC, 2025). The Neighbourhood Health Framework, published in March 2026, sets out five national minimum goals and a clearer implementation structure for integrated care boards and local authorities (DHSC, 2026). Forty-three pilot sites have been identified, beginning in the most deprived parts of the country.

The ambition has been broadly welcomed, though independent analysis has raised important questions about delivery. Health spending is planned to grow at 2.8% a year in

real terms over the next three years — below the historic average of 3.7% and well below the 6.8% seen during Labour's last period in government — raising questions about whether the financial envelope is sufficient to deliver meaningful structural change (BMJ, 2025; Health Foundation, 2025). The King's Fund has noted that previous attempts to shift care into the community have consistently struggled to reduce hospital use or generate cost savings, and that new models take time and sustained investment to embed (King's Fund, 2025). The critical question is not whether neighbourhood health is the right direction — the evidence strongly supports it — but whether the workforce, infrastructure, governance and funding are in place to deliver it at scale this time.

### 2.3 Community Health Workers in the UK: An Emerging Workforce

Central to the neighbourhood health model is the question of workforce. The 10 Year Health Plan explicitly identifies community health workers (CHWs), peer support workers and social prescribing link workers as part of the neighbourhood team (DHSC, 2025). This is a significant recognition of a workforce that has, until recently, operated without a consistent national definition, clear scope of practice, formal training pathway or career structure. Community health workers and health and wellbeing workers are operating in pockets across the country, frequently on short-term funded positions, and the evidence base on their effectiveness in the UK context — while growing — remains more limited than in international settings.

There are examples to build on. Social prescribing link workers are now embedded in many GP practices as part of the Primary Care Network model. Community outreach workers in local authority public health teams perform some analogous functions. The most significant domestic evidence base has been generated through a series of pilots modelled on Brazil's Family Health Strategy, led by Dr Matthew Harris at Imperial College London in collaboration with the National Association of Primary Care (NAPC).

The first pilot was launched in 2021 on a social housing estate in Pimlico, Westminster — one of the most deprived areas in the country — by Westminster City Council in partnership with a local GP practice and evaluated by the National Institute for Health and Care Research (NIHR) Applied Research Collaborative North West London. Five Community Health and Wellbeing Workers (CHWWs), recruited from the local area, were each assigned responsibility for approximately 150 households, conducting proactive monthly visits regardless of whether residents had presented to services. The published evaluation found that overall preventive service uptake was 40% higher in households that received visits compared to those that did not, with immunisation uptake 47% higher and cancer screening and NHS Health Check uptake 82% higher. GP consultations decreased by 7.4% in visited households over the first ten months of the pilot (Junghans et al., 2023).

Following these results, the model was extended to two further pilot sites — in Calderdale, West Yorkshire, and Warrington — with the NAPC playing a central coordinating and advocacy role across all three. A comparative evaluation published in 2025 found that local recruitment, cultural competence and relationship-building were consistent facilitators of effectiveness, while funding precarity and the absence of a nationally recognised role remained significant barriers to sustainability (Riley et al., 2025). The NAPC has since been actively advocating for national rollout of the CHWW model as a core component of the neighbourhood health workforce (NAPC, 2025).

These pilots represent a meaningful domestic evidence base. But they also illustrate the central challenge: promising results from time-limited, locally funded pilots have not yet translated into a nationally defined, sustainably funded workforce model. It is in this context — a system in urgent need of structural change, a policy commitment to

neighbourhood health, and an emerging but fragmented community workforce — that this Fellowship set out to learn from South Africa's experience of building a CHW programme at scale.

## 3. South Africa and the Western Cape: Setting the Scene

South Africa is not an obvious comparator for the National Health Service (NHS). It is a middle-income country with extreme inequality, a dual public-private health system, and a disease burden shaped by human immunodeficiency virus (HIV)/tuberculosis (TB), non-communicable diseases, injury and violence, and maternal and child health conditions. Approximately 84% of the population relies on the public system, which is managed at provincial level and operates under severe resource constraints — the private sector accounts for approximately half of health spending while serving around 16% of the population, leaving the public system to serve the majority with the remaining resources (OECD, 2020). South Africa's National Health Insurance Act was signed into law in May 2024, although implementation has been delayed amid legal challenges (Republic of South Africa, 2024; The Presidency, South Africa, 2026).

The interest in South Africa for this work is not that it offers a like-for-like comparison with the UK, but that it presents a specific combination of conditions that draws out learnings potentially applicable to the NHS. South Africa has been forced to innovate out of necessity, operating under pressures — including gang violence affecting daily life in some regions — that have shaped distinctive approaches to delivering care in underserved communities.

Cape Town, and the Western Cape province more broadly, stands out for two reasons in particular. First, the Western Cape has developed a data-driven approach to health system management centred on the Provincial Health Data Centre, which is internationally recognised as an exemplar of linked, person-level health data infrastructure (Boulle et al., 2019). Second, Cape Town has a rich ecosystem of non-profit organisations that have pioneered community-based care models over decades, many rooted in the townships established under apartheid. It is this combination — data infrastructure and community innovation operating side by side — that makes Cape Town a setting from which relevant insights can be drawn.

In 2010/11, the South African National Department of Health formalised community health workers (CHWs) into the national health system through a policy of re-engineering primary healthcare. The centrepiece was the creation of Ward-Based Primary Healthcare Outreach Teams: generalist CHWs, supervised by a professional nurse serving as Outreach Team Leader, covering a defined ward-level population (Mantell et al., 2022). This represented a deliberate move away from disease-specific CHW programmes — focused narrowly on HIV or TB — towards a comprehensive primary healthcare model. A revised framework in 2018/19 placed greater emphasis on integration with primary care facilities, supervision quality, and the use of data to direct outreach (Murphy et al., 2021).

Research evaluating implementation across provinces has found significant variation in practice. Challenges include incomplete team staffing, limited resources for training and supervision, safety concerns for CHWs in high-crime areas, and deep tensions around employment status (Murphy et al., 2021). Critically, the Western Cape has taken a fundamentally different approach to CHW employment from the rest of South Africa — one that is at the heart of an ongoing national debate, and that has direct relevance to how the UK structures its own community health workforce. This is explored in detail in Section 6.

# 4. Findings: The Community Health Worker in Practice

## 4.1 The Ward-Based Primary Healthcare Outreach Team Model

The Ward-Based Primary Healthcare Outreach Team (WBPHCOT) is the structural unit of South Africa's community health system. Each team consists of community health workers (CHWs) led by an Outreach Team Leader, usually an enrolled nurse, covering a defined geographic area and responsible for approximately 1,000 to 1,500 households. Teams are linked to a primary care facility, which anchors their clinical supervision and referral pathway (Nelson and Madiba, 2020; Buthelezi et al., 2025).

CHWs conduct household visits on a scheduled basis, delivering health education, screening for conditions including human immunodeficiency virus (HIV), tuberculosis (TB), hypertension, diabetes and malnutrition, supporting referral to clinics, and monitoring people with chronic conditions between facility visits.

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**Case Study: Nomzamo Township, Helderberg**

*Masincedane Community Service, Strand*

Nomzamo is a rapidly growing township near Strand in the Helderberg area, with an estimated population of 60,000. The settlement is predominantly Black African and isiXhosa-speaking, with a significant proportion of informal housing. CHW services in Nomzamo are delivered by Masincedane Community Service, a local non-profit organisation (NPO) contracted to provide community outreach under the WBPHCOT model.

CHW teams in Nomzamo consist of 15 to 18 workers, each responsible for three to four streets within a defined geographic area. Visits follow a structured household assessment: checking chronic medication adherence, screening for TB symptoms, monitoring child nutrition and immunisation status, and identifying social needs such as food insecurity or domestic violence. A defining feature of the model is that CHWs live in the communities they serve — they are neighbours, predominantly women, who visit the same families over many years. This continuity of relationship is the mechanism through which trust is built and sustained, and it is what makes the model effective. It cannot be replicated by rotating staff or by workers brought in from outside the community.

A visit to the Nomzamo Community Day Centre illustrated how the facility and community-based elements of the model operate together in practice. The Community Day Centre functions as the primary care anchor for the CHW teams: CHWs refer patients identified in the community, and the facility in turn refers patients needing follow-up at home — newly diagnosed TB patients requiring household contact tracing, or post-natal mothers who have missed clinic appointments. A wellness centre on the same site provides an additional layer of community-facing support, offering health promotion, chronic disease management and psychosocial services. The pathway does not stop at primary care: the Community Day Centre maintains referral links to district and tertiary hospitals, including Tygerberg Hospital, ensuring that patients who need more specialist assessment or treatment can be escalated through the system. This creates a coherent continuum of care — from household visit to community facility to tertiary centre — anchored in a defined geographic area and coordinated across levels of the health system.

## 4.2 Workforce, Supervision and Employment: The Persistent Tension

Across South Africa, the single most damaging feature of the CHW programme is the employment model. The majority of CHWs are employed on stipend-based contracts through NPOs, rather than as direct government employees. Research has consistently documented the consequences: meagre remuneration, no employment benefits, no pension provision, and contracts that are inherently precarious (Malatji et al., 2024).

The national government has been pushing for provincial governments to absorb CHWs into the formal public workforce. A January 2025 Labour Court ruling concerning the absorption of CHWs into government employment applied to eight provinces, but not to the Western Cape's NPO-based model, according to the provincial Department of Health and Wellness (Western Cape Provincial Parliament, 2026). The distinction reflects a genuine policy disagreement about how community health workers should be embedded within health systems, explored further in Section 6.

The UK faces analogous risks. Community health workers and social prescribing link workers are already being deployed in some areas on temporary contracts, often funded through time-limited grants. If the neighbourhood health workforce is to be built on this cadre, the foundation must be sustainable: fair pay, formal employment recognition, investment in training and supervision, and career pathways that retain people in communities over the long term.

Discussions in Boston highlighted similar tensions in Massachusetts. CHWs work across healthcare and community settings as outreach workers, educators, navigators and advocates, often drawing on direct experience of the communities they serve. Massachusetts has a voluntary CHW certification system, while questions about sustainable employment and reimbursement remain unresolved. Proposed legislation would expand insurance coverage for CHW services and establish a workforce development task force (Massachusetts Department of Public Health, 2026; Massachusetts Association of Community Health Workers et al., 2026; Massachusetts General Court, 2026). Similarly, an evaluation of the Massachusetts CHW workforce found that certification was associated with higher pay and greater integration into clinical teams, although its observational design cannot establish that certification caused these differences (Nielsen et al., 2024). This reinforces the importance of recognising CHWs as part of the workforce while protecting their community relationships and providing secure employment.

# 5. Findings: Technology and Data as Enablers of Community Care

## 5.1 The Western Cape's Data Infrastructure: The Provincial Health Data Centre

If there is one innovation in Cape Town that the UK should study most carefully, it is the Provincial Health Data Centre (PHDC). The PHDC consolidates person-level clinical data across all government health services in the Western Cape, built over more than two decades of sustained investment in patient registration systems, a unique health identifier, and the maturation of clinical digital systems (Boulle et al., 2019).

The PHDC's functions span direct clinical care through a single patient viewer, operational reporting, active surveillance through daily-updated alerts, business intelligence and clinical research (Boulle et al., 2019). Critically, it includes bidirectional interoperability with community health worker (CHW) mobile systems, meaning referrals between clinic and community flow through a linked data environment (Boulle et al., 2019).

During coronavirus disease 2019 (COVID-19), the PHDC generated daily risk-stratified lists of diabetic patients with COVID-19 diagnoses, enabling proactive telemedicine outreach. Within two months, the province was reaching all identified patients — only possible because the data infrastructure had been built over years, not months.

NHS England has committed to a Federated Data Platform and linked shared care records. These are analogous ambitions. But the Western Cape's experience makes clear that the return on investment depends entirely on whether the data reaches community level in a form that CHWs and primary care teams can act upon. A data system accessed only by hospital clinicians is not a neighbourhood health tool.

## 5.2 Digital Tools in the Field

The recurring theme across every conversation I had about technology during this Fellowship was a simple design principle: technology that works for community healthcare must be built around the reality of CHW work, not the preferences of system architects.

The most striking example I encountered was the Community Health Action Mobile Platform (CHAMP) app — developed as part of the Cape Town Systematic Healthcare Action Research Project (C-SHARP) programme at the University of Cape Town. CHAMP is built using an open-source platform (Medic Mobile's Community Health Toolkit, deployed via an Open Data Kit (ODK)-based system) and runs on basic Android smartphones carried by CHWs during household visits. It collects data in a hierarchical structure — locations, households, individual clients — and syncs with the Provincial Health Data Centre every five minutes when connected, while also functioning fully offline in areas with poor connectivity.

What makes CHAMP effective is its simplicity and its integration into CHW workflow. Rather than adding a data collection burden on top of existing work, it replaces the paper-based household assessment forms that CHWs were previously using, reducing duplication and making the data immediately available to supervisors and clinicians. Digital Health Officers — a dedicated frontline tech support role — work alongside CHW

teams to troubleshoot issues and maintain devices, a practical investment that many digital health deployments elsewhere neglect.

WhatsApp was also widely used. CHW teams used WhatsApp groups for daily coordination, sharing updates on patients who needed urgent follow-up, communicating with clinic staff about referrals, and receiving information from supervisors. It was not a formal part of the health information system, but it was the connective tissue that made the system work in real time. The Goliath et al. (2025) programme evaluation of community-oriented primary care (COPC) implementation in the Cape Metro confirmed this pattern, noting that CHWs used mobile phone technology and WhatsApp to communicate with facility-based staff, though insufficient airtime and mobile data remained persistent challenges.

What was notably absent from the best digital health work in Cape Town was the top-down, system-driven approach that often characterises National Health Service (NHS) digital investment. The most impactful innovations had been designed with and for CHWs, often emerging from academic-practice partnerships or the non-profit organisation (NPO) sector, and then adopted by government rather than the reverse.

### 5.3 Case Study: C-SHARP and the CHAMP App

The Cape Town Systematic Healthcare Action Research Project is a collaboration between the Western Cape Department of Health and Wellness, all academic health institutions in Cape Town, and the City of Cape Town municipality. It is the Western Cape node of the South African Population Research Infrastructure Network (SAPRIN) — a national network of Health and Demographic Surveillance System sites that generate longitudinal, population-level data for research and policy (Collinson et al., 2022).

C-SHARP operates in two sites: Bishop Lavis, a more established community of approximately 70,000 people with predominantly formal housing, and Nomzamo, the rapidly growing settlement of approximately 60,000 people where I spent a day with CHW teams. In each site, approximately 180 CHWs are employed by local NPOs — The Caring Network in Bishop Lavis and Masincedane Community Service in Nomzamo — each responsible for three to four streets. CHWs work in teams of 15 to 18, supported by nurse team leaders and digital health officers.

The CHAMP app is the digital backbone of this work. Every household visit generates structured data on living conditions, household composition, individual medical history and screening outcomes, which flows into the PHDC. This means that for the first time, community-level data from CHW household visits is linked to facility-level clinical data in a single, person-level data environment. The implications are significant: a clinician at Nomzamo Community Day Centre can see what a CHW recorded during a home visit, and a CHW can receive alerts about patients who have missed clinic appointments or who have been identified as high-risk.

The C-SHARP model demonstrates what becomes possible when research infrastructure, government health services, NPO-delivered community outreach and digital tools are brought together within a coherent data architecture. It is not a pilot or a proof of concept; it is an operational system serving real communities. The UK’s National

Neighbourhood Health Implementation Programme (NNHIP) test sites should study it closely.

# 6. Findings: System Design and the NPO/Voluntary Sector

## 6.1 The NPO Delivery Model and the Western Cape Exception

The Western Cape's community health system is delivered predominantly through a non-profit organisation (NPO) model: the provincial Department of Health and Wellness contracts non-profit organisations to recruit, train, manage and supervise community health workers (CHWs). This approach has deep roots in Cape Town's history; before the formalisation of the national CHW programme in 2011, the NPO sector had been delivering community health services for decades.

What makes the Western Cape distinctive — and politically contentious — is that it is the province that continues to contract NPOs to deliver CHW services rather than employing these workers directly. The national policy direction has favoured greater integration of CHWs into the public health workforce, although implementation differs across provinces (Western Cape Provincial Parliament, 2026). The Western Cape government has resisted this, arguing that the NPO model delivers specific advantages that would be lost through absorption: long-standing trust and relationships between NPOs and local communities; the perception among community members that NPO-employed CHWs are separate from government, which in some contexts makes them more approachable; organisational flexibility and local responsiveness that large government bureaucracies find difficult to replicate; and the institutional knowledge that established NPOs have built over decades of working in specific communities.

In Nomzamo, Masincedane Community Service has been operating for years, and the CHWs I accompanied were deeply known and trusted in their streets. At Touching Nations in Delft, the organisation had stepped in to take over CHW services after a previous NPO, Afrika Tikkun, withdrew from the area due to escalating gang violence — a vivid illustration both of the operational challenges facing community health in Cape Town's townships and of the resilience and adaptability of the NPO sector.

But there is a cost to this model, and the national government's frustration is understandable. NPO-employed CHWs remain on stipend-based contracts with no formal employment protections, no pension, and no structured career pathway. The Western Cape's resistance to absorption is in part a fiscal calculation: absorbing CHWs as government employees would carry significant cost implications that the province does not want to bear. The human consequences of this structural choice — precarious employment for a workforce that is overwhelmingly female, low-paid, and performing essential public health work — are real and visible.

A similar tension emerged in Boston. In Massachusetts, CHWs may be employed by hospitals, public services or locally rooted community organisations, with different funding and accountability arrangements. Larger organisations may provide more stable pay, employment benefits and access to clinical systems, while smaller organisations can offer local flexibility and established community relationships but may rely on short-term grants. Neither approach guarantees trust, which depends primarily on the CHW's relationship with the community. The relevant lesson for the UK is to combine formal workforce support with the local knowledge and responsiveness of community partners.

## 6.2 Governance, Accountability and Co-Production

The Goliath et al. (2025) programme evaluation of community-oriented primary care (COPC) implementation in the Cape Metro Health District documented both the achievements and the governance challenges of the NPO model. The study found that while COPC sites throughout the district had been delineated on maps and linked to NPOs, the aim of building fully integrated facility-and-community-based teams was only partly achieved. There was a persistent sense that NPO-appointed staff were responsible for community services while facility-based staff managed patients inside the clinic, with the two operating in parallel rather than as one team.

The governance relationship between NPOs and the Western Cape government was governed by contract and financial regulation. NPOs viewed themselves as partners; government tended to view them as contracted service providers. This distinction matters, because it shapes whether the relationship is collaborative or transactional — and the evidence suggests it was often the latter.

Community and stakeholder engagement were identified as the most challenging issues across all sites. There was no clear guidance on how to move from merely informing communities to enabling active participation. Training of CHW teams was ad hoc and eclectic, with no standardised approach. Strong leadership at facility and NPO level was identified as the single most important enabler of change, but was unevenly distributed.

These findings resonate directly with the challenges the UK will face in implementing neighbourhood health across National Health Service (NHS) trusts, local authorities, primary care networks and voluntary, community and social enterprise (VCSE) organisations with different governance structures, funding streams and accountability lines. The Cape Town experience suggests that co-production and shared planning between statutory and voluntary sector partners are not optional extras; they are the mechanism through which fragmentation is managed.

Political and funding decisions also shape community health provision in Massachusetts. CHW programmes may receive support from government, healthcare organisations, insurers and grants, leaving them exposed to changes in policy and funding priorities. In March 2025, the Massachusetts government reported the termination of federal public-health grants affecting public-health workers and community health centres (Healey-Driscoll Administration, 2025). While this does not establish whether the programmes discussed during my visit were directly affected, it illustrates the risks of reliance on short-term funding. As in Cape Town, consistent investment is needed to sustain community-based care.

### 6.3 Relevance to the UK VCSE Sector

The parallels between Cape Town’s NPO ecosystem and the UK’s VCSE sector are striking. Both serve as trusted intermediaries between communities and statutory services. Both are vulnerable to short-term funding, disproportionate reporting requirements, under-investment in infrastructure, and a tendency of commissioners to treat them as cheap delivery vehicles rather than genuine partners.

The 10 Year Health Plan acknowledges the VCSE sector’s importance. However, many VCSE organisations continue to face funding pressures and short-term commissioning

cycles. Cape Town's NPO model suggests the VCSE sector can play a central role — but only with the right conditions: multi-year funding, minimum workforce standards, and genuine co-production in programme design.

One model that particularly struck me was the Students' Health and Welfare Centres Organisation (SHAWCO) — a student-run NPO based at the University of Cape Town that has been delivering free preventive healthcare in underserved communities across the Cape Flats since 1943. SHAWCO mobilises over 3,000 student volunteers annually across health and education programmes, running free primary care clinics, maternal and child health services and health promotion in township communities, supported by a small core of paid staff and volunteer doctors. It is the largest student-led NPO in Africa.

What interested me most was the structural model: a university anchoring a largely voluntary community health effort, with students gaining experiential learning while communities gain access to preventive services. There may be opportunities to develop similar partnerships more widely in the UK. Universities with medical, nursing and public health faculties are embedded in communities across England, often in areas with significant health need. A SHAWCO-style model — students delivering supervised preventive health outreach in neighbourhoods surrounding their university, working alongside NHS neighbourhood teams and VCSE organisations — could provide a meaningful, low-cost additional resource for the neighbourhood health programme while building a pipeline of health professionals with genuine community health experience. This is an idea worth piloting.

# 7. Conclusion and Recommendations

The National Health Service (NHS) is at an inflection point. The Darzi review has named the structural failures of a hospital-centric system; the 10 Year Health Plan has set the direction; and the National Neighbourhood Health Implementation Programme (NNHIP) has begun testing what a different model of care can look like. The question now is how to make this happen.

Cape Town’s community healthcare ecosystem does not offer a blueprint that can be transplanted wholesale into the NHS. South Africa’s context is profoundly different. But it offers something more valuable: decades of hard-won experience in building community health systems that actually work, including a clear-eyed understanding of what goes wrong when they do not.

The Boston visit suggested that these challenges are not confined to middle-income countries. Massachusetts has leading healthcare and research institutions, but questions about community health worker (CHW) employment, funding and the value placed on prevention remain relevant. Cape Town remains the main source of evidence and practical examples in this report, while the discussions in Boston provide a further perspective on their relevance to the UK's neighbourhood health programme.

### Recommendation 1: Establish a nationally defined Community Health Worker role

A nationally recognised CHW role must be created, with a clear generalist scope of practice covering health promotion, screening, care navigation, social prescribing and chronic disease support. Recruitment should explicitly prioritise lived community experience. Employment should be through robust formal contracts with parity of pay and conditions. Training and accreditation pathways should be developed through national Department of Health and Social Care (DHSC) programmes, building on existing frameworks for nursing associates and social prescribing link workers.

### Recommendation 2: Invest in community-level data infrastructure

Building on the Western Cape Provincial Health Data Centre (PHDC) model, the DHSC should fund the development of community-facing data tools that enable CHWs to receive risk-stratified, household-level information to guide their outreach. The Federated Data Platform and shared care records will not fulfil their potential unless the data reaches community workers in an actionable form. This should be a priority investment in the NNHIP test sites.

### Recommendation 3: Develop a mobile-first digital strategy for neighbourhood health

The neighbourhood health programme needs a dedicated digital strategy that prioritises CHWs and community-dwelling patients in areas of highest health need. This means commissioning mobile-first tools designed for CHW workflow, providing devices and connectivity support, and learning from Cape Town’s pragmatic, bottom-up approach — including tools like the Community Health Action Mobile Platform (CHAMP) that integrate data collection into existing CHW work rather than adding to it.

### Recommendation 4: Align neighbourhood health outcomes and financial incentives

Current NHS performance frameworks are almost entirely hospital-centric. A new outcomes framework should measure community-level health outcomes, health equity indicators, patient experience of community care, and CHW programme quality metrics including supervision quality, workforce retention and continuity. This framework should be co-designed with communities.

A level of alignment between budgets and accountability across both hospitals and community services is critical so that organisations investing in prevention can share in the benefits realised elsewhere in the system.

### Recommendation 5: Build the VCSE sector as a long-term neighbourhood health delivery partner

The DHSC should develop a voluntary, community and social enterprise (VCSE) commissioning framework for neighbourhood health that provides multi-year funding security; specifies minimum employment and training standards for community workers; and requires genuine co-production with communities in programme design and evaluation. Contracts with community organisations should provide adequate support for fair pay, supervision and continuity, rather than shifting financial insecurity onto the CHW workforce.

## 8. What Next

The findings from this Fellowship will be shared directly with teams designing and implementing community health worker (CHW) programmes in England, including through the National Neighbourhood Health Implementation Programme (NNHIP) and relevant integrated care boards. The connections established during the Fellowship — particularly with the Cape Town Systematic Healthcare Action Research Project (C-SHARP) team at the University of Cape Town (UCT) and with the Western Cape Department of Health — offer a basis for ongoing knowledge exchange that should be maintained and developed. There is also scope to work with colleagues in the health technology sector to explore how the digital approaches documented here, particularly the mobile-first, CHW-centred design principles exemplified by the Community Health Action Mobile Platform (CHAMP), can inform the development of digital tools for neighbourhood health in the UK.

I look forward to maintaining these connections and contributing to the emerging learning community around neighbourhood health implementation — both in the UK and internationally.

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