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A REVIEW OF A COMMUNITY HEALTH CARE WORKERS' PROGRAMME IN SOUTH AFRICA

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ABSTRACT

This study explored a Community Health Workers' (CHW's) programme from the point of view the CHWs, as well as the non-governmental organizations (NGOs) that managed them, by using a mixed-methods approach. A questionnaire was used to collect data from the CHWs, and semi-structured interviews were conducted with key informants and NGO representatives. It became evident that the CHW's programmes are not contributing effectively to strengthening the health care system, and are merely playing the role of an 'emergency response' for patients suffering from HIV. The CHWs' roles have never been formalised and CHWs are viewed as "volunteers" within the healthcare system, and therefore not given the necessary support. There is also a clear disconnect between the local health facilities and the CHWs' programmes. Delays in receipt of payments from the Department of Health (DoH) hamper the NGOs' ability to run viable organisations, which impacts on their ability to deliver desperately needed health related services. The multiplier effect of the aforementioned results, in further delays in the disbursement of stipends to the CHWs, which creates hardships for some of South Africa's lowest paid workers who, are already shouldering financial and social burdens, which probably compromises the quality of critical services to those most in need. The overall impression is that as SA approaches the end of the second decade of democracy, it is a matter of urgency that primary health care (PHC) is viewed more seriously by the government and, more specifically the DoH.

Keywords: Health care, Primary health care, Community-based health care, Developing country.

Contribution/ Originality

This study documents by way of a case study, the perceptions of Community Health Care workers and NGOs, on their role and importance in fortifying the health-care system in general and primary health-care specifically.

1. INTRODUCTION

The sub-Saharan region of Africa continues to be affected by the HIV and AIDS epidemic more than any other region in the world, with more than two-thirds of all HIV-positive people living in this region [1]. South Africa has the largest number of people in the world living with

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HIV and AIDS, with an estimated 5.2 million people living with the disease and an HIV prevalence of 10.9% for people aged two years and older [2]. This, in turn, places a particularly heavy burden on service providers to curb the epidemic through effective health care and social development services.

The epidemic is overwhelming the facility-based services and, thus, community and home - based care (C-HBC) has emerged as a way in which to provide cost-effective and compassionate care to people living with HIV, and also to those affected by the epidemic [3]. Despite the fact that C-HBC is not a replacement for hospital care it does, however, constitute an essential element of "a comprehensive continuum of prevention, care, treatment, and support services that include the family, the community, and various levels of health care providers" [3]. Thus, people who are infected and affected by HIV and AIDS are not only provided with medical care, but also with social and psychosocial support at their homes by both formal and informal health care and social development workers.

Community home based care (C-HBC) was defined as "care given to individuals in their own natural environment by their families and supported by skilled social welfare officers and communities to meet spiritual, material and psychosocial needs" [4]. "Home –based care is defined as the provision of comprehensive services, which include health and social services, by formal and informal Community Care Caregivers (CCGs) in the home in order to promote, restores and maintains a person's maximal level of comfort, function and health including care towards a dignified death."

C-HBC improves the provision of a range of care to persons who have become vulnerable to HIV and AIDS, the frail and elderly, orphans and vulnerable children (OVC), people with disabilities, as well as patients with terminal diseases, chronic illnesses or other debilitating conditions. It ensures that those eligible for home and community-based care or support services receive access to the integrated services which also address their basic needs for food, shelter, education, health care, family or alternative care and protection from abuse and malnutrition.

The primary health care (PHC) approach was adopted in South Africa approximately two decades ago as an ideal vehicle for the delivery of equitable and quality health care to the country's population. Nevertheless, the country continues to perform poorly in terms of health outcome indicators [5, 6]. The factors contributing to these poor health outcomes include the fourfold burden of disease (BoD), HIV and TB, non-communicable diseases, high maternal and child mortality, and violence and injuries; the inadequate human resources to cope with the health crisis; the emphasis on curative health care instead of primitive and preventative health care, the dependence of the majority of the population on the public health care system as well as the poor funding of the public health sector [5]. In addition, there has been an emphasis on the utilisation of facility-based service delivery data through the District Health Information System, for tracking health indicators instead of the population-based data which, is more capable of providing a true reflection of the health status of the South African population. There has been a recent shift towards the re-engineering of PHC in South Africa through the provision of community-based PHC services by community health workers (CHWs) [7]. This initiative not

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only represents a step towards improving health outcomes but also towards achieving the Millennium Development Goals (MDGs) by 2015.

In order to formulate a strategy for the re-engineering of PHC in South Africa, the Minister of Health established a task team consisting of individuals from both the public and the private sectors [7]. The task team made certain recommendations, one of which was the establishment of PHC outreach teams to provide comprehensive PHC services to a defined number of families. Each PHC outreach team comprises one professional nurse and six CHWs. The minimum entry requirements for CHWs to qualify for inclusion in the PHC outreach team include the completion of some degree of training (unaccredited C-HBC 59 or 69 days, or accredited National Qualification Framework (NQF) Level 1–4); and at least one year experience as a CHW [8].

It was envisaged that the establishment of the PHC outreach teams would facilitate community involvement and participation in identifying health threats as well as vulnerable groups and individuals as well as enabling appropriate interventions to be launched to address these issues [7]. In addition, it was hoped that the establishment of the outreach teams would facilitate the collection of the population-based health data which could lead to better health outcomes. While professional nurses are expected to spend approximately 10 to 20% of their time in the community, the CHWs are expected to spend at least 80 to 90% of their time in the community. In order for the CHWs to develop a comprehensive understanding of their catchment population, they are required to compile both a map and profile of their community [7]. In view of the fact that the PHC outreach team initiative is heavily dependent on the utilisation of CHWs for community-based health services, it was deemed imperative to conduct a profile of the CHWS in all the provinces of South Africa in order to provide the Department of Health and other stakeholders with empirical information on this segment of the health workforce.

As South Africa undergoes the transition to a new PHC model, many questions are being raised about the current situation of CHWs. For disadvantaged communities, CHWs should represent the front line of the health care system – promoting health, facilitating access to services and performing home-based care tasks. In the absence of a definitive policy framework and with only fragmented support from the Department of Health (DoH), both community-based and non-governmental organisations are struggling to manage CHW programmes effectively. Without full integration into and recognition by the formal health system, CHWs contribute little to health system-strengthening.

In light of the above, the aim of this study was to better understand the current role of the CHW programme in the Merafong City Local Municipality (MCLM) from the point of view of both the CHWs themselves and the organisations that manage the CHWs (the NGOs), as well as understand the challenges confronting the programme. It is envisaged that the findings of this study will highlight areas of improvement for the CHW programmes as well as to help scale up and better define the current and future roles. The study will also assist the Merafong City Local Municipality (MCLM) in promoting the professionalism of community health care work and, assist in designing a relevant, accredited training curriculum for CHCW training.

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2. METHODOLOGY

A mixed-methods approach was used, whereby a questionnaire was developed in order to collect data from 133 CHWs, and a semi-structured focus group interview guide was used to obtain data from key informants as well as NGO representatives of CHW programmes in MCLM. The key informants were purposively sampled from among directors/founders who were known to have long experience and good insights into CHW programmes in MCLM. A total of 60 CHWs participated in six focus groups, each comprising 8-10 participants. The strategy proposed by [9] was followed in order to recruit the respondents for the focus groups, namely, the respondents were contacted one month prior to the data collection before the research, and two weeks before the group session the researcher contacted the participants to remind them about the research. One week before the session, they received a letter of confirmation indicating the venue, start time and also what would be expected of them.

The study also used convenience sampling whereby subjects were selected because of their accessibility and proximity to the primary researcher. The selection of the NGOs was based on their availability as well as their willingness to participate, because it was difficult to identify all members of the population [10]. The verbal consent of the NGO managers was sought before they were interviewed. The interviews were recorded and notes were also taken during the interviews.

3. DATA ANALYSIS AND INTERPRETATION

The quantitative data was captured on an Excel spreadsheet and imported into the STATA-8 software package which was used to conduct a descriptive analysis. The statistical report from STATA was exported to MS Excel in order to create charts and tables for easier presentation and interpretation of the results. The qualitative data analysis was conducted manually using the thematic content analysis approach which is a deductive coding technique in the sense that the researcher starts by defining the set of themes to be used in the process or identifying emergent themes [11]. The qualitative data collected from NGO managers and focus groups was captured using recorders and thereafter transcribed into MS word. The next step involved the sorting of data according to the pre-conceived themes, that is, participants' responses were grouped or categorised together based on the questions that were asked during the interviews. Once the data analysis process had been finalised, the researchers embarked on the data immersion process that is, reading and rereading the transcripts while colour coding similar responses and patterns. Similar responses were aligned to the themes that had been identified initially. New themes/categories were created for the responses which did not fit in any of the categories identified, especially where the responses denoted links and relationships between the various categories of data. The final step involved synthesising the results for publication purposes, and preparation of a report using direct quotes from the participants to support the interpretation of the results.

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3.1. Ethical Considerations

This study was classified as one of the health services' rapid appraisals/assessments which required immediate answers to inform the PHC reengineering process in the MCLM. Accordingly, ethical clearance from an ethics committee was not necessary. Nevertheless, all the ethical principles which are applicable when human subjects are involved, inter-alia, informed consent, confidentiality, etc. were adhered to. After the interviews had been conducted the participants underwent a debriefing (counselling) session, with optional, follow-up, counselling sessions on request. The focus group participants as well as the key informant interview participants were also given the opportunity to review their transcripts and also any prospective publications to enable them either to remove data with which they were not comfortable or to withdraw completely from the study.

4. FINDINGS

There were three dominant themes, namely, "professional status", "duties by default" and "supporting community health work".

4.1. Professional Status

With regard to professional status, the remarks, observations and explanations under this theme refer to the position of the CHWs within their families, communities, the broader health-care system, and the country as a whole. This includes issues of remuneration, career paths, aspirations and relations with other health professionals. From figure 1, it is clear that only 32% of the CHWs preferred a career in the health sector, which implied that they would have chosen other career opportunities if these were available.

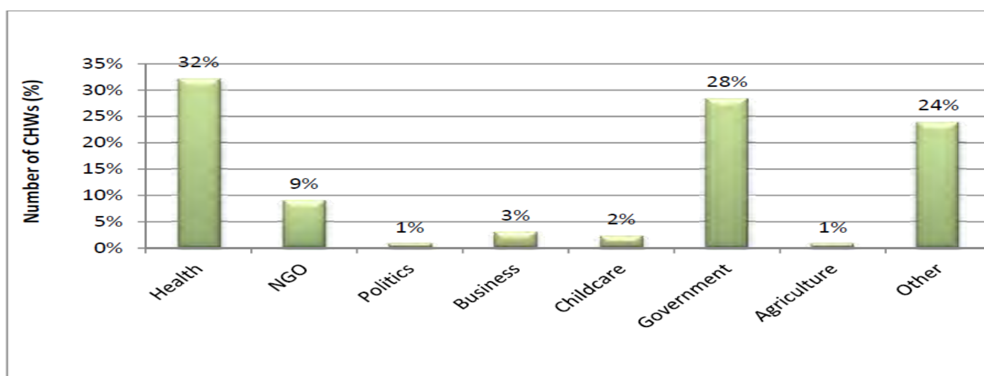

Figure-1. Preferred career path of the CHWs

Furthermore, despite their commitment to health care work, none of the respondents intended to remain as a CHW for the rest of their working lives, not merely because of the poor remuneration, but because they are indisputably on the lowest rung of the 'professional ladder' even though they were not part of the health system. However, all the respondents had

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aspirations of furthering their training, with most of them indicating that they wanted to become professional nurses or social workers.

The majority (75%) of CHWs indicated that they have permanent employment contracts with their employers, and an overwhelming (96%) majority of NGOs confirmed this. This perception that CHWs are individuals who "took on patients, who had, in some way been rejected by the health system," was concerning, since it implied that CHWs and their patients were insignificant. It also suggested that those in greatest need of public health services may be 'excluded' from the formal health service system, and that some CHWs may be taking on a workload comprising primarily palliative care for which they were unqualified, underequipped and unsupported.

It was evident that the overwhelming majority of the CHWs were female (89%), which may indicate gendered expectations as regards the caring role of women, and that women may somehow, possess an innate ability or inclination to care for people.

In spite of their low 'status' the CHWs experience pressure from both the NGOs and patients, to present themselves professionally. However, it appeared that the greatest pressure, and, perhaps the most disproportionate in respect of their training and the resources at their disposal, came from the responsibility they felt towards their patients. Most of the CHWs used their low stipends to pay for transport and communication costs, to support their own families, and sometimes even their patients' and their families. The following extract explains the reality of the situation:

"My patient, when I go there, I say "Why do you not drink these tablets?" […] He shows me his tablets. I say "Why do you not drink this one, it's a multivitamin?" He says, "You know what I am afraid to drink this one because I will be hungry and then I do not have food, you see" […] I started to bring him some food and said, "You must drink these tablets, because they are going to help you on your body, so eat this and drink this." He was right because, you know, they make a person hungry, because if he is hungry there is no food and that person is not getting a pension, they are depending on one person and they are many in the house."

The issue of remuneration was also dire when the stipends were not paid on time, and this seemed to happen frequently.

By definition, the job of CHWs is to care, to show compassion to their fellow community members and with whom they have established relationships over time. This in turn, often compels the CHWs to make impossible choices on how to use their meagre stipends. The difficult question faced is 'whether they should use the funds to support their patients or to face the possibility that a patient may die?" Thus, to be a CHW means to fill a major gap left by both the health and social services, and at the same time to be reminded that they do not belong to a "real" profession which is worthy of a reasonable salary. In other words, a CHW is expected to develop compassionate, sustained relationships with patients and the community, while also being aware that the situation is transitional. One of the most disturbing findings was the suggestion by the CHW participants that they sometimes have patients who are too ill to be admitted at a hospital, thus hinting at an unofficial triage system which is based, not on the prognosis of the patients and the available resources, but on the willingness of hospitals to take on terminally ill patients. A

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better understanding of the criteria for the referral of patients from health-care facilities to CHWs and home-based care would have been useful, as would information on determining who is entitled to receive "real care" and who is relegated to second-rate, palliative care from a "street nurse" at the patient's homes.

4.2. Duties by Default

Although the policy framework for community based care indicates that CHW's programmes should be collaboratively implemented by the Departments of Health and Social Development, the focus group participants indicated that their training had not covered the type of social welfare issues that they encountered in home-based care on a regular basis. In fact, in some cases, they had not been trained, equipped or given the resources needed in order to enable them to respond to the needs of the community. In fact the vast majority, less than 5% of the NGO managers reported that their CHWs had received some form of social services training.

The principle of responsiveness to community needs is extremely important. A 'cookie-cutter' approach (marked by sameness and a lack of originality; mass-production) to CHW training may be adequate for basic training. In theory, the strength of the NGOs and CBOs stems from the fact that they are rooted in their communities and they are therefore aware of the needs and problems of the communities, and accordingly, they should therefore be able to add value to the CHW programme with ongoing training. It is evident from figure 4 that ongoing training offered refers primarily to HIV and TB.

The overwhelming majority (91%) of the CHWs indicated that they have a job description and 96% of NGOs confirmed this. Although the CCWM policy framework is fairly explicit about the social development component of the service package, it emerged that only approximately 2% of the NGOs provided any ongoing, social services-related training. In view of the shortage of social and social auxiliary service workers, CHWs are likely find themselves thrust into the position of de facto social workers. This, in turn, increased their workloads and responsibilities, as they are forced to perform functions for which they may not be trained, but which they however cannot ignore, as they end up feeling personally responsible for the patients.

It emerged that there are no clear lines between "personal and professional" responsibilities despite the fact that both the NGO managers and the CHWs had acknowledged they (CHWs) had been given clear job descriptions. It is therefore apparent that CHWs were also taking personal responsibility for patient cases that had 'fallen through the cracks' of the health and welfare systems.

4.3. Support for Community Health Work

The stipend was a major issue, particularly in view of the fact that it was the sole source of income for nearly all the CHWs in this study. In addition, the delays which sometimes extended to between 3 to 6 months exacerbated the situation. What emerged is that the small amount of the stipend is of less concern to the CHWs if there were, as prescribed in the policy framework of community based care, definite career paths and real opportunities for them to pursue. People

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were willing to take on the poorly-paid and demanding CHW job partly because it promised to be a 'foot in the door' to formal employment.

While 29% of the CHW respondents indicated that increased pay would be a motivating factor, almost the same proportion responded that formal training was a motivator. Although many organisations offer ongoing training for CHWs, this did not usually result in further formal qualifications, career advancement or improved stipends.

Despite the fact that there are few formal incentives by way of career advancement for the CHWs, they are, nevertheless, highly motivated by the fact that they are helping, educating and empowering people. However, this comes at a cost, in that CHWs face emotional and physical hardships.

It is easy to forget that CHWs are just one stakeholder in community health work. Without the full support of their NGOs and CBOs (including backup, emotional support, timely remuneration and supervision), the DoH, and the community, CHWs are forced to assume responsibilities that overwhelm their personal capacity to cope.

The key informants were questioned about the apparent management problems regarding payment of stipends, the professional status of CHWs and the perception that the CHWs constituted a stop-gap response to the crisis in the health system, and what they would do to ensure that the CHWs became an integral, recognised and respected component of health care in South Africa. The themes from these discussions are broadly organised under the headings of "Funding and governance", "Human resources" and "Policy options".

4.4. Funding and Governance

Our key informants represented both organisations that operate without DoH funding as well as organisations that are dependent on such funding to run their CHWs programmes. All the key informants expressed strong views on the accountability of the DoH to the communities. One participant suggested that the DoH is less than transparent about how the funds were allocated to the CBO, which resulted in home based care services not being delivered to all the communities. The funding of CHW programme was identified by the NGOs as follows: 82% Government, 11% private sector, 7% international donors. It became apparent that those CBOs which lacked capacity to manage the CHW programmes will go out of business, while those with sounder management, better capacity and diverse funding sources should be able to weather the "dry spells". However, the situation is far more complicated than that of simple attrition. The national CHW programme depends on small CBOs to implement the programme precisely because these small CBOs are rooted in their communities and have low operational costs. However, few CBOs, even the most professionally managed, can be expected to endure a six month delay in receiving their funding. It was clearly almost impossible for CBOs, which were trying to remain transparent under the shadow of poor DoH management, to maintain proper accounting systems. In addition, the suggestion that nepotism may be involved in the awarding of funding to organisations without either capacity or service delivery track records, raises serious questions

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about the accountability of the state, not only to the taxpayers, but also to its most vulnerable citizens.

4.5. Human Resources

The key informants were asked what they considered would be the best ways in which to recruit and train CHWs, as well as keep them motivated to deliver quality service.

"[...] most of these that are here, they volunteered here and, so, as they come here we heard their stories of their commitment even without any stipend…there's an aspect of volunteering, which already shows the interest and exposure to this kind of work and also, in terms of their schooling, you look at all those dynamics. Do they have a passion for this kind of work? And that is informed out of what they've done before, before in terms of volunteering."

All the key informants seemed to agree that the 69 days of CHW training was a good starting point, but that ongoing training would enable them to respond to the particular needs of the community and to the changing policy priorities. This therefore implies a long-term investment, not only in training, but also in developing, over a period of time, an understanding of the services which are appropriate for the various communities.

"Ongoing training is actually where your real value lies…your initial training is good and [it] actually sets a foundation but you can't only rely on that...in our case we train our care workers once a month in the refresher courses to keep on really enforcing it. Sometimes it is just reinforcement of what they are [already] trained in but, sometimes, [there are] new topics that we realised that there's relevance, coming from the families that we work with …"

4.6. Policy Options

Based on their long experience in the field, the key informants were asked what they regarded as the most important considerations for future policies governing community-level care workers. Their concerns revolved around several important issues, namely, the type and quality of services being delivered by the CHWs, the status of the CHW programmes as a temporary solution to the crisis in the health system, and the overall challenge of the inadequate human resources for the health services, not only in South Africa, but on the African continent as a whole.

5. CONCLUSIONS

It was exceedingly difficult, using the limited data from the study, to disentangle the competence of the NGOs and the CBOs to manage CHWs, considering the challenges they faced from the DoH. The reality is that the CHW programme runs on subsidies, which subsidies are in turn, made available because of the serious limitations in the formal health system. Very few of the NGOs/CBOs would have the capacity to run the CHW programmes without the subsidies.

The policy framework for community based care prescribes that CHWs should be temporary appointees and their positions transitional. However, this is a contradiction in a situation in which the retention of health workers is so critical. CHWs are encouraged to form close relationships

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with their communities and yet they are discouraged from remaining in these communities for too long. On the other hand, in the absence of other employment opportunities, CHWs are inclined to remain in their positions for long periods and as a result, they become dependent on the stipend as a sole source of income.

Although CBOs and NGOs are important sources of employment for some individuals, families and communities, they are governed by labour regulations as formal employers and community health work is in fact, part of the expanded public works programme (EPWP). However, it would appear that CBO/NGO employment is not perceived to be officially recognised as a solution to either the human resource crisis or the unemployment crisis in the country.

In common with the CHW focus group participants, the key informants drew attention to the intersection of social and health problems in the communities which could be addressed only by CHWs with the right kind of training, support and supervision.

It became apparent throughout the study that there were very different understandings of the notion of supervision. For some of the CBOs, supervision simply entailed counting the number of home visits made by the CHWs to ensure that they were keeping up with their case loads, thus a means of managing the quantity rather than the service quality. However, one key informant stressed the importance of supervision from an ethical point of view.

There was great concern about the status of both CHWs and the CHW programmes, and the contradiction in having a cadre of workers that was not respected, was badly underpaid and, practically speaking, involved in a 'dead-end' career, despite the desperate need in the communities for the services they were supposed to deliver.

The managers were convinced that the CHW programmes were necessary, and that they were volunteer programmes; however the fact that they were temporary was hindering both their development and sustainability.

The lack of recognition of CHW programmes as a source of formal employment with a reasonable wage was seen to be at odds with the otherwise widely acknowledged human resource crisis in health. Again, the subject of missed opportunities came up.

6. RECOMMENDATIONS

In light of the exploratory findings, it is recommended that the DoH seriously reviews its health-care implementation policy and systems, more specifically addressing the issues surrounding primary health care, and according due importance to CHW by perhaps 'professionalizing' the CHWs position in the health-care service delivery system.

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