


Community Based Health Workers

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This chapter examines the use of various categories of Community Based Health Workers as first line health workers in dealing with important health and social issues, for example with Tuberculosis and HIV/AIDS. It attempts to answer certain key issues: Are Community Based Health Workers valuable and cost effective? What should be their role? To whom should they be accountable? In what way should they be selected, trained, supervised and remunerated, if at all? What methods should be used for monitoring and evaluating Community Based Health Workers?

The chapter is based on a brief review of published literature followed by a short survey that was circulated via electronic discussion groups and e-mailed to key informants around the country. This was supplemented by direct discussion with participants in a few programmes.²

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Definitions and Roles

The umbrella term ‘Community Based Health Worker’ (CBHW) embraces a variety of health auxiliaries who are selected, trained and work in the communities in which they live. The term is used in this chapter to be as inclusive as possible of all the different types of community based health workers. They include the most generic type of workers such as community/village health workers (CHWs/VHWs), *Onompilo*,^b community resource persons (CORPs) as well as a range of more specialised cadres such as community rehabilitation facilitators (CRFs), community based directly observed therapy short-course (DOTS) supporters, HIV/AIDS communicators (HACS), home based care (HBC) workers, first aid workers, lay health workers etc. All these types of CBHWs carry out one or more functions related to health care delivery and welfare, are trained in some way in the context of the intervention, but usually have no formal professional or para-professional certificated or tertiary education. Not included for example, are formally trained nurse aides, medical assistants, physician assistants, paramedical workers in emergency and fire services and others who are self-defined health professionals or health para-professionals. CHBWs may receive training that is recognised by the health services and national certification authority, but this training does not form part of a tertiary education certificate or degree.



Although the role of traditional, faith and complementary healers is important, particularly in view of the fact that new legislation is being anticipated for Traditional Healers, the scope of the chapter was already so wide, a separate chapter would be necessary to deal with the topic.



In general terms, the role of CHBWs is to act as agents for health promotion, care and health development. They also provide local outreach for health services that might otherwise be unavailable.

Brief Historical Review

For more than twenty years, since the World Health Organization (WHO) declaration of Alma Ata in 1978 established the Primary Health Care (PHC) paradigm, CBHWs in one form or other have worked in different parts of the country, undertaking varied roles. Non-governmental organisations (NGOs) in particular were early to recognise their value in extending PHC services. Some CBHWs are paid and have been able to make their work a career, but many more are unpaid and have worked as volunteers, driven by their willingness to provide community service. Whether it is fair to encourage voluntarism of this sort in poor communities, where it is important that people earn income to support their families, has been a terrain of contestation for some time.



^b Onompilo is the Zulu word for Community Health Worker.



CBHWs have had a chequered past in South Africa. In apartheid times, it was mainly NGOs and some ‘homeland’ governments who undertook the programmes although their position began to change when they gained tentative recognition by the Department of Health in the early 1990’s. As a cadre, however, there was little practical attempt at developing common standards until various professionals, the present Minister of Health Dr Manto Tshabalala-Msimang among them, from about 1992 to 1994 held national workshops to bring Community Health Workers’ (CHWs’) programmes around the country together to advocate for the application of more formal support.



In early drafts of the ANC health plan, CBHWs were seen as an important resource for PHC because of their potential to play a significant role in expanding and improving health services, provided they received effective support and ongoing training. They were viewed as catalysts for community development, who could mobilise people around issues such as the need for clean water, sanitation, waste disposal, safe playgrounds and parks. Further, they could empower people with health knowledge and encourage their participation in health issues such as nutrition, family planning and HIV/AIDS. It was envisaged that they would form an integral part of the decentralised health services, and be compensated, either by the Government, or the local community, according to their level of skills. This implied that they were to have career structure and pathways for promotion within the health system.



After the democratic transition in 1994, the hope that this idea would be implemented was initially in limbo. The official policy watered down their role by stating that although CBHWs’ programmes would be encouraged where they were integrated into local services, there would be no national programme.



In 1995, a national task force funded by the Health Systems Trust produced a report “*Assessing the Feasibility of Greater State Support to Community Based Health Programmes*” (CBHP)¹ which recommended that a phased CBHP model be considered for implementation by the national government. In the first phase, it recommended that financial, political, structural and other support be given by the government to existing programmes in order to strengthen them. In the second phase it was suggested there should be an evaluation to measure the effectiveness prior to a decision whether to expand or not. It was proposed that there be a national ‘Core Curriculum’ which should be monitored by an ‘Accreditation Committee’. The training of CBHWs, should be carried out at local training centres, with provincial training centres providing training for CBHWs supervisors known as Community Health Facilitators (CHFs). Additional recommendations were that health personnel in general be re-orientated, specifically to understand PHC and the role and functions of CBHWs; further that it was essential that mechanisms to support them be built into the district based health system



with strong linkages to District Management Committees, who it was felt should pay CBHWs and to whom they should be accountable.

Perhaps as a result of this and other strong lobbying, the generally unsupportive national policy position changed slightly in 1996, when the national Department of Health (NDoH) delegated the decision on the deployment of CBHWs to provincial and district levels. Although the official national policy regarding remunerated employment of CBHWs at the current time has not changed significantly from this position and no further national policy directives have been provided, some provincial programmes are gradually developing. For example, in KwaZulu-Natal, there has been strong commitment to establish a network of provincial support for CHWs throughout under-served areas of the province. However, even here the support has been patchy and inconsistent. Two other provinces provide or have provided funding support to CBHWs' programmes (notably Eastern and Western Cape). In the remaining provinces of Limpopo, Mpumalanga, North West Province, Gauteng, Northern Cape and Free State CBHWs are encouraged, and certain cadres receive incentives, but few are fully remunerated.



Despite advocacy and some progress, uncertainty about precise roles for CBHWs remains both at a national and provincial level. The situation has not greatly changed in two decades and the same issues that confronted CBHWs in the early 1980s remain as pertinent as ever, even with a national Health Minister who has advocated for them in the past. In addition to many of their original problems, there are now even more complex new issues as a result of the HIV/AIDS pandemic


There is, however, room for some optimism in that many local municipalities, who have only recently begun to fully function effectively, have enthusiastically begun to take on their PHC responsibilities and see CBHWs as an important element in improving health care. Also positive is that from 1999, the South African Qualifications Authority (SAQA) 'Auxiliary Health Worker' standards were agreed to nationally and provide the framework for the training of all workers in this category.



The Accomplishments of CBHWs


From reports and evaluations of the numerous examples of CBHWs' programmes in different parts of the country, it is clear that many have achieved some astonishing feats over the past decade. Although there is enormous variety in the types of CBHWs and the way they function, few communities are entirely without them. They are found in rural, urban, peri-urban and farm settings, among some of the country's most under-served communities. They have played an active role in reducing child morbidity and mortality by promoting nutrition, growth monitoring, breastfeeding,





immunisation, contraception and oral rehydration. Many groups have become involved in working with disabled children and on intersectoral social issues such as poverty relief, food security, water and sanitation, income generation, literacy education, obtaining child maintenance, care dependency grants and documents such as birth certificates. Among adults they have been important at times of epidemics such as cholera and assisted with some of the most difficult programmes aimed at controlling and improving compliance with diseases such as tuberculosis, hypertension, diabetes, epilepsy, STI as well as preventable cancers. Had it not been for the HIV/AIDS pandemic then, at this point in time, they would probably have played a most critical role in reducing child mortality, reducing fertility and improving life expectancy throughout the country. Regrettably, many of these gains are being reversed by the HIV/AIDS epidemic. But even given the challenge presented by HIV/AIDS, CBHWs continue to play a crucial role spanning health promotion, prevention, care, rehabilitation and palliation.

Are CBHWs Good Value for Money? Do They Improve the Health Status and/or Access to Health Care?



Advocates with experience in working with CBHWs value them because they:

- Are excellent health promoters who also play an important role in prevention, treatment, rehabilitation and palliation
- Enhance community participation
- Provide the District Health System (DHS) with a link to communities and a means of getting feedback. In a sense this allows DoH staff to feel the pulse of the people, helping them understand, for example, why people do or don't use certain services; what people know and why they are not accepting responsibility for certain issues.
- Unearth sensitive social problems such as child or woman abuse and reach people with physical disabilities who can otherwise only access the service with difficulty. Similarly, mental disease, which was previously felt to be a shame on the family – children once hidden or even chained, are now identified and referred for help.
- Bring all the stakeholders who need to collaborate into one forum. In this way a CBHWs' programme acts as a core integrative process around which all vertical programmes and diverse services can rally.
- Provide a mechanism for socio-economic development undertaken by a variety of other sectors.

Evidence for the value and cost effectiveness of CBHWs has been documented for a range of tasks. The following case study documents one concrete example.

The value of the KwaZulu-Natal CHW programme – a case study on cost effectiveness of DOTS undertaken by CHWs or Volunteer Lay Persons (VLPs)

Since 1991 all patients with tuberculosis in the Hlabisa health district, KwaZulu-Natal have been eligible for community-based directly observed therapy, short-course (DOTS). Tuberculosis incidence increased there from 312 cases in 1991 to 1 250 cases in 1996 because of the onset of the HIV/AIDS epidemic. Wilkinson, Floyd and Gilks (1997)² conducted an economic analysis of the DOTS strategy compared to the costs of three alternative strategies; the Hlabisa Strategy prior to 1991 based on hospitalisation, the National Strategy and Sanatorium Care, in terms of cost-effectiveness to both health service and patient. They found that the DOTS strategy implemented by CHWs in the community was the most cost-effective (R3 799) per patient and was less than half of hospitalisation cost at Hlabisa (R9 830), the National Strategy (R9 940) or Sanatorium Care (R11 145). Prolonged hospitalisation was much more expensive (R119 per day), compared to community care which was cheaper (community clinic visit, R28; community health worker visit, R7).

The largest component of the total cost was supervision of treatment. While much cheaper than hospital, supervising a patient in the community was R503, equivalent to 4.2 days in hospital, with the drug costs R157 being equivalent to just 1.3 days in hospital. The conclusion was that costs to both health service and patient could be substantially reduced by using community-based DOTS for tuberculosis, a strategy that was cheap and cost-effective in Hlabisa, a fairly typical rural community.

In a further study³ patients were supervised either by a health service provider (HSP) in a community clinic, or in the community by a community health worker (CHW) or a volunteer lay person (VLP). More patients supervised by VLPs (85%) and CHWs (88%) than by HSPs (79%, $P = 0.0008$) completed treatment. High tuberculosis treatment completion rates were achieved and sustained for several years in a resource-poor setting, despite a massively increased caseload.

These findings had important national implications, supporting the goals of the new tuberculosis control programme, and suggesting that community supervisors may be an essential and cost-effective component of any DOTS strategy. Patients may be more effectively supervised by voluntary lay people than by health service providers under these circumstances without being placed at increased risk. However there is no room for complacency. In a follow up study,⁴ it appears that the frequency of treatment interruption from this programme has increased recently. The strongest risk factor was year of diagnosis, perhaps reflecting the impact of an increased caseload on programme performance. Ensuring adherence to therapy in communities with a high level of migration remains a challenge even within community based DOTS programmes. Stigmatisation of patients with TB as having HIV may also have lead to early withdrawal from treatment.

Despite the potential, all is not well with CBHWs' programmes in most places. Part of the problem is that there is an unhelpful amount of programme variation. Often the variation is explained away as adaptation to local circumstance, but this is not entirely the case. Mostly it is because lip service is paid to the importance of community based programmes without a willingness to provide the type of support lent to hospital and clinic based services. CBHWs' programmes have most often been driven by the passion of those who want to make a difference in an environment of extremely limited and inconsistent resources. Frequently they are accepted only by the

formal health system as an afterthought; perhaps nice to have, but not essential. Sometimes CBHWs development is even seen as a digression from what are perceived to be more important facility-based strategies for improving health. Even if a programme exists, it may be inadequately supported, often leading to erroneous impressions that CBHWs' programmes fail to deliver valuable results. Most evaluations reveal that the failure is in the commitment and support and not in the potential value of the CBHWs' programmes themselves.

Current Challenges for Current CBHWs' Programmes

During the process of gathering material for this article, certain critical issues emerged repeatedly and provide a useful framework for analysis and suggest how improvements could be incorporated into future policy and programmes. Common challenges for CBHWs programmes are:

- **The fragmented roles of many different kinds of community based health workers** – different and often competitive CBHWs provide DOTS support, HIV/AIDS, sex education, nutrition, IMCI, first aid, home-based care etc. often without reference to each other or to 'generalist' CBHWs. They often lack the skills necessary to deal with even simple issues outside their range of narrow specialisation and this can lead to conflict. Many projects, in their urgency to implement vertical programmes, often introduce their own cadres of CBHWs only to find out later that this was not the best course of action.
- **The large variation in incentives and payments** for similar types of work. This has been responsible for confusion and conflict. Some 'volunteer' incentives are as low as R250 per month, whereas other paid CHWs get about R1 600 per month.
- **The excessive amount of days per week that unpaid workers or partially paid CBHWs are often expected to work.** This has blurred the boundaries of 'voluntarism' and sometimes over-extended the resources of very poor people.
- **The disconcerting range in the amount and quality of training** offered to different groups. This is not due to the justifiable need to adapt to local circumstance. Rather it is due to a lack of cooperative working. Curricula vary widely. Teaching materials that have already been produced are not being adequately disseminated, used and adapted. There is a continual re-invention of the wheel. The SAQA 'Auxiliary Health Worker' standards and approach to the training of CBHWs are not, as they should be, the starting point for all training programmes. Existing materials do not always seem to be consulted before new materials are developed.



- **The inconsistent support and supervision** given to different groups as is evident in many programmes
- **Monitoring of programmes is weak and evaluation results are sparse.** This continues to be a problem, although there is an increasing amount of information on programmes that have been evaluated. Regrettably many of these evaluations reach a limited audience.
- **Transport constraints are a major obstacle** even for those programmes where there are paid CBHWs. Many successful projects have required CHFs to have their own vehicles prior to being employed. Alternatively some are subsidised so that they can own their vehicles, and receive a transport allowance for their travel.
- **Inadequate linkages with the district health system** and a lack of involvement in intersectoral activity. Many districts do not understand the critical role of CBHWs' contribution to the success of their programmes.
- **Poor integration** with the work of community-based professionals, CBOs, NGOs, faith-based organisations (FBOs), funders, local and provincial government in different sectors. Functional District and Health Forums, which coordinate the activities of all stakeholders in the district, are absolutely essential and require strong Government support. Without such forums, even the excellent work of a few NGOs or the Government itself, flounders in the long term.
- **The potential for developing conflict between different groups** of CBHWs is great if vertical programmes do not agree on working together jointly at community level.

Should CBHWs be Paid?

Whether CHBWs ought to be volunteers, supported in kind by the community, or paid through community or government funds, has been much debated. Tanya Doherty and Sphindile Magwaza^c in an unpublished article on community involvement in health have carefully reviewed voluntarism in relation to CBHWs. They found that much of the literature tends to imply that volunteers are the ideal to which most CBHWs' schemes should aspire. Many proposing this idea have assumed that there is a sufficient pool of volunteers to provide basic health and social service in rural areas and informal settlements; some even going as far as to suggest voluntary service should be a moral obligation to the community.⁵

However, the reality is that most programmes pay their CBHWs either a salary or an honorarium. Almost no examples exist of sustained community financing of CBHWs. Even NGOs have to find ways of financially rewarding

c Personal communication based on an unpublished article.



their ‘volunteer’ CBHWs, with what are euphemistically called ‘incentives’. Moreover, where there are programmes in which CBHWs work on a completely voluntary basis, attrition rates are high and the few enthusiastic and reliable volunteers that remain become overloaded with tasks from other agencies and sectors. There is no reason to believe that the situation has changed over the last decade when a WHO draft document concluded that there was little evidence that the mobilisation of volunteers in CHW programmes was an effective policy.⁶



The tasks assigned to CBHWs are commonly time consuming and often difficult. Even when the workload is light and can be fulfilled on a part-time basis, the costs entailed by lost economic opportunities are significant. It is not surprising therefore that worldwide, most schemes which involve voluntarism are situated in predominantly industrialised countries or among upper/middle classes in developing countries, where people can afford to volunteer. Crucial prerequisites to this volunteering are time and money. A secure economic and social life makes voluntarism possible, even attractive, and may give volunteers satisfaction they do not get from paid work.




The reverse applies among volunteers from poorer settings where they are driven by the hope that it will lead to paid work or some other benefits.⁷ Where paid jobs do not materialise it can be frustrating to volunteers.^{8,9} As many of the volunteers in poor urban or rural settings are women, already heavily burdened with daily tasks, grappling with survival or subsistence issues, the cost of their participation is borne by their families.




Although extended voluntary work for the community at large may have debilitating costs for those who participate, there may nevertheless be considerable value in voluntarism. At a more immediate neighbourhood level, where reciprocity of assistance between neighbours or families at certain times may be very helpful and an investment in social capital.⁵ Rarely are communities beyond the neighbourhood level able to institutionalise this system to provide reciprocal benefits that would justify voluntarism. Therefore, payment becomes essential, particularly in urban areas where the cash economy ‘rules’, and subsistence without a salary is impossible.

Based on the burden that voluntarism tends to place on the poor, many view the intentional use of the strategy by health services as a form of exploitation. Why should poor people offer their services for free when other health personnel are paid? Why should community volunteers be expected to work under difficult conditions, without pay, while the professional health workers are not ready to do the same?

For the above reasons, it is clear that a programme is usually at a disadvantage in the long run if it relies heavily on volunteers without some kind of reciprocal benefit system. It will experience a high attrition rate which will contribute to decreased stability and increased training costs because of the need for continuous replacement. It becomes difficult to plan and manage the



programme. Such troubles caused the abandonment of a programme in Botswana.¹⁰



In South Africa, among the most successful programmes, CBHWs generally receive a monthly salary. They are employed by NGOs and work full-time. There are however, innumerable cases where CBHWs successfully carry out their tasks even though they are not paid. For example in their own households or those of their close friends and neighbours. Home carers, like first aid workers, generally work part time or only a few hours per week. Where their activities begin to extend beyond their immediate neighbourhood and it becomes necessary to reimburse them for transport costs, problems begin to emerge. Once these workers begin to offer their services more widely, exploitation both by the clients and organisations or the workers themselves increases. Once the home carer is known in the community, expectations rise and they are frequently called upon after hours to assist people. This leads to high attrition rates as the home carers work increasing hours with no pay. On the contrary, paid CBHWs generally stay in their jobs for many years as they are remunerated for their experience and level of responsibility. There are also increasing opportunities for CBHWs to undertake continuing education and to progress to positions as coordinators and project managers. Where this is successfully implemented this contributes to the stability of staff in these projects.


The important lesson that has repeatedly emerged from experiences of CBHWs' projects is that adequate and sustained remuneration is essential to maintain the interest of the CBHWs and to ensure the stability of programmes.



Remuneration Issues

The question of who pays CBHWs is an important one from the point of view of the CBHW's accountability to the community. Ideally, salaries should be paid by the community-based NGO and not directly by the formal health services. The district health authority could pay the NGO or community structure responsible for the CHWs, according to the contractual agreement. Donor funding should be supplementary and used for testing innovations prior to widespread adoption. The principal funder should be the state given that the CBHWs is one components of the district health system budget.

The feasibility of national or provincial salary structures, standardised according to level of training and years of service should also be considered.



There are various options for funding. The best option, given that government resources are restricted, is to promote public-private partnerships between the provincial Departments of Health and local private or overseas funding organisations who together can achieve more than what is possible from government sources alone.

Community Relationships and the Sustainability of CBHWs' Programmes

Ignoring important lessons such as the need to pay CBHWs and not create conflicting roles is illustrated by the following case study of emerging conflict between a group of CHWs and home based volunteers. This type of situation has arisen in many different communities and is likely to occur whenever the circumstances create these conditions.

The following case study is based on the observations of a social anthropologist attending a meeting where a volunteer group of home-based caregivers were explaining their activities to the local Department of Health and CHWs (*Onompilo*). Details which can identify the individuals involved or the situation have been changed to ensure confidentiality.

A case study of the conflict emerging between CHWs and home based volunteers

A group of CHWs (*onompilo*) who had long been providing a service to a rural community as paid workers requested a meeting with a group of newly formed Home Based Caregivers (HBC) from a Faith Based Organisation (FBO) who were operating successfully in a neighbouring township and beginning to extend their services to the rural area. The HBC workers agreed to give the *onompilo* a slot on their standing agenda.

The trainer and initiator of the HBCs, Ms K formerly a nurse in the same district, introduced the group. She outlined the history of the FBO and the principles of its home based care programme. She explained that when she initiated the home based care programme in the township, it was in recognition of a desperate need for home care by the terminally ill who were often discharged from hospital because nothing more could be done for them. This factor, coupled with the absence of the services of *onompilo* in the township (because of the existence of the clinic in the township) led her to start the home based programme. Ms K stressed the point that she had set up the home based care programme and confined it to the township because there were *onompilo* services in rural areas beyond the township. But the Church had a different idea, and wanted to widen the scope to the district. That is how the voluntary caregivers had begun to extend their services beyond the township boundaries.

Ms K emphasized that all the FBO caregivers were doing purely voluntary work for which they were not paid. They only received a stipend to cover their travel and subsistence expenses when they did home visits.

Ms T, one of the caregivers from the FBO then briefed the gathering on how food came to be integrated into the concept of home based care. She explained that at the beginning of the programme, the focus was merely on providing the sick with prayer, pastoral counselling, bandaging wounds and providing other forms of practical assistance. However, each time the caregivers did home visits, they would be constantly confronted with the stark realities of poverty and hunger, which they found difficult to ignore. As a consequence of this, a strong appeal was made to the church to include food parcels and over the counter medication into the care programme.

These briefings were followed by a round of questions from the *onompilo*.

A number of concerns were raised by the *onompilo* regarding the FBO caregivers. One of the concerns was that the caregivers encroach upon their designated areas of work; carrying food parcels and clothing to give to families that *onompilo* regularly visit. They felt that this created the situation where some the families then rejected the *onompilo* because they were not able to bring food supplies, clothing etc.



They added that while the *onompilo* had been selected by the community to serve them, their work was now being disturbed by 'strangers' (referring to the caregivers) who came and worked in their designated areas. They expressed fear that the activities of the FBO would threaten the survival of the *onompilo* programme which was set up with the same intentions and to achieve similar goals.

In response to this concern, Ms K apologised profusely on behalf of all the caregivers. She observed that it was a grave mistake that the caregivers and *onompilo* had failed to liaise from the beginning. She promised to ensure proper coordination of tasks, and appealed to the caregivers to seek out and collaborate with the *onompilo* responsible for the areas within which their patients resided. She also observed that even the delivery of food parcels should be done jointly by both *onompilo* and the caregivers.^d

An additional concern was also raised when the *onompilo* learned that the caregivers administered drugs, whereas *onompilo* were not allowed to do any more than monitor patients taking TB treatment. In fact, the coordinator of the *onompilo* programme in the area, who was also attending the meeting, observed that *onompilo* are strictly forbidden to administer drugs to the sick, even Panado which is available over the counter. In response to this, Ms K quickly explained that the caregivers ensured that their patients take only medication specified by a health practitioner. Like the CHWs, this also included monitoring their patients' TB drug regimen.

In the concluding discussion it was agreed that in future all service providers, including *onompilo* and home caregivers, would collaborate and present a united front to the communities.



Management of CBHWs' Programmes

Various studies^e have shown that the training of many health professionals such as doctors and nurses does not adequately prepare them for work in a community setting. In addition, the reported universal shortage of doctors, nurses, and other health personnel has been exacerbated recently by emigration of many professions from South Africa. As a result it has proved difficult to bring about transformation even within clinical settings where systems can be more easily managed within an environment that health professions understand. Community Based programmes which are poorly understood have therefore been almost entirely neglected.

Despite the difficulties, there is considerable agreement that CBHWs have a role to play in improving the health of communities and fill the gap in areas which existing health personnel cannot reach. In these areas CBHWs have a vital role and to do this, they need to be formally recognised as members of the district health team.



^d The Observer noted at this point: "I silently wondered how feasible this was going to be. Then I thought perhaps Ms K was just saying this to appease the *onompilo*. The fact that the bulk of the caregivers were not present at this meeting to give support to some of these assurances Ms K was making, also troubled me somewhat".

^e Personal communication – article by: Tanya Doherty (tanya@hst.org.za), Health Systems Trust, Durban and Minette Coetzee, Nell Hodgson, Woodruff School of Nursing at Emory University – The Community Health Worker: A Critical Determinant of Responsive District Health Services in South Africa.



The first crucial step requires the acknowledgement and recognition of CBHWs as an essential part of the district health team from the highest level in terms of both policy and committed funding, much as has been done in KwaZulu-Natal.

The Department(s) of Health in the national, provincial and municipal spheres of government should cooperate with each other and in partnership with NGOs to provide support for CBHWs programmes. This should include the provision of adequate supervision, training, resources, and physical space. Other departments such as Social Development and Education could assist and benefit by incorporating CBHWs into their own programmes.

Explicit national and provincial policies and supportive legislative measures are also necessary. These should formalise the position and role CHBWs, so that they can achieve their full potential.



Supervision Procedures and Structures of Accountability

A simple practical system would be for each district health authority which receives funds from the provincial department of health, to contract one or more NGOs to provide specific sets of health, welfare and development outputs to be undertaken by CBHWs working within a defined population. In this way district health authorities retain responsibility for the services, while recognising that these specific services are best delivered by NGOs using CBHWs supported by CBOs and FBOs. Examples of services that could be contracted include DOTS services, HIV pre- and post-test counselling, HBC, care of orphans and vulnerable children, health promotion, rehabilitation work and potentially even antiretroviral treatment supervision. Some of the tasks would be undertaken by full-time paid CBHWs, while other tasks might be undertaken by part-time workers or volunteers, receiving remuneration or acknowledgement appropriate to the amount of time they contribute.



An example of this is the KwaZulu-Natal model of delegating the management of the programme fully to a consortium of NGOs who receive a block grant from the province and in consultation with them, the district health management and local municipalities, decide which services to offer and help to capacitate local NGOs.



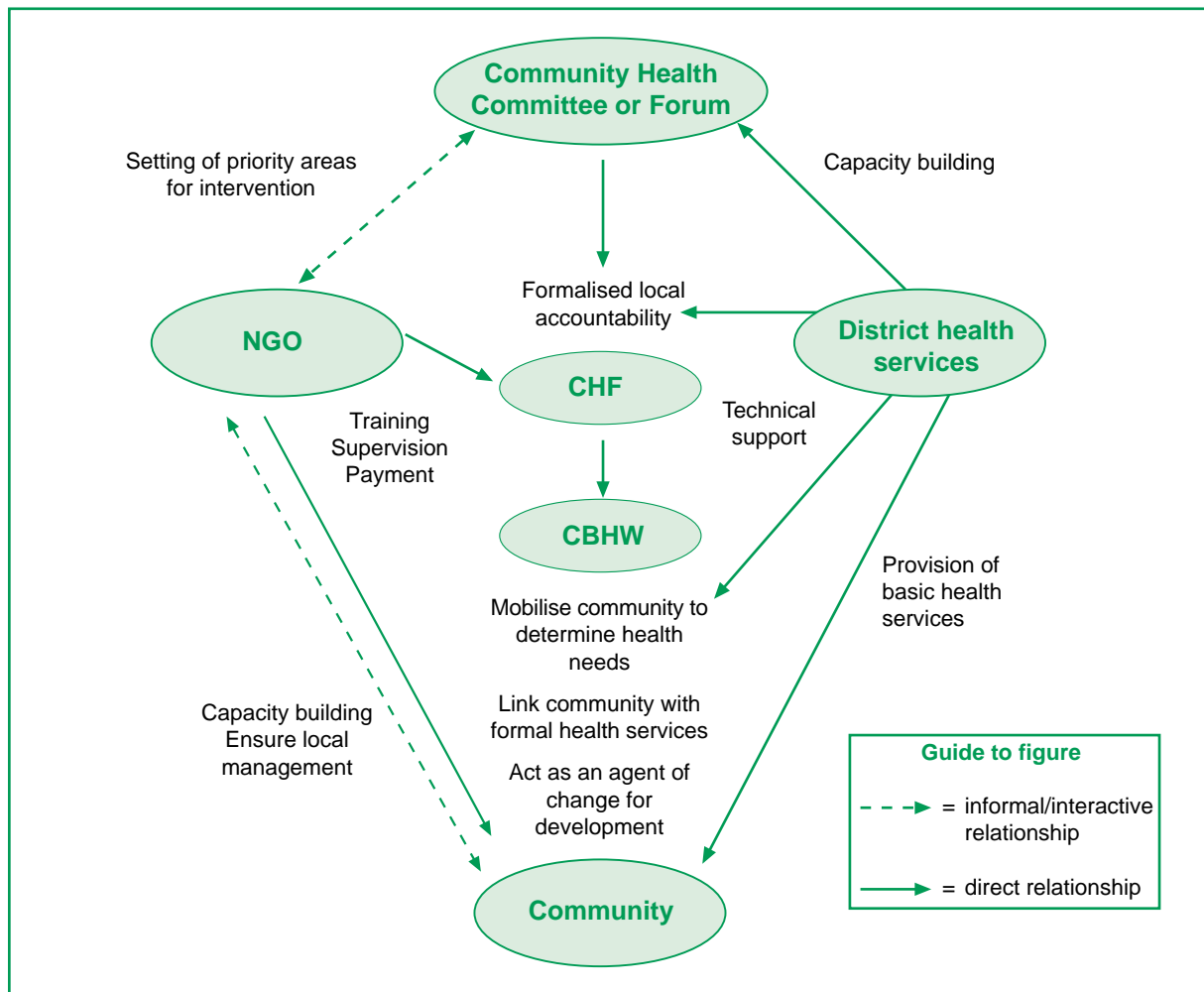


Selection, Day to Day Supervision, Monitoring and Reporting Systems – How is it Done and Who Should Do it?

Support for CBHWs is an essential element in their effective performance. While both NGOs and formal health services have a role to play in providing this, it creates multiple levels of accountability for CBHWs working at the interface between the community and the rest of the health service. This is made especially complex by the need to integrate vertical programmes and achieve inter-sectoral collaboration. Figure 1, based on a conceptual model by Doherty and Coetzee, proposes an approach that clarifies the lines of accountability. There is formal line accountability to the NGO (which could be a formalised district forum) as the employer. The CBHWs are accountable to the NGO in terms of performance and health outcomes. The NGO is in turn accountable to the district health authority that is contracting the services or the donor for reporting on the use of funds. The CBHWs is also accountable to the formal health services for the clinical component of their work. This is, however, not as much a control mechanism, as a means for providing ongoing training and technical support. The CBHWs are also accountable to communities for the provision of an accessible, equitable service through voluntary community health committees (CHCs) or broader community health forums. These committees, which exist in many districts, are appointed by communities to set priorities for health care interventions and as such, also have a role in monitoring and evaluating the work of CBHWs. They do this most effectively when it is done on an occasional part-time basis and does not require intensive day-to-day supervision. There is currently a great need for capacity building within these community structures, in order to equip them to take the role of advocacy bodies representing the community in health care matters or commissioning projects.

Given that the environment within clinics is fairly hierarchical, with a rigid management structure where nurses tend to approach CBHWs supervision from a disciplinary rather than supportive standpoint, community based facilitators (CHF) are generally necessary to provide support. For this reason, the best CHFs are not necessarily health professionals, but they must have excellent communication and management skills to plan and implement community development processes as well as enable CBHWs to handle community conflict situations.

Figure 1: Model for CHW supervision, support and accountability in the District Health System



Training of CBHWs

In general training should be a continuous, community-based, problem-oriented, experiential education process. Apart from an initial orientation course and short specific course(s) the training should be undertaken where CBHWs operate. The curriculum should be comprehensive, task oriented and outcomes based. Usually the training should start with an intensive course and then continue gradually over a few years with the CBHWs functioning during this time, gradually extending their range of their work as they become more competent. Most training programmes are not currently accredited by an approved educational institution, and this deprives CBHWs of recognition, which would enable them to develop their careers.



While there is a need for a standardised curriculum and formal accreditation for the training, there is also the need for local flexibility so that CBHWs programmes can respond to the needs of their communities. The KwaZulu-Natal model which works well has established a provincial board for

accrediting all formally trained CBHWs. This approach helps to reduce the uneven variety of training programmes, some of which are questionable.

New Tasks and Roles in a Complex, Changing Environment

Apart from CBHWs, the community and organisational support structures also require training. These include health professionals who require reorientation to the CBHWs scope of practice, as well as project managers responsible for monitoring the effectiveness and ability of CBHWs to meet their objectives. Standardised recording and reporting instruments are needed in order to evaluate progress and several projects have examples of these.

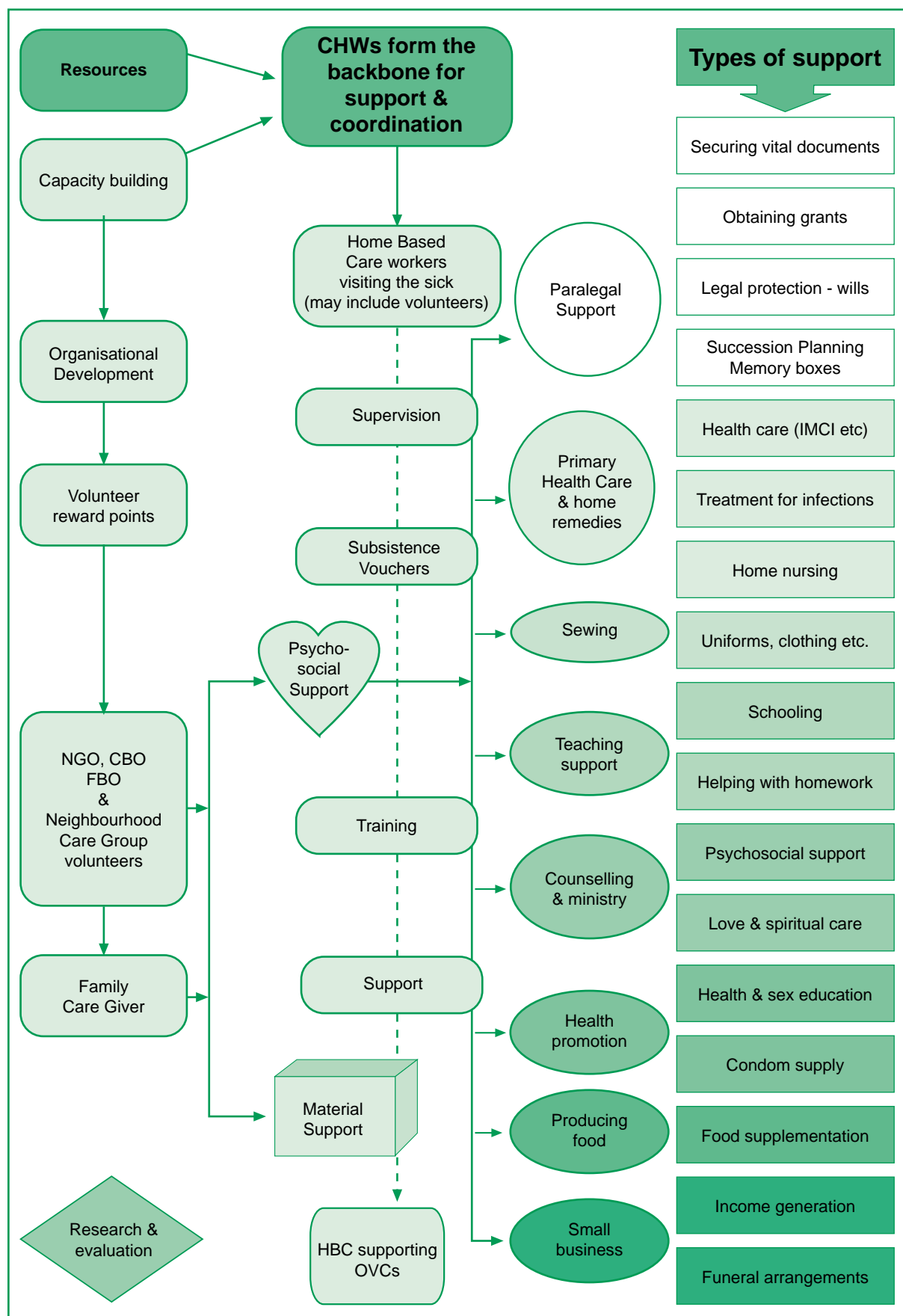
Lastly, it is important that the role of **other** CBHWs be developed coherently to specialise in dealing with HIV/AIDS, TB, rehabilitation or other problems, but also work in a coordinated way with the full-time generalist CBHWs.

Figure 2 presents a comprehensive community based care model showing how CBHWs, adequately supported with resources and training could take on the role of coordinating and supporting community based support for sick adults and vulnerable children, including orphans. The model tries to incorporate the complex situation that exists at the moment where there are both full-time generalist CBHWs working in the same communities as a wide variety of more specialist volunteer cadres.

Primarily CBHWs would support caregivers in households, supplemented when necessary by volunteers from neighbourhood care groups, community- or faith-based organisations. Organisational development would be undertaken to enhance the functioning of such groups. Other community groups who sew, garden, teach literacy, undertake para-legal work etc. are all important in providing holistic care. In certain countries, where voluntary work is undertaken, credit is given to volunteers through the allocation of 'points', to which can be allocated certain benefits in respect of training etc. Although less valuable than money, such schemes could at least document and acknowledge the large amount of time that some individuals volunteer.




Figure 2: An approach to integrating the work of CBHWs in an HIV/AIDS environment





Evaluating CBHWs' Programmes

Despite the growth of interest in CBHWs interventions and the evaluation of several programmes over the past decade, few of these systematic reviews on the effectiveness of interventions in South Africa have been published or widely circulated. It is important, as new policies on HBC, treatment support and other forms of voluntary outreach work, are being developed, that there is some evidence these interventions result in more good than harm.



There are a few examples of such evaluation research being undertaken at the current time into this important topic. The MRC,^f for example, is undertaking a randomised cluster trial for the Health Systems Trust on a project in the Boland Health District where farm labourers are trained as Lay Health Workers. They are carrying out a systematic review to examine the effects of the lay health worker (paid and voluntary) primary care and community interventions on health care behaviours, patients' health, well-being, and satisfaction with care in that environment.

In a separate research initiative,^g the School of Public Health at University of Western Cape is also at present busy with a large programme evaluation of Zanempilo and Centre for Learning Programmes.

The University of Natal Community Health Department has also been involved in an evaluation of the programme in KwaZulu-Natal facilitated by the Valley Trust.

These external evaluations are in general extensive and because they are complex they are expensive to implement therefore, they require separate funding.



Recommendations

- The feasibility of national or provincial salary structures, standardised according to level of training and years of service should be considered.
- To facilitate effective structures for supervision and accountability, NGOs should be contracted to provide specific sets of health, welfare and development outputs to be undertaken by CBHWs working within a defined population.
- CHWs need to have their own transport and this works best where they are subsidised to provide their own vehicles and are then remunerated for a fixed amount of travel per month.

^f Systematic Review of Lay Health Workers for the Cochrane collection, personal communication with Judy Dick at MRC.

^g Kirstie Rendall-Mkosi (kmkosi@uwc.ac.za) University of Western Cape, personal communication, 2002.

- To overcome the problem of CBHWs visiting poverty stricken households empty handed, it is suggested that they be provided with poverty-relief vouchers, which they could give to families and individuals in distress. These could be exchanged for food, seeds, clothing or other basic household essentials at local spazas and shops, boosting the local economy and avoiding the need to establish complex logistical systems to purchase and provide food parcels.
- In terms of the training of CBHWs, it is important that existing SAQA standards and material already developed be utilised as fully as possible.
- Simple internal evaluation can be built into the normal project monitoring activities.

Conclusion

South Africa has a rich potential of a new democracy committed to people-centred development. However, the reality is that global and national macro-economic systems often threaten rather than strengthen programmes that aim at dealing with the two-headed 'monster' of poverty and HIV/AIDS.

Community Based Health Workers offer the country one of the most viable means of dealing with this catastrophe but at the moment the very variety of creative initiatives which are being widely undertaken lack coherence and threaten the CBHWs' Programme.

Clarity of conception and the development of formal systems which link the various elements of community based health care are essential to enhance the capacity of CHBWs to provide a comprehensive service.

References

- 1 Lomax K, Mametja D (Eds.) *Assessing the Feasibility of Greater State Support of Community-Based Health Programmes*, Durban: Health Systems Trust; 1995.
- 2 Wilkinson D, Floyd K, Gilks CF. Costs and cost-effectiveness of alternative tuberculosis management strategies in South Africa implications for policy. *S Afr Med J* 1997 Apr; 87 (4): 451-5.
- 3 Wilkinson D, Davies GR. Coping with Africa's increasing tuberculosis burden: are community supervisors an essential component of the DOT strategy? *Directly observed therapy. Trop Med Int Health* 1997 Jul; 2 (7): 700-4.



- 4 Connolly C, Davies GR, Wilkinson D. Who fails to complete tuberculosis treatment? Temporal trends and risk factors for treatment interruption in a community-based directly observed therapy programme in a rural district of South Africa. *Int J Tuberc Lung Dis* 1999 Dec; 3 (12): 1081-7.
- 5 Walt G. CHW: are national programmes in crisis? *Health Policy and Planning* 1988; 3 (1): 1-21.
- 6 World Health Organization. Draft working document for the WHO Study Group on community health workers. Division of Strengthening of Health Services Geneva: World Health Organization; 1987.
- 7 Perera M. Study of the JOICFP volunteers of the Ministry of Health. Colombo: Marga Institute; 1985.
- 8 Adeniyi J, Olaseha I. Toward a conflict resolution of multiple perceptions on post training utilisation of VHWs. *Hygiene* 1987; 6: 24-28.
- 9 Jaju V. Role of the village health worker - a glorified image. In: Jayarao K, Patel A, (Eds). *Under the lens*. New Delhi: Mexico Friends Circle 1983.
- 10 De Zoysa I, Cole-King S. Remuneration of the community health worker: what are the options? *World Health Forum* 1983; 4: 125-130.

