

COMMUNITY HEALTH WORKERS A BRIEF DESCRIPTION OF THE HST EXPERIENCE

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THE COMMUNITY HEALTH WORKER PROGRAMME

What is a Community Health Worker?

A Community Health Worker is a member of the community in which she/he works and who serves and responds to the health needs of the community.

Why are Community Health Workers necessary?

Health services in poor communities are invariably inadequate.

Community Health Workers' home visits lead to an increase in and improvement to the community's access to relevant health information.

Community Health Workers, as part of the community, experience the same health problems and can promote community organisation to confront the basic causes of ill health.

What is the role of Community Health Workers?

Community Health Workers' basic function is to improve the community's access to Primary Health Care.

To achieve this they may perform one or more of the following roles:

- Linking the community with resources and services
- Spreading health information
- Mobilising people to determine their health needs and to take their health into their own hands
- Raising awareness about disease and conducting health promotion activities
- Identifying and treating minor ailments and referring chronic illnesses for treatment
- Acting as an agent of change for development
- Conducting specialist activities in areas such as malaria and tuberculosis control, rehabilitation, hypertension and diabetes

INTRODUCTION

A Community Health Worker (CHW) may be defined as 'any health worker delivering health care services and who is trained in the context of the intervention but has no formal professional, certificated or degreed tertiary education'. CHW is an umbrella term used for a heterogeneous group of health workers, their scope of practice ranging from implementing biomedical interventions to acting as community agents for social change.

The key function of CHWs is to work at community level in advocating for health services and assisting the community to become better informed about health priorities. Their particular value is that they are based in the communities in which they serve and they also act as a point of first contact with the Primary Health Care (PHC) system. Preventive and promotive activities should be the main objective of CHWs. Preventive programmes, with clearly defined tasks for CHWs, have contributed to dramatic reductions in infant mortality rates in many countries, including South Africa.

History of CHW programmes

CHWs have increasingly been advocated as a potential solution to overcome current human resources for health shortfalls in different settings. The Alma Ata Declaration promoted CHWs' role as a community's own resource. During the 1970s, CHW programmes were initiated by non-governmental organisations (NGOs) to address the intentionally inequitably distributed health services during the Apartheid era. They were viewed as an innovative, responsive, comprehensive and empowering resource for health-care providers and communities. Post 1994, South Africa committed to the Primary Health Care (PHC) approach, staffed mainly by doctors and nurses. This saw CHWs sidelined, resulting in many CHW programme initiatives collapsing. Thereafter, a cadre of disease-focused CHWs emerged employed particularly for HIV and AIDS and tuberculosis (TB) care, treatment and support. This approach resulted in a technically focused CHW programme that led to under-utilisation of a valuable community resource that has a wide social and health impact.

In more recent years there has been increasing interest and political support for CHWs due, in part, to the burden of HIV and AIDS but also necessitated by the migration of health workers from the public sector. Current CHW arrangements encouraged provincial health departments to identify NGOs to employ and implement CHW programmes while the State agreed to fund certain NGO costs and CHW monthly stipends.

CURRENT SITUATION

Currently in South Africa the CHW programme remains disease-focused, particularly towards HIV and AIDS and TB care, treatment and support. CHWs' contributions are mostly focused on taking care of terminally ill patients and tracing defaulters at community level. This situation contributes to families becoming dependent on home-based carers and not getting involved in the care of their own family members. In other scenarios, CHWs are found to be working in facilities offering health education, counselling on HIV and some even performing HIV tests. Some CHWs working in facilities are recording vital signs for clients without any supervision. This situation might contribute to poor quality of care as they have not acquired the skills necessary to perform these duties.

There has been uneven development of CHW programmes in different provinces. The supervision of CHWs varies, with some provinces requiring CHWs to report and account to PHC facility staff while in others supervision is entrusted to NGOs. Regarding remuneration, in provinces such as the Eastern Cape some CHWs are on the government payroll (PERSAL), some are paid by NGOs and others are voluntary workers (meaning that they do not receive income for services provided). In the Western Cape Province, the government subsidises the payment of CHWs through NGOs who then take the responsibility of supervision. In South Africa there is currently no policy that governs the CHW programme and there is also no standardised training to be followed when training this cadre. As a result, different organizations develop and train a particular group of CHWs according to the mandate that they are supposed to fulfil for a particular project in which they may be engaged in at the time.

Other challenges that have been identified include:

- Lack of a systematic response to community needs, resulting in CHWs becoming an extension of health services
- Lack of support to CHWs from organisations that should be providing supervision
- Lack of relevant training of CHWs
- Lack of reliable financial support
- Lack of dynamic management of CHWs

THE HST EXPERIENCE

MATERNAL, NEONATAL AND CHILD HEALTH AND NUTRITION PROJECT

During this project, CHWs from the supported districts were trained on the Household Community Component (HHCC) of IMCI, integrated with Prevention of Mother-to-Child Transmission (PMTCT) and postnatal care. Five-day training sessions were offered and the CHWs were equipped to perform the following duties:

- Regular home visits;
- Health education on general well-being;
- Detection of health problems and appropriate referral;
- Referring clients for further care to professional nurses at the clinic;
- Follow-up of clients referred by professional nurses from the facilities;
- Encouraging and referring pregnant women to attend antenatal care when less than 12 weeks or immediately when they miss a period;
- Infant feeding counselling to pregnant mothers and their families, emphasizing the benefits of breastfeeding and importance of avoiding mixed feeding;
- Encouraging HIV testing before conception and early in pregnancy;
- Postnatal visits to mother and baby pairs, two days after delivery and encouraging them to attend follow-up visits at the clinic on day 3 and at six weeks; and
- Giving information to HIV-positive parents on PCR testing at six weeks and HIV testing at 18 months for the baby.

Other aspects of the MNCH&N project's intervention involved establishing community growth-monitoring points to encourage growth monitoring at local level. The sites were also used as centres where community group discussions were conducted. Community dialogues were facilitated in sub-districts, with the aim of empowering the communities to understand their health problems and develop an action plan that they would own.

During the project it was also noted that provinces were using different reporting forms for their CHWs. Reporting and data collection tools were, therefore, developed during the project, incorporating some information from the existing forms. These tools were given to the CHWs trained by the project and were used in all the supported provinces.

PROVIDER-INITIATED COUNSELLING AND TESTING PROJECT

At the inception of the Provider-Initiated Counselling and Testing (PICT) project in the three supported provinces (Eastern Cape, KwaZulu-Natal and Mpumalanga), CHWs were already in place at the supported districts/sub-districts. Some of the project's objectives aimed to, but were not limited to:

- increase community involvement in HIV counselling and testing;
- improve the skills and competencies of health workers in counselling and testing;
- increase the number of HIV-positive persons referred for further care, treatment and support;
- increase uptake of counselling and testing among TB, antenatal care (ANC), and family planning clients and TB suspects; and
- increase the number of clients counselled, tested for HIV and who received results.

In order to achieve these objectives it was imperative for the project team to ensure that CHWs were active members of the health team. The valuable role that CHWs can play in alleviating the workload of the nurses was emphasized. During support visits to the health facilities it was advocated that CHWs should work hand-in-hand with the clinic health workers in an endeavour to interface community and facility-based health services. CHWs should be viewed and utilised as a complimentary resource and not as an "annoying extra", which is unfortunately often the case.

Community-based health workers were trained formally and on the job on HIV and AIDS counselling and testing, TB updates and on new HIV counselling and testing (HCT) guidelines. On completion of training, CHWs were urged to report to the health facilities in their respective catchment/service areas.

The health facility staff, who also bought into this initiative, were more than willing to welcome this cadre of health workers onto the team. Joint meetings at health facilities between the community and facility-based health workers were held. In these meeting briefing and debriefing sessions were conducted on issues related to PHC. As a result of these meetings a two-way referral system between community and facility-based health services was established and maintained.

The impact of these interventions was encouraging because:

- CHWs mobilized the community for HCT and child immunisation campaigns and referred them accordingly;

- The community was educated on reproductive health, ANC, sexually transmitted infections (STIs), TB and HIV and AIDS;
- ANC clients were motivated to book early for their first visit;
- TB clients were supported while they were on TB treatment, and treatment defaulters and TB contacts were traced and sent to the health facilities;
- HIV-positive clients that were not collecting their CD4 count results were traced and sent to the clinic;
- CHWs supported clients that were on antiretroviral treatment (ART); and
- Clients that were in need of home-based care were assisted and support skills were transferred to their relatives.

The health care workers in facilities supported the CHWs in the form of in-service education and the supply of sundries required for home-based care. The health professionals referred clients that needed community care to CHWs and clients' progress was discussed at the joint meetings.

The challenges related to the programme included collaboration with other sectors, such as welfare and education, and the sustainability of the programme. Despite these challenges and against all the odds, the programme has empowered communities to participate in the health, economic, social and development spheres.

RECOMMENDATIONS FOR IMPROVING THE CHW PROGRAMME

The following recommendations are suggested to strengthen the CHW programme:

- Develop a policy document that will govern the CHW programme in the country;
- Develop a comprehensive training manual and a training programme that will standardise training across all provinces;
- Identify a uniform governance structure for CHWs;
- Plan for monitoring, mentoring and coaching, and supervision of CHWs;
- Determine a career path for this cadre within the health system so as to avoid training a number of CHWs, only to lose them to other organisations who offer better career opportunities; and
- Establish evaluation as an integral part of CHW programmes to assess the effectiveness of CHW interventions.

Conduct further research on the following:

- defined functions to be performed by CHWs

- cost-effectiveness of CHW interventions
- logistic and operational issues for implementing CHW programmes on a wide scale
- sustainability of intervention effects

HST has been involved in numerous projects aimed at improving the CHW programme in the country. The activities performed by HST's MNCH&N and PICT project staff in the provinces, districts and sub-districts where their activities were focused demonstrate HST's skills, capacity and experience in this area. The organisation is also committed to being a partner to the government in addressing the optimal and ideal deployment of CHWs for the realisation of a re-engineered PHC.