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# SUPPORT NEEDED FOR COMMUNITY HEALTH WORKERS TO IMPROVE ACCESS TO CARE

## *Lessons from three CHW programmes in South Africa*

### Introduction

Community health worker (CHW) programmes strive to improve access to care. As the interface between health systems and communities, they provide outreach services and help households to overcome barriers to care such as lack of access to transport, clean water, sanitation and nutrition, which relate to the social determinants of health. While there is growing evidence that CHWs can help to improve certain health outcomes<sup>1</sup>, research suggests that programmes often fail because of lack of support and skills<sup>2</sup>.

South Africa is renewing efforts to strengthen primary health care and CHW programmes which are diverse and largely unstructured and unregulated<sup>3,4</sup>. However, there is limited local information on successful programmes for guiding policy and implementation. This study presents the factors which contributed to the success – and failure – of three CHW programmes in two provinces.

### Methods

Through case studies, the researchers compared CHW programmes in three different contexts: a small, local non-governmental organisation (NGO) in Gauteng, a local branch of a national NGO in the Eastern Cape, and a government-initiated service in Gauteng. Data collection took place in 2010 through participant observations, key informant interviews, network maps and focus group discussions.

NGOs were selected according to whether they delivered a wide range of services, utilised over 15 CHWs and were willing to participate in the study. Researchers held key informant interviews with government

### Highlights:

- Outreach services are resource intensive: successful programmes invested in ongoing training, supervision and mentoring to assist CHWs, confirming international studies 1,5,6.
- Successful programmes receive sufficient funding to establish effective organisational structures and to support CHWs as required. Without investing in capacity and support for outreach programmes, current district and sub-district health structures are unlikely to achieve their current reform objectives.
- A clear understanding of how social determinants of health are intertwined contributes to holistic services, such as accessing social grants to ensure sustained access to health care.
- Lack of accountability has compromised the role of ward councillors, which curtails the ability of CHWs to provide effective outreach services.
- The current re-engineering of primary health care is unlikely to achieve its expected outcomes unless CHWs receive adequate and appropriate support to liaise between their communities and the health system.

officials, NGO managers and key stakeholders, while three focus group discussions with CHWs explored their support and experiences with other sectors.



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## Key Findings

**Case Study 1:** A community member initiated and managed this independent NGO, which operates with funding mainly from the Gauteng Department of Health & Social Development (GDHSD). Community health workers living in the community provide general home-based care, patient tracing and assist support groups. Those CHWs who completed the National Department of Health's 69-day training course receive a monthly stipend. Further training opportunities were very limited and there was no career progression. Besides the CHWs, there was only the manager who was responsible for fundraising, management, supervision and mentorship of the CHWs.

**Case Study 2:** The HIV/AIDS Directorate of the GDHSD established and coordinated this programme which is administered by local government. A manager is responsible for supervision and daily operations of the programme. CHWs recruited from the local community attend a 5-day course on HIV/AIDS, TB and cancer, and strategies on accessing other services. They received a monthly stipend to conduct door-to-door dissemination of HIV/AIDS-related information and provide advice on how to access services from a range of government sectors (e.g. housing, social welfare, water and sanitation). There is no opportunity for career progression.

**Case Study 3:** Located in the Eastern Cape, this programme strived to improve child health outcomes of households affected and infected with HIV/AIDS. The community selected the CHWs to complete 14 training modules and regular assessments over two years. They were paid a stipend to link neglected/abused children with health, welfare legal services, and provided daily care for child-headed households. Several managers provided extensive supervision and mentorship of both their technical skills and well-being. The programme encouraged career progression, which led to retention of skilled staff.

Case Studies 1 and 2 served communities in a largely urban province. Despite this, they experienced high levels of poverty, unemployment, chronic and infectious disease. Food was limited and health and welfare services were not easily accessible. In many instances, CHWs did not have the capacity to assist patient to access identity documents or birth certificates so that they could obtain social benefits. In both case studies, there was limited support for CHWs

who experienced the same barriers as the households they served. Case Study 3 is situated in a largely rural province, one of South Africa's poorest. Government services are sparse and families often depend on migrant family members for money. These CHWs received ongoing support as well as funds to accompany clients to access services and mobile phone vouchers to keep in contact with their supervisors.

All three case studies experienced significant constraints to improving access due to fragmentation, poor referral systems and lack of coordination within and between government departments.

*"Coordination can only be achieved if the higher levels are coordinated. If those people that design the key performance targets for the specific departments spoke to one another, it would be so much easier to coordinate at the bottom, because the coordination would already have been established and developed."*

[Key informant, Gauteng]

Yet while the Gauteng-based programmes struggled to navigate this fragmentation with the limited support they received, the Eastern Cape programme were able to link clients with government departments. However, they had limited interaction with the provincial Department of Health which could have enabled them to respond better to the health needs of their clients, rather than rely on other health NGOs. This programme also enjoyed support from ward councillors (local politicians), in contrast to the Gauteng programmes which had a high turnover of officials and lack of support due to party affiliations.

## Conclusions

CHW programmes should be established with a firm understanding of the social determinants of ill-health. Such programmes need ongoing resources such as quality training, supervision, mentoring and organisational support. CHWs also need resources to navigate uncoordinated and fragmented government services. Effective government-led CHW programmes require strengthened district and sub-districts. The current re-engineering of primary health care is unlikely to achieve its expected outcomes unless there is sufficient capacity to support CHWs to operate effectively between their communities and the health system.