



PRIMARY HEALTH CARE

Community health workers in South Africa: Where in this maze do we find ourselves?

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Using lay members in the community to provide health care is a practice with a long history in South Africa.¹ The development and implementation of community health worker (CHW) programmes grew during the 1970s and 1980s, following the Alma-Ata Declaration² and in response to the inadequate provision of primary health care under apartheid. A CHW may be defined as 'any health worker delivering health care, trained in the context of the intervention, and having no formal professional, certificated or degreed tertiary education'.³ CHW project development and implementation in South Africa is well described.^{4,5}

After the 1994 elections, the new South African government was unexpectedly reluctant to support CHW programmes, instead favouring a primary health care system staffed by nurses and doctors. However, official support for CHWs has grown recently. There are several reasons for this, including the growing HIV/AIDS and tuberculosis epidemics and the ongoing migration of health professionals.⁶⁻⁸ CHW initiatives are seen as a way of addressing the human resource crisis in health in many low- and middle-income settings, including South Africa.⁹ The recently launched South African Expanded Public Works Programme incorporates a plan for implementing a nation-wide roll-out of this cadre by 2009.¹⁰ Provincial health departments are encouraged to identify non-governmental organisations (NGOs) to employ and implement CHW programmes, and the State has agreed to fund certain NGO costs and CHW monthly stipends.¹¹

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Evaluating the effectiveness of CHW programmes

CHW interventions have been evaluated using study designs ranging from descriptive case studies to randomised controlled trials (RCTs).^{3,12-15} Establishing the effectiveness of CHW interventions is complex, as the objectives of these programmes are often not associated with clearly delineated processes and outcomes.¹⁶ CHW programme evaluations tend to use a combination of quantitative and qualitative research methods.

A Cochrane systematic review of CHW interventions illustrated that using CHWs has benefits (compared with no intervention) when CHWs function within a limited scope of practice, for example in promoting immunisation uptake and breastfeeding, and initiating treatment for malaria and acute respiratory infections in children. However, evidence from trials on the effectiveness of 'generalist' programmes, in which CHWs deliver a range of primary care services, was insufficient to justify recommendations for policy and practice, indicating the need for further research in this area.³

The evolving South African context

South Africa has now identified generalist CHWs as having an important role to play in meeting the health and social needs of the majority.^{4,10-11} However, implementing a standardised, national, generalist CHW programme by 2009 seems over-ambitious, considering that standardising CHW training in the USA took 10 years to accomplish.¹⁷

In moving towards an appropriate national policy, CHW programmes need to engage with a number of broad issues. Firstly, current policy requires that NGOs, working in close co-operation with public health structures, employ CHWs. This model has the potential for misunderstanding and tension, with CHWs unsure who to whom they are responsible – the employing NGO, public health service staff or local community members. Further discussion is needed on the ability of this model to deliver and sustain a large-scale generalist CHW roll-out and how this would be co-ordinated at health district and inter-departmental levels.

Secondly, the role of current volunteer CHWs is unclear, as many, particularly those in rural areas, were trained in a specific setting to address particular community problems and are not employed by state-funded NGOs. Unless existing NGOs are strengthened and receive ongoing state funding,



they may be undermined, increasing the suffering of poor and remote communities.

Thirdly, political expectations of CHW interventions threaten to overwhelm CHW activities, when added to the already complex health and social needs being addressed by them. National government is pressurising provincial and local structures to address backlogs in water, sanitation and housing provision; adult literacy and numeracy; and identity document applications, in part using this cadre of workers. Improving access to social grants for old age, child, disability and unemployment, advocacy for gender issues, and worker and other rights are also high on the agenda. In rural areas, CHW networks are often the only functioning community structure and are sometimes expected by local politicians to be a panacea for all of these problems. The danger is that CHW programmes will take on more than they are able to deliver.

Fourthly, experience has shown that the skills required to plan a CHW roll-out are different from those needed to implement that plan. Individuals with technical insights, high levels of interpersonal skills, patience, personal conviction and drive are essential to champion CHW interventions. What to outsiders often appears to be a quick and simple method of improving health service coverage, in practice requires considerable effort to initiate and maintain. Organisations and individuals with this experience should comment on, and be involved in, current national roll-out policy.

Finally, further research is needed on these questions. During a recent workshop on CHW projects in South Africa, health policy-makers, project managers and researchers identified a number of research priorities:

- How cost-effective are CHW programmes for different health issues and under various service and community conditions? Are CHWs cost-effective compared with similar services delivered by professionals, such as nurses?
- What are the key logistic and operational issues when implementing CHW programmes on a large scale, and how can these be addressed?
- How can the effects of CHW interventions be sustained?
- What are the driving forces behind the approach of implementing generalist CHWs, rather than CHW programmes that focus on a specific health issue? Are generalist CHW programmes likely to be more cost-effective?

Evaluating CHW programmes is extremely complex, requiring a range of research methods including RCTs and observational, costing and policy studies.¹⁸ South African researchers will also need to work closely with implementers and policy-makers to examine the implications of study findings for policy and practice.¹⁹⁻²¹

There is a wealth of knowledge and experience regarding CHW programmes in South Africa and many research questions that still need to be answered. Renewed interest in CHW programmes at national and international levels provides opportunities to further the debate on the contribution of CHWs towards improving health care delivery.

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