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A shotgun marriage — community health workers and government health services

Qualitative evaluation of a community health worker project in Khayelitsha

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In 1988 the Western Cape Regional Services Council (RSC) initiated a community health worker (CHW) project in Khayelitsha in order to extend its preventive services to people in the community and promote 'community upliftment'. An evaluation of this project was undertaken in 1991 and 1992 in order to examine the potential of this local health authority-run CHW project to be an appropriate primary health care model. Qualitative research methods were used to explore the nature of the work done by the CHWs, whether they were accepted in their communities, and whether the project functioned as part of an integrated health service infrastructure in Khayelitsha.

The CHWs were found to provide the basis for a potentially effective, community-responsive service. However, several structural problems mitigated against this service. Relations between the CHWs and nurses in all the formal public health services in the area were superficial and fraught with problems. There were significant differences and conflicting policies between the RSC's CHW project and other neighbouring non-government CHW projects, and these posed various threats to both the RSC and the non-government projects. One of the most serious of these differences was that the RSC project had no structures or plans for community involvement in the running of the project.

Before a CHW project is initiated, several critical issues need to be carefully considered and discussed with all the relevant stakeholders. Furthermore, CHWs need to be flexible, and accountable to the communities in which they work. Before employing CHWs, formal public health authorities need to consider carefully whether they are able to meet these criteria.

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Khayelitsha is a rapidly growing black peri-urban township, 25 km outside Cape Town. It has a population of approximately 350 000 people.[1] Unemployment and consequent poverty are the main determinants of the health status of the people living there.[2] In 1988 the Western Cape Regional Services Council (RSC) initiated a community health worker (CHW) project in Khayelitsha in order to extend their preventive services to people in the community and promote 'community upliftment'. This was the first time the RSC had undertaken a CHW project and it was seen as an 'experiment'.

CHWs are generally local inhabitants given a limited amount of training to provide specific basic health services to the members of their surrounding communities.[3] CHWs have become the distinguishing feature of many primary health care (PHC) programmes in developing countries, and were conceived as part of the PHC move towards equity,[4] and as a means of achieving community participation in health programmes.

It was generally felt by health service professionals and communities that in peri-urban informal settlements CHWs played an important role in ensuring adequate access to health services and thereby adequate coverage. By June 1991 there were 4 CHW projects in Khayelitsha, 3 of these run by non-government organisations (NGOs). Because large parts of Khayelitsha were not covered by CHWs the RSC needed direction on the future of CHWs. The RSC's Director of Health Services in Khayelitsha commissioned researchers from the Medical Research Council to evaluate the RSC's CHW project. Were the RSC-employed CHWs doing a good job? Is there a role for RSC-employed CHWs? If so, how do they relate to CHWs employed by NGOs? Should the RSC expand the programme and employ more CHWs for other uncovered areas? The evaluation of the RSC CHW project was undertaken in 1991 and 1992 in order to examine the potential of this local health authority-run CHW project to be an appropriate PHC model.

The objectives of the project were to ensure: (*i*) that all families were aware of the health facilities available in their area; (*ii*) that all children under 5 years of age were in possession of a Road-to-Health record card and were up to date with immunisations; (*iii*) that health education on breast-feeding, oral rehydration, family spacing, nutrition and tuberculosis was given to mothers; and (*iv*) that malnourished children were brought to the clinic. Further objectives were to follow up all tuberculosis 'defaulters' and new births; to undertake home visits to contacts of patients with tuberculosis and sexually transmitted diseases; to undertake domiciliary treatment of tuberculosis patients; and finally to undertake projects that would contribute to community upliftment.

Within the first 2 years of the project's inception the RSC management had twice changed the area in which the CHWs worked. This was as a result of the rapid expansion of Khayelitsha and the mobility of the population. At the time of the evaluation, the CHWs were working in a newly created formal site and service area. They were transported from the clinic every morning at 09h30. They worked office hours. Most of the CHWs were not residents of the area in which they worked. The evaluation focused on various processes in the project and was based primarily on qualitative methods.

Aims of the evaluation

The evaluation aimed to explore the nature of the work done by the CHWs, whether they were accepted in their communities and whether the project functioned as part of an integrated (governmental and non-governmental) health service infrastructure in Khayelitsha. In addition, and not reported here, it aimed to explore whether their health education entailed good communication methods and dialogue, and what their needs and feelings were with regard to their work.

Methods

The evaluation methods consisted primarily of free-attitude interviews[5] and focus groups with representatives of the various stakeholders in the CHW project. As far as possible their own words were used as evidence of the quality of the project.

A record review was conducted to discover the nature of the CHWs' work. The official records of home visits for the months of September, October and November 1991 were analysed.

A sample of 10 randomly selected community members who had been visited by a CHW in the previous 2 weeks was selected from the CHWs' records. The researchers, using an interpreter, interviewed the community members on how they perceived the purpose and content of the CHW's visit, how they felt about the visit and how they felt about the CHW as opposed to nurses from the clinics. Open-ended questions were asked, and free-attitude interviewing skills[5] were used to allow the respondent to explore his or her feelings and thoughts about each question without being influenced by the interviewer. With the permission of the respondent, the interview was tape-recorded. Each community member interviewed had been visited by a different CHW. In addition, three pilot interviews were included in the analysis.

The integration of the CHW project within the health service infrastructure in the area was investigated by review of the responses to referral letters (used by CHWs to refer people to other health services) for the months of September, October and November, and by 3 focus group discussions. The first was with 4 nurses from the RSC clinics and 4 staff nurses from the Cape Provincial Administration-run Midwife Obstetric Unit (MOU). The questions asked of the group were: 'What do you know about the project?', 'How do you see the role of CHWs?', and 'How do you see the future of the project?' The second focus group involved members of the Progressive Primary Health Care Network (PPHCN)'s working group on CHW training. The PPHCN is a non-government network of PHC projects. Those present were representatives from NGO PHC projects in Khayelitsha and other areas, and PPHCN office holders. The question for discussion was: 'How does the RSC CHW project relate to non-government PHC projects and the PPHCN at present, and how could it relate in future?' The third discussion was with the CHWs, who were asked to discuss the problems they experienced in their work.

Analysis

Records were analysed by means of simple frequencies. The tape-recorded interviews were fully transcribed, translated into English and analysed in terms of content analysis.[6]

Results

The record review

The records consisted of weekly and monthly statistic sheets with information on the address of each home visited, the date of the visit, the type of intervention given, and whether there had been a referral.

During the months of September, October and November 1991, the CHWs as a group recorded a total of 2 995 visits. Fig. 1 illustrates the nature of the interventions given during the home visits and the frequency of each type of intervention in these months. (The records of home visits did not provide information on the number of 'cases', e.g. of diarrhoea, found.) The overwhelming emphasis of the work was checking of immunisation records and referral for immunisation. During the month of September the median number of visits per CHW per week was 26, with the range being 5 - 61.

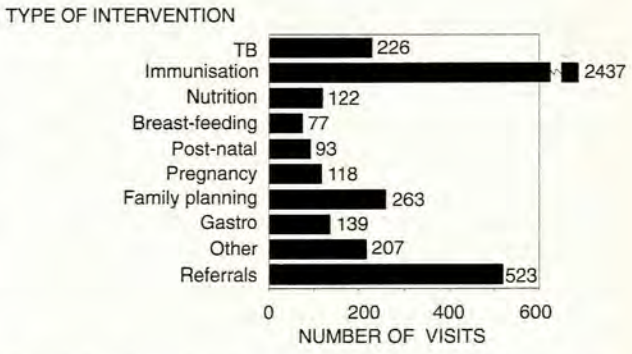

Fig. 1. CHWs' home visit records, September - November 1991.

First-time visits were not noted separately in the records, and every visit was recorded as a 'follow-up'. Thus coverage of all households could not be monitored with the records, and the CHWs had no procedure for ensuring that all houses were covered by their project.

Community perceptions of the CHWs

Community members perceived the CHWs' main activities to be reminding mothers about their clinic appointments for weighing and immunisation of their children, checking Road-to-Health cards and promoting the use of oral rehydration solution.

Every community member interviewed expressed positive feelings about and appreciation of the visit and the health education it involved. The health education did not always relate only to narrowly defined health issues, and community members appreciated discussing social and personal problems with the CHW. This provided relief from anxiety. For some community members, the CHW's visit was convenient, as access to clinics was a problem for them.

Table I compares community members' perceptions and feelings about the RSC CHWs and nurses at the health services in their area. Most people interviewed felt there was a great difference between the CHW and nurses with regard to the quality of the relationship between the nurse or the CHW and community members. Most community members spoke at length with a great deal of emotion. CHWs were seen to respond to people with an attitude of respect, while nurses' attitudes by contrast were perceived as lacking in respect and humiliating, which limited access to services. A minority of those interviewed did not perceive a difference in attitudes between nurse and CHW. Rather they perceived differences in the content of their work or their uniforms.

In order to assess whether the CHW had responded to the needs of community members, the researchers asked community members to talk about the health problems they were experiencing, and then whether they had talked to the CHW about these. Most of the problems mentioned had not been discussed with the CHW at the last visit, or at all. In order to assess whether the CHWs were accessible to the community in times of need, the researchers asked the community members how they would find the CHW in times of need. Most interviewees did not know how to find the CHW and had to wait until the CHW visited them, or until they saw the CHW in their area.

Relationships and collaboration with formal public health services in Khayelitsha

As one indication of the nature of collaboration between the services, the responses to the CHWs' referral letters to the RSC clinic and to the MOU were reviewed. During the 3 months surveyed, 9 responses had been received to 520 referrals by the CHWs. Many of the responses filed were undated, and thus a few more may have been received during these 3 months. All 9 responses were received from 2 sisters at one clinic. The CHWs reported that NGO health projects were usually far more responsive to referrals than any of the government health services.

The focus group discussion with the nurses from the RSC clinic and the MOU, and the workshop with the CHWs revealed further problems in the relationship between the CHW project and the government health services in the vicinity. Table II shows nurses' opinions about the CHW project, and CHWs' opinions of the nurses they came into contact with, illustrates their respective feelings towards each other and indicates the nature of the problems.

The relationship between CHWs and nurses was recognised by all as unequal and that the CHW was subservient. The level of communication appeared to be superficial and limited to the bare minimum. The collaboration between the CHWs and nurses in the same organisation (RSC) appeared to be slightly more successful than that between CHWs and the MOU or day hospital.

Despite the many problems the nurses did acknowledge the potential of the CHW project. Motivated by financial imperatives, they recommended the extension of the project to other areas, and stressed the need for ongoing training of CHWs, more contact between themselves and CHWs and a change in their own attitudes.

Relationships and collaboration with NGO PHC projects and organisations

The CHW project of the RSC was an active affiliate of the PPHCN yet there were several significant differences between this project and other PPHCN-affiliated non-

Table I. Comparison of community members' perceptions and feelings about CHWs and nurses

How the community members perceived the CHWs	How the community members perceived nurses
Their health education was helpful and accessible.	They did not provide sufficient health education and were intolerant of community members who had poor health knowledge
They were respectful towards community members.	They lacked respect for community members.
It was easy and helpful to share personal and health problems with them.	They lacked interest in community members' problems.
They were supportive and encouraged clinic attendance.	They were authoritarian and this frightened community members when they had failed to attend the clinic.
Their attitudes made their service appreciated.	Their attitudes resulted in people turning away from their services.

Table II. Relationship between the RSC CHW project and government health services in Site B, Khayelitsha

How CHWs perceive nurses	How nurses perceive CHWs
As exerting their authority while being uninformed about the project.	As useful in carrying out instructions and facilitating their work.
As lacking acceptance and respect for them.	As lacking confidence when dealing with them.
As having inadequate contact with them.	As having inadequate contact with them.
As ignoring the established referral procedure.	As having an inadequate referral system.
As obstructing their referral of patients to clinics, by their unpleasant attitude when receiving these patients.	As obstructing their work by discouraging clinic visits.
As lacking respect for patients/community members.	As having the confidence of community members.
As beginning to accept their role.	As untrained and dangerous, yet also as effective and helpful.

government CHW projects in Khayelitsha and other areas. These were highlighted during the focus group discussion with PPHCN members, and are presented in Table III. These differences were seen as a potential threat to the RSC project's relationship with the community, as communities had begun to insist on some involvement in project management, and specifically that CHWs were elected from among their own residents.

It was recognised that to achieve community accountability was very difficult, especially in a divided community like Khayelitsha where there is constant jockeying for power. However, based on their experience in neighbouring communities, the PPHCN members recommended that the structure of the RSC CHW project be changed to give it greater autonomy and flexibility within RSC structures, so that it could facilitate community involvement in management.

Discussion

The work of the CHWs

Community perceptions of the CHWs indicated that they could provide the basis for a potentially effective, community-responsive health promotion and disease prevention service. However, there were several problems in the approach and procedure of the CHWs' work. Firstly, they often failed to discern the community members' own heartfelt problems. One of the functions of the PHC workers is to increase people's awareness of their own situation, to help them recognise problems, and to develop a reasonable and jointly agreed upon plan of procedure.[7] The bulk of the CHWs' work was to do with Road-to-Health cards, probably a priority determined by the RSC.

One of the main aims of CHW projects is to facilitate access of all in the community to health services. The RSC project lacked a routine method for systematically planning to cover all homes and coverage was not monitored. Furthermore, the CHWs did not have a base in the area in which they worked, and community members had no regular access to them.

Other local non-governmental CHWs carry basic medicines and do basic curative work. This caused a problem for the RSC project where curative work was expressly excluded. This fundamental difference in the role of CHWs needs to be debated and a uniform policy accepted.

Integration into the health service infrastructure

For CHWs to be able to work effectively, a good referral system for all service providers is crucial. Effective referral is facilitated by an efficient formalised referral system, and the mutual co-operation and respect of health workers. For the RSC CHWs, the referral system between themselves and the day hospital was especially important because they did not treat minor ailments. The RSC CHW project referral system, although formalised, was ineffective, with an extremely limited response from the RSC clinic and the other government health services in the area. Even though the project was clinic-based rather than community-based, relations at that 'base' (the RSC clinic) were far from optimal.

Relations between CHWs and nurses in all government health services were superficial and fraught with problems. It has been recognised worldwide that there is a potential for 'role strain' in PHC teams that include CHWs and nurses, and that conflicts may arise over skills, competence and status.[4] Nurses need to be involved in the planning of CHW projects, in order to understand their broad role in PHC.

While the government health services were not sufficiently involved in the CHW project, neither were the non-government projects in the area. Conflicting policies had not been discussed and resolved; these posed various threats to both the RSC project and the neighbouring non-government CHW projects.

Despite the above-mentioned problems, there was a willingness on the part of the nurses in the government services and the non-government project representatives to start working together with the RSC CHWs.

Community participation

PHC programmes themselves ideally aim to involve the community in attempts to address the underlying causes of ill health and to improve health.[8] Many NGO PHC projects in

Table III. Differences between the RSC CHW project and NGO CHW projects in Khayelitsha

RSC CHW project	NGO CHW projects
CHWs handled preventive and promotive work only. They undertook no curative work and had no medicines.	CHWs do preventive, promotive and curative work, and carry medicines.
CHWs earned comparatively high salaries.	CHWs earned about half the salary of the RSC CHWs.
CHWs did not live and work in the same area.	CHWs live in the area in which they work. This is a condition of their job.
Project was clinic-based and CHWs operated from the clinic.	Projects are community-based and CHWs operate from their homes.
CHWs were not selected by the community.	The community is involved in the selection of CHWs.
The civic associations were aware of the project but had not been involved in it.	The civic associations are involved in projects from their inception.
There were no mechanisms for accountability to the community.	Various mechanisms have been developed to ensure that the CHWs are accountable to the community.
Project management was hierarchical.	Project management is participatory.

South Africa are attempting to establish mechanisms for the involvement of their communities in project management.[9] The RSC CHW project had no structures or plans for community involvement. This shortcoming was exacerbated by the presence in Khayelitsha of other CHW projects which had set such a precedent for community consultation and involvement. In the RSC project there were no attempts to establish, even partially, mechanisms to formalise accountability to the community.

The value of qualitative evaluation

Qualitative research methods were valuable in this study as they provided a holistic view of the project which included an understanding of its internal dynamics and to some extent its context.[10] Furthermore, the statements in the various key stakeholders' own words gave an accurate picture of their experience of the project,[11] and thus evidence of the quality of the project. The attitudes of key stakeholders are assumed to determine their support of and involvement in the project, thereby providing indications of some of the determinants of the project's success.

In order to develop a community-responsive approach, the managers of health projects need information on clients' perceptions of their services. The management of the RSC CHW project recognised the importance of adopting a client-responsive approach, and regarded the data in this evaluation as valuable for that purpose.[12]

Conclusions

In peri-urban informal settlements, such as Khayelitsha, CHWs who live in the community are capable of being a focus of development in the community. They are at the 'cutting edge' of PHC and as such can play a pivotal role in improving coverage and access to formal health services.

However, as can be seen from this evaluation, the role of CHWs, who employs them, what they do and where and when, are all critical issues which need to be thought through carefully and discussed with all the relevant stakeholders before any implementation occurs. The commitment and collaboration of health services in the area, and especially of the nurses within those services, are vital. CHWs are definitely not a 'quick fix' for PHC.

Whether they should be employed by the formal health authorities is a moot point. They need flexibility above all, as well as accountability to the communities in which they work. As has been shown in this evaluation the CHWs were well accepted by 'rank and file' members of the community. Despite this, the project was closed down during 1992 because the community's political structures began to demand a role in the management of the project, and specifically in the control of resources deployed in the community. Flexibility within the RSC bureaucracy was limited, and they were unable to meet community demands. The potential demand of communities for control of health resources should be carefully considered by authorities considering employing CHWs. Furthermore, project evaluators need to recognise that a community's political players are crucial stakeholders in a PHC project, and details of their support of and involvement in the project are valuable evaluation data.

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