The value of the community health worker in the South African health care system

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The community health worker (CHW) plays a valuable role in promoting both health care and social support in the communities in which they work, and indirectly in the communities in which they live. A master's research study was completed on traumatic experiences of CHWs – at work and home – and a paper (or two) will be written about the trauma exposure for this cadre of worker. Through the research experience other matters related to the role of the CHW and the Primary Health Care (PHC) Re-engineering Model were also talked about and considered important to report on as this work context supported or challenged how they responded to work and trauma experiences.

Social context of working in public health

In public health settings patients bring with them, not just their illness or physical challenge, but their social, behavioural and ethical experiences and views which potentially aid or hinder the treatment process. "HIV epitomizes the notion of disease as social ecology, the absolute necessity of understanding context in order to effectively prevent ongoing disease transmission… and to implement effective HIV interventions" (1). Understanding individual behaviours as well as societal structures and beliefs is crucial to improve adherence to chronic treatment and improved health outcomes in the population. Physical and mental health is inextricably linked to social context and support. Hence, the PHC Re-engineering Model is an important model in addressing health within the social context. This model is a community based health model. This approach proposes delivery of primary health care (PHC) services via an outreach team (of community health workers) at a household level (2). This service is to be provided in close association with facility based health services, other sectors and government departments, community based organisations (CBOs) and non-profit organisations (NPOs) providing community based services (3). Although health workers have worked within communities within South Africa for a number of years, there have been many different role expectations, therefore a national standardized training programme for this specific cadre of workers has been developed within this model.

Working with CHWs is not a "cheap option" in providing access to health care to all. The initial effort and input to make the structure credible needs to include understanding about the social, political, and economic community context as well as developing the skills of the worker to meet the needs. An understanding of the community – as best as is possible, in terms of its structure, history, services available and its current needs – is integral to implementing services or programmes into a community. All too often, the political and violent history of the community and current violent context is not taken into consideration, yet this has a huge impact on peoples' current lives and thereby on service implementation and delivery. The areas where there is greater challenge in service delivery, one needs to explore the history and needs of the area. Understanding the social structure of the area will assist in adjusting the roles and work of the CHWs to meet the health demands and outcomes of the facilities and health department. All levels of the PHC Re-engineering Model structure (including the CHW and the Ward based Outreach Team Leader), the Health Facility district management (including the PHC manager and Facility Manager), as well as other relevant departments (e.g. the Expanded Public Works Programme (EPWP) Coordinator) need to have the skill to support and manage health and social structures and the emotional impact of the direct stories from patients and staff. Managing the impact of the social environment on the work/service delivery helps in the realistic planning and work outputs that are achievable.

Hence social development and the PHC Re-engineering community focused health Model are closely aligned and linked. The focus on interdepartmental planning and service delivery ensures the prevention focus which attempts to alter the broader community issues such as poverty and dependency that contribute to the environment in which traumatic events and health issues are experienced (4-6). This collaboration also goes further, as it is not just interaction between government departments, but also working together with non-governmental organisations (NGOs), faith based organisations (FBOs), informal and commercial sector organisations and businesses as well as including and encouraging community participation and involvement.

The CHWs role has a health focus (7). However, as they get to know the community members better and people feel more comfortable in talking to them, they hear more stories and situations which go beyond health concerns. By connecting and communicating with the community members, the ability to access and provide support through this cadre of worker should not be underestimated. These systems in which CHWs work are experienced as overstretched and overwhelmed by the type and number of events that are happening to individuals and communities. This supports the theory that any service or programme (health, social, economic) should be encouraged to take the socio (including traumatic experiences) -political context into consideration in planning and implementation (8-11).

Role of the community health worker in South Africa

The CHW role has been part of a broader labour context within South Africa where the blur of boundaries of employment and volunteerism was and still is politicized. This structure is also broader than the daily functioning of the clinic. The term "community health worker" has been used to describe many different types of roles within community spaces and in literature. The legitimization of the role of the CHW, both in policy and service delivery development within PHC Re-engineering Model, helps to clarify roles and descriptions and allows CHWs and the community health programmes to be utilized more systematically (12-15). CHWs have the potential for strengthening service delivery, as they can have health/social focus and also be seen as key drivers to and for linkage to care. Within the social development context, the CHW role could be crucial to fulfil the inter-sectoral collaboration for the effective provision of social and health service requirements to meet the needs of the people of South Africa, especially those that are poor and marginalised (16-18).

The experience and value of community health workers within primary health care re-engineering

Through the master's research experience some of the experiences and values of the role of CHWs were highlighted. The points below were not the focus of the research, yet are important to share when thinking of the CHW role and structure (19). Some key quotes and learnings are reported.

What Community Health Workers' say that they enjoy most about their work role

The CHWs were passionate about working in and supporting the communities. They wanted to be able to assist and help people. The participants of the research showed an interest and motivation in their work and encouraged community members to access the clinic.

> *"I like helping people and communicate with people." (CHW 20)*
> *"The things that I'm enjoying, when I come to the community and talk to them who I am, and what I'm going to do with them, they understand me and the others they didn't want to come to this clinic, they said the sister of this clinic is not treating them good. So I convince them and they came, they came a lot to the clinic, and they attend their treatment according. Ja. So I see I help a lot of people. " (CHW 6)*

The CHWs liked being able to educate about basic health issues and added that they would also like to be able to give other basic information, such as information about grants. The participants also requested that, for them to be more effective in their service delivery, they would have the opportunity to develop some of their own skills, e.g. to be able to provide counselling, especially trauma counselling to assist with the experiences that people shared with them.

> *"What I like about them now they see me as of help because if they have a problem they know that they can talk to me." (CHW 4)*
> *"Just helping people, who can – who – there are those who can't help them self and there are those who don't have right – as to where to go, what to do maybe or how to – to – how to deal with other problems they are facing, ja." (CHW9)*

Community Health Workers' experience within the community

Initially the CHWs found it quite difficult to work within the community as they carried fears about the traumatic events that could happen and because they often did not know the area in which they are working. The community members were also not sure of the CHWs' role and were not so welcoming. There was fear of harm on both sides about what the other person may do to them.

> *"There is lots of fear in the community, like you knock on the door and they think you are there to hurt them. Especially like we don't have a uniform (as identification)." (CHW 20)*
> *"Before they were so scared thinking we are going, we are going to come you and visit you and say, got this one, two, three and when I go to the next one, go to talk about you, I am coming from you. You know this, the neighbour of yours*

is like this and this. We are not doing that. They now, they realise that, we are not doing that... Anything they can come to us. Whatever we are going, whatever, they call us, there is a problem this side, so you can help us, I know you can help us and then they – if there is someone who is sick, they can call us to help out." (CHW 7)

As time passed, the CHWs got to know the community members better and vice versa. The CHW's role was better understood and support relationships were built. When the second interviews were conducted, the CHWs had worked in the community for a further 7-8 months and they noticed a positive change in the community members' responses to them.

"I feel safe now just, just because it's been a while since I've been working there" (CHW 4)

"When they accept you, when your role's clear, then, ja, that's good you can see that space and see that change" (CHW 6)

It was also noted that community members started sharing events with the CHWs. Although this felt positive for the CHWs as they had built trust with the community members, it was at times overwhelming difficult as the life experiences were challenging and at times traumatic.

"And that's when the person starts trusting you, they tell you what's really happening." (CHW 17)

"I hear the stories because I'm a community health worker. So people come and talk to you about things" (CHW 2)

<u>Community Health Workers' experience within the clinic</u>
The World Health Organizaton (WHO) (1990) reported that CHWs are perceived as lowly aides and not easily integrated as fellow staff members with other clinic staff which was evident at the beginning of the implementation of this model (20). Initially the nurses in the clinics were not so clear and certain about the CHW's role. The two main misunderstandings were that the CHWs were not really part of the clinic and there was a perception that these workers may increase their work at the clinic. A few participants described the first 3-6 months as being the most difficult in the clinic as everyone was trying to work out their role (including themselves). The CHWs would not use the kitchen or staff toilets as they did not consider themselves staff and were not considered as such.

"Before it was too hard. When we were coming here, the morning, I don't know

what they (facility staff) how they feel... They was insulting us, we are different people, but now they are right, because we are helping them to set their, their defaulters. If somebody is defaulted, he is not coming anymore to the clinic, they give us the list, we must check this and we do that, to certain people they are reporting." (CHW 7)

"It needs to be looked at because we don't feel as part of the clinic, they still treat us as the people outside, except with the sisters that we work with because they know us and they know our ability and they know how we can explore so then the sisters we work with we are happy with that" (CHW 3)

However, due to the work of the team leaders – who were passionate and clear about their and the CHWs role – and the openness of the clinic managers to understand this role better, misunderstandings disappeared and clarity of the role has improved. A clear and positive shift in this district did happen and this was largely supported from the higher level managers of PHC re-engineering. The CHWs felt more part of the team at the clinic and also understood their and the nurses role better so referrals between the community team (CHWs) and the clinic team (nurses) were consistent and clear.

"Ja. It is a good link now. Now we are – like their colleagues, the better like before. We are doing better now." (CHW 7)

"Ja, it's better now than at the first when we first came here and really they didn't appreciate us that much but now it's. Ja, now they better" (CHW 18)

The nurse team leaders were reported as passionate about the model of the PHC re-engineering and supportive of the CHWs. The team leaders were advocates of the CHW role with their colleagues and managers. The CHWs in both of the clinics in this study spoke highly of their team leaders and the support that they received from them to do their work.

"Ja, I think she does have the vision. Ja, because I believe she agreed to be the team leader of this, of this program because she can reach out to people. So that means a lot to us, because she does that work, ja she is passionate about her job, ja." (CHW9)

"Sister (name) is of great help to us... All the things she is willing to discuss with us... We go straight to her and she helps us out." (CHW 4)

As the CHW's role was broader than just health, it was important that links between other government departments (especially Department of Social Development, Department of Home Affairs, Department of Housing and the South African Police Service) and other community organisations were made for clear and consistent referrals. However, these links were not always clear and referrals were not always followed up. The development of links to community organisations and FBOs that assisted and provided basic services such as home based care or the delivery of food parcels was also crucial for linkage to broader care.

> "Because in the primary health care you find, uh, so many problems. We don't just work with the HIV person only, and then OVCs and then we refer to social workers. Ja, if you find somebody, he didn't go to school, we refer there and then so many things" (CHW 14)

> "Especially most of them they are not working, then they are not getting grant. But we try to refer them to the social worker... Maybe they took a long time to respond to them, and then the community was complaining about that. You always coming to me, and you promise me you will help me because you refer me to somewhere, or to the social worker but they didn't respond. I tell them no, okay fine, maybe they will respond, I do not know when because they told us that if we have got a problem to the community we are supposed to refer them to." (CHW 12)

Continued support and training for community health workers

Understanding the societal and specific community context in which people are working should form a central part of the education, training and management of the CHW. The assumption that the CHW is from the area or a similar area should not be depended on, as the lived experience of the person may not encompass all key issues of the societal context. This could include understanding the broader context and how this affects the CHW in their role.

Acknowledgement of the CHWs as people as well as the work they do should be part of daily meetings. It would be good for this to be evident within the broader clinic space and for the CHWs themselves to acknowledge each other as well as the nurses and other people they work with in the community. Aspects of the debriefing process (specific questions) can be taught to the team leaders who can then facilitate it as part of the regular meetings. In terms of personal issues, there could be encouragement to receive counselling when there are issues that are overwhelming. Not all community counselling centres have high quality counselling, but it is important to explore further as to which counselling services offer quality counselling.

Other support suggestions include monthly debriefing of the actual CHWs. The debriefer should have an understanding of trauma, community work/development, health and social issues. Checklists (from the research) could be used to give a context for each CHW for each month of work and to discuss cases and situations that will be influenced by the context. Monthly or bi-monthly debriefing of the team leaders should be undertaken. This supervisory support could provide a framework to help CHWs to contextualise and think about the work issues and the effect generated by the work. This could be facilitated by an external person or someone within the health structure. This would be useful to help process the actual emotional impact of the work as well as strengthen links and structures to support the need and response of the work.

Three areas of training that were highlighted by both the team leaders and the CHWs themselves were:

1. First Aid. They would like to know some basic first aid as they are often asked by community members to assist and at times are the first at the scene of crisis/trauma (e.g. shack burnt down).

2. Understanding working in a community: community dynamics; working with different cultures; working with difficult people. This understanding would help them manage situations differently. The training should also include the social and trauma history of South Africa and the community in which they work.

3. Continued development of counselling skills, especially trauma counselling. As CHWs get to know community members better, more information is shared and it would be useful to continue to develop advanced counselling and problem-solving skills and to be able to assist in the initial management of trauma cases that are shared with them or those that they come across in order to contain and appropriately refer. This is particularly so as traumatic material feels overwhelming and improved skills will enhance the CHW's capacity to cope with the experiences to which they are exposed.

In conclusion, CHWs are well placed to strengthen service delivery, build links for different government departments in the community and be linkages for patients to access health care as well as other support systems. The CHW is the on-the-ground support to the patient/community member and the link to the health and social service departments. This link is essential and needs to be valued and recognised. The passion of the CHWs to help their community is something valuable to be supported and nurtured. Further collaboration that could be considered includes an on-the-ground connection between the Department of Social Development and Department of Health by having a social auxiliary worker work alongside the CHW so that both health and social issues can be dealt with, as raised by the community. The CHW is a valuable resource for the development and maintenance of the South African public health system. For it to be sustainable, the support, guidance and development of this cadre of worker is essential.

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