Strengthening community-based child health services in South Africa

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South Africa has made significant progress in improving children's access to health care services through the expansion of primary health care (PHC) services and the introduction of free health care services for pregnant women and children under six years old. Despite these efforts, the country is not on track to meet Millennium Development Goals 4 and 5 which call for substantial reductions in maternal and under-five mortality.[1]

Whilst the failure to reduce maternal and child mortality rates can largely be attributed to the impact of the HIV/AIDS pandemic, failure to engage with and empower communities to participate in improving their own health is another important gap. Maternal and child mortality audit processes have consistently identified community factors, such as failure to recognise the severity of illness and to access preventive and emergency care, as modifiable factors in approximately a third of deaths amongst pregnant mothers and young children.[2]

This essay examines the following key questions:

- What are community-based maternal and child health services?
- What is the current situation in South Africa?
- How can community-based maternal and child health services be strengthened?

What are community-based maternal and child health services?

Most child care, both during good health and illness, takes place at household level. There is good evidence that community interventions can play an important role in improving child health and survival.[3] In South Africa, as in many developing countries, community health worker (CHW) programmes are regarded as the cornerstone of community-based health services, although it should be remembered that other health workers, including both mid-level and professional cadres, can and do provide services in the community. CHW programmes have been shown to provide promising benefits in promoting immunisation and breastfeeding, improving tuberculosis (TB) treatment outcomes, and reducing child morbidity and mortality.[4]

CHWs are community members who should be selected in trust by the community to enter their homes and to assist them to improve their health status. CHW programmes are enormously diverse, with CHWs having been trained to perform a wide range of activities that include preventive, promotive and curative health as well as developmental activities. While some CHWs perform a wide range of different tasks, other CHWs are appointed for very specific interventions[5] such as the directly observed treatment supporters in TB programmes, home-based carers for people living with AIDS, and community caregivers who support orphans and vulnerable children.

CHWs can play a variety of roles, outlined briefly below. It is important that the role of CHWs in a particular programme is clearly defined to prevent CHWs being overloaded with unrealistic expectations.

Community or social mobilisation

The early literature on CHWs tended to stress their role as community advocates and agents of social change.[6] Whilst this focus has largely been replaced by a more technical approach that conceptualises CHWs as an extension of formal health services, CHWs in some programmes still play a role that extends beyond the delivery of basic health care services and includes actions that address the social determinants of health such as poor water, sanitation and infrastructure. Although there are local success stories (see case 5 on p. 73), CHW programmes have generally not been successful in promoting development on a large scale. CHW programmes can play an important developmental role in communities which are already organised and motivated to address the underlying causes of ill health, but that CHWs struggle when they themselves are responsible for motivating and mobilising communities to address these issues.

Health education and promotion

Health education and the promotion of healthy behaviours form the core of most CHW programmes. CHWs tend to function as a link between the formal health service and communities. Regular home (household) visits are generally regarded as the most effective strategy for delivering these interventions – routine visits are generally conducted with special priority given to households with high risk individuals such as pregnant and lactating mothers. Where health services are reasonably accessible (as in most parts of South Africa), CHWs can play an important role in ensuring that household members access these services, and in supporting adherence to recommended treatments.

Support groups are another powerful strategy, allowing mothers with similar problems to meet and share experiences. Case 4 gives an example of the effectiveness of support groups on positive behaviour change through the mothers2mothers (m2m) programme.

Case 4: Mothers2mothers

The m2m programme started in Cape Town in 2001 and has now spread to 634 sites in seven countries and enrolled more than 500,000 HIV-positive mothers since its inception. The design of the programme is simple but effective: Mothers who are HIV positive are trained and employed to educate other women who are also HIV positive through the prevention of mother-to-child treatment (PMTCT) programme.

The project helps to break social, emotional, cultural and psychological barriers that would be difficult for health personnel to overcome, as the education and information are provided to the pregnant mother by another mother who is also HIV positive and who has therefore been in the same situation. A study conducted in 2007 by the Population Council's Horizon Project in Pietermaritzburg, KwaZulu-Natal, found that 95% of the mothers on the project have been provided with the antiretroviral nevirapine and 88% of the babies received prophylaxis treatment. Ninety percent of the mothers opted for an exclusive method of infant feeding and 70% used contraception after giving birth.

Source: Mothers2mothers (2010) *Programmes*. Accessed on 3 March 2010: www.m2m.org/programmes/index.php; Personal communication. Besser M, Mothers2mothers 2010.

Providing curative services

Although CHWs have historically focused on preventive and promotive aspects of care, communities which do not have access to curative services have tended to demand these services from CHWs. The inability of CHWs to provide such services can lead to disappointment and a lack of confidence in the programme. Equipping CHWs with curative skills (such as management of ill newborns and childhood pneumonia with antibiotics) has not only been shown to be highly effective in reducing child mortality,[7] but also gives CHWs more credibility[8]. Despite evidence of effectiveness, current regulatory systems in many countries, including South Africa, do not allow for CHWs to prescribe medication such as antibiotics.

Providing care and support

The role of CHWs has evolved and expanded in response to HIV/AIDS, with CHWs playing an increasing role in providing care to individuals and families. CHWs, especially home-based carers, play an important role in assisting and supporting families to care for dying relatives, and in providing support to orphans and child-headed households. These services often have a strong social support element, and are often provided under the auspices of, or in collaboration with, the Department of Social Development.

Task-shifting

The use of CHWs has also been identified as a strategy to address the growing shortage of health workers, especially in developing countries. CHWs may perform tasks within facilities (such as HIV counselling) or in the community. The process of CHWs taking on tasks that were previously undertaken by health professionals strengthens the argument that CHWs be formally recognised as public sector employees.

What is the current situation in South Africa?

South Africa's strategy to provide health services relies on the primary health care approach, which is based on the principles of equity, inter-sectoral collaboration and community participation, with community participation being seen as a means to increase people's control over the social, political, economic and environmental factors that determine their health. The practice of community members rendering certain basic health services in the spirit of volunteerism has a long history in South Africa.

A commitment to strengthening community participation in health has formed part of many national policy documents, most recently the Department of Health's 10 Point Plan, which

calls for "mass mobilisation for better health for the population".[9] Likewise, the National Health Act stipulates that provincial legislation should make provision for the establishment of clinic and community health centre committees[10] (see *Part one: Children and law reform*, pp. 12 – 17). However, as in many other countries, sustained, wide-scale participation by communities has been difficult to achieve.

At a local level, community participation is one of the key determinants of successful community-based health care programmes. Community empowerment enables communities not only to accept and support community health workers, but also to address broader health issues that affect the welfare of the community. Case 5 illustrates this by giving a brief overview of the Mbabakazi community-based health care programme.

Yet community participation is often perceived as a challenge by health workers and health service managers, as they are used to providing a service rather than working in partnership with communities. Health professionals need to develop the skills and sensitivity to engage with communities as equal partners. Similarly, communities require skills, information and confidence to engage with health professionals, and it is important to allocate sufficient time and resources to this capacity-building process.[11]

Household and community IMCI

Recent efforts to strengthen child health and child health services at the community level have focused on the implementation of the household and community component (HHCC) of the Integrated Management of Childhood Illness (IMCI) strategy. The HHCC aims to initiate, reinforce and sustain household practices that are important for child survival, growth and development within an overall framework of community capacity development.[12] Sixteen key family practices have been adopted as a basis for planning interventions to improve family and community practices. The IMCI implementation framework identifies three key activities, namely: building partnerships between health services and the communities they serve; increasing the capacity of community-based

Case 5: The Mbabakazi community-based care programme

Mbabakazi is a cluster of remote villages in the Ngcobo sub-district of the Chris Hani Municipality in the Eastern Cape province. Ngcobo has poor health outcomes and is one of the 18 priority health districts in South Africa

Mbabakazi is located far from the referral clinic and other basic services. Pregnant mothers have to walk approximately 25 km to reach the clinic, which makes it difficult to adhere to 4 – 5 antenatal visits during pregnancy. The same difficulties apply to children's immunisations and growth monitoring. Mobile services from the sub-district have also been inconsistent due to transport and staffing challenges, and overflowing rivers during the rainy season. With a population of 2,589 scattered in eight villages on the mountainside, there is a strong need for community-based health care services.

A non-governmental organisation initiated a community-based health care programme in Mbabakazi. A steering committee, which included the sub-district health personnel and the community, was established. Eight volunteers, one from each village in Mbabakazi, were selected by the community, and trained in community-based health care and the household and community component of IMCI, as well as labour, delivery and PMTCT.

This was followed by a community empowerment process that involved the wider community and the community health workers to create an enabling environment for the programme. Three community workshops were held. One attended by the district, sub-district staff and provincial managers provided an opportunity for the community to share their problems and increased provincial commitment to provide on-going support to the community. The process used participatory approaches to identify strengths and resources within the community, and to enable the community to take the lead in responding to their own problems.

To date, the community has built a structure out of their own resources that can be used as a health post when the mobile clinic visits. Community health workers conduct door-to-door visits in their respective villages. They have collected antenatal, postnatal, child health and immunisation data using a simple data collection tool. They hold discussions with mothers on maternal and child health problems and encourage them to use the mobile clinic. They have also motivated mothers and the community to establish 99 food gardens. Since June 2009 to date, they have weighed over 90 children a month using Salter Scales. The health steering committee has also succeeded in getting the local council to improve the access road to Mbabakazi.

Source: Management Sciences for Health (2010) *Maternal, Neonatal and Child Health project – Final report. January 2010*. Pretoria: MSH Integrated Primary Health Care Project.

providers to give appropriate and accessible care and information; and promotion of the 16 key family practices, which include growth promotion and development, disease prevention, home management, care-seeking and compliance with treatment prescribed by health workers.[13]

However a recent review of HHCC implementation in South Africa concluded that, whilst the approach has been widely endorsed with evidence of good practice in a range of settings, implementation has been patchy and inconsistent. This situation is by no means peculiar to South Africa – an international evaluation concluded that most countries had expended considerably more effort on the first component of the IMCI strategy, which focuses on improving the case management skills of health care workers at the primary level, than on the implementation of the community components which received far less attention and resources.[14]

Despite a strong evidence base and a stated commitment to implement the HHCC, dedicated financial and human resources to drive the process have been lacking. This component has been implemented as a vertical programme under the auspices of the Maternal, Child and Women's Health units at national and provincial levels. Whilst national and provincial managers are able to provide technical input, implementation at district level depends on commitment and allocation of financial and human resources by already overstretched district and sub-district management structures. The articulation between vertical programmes, such as HHCC IMCI, and current CHW programmes, outlined below, has also proved challenging.

CHW programmes

At the same time, a range of CHW programmes have played an important role in the country's response to the HIV/AIDS and TB pandemics: There were nearly 65,000 such workers in the health and social development sectors across the country by 2005/06.[15] Almost all the CHW programmes are currently funded and managed by the HIV/AIDS programme. Initially the main focus of the CHW programmes was to provide home-based care to terminally ill patients; this role has expanded over time to include other aspects of HIV and TB care, especially treatment adherence and support. While pregnant mothers and children benefit from these programmes in many instances (particularly from those with a more comprehensive approach), the majority of programmes do not explicitly provide maternal and child health services.

Although the State has funded and driven the recruitment and deployment of CHWs, they are not formally employed civil servants. Where they provide regular services, CHWs are supposed to receive stipends through contracted not-for-profit organisations (NPOs). However, a recent mapping exercise illustrated a number of difficulties:[16]

- Unregulated and unco-ordinated proliferation of different cadres, functions, forms of training, remuneration and management.
- Failure to recognise CHWs as employees and to ensure appropriate and standardised systems of remuneration and employment benefits.
- Frequent reports of non-payment of stipends, and poor disbursement of funds to NPOs employing CHWs.
- Poor integration of CHWs into primary health care teams, problematic relationships with health professionals, and inadequate support and supervision.
- Lack of appropriate career pathways in the formal health system.

A package of services for mothers and children

In an effort to address the lack of articulation between CHW programmes and the current HHCC of IMCI and to speed up the implementation of community-based maternal, neonatal, child and women's health interventions, a draft framework for provision of these services has been developed.[17] This framework builds on the existing HHCC of IMCI, but recognises the need to expand the focus of the current strategy to include more emphasis on the health and well-being of mothers and newborns. The framework also aims to maximise service coverage, quality and overall impact by expanding the interventions and packaging them into six main service delivery modes. These include structured home visits, community-based mother support groups, joint preventive and curative outreach services by professional nurses and CHWs, twice-yearly child health days and regular visits to early childhood development (ECD) centres; all of which are supported by an effective community mobilisation strategy.

The framework also defines a package of services which should ideally be made available to all mothers and children. This is shown in table 12.

Table 12: Package of community-based mother, child and women's health and nutrition services

Strategy	Pregnancy	Postnatal	Infancy/childhood
Key interventions	• Antenatal care, including maternal nutrition • PMTCT • Birth preparedness • Newborn and child care, including infant and young child feeding	• Postnatal check, including family planning • Neonatal care • Infant and young child feeding (IYCF), including support for exclusive breastfeeding (EBF) • Early identification and management of HIV infection in HIV-exposed infants • Promote birth registration	• Promote key family practices • Counselling on IYCF/EBF, family planning and maternal nutrition • Ensuring that preventative services are accessed, eg immunisation, HIV services, vitamin A, deworming, growth monitoring
Home visits by CHW	4 – 6 visits	Four visits: When child is two days, seven days, 14 days and six weeks old	• Monthly visits until six months of age • Nine months and 12 months: three monthly visits • 1 – 5 years: six monthly visits
Child health days	–	–	Should be conducted twice a year
Support groups	All facilities should have support groups for pregnant women and mothers. Counselling and sharing experiences of IYCF/EBF, family planning, PMTCT and maternal nutrition.		

Source: MCWH Cluster, Department of Health (2009) *Framework for accelerating community-based maternal, neonatal, child and women's health and nutrition interventions. Third draft.* Pretoria: DoH.

One of the benefits of defining a package of services is that the cost of providing it to all women and child in South Africa can be calculated. It has been estimated, for instance, that it would cost approximately R710 million during the first year to provide the package of services to 95% of the uninsured population in South Africa.[18] However it is not envisaged that the package should be provided as a stand-alone programme, but that it be provided as part of a more comprehensive package of community-based services.

How can community-based maternal and child health services be strengthened?

It is clear that community-based health programmes have a central role to play in extending health care to communities. However there is an urgent need to overcome fragmentation and to ensure a more coherent approach based on realistic expectations regarding the roles that CHWs can play, and assessments of the costs associated with provision of large-scale programmes.

Ensure provision of maternal and child health services

There is good evidence to suggest that maternal and child health services should be at the core of community-based services. It makes more sense to incorporate maternal and child health services into existing CHW programmes, and to provide them as part of a comprehensive service, rather than to establish a parallel set of programmes. There is thus a need to ensure that the many small-scale initiatives undertaken as part of the HHCC of IMCI are incorporated into existing CHW programmes, and that the existing CHW infrastructure is used to provide these services at scale. A first step would be to establish the principle that all CHW programmes must provide at least a minimum basic package of services to mothers and children.

Develop a comprehensive policy framework

The Departments of Health and Social Development are currently developing a Community Care Worker Management Policy Framework[19] which aims to provide a standardised approach to the organisational management, training, supervision and

financial structure of CHW programmes. The framework endorses the current role of NPOs in managing CHW programmes and outlines the relationship between the NPOs and the two departments. It defines the roles and responsibilities of care workers within the different health and social development fields, and advocates for a multi-skilled, generalist community care/health worker.

Whilst the policy framework contains detailed recommendations on many human resource management issues related to CHWs, less attention is paid to the goals and objectives of CHW programmes, and to the package of services that should be provided.

It is also important to ensure that the role and responsibilities of other cadres of health workers, including mid-level workers, health promoters and other health professionals, are clearly defined with regards to the provision of community-based services.

Strengthen organisational capacity

Whilst there are a number of policy issues which need to be addressed, it is also important to strengthen capacity to manage CHW programmes at all levels of the health system. Lehmann and Sanders argue that, "community health workers are not a panacea for weak health systems and will need focussed tasks, adequate remuneration, training, supervision, and the active involvement of the communities in which they work".[20]

Ultimately, districts need to take over the management and monitoring of CHW programmes in their districts and provide supervision, strengthen linkages with formal health services and, critically, ensure that CHWs are regarded as key members of a health care team. This can be achieved through the incorporation of these programmes into District Health Plans and the Integrated Development Plans of municipalities. This will not only ensure better co-ordination, but will also ensure sustainability of activities.

Ensure adequate funding

Implementation of effective CHW programmes is neither cheap nor easy, although it can be argued that such programmes represent a good investment.[21] There are little data available in South Africa regarding the cost of providing community-based services at scale, and it will be important to ensure that implementation of proposed CHW programmes is adequately costed and funded.

Conclusion

Community-based maternal and child health services and particularly comprehensive CHW programmes have an important role to play in improving the survival and well-being of mothers and children in South Africa. Although some progress has been made in this regard, implementation at scale will require political will, greater clarity regarding how these services are structured and delivered, and improved capacity to implement and manage these programmes at all levels of the health service.

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