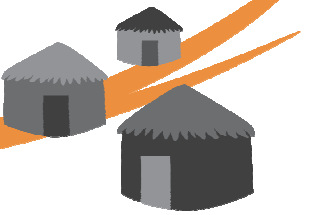
Institutionalizing Community Health Conference



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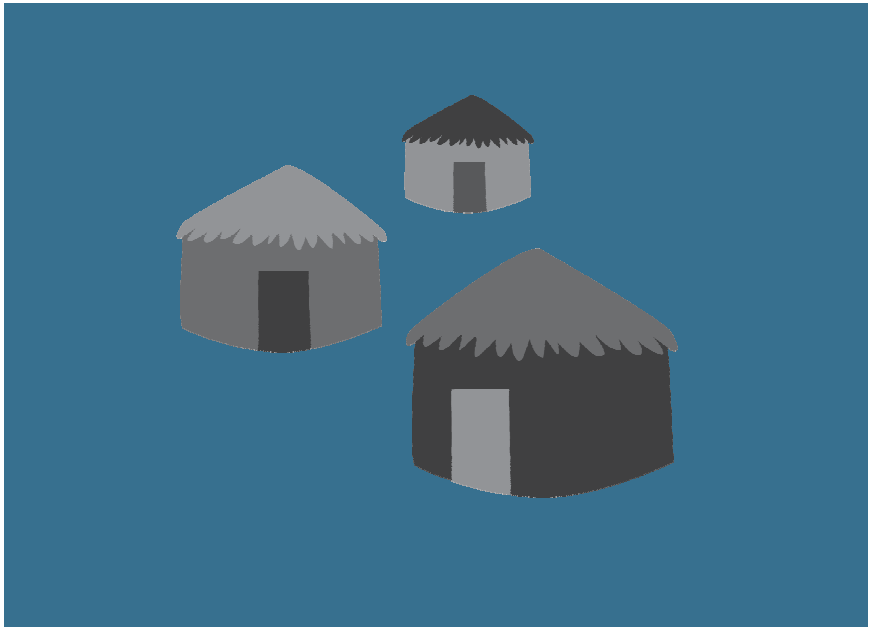

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One or two-tier community health worker cadres? Resource implications for South Africa

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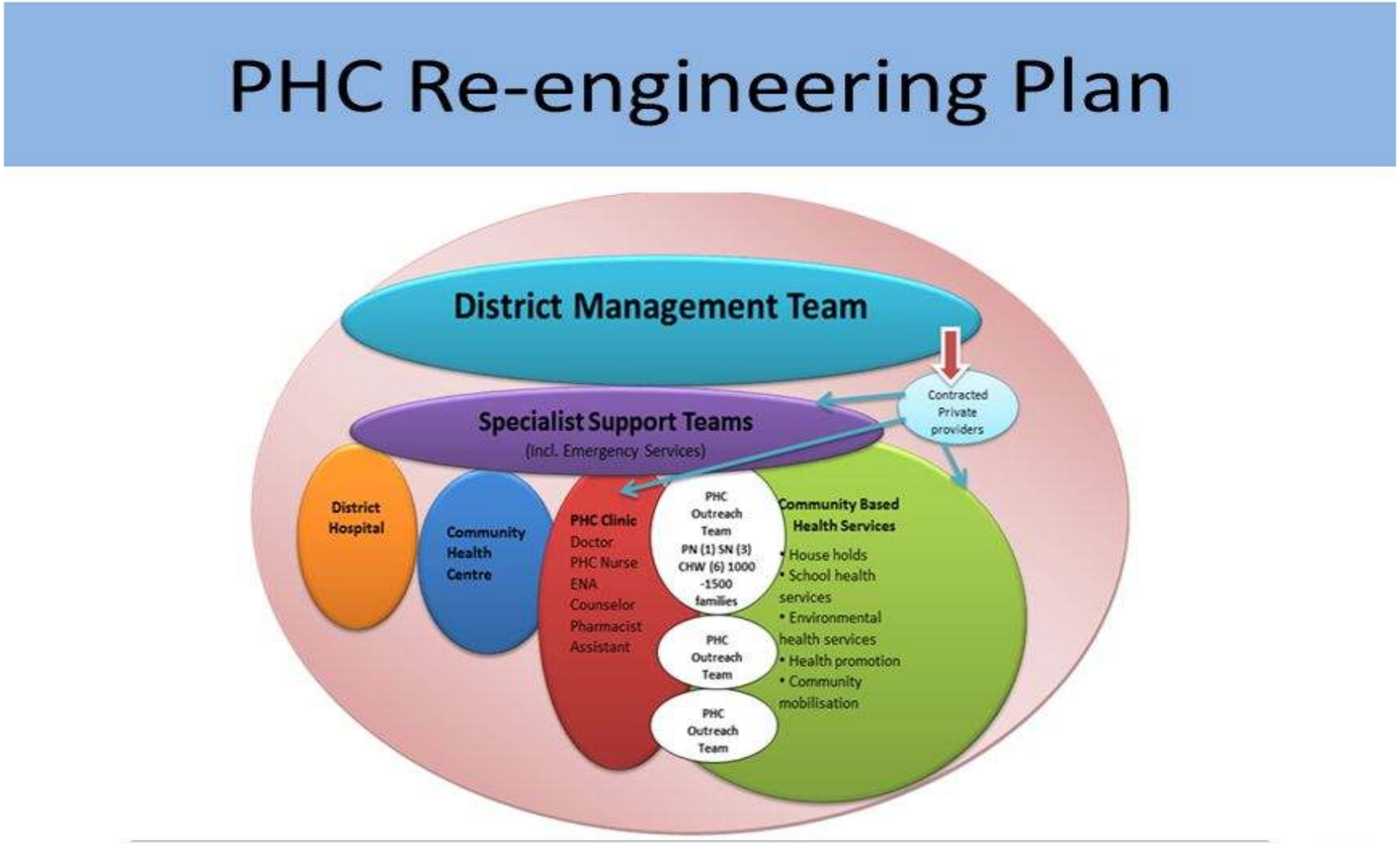
South African Health System

- 10 fold difference in annual per capita expenditure in the private sector compared to the public.
- 30% of the country's physicians in public sector catering for 84% of population.
- 43.6% of the population living in rural areas, served by 12% of the doctors and 19% of the nurses
- High attrition rate of health workers (25%)

History of CHWs in SA

- 1970s: CHW programmes developed by NGOS to address the inequitable distribution of health services due to Apartheid
- After 1994: South Africa initiated a Primary Health Care approach spearheaded by doctors and nurses, resulting in collapse of many CHW programmes
- New era of disease-focused CHWs emerged thereafter, focusing on HIV and TB related treatment and support
- Re-emergence of generic CHWs with PHC re-engineering in 2012

CHW policy


PHC Re-engineering Plan
District Management Team
Contracted Private providers
Specialist Support Teams
(Incl. Emergency Services)
District Hospital
Community Health Centre
PHC Clinic
Doctor
PHC Nurse
ENA
Counselor
Pharmacist
Assistant
PHC Outreach Team
PN (1) SN (3)
CHW (6) 1000 -1500 families
PHC Outreach Team
PHC Outreach Team
Community Based Health Services
• House holds
• School health services
• Environmental health services
• Health promotion
• Community mobilisation

Two-tier community cadres globally

- Where do they exist? Niger, Ethiopia, Malawi
- Volunteer cadres:
  - strong focus on health promotion and disease prevention
  - work closely with both CHWs at health post in their catchment area.
  - Identify sick and malnourished children and refer to CHWS
- Finer coverage of services at household level
- Scope of CHWs outside SA includes increased curative tasks

Roles of CHWs in South Africa

- Raising awareness about disease and conducting health promotion activities
- Screen for and refer new TB/HIV cases, ill children, and at-risk pregnant women; rehabilitate malnourished children at home;
- Follow-up after clinic and hospital care,
- Support TB and HIV treatment adherence and defaulter tracing
- Treat diarrhea, worm infestation, and skin problems; and distribute vitamin A.
- Assist in accessing social grants
- Community campaigns

Rationale for home based care

- AIDS epidemic and increase in non-communicable diseases,
- Complications of ageing population
- Shortage of hospital beds.
- Over-crowded and over-stretched hospitals unsuitable for managing patients with terminal or long-term diseases
- Inadequate number of medical, nursing and allied health professionals in the public sector leading to task-shifting
- Increasing demands of curable conditions on existing institutional care.
- Cost of institutional care.

CHWs vs HBCs

Community Health Worker	Home Based Care Worker
They are trained for 6 weeks to 3 months (level 4)	They are sometimes trained for 10 days sometimes not trained (level 1-2)
They have a job description	They sometime don't have a job description if not working under NGO's
They are allocated an average of 250 households	They may have or may not have a household allocated
They are on contract or employed with a stipend	Sometime on a stipend when employed but mostly volunteers
They render comprehensive services within their scope of practice	They render home based care and other services based on what they are trained in
They are sometimes supplied with working kits	They are mostly supplied with HBC kits

One or two cadres?

- Optimization of HR use
- In rural contexts with longer travel time for community health workers, combining CHW visits with any home based care duties would optimize time use.

Geographical differences in need

- Study conducted by SAMRC and RHAP to compare the resource implications (both financial and human resources) of the CHW components of WBOT between rural and urban communities.

Travel time in Sedibeng

Number entries	Household registration	Household Screening	Home Visits other	Health Post / Clinic /CHC	Support Groups	Creche, ECD inst	Other Institution	Health Days	School Health f/u	Meeting Other	Other	Median
Peri-urban	911	205	938	495	2	11	8	7	4	5	209	
Rural	218	135	538	304	5	0	15	3	3	6	111	
Median Travel Time												
Peri-urban	15	15	15	**15**	28	20	10	15	18	30	**17**	**15**
Rural	15	17	15	**30**	16		25	10	10	165	**9**	**16**
Median Activity Time												
Peri-urban	**19**	**15**	20	25	10	15	10	20	53	330	**24**	**20**
Rural	**24**	**23**	20	30	34		10	15	21	225	**30**	**23**

CHWs in rural sites spent 7% longer traveling than those in peri-urban sites and 15% longer on activities

Activity of home visits-Sedibeng

- Home-based care (HBC) defined by the CHWs as dressing wounds **was twice** as common in rural than urban areas probably due to the distance to clinic or health post.

Type of Site	Screening	Health Educ	Bring meds	Tracing defaulters	HBC	Referral	DOTS	Other
Peri urban	**40%**	**30%**	**28%**	**4%**	**3%**	4%	3%	**4%**
Rural	**30%**	**19%**	**18%**	**26%**	**7%**	3%	2%	**7%**

Travel time-uMzinyathi

Number Entries	Home visits	Clinic/CHC incl Meeting with supervisor	Philamhtwena	Creches and other instutions	Campaigns	Meeting w/comm and other	War room	Training	Support Groups	Other
Peri-urban	434	64	25	6	5	11	6	9	3	15
Deep-Rural	1301	147	100	40	30	24	20	67	13	151
Median Travel time										
Peri-urban	**15**	**25**	30	27	20	20	30	35	30	16
Deep-Rural	**20**	**30**	30	23	30	30	35	30	30	15
Median Activity time										
Peri-urban	**40**	**120**	**360**	50	150	**40**	122	**51**	55	43
Deep-Rural	**60**	**115**	**425**	73	235	**100**	188	**120**	95	40

CHWs travel time for home visits was 33% longer in rural areas that in peri-urban areas

Resource implications?

- Modeling study conducted by SAMRC found:
  - Based on assumption that 0.5% of total South African population would require HBC service with an average of 2 visits a week per case
    - 52% more CHWs would be required to ensure delivery of all services under a model consisting of one cadre of CHWS vs two cadres.
  - If same number of home based carers were added instead of CHWs, cost to health service would be lower given the higher stipend provided to CHWs without necessarily improving the quality of home based care.

Excluding home based carers has implications…

- New training policy requires high school diploma-excluding a large number of health workers currently providing community based services.
- Home-based care services requires lower levels of skills and keeping the cadres separate would prevent exclusion and loss of a large number of workers
- With one cadre, families would receive a more holistic response to their needs by seeing one provider in the home.
- With two cadres, lines of communication need to be strengthened to maximize synergy between CHWS and home based carers.


NO STIPEND!!
NO FOOD! NO HOME!
NO EDUCATION

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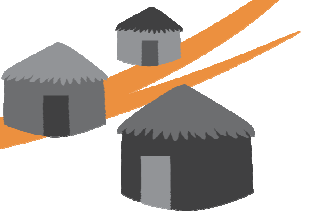

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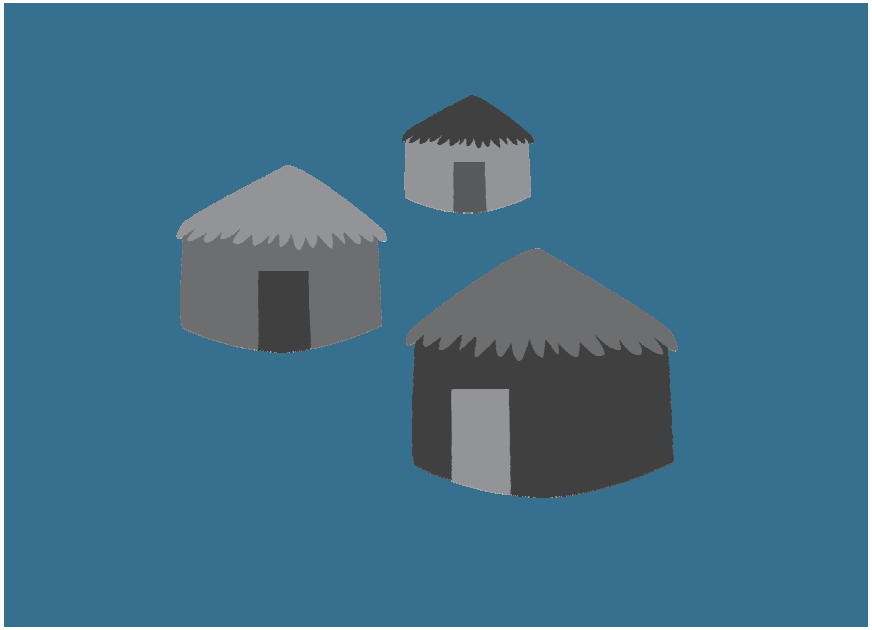

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