DEPARTMENT OF HEALTH **EVIDENCE BRIEF**

Connecting Policy and Practice

CHWs POSITION AND ROLE: REALISING COMMUNITY HEALTH SYSTEMS SOLIDARITY FOR COMPREHENSIVE PHC

Verbal Autopsy with Participatory Action Research (VAPAR):
expanding the knowledge base through partnerships for action on health equity
Series 3, Number 3

July 2022



CHWs receiving certificates on completion of
VAPAR Community Mobilization Training (May 2022)

This brief concerns CHWs positioning and role in the health system. With low-cost/low-tech learning partnership interventions, supported by stable research infrastructure in Mpumalanga and South Africa, significant potential to realise the objectives of PHC Re-Engineering identified through a focus on CHWs as an empowered workforce to support realisation of comprehensive PHC strategy.

www.vapar.org

vapar

1 **Situation** CHWs and PHC policy-implementation paradox

Policy-implementation gaps in PHC Re-engineering undermine the potential of WBPHCOTs, CHWs and PHC regarding the community mobilisation mandate – including and beyond CHWs

A major district health systems revival is underway across South Africa. National Health Insurance (NHI) was introduced in 2012 with provincial guidelines for PHC Re-engineering [1]. In 2017, a policy framework and strategy for Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) underscored commitments to *bringing services to people,* devolving power to communities for a patient-focused and community-oriented system [2 3].

Despite policy commitments, implementation reveals limited operational spaces to engage with and respond to community health needs [4]. Participatory governance structures, such as clinic committees and hospital boards, for example, do not function effectively [5]. Top-down governance persists, and organisational 'compliance cultures' are the norm, with centrally-defined targets and outputs and limited space for local planning management and 'everyday learning' [6 7 8 4]. This overlooks significant ingenuity, innovation and resilience at lower levels [8 9 10].

Furthermore, implementation of WBPHCOTs has been slow and uneven and there is low coverage [11]. There is low awareness of expanded CHW roles and functions in communities, resulting in roles that are not well-defined, valued or supported [12 13]. A 12-month curriculum for training CHWs was developed but funding is yet to be disbursed [11]. No clear leadership at the national level exists and investment has been low [11]. CHWs are poorly remunerated; budget allocations are insufficient, and policy governance remains unclear [11].

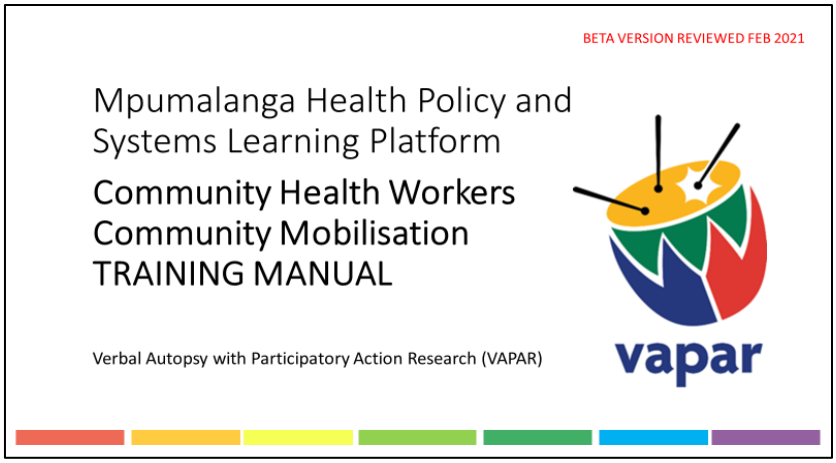
Nevertheless, within and beyond South Africa, CHWs make critical contributions in local surveillance and response efforts for more informed district health systems responses, supporting calls for recognition of, and support for, this critical cadre [14–20]. This brief presents evidence that modest resource allocation with low-cost/no-cost learning partnership intervention can strengthen this cadre, and by extension, this central stream of PHC re-engineering.

2 **Intervention** fulfilling CHW roles through 'everyday learning'

CHWs are uniquely placed to connect communities and the system but need credibility and authority to fulfil this role. Empowering CHWs is achievable with low-cost interventions that support 'everyday learning' and engagement with communities and at higher levels of the system.

The VAPAR (Verbal Autopsy with Participatory Action Research) programme 2015-2023 aims to improve the evidence base on the health of disadvantaged populations and promote utilisation of this evidence in the health system. The process combines verbal autopsy (VA), a method to measure levels and causes of community and facility deaths, and participatory action research (PAR), an equity-oriented method where different stakeholders organise evidence for local learning and action. As COVID-19 took hold in 2020, along with community and district health stakeholders, VAPAR was redesigned to support CHWs to connect with communities and rapidly generate evidence on local needs and situations and make practical contributions in the context of COVID-19 [26].

- Build capacities for CHWs and district health systems to conduct rapid research on local health priorities.
- Support evidence use in routine PHC, on community deaths, lived experience, and feasible local action.
- Develop multisectoral engagement supporting community responses addressing social causes.



Delivered as a Community Mobilization training Programme, CHWs were trained to build learning networks between otherwise disconnected stakeholders (district, clinic and community health officials and staff, community stakeholders and researchers). The process established conducive working relationships, aligning to DoH priorities, and embedding into routine PHC planning and review [21].

3 Analysis costs/benefits **Complementing/strengthening standardised prescript**

INPUTS	OUTPUTS AND OUTCOMES
- **Data/evidence**: codesigned/generated with community and systems actors, supported by Wits/Agincourt - **Local learning workshops** (20-30 of 6-50 participants) coordinated by Wits/Agincourt - **Training of trainers**: VAPAR has trained CHWs across the BBR sub-district. Community stakeholders and Community mentors. The process is relative 'low tech'. We have trained trainers in a sustainability-oriented response o VAPAR-CHW Community Mobilization Training Module	• **Evidence for local policy and planning** Timely robust evidence produced *with and for* the district health system. With the agenda driven by CHWs, people lost to follow up for HIV/TB treatment was identified as a critical issue locally, and potentially overlooked as the service shifted to a focus on the COVID-19 emergency. The power of local intelligence to rapidly identify and respond to local concerns has a relevance that extends beyond the pandemic as the health systems struggles with a range of competing demands requiring systems responses. • **Community engagement** VAPAR supports engagement between communities and health authorities for collective planning and implementation of services. In the contexts of lack of trust and dialogue, the participatory approach improved and encouraged continued engagement between stakeholders. Community stakeholders report that the authorities have started to pay attention to the community since VAPAR started and, although changes cannot be directly linked to VAPAR, that service provision has improved in the community. • **District health systems engagement** Government stakeholders report finding the process appropriate and relevant to promoting community participation in the health system and a complementary model for community participation in PHC. They are also enthusiastic about opportunities to learn about and engage with other departments to support policy and strategy implementation, and to hear the community voice directly. • **Health literacy, changes in health behaviours**, **social solidarity for health** Community stakeholders consistently report that raising local issues and building dialogue with the authorities on local action builds analytical and public-speaking skills and confidence, and shared awareness of local priorities and strategic alliance building. • **Organization and delivery of health care services** VAPAR is informed by realities on the ground. While service delivery improvements attributed to VAPAR are cautiously interpreted, service delivery improvements could be realized if government structures collectively act on the needs and priorities of the community and address these jointly with community structures. VAPAR participants valued that the process allowed for role clarification, including that of CHWs as perceived by the community as well as by other health system stakeholders. • **Policy and planning** Community engagement, consultation and participation lead to improved policy and planning, as community needs are prioritized, rather than policy decisions based on selective, biased, and anecdotal evidence and political priorities. Communities are most likely to buy into policies and plans if involved in the process of developing them. • **Health outcomes** Although no direct improvement in health outcomes was demonstrated, community awareness, education and engagement were identified as means to improve health outcomes over time through improved health behaviour, and service responses. • **Practical, acceptable process** VAPAR process was considered acceptable, relevant, participatory, inclusive of "community voice", non-prescriptive and owned by stakeholders. It was noted that there was potential for VAPAR data and processes to be incorporated into routine health system planning, for officials from the department to participate in all stages of VAPAR and for the VAPAR process to support community participation in routine health system processes. • **Multisectoral and multilevel design** role clarification between different sectors allowed for an improved understanding of the multisectoral approach, allowed stakeholders to understand where services are complementary and where referral between sectors can further support communities. Integration of the programme with routine health system processes and through a skills exchange by inclusion of frontline health workers in the programme processes.

4 Recommendation

Fill service delivery gap with CHW training, with low-cost learning partnership

There was timely and decisive action to COVID-19 with strict lockdowns, integrated support and community-based screening and testing [22]. While a highly centralised strategy initially slowed the rise in cases, the phased lifting of lockdown has been accompanied by further waves, driven by new, more transmissible variants. There have also been severe impacts on incomes and food security, particularly in informal settlements, and there are serious concerns over diagnosis and treatment of other conditions, particularly HIV/AIDS and TB and other chronic conditions [23] [24] [25]. The new demands to already-challenged systems underscore the necessity of real-time local data and action, community involvement, and multisectoral approaches.

PANEL1: OUTCOMES SUMMARY

Stakeholder engagement

- Appropriate platform for the Department of Health to engage with community members, allowing collective identification of health-related challenges and planning to address these challenges
- Engagement among diverse stakeholder constituencies, including government and parastatals, nongovernmental organizations, and community members
- Supports role clarification among different government departments, parastatals, and NGOs, thereby identifying areas for collaboration towards specific goals, and opportunities to hold each other accountable for respective responsibilities
- Empowered community stakeholders to further engage with official structures

Health literacy, health behaviours, solidarity for health

- Empowered community stakeholders report improved approaches to local problems, a sense of agency and willingness to work in partnership with the health system
- Improved understanding of health services and structures, along with health promotion messages aimed at improved health literacy and would potentially improve health behaviour (reducing disease risk) and health seeking behaviour
- Pro-active and participatory planning with communities could prevent service delivery protests and improve uptake of services, through alignment of priorities

Organization and delivery of services (including/beyond health)

- Improvement in the delivery of water to communities in the study site (water priority area identified in prior cycle) recognized and acknowledged as a perceived outcome by community interviewees
- Improvements in law enforcement regarding taverns trading hours, as well as noise levels, reported and attributed through which police services became aware of community concerns

Establishing an evidence base for policy and planning

- Potential to influence policy and planning with buy-in from the community when their health priorities are acknowledged and attended to
- Community engagement for more responsive and informed policy and planning

Improving health outcomes

- Community awareness, education and engagement regarded as ways to improve health behaviour and therefore also health outcomes over time
- No direct improvement in health outcomes demonstrated to date

PANEL 2 - VIGNETTE OF PROBLEM TREE AND IMPROVED MEDICATION DISTRIBIUTION

Following attendance of the VAPAR community mobilisation training, a CHW based at a local clinic, with support from the clinic operational manager who has supported the training, applied one of the participatory tools (problem tree) to address HIV/TB loss to follow-up. The operational manager and CHW facilitated a session with the clinic team to identify why the facility's HIV loss to follow-up rate was high. Through applying this tool, designed to identify cause-and-effect relationships pertaining at different levels as it relates to an identified problem (e.g., HIV loss to follow-up), the team realised that a main underlying cause of the poor performance was inaccurate data due to the incorrect completion of routine daily operational statistics.

This error resulted in individuals on HIV treatment not being captured as having collected their medication, therefore being listed as defaulters and requiring tracing by the CHWs. By correcting the data input, the defaulter list was reduced. In addition, the tracing process was redesigned, to include two steps - with a CHW first making telephonic contact with defaulters and a second CHW physically tracing them at the last known address if they could not be traced telephonically.

The overall gains from this process included:
- Improved data accuracy
- Underlying cause identified / false impression corrected
- Defaulting rate reduced
- Efficiency improved, not spending time on tracing patients who have not actually been lost to follow-up
- Improved communication between stakeholders within the clinic

This brief presents material adapted from:

- D'Ambruoso et al 2022 https://doi.org/10.1101/2022.07.03.22277088
- D'Ambruoso et al 2021 https://chwcentral.org/twg_article/supporting-chws-to-connect-with-communities-in-rural-south-africa-during-covid-19/
- van der Merwe et al 2021 https://doi.org/10.1186/s12961-021-00716-y

© 2022 VAPAR/Wits/DoH Mpumalanga
The research is supported by the Health Systems Research Initiative from Department for International Development (DFID)/ Medical Research Council (MRC)/ Wellcome Trust/ Economic and Social Research Council (ESRC) (MR/N005597/1, MR/P014844/1)

REFERENCES

1. DOH. *Provincial Guidelines for the Implementation of the Three Streams of PHC Re-Engineering*.; 2011. https://tinyurl.com/sruskxh.
2. Setswe G, Witthuhn J. Community engagement in the introduction and implementation of the National Health Insurance in South Africa. *J Public Health Africa*. 2013;4(1):6. doi:10.4081/jphia.2013.e6
3. DOH. *Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018/19-2023/24*. Pretoria: Department of Health; 2017.
4. Cleary SM, Molyneux S, Gilson L. Resources, attitudes and culture: an understanding of the factors that influence the functioning of accountability mechanisms in primary health care settings. *BMC Health Serv Res*. 2013;13(1):320.
5. Haricharan HJ, Stuttaford M, London L. Effective and meaningful participation or limited participation? A study of South African health committee legislation. *Prim Health Care Res Dev*. 2021;22. doi:10.1017/S1463423621000323
6. Hove J, D'Ambruoso L, Kahn K, et al. Lessons from community participation in primary health care and water resource governance in South Africa: a narrative review. *Glob Health Action*. 2022;15(1). doi:10.1080/16549716.2021.2004730/SUPPL_FILE/ZGHA_A_2004730_SM1697.DOCX
7. Mulumba M, London L, Nantaba J, Ngwena C. Using Health Committees to Promote Community Participation as a Social Determinant of the Right to Health: Lessons from Uganda and South Africa. *Health Hum Rights*. 2018;20(2):11-17. http://www.ncbi.nlm.nih.gov/pubmed/30568398. Accessed October 2, 2019.
8. Moosa S, Derese A, Peersman W. Insights of health district managers on the implementation of primary health care outreach teams in Johannesburg, South Africa: a descriptive study with focus group discussions. *Hum Resour Health*. 2017;15(1):7.
9. Gilson L, Barasa E, Nxumalo N, et al. Everyday resilience in district health systems: Emerging insights from the front lines in Kenya and South Africa. *BMJ Glob Heal*. 2017;2(2).
10. Gilson L, Goudge J, Lehmann U, Schneider H. Dear Mr President, we need to talk about our health system. *Spotlight*. 2018. https://www.spotlightnsp.co.za/2018/09/18/dear-mr-president-re-our-health-system/. Accessed January 9, 2019.
11. Schneider H, Besada D, Sanders D, Daviaud E, Rohde S. Ward-based primary health care outreach teams in South Africa: developments, challenges and future directions. *South African Heal Rev*. 2018;Chapter 7:59-65.
12. Ameh S, D'Ambruoso L, Gómez-Olivé FX, Kahn K, Tollman SM, Klipstein-Grobusch K. Paradox of HIV stigma in an integrated chronic disease care in rural South Africa: Viewpoints of service users and providers. *PLoS One*. 2020;15(7):e0236270.
13. Murphy JP, Moolla A, Kgowedi S, et al. Community health worker models in South Africa: a qualitative study on policy implementation of the 2018/19 revised framework. *Health Policy Plan*. 2020. doi:10.1093/heapol/czaa172
14. Igumbor J, Adetokunboh O, Muller J, et al. Engaging community health workers in maternal and infant death identification in Khayelitsha, South Africa: a pilot study. *BMC Pregnancy Childbirth*. 2020;20(1):1-12. doi:10.1186/s12884-020-03419-4
15. Basera TJ, Schmitz K, Price J, et al. Community surveillance and response to maternal and child deaths in low- And middleincome countries: A scoping review. *PLoS One*. 2021;16(3 March):1-21. doi:10.1371/journal.pone.0248143
16. Nichols EK, Ragunanthan NW, Ragunanthan B, Gebrehiwet H, Kamara K. A systematic review of vital events tracking by community health agents. *Glob Health Action*. 2019;12(1). doi:10.1080/16549716.2019.1597452
17. O'Connor EC, Hutain J, Christensen M, et al. Piloting a participatory, community-based health information system for strengthening communitybased health services: Findings of a cluster-randomized controlled trial in the slums of Freetown, Sierra Leone. *J Glob Health*. 2019;9(1):1-15. doi:10.7189/jogh.09.010418
18. Hutain J, Perry HB, Koffi AK, et al. Engaging communities in collecting and using results from verbal autopsies for child deaths: An example from urban slums in Freetown, Sierra Leone. *J Glob Health*. 2019;9(1):1-11. doi:10.7189/jogh.09.010419
19. Nabukalu D, Ntaro M, Seviiri M, et al. Community health workers trained to conduct verbal autopsies provide better mortality measures than existing surveillance: Results from a cross-sectional study in rural western Uganda. *PLoS One*. 2019;14(2). doi:10.1371/journal.pone.0211482
20. De Savigny D, Renggli S, Cobos D, Collinson M, Sankoh O. *Maximizing Synergies between Health Observatories and CRVS: Guidance for INDEPTH HDSS Sites and CRVS Stakeholders*. INDEPTH Network and the Bloomberg Data for Health Initiative; 2018. https://getinthepicture.org/sites/default/files/resources/Maximizing Synergies between Health Observatories and CRVS v2.5.pdf. Accessed March 20, 2021.
21. Merwe MS Van Der, D'Ambruoso L, Witter S, et al. Collective reflections on the first cycle of a collaborative learning platform to strengthen rural primary health care in Mpumalanga, South Africa. *Heal Res Policy Syst*. 2021;19(66).
22. DOH. *COVID-19 – Community Screening and Testing Programme*. Pretoria: Department of Health; 2020.
23. van Ryneveld M, Whyle E, Brady L. What Is COVID-19 Teaching Us About Community Health Systems? A Reflection From a Rapid Community-Led Mutual Aid Response in Cape Town, South Africa. *Int J Heal Policy Manag*. 2020;2020:1-4. doi:10.34172/ijhpm.2020.167
24. Odendaal N. Recombining Place: COVID-19 and Community Action Networks in South Africa. *Int J E-Planning Res*. 2021;10(2). doi:10.4018/IJEPR.20210401.oa11
25. Kirby T. Global tuberculosis progress reversed by COVID-19 pandemic. *Lancet Respir Med*. 2021;0(0). doi:10.1016/S2213-2600(21)00496-3
26. D'Ambruoso L, Twine R, Mabetha D, et al. Supporting CHWs to connect with communities in rural South Africa during COVID-19. *CHW Cent*. 2021. https://chwcentral.org/twg_article/supporting-chws-to-connect-with-communities-in-rural-south-africa-during-covid-19/. Accessed November 10, 2021.











