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ORIGINAL RESEARCH

Improving Community Health Program: Perspective of Community Health Workers in the Eastern Cape, South Africa

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Introduction: One of the challenges CHWs face in their profession is their underrepresentation in program advancement. Despite the importance of community health workers as an adjunct health workforce providing crucial healthcare services to the rural, marginalized, and underserved populations, their opinions on strengthening the CHW program remain understudied in certain geographical contexts. Consequently, this study explores the opinions of community health workers regarding the support systems desirable for their effective delivery of healthcare support services in the Buffalo Municipality City, Eastern Cape Province of South Africa.

Methods: In-depth individual, semi-structured interviews (n=10) as well as focus groups interviews (n=13) were conducted with 23 community health workers, using an audio recorder with their permission to record the interviews. Content and thematic data analysis was applied.

Results: The CHWs made several suggestions to assist them serve the community better and improve the community health program. These include provision of transportation, constant training workshops to enhance and maintain their skills and knowledge, support to improve communication with clients, provision of work identifiers to earn community's recognition, respect, and trust, and improvement in human and material resources to mitigate the overwhelming workload. In addition, they emphasised the need to address job insecurity by offering them with permanent, salaried positions, as well as the safety concerns posed by violent crimes in the communities they served.

Conclusion: The findings of this study have implications for improving the practise of CHW programs, policies, and future research recommendations, emphasising the need to take into considerations, the suggestions of the CHWs in improving the CHW program to enable them to provide effective and optimal healthcare support services to clients and the community. We advocated for the integration of community health workers into the larger healthcare system.

Keywords: community health workers, challenges, strategies, strengthening, South Africa

Introduction

Community health workers play a crucial role in the health system strengthening contexts of many countries around the world. They support in the provision of healthcare to rural and disadvantaged populations. Community health workers educate the public on a variety of health issues affecting the community, assist patients with chronic illnesses in adhering to their medications and treatments, provide immunisation services, and administer vaccines.[1] Additionally, in the light of a healthcare workforce shortage, community health workers are recruited to assist in the prevention and control of pandemics such as COVID-19.[2] Thus, CHWs perform crucial roles in facilitating primary healthcare and community health initiatives. According to Perry et al[3] community health workers (CHWs) should be viewed as the foundation of primary health care (PHC) and as an essential component of health systems in contexts characterised by ineffective health delivery and inequity. In recognition of the strategic role of CHWs in attaining global public health objectives,[4] the 2019 World Health Assembly urged countries to adopt the WHO guidelines on health policy and system support to

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optimise CHW programmes.[5] Evidently, CHWs are potentially strategic in attaining the objectives of PHC, not only in the preventative spectrum, but also in controlling non-communicable diseases.[3] Therefore, strengthening CHWs is essential for enhancing community healthcare delivery and the health system.

In South Africa, CHWs conduct a variety of roles and responsibilities. These include health promotion, support and delivery of chronic medication adherence to HIV, TB and pensioners, household registration and risk assessments, contact tracing, and facilitating referrals and links to clinics or primary healthcare centres, and maternal and child health services, promoting child and adolescent health, and promoting family planning.[6,7] However, community health workers (CHWs) encounter many challenges that impede their capacity to efficiently fulfil their specified tasks and responsibilities, which largely involve delivering healthcare services to the community. Previous studies have cited a spectrum of challenges impeding the effective function of CHWs in various geographical settings in South Africa. The lack of training or ineffective training,[6,8–10] insufficient material resources,[7,8,10,11] shortage of staff,[7,12] lack of or suboptimal supervision,[6,8,10,11] lack of transportation,[6,8] limited respect/distrust,[7,11] low remuneration,[7,11] high burden of data collection and reporting,[7,11] safety and security issues,[7] traditional and cultural beliefs,[6] and lack of clarity on role definition[11] hinders the effective practice of CHWs in South Africa. To address the needs of the community health workers, it is essential to comprehend their views on what specific needs they required to aid them function optimally within a geographical context. Given that CHWs are an intermediary between the health system and the community, they should be acknowledged and not neglected; therefore, it is necessary to seek their perspectives on how best to improve the CHW program for effective service delivery.

Notably, obstacles to a community health program's effective operation vary depending on the health system, socioeconomic factors, and other social determinants of health in a specific setting. In this context, to develop the most effective support strategies for the development of CHWs, it is necessary to understand the supportive strategies that are unique to their context. To the author's knowledge, there is no study exploring the approaches for enhancing the community health program in Buffalo City Metropolitan Municipality, Eastern Cape Province, South Africa. Considering this, this study explores the opinions of community health workers regarding the support systems needed to improve the program in this region.

Methods

Research Design and Setting

This study used a qualitative approach to explore the opinions of community CHWs regarding the support systems to improve their ability to serve the community better. A purposeful sample of 23 CHWs was selected from two community health centers namely Nontyatyambo and Duncan Village Day Hospital, and one local clinic, John Dube clinic, all in Buffalo City Metropolitan Municipality, Eastern Cape Province. Buffalo City Metropolitan Municipality is located on the East Coast of the Eastern Cape Province of South Africa. The Buffalo City Municipality is comprised of a total population of 884,000, or 12.2% of the total population of the Eastern Cape. It is estimated that 460,000 (51.99%) of the total population are females, while 424,000 (48.01%) are males.[13]

The Eastern Cape Province, created in 1994, includes areas from the former Xhosa homelands of the Transkei and Ciskei, and parts of the Cape Province. It is one of the poorest provinces in South Africa,[13] due to the historical injustices of the apartheid government policy which coerced the Black South Africans to sparsely populated, isolated and poorly developed geographical areas.[14] The province is characterised by scarce resources and services and most of the populations residing at considerable distances from clinics.[14]

Participants

Eligibility for participating in this study were for CHWs with at least three years working experience, 18 and above years (legal age of consent in South Africa), ability to speak and communicate in English and those excluded in the study include CHWs who absent during the time data was collected (on Leave), those that does not consented to participate. The CHWs were invited to participate in individual interviews (n=10) and focus group discussions (FGDs) (n=13).

Written consent was obtained from all participants, and there was no financial incentive for participation. Most of the participants reside in the community where they work while others live in the nearby community.

Data Collection Procedure

Participants individual and FGDs interviews were conducted at the clinics from February to March 2023. Participants were provided with informed consent form to sign and return before data collection. Participants informed consent included publication of anonymized responses/direct quotes. They were contacted through cell phone for dates, time, and place for their conveniences to indicate a suitable date for their interview. The interview guide contains open-ended questions probing about the opinions of community health CHWs regarding the support systems needed to enhance the program. The interviews lasted between 45 and 60 minutes on average. Interviews were recorded and notes taken. The interviews were audio-recorded with the permission from the participants. In addition, FGDs were conducted with 13 participants for approximately 1 hour 20 minutes. Similarly, with the permission of the participants, the FGDs were audio recorded and transcribed verbatim. Even though the FGDs were large, the moderator established a ground rule for the conversation that no one should interrupt the other while speaking and that everyone should respect each other's viewpoints. Furthermore, there was an audio recording that accurately captured the participants' opinions and points of view without imposing their own interpretations or biases. By recording and transcribing the data verbatim, it reduces the researcher's impact during the data analysis process.

Data Analysis

The data was analysed by an expert in qualitative data analysis, using the thematic analytical framework as proposed by Braun and Clarke.[2] Based on the topics from the interview guides, a coding framework was designed deductively. The recorded interviews were listened to, and the field notes read repeatedly to gain a deeper understanding of the participants' perspectives concerning the opinions of participants regarding the support systems needed to enhance the program. The text was categorised into meaningful units, which were then collapsed, abstracted and codes assigned accordingly. After coding the data, codes with comparable or shared characteristics were categorised. The identified themes as well as sub-themes were then categorized, coded, and reviewed by an independent coder.

Data Trustworthiness

Several measures were applied to maintain trustworthiness. Building trust with participants by explaining the research objectives and methodology and interviewing them for an extended period ensured data credibility. We conducted literature control to confirm the collected data and upheld quality standards throughout the research process to ensure reliability. Multiple approaches were used to collect data, including an audio recorder during interviews. Each phase of the data collection technique was rigorously documented to ensure uniformity in each interview. Participants also confirmed the audio recordings. Moreover, an audit trail was established to ascertain the verbatim narratives and emergent themes and subthemes from the data.

Ethics

We obtained ethical approval for the study from the University of Fort Hare Research Health Ethics Committee (Ref#2020=10=10=GoonD=ObasanjoI), and the Eastern Cape Department of Health Research Ethics Committee granted permission. The participants signed an informed consent document following a thorough clarification of the study's nature, objectives, and methodologies. The participants' identities were concealed, and their information was kept confidential.

Results

The ages of the participants were between 24 and 61 years. Most of the participants were female (n=15), had grade 12 (secondary certificate) (n=16), single (n=17), had two-three and above children (n=12), living with someone (n=14), and their grandmother/children (n=13). Also, all the participants were the main source of income for their family, working as CHWs for 2–10 years (n=17), with majority earning a monthly stipend or salary of R4000 (equivalent of UDS 210) (n=14) and mostly were serving the Mdantsane black township community (n=13). Other interviewee characteristics are provided in Table 1.

Table 1 Demographic Profile of the Participants (n=23)

Variables	n
Sex	
Male	8
Female	15
Education level	
Grade 11	1
Grade 12	16
Diploma	6
Marital status	
Married	4
Single	17
Widowed	2
Number of children	
One child	9
Two-three and above	12
None	2
Does anyone else live with you?	
Yes	14
No	9
Who else live in your household?	
Mother	2
Grandmother/children	13
None	8
Main source of income for your family	
Yes	23
No	-
Monthly stipend or salary earned	
R2200	1
R4000	14
R4020	1
R4050	3
R4100	1
R4200	2
R4300	1
How long have you worked as a CHW for the health district?	
2–10 years	17
11–20 years	6
Community served	
Duncan Village	5
Scenery Village	5
Mdantsane	13

Suggestions for Improvement

When asked on how they perceived to make their jobs easier, the CHWs stated ways on how their work can be improved. The theme and subthemes indicating the various ways that CHWs suggest their employment could be improved are depicted in Figure 1.

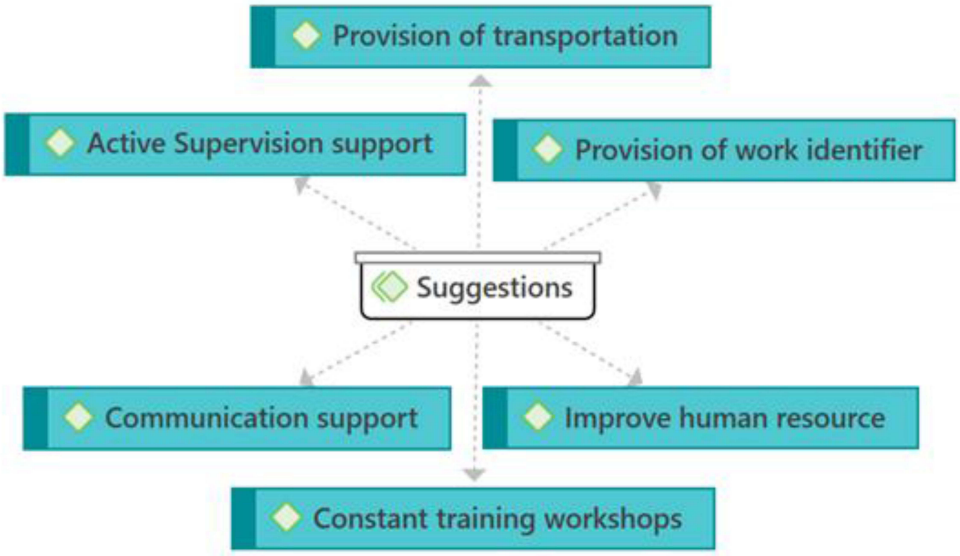

Figure 1 Suggestions showing various ways of improving community health program.

Provision of Transportation

CHWs suggested the need for transport services to facilitate their travel from work to their respective homes to reduce fatigue, safety risks, and anxiety. They maintained:

> We don't have transportation; we must trek, which makes us tired. Sometimes, we use our personal transport. Whenever we visit our community, we fear for 'tsotsi' (thieves). Even though we don't go alone, we are told that we must move as a group to keep from getting harm. (CHW 01, 02, 07, FGD)

> I believe providing we with means of transportation that will convey us to the community would make our job easier. Truth be told, we do a lot of trekking, which makes us fatigued when we get at our various working areas. (CHW 02, 05, 09, FGD)

Active Supervision Support

According to CHWs, to balance their workload, supervision is required. One of the participants remarked:

> We need a supervisor whom we will be reporting to. Yes, I stated this because we do not have a community-based supervisor who will accompany us to rural areas. It makes our work extremely difficult that there is no supervisor; we report to the unit manager, who is based in a clinic. (CHW 03, 06, FGD)

Constant Training Workshops

Participants expressed a need for training to enable them to work more effectively and efficiently. They indicated as follows:

> Workshops and training, particularly when evaluating someone and determining that her situation is not favourable, allow you to communicate with the manager. But with training, you will be able to know certain things and what to say. (CHW 04, 07, FGD)

> I want to attend training to gain more knowledge about this job because I am new in the job. (CHW 06, 10, FGD)

Communication Support

CHWs require a financial allowance to purchase cell phones for after-hours communication with clients. This is essential for work-life balance.

> They should give us allowances for internet, airtime for calls, and phone instead of our personal phones. Sometimes a client you gave your cell phone will call you late at night to discuss something personal or to arrange a visit, but if I have a cell phone for work, I turn it off by 20:00 and turn it back on by 08:00 the following morning. (CHW 01, 08, 10, FGD)

> We need cell phones and data. You can see that we need data on our smart phones to find people and talk to them. If you have internet, you can make calls, which is cheaper. (CHW 03, 04, FGD)

Provision of Work Identifier

CHW also need uniform, and name tags for easy identification as reflected in participant's responses.

> We don't have a uniform or name tags to identify ourselves. But we are required to work efficiently. How do you go to people's homes when you don't have any kind of identification? They've been promising us uniforms for over 5 years. I wish they can provide us with uniform for easy identification. (CHW 02, 04, 05, 07)

> For me, it is ok if the Department of Health provides us with a uniform and a name tag for identification. This is because it can sometimes be beneficial to be identifiable when participating in community outreach. (CHW 01, 06, FGD)

Improve Human Resource

The CHWs complained about the need to increase their salary, reduce their workload, and enhance their job security. Additionally, they requested the employment of more CHWs to reduce the workload.

> If more CHW can be recruited, who can join us to work because we are overworking ourselves. (CHW 10, 04, FGD)

> It's because there's usually a staff shortage, so we have to fill-in at the clinic. So many works in admission like assisting with organising clinical cards, while others work in pharmacy to assist with dispensing or distributing client medications. Others assist with the distribution of patient food, while others serve as porters. Is hectic. (CHW 01, 04, FGD)

CHWs reflections on salary increases are mentioned below:

> If they can increase our salary, they pay us very little for what we do, which is not at all encouraging. From year-to-year, promise. Is hard. (CHW 05, 09, 10, FGD)

> We are paid peanuts (though is better than nothing) and we do a lot of works. They keep making promises to us but we never see anything. Some community members do not regard or respect us because they know who we are. (CHW 04, FGD)

The CHWs expressed their opinions on their job security are as follows:

> …The small amount they pay us. It is very painful. They don't want to make us permanent. (CHW 02, 05, 08, FGD)

> There is no job security. We don't have any medical aids. They don't provide us with uniforms or name tags. We struggle with everything. (CHW 05, 08, FGD)

Job security was more concerned with the safety of CHWs, who are vulnerable to attack and are dissatisfied with their situation.

> The fact is that we must hide our phones and other important things from the criminals. If you aren't careful, they might even stab you to get your phone or bags. This is why we don't walk or go alone when we work in the community. (CHW 11, 05, FGD)

Discussion

The CHWs complained about the need to address job insecurity and increase the number of CHWs to reduce their workload. These concerns were echoed in a study by Olateju et al[15] in which CHWs raised the issue of financial incentives and the employment of more CHWs. Financial incentives motivate community health workers.[2] CHWs emphasised the need for a financial allowance to enable them to purchase cell phones for after-hours client

communication. Aside from that, they occasionally use their personal phone, airtime, and data to contact clients. The communication support would help them coordinate their work and personal lives. In addition, the provision of work identifiers was mentioned as a strategy to achieve the community's recognition, respect, and trust. The community health workers in this study require uniforms and name tags for simple identification. Other studies have found that community health workers in South Africa advocate for the provision of uniforms, name badges, and working tools.[7,8,16,17] CHW volunteers in Ghana made a similar request for raincoats, T-shirts, and certificates as desirable identifiers to demonstrate that their work was recognised and valued.[18] It should be noted that CHWs in our study are driven by intrinsic motivations; therefore, it is crucial that they are adequately incentivized by adequate financial and non-financial means, such as uniforms, T-shirts, nametags, office stationery, training opportunities, supervision, cell phones, and airtime and data bundle package, as mentioned by them. Given that the needs of CHWs cannot be completely met, it is of the utmost importance to prioritise their material requirements.[18] In addition to providing CHWs with non-financial incentives, it also serves as a source of motivation and recognition.[7,9,19] The CHWs require fundamental resources to enhance their acceptability and credibility within the communities they serve.[8] According to Perry et al[3] inadequate funding, a lack of supplies, low compensation, and inadequate supervision are the fundamental challenges that must be addressed to strengthen the CHW programme and assist them in performing their duties more effectively. In addition, as highlighted by Colvin, Hodgins and Perry,[20] CHW motivation can be sustained if they are appreciated, respected, and there is an understanding of their roles and responsibilities within the health system in which they work. We advocated, as suggested by other studies, that CHWs be accorded a sense of being valued by receiving awards, certificates, appreciation days,[18,21,22] and daily informal signals of respect.[20] The recognition and support of CHWs would motivate them to work even harder to accomplish their desired effect on the community.

The CHWs expressed a need for transportation to alleviate the burden of trekking, minimise risks and fear of getting attacked by gangs and criminals. Findings related to lack of transportation to facilitate access to health facility and community are similar to those reported in a number of studies across different contexts,[23,24] and specifically among CHWs in South Africa,[6,8] Similar to our findings, Mash et al[16] reported that due to safety concerns, CHWs worked in pairings and delivered medications predominantly on foot. Their study also revealed that CHWs advocated for the need to provide them with transportation, bags, mobile phones, and professional nurses, and above all, to address the community violence and crime.[16]

In this study, CHWs indicated that they require regular training to enhance and maintain their skills and knowledge. In other studies, too, CHWs in South Africa calls for the need to empower them through constant training, which could be pre-training or in-servicing and mentorship.[8,10,17] Wilford et al[10] emphasised the need to shift from the traditional classroom-based method of instruction that is presently available in South Africa to a more skill-oriented method. CHWs required practical skills to perform efficiently in the majority of health services requiring practical skills and demonstrations, such as blood pressure screening, fundamental anthropometric measurements (weight, height, and circumferences), and sugar screening, among others. In addition, in instances where CHWs require practical examination skills to provide maternal and child health services, such as assessing the condition of mother and baby in the days following delivery and identifying danger signs,[10] CHWs must have the ability to conduct practical examinations. Additionally, training as an element of improving the CHW program was stressed by CHWs in the USA.[25]

Supervision is crucial to the success of CHW program.[26,27] Regarding supervision, CHWs acknowledged that there is no or inadequate oversight of their work. In South Africa, the Professional Nurse who is assigned to the team in a specific health district supervises the work performance of the CHWs. Nonetheless, due to a staffing shortage at the clinic-based health facility level,[10] this supervisory function is rarely carried out. Thus, CHWs are left to perform whatever they can. In Austin-Evelyn et al[8] study in the Eastern Cape, supervision was mentioned as one of the major quality program challenges. Yet, another study has highlighted the lack of providing mentorship to CHWs in South Africa.[6] Because CHWs work autonomously in geographically isolated areas with little or no formal training,[28,29] they require regular supervision and encouragement from facility-based health workers to achieve the desired health outcomes. Supervision of CHWs is essential to improve their performance, raise awareness about their activities, elucidate their function in the community, and improve CHW motivation and retention.[27,30] Notably, whatever the supervisory approach, the most essential caveat is that it should be tailored to the context of the setting for it to address specific supervisory challenges.

In the present study, CHWs emphasise the importance of team leader supervision. This is similar to the finding from USA where CHWs advocated for the provision of adequate supervision of their work.[25] Regular and effective supervision of community health workers would encourage them to work harder.

CHWs advocated for an increase in their enumeration package to enable them to cope with the severe economic challenges; otherwise, their current enumeration is barely enough to face the challenging economic condition while supporting themselves and their family members. This is concerning because most community health workers in this study are women from disadvantaged social and economic backgrounds. They advocated for job security by providing them with permanent, salaried employment. Similar suggestions regarding increase in the enumeration package of CHWs have been reported from studies in South Africa[7,11,17] and in the USA.[25] In addition, CHWs in South Africa have advocated for job permanence[7,17] with a salary to enable them to register with the Unemployment Insurance Funds scheme and receive leave benefits.[17] A study in India indicated that the accredited social health activist (ASHA) demanded a "fixed salary" to incentive them.[31] In contrast to South Africa, countries including Ethiopia, Ghana, Malawi, and Nigeria have formalised the salaries of their CHWs in the civil service cadres.[20] Our study underscores the yearnings and aspirations of CHWs in South Africa; hence, they are not formally integrated in the health system whereby they will be receiving salary and other benefits accruable to other categories of the health workforce. Considering the significance of their tasks, they conduct in the community; community health workers deserved recognition and adequate enumeration or pay. Appropriate financial compensation increases the job satisfaction and professional well-being of CHW.[20,32]

Limitations of the Study

The potential for generalisation of these findings is limited using a purposive sample and a single sub-district, but they are consistent with previous research. Furthermore, given that the interview was conducted in English, a few of the participants may have had trouble expressing themselves adequately. In addition, the perspectives of other critical stakeholders, such as nurse supervisors, clients, and community leaders, were not investigated; thus, future research is warranted. Nonetheless, this study sheds light on the views of CHWs serving in understudied, rural, Black communities to inform local contextual measures suggested by them to improve the CHW program in these geographical settings. Lastly, our research strategy of conducting both individual interviews and focus group discussions enriched the interpretation of the findings and increased their credibility.

Conclusion

Our findings emphasise the need to consider the supportive strategies highlighted by the CHWs in Black, rural, and resource-constrained communities in the Eastern Cape, which serves as a guide for the government, policymakers, and other stakeholders involved in community health programmes to consider and implement. From the standpoint of public health, a positive action to strengthen the CHW programme will impart dual benefits. First, the CHWs will be incentivized to provide better, more efficient, and more effective service. Second, it may facilitate the cardinal objective of universal health coverage and population health objectives, thereby reducing health inequality and burden in rural and underserved communities in South Africa. It is time to reconfigure and reposition the CHW program in South Africa with strong, firm, and decisive support initiatives and political action. To echo the thought of Perry et al,[3] it is necessary to persuade diverse strata of leaders, including government, political, medical opinion, civic society, and local grassroots, of the importance of CHW programs, their value, and the benefits that would result if they were strengthened and government funded.

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Author Contributions

All authors significantly contributed to the reported work, encompassing conception, study design, execution, data acquisition, analysis, and interpretation; participated in the draft, revising, or critically reviewing the article; provided final approval for the published version; consented to the journal of submission; and accepted accountability for all aspects of the work.

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The authors declare no conflicts of interest in this work.

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