Training, mentorship and supervision as key components of a facility-based Community Health Worker model

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Background

The Minister of Health's initiative to re-engineer Primary Health Care (PHC) in South Africa is grounded in improving health service delivery and health outcomes across the country. An integral part of the plan is the inclusion of Community Health Workers (CHWs) as a formal part of the health system. Civil society organisations and the Department of Health have long included different kinds of lay or community health workers in their models, particularly in the response to the HIV epidemic. These workers are able to support various aspects of PHC, especially in managing HIV/AIDS and TB, and to improve health outcomes. CHWs are perfectly positioned to act as agents of change within their communities, and while they may have little formal medical background, they have often been intensively trained on key health issues and can provide detailed health education, patient support and advocacy.

Community Media Trust (CMT), a non-governmental organisation, believes in the fundamental role that CHWs can play in improving health outcomes, particularly in resource-challenged settings. In collaboration with the University of Cape Town, CMT commenced operational research; a pragmatic randomised control trial evaluated the impact of CHWs on PMTCT coverage and health outcomes in HIV positive mothers and their children in Motheo health district, comparing outcomes in 16 intervention versus 16 control sites. Quantitative results are presented in a separate poster, but the overall conclusion suggests that CHWs positively influenced continuity of care.

Recruitment

Positions were advertised according to where the intervention sites were located. CMT interviewed 51 applicants for 17 posts (Excelsior Clinic had 2 CHWs). The majority of applicants were unemployed, with many having not previously worked in the health field. Others were volunteers at their local clinic on a stipend. The majority had a Matric qualification and could speak English, although this was not required. They were expected to prepare and present a health topic and write a motivation regarding the role of CHWs in the community. The project employed 12 female and 5 male CHWs. The CHWs were employed from November 2010 to June 2013. Data analysis was over 2 years from April 2011 to March 2013. Out of 17 CHWs originally employed, 1 left very soon after recruitment for a higher post and another 2 left in 2012 after receiving bursaries for nursing college.

Training

The CHW underwent 3 weeks of training prior to entering the field. Week 1 covered orientation to working at CMT, job description, purpose of the project, role of CHWs in the health care system and M&E. Week 2 covered *health literacy* content which included a scientific understanding of how the body works, virology of HIV, HCT, ARVs, PMTCT, behavioural change for HIV prevention, maternal and child health, and HIV / TB co-infection. Training also included an introduction to the Individual Follow Up Schedule cards utilised during the intervention; CHWs had to apply PMTCT knowledge gained from training into clinical scenarios and complete the cards - mocking what they would implement in clinics. Week 3 provided an opportunity to re-cap content and clinical scenarios, and for CHWs to practice facilitating health talks.
All CHWs completed the an accredited HIV Counselling and Testing course with the practical component undertaken in clinics and supervised by clinic staff. Over the course of the project, CMT provided ongoing training for the CHWs including completion of the HWSETA-accredited Advanced Peer Educator Skills Programme offered by CMT. The emphasis on accredited training was intended to provide the CHWs with further career-path options.

Mentorship and Supervision

The Project Coordinator and Project Trainer made routine and regular visits to the CHWs at their respective clinics, to check the accuracy of health promotion sessions and ensure that relationships with clinic managers were nurtured and maintained. CHWs were supervised by the nurse-in-charge, as part of the clinic team. CHW worked clinic hours, attended clinic meetings, and signed clinic attendance registers. All HR management of the CHWs was handled by CMT, as all CHWs were employed as full-time contract employees, and were not on stipend.

CHWs met weekly at the project office to discuss any challenges and to receive on-going training and support. CHWs were tasked with assignments and presentations at these meetings, which provided a forum to address challenges in content and to provide updates on treatment guideline changes.

CHW Model

CMT's vision was to provide a model of community health work in health service delivery which could be taken to scale in order to empower individuals and communities to increase their health seeking behaviour through increased health knowledge and awareness. This "*health literacy*" approach aims to capacitate CHWs with accurate and updated information on all aspects of HIV/AIDS and other important health topics, such as maternal and child health, and chronic non-communicable diseases so that the CHWs can, in turn, share this information in an easy-to-understand way and in the local language. In this way, accurate health information spreads through populations, mobilising communities towards understanding the biomedical approach adopted by the health system, and to take an active part in preventing disease and managing their own health. CHWs are also equipped with the skills to identify those requiring social support and link them to relevant services, such as the Department of Social Development to apply for grants.

Placing a strong emphasis on training, mentorship and supervision is hypothesised to be an investment in the true value of the CHW to the facility. Common criticism of CHW models is that the workers often take on menial tasks within the clinic and lack a defined role, but this project has shown that with ongoing mentorship, training and support, this pitfall can be avoided.

IFS Appointments

Expectant mothers were offered the opportunity to voluntarily participate in the individual follow up programme. Women testing HIV negative were counselled on HIV prevention strategies and were followed up for re-testing at 32 weeks gestation. Women testing HIV positive were counselled and contact information was recorded.
CHWs highlighted important dates, and stayed in contact by telephone or SMS to offer support and provide reminders for specified dates. This assisted with reducing missed opportunities and increasing PMTCT programme coverage.

Health Promotion Sessions

CHWs provided health promotion sessions in clinic waiting rooms, encouraging all pregnant women to test for HIV and to book early for antenatal care. Sessions were aimed at both HIV positive and negative patients.

CHWs had access to supporting materials including printed flipcharts, a DVD series and detailed information pamphlets to assist with the sessions. These materials, designed to overcome language and literacy barriers, were available in Sesotho, English and Afrikaans.

Open Day Events

CHWs hosted large awareness events at lively locations near the clinic, such as taxi ranks, shopping malls or community centres. Events featured entertainment and health promotion sessions. Information pamphlets and condoms were distributed, and prizes were awarded to active listeners.

The events promoted the programme and raised awareness of HCT and PMTCT services, thereby driving demand for access to and uptake of PMTCT services.

Task Sharing

CHWs assisted with clinic duties, with an emphasis on antenatal services. Tasks included general patient administration, weighing of babies, assisting nurses with immunisations, disclosure of PCR test results, and registering and providing readiness counselling for new ARV patients.

CHWs were also trained to offer HCT, providing an ideal opportunity for the CHW to test and counsel pregnant women, and to facilitate an early entry point into the PMTCT cascade.

Project Feedback

CHWs acted as an interface between the community and professional health care environment by supporting and navigating pregnant women through a complex treatment cascade and health system. They were able to prevent loss to follow up and reduce barriers to accessing care such as ensuring drug readiness sessions took place when the clinics was busy. In many cases, the CHWs were able to provide 1-on-1 support to the patient, from when they tested for HIV right up until they started accessing treatment.

The project was well-received by the Free State Department of Health, District Management Teams, as well as the clinic sisters themselves. Sister Maloale in Thaba Nchu, attests to the support she received from Nono Mphaloane, a CHW working at Gaongalelwe Clinic "***Working with Nono has been very interesting; she has taught us all a lot, including patients. The whole process of making follow ups with patients has ensured that we do not miss out on patients. She would also remind us, during patient care, of what to do where we may have forgotten and we would immediately rectify what could have been a big mistake. She has also built a good relationship with the patients to a point where they understand each other very well. Sometimes when I can't immediately remember information about a patient that is coming for follow up, I just ask Nono and she is able to fill me in so well that I am able to go on with the session. She has not helped with only what she is supposed to do; even in the admin area she has been helpful as part of task-sharing***."

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