Health

Healthworkers shafted by SA's

The community healthworker system is in a state of chaos, leaving vulnerable communities at risk

ANALYSIS
Mia Malan

Home care: Community healthworker Nonqaba Melani weighs a child in Khayelitsha, assisted by Chuleza Nangu. Melani is a 'Mentor Mother' who looks after the health of mothers and children. Photo: Jacques Smit

If you're one of the health department's new "ward-based" community healthworkers, who all undergo the same training, have the same job title and work the same hours, your monthly stipend will be R1 000 in Mpumalanga, R1 500 in the Northwest and R2 263 in Gauteng.

In the Eastern Cape, Gauteng, Northwest and KwaZulu-Natal, you'll be paid directly by the provincial health department, which would eliminate "dry seasons" or payment interruptions because you will have been uploaded on to the department's automatic payroll.

But in the Free State, Limpopo and the Northern Cape, you'll be employed and paid by a nonprofit organisation contracted by the local government. If the provincial health department pays the nonprofit organisation late or not at all, you'll be paid late, too, or even lose your salary (see graphic).

If you happen to be one of the thousands of "single-purpose" community healthworkers in South Africa who focus on one health issue only — for instance, HIV counsellors or TB tracers (who track tuberculosis patients who have defaulted on their treatment) — and you currently work for a nonprofit organisation outside the "ward-based" system, you're likely to be retrained as a "ward-based" community healthworker, which will enable you to address all health issues in your community.

But this is only if you live in KwaZulu-Natal, Limpopo, Mpumalanga and Northwest. If you're based in the Eastern Cape, Free State or Gauteng, it's possible that you will lose your job.

And, if you're from the Western Cape, you won't fall under the "ward-based" system, in which six community healthworkers are allocated to each municipal or electoral ward, because the province has chosen to follow an entirely different system.

"This is exactly what happens in the absence of a policy: you leave every province to do whatever it wants," says Pranitha Pillay from the Rural Health Advocacy Project, a partnership between the University of Witwatersrand, Section27 and the Rural Doctors' Association of Southern Africa. "How can that be a national strategy?"

In countries like South Africa that have a serious lack of doctors and nurses, community healthworkers are often used to address the crippling healthworker shortage through "task shifting" — transferring some of the easier but time-consuming tasks of professional healthworkers, such as following up on HIV or TB patients to ensure they take their medication correctly.

Such "lay" workers, who are trained using a combination of short, in-service and slightly more formal courses, generally live in the communities they serve. They do home visits during which they compile inventories of vulnerable groups, such as pregnant women and children under five in their neighbourhoods, keep track of people's general health concerns and link them to health facilities when needed.

Since 1994, according to a 2013 study in the journal, *Health Policy and Planning*, South Africa's community healthworker programmes haven't had much of a positive impact. In stark contrast, in countries such as Ethiopia and Brazil such programmes have led to dramatic drops in the number of deaths of children of five years and younger and mothers during pregnancy, birth or shortly thereafter.

Researchers attribute this to the fact that our programmes are uncoordinated, unregulated and unstructured, with none formally forming part of the country's public health system.

Also, rather than being trained "comprehensively" to deal with general prevention and care, most of our 72 000 healthworkers have focused on "single health issues", such as HIV or TB. Their training ranges vastly from between two weeks to four years, according to a 2011 health department document.

After a visit to Brazil's community health programmes in 2010, Health Minister Aaron Motsoaledi decided to correct this situation. On his return he announced that he was going to create community healthworker programmes similar to those in Brazil — programmes that would hopefully have the same kind of positive impact on health indicators such as maternal and child mortality.

This would mean that community healthworker programmes would be standardised, would form part of the public healthcare system and would be comprehensively trained, as opposed to each dealing with different "specialised" health issues.

Motsoaledi announced his new strategy with the release of a discussion paper, "Re-engineering Primary Healthcare in South Africa," in November 2010. It recommended that each municipal or electoral ward be assigned at least one primary healthcare outreach team consisting of six community healthcare workers, led by a professional nurse.

Three and a half years later, the minister's strategy is being implemented, but with a serious impediment: there is no national policy, despite health activists having lobbied for this for years. The result is chaos, with each province implementing the strategy differently.

According to Pillay, in the absence of a formal policy, the health department risks "sabotaging" its own programme and undermining its "primary health strategy".

"There is a failure of leadership to articulate how provinces are supposed to make the community healthworkers strategy happen, where the money is going to come from and how we will properly support the right number of workers with a decent scope of work," Pillay says. "If we don't say anything about it, we breathe life into the failure of leadership."

One of the main recommendations of Motsoaledi's strategy document is that community healthworkers should be paid significantly more and that their remuneration should be standardised. If "community healthworkers are to play a meaningful role in revitalising primary healthcare ... there needs to be .... an immediate and tangible improvement in salaries and conditions of service," the document stipulates.

According to Helen Schneider, who heads the University of the Western Cape's public health department, and who helped to produce the 2010 document, the average domestic worker earns more than community healthworkers. "I would say we need to double their stipend," she says.

The strategy document calculates workers' remuneration at a package of R75 000 (R6 250 a month, including benefits) if they become full-time government staff members, amounting to an overall cost of R3.2-billion a year. If nonprofits were to manage and pay the workers the cost would be reduced to an annual package of about R30 000, but the strategy document does not recommend the nonprofit route.

In practice, not a single "ward-based" community healthworker receives a salary close to either of the government or nonprofit packages, and all provinces pay different stipends.

A 2013 study authored by Schneider

How many households should a healthworker serve?

The health department's 2010 primary healthcare strategy document and a consequent 2011 "implementation toolkit" differ on the number of "ward-based" community healthworkers South Africa needs to revitalise its primary healthcare system.

The workers are called "ward-based" because they're expected to work in municipal or electoral wards as part of primary healthcare outreach teams: each ward will have at least one team of six community healthcare workers led by a professional nurse.

According to the 2010 document, the country needs 41 440 community health workers, each of whom will serve 250 households (each household consists of average of four people). But the 2011 document's "training and orientation plan" calculates the need at only 33 000 workers, each to be responsible for 270 households.

Health activists say both these numbers are far too low. "Given our very high burden of disease in South Africa, 250 to 270 households will mean that many members of households will go without care and may not even be able to be visited," says David Sanders from the People's Health Movement pressure group.

"Acute illnesses, particularly among children, are quite likely to be missed, especially in rural areas, where homes are spread over vast areas."

What's more, says Prinitha Pillay from the Rural Health Advocacy project, "we don't know what '250 or 270' households means. Is it one visit a month to each household or one a year? We just don't know."

In comparison, Brazil community healthworkers are each assigned 150 households and are expected to visit each home at least once a month. According to Pillay, "village health communicators" in Thailand are responsible for as few as eight to 15 homes.

In KwaZulu-Natal, where "ward-based" community healthworkers have been working since the early 2000s as part of a separate provincial programme, each worker looks after only 60 households, according to Gcina Radebe from the local department's primary healthcare directorate.

Another challenge is that South Africa does not have enough professional nurses to lead the 6 907 (according to the 2010 document) or 5 842 (according to the 2011 document) primary healthcare outreach teams.

In KwaZulu-Natal a shortage of professional nurses has led to the department announcing that it would use staff nurses (with two years of training, rather than the four years of training required for professional nurses) as team leaders in the remote northern district of Umkhanyakude.

In the Western Cape, which does not follow the "ward-based" system, but funds nonprofit organisations to manage "home- and community-based care teams", a ratio of one professional nurse to 15 community healthworkers is used, according to the Western Cape Health MEC's spokesperson Helen Rossouw.

"The national norm of 1:6 is currently not affordable and none of the provinces have been able to put this norm in place. The Western Cape is planning towards a ratio of 1:10 for 2030," Rossouw says. — ***Mia Malan***