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Community Health Workers and Professional Nurses: Defining the Roles and Understanding the Relationships

Tanya M. Doherty and Minette Coetzee

ABSTRACT The use of community health workers (CHWs) has been advocated in both developed and developing countries for many years. This article reports the findings of a descriptive research study that explored the relationship between CHWs and nurses working in resource-poor settings in South Africa. The findings of the study highlight dimensions of complex interactions occurring between these two main providers of care at the district level. Understanding the primary interaction of CHWs with nurses offers further understanding of the broader role of CHWs within the district health system. It is evident that CHWs are ideally suited to play a pivotal role in supporting the public health services. However, their role and functions are not formalized and the effectiveness of programs is often not rigorously evaluated. This article discusses some of the issues related to this cadre of health worker and their role in public health care structures.

Key words: community health workers, nongovernmental organizations, nurses, primary health care, qualitative research.

Community health workers (CHWs) have become a distinguishing feature of many primary health care initiatives in both developed and developing countries. They are an important component of the health service delivery recommended by the World Health Organization, as they act as a bridge between the community and the health service (Kuhn et al., 1990). Even in developed countries, however, the nature of their role within health care systems is unclear and is still being explored (Swider, 2002). While attempts are being made to formally describe their role, CHWs are not yet recognized in South African health policy. This lack of clarity on the role of CHWs at national levels results in even greater confusion amongst health professionals at the level of service delivery.

Numerous CHW programs were initiated in South Africa in the 1980s primarily in rural areas (Tollman & Friedman, 1994). In the 1990s, as urbanization increased, peri-urban informal settlements grew rapidly. The same organizations, mostly nongovernmental organizations (NGOs), which had initiated primary health care programs in the rural areas, began to see the need for similar services within the peri-urban areas. The role of CHWs within these informal settlements involved home visits, health education, basic preventive care, and tuberculosis (TB) treatment supervision. This closer relationship with formal health services was a particular characteristic of peri-urban primary health care programs and brought to the fore some of the tensions between CHWs and formal health service personnel.

Worldwide, it has been mainly progressive medical professionals who have promoted the idea of CHWs (Walt, Perera, & Heggenhougen, 1989). In South Africa, involvement of nurses in planning

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CHW schemes has been minimal, although it is nurses who staff community clinics and have the most contact with CHWs. Thus, it is not surprising that the relationship between CHWs and nurses in many programs is strained (Marchione, 1984).

During the 1990s, a vigorous debate on the role and functions of CHWs took place within the national government. However, no firm position was reached. The lack of a defined role for CHWs within the health system means that there are no clear performance outcomes and thus no standards that can be monitored.

As the interaction between CHWs and professional nurses represents the interface between community-based health care programs and the formal health services, the aim of this study was to explore the relationship between CHWs and professional nurses in two informal settlement communities in the Western Cape, South Africa.

Methods

This study utilized an exploratory descriptive qualitative research design. The aim was to describe and understand the interaction between CHWs and nurses.

The sites chosen for this research were two informal settlement communities on the outskirts of Cape Town. Both of these communities had CHWs working in them, and the CHW projects were managed by NGOs. There were formal health services (clinics and community health centres) situated in close proximity to the CHW projects in both the areas.

All the CHWs and nurses in the two sites were made aware of the study through written information sent to each health unit and CHW project. Individuals were invited to volunteer to participate. Purposive sampling was used to sample nurses who had the most contact with CHWs such as TB-control nurses.

Data collection included individual interviews and focus group discussions. All of the interviews and focus groups were conducted by a trained qualitative interviewer. The interviews with CHWs were conducted in a private room within the NGO offices, and interviews with nurses were conducted in a private room within the clinics. An individual interview guide and a focus group discussion guide were used to provide the interviewer with key areas to be covered. All interviews were audio taped and transcribed verbatim.

A total of 16 individual interviews were conducted; eight with nurses and eight with CHWs. In addition, one focus group was held with nurses and one with CHWs. There were six to eight participants in each of the focus groups. Seven of the CHWs were women and one was a man. They had all been working as CHWs for at least 18 months. Their ages ranged from 30 to 55 years. All of the nurses interviewed were women. The positions of nurses interviewed included junior nurses, senior nurses, and clinic managers. Ages of nurses ranged from 25 to 53 years.

Informed consent for interviews and group discussions was negotiated with individual participants. In order to maintain confidentiality, codes were used on all transcripts and reports. Data analysis involved an interpretive approach of identifying key categories and recurrent themes within the transcripts. Data analysis continued until no new themes or ideas emerged. The authors read all of the transcripts and met regularly to review emerging themes and to reach consensus on the interpretation of the data.

Results

From the individual interviews and focus groups, it became clear that the relationship between CHWs and nurses could be described as a process. It began when a CHW project was initiated in a community. In both the sites, the appointed CHWs had used the clinic as the initial point of contact when they began work. When a new project was established, both nurses and CHWs had certain expectations, perceptions and fears. These were explored further in the three phases that emerged from analysis of data:

1 The initiation phase: Nurses were unsure of the CHW role; CHWs experienced being undermined.

2 Beginning to understand each other: Nurses began to understand the CHW role; CHWs were used as an extra pair of hands.

3 Uneasy cooperation: Nurses began to value CHWs; CHWs looked up to nurses as role models and mentors.

The initiation phase

This phase was characterized by the nurses being unsure of the role of CHWs and regarding them as a threat. The CHWs felt an overwhelming sense of being undermined and not recognized. Nurses at this

stage considered CHWs as an additional burden rather than a help to them, and CHWs experienced their relationship with the nurses as being unpredictable.

Nurses were unaware of the training that CHWs had received. The initial training which CHWs undertake for 12 weeks is not accredited within the South African National Qualifications Framework. This exacerbated the lack of understanding which nurses have about the CHW role. As one nurse described:

> I think, as you know we were trained and we do our training all the years. and here these people come who were training for a short while, and all the things that we had to have education for and certificates for and pay the council, they are actually doing part of this. Not everything but part of it … and that is what most of our people *(nurses)* don't understand. They think that they are taking our space and our work out of our hands. But it's not that. They're just trying to make it easier for us. If people could see that they're making it easier for us, they won't work against them.

CHWs experienced the nurses' lack of knowledge about their training as a major barrier to establishing relationships with them. As one CHW described: "I don't know whether they undermine us or what, but we had problems. They didn't want to accept us because they said we have basic education. So we are not professionals." The sentiments described above represent a widespread notion amongst CHWs of "not belonging." They described working within the health sector providing a service to communities that are underresourced and rely heavily on NGO initiatives, yet they were constantly embattled in a struggle for recognition and acknowledgment. One CHW captured this struggle most vividly: "We are always standing on the platform of sorrow … waiting for that … if government would recognize us too."

Beginning to understand each other

During this phase, CHWs and nurses began to understand each other, and the conflicts appeared to be less frequent. The nurses had had time to work with the CHWs and to discover that they have a good knowledge base and are reliable. This led the nurses to use CHWs as an extra pair of hands in the clinic.

The CHWs described an internal struggle, as they dreamed of becoming nurses but had often chosen to become CHWs, because they did not have the financial or academic resources to train as nurses. When faced with the options of working in the clinic rather than performing home visits, their major activity, they experienced some confusion over their loyalties. They wanted to work in the clinic to feel like nurses, yet they knew that their role was to be in the community.

During this phase, there was also a reported increase in clinic attendance. CHWs were known by their community, and they set about motivating people to utilize the health services. At this time, the CHWs worried that the reason why their relationship with nurses was so difficult was because they brought them more work. Some nurses, however, did start to see the increase in service utilization as valuable and began to consider CHWs as the link between themselves and the community. The following nurse expressed the usefulness of CHWs in recalling patients with TB who had not collected their medication: "Because they know the areas. When someone was defaulting, I was using them to go and recall them for me."

In circumstances of severe staff shortage, CHWs were asked to assist with procedures at the clinic. As one nurse explains: "For instance, here at the health center we are short staffed. Sometimes there will be only the two nurses staffing that clinic. And we've had days when the people from the CHWs would come and work in the dressing room."

This description highlighted the irony that CHWs are in some cases used as nursing workforce within the clinics, yet they are not officially recognized for the work that they do as CHWs.

Uneasy cooperation

During this third phase, the nurses began to regard the CHWs as their link with the community, in terms of knowing the area and the people and in terms of language difficulties. None of the nurses in the study sites actually lived in the area where they worked, and they recognized this as a barrier to their full understanding of the context, in which they work.

The data indicate that, at this stage, nurses began to understand the value of CHWs. They were relieved that CHWs were "there when we are not," and this appeared to provide some sort of comfort and reassurance for them. Some nurses reached the stage of understanding the broader role of the CHW within

the community and allowed them to perform this work without being given inappropriate tasks to perform in the clinic.

In comparison with the initiation phase, when the nurses were reluctant to accept referrals from CHWs, they now welcomed them. This was clearly a sign that nurses began to recognize the work of CHWs and to see it as complimentary. As one nurse describes:

> They are working well. They do their job. I don't have a problem with them. Because sometimes there will be some clients who come to us and tell us: "Nurse, I've been referred by Nompilo (CHW) to come here." So that means they are doing their job. I don't have a complaint concerning them.

This indicated the shift in thinking that occurred when nurses stopped seeing CHWs as a threat but rather as people who are there to help them. Unfortunately, there was evidence in this study that few nurses reach the stage of regarding CHWs as colleagues. This, however, may have been more related to the lack of clarity about the role and function of CHWs than to a feeling of insecurity.

The three stages described above track the complex changes that occur in the relationship between CHWs and nurses. Even if the relationship often remains an uneasy cooperation, major shifts are seen in the mindset of nurses, as they begin to understand the role of CHWs as the link between the community and the clinic.

Discussion

Implications for community nursing practice

Changes in the South African health sector have had a significant impact on the role of community nurses. As a result of the policy shift toward primary level care, the demand for services at the district level has grown. Shifts in policy have, however, not been adequately matched with support or training needs of nurses. The training of nurses in South Africa is still largely hospital based. Many nurses begin work at clinics with little training in the health issues seen at the district level, let alone the unique challenges of working with community-based groups such as CHWs (Edelstein, 1996). As found in this study, this can lead to conflicts and misunderstandings over the roles of various providers of care at the community level.

The lack of understanding of the role and functions of CHWs undoubtedly influences relationships. This study confirmed the need to address the training and ongoing support needs of community nurses in the context of an increased demand for primary level services and greater need for community-based care. Results indicate that nurses found it difficult to engage fellow health care providers as partners in care. More inclusive and participatory management methods may facilitate this shift. A shift in all undergraduate nursing curricula toward a primary health care approach would ensure that nurses leave basic training with the essential competencies needed to function within primary level services.

Implications for CHWs and their practice

In countries such as South Africa where the public health infrastructure is still poorly developed, particularly in rural and peri-urban areas, CHWs and other community-based workers are playing a major role in improving coverage and access to health services. As this research has shown, their ability to function as part of a district health team is limited by the unclear nature of their role and function within the health system. If the training of CHWs were standardized and accredited by a nationally recognized accreditation body, this would help to reduce the confusion over qualifications and training and potentially reduce the threat that CHWs may have posed to nurses.

The creation of a category of mid-level health worker is currently being considered at a national government level. This category would include workers such as CHWs, directly observed treatment supporters, antiretroviral (ARV) treatment supporters, home-based carers, and lay counselors. All of these workers are playing an increasingly important role particularly in the newly implemented comprehensive HIV/AIDS plan that relies heavily on mid-level workers for HIV counseling and treatment adherence support. The formalization of this category would help to standardize employment conditions, remuneration, and performance measures, and consequently better working relationships.

This study found that a major difficulty faced by CHWs working as the interface between the community and the rest of the health service is that of multiple levels of accountability. There is formal line accountability to the NGO, the employer, in

terms of performance measures and outcome targets. The NGO is in turn accountable to the district health authority that is contracting the services. CHWs are also accountable to the formal health services, mostly the registered nurses. This, however, seems to be a control mechanism rather than providing ongoing training and technical support. Finally, CHWs are accountable to the community, through the community health committee. This committee, which exists in many informal settlements, is appointed by the community to set priorities for health care interventions, and as such, they have a role in monitoring and evaluating the work of CHWs.

A critical factor in the sustainability of CHW programs is performance measurement. To date, CHW programs have been poorly evaluated with weak study designs (Nemcek & Sabatier, 2003). The lack of rigorous data to support CHW effectiveness has contributed to the lack of support for CHWs at the national government level in many countries and has further undermined their credibility. Performance outcomes that can be monitored in communities that have CHW programs include: health care utilization, TB-cure rates, immunization coverage rates, HIV-testing uptake rates, ARV treatment adherence rates, and family planning uptake rates. These outcome measures should be determined jointly between the CHWs and the nurse managers working in the target communities. They should be tailored to the specific role and functions of CHWs within a particular community and to the needs of the local health authority that is contracting their services. Process outcomes would inform ongoing training and supervision for both nurses and CHWs.

Recommendations and areas for further study

This study has raised several issues for further inquiry. The training needs of nurses working in the community setting requires further study in order to explore different options and modes of learning such as problem-based learning and experiential learning. These methods would enable the development of reflective practice and the interpersonal and facilitation skills that are vital for community nursing.

Evaluations of community-based programs are best suited to a participatory action research methodology. This is based on the assumption that if participants (e.g., nurses and community-based health workers) were involved as co-researchers in a process of discovery, they would be able to study their own practice and develop internal strategies to improve the situation.

Conclusions

As health facilities continue to be overburdened because of the effects of diseases such as HIV/AIDS with concomitant shortages of health care personnel, the role of community-based providers becomes increasingly critical. In order for CHWs to support to public health services effectively, their education needs to be standardized and accredited with local educational authorities. Once nurses become more oriented to community-based practice and accepting of different roles, various community-based health workers may be more easily incorporated. Many public health programs, notably HIV/AIDS programs are heavily reliant on community-based providers and failure to recognize and address these issues could seriously compromise the effectiveness of these programs.

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