

Considerations for linking South Africa's Youth-friendly Services to its community health worker programme

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In this article, we open the debate on whether or not South Africa's Youth-friendly Services (YFS) programmes should be linked to community health worker (CHW) programmes. Both are important in South Africa's efforts to re-engineer primary healthcare in the country. This article presents the pros and cons of linking the two programmes by incorporating YFS into the current list of CHW competencies. Also, we explore the alternative of training specialist CHWs to deliver YFS. We argue that regardless of which approach is adopted, research is required. Furthermore, efforts should be made for policy-makers, researchers and practitioners to join together and channel research findings into the design of people-centred health policies.

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South Africa (SA) has adopted measures for both nation-wide adolescent-friendly health services and community health worker (CHW) programmes. This article opens the debate on whether or not the two should be linked, and asks whether specialist CHWs would add value to adolescent health services. We provide a brief background of both programmes and explore the pros and cons for different forms of service delivery.

SA's youth-friendly services

In 2002, the World Health Organization developed the Adolescent-friendly Health Services model.^[1] The model focused on providing a package of health services that effectively addressed the specific health needs of adolescents (13 - 19 years of age). The package has been broadened to include the health needs of young people aged 10 - 24 years, and is called Youth-friendly Health Services (YFHS).^[2] This model addresses complex issues such as substance abuse, obesity, violence and psychosocial support in addition to the sexual and reproductive health services that typically target young people. YFHS consists of a framework in which effective and appropriate health services are delivered in equitable, accessible and acceptable ways for youth.^[1] While some programmes have experienced success, often YFHS are plagued by poor coverage, inadequate implementation or brief follow-up periods.^[2] There have been international calls for YFHS to be brought to scale and to be implemented over a longer period of time.^[3,4]

One of the few examples of adolescent health programmes operating at scale is SA's Youth-friendly Services (YFS) programme (previously the National Adolescent-friendly Clinic Initiative (NAFCI)). NAFCI began in 1999 as a collaborative project among various organisations, including the Reproductive Health Research Unit of the University of the Witwatersrand, Chris Hani Baragwanath Hospital, and LoveLife, SA's largest national HIV-prevention initiative for young people.^[5] NAFCI aimed to: (i) make health services accessible and acceptable to adolescents; (ii) establish

national standards and criteria for clinical adolescent healthcare; and (iii) build the capacity of healthcare workers to provide high-quality adolescent health services.^[6] The Department of Health (DoH) was actively engaged over the 6 years of the programme; however, funding through LoveLife ceased in 2006. The DoH agreed to manage a simplified version of NAFCI as the YFS programme. The 'adolescent-friendly' standards developed by NAFCI, as well as its strong ties with LoveLife, remain integral to YFS.^[5]

Despite widespread implementation of YFS in SA, early evidence indicates that the service delivery model could be significantly improved. In 2010/2011, YFS was estimated to be operating in 47% of national primary care facilities, with an expected increase to 70% by 2012/2013.^[7] Yet, a recent case study (unpublished) in rural Mpumalanga Province found that only two out of eight health facilities had ever provided YFS. Moreover, the two facilities providing YFS were trained before 2006 under NAFCI, not the newer DoH programme. Although one of these facilities was awarded the highest level of recognition for achieving >90% of 'adolescent-friendly' standards by NAFCI, staff reported that oversight and support have since disappeared. The facilities in Mpumalanga reported several human resource, infrastructure and management shortcomings that compromised the quality and uptake of YFS in the area (unpublished data from Agincourt, SA, 2012). More research should be conducted to see if these findings are an accurate reflection of the challenges faced by YFS nationwide. If so, this would lend support to international calls to shift youth services away from centres and into alternative community forums such as schools, households or even through social media.^[8] CHWs could potentially offer the type of sensitive engagement and outreach that is needed.

SA's child health workers

CHWs have featured prominently in the international primary care discourse since the Alma-Ata Declaration of 1978.^[9] CHWs have been defined as 'any health worker carrying out functions related

to healthcare delivery; trained in some way in the context of the intervention; and having no formal professional or paraprofessional certificated or degreed tertiary education.^[10] Despite their promise in addressing the human resources crisis in low- and middle-income countries, programmes have been criticised for their fragmented delivery systems, inadequate supervision, inconsistent training, resource shortages and political controversy.^[11]

In SA, CHW programmes were originally implemented by non-governmental organisations (NGOs) to help deliver health services to non-white communities during the apartheid period.^[12] Since the transition to democracy in 1994, SA has increasingly invested in CHWs in response to the HIV epidemic.^[10,12,13] Although these programmes are offered through community-based organisations with government funding, they are not well integrated into national primary care programmes. Moreover, the patchwork of CHW programmes varies greatly in structure, size, scope and performance.^[14]

In an attempt to shift the health services from curative to preventive, the DoH has embarked on an ambitious re-engineering of primary care in SA that includes a formal integration of the confusing patchwork of CHW programmes. Under the new system of primary care, municipal ward-based outreach teams are being developed to strengthen the organisation of health promotion, prevention services and identification of high-risk individuals at district level. Each team should ideally include five to six 'generalist' CHWs with a broad range of responsibilities that include assessing health needs, facilitating access to services, providing community-based information, education and psychosocial support, delivering basic healthcare and supporting community campaigns.^[15,16] The generalist CHW approach has been favoured because it allows the new arrangement to harness the diverse skills of fragmented CHW programmes run by NGOs, but this does not preclude the possibility of integrating specialist CHWs into the new arrangement. By translating and adapting information, education and communication, CHWs serve as a vital link between the formal health sector and communities, at both the household and facility level.^[16] As of 2011, there were an estimated 72 000 CHWs operating nationwide.^[15] A standard training curriculum has been developed, and existing CHWs are undergoing a reorientation to develop competencies that align with the ward-based outreach team objectives.^[17]

Could existing or new CHWs be used to deliver YFHS?

This article considers the use of CHWs as a means to provide YFS outreach service to households. The justifications for such an approach are multiple. First, CHWs are well established in SA. Second, the CHW model focuses on engaging communities in ways that facilitate the uptake of healthy behaviours,^[18] which is precisely the sensitive community-based approach necessary for YFS. Third, strategies to strengthen YFS do not require advanced technical or clinical training.^[2] However, it may be more desirable to create a whole new cadre of specialist CHWs devoted exclusively to SA's youth.

To inform the debate, we conducted a review of 'specialist' and 'generalist' CHWs.^[19] We defined specialist CHWs as those who have acquired and deployed a narrowly defined set of skills determined by population group (e.g. adolescent health) or disease (e.g. tuberculosis). Generalist CHWs, in contrast, have a broader mandate, which attempts to serve the primary healthcare needs of the whole community. In SA, in an attempt to better coordinate previously fragmented CHW services, the new district-level CHW model is a generalist approach,^[20] but the policy framework does not preclude the integration of specialists. In this debate, 'specialist' is tantamount to developing a YFS-specific health worker. The generalist model would be where current CHWs, in addition to their existing

responsibilities, also provide adolescent services. Unfortunately, our review found little evidence on the comparative advantages of both generalist and specialist models in sub-Saharan Africa. In the absence of evidence, we reason through both approaches below.

The generalist (linked) approach

The generalist YFS-CHW approach suggests linking adolescent health services to an existing arm of the health system. This could have several advantages. First, adolescent health services delivered through a well-formed delivery apparatus might be implemented more quickly and affordably. Second, simply adding an additional element to an existing training programme for CHWs could present minimal disruptions to existing CHW protocols. Third, incorporating adolescent health services into existing generalist CHW models might be politically easier to sustain, rather than establishing a (possibly overlapping) cohort of health workers. Where the model performs well, adolescent health-trained CHWs could strengthen the existing health system by delivering services in a culturally, age-acceptable manner at both household and facility level.

However, this approach is also not without limitation. CHWs are predominantly local women in their 40s to 50s, and they may find it hard to gain the trust of young people, who are accustomed to being 'judged' by adults. CHWs are notoriously overburdened, and concerns over the quality of their service persist despite increased investment in large-scale programmes. Adding another set of skills to an already overwhelmed CHW may not yield additional health benefits but could even interfere with existing health services. The additional set of skills might also further accentuate gaps in supervision. Without increasing investment in incentives and avenues for professional advancement, placing additional responsibilities on CHWs might affect levels of motivation and retention.

The specialist approach

There are many advantages to creating a cadre of YFS-CHW specialists. Recruitment criteria could be designed with adolescents in mind, engaging young people who are more likely to gain the trust of their peers. YFS specialists could exclusively target households with adolescents, thus reaching a greater number of households. Without additional responsibilities, a YFS specialist may develop a higher level of YFS skills, develop relevant professional relationships more quickly, and so create a new, more visible community-based adolescent health worker. The cultivation of a precise set of skills through training and supervision might rapidly lead to a high level of expertise in adolescent health. In this way, YFS specialist programmes may achieve significant results by linking facility and household services in a relatively short period of time.

Despite the promise of a specialist YFS approach, there are several limitations. Adolescent health cannot and should not operate in a vacuum. Adolescents are often part of an intricate network of friends, family and neighbours whose distinct health needs are interconnected. Furthermore, it is not clear whether having a specialised CHW would increase or decrease stigma associated with home visits; this would depend on the way the programme was introduced and managed in the local community. A highly specialised workforce might complicate existing strategies for delivering comprehensive primary healthcare. Although coordination of adolescent health services might be strengthened, pouring resources into a highly skilled and separately managed workforce might place further strain on fragile, inefficient and uncoordinated service delivery mechanisms prevalent in parts of SA. Also, evidence from other CHW programmes shows that a massive amount of supervision is necessary to offer CHWs the support they need.^[9,10] Therefore, a huge increase in essentially multiple layers of an isolated workforce could be very costly, difficult to implement and politically challenging to sustain.

Conclusion

In light of these considerations, it remains unclear exactly which approach would be preferable. We recommend the formulation of a research agenda with inputs from research institutions, practitioners and decision-makers alike. In order for the resulting research to be embedded into decision-making processes, careful attention should be given to the type of evidence generated and the institutional arrangement of the health research system.^[21] One gap that has been identified is the need for rigorous comparative data as well as economic data that demonstrate some measure of cost-effectiveness.^[22] In addition to this, more policy analysis that carefully demonstrates the effect re-engineering will have on existing health organisations and the intricacies of the implementation process is sorely needed if CHWs are to maintain their constructive relationships with marginalised communities.^[23] Such research would enable SA to strengthen the quality of services delivered to young people, and hence improve their lives.

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