

Community-Based Worker Systems – a possible solution to more services, reaching many communities, and within budget

CBW partners in South Africa, Lesotho, Uganda and Kenya

One of the major problems in Africa is that services provided by government often do not reach communities, especially rural communities (eg see Khanya, 2001). One way of addressing this is via community-based workers (CBWs) such as community animal health workers, home-based carers, peer educators etc. Lessons from Uganda, South Africa, Lesotho and Kenya suggest that these models can be applied at large scale and can have a major impact on livelihoods. These lessons are drawn from several sectors including natural resources. To scale up such approaches successfully requires rethinking service provision, and a major investment in the capacity of civil society. Methodologies for scaling up need to be developed including standardisation of training and allowances, large-scale capacity-building of civil society to take forward such approaches, as well as coordination and management of potentially numerous CBWs in communities. Government will need to mainstream funding such approaches, seeing them as front-line service delivery and so a priority rather than the last to be funded. Resistance from some professionals needs to be addressed for this to succeed, with clarity that improved front line delivery will result in increased demand for value-added professional services.

Policy conclusions

- There is significant evidence that CBW systems have improved the quality of life of their clients. This evidence is strongest in the health sector although qualitative evidence suggests this to be true in the NR sector as well, eg with community animal health workers (CAHWs);
- These models, although using 'alternative' providers (the CBWs), are often well integrated with government systems;
- Like-for-like, the systems appear to cost around one-third that of conventional services;
- Therefore community-based and para-professional services offer the opportunity of devolving aspects of services to those who can be trained more cheaply and quickly and are paid less, so that, within a given budget, their numbers can be increased;
- If the model is to be applied widely, national governments need to develop policy and legislation to support the development and scaling up of this method of service delivery;
- Up-scaling will require greater standardisation of training outcomes, standards of delivery, conditions of service and remuneration;
- Funding at scale will have to come from government, possibly with support from external funders. The costs of paying the CBWs could be offset to some extent by savings elsewhere eg in reduced hospital admissions. In a wider vein, benefit:cost ratios are expected to increase as livelihoods improve;
- These cadres need to be recognised in law, eg CAHWs;
- A system needs to be created for coordination and management of what could be numerous CBWs of different types in the same community, and for capacity-building of civil society;
- If they are to be widespread, a representative body and specific legislation is needed to regulate and advocate for CBWs within their different spheres of work so that they know their rights and responsibilities and are protected from exploitation.



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Introduction

Community-based services offer the potential to reach many more people within the limited financial resources available to African governments, to respond to widespread need as in the situation of

HIV and AIDS, and to significantly improve people's quality of life. In addition, they allow communities to influence services to meet their own, locally-specific needs, and to monitor the performance of delivery agents.

CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task, supported and supervised by a facilitating agent (FA) which may be either a non-governmental organisation (NGO) or government entity, and often supported by technical service providers (see Figure 1). The CBW may play some of the following roles:

- acting as a conduit for information and technologies (and sometimes inputs);
- being a bridge/link person between the community and service providers/facilitating agent;
- mobilising the community into groups for learning activities;
- providing advice and training for community members and providing follow-up support;
- working on their own activities and providing demonstrations from their own farm or household;
- animating the community by providing energy and enthusiasm for development activities and maintaining the momentum to pursue them.

Action research conducted by Khanya and its partners in Kenya, Lesotho, South Africa and Uganda has been investigating how community-based worker (CBW) systems can be used to widen access to services and empower communities in the process. This NRP summarises some of the learning from this action research project funded by DFID.

Government policies, systems and structures in service delivery

In many countries, government is not only the funder, but also the main provider of services. However, community participation is often recognised in policy contexts. Thus South Africa has a Community Health Workers Policy Framework (2004). Lesotho’s social welfare strategic plan 2005-2010 and its primary health care strategy involve training additional village health workers and introducing incentives for them, establishing training for traditional healers to complement health delivery and emphasising health education to prevent disease transmission.¹ In Uganda the National Agricultural Advisory Service (NAADS) has revitalised agricultural extension services including using community-based farmer-to-farmer extension, and Kenya’s National Agricultural Extension Policy has provision for CBWs.

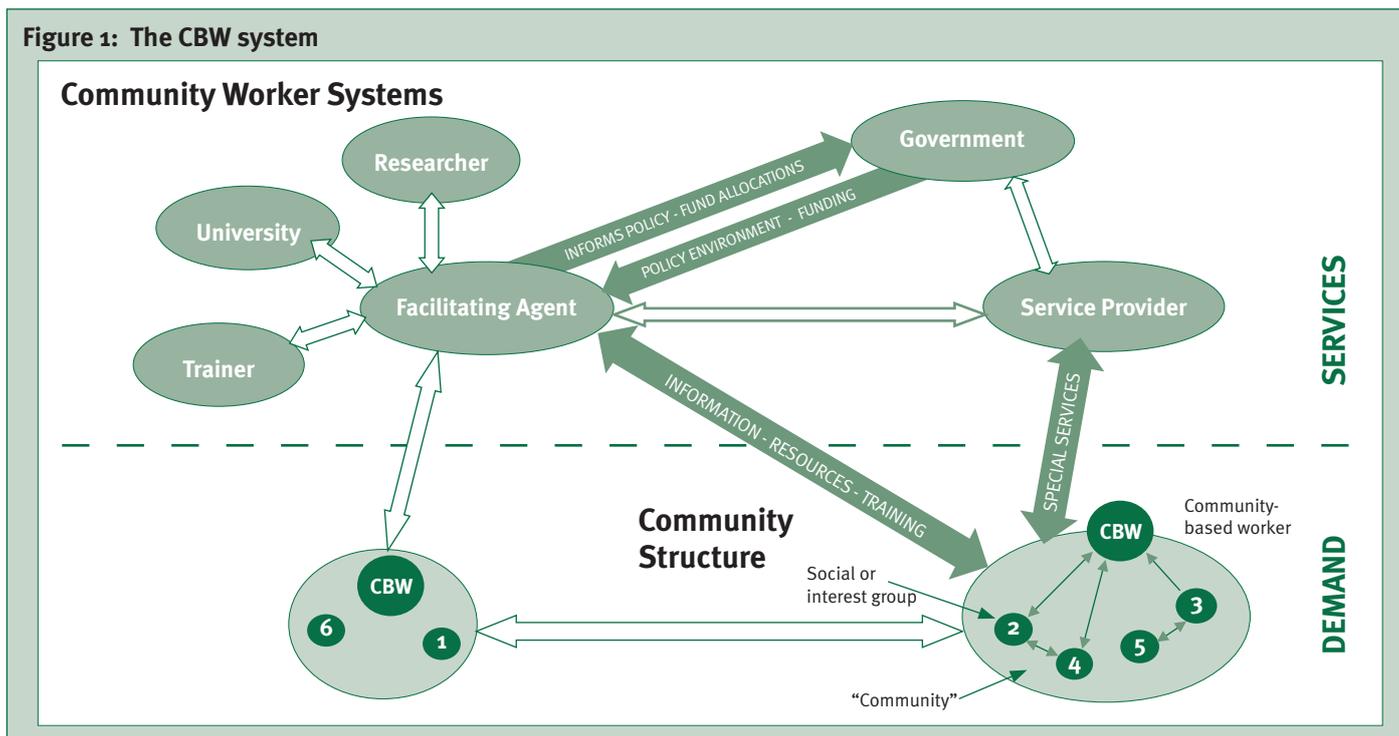
Of the four countries, Uganda has gone furthest in terms of decentralisation, and implementation of community-based worker systems is now widespread in both the health and natural resource sectors. In South Africa, community-based workers are being deployed in a range of sectors notably HIV and health-related, but, with the exception of the health sector, the scale is small and the policy environment and coordination of these remains undeveloped. The relevant services are provided essentially by provincial governments, and in some cases by NGOs, Faith-based organisations (FBOs) and Community-Based Organisations (CBOs). Government has decided to mainstream funding of stipends for CBWs in the HIV and AIDS, and early childhood development sectors.

In Lesotho, community-based services have struggled in terms of continuity of funding but community-based worker programmes exist in adult education, agriculture and health, and the CBW concept is now being considered at high levels of government. Kenya still retains a highly centralised service delivery system. However, in recent years, its health department has looked to community-based health workers

Table 1: Common models of CBWs

Type of model	Key characteristics
Occasional volunteers	Typically 4-8 hours/wk; not paid
Part-time volunteers	20 hours (exceptionally up to 40 hours/wk); not paid, expenses often covered
Part-time volunteers paid a stipend	20-30 hours/wk; paid a stipend and expenses covered
Paid supervisors/para-professionals	40 hours/wk; often supervisors of CBWs or first line technical support
Business (paid by user) model	Hours variable, paid commission on sales (e.g. of drugs) or for services

Figure 1: The CBW system



to manage the large numbers of people affected by HIV and AIDS. Private sector CBWs provide drugs and other services in the animal health sector which is perhaps the most advanced in Africa, but face some resistance from the veterinary establishment. The creation of a cadre of community health workers, offering home-based care and other services in response to HIV and AIDS, has happened across all countries.

Pilot CBW programmes

The action research project reviewed experience in the four countries and supported a number of 'pilots' to test out good practice. The Kenyan pilot projects were ABC Kisumu, a sexual and reproductive health and rights project promoting behaviour change and communication; WASDA, a community animal health worker project in the arid and semi-arid lands and KICOSHEP-Kenya, a health services NGO. The South African pilot projects were Golang Batcha and CHoiCe Trust, offering home-based care and other health services, Kodumela, an area development programme (ADP) offering health and social services, and in the natural resources sector the Thaba 'Nchu Food Security Programme and Ramalema Environmental Pollution Prevention Project. The Ugandan pilot projects were Bucongo Development Organisation (BUCODO), a CBO primarily running an agro-forestry programme, the NAADS farmer extension programme, two health education and home-based care programmes and Rukungiri Functional Literacy Resource Centre, an adult education and community development programme.

Impact

Most of the pilot projects underwent an evaluation in 2006 to establish the impact and cost-effectiveness of the CBW approach. The hypothesis was that well-run CBW programmes would reach more people in a cost-effective manner and be more culturally appropriate and sustainable than traditional models of service delivery.

Impact on beneficiaries

In the health sector, interviews with beneficiaries and statistical data provided strong evidence of impact. Examples given were increased understanding of health, disease, nutrition and hygiene and increased adherence to treatment resulting in improved health outcomes. Beneficiaries reported significant psychosocial support. A reduction in stigma against PLWHA and changes in attitudes towards women was reported by ABC-Kisumu. Some health care organisations also had statistics confirming extensive social support such as distribution of food parcels, supporting orphans and vulnerable children (OVCs) and alerting the relevant authorities about vulnerable members of the community. Kodumela ADP was involved in food gardens and psychosocial support to OVCs. KICOSHEP-Kenya also runs a primary school for 450 children.

In the NR sector, few statistical data were available from the projects. However reported benefits included adoption of new technologies, replanting of trees, income from sales of seedlings, fruits and honey, improved livestock management, improved soil conservation, and greater understanding of land use rights. The NAADS farmer extension programme in Uganda is being rolled out on a large scale with over 2000 CBWs, on the basis of observed impact. A pilot project in South Africa had limited impact but poor conceptualisation of the project and management problems seem to have been the cause rather than the CBW model itself. Criticisms from NR projects suggested that CBWs are not always sufficiently knowledgeable and equipped to pass on information to others adequately.

CAHWs in Kenya are providing a valuable service in the arid and semi-arid lands which would otherwise have no veterinary services. Ramalema Environmental Prevention Project has had an impact in terms of cleaning its environment and raising awareness

of pollution among the youth from the evidence of stakeholders but unfortunately did not log activities systematically or collect photographic evidence.

Impact on the livelihoods of the CBWs

In terms of impact on the CBWs themselves, the benefits they reported from their work included the satisfaction of being of service to their community, increased knowledge, skills and confidence, greater status in their community; increased income (for those who received stipends) and gifts in kind such as tools or farming inputs. The negatives were loss of economic opportunities because of their commitments as CBWs, personal risk, emotional strain, feelings of being exploited and concerns that their community commitments were causing their family to suffer.

Impact on service providers

In terms of impact on the service providers, health CBW programmes are strongly integrated with the formal health services. The formal health services view them very positively and appear to see them as effective and essential partners reaching deeply into the community, following up on patients, conveying important health messages and freeing the formal services up to concentrate on work which previously they did not have time for. Nurses in the South African evaluation stated that there needed to be clearer specification of the roles of CBWs in government policy and recognition that staff had to be assigned to supervise CBWs.

In the NR sector, CBWs are integral to extension services in Uganda. The Kenyan Veterinary Services accept that CAHWs are the only way to provide a service to arid and semi-arid lands but they do have concerns. The Department of Agriculture in South Africa is experimenting with CBW projects in some areas but has not yet fully explored their potential. Lesotho is exploring implementation of a national system of community livestock workers, learning from the Kenyan experience, to support small livestock and create a response system in case of an avian flu epidemic, so there is clearly a positive response there. The NGOs supporting CAHWs in Kenya have helped to reduce the cash flow problems faced by CAHWs and the legal uncertainty surrounding their positions.

Cost-effectiveness

In the Kenyan health sector, the cost of home-based care treatment was compared with that of treatment at a primary health care clinic, and the cost of employing a CBW to work in HIV/AIDs advocacy and behavioural change was compared with the salary of a social worker. This indicated that the CBW service costs less than one-third of the conventional service. Of course, the comparison is of limited value in that the roles of the service providers in each case are not identical.

In the NR sector, the evaluations did not have sufficient data to compare the CBW programmes with conventional models. However, a cost-effectiveness study that Khanya carried out in Lesotho in 2002 suggested that the cost per farmer of achieving significant impact was \$298 compared with \$989 for a conventional government extension system. Transport availability and distances which CBWs have to cover on foot or by bicycle to see clients were identified as a challenge in the NR sector. The Ugandan strategy of gathering farmers at demonstration sites is a model to be explored further.

Implications for upscaling, policy and legislation

Community-based and para-professional services offer the opportunity of bridging the gap between professional services and the general community by devolving aspects of services to less trained personnel. Lower-cost training means that more can be trained for a given budget. The study indicates many benefits in using such models of delivery including cost-effectiveness. However, if the model is to be



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applied widely, national governments need to develop policy and legislation to support the development and scaling up of this method of service delivery.

Insights into the preconditions for successful scaling-up were provided by Khanya's work with Lesotho's Ministry of Agriculture and Food Security in 2006-07 to design a national programme for the rollout of community livestock workers (a form of community-animal health worker) and the Government is also considering how to upscale CBW models in the HIV/AIDS sector. The learning and recommendations that emerged from this collaboration have been developed into comprehensive operational guidelines for CBW systems (see www.khanya-aicdd.org). In addition a Policy Forum was held from 19-21 September, 2007 organised by Lesotho's First Lady to review the policy implications emerging from this project for upscaling CBW systems. This provided significant impetus to taking these forward in the 4 partner countries (as well as in Malawi, Tanzania and Zimbabwe).

Preconditions are of three broad kinds:

i) greater standardisation of training outcomes, standards of delivery, conditions of service and remuneration.

There was a general consensus that training should reflect agreed outcomes and curricula should be more standardized. Accreditation should also be considered and be based on the achievement of minimum standards. Stipends, if agreed to, would require more careful monitoring of delivery which, in turn, would increase supervisory costs. There would be tighter definition of the roles of CBWs and more formal recruitment processes, work contracts and benefits. In effect, a new cadre of community-based service providers with titles created such as community forestry workers or home-based carers. These would be supported by para-professionals such as animal health technicians or medical clinicians. Career-pathing would be a reasonable expectation of CBWs. Friedman (2005: 186) suggest the use of credits as a reward for voluntary work. The idea is that CBWs could be allocated points for hours worked which could be accumulated and used, for example, to "pay" for further studies.

ii) higher and more regular funding.

In most contexts, government would be the most appropriate funder, whilst delivery could be through a wide variety of implementing agents. In some contexts supplementary funds through partnerships with donors would be necessary. The cost to the government of paying the CBWs could be offset to some extent by savings elsewhere eg in hospital admissions, increased taxes through lower livestock mortality. At a wider economic level, benefit:cost ratios are expected to increase as livelihoods improve. The 'user pays' model needs to be explored, as do models where the implementing agency uses income-generation activities to fund the provision of services.

iii) changes in policy and legislation.

Urgent change is required in some cases e.g. in Kenya where CAHWs are not recognised in law.

The lowest cadre of personnel qualified to offer animal health services in Kenya is an animal health technician. It is unlikely that there will be enough trained technicians in the near future so it is important for the government to regularise the position of the CAHWs and the service providers who support them.

Friedman (2005) notes that, in the health sector at least, there is a serious problem with the proliferation of many types of health ancillary workers without any overarching coordinating body. Policy development is therefore needed both within across sectors, for instance, to create coordination between health and social services.

A representative body and specific legislation is needed to regulate and advocate for CBWs within their different spheres of work so that they know their rights and responsibilities and are protected from exploitation.

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A wide range of partners have contributed to this work and a full list can be seen on the CBW section of the website at www.khanya-aicdd.org. For the list of partners refer to the Final Report on the Project "Experiences with community-based worker systems in Kenya, Lesotho, South Africa and Uganda: final report of the four country CBW project".

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Endnotes

¹ http://www.lesotho.gov.ls/articles/2005/chapter_8.pdf