

The Impact of Community Caregivers in Côte d'Ivoire

Improving Health and Social Outcomes through Community Caregivers in Côte d'Ivoire

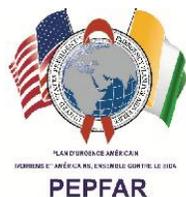
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This research was supported by Save the Children USA and USAID, a key implementing agency of the President's Emergency Plan for AIDS Relief (PEPFAR). Special thanks to the families, community leaders, community caregivers, and local NGOs who shared their knowledge and experience with us. Correspondence concerning this paper should be addressed to Hannah.Newth@savethechildren.org. The contents do not necessarily reflect the views of USAID or the United States Government.



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Abstract

Background: Côte d'Ivoire has one of the highest adult HIV prevalence rates in West Africa, which has directly affected an estimated 410,000 HIV-related orphans and vulnerable children (OVC). Some OVC programs have used local NGO to recruit and support community caregivers (CC), to provide care and support to children left vulnerable by the epidemic.

Objective: The study examined the impact of community caregivers on households/children orphaned or made vulnerable by HIV/AIDS in Côte d'Ivoire.

Methods: A sequential mixed methods design was used to combine quantitative (survey design) and interpretive qualitative aspects. The study employed quasi-experimental method to compare/evaluate, an intervention group of 512 households who received community caregiver support to a control group of 212 households not in the program and not receiving CC support to gain an in-depth understanding of the CC role.

Results: Almost all the children in the CC supported intervention group received support and accessed services, while about 30% of the control group did not receive any services. About half had received two HIV-related clinical services and over two-thirds (68%) had received 5 to 8 of the 10 services measured by the study. Those who received caregiver support were more likely to be connected to social support groups. The results found on average, CC-supported OVC were satisfied with the support they were receiving.

Conclusions: The study found that CCs have had a significant impact on OVC's lives, improving social and clinical outcomes. The results consistently showed that CC supported OVC got higher access to care and at a higher rate than those not being supported by a CC. The study recommends the CC intervention model be formalized and embedded into the government welfare and health system in Côte d'Ivoire.

Keywords: HIV, AIDS, Côte d'Ivoire, community caregivers, community based care, local NGO

Improving Health and Social Outcomes through Community Caregivers in Côte d'Ivoire

Introduction

Côte d'Ivoire has one of the highest adult rates of HIV prevalence in West Africa, estimated at 3.7% (MoH, Fight against AIDS, NIS, MEASURE DHS, & ICF International, 2013). HIV-related orphans and vulnerable children are estimated to number 410,000, of which 61,000 are children living with HIV (PEPFAR, 2012). The pressures that HIV puts on families and communities have often resulted in the disruption of the family structure and difficulties in accessing essential services, such as health care, education, and adequate shelter and nutrition (Ankrah, 1993; Atwinea, Cantor-Graaea, & Bajunirwe, 2005; Hosegood, 2009; Ssengonzi, 2009).

Programs in Côte d'Ivoire

In Côte d'Ivoire, community-based organizations are pioneering solutions to support children left vulnerable by the HIV epidemic. Much of the support is provided by an invisible workforce, known as the '*conseillers communautaires*' or community caregivers (Peel, 2010; WHO, 2012). Community caregivers (CC) are usually members of the community in which they 'work' (Friedman, 2005; Hayes, 2010; Uys, 2002). They offer care and support to OVC and their families through home visits, during which they assess the families' needs, refer them to appropriate services, and provide emotional, psychosocial, and practical support (Hermann et al., 2009; Kang'ethe, 2009). However, this is a largely unrecognized, unregulated work force. There are no legal texts to frame the actions of community caregivers and no national guidelines or standards governing their role. These grassroots workers are not remunerated or officially recognized by the state, despite the fact that the Ministry of Solidarity, Family, Women, and Children (MSFFE) among others relies on the data CC produce. PEPFAR, by allowing its partners to provide training and regular stipends for community caregivers, has made huge investments in this cadre of workers in the community-based response to HIV (Peel, 2010).

Since September 2008, USAID/West Africa through PEPFAR, has funded Save the Children to build the capacities of local NGOs and government entities to provide care and

support for orphans and vulnerable children in 8 regions of Cote d'Ivoire (Peel, 2010). One of the specific objectives of this program was to strengthen the capacity of families, communities, and local partners to provide quality care and support for orphans and children made vulnerable by HIV/AIDS. To this end, Save the Children has worked with 13 local NGO partners who provide care and support to vulnerable children and their families, in accordance with the national strategic plan for OVC (PEPFAR, 2012). During the fiscal year 2011-2012, these NGO partners recruited and trained nearly 400 community caregivers who provided direct care and support to about 20,000 vulnerable children and their families (Save the Children, 2012; William & Biti, 2013). Save the Children believes that community caregivers have played an important part in reaching these communities affected by HIV/AIDS and the households caring for OVC. However, they have no empirical evidence of the impact that CCs have had on the health and social outcomes for children affected by HIV or of the importance of their role in the social welfare system in Côte d'Ivoire (Peel, 2010).

Study Aims and Objectives

This study sought to evaluate how community caregivers impact access to health care and social services for these children and families. It compared the services provided by Save the Children's program to other similar programs that do not use community caregivers in their model of service delivery. The study investigated a range of activities carried out by caregivers and evaluated the impact of their efforts on clinical and social outcomes; it also investigated the support and supervision of community caregivers and the barriers that community caregivers must overcome to provide support to this vulnerable population.

Methods

Study Design

This study used a sequential mixed-methods approach to evaluate the impact of community caregivers on children orphaned or made vulnerable by HIV/AIDS in Côte d'Ivoire (Greene & Caracelli, 1997; Johnson, Onwuegbuzie, & Turner, 2007; Teddlie & Tashakkori, 2009). The study included two quantitative aspects (analysis of existing project administrative

and survey data collected from OVC, and guardian/parent) complemented by qualitative research at the household, caregiver, and NGO level. This mixed-methods approach permitted a more rigorous analysis of the impact of community caregivers on this vulnerable population, while understanding further elements that might impact the sustainability of this workforce.

The study also used a quasi-experimental design to compare data from 512 orphans and vulnerable children (OVC) who received community caregiver support (the intervention group) to 212 OVC who were not receiving any community caregiver support (the control group). Participants were selected from 5 of 8 regions in which Save the Children works in Côte d'Ivoire: Lagune (Abidjan), Indenié-Djuablin (Abengourou), Guémon (Duékoué), Tonkpi (Danané) and Kabadougou (Odienné). These regions were purposively selected based on the number of caregivers in the Save the Children program and the number of vulnerable children in these regions, and north/south location. Since all participants had access to similar services, the defined intervention group had CC support. The selected control group was supported by NGOs with similar demographic attributes but not using community caregivers in their program.

Sample

The participants for the intervention group were selected using data provided by Save the Children offices in Côte d'Ivoire. The data was used to match community caregivers to the households. Caregivers were randomly selected and stratified by region, cities, suburbs, or villages. The study selected 174 community caregivers who worked with 13 NGOs in the Save the Children program.

Children enrolled in the Save the Children program were either HIV+, lived in a household with someone identified as HIV+, or engaged in risky behavior that increased their chances of HIV infection (e.g. commercial sex work, injecting drugs). Proof of HIV status had to be provided before enrollment. A similar definition was used by the other OVC programs in the country which also includes those in the control group.

The control group included vulnerable children who lived in the same program area as

the intervention group, were in the same age range as the intervention group (approximately 1-24 years in age), and were known by the caregivers, although not receiving direct support from Save the Children's program.

For both the intervention and control group, the vulnerable households were first selected and then a child was identified for review. If there were more than one child in the household, only one was selected to be in the study. For children who were unable to talk, their parents or guardians were questioned instead. We had difficulties identifying participants for the control group in Abidjan and Kabadougou, where there is a large transient urban population, so those areas were excluded from the control group. This challenge resulted in approximately one participant in the control for every two in the intervention group. These responses were coded around the OVC in the household (Table 1).

Ethical Consideration

The research study followed the standard child safeguarding protocol set by Save the Children. All research investigators, supervisors, and field interviewers reviewed and signed the Child Safeguarding Policy requiring researchers to have an agreement framework that protects the confidentiality of the research participants. Participation in the study was voluntary and informed consent was provided. The consent form was also read and explained in the local language. Data was placed in a secure and locked location at the Save the Children office. All identifiable information was removed and (in keeping with WHO guidelines for Ethical standards and procedures) only summary and aggregate data have been analyzed, presented, or shared (WHO, 2011).

Table I: OVC Distribution by Region and Gender

	Intervention		Control	
	Male (%)	Female (%)	Male (%)	Female (%)
Abidjan	29 (6%)	47 (9%)	-	-
Indenie-Djuablin	48 (9%)	55 (10%)	31 (15%)	38 (18)
Guemon	61 (12%)	72 (14%)	42 (20%)	33 (16)
Kabadougou	42 (8%)	59 (12%)	-	-
Tonkpi	47 (9%)	50 (10%)	33(16%)	33 (16)
TOTAL	227 (45%)	283 (56%)	106 (50%)	104 (50%)
Goodness of fit χ^2	0.65		0.41	

Instruments and Data Collection

The questionnaires were designed to capture seven indicators of social support (food and nutrition, health, education and apprenticeships, psychosocial support, legal and child protection, shelter and care, and household economic strengthening) and two clinical indicators (HIV testing and adherence to HIV treatment.). The questionnaire also included a section that asked for the level of satisfaction with the community caregiver support (intervention group) or the desire for a community caregiver (the control group). The questionnaire used a Likert scale designed to capture satisfaction ranging from 0 (least satisfied) to 5 (very satisfied).

The semi-structured interviews were used to collect information from the 8 NGO key informants. The 174 community caregivers participated in 30 focus group discussions across the 5 regions. Personal interviews and focus groups took a little longer, depending on the field dynamics and the desire to capture key information. The interviews and focus group discussions were conducted in French and in the local language by trained interviewers led by the local researcher. The interviews were taped, and then summarized in English, based on notes and review of the audiotapes.

Definitions

The study was interested in health seeking behaviours and adherence to antiretroviral (ARV) treatment for HIV positive OVC. The study defined adherence to treatment as the self-

reported ability to follow a treatment plan and take medication at a prescribed time and frequency. This includes not skipping or stopping taking the medication or dropping out of the treatment plan (Gonzalez et al., 2004; Hermann et al., 2009; O'Laughlin, Wyatt, Kaaya, Bangsberg, & Ware, 2012). The study also investigated retention in health services for the OVC. The study defined this as seeking, registering and using health care services and treatment, as well as consistently keeping up with medical appointments on a regular basis as required.

Data Analysis

Epi Data version 9.0 was used for data entry and analysis was completed using SPSS version 19.0. Univariate and bivariate analysis were carried out on the social and clinical indicators that had been collected. Summary descriptive statistic and odds ratios (OR) were used to compare the impact of the intervention with the control group.

Qualitative analysis of transcripts of the interviews and focus groups was completed to gain an understanding of the experiences of community caregivers and meanings derived from their work in Côte d'Ivoire. The study employed interpretive phenomenology to analyze the interviews and focus groups (Benner, Tanner, & Chesla, 1996; Tan, Wilson, & Olver, 2009). This approach offered the best method to describe the meanings and culturally situated social experiences of the participants. The local research team reviewed the interviews and focus groups, and generated an interpretive summary highlighting emerging thematic patterns, distinctions, and particularities of meaningful and challenging experiences. The lead researcher also reviewed the transcripts to ensure there was consensus in the summary.

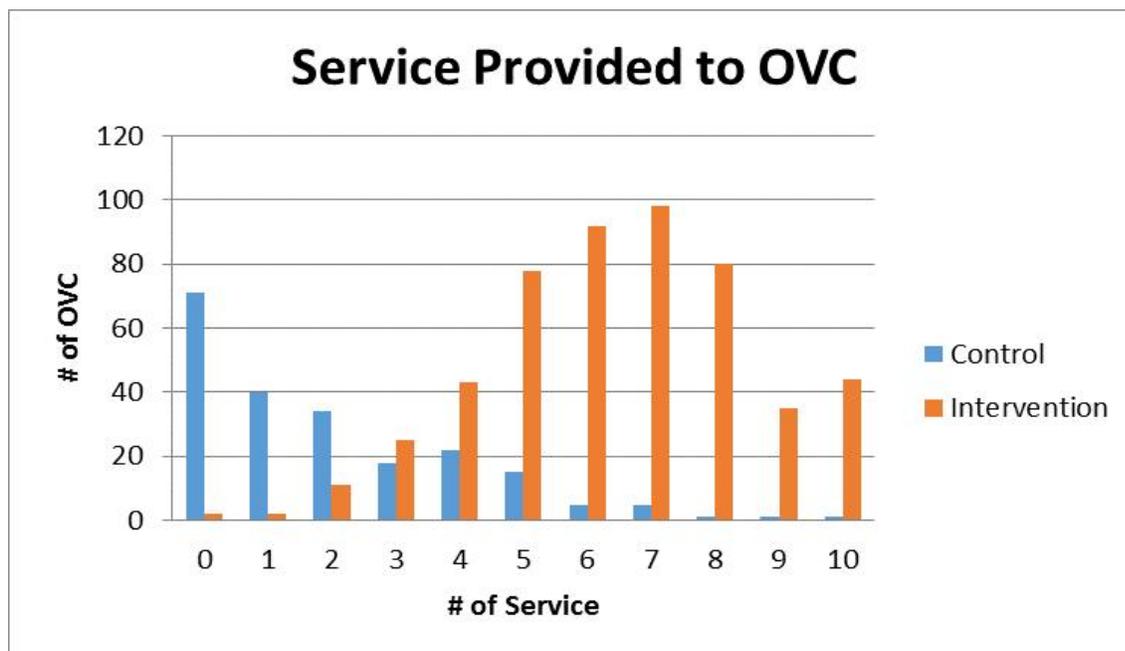
Table 2: Descriptive OVC Information for the Intervention and Control Groups

	Intervention	Control
	N = 512	N = 212
Mean Age (years)	10.8 (SD=4.3)	10.3 (SD=4.2)
Range	0.6 to 19 years	1 to 24 years
Average Time with CC	2 years	-
Gender		
Male	227 (45%)	106 (50.5%)
Female	283 (55%)	104 (49.5%)

Results

The average age of children in the study was 10.8 years (SD=4.3) for the intervention group and 10.2 years (SD=4.2) for the control group suggesting that there was not much of a difference between the participating households (Table 2). On average, children who received community caregiver support had received 2 years of support. The intervention group had more girls (55.5%) than boys while the control group was evenly divided (50%) but the gender difference in the groups was not significant.

The maximum number of services available to OVC households in any of the programs was ten, and we expected to find all OVC benefiting from at least one activity. About half of CC supported OVC received 2 clinical services, with over two-thirds (68%) receiving 5 to 8 services of the 10 available. Those who received caregiver support were about 12 (average) times more likely to receive care and services than those who had no community caregiver (Table 3). They were also more likely to be connected to the community through social support groups. Children supported by a community caregiver had a higher rate of access to services (both social and clinical) than those in the control group. Almost all the children in the intervention group received some support to access services, but about 30% of the control group that were registered with a local NGO did not receive any services (Figure 1).

Figure 1: Number of services provided to OVC

The most common services accessed by households who had caregiver support were psychosocial support (93%), health care (86%), and nutrition and food (85%), followed by child protection (70%) and education (68%). Fewer than 40% reported accessing resources for household economic strengthening or care and shelter. For non-CC supported OVC, most common services accessed by them were health care (61%), and education (62%), while all the others services were at less than 40%. Fewer than half non-supported OVC (46%) accessed HIV testing, compared to nearly three-fourths of those who had received CC support (74%).

Table 3: Descriptive Statistics of the Impact CC have on OVC (n=512) compared to the Control Group (n=212)

SOCIAL OUTCOMES	Intervention		Control		OR (95% CI)
	Yes (%)	No (%)	Yes (%)	No (%)	
Nutrition and food***	432 (85)	75 (15)	36 (17)	171 (83)	27.4 (17.7, 42.3)
Improved nutritional Status***	386 (83)	79 (17)	26 (14)	155 (86)	29 (18.4, 48.8)
Health care***	431 (85)	73 (15)	73 (35)	133 (65)	10.4 (7.2, 15.2)
Health education, & advice, referral***	417 (83)	84 (17)	126 (61)	82 (39)	3.3 (2.3, 4.8)
Accessing care at health centers***	290 (67)	141 (33)	58 (33)	125 (68)	4.3 (3.1, 6.4)
Having regular medical check-up***	94 (32)	196 (68)	19 (14)	114 (86)	2.8 (1.6, 4.8)
Education and apprenticeship***	344 (68)	160 (32)	52 (25)	154 (75)	6.4 (4.4, 9.2)
Vocational training / apprenticeship ***	68 (20)	279 (80)	9 (5)	163 (95)	4.3 (2.1, 8.9)
School attendance*	354 (70)	151 (30)	128 (62)	78 (38)	1.4 (1.0, 2.0)
Psychosocial support***	475 (93)	35 (7)	46 (22)	161 (78)	47.5 (29.6, 76.4)
Receiving psychosocial support – Participating in a support group***	275 (56)	216 (44)	14 (7)	178 (93)	15.9 (9.0, 28.2)
Legal and child protection***	353 (70)	152 (30)	21 (10)	184 (90)	20.4 (12.5, 33.2)
Resolving Legal Issue Receiving legal support***	288 (58)	210 (42)	17 (8)	190 (92)	15.3 (9.1, 26.0)
Care and shelter***	180 (37)	310 (63)	9 (4)	196 (96)	12.7 (6.4, 25.4)
Accessed the Shelter***	136 (28)	357 (72)	10(7)	196 (95)	7.5 (3.8, 14.5)
Household Economic Strength***	164 (34)	324 (66)	5 (2)	201 (98)	20.5(8.3, 50.7)
Microcredit association***	80 (18)	355 (82)	13 (7)	167 (93)	2.9 (1.6, 5.4)
Holding a bank account**	42(10)	375(90)	7 (4)	189 (96)	3.0 (1.3, 6.8)
	Intervention		Control		
CLINICAL OUTCOMES	Yes (%)	No (%)	Yes(%)	No (%)	OR (95% CI)
Have been tested for HIV***	372 (74)	134 (26)	98 (46)	114 (54)	3.2 (2.3, 4.5)
Adherence to treatment! ***	111 (57)	84 (43)	25 (13)	175 (88)	9.3 (5.6, 15.3)

Comparing Access to Services

We endeavored to understand the activities in which the caregivers engaged and the impact of their support on the children and families they served. We compared the different rate in access to services for those in the intervention group with those in the control group. We used relative risk and odds ratios to analyze the impact (Table 3).

Nutritional status: The program provided emergency food kits or rations to children on a temporary basis and helped them with some nutrition-related activities, such as providing nutritional advice. Nutrition-related activities included food/hygiene education, buying food items, and cooking with and for some children. Nearly 85% of the CC supported OVC reported that they had received some nutrition-related support from the caregivers compared to 17% for the control group. The CC supported OVC were able to access a number of activities to achieve this higher rate. Over half (51%) acknowledged that caregivers brought them food at one time, while over a third (35%) reported that caregivers bought food often. About 16% of the CC- supported OVC also reported that caregivers cooked with them or for them since getting into the program.

We reviewed weight information in the medical records from the time the children entered the program through August 2013. Based on this data, children in the intervention group were 29 times (OR=29, 95% CI = 7.2 – 48.8) more likely to have an improved nutritional status compared to the control group.

Table 4: Distribution of Healthcare Education

Frequency	Intervention	Controls
Never	4%	66%
Often	33%	27%
Very often	64%	5%
TOTAL	487	204

Health: Those in the intervention group had proportionally higher access to health care and higher health education than those in the control group. The frequency of health education, including HIV prevention information, ranged from none to very often (Table 4). Nearly two-thirds of those in the intervention group (64%) reported receiving health advice or education very often, while nearly two-thirds of those in the control group (66%) reported *never* receiving any health advice or education. Of those receiving health advice and education, five out of six (83%) received healthcare counseling related to HIV infection and HIV testing. Those in the intervention group were ten times (OR=10.4, 95% CI = 7.2 – 15.2) or more likely to receive health care when needed compared to those in the control group (Table 3). They were also 3 times more likely to be tested for HIV than those in the control group.

Adherence to treatment: Since the program served children that were HIV+, at risk of HIV infection, or had family members who were infected, the program had a higher number of HIV+ children that needed treatment. Consistent ARV treatment for HIV+ children would improve their quality of life and lower treatment costs for the community and country. About one-fifth (21.6%) of those in the intervention group were under ARV treatment, compared to 12% of those in the control group. Treatment duration varied from one week to 8 years. About 57% of CC supported OVC reported adherence to treatment compared to 13% in the control group. The majority (62%) said that the caregiver's support for their adherence to treatment was good; a third (33%) rated it as excellent. Only 5% said it was not good. CC-supported OVC were 9 times more likely to adhere to treatment compared to the control group.

Education and apprenticeship: The percentage in the intervention group attending school was slightly higher (70%) than in the control group (62%). The difference between the two groups was more pronounced when we examined the rate of children accessing vocational training or apprenticeships (20% to 5%). Although those accessing vocational training in both groups were in the minority, (they represented less than 10% in each group) those in intervention group were 4 times more likely to receive vocational training than those in the control group.

Psychosocial support: Psychosocial support included not only the frequent visits of

the community caregiver, but also membership of support groups. Almost all in the intervention group reported that their caregiver provided psychosocial support (93%) compared to about a fifth (22%) in the control group. Most (89%) also reported that their caregiver encouraged them to become part of a support group. They were more likely to be involved in a support group than those in the control group (56% compared to 7%). The caregiver also counseled them on HIV transmission (89%) that included but was not limited to risky sexual behavior, HIV treatment (47%), STI infection (55%), and personal hygiene practices (86%).

Legal and child protection: Nearly three-fourths (70%) of those in the intervention group accessed the legal services through the program, compared to only 10% in the control group (OR=20.4, 95% CI = 12.5 – 33.2) (Table 3). Of those who accessed these services, about 82% of those in the intervention group and 77% in the control reported facing legal problems or issues. Problems included fighting with peers/family, disagreements with adults, child abuse (e.g. abuse-physical, sexual, emotional), refusing to go to school, and accessing a birth certificate. Of those that were supported with legal or child protection issues, most of them (96%) acknowledged that the caregivers were part of the process of resolving their problems.

Economic strengthening: About a third (37%) of those in the intervention group reported that they benefitted from economic strengthening activities compared to 2% in the control. Over half (53%) recognized that the caregivers contributed to changes in their economic status. Those in the intervention group were nearly three times more likely to become members of a micro-credit association (OR=2.9, 95% CI = 1.6 – 5.4) than those in the control group. They were also three times more likely to open a bank account.

Table 5: OVC Level of Satisfaction with CC

	Not satisfied	Satisfied
Nutrition and food	5%	95%
Healthcare	2%	98%
Education and apprenticeship.	12%	88%
Psychosocial support	1%	99%
Legal and child protection	5%	95%
Care and shelter	44%	56%
Household economic strengthening	27%	73%

Levels of satisfaction. The level of satisfaction with the caregivers' actions and support was generally high. The satisfaction level ranged from 56% for care and shelter services to 99% for psychosocial support (see Table 5). The average satisfaction rate for all the services provided by the program was about 86%. Almost all (96%) of those in the control group reported that they wanted to be supported by someone like a community caregiver. They saw community caregiver support as an opportunity to get better access to care and support.

Support for Community Caregivers. The key informant interviews with NGO staff revealed a lack of consistency in the supervision provided to the community caregivers across all organizations. Larger and better-organized NGOs had more robust human resource structures that provided greater oversight for the caregivers and tracking of assignments in the NGO zone of intervention. In addition, the larger organizations were able to provide services on site and better utilize the caregivers for support to the children they served. For example, some organizations had their own healthcare center. Organizations with limited financial and human resources were less able to support caregivers in their activities.

While the quantitative findings show the extent to which community caregivers were a

valuable social capital, the qualitative findings like the focus group interviews often added insights into the community caregivers own experiences of social and health care delivery. Some of the caregivers reported that they were HIV+, yet many were not able to access healthcare and medication support for themselves. They also felt their efforts were not sufficiently valued given the lack of a consistent and secure income to ensure their own economic stability.

Discussion

The study documents the impact that community caregivers have in enhancing the quality of life to households impacted by HIV/AIDS in Côte d'Ivoire. We found that having a CC made a significant difference in the children's lives and had a positive impact on their well-being. The results consistently showed that those in contact with a community caregiver received better access to care than those who did not. The program increased access to support and improved the efficacy of the services by increasing their utilization and reach. The difference in services was large and significant. The widest difference between groups was in accessing psychosocial support.

The community caregivers themselves provided psychosocial counseling as well as counseling in personal hygiene practices, nutritional information, health-seeking behavior, adherence to treatment, HIV and STI infection information. This support may have had a big impact on the children and their families, contributing to the increased likelihood of accessing the social services supported by the Save the Children program. The presence of the caregiver in the children's lives may have provided them with the stability they needed to seek other forms of support.

While the community caregivers provide an invaluable source of support to the children and their families, our research also revealed a number of problems that need to be addressed to continue and extend the program. At the individual and family level, one of the barriers to joining in the program is the issue of privacy, rooted in the fear of stigma and of exposure to issues that are perceived or expected to be kept confidential within the family. Better communication and greater assurances of confidentiality may help to address these concerns. However, some of these fears are deeply embedded in the cultural stigma associated with HIV

that no organization or program can eradicate single-handedly.

Recommendations

The status of community caregivers needs to be formalized and their work recognized in social and health related sectors as para-professionals.

At the organizational level, CCs need to be provided with more regular and better quality supervision to enable them to carry out their role effectively. A collaborative system needs to be created or enhanced between NGOs and the state. If the CCs are to continue being primarily attached to NGOs; they also need broader support and better linkages to the government social welfare and health systems. Direct supervision by the state may require a modified service delivery model for OVC support that addresses bypassing NGOs.

Remuneration for community caregivers in Côte d'Ivoire also needs to be reevaluated in order for them to continue and sustain the quality of the services that they offer. Research in other African countries has found similar compensation issues (Hayes, 2010). The allowance provided currently does not take into account the cost of living in the country based on the amount of work they do. Even though most CCs do not work full time, they should not be expected to carry out their work in a voluntary capacity. They contribute to improvements in the lives of vulnerable children and families, as well as collecting data on behalf of the government that feeds into the national M&E system. This valuable contribution should be formally recognized and rewarded. The lack of a clear plan for future funding or remuneration for services that CC provide, could impact the long-term effectiveness of the care giving in the country.

When CCs come from households which are themselves impacted by HIV, they should be included as project beneficiaries and be afforded the same services provided to the vulnerable families they serve. CCs who are from poor households, but who do not match the program's criteria as beneficiaries, should be appropriately remunerated so that they can afford to access services and ensure their families' well-being. Programs will need to pay more attention to addressing the needs of CCs and consider ways in which CC can participate in

some of the microfinance program activities such as Village Savings and Loans Associations (VSLAs) to improve their own household economy¹⁶.

Given the strong association between the work of the community caregivers and improvements in clinical outcomes, CCs could play a powerful dual role in the community by promoting access to services in both social and medical care. This suggests that they have the potential to improve care and adherence to treatment and could help reduce the number of patients who are lost to follow-up. They can also promote increased use of social, educational, nutritional, and clinical services. These findings were similar with studies focusing on other community-based workers (Hermann et al., 2009; Rosenberg, Hartwig, & Merson, 2008; Uys, 2002). Considering the CCs positive impact, continued funding would be recommended to ensure uninterrupted service and support of the community caregivers in the country.

Limitations of the study

The study had a number of limitations that included the subjective nature of the information provided by OVC, CCs, and NGOs and recruitment. The OVC, CCs, and NGOs provided information from their worldview and experience. The other challenge included recruiting the best matching NGOs for the control group. This limitation could have been due the time allocated for recruitment in the study.

Conclusion

The study found a majority of those surveyed were satisfied with caregivers' work and almost all who were in the control group wanted the support from a community caregiver. This has demonstrated that there are compelling reasons why this cadre should be supported formally by the existing social welfare and health systems so that they could continue addressing social and healthcare issues within and with the communities that are affected. The study also highlights the impact community social workers and health workers can have on the lives of the community they serve. Researchers should continue to explore ways to expand and enhance the work of community caregivers in resource poor communities.

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