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# RAPID APPRAISAL OF WARD BASED OUTREACH TEAMS

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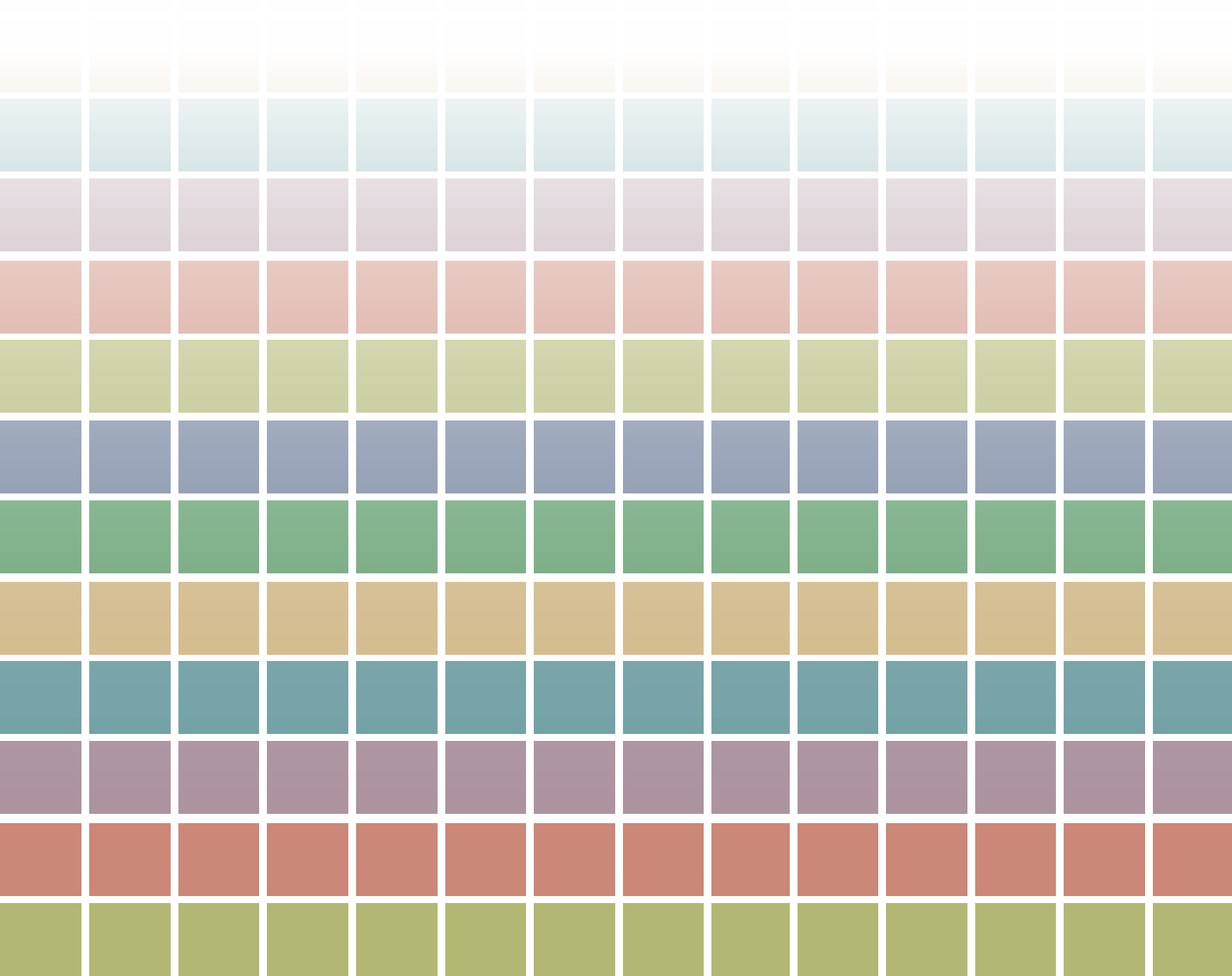
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ASELPH is a partnership among the University of Pretoria (UP), the University of Fort Hare (UFH), the Harvard School of Public Health (HSPH) and South Africa Partners (SAP), in collaboration with the South African National Department of Health (NDOH).

The goal of the ASELPH programme is to strengthen the ability of the NDOH to meet health transformation challenges, particularly at the district level. The programme does this by addressing the following objectives:

- Establish and maintain a critical mass of knowledge, skills, competencies and leadership among current and emerging District Health leaders;
- Improve policy implementation strategies through a collective understanding of the political and organizational context and the cross-cutting issues that underpin decision making and implementation;
- Promote and maintain high quality service delivery standards at the district and community level; and
- Build an executive leadership pipeline through increased executive leadership training capacity among South African faculty and educational institutions that includes increased capacity in curriculum development and distance learning technology and techniques.

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Health care leaders around the world have recognized the importance of community based primary health care in a strong health delivery system. In reengineering primary care, the South African government has created a policy environment to support this commitment. There are many challenges that need to be overcome to make this policy into a practical reality, however.

The **findings** presented here are based on a rapid appraisal of the Ward Based Outreach Team (WBOT) model in National Health Insurance (NHI) pilot sites in seven provinces three years into the process of implementation. The findings provide a snapshot of the initiative from the perspective of middle (District & sub-District) and lower level facility managers (sub-regional managers and team leaders) and community health workers. They also take into consideration the experiences of 'best practice' described in the case studies.

## 1. Approach and Purpose

Re-engineering primary health care and the establishment of the WBOTs by the South African government marks a significant milestone and departure from previous attempts at introducing auxiliary health workers into the primary health care system. In the past, community health and variously named care workers were donor, non-governmental or community driven ad-hoc, informal and localized solutions designed to address crises of care and need. With PHC re-engineering, WBOTs are the first national attempt to formally integrate community health and care workers into the public primary health system. WBOTs were operational and functioning in the district health system in all the NHI sub-districts included in this study.

Current national policy documents envisage the model of ward based outreach teams (WBOTs) as an add-on service attached to primary care clinics. It functions to extend the reach of existing facilities at the bottom of the health care hierarchy. This notion of primary health care clinic service extension is generally how the model is understood across all districts. However, in the Eastern Cape as well as Tshwane (Gauteng), the approach is more community based. Whereas all teams are linked to defined clinics, in the Eastern Cape they are delivered from service points and in the City of Tshwane from health posts that are situated at sites that already provide local services (Case Study 1). In this, the approach is similar to the practices of non-governmental and community based projects like Philani and Community Action (Case Study 2 and 3).

The purpose of WBOTs is to support the provision of comprehensive primary care. In all study districts, respondents put particular emphasis on health promotion and disease prevention, including treatment support. Only limited reference was made to treatment.

Respondents see that both the approach and purpose are different from the legacy model of facility-based primary health care management.

For them, WBOTs

- work in defined areas with defined people and communities.
- extend health care beyond the individual patient.
- provide services to people in their homes.
- extend health care to remote, rural and marginal populations, who find it difficult to access services at facilities because of their physical location or social position.
- extend health care to people who are homeless, abuse substances, engage in sex work or are on the margins of society in other ways.
- extend the care focus beyond health conditions and diseases.

## 2. Organisation and Functioning

In all districts, there is concerted effort to manage WBOT by all levels of management. This said, respondents confront common basic management problems that relate to WBOT structure and functioning in the health care system. Practical challenges and conceptual flaws that they identify include:

**2.1 Policy conceptualisation.** They have not been part of decision-making processes – be it in respect of policies, finances and management structures or the implementation process itself.

**2.2. Team composition** envisaged in national policy documents is difficult to create.

- a. There are problems with team leadership, given the dearth in professional nurses. They have tried to get around this problem by recruiting retired nurses, appointing enrolled nurses and/or by double tasking available facility staff. However, these solutions impact on WBOT and facility functioning. They are unable to meet the need leaving teams without leaders and are not sustainable even in the short to medium term.
- b. There are problems with the kinds and levels of competencies in WBOTs. The envisaged appointment of health promoters and environmental officers to WBOTs has not occurred. Moreover these are not the only competencies that are needed to make ward based health and care work. Respondents point to the need for people who are able to do psycho-social work and data capture support. More generally, CHWs are inadequately prepared, often have low levels of education and are limited by competencies created through legacy vertical programmes.
- c. There is a problem with the size of teams – with some being too small and others being too large to effectively manage.
- d. All of the above has a direct bearing on WBOT coverage. The envisaged model of health care teams in all wards is not the case in any province, district or even sub-district. While the program is still at an early stage of implementation, working in a partial system affects the ability of the approach to realize its goals and it impacts on the functioning of WBOTs.



**2.3. Functional authority and jurisdiction** is a problem for both team leaders and community health workers working in WBOTs.

- a. Locating WBOTs in and under the supervision of primary health care facilities overburdens facility management and is onerous on CHWs.
- b. Outreach team leaders (OTLs) are expected to play a dual role, working both inside and outside the facility.
- c. WBOTs are poorly understood at various levels of management in the public health care system. Facility staff often have little control over their working day.
- d. Facility staff don't have control over CHWs deployed to WBOTs by NGOs. This creates practical and organizational culture management problems.

**2.4. Working Conditions.** Insufficient attention has been paid to human resourcing, infrastructure and materials, problems that can be attributed in large part to the fact that the WBOT model is appended to the existing primary health facility-based system and the legacy practices regarding community health workers within it.

- a. In terms of human resources, there are problems of understaffing, lines of authority, accountability, supervision and dual tasking already described. These compound and are compounded by challenges of appointment and pay. Community health workers are considered to be neither workers nor volunteers. What this means is that the system does not accord them the status of an employee, with the rights and benefits that come with it under South African labour law. By entitling them to a stipend, government and non-government organisations acknowledge their labour and provide a form of compensation for their work, so they are not volunteers. This grey space leads to demotivation, hardship and attrition. It makes it very difficult to create a sustainable system of community based health care.
- b. There is inadequate attention to infrastructure and material resourcing. There is a problem of physical space, a general shortage of essential office equipment to support WBOT functioning, including not having desks and chairs, lockable filing cabinets, photocopying equipment, access to phones and computers and stationery to register and collect information where the system is paper based. There is a lack of uniforms and name tags that identify them to the community, protective clothing, properly equipped kitbags and essential equipment. Transport is a major problem.
- c. These deficiencies arise, in part, from the assumption at national and provincial level that resources would be met from NHI and other grants.

**2.5. Education, Training and Career Pathing.** The NDoH has approached the educational preparation requirements for primary care reengineering as short course training. This approach is informed by the assumption that facility supervised outreach teams would be led by professional nurses (with a four year B nursing degree). It also is informed by the legacy system of training rather than educating care workers who work at the community interface. Training for team leaders is a once off, five-day course to reorient OTLs to the model (initiated in 2011). Training for community health workers involves two 10-day courses – Phase 1 (initiated in 2012) followed by practicals, and Phase II (initiated 2014) and a one-year NQF L3 Health Promoter qualification (initiated in 2015).

The rapid appraisal found that

- a. Education and training is considered by all respondents in all sites and case studies to be essential to making ward based primary care work.
- b. Practical in-service continuous learning is practiced and highly regarded as an essential component of capacity development of CHWs, OTLs and managers.
- c. Teams and individuals were at different points in the short-course training program developed by the NDOH at the time of the study.
- d. The organization and timing of available training is inadequate, particularly the need for CHWs to complete Phase 1 before they begin to go out into the community; the slow pace of progression through the phases; the absence, shortages or delays in materials, un-conducive learning spaces, and a lack of budgeting and generally poor planning.
- e. Training methods and content do not take account of existing capacity and gaps in knowledge and skills. These include computer, language and health literacy as well as management and leadership.
- f. The program is not well linked to formal qualifications or WBOT competencies and scope of work.
- g. The focus on orienting and training CHWs and team leaders is too narrow and should be extended to other personnel within the local health care system as well as ward councillors, municipal and district health managers and other service providers.

**2.6. Information and data** are an integral part of the implementation model of ward-based primary care. NDoH has devised an information management system of forms and tick lists to support service monitoring and workforce management that is designed to report upwards into the system hierarchy.

- a. A paper-based system of forms and tick lists is extensively used in all provinces and most districts. Only Northern Cape (Britstown) and Gauteng (City of Tshwane) were exceptions to a paper based information collection system.
- b. A lot of effort is put into ensuring that the information that is fed into the system is quality controlled, as far as possible.
- c. A lot of effort is put into using information to support planning, training, service delivery, performance monitoring and evaluation.
- d. Respondents are acutely aware of the existing paper based system's limitations. It requires a time consuming process of information gathering, verification, capture and distribution that is prone to error, loss and delay. It is not easy to access and therefore not easy to use by WBOTs in service delivery on the ground. They are acutely aware of possibilities that an electronic system offers.



### 3. Collaboration and Cooperation

National policy and training documents outline an implementation process that is based on community cooperation and that critically depends on teams working in partnership with local organizations and services that are active in a defined geographical area. The rapid appraisal found that respondents are familiar with the described process of implementation.

In terms of **organisational partnerships**, all work extensively with government departments as well as faith and other not-for-profit organizations. The range of private sector and agency partnerships is narrow in scope however, and there is little reference to civil society organisations.

- a. Partnerships are reported to play an important practical role in helping health care teams deliver services, variously assisting with community entry, education and training, problem identification and problem solving etc.
- b. There are also partnership challenges within and across divisions and sectors. This includes a recurrent (but not universal) problem of potential partners and stakeholders not being aware of or not having been properly introduced to the program, irregular and erratic contact and communication as well as insufficient support and engagement. These problems negatively affect ward based health care team functioning.  
Amongst other things, they lead to non-cooperation, confusion, duplication of work as well as increased costs in time, money and effort not only for health care teams but also for people using the services.

In terms of **community cooperation**, ward based health care is positively received by communities in all sites across the provinces. This, in large measure, is due to the hard and careful work done through WBOTS as well as the still limited, but positive impact of taking health care to people in their homes and communities.

Overall, the rapid appraisal shows unequivocal support for a primary health care model that takes health to people in their homes and streets. For every challenge identified, respondents have sought or proposed practical solutions.

The findings of this study point to a number of critical strategic, operational and management policy and practice issues that need to be addressed to optimise the potential of a ward based primary health care system's contribution to health for all in South Africa.

## 1. Policy Approach & Harmonization - National and International Imperatives

There are three key policy and strategic imperatives and national and international mandates that inform this recommendation:

- the Draft Municipal Ward Based Primary Health Care Outreach Team (WBPHCOT) Policy Framework and Strategy of the National Department of Health (NDOH, April 2015);
- the WHO Call for Harmonization of CHW Program (Harmonization Framework) in Recife, Brazil (2013); and
- the Sustainable Development Goals (SDGs 2015) adopted by the United Nations (UN), in particular Goal 2: Zero Hunger, Goal 3: Good Health & Well-Being and Goal 6: Clean Water & Sanitation.

The Draft WBPHCOT policy sets out strategy and framework directives to provide service delivery as part of the re-engineered primary health care strategy (NDOH, 2011). It also outlines the opportunities for the initial phases of the WBPHCOT implementation.

In the first three-year phase of implementation (2012- 2015) it has been established that there is strong support for the WBOT program in communities and among ward based teams. They have called for program expansion in breadth and depth. There is also strong support for ward based primary health care among the middle & operational managers at district, sub-district and facility levels. Their support is contingent, however, on there being greater clarity on the following five aspects;

1. policy directives,
2. the provision of resources for implementation,
3. better integration into the health care system,
4. greater cohesion of services among government departments (especially in respect of Social Development, SASSA, SAPS, Education, Agriculture and Local Government),
5. deeper and wider consultation with all public, private, not-for profit and community stakeholders.

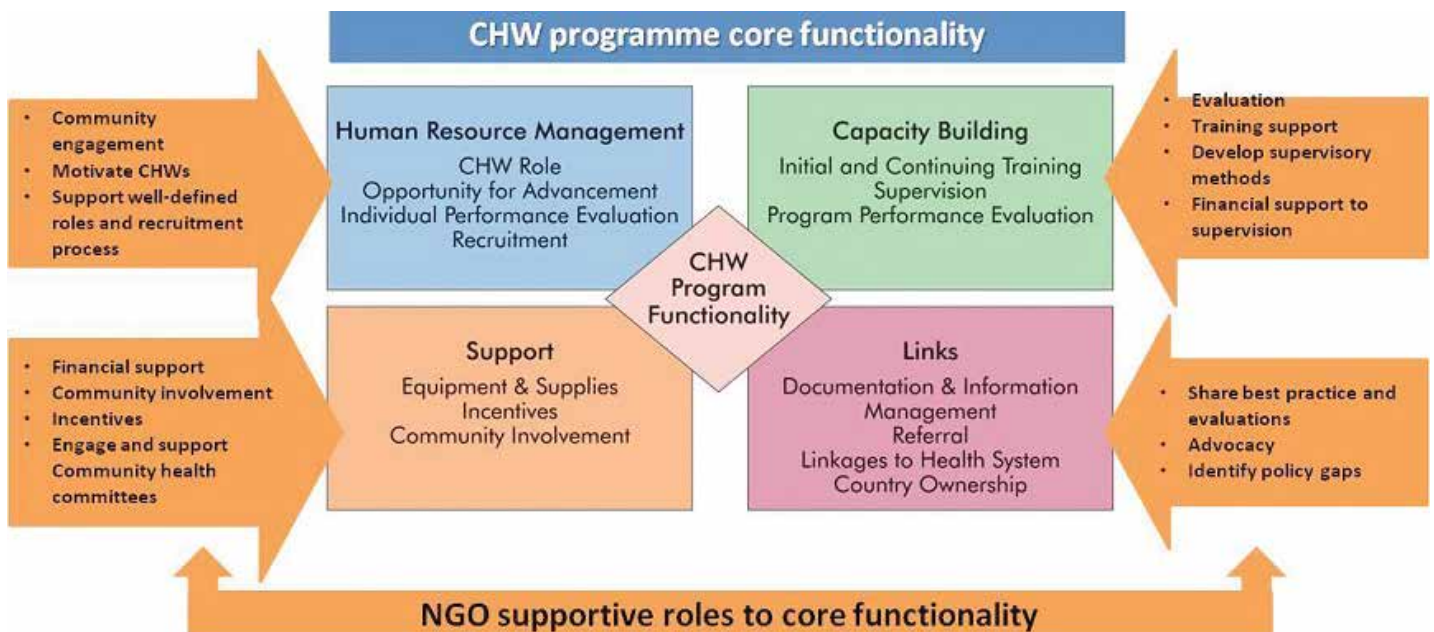
The international harmonization framework is an agreement and a framework built on a 'three ones' paradigm for harmonization of community health worker programs to optimize synergies and increase program efficiency and effectiveness. The "three ones are "one national strategy, one national authority, one monitoring and accountability structure" (Fig. 1 below). This framework comes out of the Recife statement "Moving From Fragmentation To Synergy Towards Universal Health Coverage",) adopted at the Third Global Forum on Human Resources for Health (Recife, 2013) and the "Joint Commitment to Harmonized Partner Action for CHWs and FLHWs" established at the forum.

**Figure 1: The ‘Three Ones’ Unified Framework for Community Health Worker Programs.**



In support of this framework, a set of principles of practice has been developed to enable the scale up of community health worker based programs. (Fig. 2).

**Figure 2: Principles of Practice.**



On 25 September 2015, Agenda 2030 was adopted by the United Nations (UN) General Assembly<sup>iii</sup>. Of the 17 sustainable development goals (SDGs) in it, three SDGs directly relate to health (Goal 2: Zero Hunger, Goal 3: Good Health & Well-Being and Goal 6: Clean Water & Sanitation) while four, have less direct but still significant bearing on health issues (Goal 1: Ending Poverty; Goal 4: Quality Education; Goal 5: Gender Equality and Goal 13: Climate Change (Goal 13)).

## RECOMMENDATION Policy Approach & Harmonization

Create a harmonized, focused and aligned ward based health care program to fulfill national and international mandates as outlined in the Recife Statement and the UN General Assembly Agenda 2030 SDG goal. *Inter alia*

- expand and align the Draft WBPHCOT Policy of the NDOH (NDOH April, 2015) to the emerging consensus on universal health coverage (UHC) and the roles and contributions of community health worker programs in it
- give attention specifically to all aspects of harmonization and the linkages of health care with Agenda 2030 SDG Goals 2,3,5 and 6
- Create a single, coherent regulatory, management and institutional framework for all variants of community based workers deployed or supported by government departments as well as non-governmental, faith and community based organisation

## 2. The Structure of the Primary Health Care System and The Social Determinants of Health

Throughout the field site visits in all seven Provinces, a consistent observation was the pervasive poverty, under-development and inadequacy of health and social resources – worst in the deep rural areas of SA. This cycle of poverty has a direct negative impact on the physical, social, psychological and spiritual dimensions of health and wellbeing (SDG goals 1, 2 & 3). It also undermines the achievements of democracy and the aspirations embodied in the National Development Plan (NDP).

All stakeholders consulted – from provincial and district managers through OTLs and CHWs to NGO and householders members – support the WBOT and favour a community based approach. However it was noted that currently the WBOT is an “add-on” to the PHC clinics, adding considerably to the burden of (largely curative) care and support provided by the clinic staff. Programmatically and in terms of professional training, PHC staff were comfortable in providing clinical care and support but uncertain about how to deal with epidemiological, socio-demographic and household data and how to use this information for service delivery. Sub-district, operational and facility managers were ambivalent about their ability to sustain let alone expand the WBOT program as it is presently organised.

OTL and CHWs felt they were “imposing” on and adding further to the over-burdened clinic staff workload. In some clinics they had to do their work outside the clinics due to shortages in space, equipment, and administrative resources – making them feel “unwanted” and unappreciated.

Community oriented primary care (COPC) and the WHO social determinants of health (SDH) specifically seek to address health and wellbeing in all dimensions, while the reengineering of PHC policy and strategy aims to address South Africa’s burden of disease by shifting the existing curative, bio-medical focus in the health system towards one that is able to more effectively promote health and prevent and manage disease.

A key aspect of WBOT that requires serious consideration is to move from the current idea of “outreach”, which was necessary in the WBOT start-up phase to conceptually and programmatically designing the WBOTs in the next phase as an independent community based component of the primary health platform that stands alone like facility based fixed PHC clinics. In Tshwane and in the Eastern Cape, ward health care teams operate from posts in the community rather than from clinics and facilities.

Fixed, clinic based facilities are the current foundation of the PHC system in SA. They are managed by Professional Nurses (PNs) with strong bio-medical and clinical training who provide a largely curative service. While these clinical services are a necessary and essential aspect of providing health care and support, they are not sufficient to address the SDH – which require a much wider range of skills, competencies and attributes to provide community and home-based interventions, care and support.

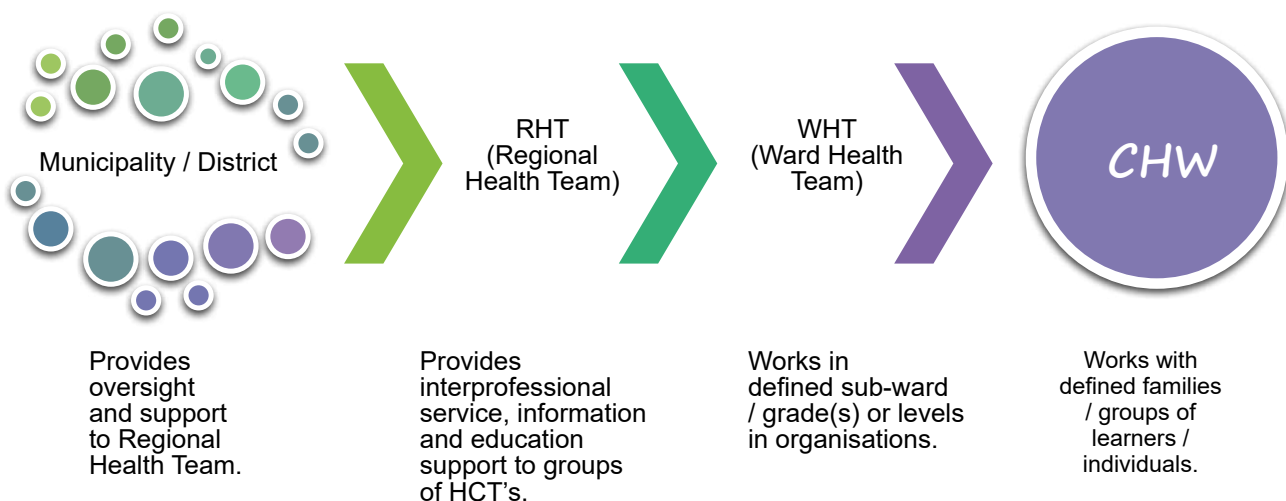
Thus from a WHO health systems thinking perspective, WBOTs would conceptually, structurally and functionally fulfil the comprehensive PHC goals – with a strong focus on the epidemiological household registration and community diagnosis tasks, identifying “at risk” individuals, families and communities, following-up on patients, pregnant women and new mothers and babies etc. They would be linked to but not part of clinics and other health and care services in the district that would continue to provide largely curative, bio-medical clinical services. Thus WBOT members would then become a fully functional additional health cadre, with semi-autonomous functions and shared responsibilities.

Ward health care teams would comprise a team leader and community health and care workers. Team leaders could be drawn from nursing and community health worker cadre with sufficient qualifications, without appointing professional nurses who are in short supply and are the back bone of clinical care at facilities.

Since health for all means meeting people’s expectations of quality care, there is still the need for clinical and professional oversight that the first phase clearly sought to accomplish by assigning professional nurses to lead WBOTs. From the experience in Tshwane, this can and should be provided by a Regional Health Team (RHT). These teams must include clinicians (doctors, clinical associates, professional nurses) and other professionals (social workers, psychologists). Ideally they should be led by Family Physicians. Similar in function to the District Clinical Specialist Teams that support facilities, each RHT provides clinical and professional service, education and information leadership to approximately 10 ward health care teams in their region.

Schematically, the model of ward health care is depicted in Figure 3, below.

**Figure 3: Ward Health Care in the Primary Health Care Platform**



Such a re-organization would also overcome some of the challenges faced by WBOT members, notably their conditions of service, scope of practise, remuneration through the Government's PERSAL system (rather than irregular stipends), uniforms, resources such as kit bags, basic medical equipment, supplies and sundries). It would then unleash their full potential to be genuine community based health care workers, structurally part of the Re-Engineered PHC system, clinically and professionally supported and functionally harmonized with all the other health cadres.

In the HRH2030 Report the NDOH has proposed the establishment of Public Health Units (PHU) to provide some of these services. Conceptualized as inter-professional as Regional Health Teams, they could greatly complement the range of services offered at District level.

## **RECOMMENDATION: The Structure of the Primary Health Care System and the Social Determinants of Health**

There is a need for a structural response to support equity through broad community based interventions in order to impact on the social determinants of health (SDH) in a developing country context like SA and to seriously meet the Agenda2030 SDGs 1, 2, 3 and 6 requirements. This can be achieved by expanding and deepening the service delivery footprint of the health care system within the existing PHC platform.

Ward based health care should become an independent "stand alone" component of the primary health care platform. In this way it can support and be responsive to facility needs at all levels of the system. And it can address the social determinants as well as the health needs of individuals and families as they present themselves in communities.

Ward health care should comprise health care teams (WHTs) of integrated community and care workers led by a qualified team leader. Groups of health care teams should be supported by regional support teams (RHTs) made up of suitably qualified professionals that can provide managerial, clinical, education and information leadership.

### **3. Functioning of WBOT in the primary health care system.**

The addition of WBOT to the existing facility based primary health care system that is divided between provincial and local municipal authorities overburdens facilities, creates multiple and competing lines of authority for health workers and managers, aggravates existing resource constraints, under-supports service efficiencies and negatively impacts on health. It has influenced the selection, recruitment, remuneration, conditions of employment and ultimately accountability, reporting and line functioning of community health and care workers and professionals. As if relegated to the bottom of the health system hierarchy, ward based health care is at risk of being a discretionary and disposable extra.

In many of the wards and districts the WBOTs are actively involved in campaigns, advocacy work and social mobilization around health, social, developmental and educational issues. They also are actively involved in networking and co-ordination with NGO, CBO, and faith based organisations (FBOs) and to a much lesser extent with private sector organisations that provide services in communities. This is fully consistent with the philosophical and programmatic focus of the National Development Plan (NDP) and municipal integrated development plans (IDPs), which recognize the need to address the multi-dimensional nature of poverty in society.



Uneven cooperation across departments and sectors, however, means that while there are examples of excellent working relationships, accountability and reporting between WBOTs and their respective local authority and other partner organisations, there are also examples of minimal involvement and support from local government, line function departments and other organisations. There is therefore a need to improve the standing and ownership of ward based health care at local level.

The creation of ward based health care as part of the primary health platform provides an opportunity to review and possibly redefine existing authorities between provincial and local tiers of governments to provide integrated, effective health care services through the three spheres of government aligned to the National Service Delivery Agreement (NSDA) and the Strategic Plan of the NDOH.

## **RECOMMENDATION: Functioning**

In keeping with the global call for harmonization and Agenda 2030 SDGs as well as the drive by government to foster integrated service delivery on the ground, ward based health care should be delegated to and fall under the responsibility of the Municipal – Local Authority tier of government—either through Service Level Agreements (SLAs) or contracts. Alternatively the current focus on “provincializing” Local Authority health services must actively support and engage with the demands of integrated services delivery at a local level.

In keeping with South African labour law, all employees must be accorded a status that is commensurate with the work they do. Community health and care workers should be considered as employees with the attendant responsibilities, rights and benefits. As in all other contexts, specific human and financial resource accommodations can be made for age, educational background and permanence. The goal however must be to recruit at or progress all community health workers to NQF Level 4 and to ensure continuous occupational qualification and development for CHWs, team leaders and managers.

In keeping with the recognition that partnerships play a critical role in supporting integrated primary care, fostering cooperation and collaboration across all sectors and divisions must be a key indicator of ward based health care performance. In this, the role of local government, higher education, non-governmental, traditional, faith and community organisations is critical.

## **4. Education and Training**

The provision of a learning program to support health workers to deliver health care at the level required of them in the communities is an unresolved challenge in WBOTs.

During this first phase of the WBOT roll out, the only formal learning available to CHWs in all the Districts was short course training. Most CHWs underwent a 10 day training programme (NDoH Phase 1) with a few having also completed the subsequent Phase 2 short-course. Most team leaders underwent a once off five-day team leader training as well as the CHW 10 day training. Drawing on their own professional backgrounds, team leaders also introduced workplace learning to support effective functioning, although this was only integrated into the model and systematically done in the City of Tshwane.

Existing NDoH offerings and ad hoc solutions are unable to meet the competencies required from health care teams that work in wards. They also do not meet individual education and training expectations of managers, team leaders and community health workers employed to do ward health care. They are poorly articulated with the National Department of Higher Education<sup>iv</sup> post school objectives to create a single coordinated system built on a cooperative relationship between education and training institutions and the workplace, to make workplace training and work-integrated learning (WIL) a central part of the training system, and to enable individuals to develop a career path through education.

## **RECOMMENDATION: Education and Training**

Continuous education and training needs to be structured into ward health care practice. Work integrated learning should be a condition of employment and planned for as part of team functioning. It should be routinized into the work schedule, delivered in a structured way that draws from experience and individual learning needs, linked to assessment and on-going. More generally, all education and training interventions must be curriculated to ensure training standards and quality. They need to be certified to ensure quality and retention. And they must be articulated to work and to further education so that they provide learners with opportunities to expand and progress in their careers and their educational development.

## **5. Information, Data Management & Monitoring & Evaluation**

A considerable effort is put into collecting information. However, the collection, storage, utilization and retrieval of the household registrations forms, referral forms and other data from household visits is uneven, patchy and poorly used by over-burdened clinic and facility managers. Information is rarely used to transform health service delivery platforms according to community based needs. Back-referrals are patchy. Also while some clinic and hospital personnel value the information from WBOTs, others regard it as simply adding to workloads. Most seriously the current District Health Information System (DHIS) has limited provision in its data fields for capturing, analysing and transforming household registration and other data. This has important implications for health service managers who are expected to report on their service delivery targets, their Key Performance Indicators (KPI) and to measure and record their response to the burden of disease.

It is also important to note that all the household information collected by the WBOTs are confidential. As such it is incumbent on the managers to store, record and utilize this health information with proper care and caution according the legal requirements governing such data. We note from the field that the full medico-legal requirements and implications of managing this data is poorly understood with limited compliance from the managers.

Despite this scenario, this study has established the tremendous potential of the WBOTs to empirically collect information that has a direct bearing on health and its social determinants, to tailor health and care services to individual and family needs and to monitor and evaluate the burden of disease and the impact of health and social services interventions at household levels.

As demonstrated by the City of Tshwane, Philani and Britstown (Northern Cape), the application and use of an ICT enabled platform to collect individual and family health and related information from people in defined geographically areas who are supported by ward based health care teams greatly enhances service delivery across the entire referral pathway from home to clinics and hospitals to homes. It also enables harmonization of the Integrated Development Plans (IDPs) of Municipalities with the District and Annual Performance Plans (APPs) of Districts & Hospitals.

## **RECOMMENDATION: Information, Data Management & Monitoring & Evaluation**

There is a need to support the implementation of a full serviced ICT enabled information platform for primary health that extends to and from the home to the clinic and facility and is articulated with the DHIS.

## **CONCLUSIONS**

The WBOT initiative is the first systematic, national effort to formally bring community health care into the public health care system. This rapid appraisal of the first phase of reengineering primary care through WBOTs has identified considerable potential for ward based health care to substantially improve the health status of individuals, families and communities. It has established critical factors that can entrench quality ward based services in primary health care. By implementing the recommendations above, through consolidation, refinement and research, the government will be able to accelerate and better meet its commitment to supporting a long and healthy life for all.

## 1. Introduction and Overview

Primary Care reengineering is nested in national health care system reform initiated by government in 2011. As the bedrock of National Health Insurance the new primary care model includes community based outreach services, school health services, effective referral systems and improved emergency and planned patient transport system. These services are effected through District Specialist Health Teams, School Health Teams and Ward Based Outreach Teams.



**Figure 4: Re-Engineered District Health System (DHS).**

The envisaged role of WBOTs is to offer an integrated health care service that includes health promotion, disease prevention and early detection, ante- and post-natal care as well as psychosocial support at community, household and individual level. Structurally, the composition of WBOTs has been set out as comprising a professional nurse as team leader (OTL), six specialist community health workers (CHWs), a health promotion practitioner and an environmental officer, with each CHW being responsible for 250 families.

Implementation of WBOTs began in 2011. The target for national coverage was to create some 7467 teams. Roll out has been slow. According to the National Department of Health “1063 Municipal Ward Based Primary Health Care Outreach Teams (WBPHCOT) were established and reported their activities on the District Health Information System” (Department of Health. Annual Report 2013/2014:16). In addition, various implementation challenges have come to light in piloting sites and districts, including the recruitment of CHWs, a shortage of professional nurses to drive the WBOTs, a lack of training of team leaders and teams that are not attached to health facilities.

The National Department of Health identified the need to better understand roll out and implementation in order to enable the development and upscaling of effective WBOTs. It commissioned a rapid qualitative appraisal study of WBOTs in seven NHI pilot districts to better understand WBOT implementation in primary care re-engineering.

In addition, the NDOH requested that 'best practice' projects be included in the rapid appraisal as case studies. Practically it was only possible to complete three of the proposed four. The primary objectives of the research included gathering information on structural and operational issues that impact positively and negatively on implementation.

This report presents the findings of that study.

## 2. Study site

Geographically the study area covered seven NHI pilot districts in seven provinces. Research was undertaken in two sub-districts in each (Table 1 below). With the assistance of district health staff, sub-districts were purposively selected to reflect the best and the worst performers.

**Table 1. Selected Study Districts and Sub-Districts Profile**

Province	District	Sub-Districts	Health Facilities	Population Size	Number of Households
Eastern Cape	OR Tambo		256	1 364 943	298 229
		Mhlonto	52	188 226	43 414
		Nyandeni	64	290 390	61 647
Free State	Thabo Mofutsanyane		109	736 238	217 884
		Mantsopa	15	51 056	15 170
		Setsoo	18	112 597	33 687
Mpumalanga	Gert Sibande		114	943 125	273 490
		Chief Albert Luthuli	28	186 010	47 705
		Dr Pixley ka Isaka Seme	16	83 235	19 838
Limpopo	Vhembe		165	1 294 722	335 276
		Thulamela	69	618 462	156 594
		Makhado	67	516 031	134 889
Gauteng	Tshwane		90	2 921 488	911 536
		Tshwane 1 (Soshanguve)	27	709403	
		Tshwane 2 (Hamanskraal)	16	296478	
Northern Cape	Pixley Ka Seme			186 351	49 193
		Siyancuma		37 076	9 578
		Emthanjeni		42 356	10 457
North West	Dr Kenneth Kaunda		61	695 933	208 047
		Maquassi Hills	12	77 794	20 505
		Matlosana	23	398 676	120 442

### 3. Methodology

The goal of the rapid appraisal was to generate programmatically useful information that would assist the Department of Health (NDOH) make decisions about WBOT implementation. Accordingly, the study used an established peer review methodology whereby a group of academic and practitioner experts with experience of similar issues evaluate policies, programmes and practices together at a particular site (place or institution). Evaluation is structured around a 'benchmark for integrated learning'. This is a common standard for assessment that focuses on key implementation challenges. In the case of the WBOT rapid appraisal, public health researchers and district/sub-district managers evaluated selected WBOT sites against defined benchmarks (mindset/approach, preparation, implementation, networking/relationships, monitoring/evaluation) in order to learn from and to strengthen the sites and the system. The method embodies an important value i.e. that participants in the process – evaluators and evaluated alike – are equals. It also purposively is designed to support learning through exchange and reflection.

In the WBOT rapid appraisal this was structured into the field work plan. Fieldwork was conducted by teams of three to five people (a research manager and between two and four field workers and peers). Each team spent five days in an assigned sub-district. They carried out the research according to the following workplan:

- Arrival and initial management meetings (an overview of the study objectives and the research process and ensuring familiarity with the benchmark self-assessment (Day 1));
- Interviews and observations – with each field worker allocated to between one and three WBOTs (Day 2&3);
- Researcher meetings and debriefing session to compile a draft report (Day 4);
- Peer learning workshop to share and reflect with management and other key stakeholders on the emerging review.

Two research teams (one from the University of Fort Hare and one from the University of Pretoria) undertook the field research visiting each study site in their designated provinces.

Using the benchmark as a guide, they observed WBOT work, conducted individual and group interviews and reflected on their work. Members of the respective research teams observed the WBOTs in multiple settings, including in the community setting, at the primary health care facility and during team meetings. Individual key informant interviews and group discussions were conducted with community health workers (CHWs), team leaders, facility operational managers, community members, Integrated School Health Program coordinators, clinic committee members, ward councilors and household members.

In addition, quantitative data was collected from health facilities. These included samples of WBOT reports, plans, schedules, referral forms, copies of training manuals, operating guidelines and log sheets where available.

For the three case studies, information was collected using a mix of documentary review and key informant stakeholder interviews. Information collected during field work was recorded in the form of group discussion and individual interview notes, research field notes and reflections. Information was captured electronically (in Word) both in and post-field work. It was subsequently cleaned and captured into Excel by a team of interns. Thereafter, it was subjected to thematic review, description and analysis by the report authors.



## 4. Ethical considerations and permissions

Ethical clearance for the study was obtained from the University of Fort Hare Research Ethics Committee and the Faculty of Health Science Main Research Ethics Committee (University of Pretoria).

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Health care leaders around the world have recognized the importance of community based primary health care in a strong health delivery system. In reengineering primary care, the South African government has created a policy environment to support this commitment. WBOTs are the first national attempt to formally integrate community health and care workers into the primary health system since the late 1940s. WBOTs are operational and functioning in the district health system in all the NHI sub-districts included in this study. There are many practical and policy obstacles that need to be overcome to realize the full potential of the model, however.

The findings from this rapid appraisal three years into the process provide a snap shot from the perspective of middle and lower level managers (sub-regional managers, facility managers and team leaders) and field workers (CHWs) who are trying to implement community based health care on the ground.

## 1 The Approach and Purpose

National policy documents envisage the model of ward based outreach teams (WBOTs) as an add-on service attached to primary care clinics. It functions to extend the reach of existing facilities at the bottom of the health care hierarchy. The responses below reflect that the notion of primary health care clinic service extension is generally how the model is understood across all districts.

*“(It is) the eyes, ears and hands of the clinic sisters”. WBOT is there to help the sister in the PHC setup to reach the patient to oversee the adherence of the patient treatment. (Northern Cape SA R2, R3, R6)*

*“This is an extra hand to the fixed facilities. Previously PHC nurses were solely responsible to reach out to the communities. This was very difficult because the clinics are usually full of patients hence it became difficult to reach out.” ... WBOTs are expected to deliver PHC services to communities. They are attached to fixed health facilities and operate there. (Free State SA R6)*

*“The ward based outreach team serves as the bridge between the community and health facilities.” (Limpopo SA R3)*

In the Eastern Cape and Tshwane (Gauteng), however, the approach is more community based. Whereas all teams are linked to defined clinics, Eastern Cape respondents describe operating from service points in communities.

*“There are service points where we do all the programs at least once a month together with NGOs (HIV, AIDS and TB).” (Eastern Cape SA R4)*

In the City of Tshwane, they are based in and run from health posts in the wards. These posts are situated at sites that provide various local services, such as schools, NGO offices or churches as well as hospitals and clinics, as appropriate.

The purpose of WBOTs is to support the provision of comprehensive primary care. In all study districts, respondents put particular emphasis on health promotion and disease prevention.

*“They are expected to give basic health education re preventative and promotive health activities. They are expected to refer all the health problems they come across (and) do follow up activities organised by fixed clinics. ... . . . Mostly preventative measures implemented through health talks, demonstrators, and defaulter tracing by WBOTS - referring of clients to facilities where necessary for curative intervention or further referral”. (Free State SA R6)*

*“The programme focuses on psychosocial support, screening and early detection of diseases. It includes antenatal care, post-natal care, the care of under 5s, our chronic patient.” (Limpopo SA R1)*

*“They can give information to patients in the community, identify problems and refer them to the clinic.” (Northern Cape SA R5)*

*“The core components are (to) promote health child and women's health, prevent ill health, (provide) acute and post-natal community based support and reduce maternal mortality by doing health education to pregnant mothers.... Community health workers promote health and ways to live a healthy lifestyle.” (Eastern Cape SA R8)*

There is also some reference to limited treatment provision.

*“CHW are trained as health workers. ...They (do) child health, ANC, give psychological support, treat minor injuries and (do) first aid.” (Limpopo SA R4)*

*“Community health workers -promote health and prevent illness, conduct home visits, identify and manage minor health problems, advocate for improved health and community services.”(Mpumalanga SA R2)*

However, respondents also see that both the approach and purpose are different from the primary health care legacy model of facility-based management.

WBOTs work in defined areas with defined people and communities.

*“WBOT differs from PHC in that the WBOT identifies a catchment area for each CHW. WBOT allocates households to community health workers.” (Eastern Cape SA R8)*

WBOTs extend health care beyond the individual patient.

*“While in primary health care (facilities) the focus is on addressing the problems that a patient presents with, but not extending to family health, which in most cases it is the cause of ill-health. WBOT is community, family and individual orientated. It's focus is to ensure the well-being of the community starting from an individual, family and this comprehensive management extends health to the community as a whole.” (Limpopo SA R1)*

*“Primary health care used to go to specific patients not covering the whole catchment area.” (Free State SA R4)*

Health care teams provide services to people in their homes.

*“WBOTs are different from PHCs because services are provided at the household. The source of the problem is seen in the household. If there is diarrhea, when visiting, you find unhygienic methods ... contaminated water.” (Eastern Cape SA R5)*

*“Primary health care was normally seen as the entry level of service that the community accessed through a primary health care facility. Patients had to come to the facility to get a service. District services from clinic staff to households were extremely limited and services therefore were mainly geared at patients coming to the facility. With WBOTs the entry level of the service is at community / household level.*

*... WBOTs see the person's needs at home - my eyes and hands in community. The WBOT knows exactly the health profile of the family in that household. They can give health information to the family themselves, refer to the clinic or follow up referrals from the health staff at facility level...." (Northern Cape SA R5)*

WBOTs extend health care to remote, rural and marginal populations, who find it difficult to access services at facilities because of their physical location or social position.

*"In primary health care people were defaulting treatment because of bad roads and the long distances they used to have to travel. The WBOT team is able to visit households in the community as well as screen children in schools." (Eastern Cape SA R3)*

In Tshwane Inner City, in addition to going to households, WBOTs go out to people who are homeless, abuse substances, engage in sex work or are on the margins of society in other ways.

The approach of working in the community also means that WBOTs are able to extend the care focus beyond health conditions and diseases.

*"WBOTs do not just focus on illness but also provide psychological support and social support that can also affect the health status of a person." (Limpopo SA R2)*

*"It is health care that is available and easy for community members to find and to use. WBOTs bring health services to the household and identify those that need to be referred to other stake holders." (Free State SA R8)*

*"It deals with the communities, families and individuals, networking with other departments and NGOs. ... There is collaboration of different sectors, be it government or non-government - the goal is one. ... (In) outreach teams ...interaction and interpersonal relationships take place with other services within the community." (Eastern Cape SA R1 SA R3)*

## 2 Organization and Functioning

In all sites, considerable effort is made to manage WBOTs within the existing health care system. However, respondents confront common basic management problems that relate to WBOT structure and functioning in it. The fact that they work in a predetermined framework that they have not helped construct has a bearing on some of the practical challenges they face as well as the conceptual flaws they identify.

### 1. Policy Conceptualization

Respondents work at the district, sub-district and team leader levels as middle and low-level managers and community health workers.

For the most part they have not been part of decision-making processes – be it in respect of policies, finances and management structures or the implementation process itself.

*"The policies, finances, recruitment criteria and responsibilities of the WBOTs are as stipulated by the NDoH." (Free State SA R6)*

*"We are not included in the decision making regarding policies, finance and management structures." (North West SA R3)*

## 2. Team Composition

Respondents are familiar with the team composition, describing the envisioned ward based outreach team in a more or less standard way.

*“It is formed by one professional nurse, six or more community health workers, one health promoters and one environmental officer.” (Mpumalanga SA R2)*

### 2.1 Team Leadership

As the people responsible for implementing the program on the ground, they face a series of problems, first amongst which is team leadership. WBOTs are supposed to be led by professional nurses. However, the context is one where there is an absolute national shortage of professional nurses that is further exacerbated by a high demand from the private sector for their skills.

Where recruitment into the system is attempted, it is stymied by the dearth of professional nurses.

*“In my district 53 posts for OTLs were advertised and only 10 filled.”  
(Free State SA R6)*

To get around this, in some districts recruitment has focused on retired professional nurses.

*“Many team leaders recruited by the City of Tshwane are retired professional nurses.”  
(Gauteng SA R6)*

More often, though, health system managers assign existing professional nurses working at facilities as WBOT team leaders.

*“Operational managers in clinics identified team leaders.... Team leaders were recruited from non-busy clinics and are professional nurses attached to primary health care structure” (Limpopo SA R2)*

*“A professional nurse was delegated from the facility.” (Mpumalanga SA R2)*

*“(Initially) the team leader was allocated from other contract programs - HCT and TB. Later a permanent appointment of an OTL was done.” ... (Free State SA R3)*

*“Team leaders were identified from staff from the facility and training was given to them. ...Dedicated team leaders are not yet appointed.” (Northern Cape SA R5)*

Or they appoint enrolled nurses as team leaders.

*“Originally team leaders were supposed to be PNs. In our district they now allocate ENs at OTLs.” (Free State SA R1)*

These solutions bring their own problems.

In several districts respondents report that team leaders are required to manage more than one team or they do more than one job.

*“A registered nurse that was a TB tracer was used to start reengineering. She was doing both these duties as well as managing 6 CHWS she had....” (Free State SA R1)*

*“I first had to lead two teams for two months...After another team leader was appointed I started managing my team.” (North West SA R3)*



*“At present the team leader is part of the staff of the clinic. It is very difficult to have a team leader that has to work at the clinic as well. .... (She) does not have the time for WBOTS.” (Northern Cape SA R7)*

*“Team leaders are full time nurses at their respective clinics. It is hard to do home visits as required by WBOT.” (Limpopo SA R1)*

*“I am not able to manage the team properly since some of the days I have to work inside the clinic.” (Mpumalanga SA R3)*

*“Some team leaders are kept in the clinic.” (Gauteng SA R6)*

There are also teams without team leaders.

*“Other team leaders are contract workers, so for about 2 to 3 months the ward is without a team leader”. (Eastern Cape SA R4)*

*“Most WBOTs do not have team leaders so the clinic manager of their parent clinic acts as their team leader. In such cases the clinic would not be able to provide adequate supervision.” (Free State SA R5)*

Or their team leaders, being facility based, are remote and distant from them.

*“(It is) difficult for them to report weekly to the team leader at the facility because of the distance and (it is) difficult for team leader to do supervision because of transport.” (Eastern Cape SA R4)*

## **2.2 Kinds and Levels of Competencies**

The kinds and levels of competencies expected of team members is also a problem.

It is unclear if the envisaged appointment of health promoters and environmental officers to WBOTS has occurred. The data imply that there were none or few in place at the time of the study. Mention was made of an environmental health officer and a health promoter working in the field with the WBOT only in the Eastern Cape. There also were suggestions that they be appointed to local areas “if it cannot be afforded per ward” (Free State SA R3) and that fully formed teams be established including specialists and environmental health practitioners” (Limpopo SA R5).

Respondents indicate that the envisaged composition also does not adequately meet the competency requirements needed to implement ward-based health care. Several respondents expressed the need for social workers to be integrated into the program (Northern West, Limpopo). Also, respondents variously point to the need for data capture support (Eastern Cape, Mpumalanga), especially as the paper based model is being implemented in many provinces. In an information-intensive model there is a need for data management support, even where data is captured electronically (Northern Cape, Tshwane),

Added to this is the legacy system of vertical programs. Driven by professional specialization around diseases and conditions, these have created a multiplicity of compartmentalized primary health and care services. In these, community care workers have invariably worked within very limited and narrow parameters, with very limited or even without much training.

*“(CHW) recruitment was sourced from DOT supporters, HBC, lay councilors, condom distributors (etc.)” (Free State SA R3)*

These divisions carry over and are reproduced in WBOTs.

*“CHWs reported that home based carers refused to do duties delegated by CHWs ... Since the CHW are there to refer bedridden household. They said that even the CHWs know how to perform those duties.” (Mpumalanga SA R1)*

*“From their meeting at (the NGO) they were told not to do street outreach. They said they are only allowed to work in flats and refer patients.” (Gauteng, Report)*

Team leaders find they have to manage CHWs who are inadequately prepared and have low levels of education.

*“Most of the WBOTs were community home based workers before.” (Northern Cape SA R5)*

*“No educational background was considered.” (Free State SA R3)*

## **2.3 Team Size**

Several respondents report that there are either too few or too many CHWs in a WBOT. This affects both WBOTs ability to provide services and the ability of team leaders to properly manage their teams.

*“The WBOT comprises four CHWs. (It) is allocated to one ward. The challenge is that when performing their duties they have to cover a ward population that is far larger than the required numbers.” (Free State SA R8)*

*“There is a shortage of CHWs. CHWs serve three wards and above. (Eastern Cape SA R2)*

*“For effective implementation, monitoring and evaluation at least each team leader to have 12 CHWs, not large numbers.” (Gauteng SA R1)*

## **3. WBOT Coverage**

All of the above have a direct bearing on WBOT coverage. The envisaged model is one where there are health care teams in all wards or study site. At the time of the study, this was not the case in any province district. Respondents regard this as a problem, because it affects the ability of the approach to realize its goals. Also working in partial system impacts directly on WBOT functioning.

*“I think we need more teams to cover all the wards because if other wards are not covered with WBOT, prevention of ill health is impossible since some diseases are infectious.” (Mpumalanga SA R3)*

*“In Mansopa local area there are 9 wards. To my understanding there is a need to have 9 WBOTs for this approach to function effectively.” (Free State SA 6)*

*“(We) need enough CHWs ... enough team leaders to be employed so that all wards can be covered.” (Gauteng SA R1)*

*(The) shortage of CHWs is causing desperation. ... Other areas have no CHWs at all so no information is collected, no challenges are met or solved. (Eastern Cape SA R1; SA R7)*

#### 4. Authority and Jurisdiction

The next set of problems relate to functional authority and jurisdiction. This is a problem for both team leaders and community health workers working in WBOTs. Team leaders are expected to play a dual role, working both inside and outside the facility. But they have little control over their working days.

*“It is not possible for me to plan my duties since I never know where I will be and when. Somebody who is an operational manager is always planning about me.”  
(Mpumalanga SA R3)*

Team leaders also don't have control over CHWs deployed to WBOTs by NGOs.

*“The CHWs are taken from NGOs, so they do a double job - (one) for NGOs who give them stipends and (one) for WBOTs with no funds” (Limpopo SA R2)*

*“CHWs were home base carers who still receive their stipends from the NGO.”  
(Mpumalanga SA R3)*

Respondents report that WBOTs are poorly understood at various levels of management in the public health care system.

*“(There is a) lack of knowledge on the part of management on WBOT activities and roles leading to restrictive behaviors on the part of some local area managers.” (Free State SA R3)*

*They report a similar lack of understanding where CHWs are employed by NGOs, including those funded by provincial government.*

*“Currently the WBOTS still form part of Hospice and get their stipend through Hospice. The stipends are paid over to Hospice from Department of Health from the HIV grant. ... WBOTs being appointed by an NGO (Hospice) have to account to Hospice AND be part of DoH. It is difficult to manage working hours, responsibilities, and data for NGO and DHIS. ” (Northern Cape SA R5; SA R8)*

*“CHW's were recruited from funded NGOs, and were trained as CHWs but they are still receiving stipends from their respective NGOs.... NGO managers have a different understanding regarding the role of CHWs in WBOT. CHWs are not allowed to go out and perform WBOT. They are told to do that during the weekend in their own time.”  
(Limpopo SA R1; SA R2)*

There is also the problem of organizational culture. In the NGO sector, community health workers often work with little or no supervision. In fact, direct and close supervision is a factor that distinguishes both Philani and Community Action from similar projects. In the public health care system, like them, there is both a clear hierarchy of authority and a strong expectation of supervision and oversight.

*“It is a struggle to start with CHWs from NGOs who were used to working alone without any supervision. So joining them and telling them what to do was (met) with resistance. The line of command had to be taught (and) gradually there was cooperation with a few.” (North West SA R4)*

*“There is close monitoring of CHWs by team leaders who supervise their work rather than (in) home based care (where) their current supervision is not clear.”  
(Limpopo SA R2)*

Respondents observe that the approach of locating WBOTs in and under the supervision of primary health care facilities overburdens facility management.

*“WBOT is taking a back seat in our facilities’ priorities. Our facilities are under staffed even before the WBOT. (It) is adding a serious strain to our facility managers as the facility work is still as it was, if not worse, but team leaders are required to do home visits, attend meetings and workshops and the facilities are balancing their shifts with WBOT teams.” (Limpopo SA R1)*

*“Most WBOTs do not have team leaders so the clinic manager of their parent clinic acts as their team leader. In such cases the clinic would not be able to provide adequate supervision.” (Free State SA R5)*

*“Management in the programme is on and off.” (Eastern Cape SA R3)*

*“Education and training is difficult, because I’m full time working in a clinic.” (Northern Cape SA R6)*

It also is onerous on CHWs who lose valuable working time reporting before and after work at their base clinics.

*“Time is wasted between homes and catchment clinics.” (Free State SA R3)*

## **5. Working Conditions**

Insufficient attention has been paid to human resourcing, infrastructure and materials. The fact that the WBOT model is appended to the existing primary health facility based system and the legacy practices regarding community health workers within it are two key factors amongst several that have contributed to this situation.

### **5.1 Human Resources**

In terms of human resources, the problems of understaffing, lines of authority, accountability, supervision and dual tasking already described compound and are compounded by challenges of appointment and pay. Team leaders are either ‘delegated’ from within existing staff or they are recruited on contract individually or through NGOs.

*“They are chosen and no posts are there for those positions (CHW, trainers, coordinators and team leaders).” (Limpopo SA R5)*

*“OTLs are delegated not appointed. ... I would have appreciated to be appointed to that post of an OTL rather than to be delegated. (Mpumalanga SA R3)*

Community health workers are recruited through existing NGOs (all provinces), from communities (e.g. in the Eastern Cape) and/or directly by local or provincial government (e.g. Gauteng, North West) on short-term contracts or sub-contracts.

*“Currently the WBOTS still form part of Hospice and get their stipend through Hospice. The stipends are paid over to hospice by the Department of Health from the HIV grant. (Northern Cape SA R5)*

In terms of employment community health workers are considered to be neither workers nor volunteers. What this means is that the system does not accord them the status of an employee, with the rights and benefits that come with it under South African labour law. By entitling them to a stipend government and non-government organisations acknowledge their labour and provide a form of compensation for their work, so they are not volunteers.

Respondents mention that this grey space leads to demotivation, hardship and attrition. Stipends are low and they are often paid erratically.

*“They perform very badly if they don’t receive their stipend for long as it creates a big stress to them. ... It is so hard to work with people who are hungry.” (Mpumalanga SA R1)*

*“Ward based workers still only get a stipend therefore the attrition is very high. Some exit due to better job opportunities (with better financial benefits to them).... Community based workers cannot forever be paid a stipend. (They need) salaries not stipends.” (Northern Cape SA R5)*

Team leaders and community health workers are aware of differences in levels of compensation, which increases dissatisfaction and their sense of being treated unfairly.

*“Our salaries are different to other provinces. There are differences of R8000.00 between professional nurses.” (North West SA R4)*

## **5.2 Infrastructure and Material**

In all provinces there is inadequate attention to infrastructure and material resourcing of ward based primary health services. These deficiencies arise, in part, from the assumption at national and provincial level that resources would be met from NHI and other grants. This has not happened, partly because these grants are restrictive, partly because they are also subject to competing interests.

*“There is no clear strategy from a provincial level - no dedicated budget to implement. (We) use the NHI grant for certain aspects, but it is very prescriptive and cannot be used for anything (Northern Cape SA R5)*

In part, the lack of material resourcing may have arisen from an absence of strategy, leaving districts and facilities to devise solutions from within their already limited means.

*“There was a lot of pressure on the district to start the service. The district therefore had to work out its own strategy. (Northern Cape SA R5)*

Respondents in all provinces report infrastructural and material constraints that seriously hamper their ability to work. There is a problem of space.

*“Where do you start if you hardly have a place to work from. How do you organize and allocate work. Reporting back from field needs a place. ... There is no space for the teams. Most of the time you will be told that re-engineering doesn’t have a budget for offices. Sometimes we are outside the facility.” (North West SA R1, R4)*

*“Prepare space for the teams to work. It is a problem now that the team is working in a very small clinic that does not accommodate workers. (Free State SA R6)*

*“Infrastructure at some of the clinics is very poor, because the clinic is too small.” (Northern Cape SA R2)*

Respondents report a general shortage of essential office equipment to support WBOT functioning, including not having desks and chairs, lockable filing cabinets, photocopying equipment and stationery to register and collect information where the system is paper based, and access to phones and computers is restricted or limited.

*“At some of the clinics there are no fax or photocopy machine or the machines are faulty or out of order.” (Northern Cape SA R2)*

*“Initially they were provided with cell phones but now they are not functional. So they can’t communicate risks which need the OTL intervention.” (Free State SA R8)*

*“(There is) no furniture for our offices. We are not able to communicate with CHWs because there are no phones. (Eastern Cape SA R3)*

*“There is no space to put or store daily information collected from households, therefore we cannot maintain confidentiality of household members. (Gauteng SA R5)*

Respondents also point to a lack of uniforms, name tags that identify CHWs to the community, protective clothing, properly equipped kitbags and essential equipment.

*“The ward is deep rural, walking distances are long. (CHWs work) with no protective clothing. ... Adequate medical equipment is needed - BP machines (portable ones), HB machines and a bag to carry the stuff. We also need to be provided with duster coats, takkies, umbrellas and sun hats.” (Eastern Cape SA R2; SA R7)*

*“You want to get up and want to go to work, but sometimes it’s wet.” (North West SA R4)*

Transport is a major constraint in all provinces. It is made worse by a facility based outreach model that is, by definition, distant from and difficult to access by remote communities.

*“Ferrying CHWs to search out their destinations is a problem. They do not have access to transport. ... (because) transport is unavailable we postpone appointments with clients at service points.” (Eastern Cape SA R2)*

*“We were promised cars when we started. I drive a small bakkie. I can only take one CHW at the time otherwise they should sit at the back. ...I travel 25 to 27 km from work, 58 km daily. Claiming money for our travelling is a nightmare. Our forms are always returned for small mistakes.” (North West SA R4)*

## **6. Education and Training**

The NDoH has approached the educational preparation requirements for primary care reengineering as short course training. This approach is informed by the assumption that facility supervised outreach teams would be led by professional nurses (Four year B degree). It is also informed by the legacy system of training rather than educating care workers who work at the community interface. As a consequence, specific short course training has been developed. Training for team leaders is a once off, five-day course to reorient OTLs to the model (initiated in 2011). Training for community health workers involves two 10-day courses – Phase1 (initiated in 2012) and Phase II (initiated 2014) and a one-year NQF L3 Health Promoter qualification (initiated in 2015).



All respondents consider education and training to be essential to making ward based primary care work. They variously report to be at different points in the short-course training program. A few have yet to attend any training, while most OTLs have completed the 5 day training and most CHWs are progressing through the phases, albeit with the majority being in or having only completed Phase 1.

Respondents make several observations about the training on offer. Some of their concerns relate to the organization and timing of training, particularly the need for CHWs to complete Phase 1 before they begin to go out into the community (Free State), the slow pace of progression through the phases (North West), the absence, shortages or delays in materials, un-conducive learning spaces, and a lack of budgeting and generally poor planning (Limpopo, Northern Cape, Free State, Mpumalanga).

There are concerns about the method. Respondents are doubtful of the impact of the short-courses on CHW learning outcomes, given that CHWs do not have general health care backgrounds and their low levels of literacy.

*"I think the training was not good for them because they can't even express themselves and some of them they don't know what is a ward base outreach team."  
(Mpumalanga SA R2)*

There is also concern that the content does not take account of existing skill gaps. Particularly, they point to the omission of computer literacy in both the OTL and the CHWs short-course training. They also indicate that there is a need for management and leadership training as well.

*"The team leaders need to be trained as team leaders, to help build management skills and leadership skills. I believe for WBOT to function effectively we need strong managers for the teams." (Limpopo SA R1)*

In the City of Tshwane initial management training focused on team leaders. In 2013 there was a two week introduction to COPC to familiarize management with the model. Subsequently, it was recognized that not only was there a need to train all managers but that the demands of community based health care also required that management training had to be provided in an on-going and continuous way. This is now addressed by holding bi-monthly or monthly three hour master classes. (Gauteng – personal interview)

Respondents believe that just focusing on training team leaders and community health workers is too narrow.

*"I think I would have liked to have a formal in-service training to know what my responsibility as operational manager links to the team." (Free State SA R2)*

They also argue that training should be extended to other personnel within the local health care system as well as ward councilors, municipal and district health managers and other service providers.

*"All stakeholders, integrated department, chiefs, traditional healers need workshops on how WBOT works in the community." (Limpopo SA R2)*

Respondents are concerned about how formal training relates to CHW and OTL competencies and scope of work.

*"What will the exact scope of work be of the WBOT? For example what can they do after completion of phase 1 and phase 2 training? What will the exact role of the fully qualified ward based worker be? ...How will they function in the Northern Cape?"  
(Northern Cape SA R5 SA R7)*

More positively, they emphasize the importance of practical, in-service continuous learning to enable CHWs to meet the range of services they have to support. Respondents in all sites provide CHWs with some form of in-service learning.

*“We educate our CHWs on how to check RTH booklet so they know about catch up immunization; about pregnancy tests to detect early pregnancy; how to treat pressure sores for bedridden visited at home. Trained for Vitamin A in the households. Trained for how and what to look at in ANC.” (Eastern Cape SA R7)*

*“Retrained the CHWs – (to) improve their writing skills, literacy, report writing. (I) exposed them to register for ABET, learning from experience from others with different skills, supervising their visits, examining mothers and babies in their presence in real life to have real life feel, conducted practical skills.” (Free State SA R3)*

*“We do weekly short meetings to share information and experiences and fill loopholes. As a team leader I appreciate good work and ask my CHWs how we can improve our performance.” (Mpumalanga SA R1)*

*“One of the purposes of weekly team meetings in COPC is to support learning. We provide medical and other technical information like current immunization practices, treatment of common minor conditions, techniques of growth measurement etc. We also do it by reviewing cases.” (Gauteng – notes)*

Respondents often find it difficult to adequately attend to CHW education and training, given their workloads, resource and context constraints as well as their own and their teams' backgrounds.

*“Education and training is difficult, because I'm full time working in a clinic. We do sometimes do early morning short in-service training.” (Northern Cape SA R6)*

*“Medical students, clinical associate, allied health and non- health undergraduate and post graduate students participate in peer learning sessions with WBOTs and provide services at various CoT health and social development supported service sites.” (Gauteng – Report)*

To help address this challenge in Tshwane, undergraduate and post graduate students at the University of Pretoria have become part of the community based health care learning platform.

## **7. Information and data**

### **7.1 Methods of Collection and Capture**

Collecting information is an integral part of the implementation model of ward-based primary care. NDoH has devised forms and tick lists to support service monitoring and workforce management. These are extensively used in all provinces and most districts.

*“Community health workers have forms for summarize their work. We use different forms. For household registration, a household registration form is used. There are forms for chronic conditions. There are forms for confidential reports. There is a form for children.” (Limpopo SA R2; R5)*

*“Data collection is done through tick sheets, referral forms, child and maternal form, individual forms, tick register...” (Eastern Cape SA; R1)*

*I collect the information by visiting the household with the community health workers using relevant forms, for example, household registration forms ... maternal individual forms, referral forms. (Mpumalanga SA R2)*

At the time of the assessment only Northern Cape (Britstown) and Gauteng (City of Tshwane) were exceptions to a paper based information collection system. Gauteng (Tshwane District) and both sites have devised an electronic data collection system to meet the information requirements of the health care system.

*"In Britstown, all data including the household survey is being captured on tablets. The information is integrated with information from the patient record system of the clinic." (Northern Cape SA R7)*

In the Philani project, a cell phone app is being used to collect data. And in the City Tshwane, all WBOT information is collected by community health workers using a customized application on a cell phone that is linked through a web based system to team leaders, facility and other WBOT managers.

Respondents describe the paper-based system as a time consuming process of information gathering, verification, capture and distribution.

*"The clinic manager must, together with the CHW/OTL verify the data that are brought in. It is then sent to the data capturer for the local area who captures and submits it to the DHIS and province." (Free State SA R1)*

*"I use a register and total up daily. I use weekly forms and monthly forms. I do verification. Then I send the information to the service manager. Then the information is sent to the information officer to capture." (Eastern Cape SA R2)*

*"Once a week WBOTs have an admin day in HCSP where data are combined. Data are then sent to the NGO (Hospice) as well as to the data capturer of each facility for the DHIS report. Facility data capturers send data to the sub-district data coordinator who combines all data to submit to the district monitoring and evaluation team for DHIS." (Northern Cape SA R8)*

*"Team leaders give statistic to data capturers of home base care and submit the sub-district consolidated statistics to sub-district data capturers who submit them to the district information system and to the WBOT focal person in district." (Limpopo SA R2)*

Respondents report that the information system gives rise to a number of problems.

In addition to the time it takes, writing, manually capturing and then electronically capturing information is labor intensive and prone to loss, error and delay.

*"There is a problem of incorrect data, as there are no qualified OTLs in all teams that work with CHWs in the field to verify the information collected." (Free State SA R2)*

*"Sometimes WBOT information by team leaders is not done due to a lack of time." (Limpopo SA R2)*

*"I receive stats a little bit later from far places where we depend on a courier. ... The shortage of staff also delays collection of information due to the fact that there is no data capturer." (Eastern Cape SA R2)*

*“We write everything. Nothing is on the computer. If it could be computerized, it will save a lot of time.” (Northern Cape SA R6)*

*“Reports by community health workers are not submitted on time. Forms are incomplete or are not signed by the household members. Information is not clearly written or it is put on the incorrect form. I need to do in-service immediately to do corrections.” (Mpumalanga SA R2)*

Data is also less easily accessed and therefore less likely to be used.

*“With household data in a paper format, it is difficult to use the data. It stands in the file of the clinic. With the electronic version the data and referral mechanisms are available at all times and can be updated regularly. ... I get the information on time from the WBOT. The stats are filled in correctly. They do a lot of TB screenings that has increased our TB screening” (Northern Cape SA R5)*

This said, there are technical and training challenges associated with the electronic system that also have to be addressed.

*“Handheld devices sometimes giving network problems. Not all CHWs have mastered how to use the hand held device.” (Gauteng R1)*

## **7.2 Use of Data**

The information management system is designed to report upwards into the system hierarchy. Respondents put a lot of effort into ensuring that this happens and that the information that is fed into the system is quality controlled, as far as possible.

*“I have been able to keep the monthly collecting tools up to date. With the areas near where I am working I am able to know the correct numbers of the indicator, as I am able to pay visits even when there is no transport. I have been able to do verification before sending statistics to the service manager.” (Eastern Cape SA R2)*

Just as importantly, and notwithstanding context and system constraints, respondents in all provinces see the information collected by WBOTs in the community as a valuable tool to support planning, training, service delivery, performance monitoring and evaluation.

*“Obtain information from the CHW s of the prevalence of any disease in the community. Draw an action plan to address the risk reported. Allocate and delegate responsibility to the CHWs to attend the household and what and how to deal with the situation. Input more afterwards, in the form of education to skill the CHW. Train every week on a particular program. Need to empower CHWs. Evaluating that the work is done every Friday, whereby we reassess and review our plans and monitor progress and impact.” (Free State SA R8)*

*“It is WBOT to plan and manage the team schedule. You should always know who is doing what, where your members are each day why they are there. ... I have prepared the monthly reports that the community health workers bring to me. Every month we discuss every indicator.” (Eastern Cape SA R2)*

While they use what information they have as best they can, respondents are acutely aware of the limitations of the system.

*“The line that the information must go through from me to DHIS. I wish that something from each OTL could go straight to sub-district at the department. ... (Also) you must request reports from the facility managers. I would like to receive them.” (Eastern Cape SA R9)*

They are also aware of the possibilities that an electronic system offers, both for ease of use and to support improved information flows. Simply put

*“I think computer systems can be used to capture data” (Mpumalanga SA R3)*

*“Every team leader should have a laptop and internet connection. Every CHW to have hand held device and be trained to master it.” (Gauteng SA R3)*

## **8. Collaboration and Cooperation**

Respondents are familiar with the process of implementation outlined in national policy and training documents. They succinctly sum up envisaged implementation as a series of steps:

*“Community entry and find out resources that are available, for example old age homes. Map households, schools and crèches in the geographic area by the primary health outreach team. Compile a profile. Initiate community based primary services to households, schools and crèches in the geographic area. Establish and maintain collaboration and liaison with local community and service providers for the catchment population.” (Eastern Cape SA R1)*

*“Community health workers work with a team leader in a defined ward, doing door-to-door household visits where they register households and do individual health assessments. (Gauteng SA R1)*

In terms of implementation, the focus of the rapid appraisal was on partnerships within and across organizations and community cooperation.

### **8.1 Organisational Partnerships**

Effective implementation of ward based primary health care critically depends on teams working in partnership with local organizations and services that are active in a defined geographical area. In all three case study projects public, private, non-governmental and university partnerships play an important role in community health care delivery.

As Table 1 shows, respondents in all sites describe working extensively with government departments as well as faith and other not-for-profit organizations. The range of private sector and agency partnerships is narrower in scope, with the exception of North West. In general, there is little reference to civic society organizations.

**Table 1: Partnerships by Provinces**

TYPE / PROVINCE	GOVERNMENT DEPARTMENTS	FAITH & NOT FOR PROFIT ORGANISATIONS	FORUMS / CIVICS	PRIVATE SECTOR / AGENCIES
<b>Eastern Cape</b>	<ul style="list-style-type: none"> <li>• Dept. Social development</li> <li>• Dept. Home Affairs</li> <li>• Local Government</li> <li>• Municipality</li> <li>• Dept. Education</li> <li>• Dept. Agriculture</li> <li>• Dept. of Health - NHI</li> </ul>	<ul style="list-style-type: none"> <li>• TB/HIV NGO -HCT</li> <li>• Siyabonga</li> <li>• Council of Churches</li> <li>• Faith Healers</li> </ul>		<ul style="list-style-type: none"> <li>• Traditional healers</li> <li>• BroadReach</li> <li>• SASSA</li> </ul>
<b>Free State</b>	<ul style="list-style-type: none"> <li>• Kerklike</li> <li>• Municipal councillors</li> <li>• SASSA</li> <li>• Home Affairs</li> <li>• Dept. of Education</li> <li>• SAPS</li> <li>• Dept of Health - Hospitals and clinics</li> </ul>	<ul style="list-style-type: none"> <li>• Lechabile NGO</li> <li>• Lesedi (home for the homeless)</li> <li>• Maatskaplike Dienste (NGO for the aged)</li> <li>• Golden Gate NGO</li> <li>• Home Based Care Organisations</li> </ul>	<ul style="list-style-type: none"> <li>• Child Care</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional Healers</li> <li>• SASSA</li> </ul>
<b>Limpopo</b>	<ul style="list-style-type: none"> <li>• Dept. Road and Transport</li> <li>• Dept. Water Affairs</li> <li>• SAPS</li> <li>• Social workers</li> <li>• Dept. Education</li> <li>• Dept. Home Affairs</li> <li>• Municipality</li> <li>• NDoH</li> </ul>	<ul style="list-style-type: none"> <li>• IOM</li> <li>• AgriAID</li> <li>• Centre for Positive Care</li> <li>• FPD</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic committee</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional healers</li> <li>• BroadReach</li> <li>• SASSA</li> </ul>
<b>Mpumalanga</b>	<ul style="list-style-type: none"> <li>• Ward councillor</li> <li>• Dept. Home Affairs</li> <li>• Dept. of Health (District Clinical Specialist Team, Clinic)</li> </ul>	<ul style="list-style-type: none"> <li>• Home Base Care</li> <li>• Ward pastors</li> <li>• Right to Care NGO</li> <li>• HST</li> <li>• FPD</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic committee</li> </ul>	<ul style="list-style-type: none"> <li>• SASSA</li> <li>• BroadReach</li> </ul>
<b>Northern Cape</b>	<ul style="list-style-type: none"> <li>• Dept. Health (District Specialist, Hspital, Clinic, School health)</li> <li>• SAPS</li> <li>• Dept. Education</li> <li>• Dept. Home Affairs</li> <li>• Dept. Social Development</li> </ul>	<ul style="list-style-type: none"> <li>• South to South</li> <li>• Hospice NGO (Casipo)</li> <li>• Virtual Health (Catholic Health Initiatives)</li> </ul>		<ul style="list-style-type: none"> <li>• PEPFAR</li> <li>• SASSA</li> </ul>



<b>North West</b>	<ul style="list-style-type: none"> <li>• Dept. of Health</li> <li>• SAPS</li> <li>• Dept. Agriculture</li> <li>• Dept. Home Affairs</li> <li>• Dept. Social Development</li> <li>• Dept. Education</li> <li>• Government (politicians)</li> </ul>	<ul style="list-style-type: none"> <li>• Alcoholics Anonymous</li> <li>• Churches</li> <li>• Resolofetse home based care</li> <li>• Social workers</li> </ul>	<ul style="list-style-type: none"> <li>• Clinic committee</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Practitioners</li> <li>• Traditional healers.</li> <li>• Mining Houses</li> <li>• SASSA</li> <li>• Pharmacist</li> <li>• Dieticians</li> <li>• Social Workers</li> </ul>
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Partnerships play an important practical role in helping health care teams deliver services in their defined wards. They variously report being assisted with community entry, education and training, problem identification and problem solving etc.

*“We hold meetings together to solve some referring problems – (people) not having the correct documents that’s why they send them back, un-helped.” (Mpumalanga SA R2)*

*“We had good relationship with the community because before WBOTS were formed all village stakeholders in that particular ward sat together in tribal authority meeting to introduce this programme. The aims of the model were highlighted to the stakeholders. CHWs do not have problem in community. They are accepted by clients, because the chief knows about WBOTS. ... If ever there is a service we need to provide to the community they really support us and call a community meeting and they allow us to address the community. This is a very effective way to send a message across as every household is expected to send representatives to the community meeting. They even sign indicating their house number.” (Limpopo SA R1, R2)*

*“Meetings were held to explain our expected relationships. ... by working together we are able to support the community” (Free State SA R3)*

*“We have a good relationship with ward counselors. ... Any health risks and campaigns are reported so that they should be aware and be involved in campaigns. Schools do help with accommodation in classrooms. Churches accommodate us during presentations. (Gauteng SA R6)*

Respondents describe their relations with partners as mutually supportive.

*“When they do have problems they call me to assist them. ... All of our partner organizations work with us positively and successfully.” (Mpumalanga SA R1)*

*“The Hospice partners go to the community and deliver health care services to the people out there monitoring and evaluation are done with the help of WBOTs.” (Northern Cape SA R2)*

*“Schools and churches assist us with accommodation when doing training.” (Gauteng SA R1)*

*“Chiefs are participating a lot in this program. (They are) doing imbizo to communicate with their members so that each should know how to reach the WBOTs team when they visit them.” (Eastern Cape SA R6)*

They also describe their relationship as being based on familiarity and trust.

*“We know one another well. D... is a small town. I know who to phone with a specific problem.” (Northern Cape SA R6)*

This said, there are also partnership challenges within and across divisions and sectors. There is a recurrent (but not universal) problem of potential partners and stakeholders not being aware of or not having been properly introduced to the program. In several sites in different provinces, respondents report that partner stakeholder meetings either are not held regularly or are poorly attended. Several respondents comment that there is insufficient support and engagement in general. These problems negatively affect ward based health care team functioning. Amongst other things they lead to non-cooperation, confusion, duplication as well as increased costs in time, money and effort not only for health care teams but also for people using the services.

*“They (must) assist to strengthen the WBOTs and not give conflicting messages or systems that make it difficult for the WBOTs to go forward.” (Northern Cape SA R5)*

*“Departments like home affairs, they don’t recognize our referral letter because it doesn’t have a reference number. We rely mostly on a supporting letter from the councilor. ...Managers of NGOs resist releasing CHWs for profiling households and to do follow-up in community. Broad Reach- they train few trainers, which slows the process of training in the district especially for Phase 2. Sub-district managers do not support WBOTs and do not have any information about WBOTs.” (Limpopo SA R1, R2)*

*“(We need a) good open free relationship, so that we can work together for better services. There needs to be a proper introduction of newly established partners, what their roles are in relation to ours...” (Free State SA R5)*

*“I wish we could organize as a group with partner organization to meet once a month to sort out problems and get feedback get to know each other better.” (North West SA R4)*

*“The communities, facility managers, ward councilors need to be informed or in-serviced about WBOT services.... There needs to be a better cooperation from management to practically integrate between district and the municipality.” (Gauteng SA R5)*

## **8.2 Community Cooperation**

In all provinces respondents report that ward based health care is positively received by communities.

*“The community I work in accepts WBOT services very well. They said they are happy to be visited in their homes by people from Dept. of Health.” (Mpumalanga SA R1)*

*“The relationship is good. They have confidence in me as a team leader. They report matters that affect the health of individuals by phone because they have trust. They participate in everything that is done in their communities. They make use of the service point and bring their babies for immunization.” (Eastern Cape SA R2)*

*“The communities are very cooperative and ready to do anything to assist the health care workers. This observation is from the clinic committees and facilities. ...I don't have a direct relationship with communities, but most of them are aware that I'm the manager of "clinics" and I'm contacted sometimes directly when they experience challenges. ...My relationship with the community is very good - patients respect me and I respect them.”*  
(Free State SA R5 SA R1, SA R2)

*“(There is an) open door policy at all facilities. There is a process in place for complaints at every facility - good relationship with community. ...The community accepts WBOTs. People cooperate when WBOTs do the household survey.”* (Northern Cape SA R, SA R8)

Also evident in these responses is the inherent challenge of distance from the community that comes from a facility-based system where people are seen as patients.

## 8.2 Impact

There is a strong sense across all provinces that engaging with health in the community in a systematic way has had a positive impact on key health and social indicators, as formative and challenging as the process of implementation has been.

### Successes:

- “1. Service points that are well needed.*
- 2. Immunisation capturing that make us be aware of success as we see a large*
- 3. number of well babies and have complete immunization sites.*
- 4. Discovering disabled children and have to give wheelchairs and support.*
- 5. Finding children who are not able to access grants and being able to help those.*
- 6. Finding people that are trapped in poverty and being able to refer people for care.”*  
(Eastern Cape SA R9)

- “- 1. More people traced*
- 2. More people put on treatment*
- 3. More lives are saved*
- 4. No more TB defaulters.*
- Adherence of the medication. Waiting time improves a lot. TB cure rate improve.*  
*Adherence of ART patients.*
- Support from community. WBOTs easily adopted by community. Willing to participate.*
- Some groups function very well e.g. the Britstown group. All households were visited and household surveys conducted. All information is available electronically.”*  
(Northern Cape SA All)

- “- Child support grant, certificate, ID documents, food parcels*
- Acceptance by the chief, households profiling is going, ward councilors knows, no refusal of clients to clinics, increase access of health care.*
- Co-operation. Commitment. Understanding Eager to learn more.*
- Allowing CHWs to work. Accepting programme, being happy about WBOT.*
- Problems being identified. Problems being solved.”* (Limpopo SA All)

Anecdotal accounts from several respondents give a depth to the impact of the work done by health teams in wards.

*“We refer those who defaulted in treatment. For example, there was a village where we found a man sleeping in a room. His face was shining and blackish. His stomach was so big as if he was pregnant. We ran away thinking he was not human. He called us with a hoarse voice saying he was staying alone with no one to help him. He said he was taking TB and ART Rx but failed because he had no money to go to the clinic for the treatment. We admitted the man at the Hospital. When we visited he was light in complexion, fat and happy.” (Eastern Cape SA R7)*

- “- An abandoned boy of ± 11 years. Abandoned by mother then father. started stealing from neighbours. The police acted promptly when the case was reported to them and brought local social worker along. Boy was taken to a place of safety. Stays there and is attending school.*
- A woman who left home 39 years ago to come to the mines was returned home. Her family fetched her. We did it using the old fashioned way of communication -writing a letter.*
- A very sick old man was returned to Mozambique ± 80 yrs. He came to the mines when he was a young man.*
- A very sick man ± 50 yrs. Relatives in Jouberton. Each-time the mobile clinic came and he was to be taken there, he ran away. He was only able to get medical care when he was very ill and taken to hospital. It took me 3 days to get to his people. He is now much better and home.”*

*“A sick women from Lesotho Stage 4 HIV. We traced relatives who came to fetch her left for home and in 2 to 3 days was reported to have died at home.”  
(North West SA All)*

*“I managed to assist two of my clients with identity documents.  
I managed to trace tuberculosis defaulter and those who had interrupted the treatment.  
I managed to solve the problem of someone who is taking his brother disability grant, not caring for him they are not even staying together.  
I managed to reach the target of vitamin A for my facility.” (Mpumalanga SA R2)*

*“Children who never have been registered have been traced by the WBOTs and referred to home affairs. The same with people without identity documents.”  
(Limpopo SA R5)*

### 3 Prospects and Potential

Overall, there is unequivocal support for the strategy of taking health and care to people in their homes.

*“It’s the best thing ever to happen to our country. Not only are we addressing the health of our people, but most importantly, we are entering their household to identify the possible causes of (disease) and by assessing the community as a whole. If this programme is implemented as intended, South Africa is going to be wonderful country to live in. The individual, family and community needs are addressed and by achieving this we improve health.” (Limpopo SA R1)*

*“The difference that I see is the fact that for primary health the client has to come to the facility or mobile clinic to access health care whereas in WBOTs the client gets health care at his household. This service is an economic relief for them especially for disadvantaged communities that are very far from health care.” (Eastern Cape SA R9)*

Respondents in all sites are also acutely aware of the scale of the work that has to be done to address the health and social problems that exist in communities. They mention poverty, alcohol and substance abuse, violence and injury as well as unattended illness and disease. They mention the need to address health literacy and the importance of empowering people to take responsibility for their own health and well-being.

#### 3.1 Recommendations

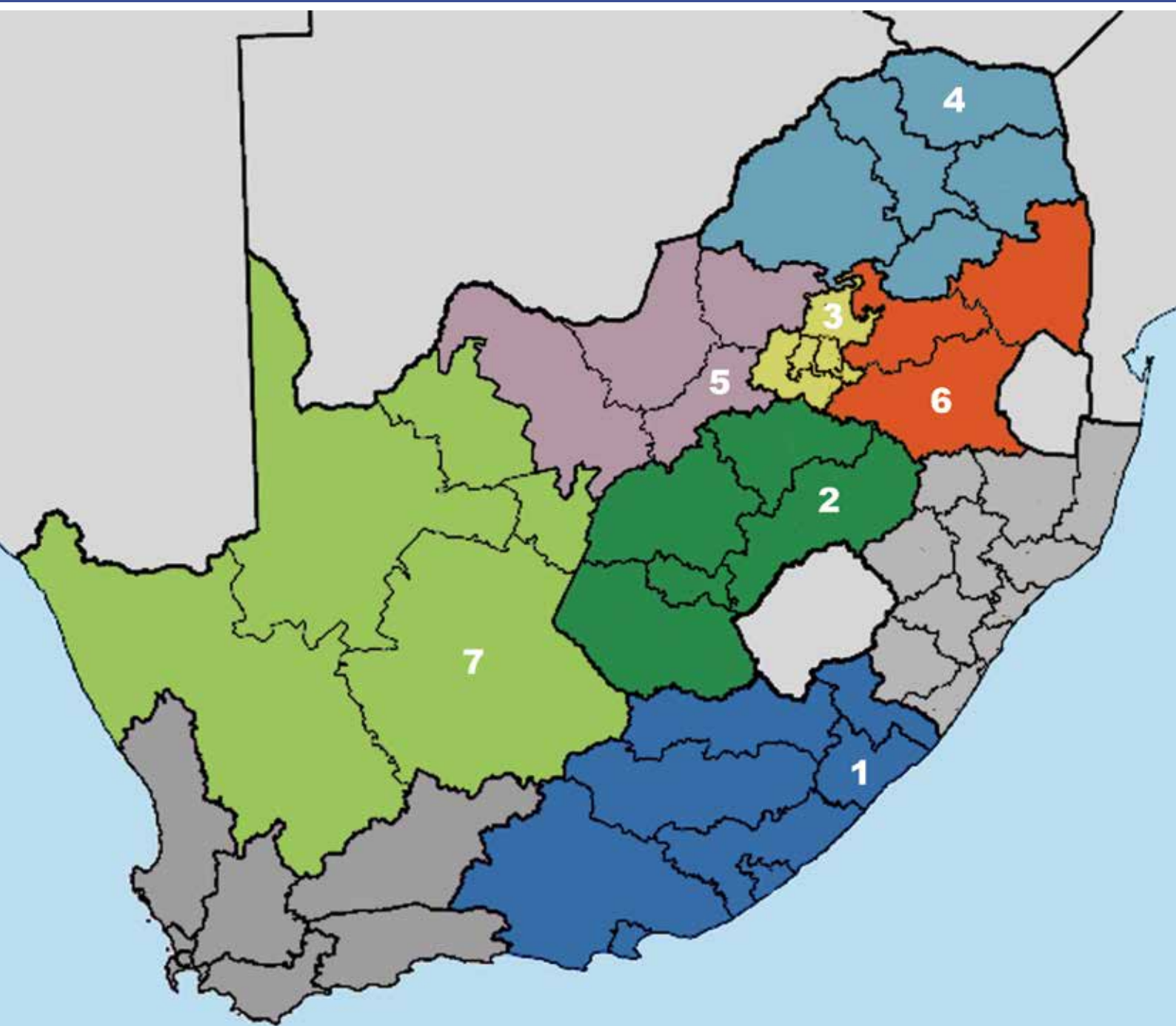
Respondents believe that the model has to be developed properly in order for services to deliver on the promise of better health and care on the ground.

Drawing from their experience, their recommendations can be distilled into the following 10 points:

Ward based health and care should be

1. part of an integrated health care system.
2. outside of clinics.
3. budgeted for independently.
4. staffed to meet service needs (teams with team leaders)
5. led and supported by clinical and other professionals.
6. normalised in terms of conditions of employment.
7. equipped to be functional and effective.
8. enabled for continuous learning (work integrated and linked to qualifications and employment) by all levels of managers and health care workers.
9. assisted by information technology to plan and provide services, monitor and report on performance and communicate from the home to the facility.
10. formally integrated across services and sectors in all localities.







**1** WBOT RAPID APPRAISAL: OR TAMBO DISTRICT, EASTERN CAPE

**2** WBOT RAPID APPRAISAL: THABO MOFUTSANYA DISTRICT, FREE STATE PROVINCE

**3** WBOT RAPID APPRAISAL: THSWANE DISTRICT, GAUTENG

**4** WBOT RAPID APPRAISAL: VHEMBE DISTRICT, LIMPOPO PROVINCE

**5** WBOT RAPID APPRAISAL: KENNETH KAUNDA DISTRICT, NORTH WEST PROVINCE

**6** WBOT RAPID APPRAISAL: GERT SIBANDE DISTRICT, EASTERN CAPE

**7** WBOT RAPID APPRAISAL: PIXLEY KA SEME DISTRICT, NORTHERN CAPE

# 1 WBOT RAPID APPRAISAL: OR TAMBO DISTRICT, EASTERN CAPE PROVINCE

*OR Tambo District: Eastern Cape*



The rapid appraisal of Ward Based Outreach Teams (WBOT) is a national research project conducted by the Albertina Sisulu Executive Leadership Programme in Health (ASELPH), at the request of the NDOH. The Eastern Cape is one of the seven provinces selected for the study. The purpose of the study is to review the current status of WBOT and to identify factors that impact the effective and efficient functioning of WBOTs in the Eastern Cape.



# 1. OVERVIEW

The Eastern Cape site visit research team:

- Prof CC Jinabhai
- Prof DT Goon
- Mrs N Rala
- Mrs T Mtise
- Mrs N Jack
- Mrs S Monakali
- Mrs A Okeyo
- Ms M Hlabahlaba

University of Fort Hare Team

A WBOT preparatory meeting was held on the 28th April, 2015 at OR Tambo district, Eastern Cape. Two sub-districts were identified (Mhlontlo and Nyandeni). The methodological approach of documentary review, structured interview questionnaires and direct field observations was outlined. Members of the management team were requested to complete the self-assessment questionnaires and return them to the research team during their field visits.

## 2. Work Plan and Implementation

Below is the report of the five-day rapid appraisal conducted in these two sub-districts in the week 29 June-3 July 2015.

<b>Day 1:</b>	The research team met with the WBOT Manager and coordinators in the two sub-districts to strategize the weekly activities pertaining to the WBOT rapid appraisal. The WBOT documents earlier requested (Appendix A) in addition to the WBOT self-assessments questionnaires (Appendix B) were collected. Two persons from each of the sub-district were identified to join in the research team. The team interviewed 24 respondents (2 sub-managers, 2 community-based Service Managers, 1 facility manager, 12 outreach team leaders (OTLs), 1 health promoter (HP) and 6 community health workers (CHWs) in Mhlontlo sub-district.
<b>Day 2:</b>	17 household interviews were conducted at Mhlontlo sub-district. Also interviews were conducted with 1 facility manager and 31 CHWs.
<b>Day 3:</b>	At Nyandeni sub-district, One focus group discussion (12 OTLs) and 18 interviews were conducted with HPs (4), CHWs (8) and households (6)
<b>Day 4:</b>	14 interviews were conducted at Port St John in Siyancuma sub-district (3 OTLs, 1 HP, 5 CHWs and 5 households).
<b>Day 5:</b>	The preliminary findings of the WBOT rapid appraisal in the Eastern Cape from the two sub-districts were presented and discussed in a peer learning workshop with the WBOT manager, district coordinators, health promoters, outreach team leaders and community health workers.

## 3. FINDINGS

Findings from the fieldwork are presented in three sections:

- 3.1. CHW Individual Interviews analysis
- 3.2 Household Interviews Analysis
- 3.3 WBOT Management Thematic Analysis.

### 3.1 WBOT Community Health Worker interviews

#### Services

Community health workers say that WBOT supports health in the community. In their daily work CHWs promote health, prevent illness, do direct observed treatment support (DOTS), support referrals, do chronic screening, do home base care, assist with registrations of births at the Department of Home Affairs, provide food parcels and do health talks on things like teenage pregnancies, contraceptives and HIV/AIDS are conducted.

They also attend to under 5s, ANC and PNC and use Mom Connect (\*134\*550\*1#) to support pregnant women and to encourage early ANC booking.

CHWs describe the work they do as both difficult and rewarding.

*"It makes me feel good to do the basic nursing care although at some stage we are not free because there are no gloves to use during service delivery."*

*"We feel good because it is within us to give services to community, although at some cases we feel like giving up because of the family attitude."*

*"I feel a lot of sympathy and empathy for the clients who are bed ridden".*

Doing WBOT makes CHWs feel useful.

*"It makes us feel useful to communities because they trust us. It makes us feel good when we help those in need; we give hope to the clients".*

The CHWs value the training they received as it has taught them to record data, perform household registrations, sign referrals and communicate with community members.

#### Cooperation and Partnerships

WBOT relations with staff at the sub-district hospitals and facility management is positive in one setting and negative in the other (Mhlontlo) sub district.

Ward councilors cooperate with WBOT CHWs in the two sub-districts.

*"The relationship between health promoters and ward councilors is good. The ward councilors are supportive and work with the Department of Social Development on teenage pregnancy, INP-Integrated nutrition programme; and interact with the Department of Agriculture."*

## Operational constraints

CHWS report the following operational constraints:

- There are too few teams to cover all the areas
- WBOT teams are short of CHWs
- CHWs don't know their managers
- Sisters in the clinic want them to work in the clinics rather than in the community

*"We are working more in the clinic. We are in between because we do not know where we belong."*

- 10 day Phase 1 training was not facilitated in a language they could understand and it was not translated
- Most CHWs in Ndayeni have not done the 10 day training.
- There is no transport to get to the community or they have to provide their own transport
- They are not provided with the equipment (tool kits) and resources (rain coats, gumboots) they need to do their work.

## 3.2 Household interviews

### WBOT Services and experiences

Household respondents interviewed describe only having had limited experience with WBOT in both sub-districts. Respondents mostly say they see WBOT CHWs occasionally, from time to time.

*"I haven't seen one. I saw them last week. I have met one last year but now I only see them around the community. I saw them once in 2012. I saw them last year and once this year"*

However, those that have had contact say that when CHWs visit them they check treatment adherence, screen for TB, offer counseling for HIV/AIDS and other health related problems, educate them refer patients to the clinic. Some also clean and disinfect the house and wash patients' clothes.

Respondents value the services they receive:

*"We feel good with the services they provide especially on education about the need to get nutrition and hypertension. They respond quickly when called. They go the extra mile to assist families"*

### Recommendations

The following recommendations were made to improve WBOT in the province:

- CHWs need to perform more frequent and regular household visits
- WBOT team numbers need to increase in order to cover the need of teams
- Recruit more CHWs
- Provide continuous in-service training and improve feedback by team leaders after training or workshops.
- Provide transport, equipment and basic resources

# WBOT THEMATIC ANALYSIS - MANAGEMENT RESPONSES EASTERN CAPE - SELF ASSESSMENT FORMS & INTERVIEWS

TOPICS	RESPONSES	STRENGTHS
<p><b>1. Knowledge about WBOTs</b></p>	<ul style="list-style-type: none"> <li>• Supportive because they are bringing access to health services closer to the Households (HH) &amp; doing house hold registration &amp; ensure accessibility of health to communities.</li> <li>• They research hidden agendas of communities like hidden HIV clients, vulnerable children, and orphans, not attending immunisations, refer needy clients to facilities.</li> <li>• Teamwork, inter-sectorial and interdepartmental collaboration &amp; referral system.</li> <li>• They act as foot soldiers visiting communities.</li> <li>• Assist in decreasing workload in PHC facilities &amp; make health more accessible to communitiesWBOTs is a corner stone of PHC, is a third stream of RPHC which strengthens service delivery of PHC to the implementation of NHIBring health at doorstep.</li> </ul>	<ul style="list-style-type: none"> <li>• Take health services directly to the HH and communities.</li> <li>• Stipend of R2,000 pm on abnormal Persal.</li> <li>• The glaring diseases burden in selected areas is more glaring and can be identified.</li> <li>• CHWs can “dig down “and find the malnourished, out of school children, disabled, pregnant girls etc. Therefore able to do early detection of (health) problems.</li> <li>• The roles of the different health workers are becoming known and clearer.</li> <li>• WBOTs attend District Office meetings to meet, share, learn and collaborate.</li> <li>• Existing staff and WBOT committed to rendering services.</li> </ul>
<p><b>2. Services rendered by WBOT</b></p>	<ul style="list-style-type: none"> <li>• If WBOT teams are fully fledged and deployed, they would have a dramatic impact on service delivery; because they are closer to the HH’s, visit more frequently.</li> <li>• H Education, finding defaulters, abandoned OVC Children, geriatric patients needing basic care, chronic &amp; disabled patients.</li> <li>• On dedicated days go out with H Promoters to identify community needs. Early detection of diseases and other conditions either than HIV/ AIDs and TB.</li> <li>• Promote and prevention of diseases</li> </ul>	<ul style="list-style-type: none"> <li>• Most CHWs did the 10-Day training; but also did School H services, IMCI, BANC, ESMOE, and ORT.</li> <li>• Lay Counsellors are clinic based. KSD piloted tablet based data collection via an NGO.</li> <li>• Quality of WBOT training is good, they have the tools to collect &amp; analyse data.</li> <li>• They are very flexible- always willing to assist with and contribute to Clinic duties, house visits, campaigns etc.</li> <li>• Empower communities: motivate thru garden projects, work with CBO’s, refer to social workers, doctors, nurses at clinics.</li> </ul>



WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Serious levels of inequalities and poor health indicators.</li> <li>• Sub-district Manager is based in the Sub-district office, not the Clinics- so links with the PHC clinics weak.</li> <li>• OTL members only being trained in management in July 2015.</li> <li>• Limited support from any H Practitioners, &amp; H Promoters.</li> <li>• Have only an average of 3 CHW for 26 Teams in sub-district.</li> <li>• Make CHWs full time not contracts staff; this would allow proper planning &amp; make the CHWs permanent employees of DOH.</li> <li>• Need clear Mx structure from Community Based Managers to WBOT; and need more OTLs to be employed to assist them. All data collected is currently paper based, and too few Data capturers to enter data.</li> <li>• Traditional Practitioners doing trad. Circumcisions not co-operating – have had five reported deaths of young men this season already. Difficult to integrate them with the MMC prog.</li> <li>• Transport for CHW's limited, can't cover entire area in Wards.</li> <li>• No stationary, raincoats, gumboots, umbrellas.</li> <li>• Facility managers misunderstanding the WBOT concept at first.</li> <li>• Same CBO staff used as WBOT and are more resourced than WBOTs. WBOT and CBO action plans not harmonised.</li> <li>• Weak management support -WBOTs were not considered part of the clinicPoor training of operational management of WBOT. Trust of CHWs from the community is poor.</li> <li>• Some change career and train for nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Not all WBOTS are complete, limited transport, services rendered are disparate and spread out, geographic area is very spread out and scattered, making service delivery difficult.</li> <li>• When CHW contracts not renewed timeously, have a break in services.</li> <li>• Give the CHW confidence and ownership of the PHC Supervisors should also be involved in WBOT.</li> <li>• Household profiling not complete – only half done. Require a proper structure to manage the programme.</li> <li>• Need fully staffed additional data capturers for WBOT, not Facility aligned &amp; trained to enter WBOT data.</li> <li>• Need vehicles.</li> <li>• Standardise training for ALL categories of Workers.</li> <li>• Requested tablets to collect &amp; analyse data.</li> <li>• EHO used to do water sampling of water tanks- but now stopped.</li> <li>• CHW's have to go in pairs because of Security &amp; safety concerns.</li> <li>• Hierarchical relationship exists between facility nurses and WBOTs.</li> <li>• WBOT and other stakeholders not communicating re resolving management/operational obstacles.</li> <li>• Health prevention and promotion activities may become secondary to meeting social needs.</li> </ul>
<ul style="list-style-type: none"> <li>• Lack of resources</li> <li>• Nurses and doctors do not respond to back to back referral</li> <li>• No proper supervision by Sub district. Only Community based manager directly supervising WBOTs. Limited coverage, due to small no of WBOT &amp; CHW's.</li> <li>• Some CHW's prefer to stay in the Clinics &amp; not go out to HH.</li> <li>• Team Leaders (TL's) allocated to too many Wards.</li> <li>• CHW's should be attached directly and report to the Wards, not Clinics &amp; start work immediately in Wards, and not struggle to go to the clinics.</li> </ul>	<ul style="list-style-type: none"> <li>• Geographic area is very spread out and scattered, making service delivery difficult, to a population of 180,000 persons.</li> <li>• When CHW contracts not renewed timeously, have a break in services.</li> <li>• WBOTs do not have tools of service.</li> <li>• Interventions need to be focused, CHWs cannot provide comprehensive care for all</li> <li>• Bad weather</li> <li>• Clients referred by them not given priority.</li> <li>• Not all CHW's live in the Wards they work, due to historical employment of previous cadres of Health Workers such as DOT supporters, HBC, volunteers etc.</li> <li>• Improve working conditions of TL's, in this Libode Sub-district, they haven't been paid for 3 months, while awaiting contract renewals.</li> </ul>

TOPICS	RESPONSES	STRENGTHS
<p><b>2. Services rendered by WBOT</b></p>	<ul style="list-style-type: none"> <li>• Empower communities about why clinicians are doing this as they are guided by policies. Treatment used and treatment adherence. Give health education to communities. Identify treatment interruptions</li> <li>• Support &amp; empower communities on garden projects</li> <li>• Refer clients to nurses, doctors &amp; social development</li> <li>• Go to health post and imbizo's with health promoter for awareness campaigns, traditional leaders Purpose: reduce workload on clinics, do assessments, then refer to Clinics.</li> <li>• Do basic nursing care at HH level.</li> </ul>	<ul style="list-style-type: none"> <li>• Empower communities: motivate thru garden projects, work with CBO's, refer to social workers, doctors, nurses at clinics.</li> <li>• Also assist with outbreak investigations, MMC support and liaison with Traditional Practitioners.</li> <li>• Nurses appreciate that WBOT visit families that are afraid, unwilling or unable to come to the Clinics.</li> <li>• CHW's very motivated &amp; positive attitudes Integrate well with other services: education, Social development, Social workers, Child protection unit, abused children and women.</li> <li>• Undertake Screening, assessments, treatment &amp; referral to Clinics.</li> <li>• Able to be multi-purpose workers, addressing diverse issues- not just health problems, &amp; refer.</li> </ul>
<p><b>3. Interpersonal relationships between facility Professional nurses and WBOTs</b></p>	<ul style="list-style-type: none"> <li>• Good relations among health staff.</li> <li>• Through the MRU the CHWs, WBOT, PHC nurses and Hospital staff are getting to know each other.</li> <li>• Welcome the basic nursing care provided at household levels.</li> <li>• Nurses feel they are doing very good work in community.</li> <li>• Increase facility utilization rate</li> <li>• Brought abandoned children to facility and refer to social dept.</li> <li>• Good relationship with team leaders and other clinic staff.</li> <li>• Not good sometimes, because other facilities do not understand that WBOT assist others "We know the family &amp; patients we are reaching".</li> <li>• "We reach to their level, knock on their door- they feel honoured &amp; cared for".</li> <li>• "They (the families) trust us more than the Clinic nurses".</li> <li>• Affiliation to several Multiple Wards confuses the Clinic staff, because medicines from a service point are shared across service boundaries.</li> </ul>	<ul style="list-style-type: none"> <li>• The roles of the different health workers are becoming known and clearer.</li> <li>• Nurses appreciate that WBOT visit families that are afraid, unwilling or unable to come to the Clinics.</li> <li>• They have NHI truck for eye services that only accommodate two WBOTs- rotate amongst them.</li> <li>• Facility staff are greatly appreciative of our work; but insight of their work is lacking</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Slow responses to community needs</li> <li>• Interpersonal skills training lacking</li> </ul>	<ul style="list-style-type: none"> <li>• Team Leaders (TL) not always able to accompany CHW to HH visits. Hierarchical relationship exists between facility nurses and WBOTs Community needs, beliefs and expectations will only be known by CHWs and not rest of health care system We shouldn't only listen to complaints from Clients, we should have the full toolkit to render comprehensive services with all the basic equipment.</li> </ul>

TOPICS	RESPONSES	STRENGTHS
<b>4. Interpersonal relationships between ward councillors and WBOTs</b>	<ul style="list-style-type: none"> <li>• All attend Clinic Committee meetings, participate in imbizo's, community problem identification and referrals.</li> <li>• Also attend District office meetings to share, learn and interact with District staff.</li> <li>• Have Operational manager allocated to help WBOTs Good relations with most nurses.</li> <li>• Was bad at first due to improper introduction of WBOTs.</li> <li>• Good interpersonal relations with nurses at the clinic currently.</li> <li>• They share statistics.</li> </ul>	<ul style="list-style-type: none"> <li>• Councillors refer Community issues, problems &amp; families needing assistance to WBOT's.</li> <li>• CHW's lives in the communities served.</li> <li>• The facility managers support the program.</li> <li>• Participation in Imbizo's.</li> <li>• Trust, cooperation, Communities have confidence on them.</li> </ul>
<b>5. Interpersonal relationships between WBOTs and other stakeholders</b>	<ul style="list-style-type: none"> <li>• Some WBOT also involved with School health services; partly because SH Nurses not employed.</li> <li>• Regular good monthly meetings Clinic Committee attended by CHC Managers, Councillors, Chiefs, community members, and nursing staff.</li> <li>• "Taking services to the people".</li> <li>• Even Ward Councillors refer people to WBOTs.</li> <li>• Work with social development especially with teenage pregnancy</li> <li>• Health promoter give health talks about Male Medical Circumcision</li> <li>• Area with high death rate of initiates have circumcision team</li> </ul>	<ul style="list-style-type: none"> <li>• WBOTs attend District Office meetings to meet, share, learn and collaborate.</li> <li>• Good because trying to facilitate integrated services delivery, including CBO's.</li> <li>• Even child headed households assisted with food parcels, grants &amp; education".</li> <li>• Able to be multi-purpose workers, addressing diverse issues - not just health problems &amp; refer.</li> </ul>
<b>6. Management concerns</b>	<ul style="list-style-type: none"> <li>• If the Sub-District Managers Job description is too wide &amp; includes everything such as admin, HR, finances, supply chain etc.- then they spend too much time on admin; and not enough on management and supervision.</li> <li>• Quality services provided very much appreciated.</li> <li>• No support from managers.</li> <li>• Team leaders not consulted in management of WBOT</li> <li>• Do support visits inconsistently</li> <li>• Policy developed at National &amp; Province, only come to sub district for implementation.</li> <li>• No specific budget for WBOTs Municipal demarcation not addressed</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT's report to the Outreach Ops Manager.</li> <li>• Directly supervised by OTLs at their reporting facilities.</li> <li>• Have Community Based Manager at sub district office.</li> <li>• Organise food parcels, grants for needy people.</li> <li>• Change strategy of having 1 OTL serving several Wards, to be more flexible.</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Councillors have different mandates &amp; understanding of work of CHW's, this creates conflict.</li> </ul>	<ul style="list-style-type: none"> <li>• Accountability system put in place for community is a concern.</li> <li>• No office space for WBOTs.</li> </ul>
<ul style="list-style-type: none"> <li>• Some Traditional healers not co-operating.</li> <li>• Facility managers misunderstanding the WBOT concept at first.</li> <li>• WBOT and CBO action plans not harmonised.</li> <li>• Weak referral system due to unresolved operational/ management matters.</li> <li>• Only one environmental health officer for the area.</li> <li>• “They see us as visitors”.</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT and other stakeholders not communicating regarding resolving management / operational obstacles.</li> </ul>
<ul style="list-style-type: none"> <li>• Make the CHWs full time, permanent employees of DOH.</li> <li>• Need clear Mx structure from Community Based Managers to WBOT; and need more OTLs to be employed to assist them.</li> <li>• Need at least 2 Community Based Services Managers in this sub-district.</li> <li>• WBOTs were not considered part of the clinic before but there is improvement currently.</li> <li>• Weak management support.</li> </ul>	<ul style="list-style-type: none"> <li>• Give the CHW confidence and ownership of the Programme; thru full time employment.</li> <li>• PHC Supervisors should also be involved in WBOT.</li> <li>• Household profiling not complete – only half done.</li> <li>• Nearby houses, they walk, far away they get dropped off by transport, when available.</li> <li>• Household profiling not complete.</li> <li>• WBOT poorly introduced and managed.</li> <li>• Requires dedicated staff and Team leaders' roles are shared between WBOT and PHC clinics.</li> <li>• Shortage of personnel Some CHW are known as “Nomkhayas” – negative attitudes towards them.</li> </ul>

TOPICS	RESPONSES	STRENGTHS
<b>7. Resource constraints</b>	<ul style="list-style-type: none"> <li>• They are happy to serve their local communities.</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT &amp; CHW's have been initiated and being rolled-out.</li> </ul>
<b>8. Training of OTL/CHWs</b>	<ul style="list-style-type: none"> <li>• Gaps in their training identified. Multiple categories of workers - DOT supporters, CCG's, Home based careers, with different training standards.</li> <li>• WBOT team leaders are retired staff, and not replaced when there is a vacancy.</li> <li>• Dedicated but disadvantaged by circumstances.</li> <li>• OTL's had 1 week of Orientation, 1 week of School H services &amp; in-service training.</li> </ul>	<ul style="list-style-type: none"> <li>• Most CHWs did the 10-Day training; but also did School H services, IMCI, BANC, ESMOE, and ORT.</li> <li>• 15 CHWs undergoing Second Phase training.</li> <li>• Lay Counsellors are clinic based. KSD piloted tablet based data collection via an NGO.</li> <li>• Quality of WBOT training is good, they have the tools to collect &amp; analyse data.</li> <li>• Have had extensive short courses training - chronic dis mx, VCT, HIV TB, IMCI Some CHW's attended joint training with TL's - not all.</li> <li>• OTL's give on - job training to CHW's.</li> <li>• Some CHW's attended joint training with TL's- not all.</li> </ul>
<b>9. Operational challenges</b>	<ul style="list-style-type: none"> <li>• There are some WBOT Indicators in the DHIS, but not fully used.</li> <li>• WBOT provides multi-disciplinary services, including going to Schools to identify children in need.</li> <li>• Report problems &amp; crises to Clinic committees &amp; Ward Councillors.</li> </ul>	<ul style="list-style-type: none"> <li>• Some CHW's are doing practical as part of the 1 year Course.</li> <li>• Integrate well with other services: education, Social development, Social workers, Child protection unit, abused children and women.</li> <li>• Willing to learn.</li> </ul>
<b>10. WBOTs success</b>		<ul style="list-style-type: none"> <li>• WBOT's increasing staffing resources; providing tablets for data capture- can all assist in Community diagnosis &amp; improve Indicators and Health status.</li> <li>• All staff members in the CHC appreciate the WBOT's.</li> <li>• Upgraded health services, we can reach communities easily".</li> <li>• Even Community problems are channelled thru them".</li> </ul>

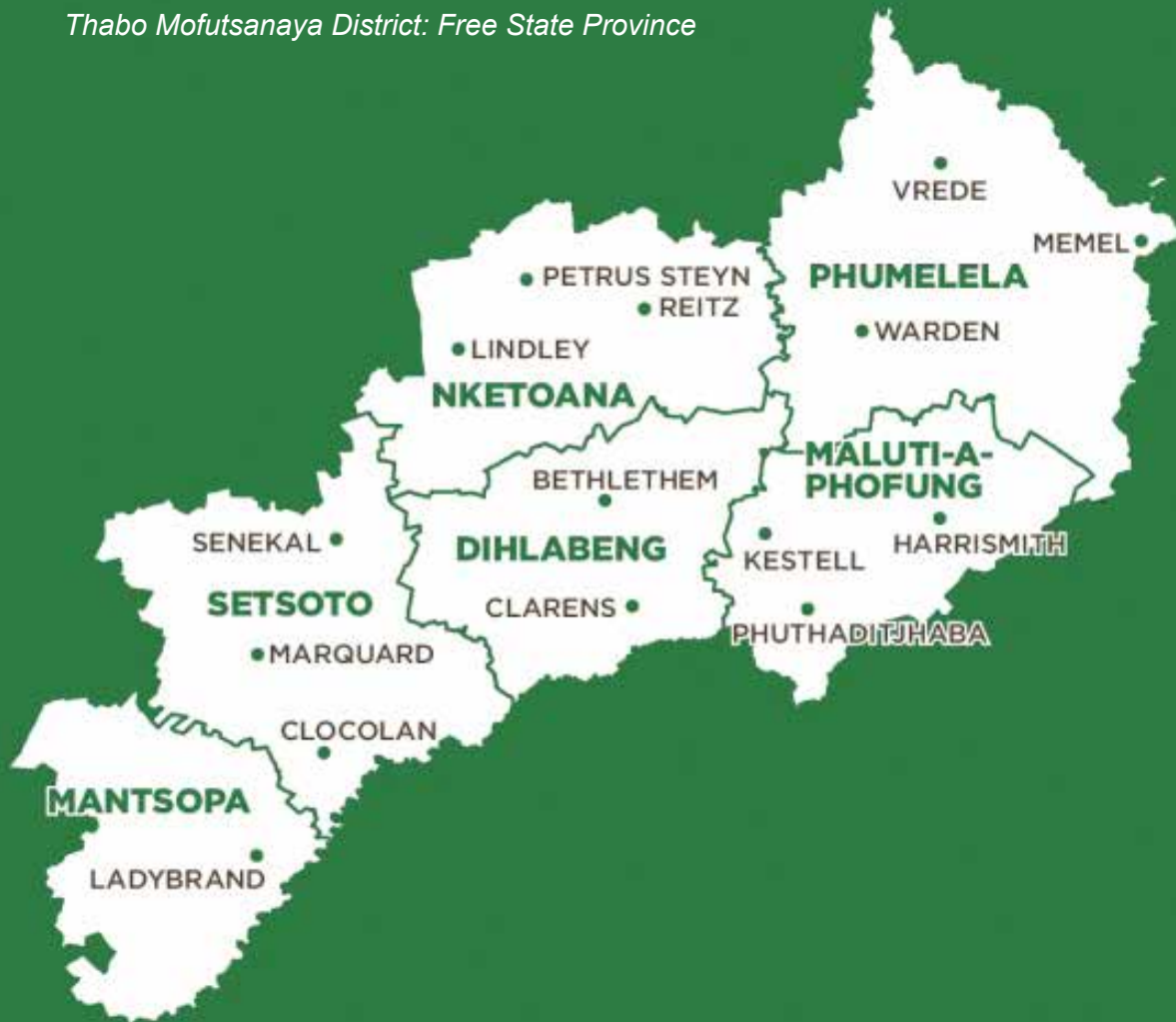


WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Lack of transport, kits, equipment, rainwear, supervision &amp; support from TL.</li> <li>• No cars to travel.</li> <li>• Some have no tool kits.</li> </ul>	<ul style="list-style-type: none"> <li>• Poor management support, co-ordination and consultation to address these issues and constraints.</li> </ul>
<ul style="list-style-type: none"> <li>• CHWs need further training &amp; development. Current training is inadequate.</li> <li>• Larger team of CHW's can support &amp; motivate each other.</li> <li>• Poor training of operational management of WBOT/daily implementation of WBOTs Trust of CHWs from the community is poor.</li> <li>• Requested continuous in-service training in clinical protocols, medications regimes - to both update &amp; provide good quality care.</li> </ul>	<ul style="list-style-type: none"> <li>• Standardise training for ALL categories of Workers.</li> <li>• Currently CHWs doing Second Phase training of 1 year, and Practicals- need to be supported.</li> <li>• Training of daily WBOT activities for the CHWs is the team leaders' responsibility - because of no management skills they are unable to train CHWs on activities that fall outside of the clinic.</li> <li>• Community profiling system based on incorrect information, which will discredit the programme.</li> <li>• Even though OTL's are retired nurses, they need to be updated on current policies, procedures &amp; practises.</li> <li>• Some CHW's can't write, not matriculants in E Cape.</li> </ul>
<ul style="list-style-type: none"> <li>• All data collected is currently paper based, and too few Data capturers to enter data.</li> <li>• In the beginning attitudes of CHWs was very negative, but now is much more positive and supportive of the work.</li> <li>• Prefab rooms not suitable for morale &amp; data entry.</li> <li>• Demotivated WBOTs - some change career and train for nursing.</li> <li>• As OTL's we constantly need in-service training, as nursing is dynamic &amp; ever-changing".</li> </ul>	<ul style="list-style-type: none"> <li>• Requested tablets to collect &amp; analyse data.</li> <li>• Require 2nd Phase Training for CHWs.</li> <li>• CHW's have to go in pairs because of Security &amp; safety concerns.</li> <li>• "Allow contract workers to drive vehicles - makes the work easier".</li> </ul>
<ul style="list-style-type: none"> <li>• Contract and short term employment creates uncertainty and discontinuity in service delivery.</li> <li>• No health related success of WBOTs was raised by team leaders Clinic PN staff, Councillors, other sectors- gradually accepting them.</li> </ul>	<ul style="list-style-type: none"> <li>• Social health needs in the community are overwhelming WBOTs</li> <li>• Health prevention and promotion activities may become secondary to meeting social needs.</li> <li>• While most HH families are respectful &amp; accept them &amp; their services; a few are still negative and reject them.</li> </ul>

TOPICS	RESPONSES	STRENGTHS
<p><b>10. WBOTs success</b></p>		<ul style="list-style-type: none"> <li>• Many benefits for Ideal Clinic strategy &amp; compliance with NCS- WBOT's / CHWs can significantly contribute to meet these goals.</li> <li>• Primary focus of PHC clinics is Community development, empowerment and support – WBOT can assist greatly.</li> <li>• They assist the nursing &amp; medical students from WSU Health Sciences Faculty to learn about Community Based H Care, do house visits &amp; interviews, and clinical care at HH / Family levels.</li> <li>• Assisted communities to get toilets in most villages, water tanks, social and child support grants, birth certificates, wheel chairs, food parcels, and crutches.</li> <li>• Organized RDP house for disadvantaged family.</li> <li>• Organised wheel chair for needy client.</li> <li>• Established garden project for communities at Ngqeleni including seedlings.</li> <li>• Medical equipment availability.</li> <li>• Multi-disciplinary team to render services to communities and schools.</li> <li>• Documents that we submit to the facility manager each month.</li> <li>• Process flow of information submitted by WBOTs to DHISA Ability to trace defaulters</li> </ul>

WEAKNESSES	CHALLENGES

*Thabo Mofutsanaya District: Free State Province*



The rapid appraisal of Ward Based Outreach Teams (WBOT) is a national project conducted at the request of the NDoH pilot sites in seven provinces. The Free State is one of the seven provinces selected for the study. The Albertina Sisulu Executive Leadership Programme in Health (ASELPH) undertook the rapid appraisal. The purpose of the research is to review the current status of WBOT in Free State Province and to identify factors that impact on the effective and efficient functioning of the WBOT in the Province.

The Free State field research team:

- Prof CC Jinabhai
- Prof DT Goon
- Mrs T Mtise
- Mrs NM Vellem
- Ms M Hlabahlaba

University of Fort Hare

# 1. OVERVIEW

A WBOT preparatory meeting was held at Thabo Mofutsanyana New Mantsopa hospital board room on April 14, 2015. Two sub-districts were identified (Mantsopa and Setsoto) and two (2) Peer Reviewers from each sub district were selected to work with the research team.

Self-assessment forms were distributed to all the senior management members, together with copies of WBOT documents. The methodological approach based on documentary reviews, structured interview questionnaires and direct field observations was outlined. Managers were requested to complete the self-assessment questionnaire and submit them with other relevant documents to the research team during their field visits. Below is the report of the five-day rapid appraisal conducted in these two sub-districts.

## 2. Work Plan and Implementation

The rapid appraisal of the two sub-districts in Free State was conducted between the 4th and 8th of May 2015.

Below is the report of the five-day rapid appraisal conducted in these two sub-districts in the week ... 2015.

<b>Day 1:</b>	The research team met with the WBOT Manager and coordinators in the two sub-districts to strategize and plan weekly activities pertaining to the WBOT Rapid Assessment. Documentation requested prior to field research was collected (Appendix A) in addition to the WBOT self-assessment questionnaires (Appendix B). Two peers from each sub-district were identified to join the research team. A focus group discussion was run with 4 CHW in Mantsopa sub-district were interviewed (focus group) and interviews were conducted with the WBOT District manager, team leaders and 6 households.
<b>Day 2:</b>	Two focus group discussions were held (11 CHWs) and interviews were conducted with 2 district managers and 12 households (Maqheleng, Setsoto sub district).
<b>Day 3:</b>	Two focus group discussions were held (10 CHWs) and interviews were conducted with 2 district managers and 11 households (Senekal, Setsoto sub district).
<b>Day 4:</b>	The results of the qualitative data collected in Free State were analyzed.
<b>Day 5:</b>	Preliminary findings from the data collected in the two sub-districts were presented and discussed in a peer learning workshop with the WBOT district manager, the district coordinator, PHC: DD, Local Area Managers, Clinic Managers attached to WBOT, WBOT OTLs, Quality Assurance Manager and DIO.

## 3. FINDINGS

Findings from the fieldwork are presented in three sections:

- 3.1. CHW Individual Interviews analysis
- 3.2. Household Interviews Analysis
- 3.3 WBOT Management Thematic Analysis.

### 3.1 Community Health Worker Individual Interviews

#### Services

The respondents maintained that WBOT is geared towards promoting health and wellness, reducing illness, HIV prevention, malaria awareness, preventing illness and providing education to avert maternal and child mortality, as well as sharing information in the community. WBOT provides a range of services to the community, including basic services, social services, counseling and support, promoting adherence to medication and treatment, screening for TB, HIV and hypertension, referral services, conducting health talks on teenage pregnancies, contraceptives, cancer, need for HIV screening and testing, importance of good diet and household registration.

The WBOT expressed a sense of satisfaction and, self-fulfillment and contentment in providing the health services to their community.

*“Though at the beginning, they were reluctant, shy opening to us. But with time, they trust us and now feel free to tell us about their health problems. We feel happy helping them”.*

The CHWs report that relationships between themselves and the community are good and warmly welcomed. They feel passionate and motivated because they are helping the community.

*“We like helping our communities. The community smile when they see us, and clients feel grateful when they are helped by us. We like working with people. It makes us feel important and proud. We like the way community treat us”.*

According to CHWs, morbidity rates seem to be decreasing as many clients are taking their chronic medications regularly at home. Initially, CHWs were not recognized in the community but now they have gained their trust and confidence and thus are accorded respect and recognition.

#### Cooperation and Partnerships

Although some professional nurses are supportive, CHWs report that many are antagonist, uncooperative and arrogant, a lot of work in the clinics. Apart from working in the WBOT, they also work at the clinics without any recognition.

*“Sometimes the nurse(s) give us support with our referrals. Sometimes they do not want to fill out our forms, complain that we are referring many patients to them. They complain that we bring more work ...they want us to help in the clinic before going to the community”.*

*“At times they would refer to our work as ‘this thing of yours’, ‘this re-engineering of yours’. This makes us frustrated. Most of the nurses look down on us. We work as slaves at the clinic, but our work is not recognized”.*



In Mantsopa sub-district, CHWs report that ward councilors are uncooperative, whereas exactly the opposite pertains in Setsoto sub-district.

There

*“The Ward councilors are good, even offered us offices to use. They are very supportive, follow our referrals, always inviting us in their meetings”.*

In Senekal, the CHWs stated that it depends on the individual counsellor. Some are cooperative while others are not.

## **Operational constraints**

The CHW narrated various challenges of WBOT in the two sub-districts. Notable amongst these were

- a general lack of resources (human and material);
- too few CHWs to cover a vast geographical area;
- no stationery, office and cabinet for filling their documents or papers;
- lack of transportation; many a times, the OTL would use their cars for visits.
- irregularity of payment of their stipend (R1800);
- poor or inadequate management
- little support for problems and complaints.

*“When we complain to the OTL there is nothing she can do. She does not get answers from management...She jsut gets told “I will buy you a loaf of bread and a tin of fish”.*

*“We have no shoes, not supervised by the NGO, no support, no recognition. We are working 4 hours in the clinic and 4 hours in the community with little stipend of R1800”. We spend our money buying stationery. At the clinic, we are allowed to print only 10 papers. We then have to look elsewhere to print the papers”.*

*“The management of WBOT is poor; they do not recognize our work and information is not communicated to us in time or not at all”.*

Their work and their reception in the community is affected by failed service follow-up. It takes them a long time to repeat a household visit because of the vast areas they have to cover and because the teams are too few in number for the need.

Overall they prefer working in the community than in clinic and generally regard the WBOT as a good program.

In terms of training CHWs have completed Phase 1 and 2 of WBOT training in Mantsopa sub-district, whereas in Senekal, while all the CHWs had phase 1 training, only 3 CHWs have undergone phase 2 training. They also report having been trained for foundation learner certificates (FLC) which exposed them to health issues.

They however, found FLC too difficult because of the mathematics component.

## Suggested Improvements

In Mantsopa Sub-district, the CHWs highlight that the structure of WBOT is incomplete. The WBOT has only four CHWs, which means that they are unable to cover many areas. They recommend that at least 2 more CHWs be appointed to help in order to reach areas in the community that are not covered.

In Setsoto Sub-district, CHWs would like monthly meetings to be held with them in order to share their experiences, challenges and plan for health campaigns. They would also like to be represented in the clinic management meeting.

*“The clinic sisters talk about their problems in the meeting not our problems”.*

CHWs indicate that they also want to be paid regularly, they want to be paid by the DoH and they would like an increment in their stipends.

In addition, they suggest that the mobile/container should be taken nearer to the community, as this will solve the problem of long queues at the clinic and that the WBOT are provided with test kits.

## 3.2 Household interviews

### Experience with WBOT and what they do

CHWs are seen to be working in the community.

*“I have met one, they come every month, they treat us well, they are always available, I find it very important, people are sick in the household and they do not have money to go to the clinic. The CHWs come to see us often, maybe 3 times a week”.*

CHWs were known to care about their health. They said they asked people about chronic medication and even collected medications from the clinic for them. They said CHWs also gave them health education on treatment adherence and side effects of non-adherence to treatment, HIV, TB and hypertension, pregnancy and contraceptives, etc.

Household members reported:

*“After I have visited the clinic, they do follow up to see if I take the treatment; assess people who are sick and assist them, come to check whether I have taken my medication, ask about my medication and clinic card. They would inquire if I have any problems; check the children, remind us about the next clinic visit, and ask us about TB symptoms, encourage us to go for HIV testing, refer our sick child to the clinic, and do household registration.”*

### Feelings about the services provided by WBOTs in the community

People interviewed in the community appreciated and felt positive about the services provided by the WBOT.

*“It helps a lot. I was afraid to go to the clinic, they told me about the importance of going to the clinic. I had an STI and now I feel better. I have never heard anyone in the streets talking about my illness. They hold confidentiality very well”.*

*“They are helping a lot. They bring the treatment to our houses. Ever since they have come, I have accepted my status”.*

*“They are always smiling and friendly, they came in the house when I was very sick and tested me and started treatment. Now I am fine and appreciate their service”.*

They describe CHWs are dedicated, hardworking and as providing a good quality service that is practiced with integrity.

*“With their assistance my child got well”.*

*“They help us a lot, we like them. The quality they give us is good because it is the same thing we hear at the clinic. They know how to explain the pills and assist”.*

*“Being able to disclose without any fear and they helped me to talk about my status without any fear. They listen to me and assist me. They are very patient with to us”.*

Several point out that there is a problem with the regularity and follow-up of CHW visits that leads people to miss medications and to not see them as regularly as they feel they should.

Generally, however, people interviewed in the community like WBOTs because they save them time and CHWs are respectful.

*“It is on the same level as the clinic for me. As a CCG myself, I would say they provide higher quality than CCG. The service is good because it is for free, and they visit you at your house. They are good they tell the truth unlike other structures. There are no other structures except clinic and hospitals and their attitude is the same. CHWs are better than the clinic. At the clinic people are shouted at especially when they defaulted in treatment. They provide equal services as the clinic because CHWs answer the same way as the nurses at the clinic when I ask questions. They work very hard. If I could, I would swap them with the clinic nurse. The nurses shout at us”.*

*“The communication is good. We have a good relationship with them. They give us knowledge about our illnesses. CHWs are knowledgeable educating us about side effects and health issues. They are nice and kind and willing to assist. The most important is when they remind us about family planning days. They make those who didn't normally go to the clinic to go”.*

## **Recommendations to improve WBOT**

People in the community suggested the following improvements:

- More recruitment of CHWs to perform more frequent and regular visits
- Considering the vast area WBOT CHWs cover, the government should provide WBOT CHW with transport to serve the community better.
- Households would like professional nurses to visit them too
- They should be provided with testing kits for HIV, diabetes and BP machine so they will lessen visitation to the clinics.

One household stated:

*“Government should provide more money to the CHWs because they work very hard, the way I see them they are like nurses. They should be taken to nursing school and improve their career”.*

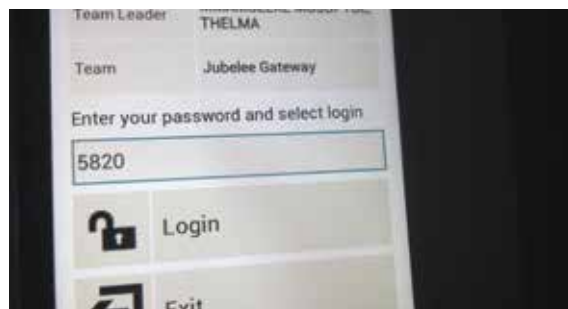
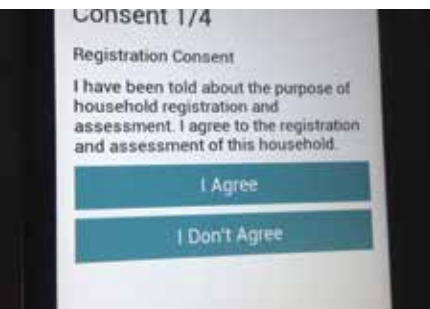
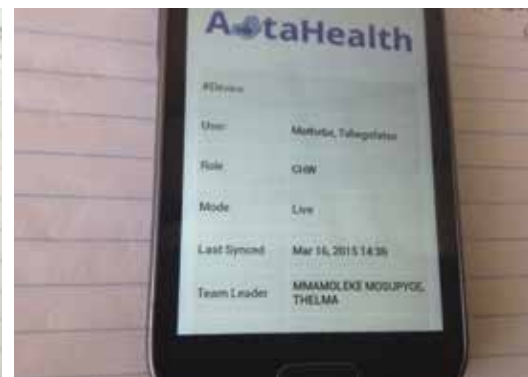
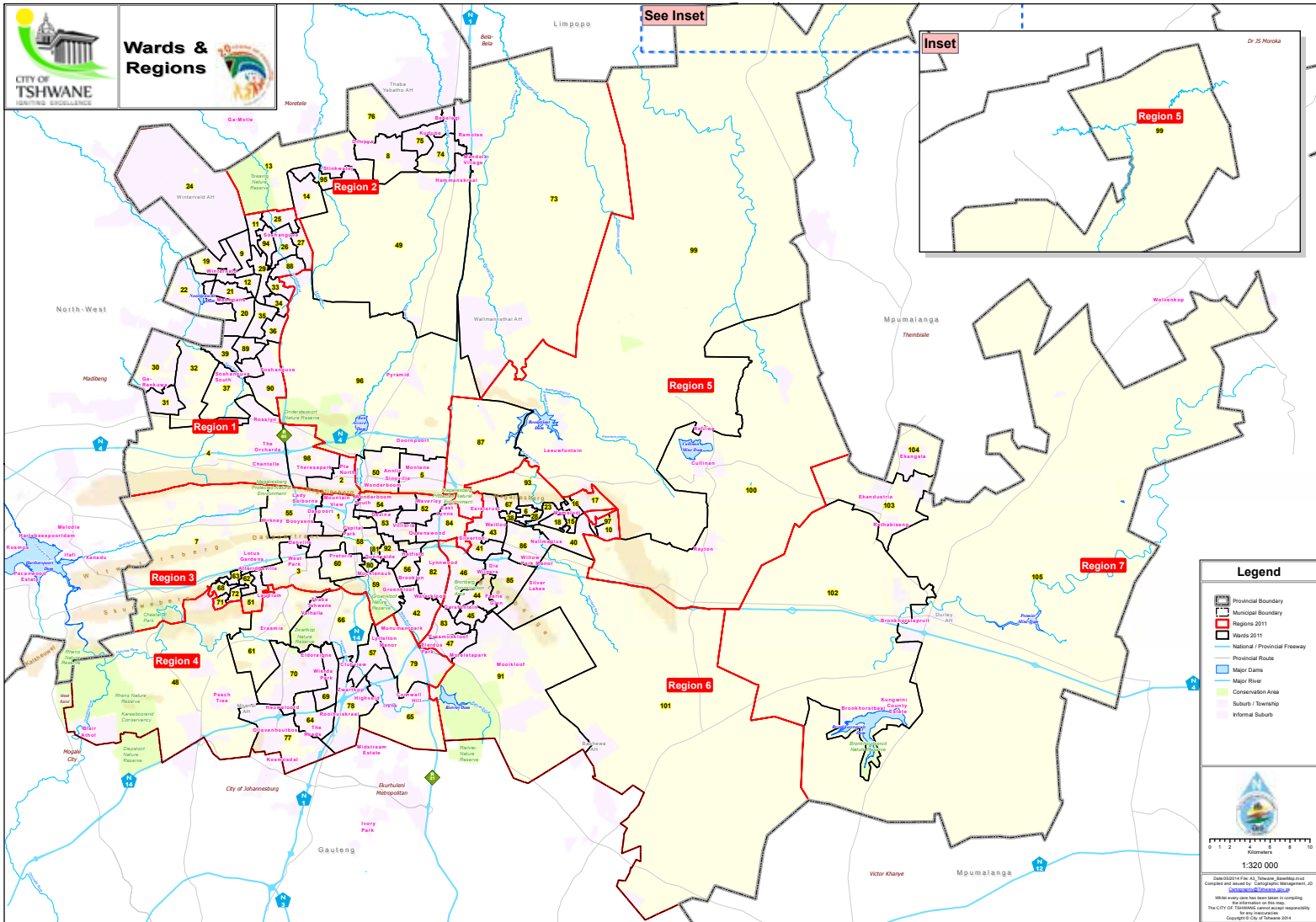
# WBOTS MANAGEMENT INTERVIEWS: THEMATIC ANALYSIS

TOPICS	RESPONSES	STRENGTHS
1. Knowledge about WBOTs	<ul style="list-style-type: none"> <li>• Team working hand in hand with the community and are the helping hands of the clinic, ears and eyes of the clinic</li> <li>• Promote, prevent illnesses before they occur and refer to clinic, and reduce the load</li> <li>• 297 CHW</li> <li>• 38 wards</li> <li>• 240 Assessed for the career pathing</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge of Palliative care.</li> <li>• Manual as a guide</li> <li>• One manager has been trained as WBOT.</li> <li>• An enrolled nurse who works as a team leader worked with the WBOT leader who was trained before pension.</li> </ul>
2. Services rendered by WBOT	<ul style="list-style-type: none"> <li>• Focus in more palliative, TB, HIV/ AIDS adherence, home base, MNCWH</li> <li>• Household registration</li> <li>• Promotion and prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Provide equipment for service</li> </ul>
3. Interpersonal relationships between facility Registered Nurses and WBOTs	<ul style="list-style-type: none"> <li>• There is good relationship because of the good statistics from the facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Each facility got CHW's manuals as the guide</li> </ul>
4. Interpersonal relationships between Ward Councillors and WBOTs	<ul style="list-style-type: none"> <li>• No relationship except ONE ward councillor who support</li> </ul>	
5. Interpersonal relationships between WBOTs Managers and District Coordinators	<ul style="list-style-type: none"> <li>• No clear lines of communication, poor coordination between District and facility managers who act as OTLs, Area managers &amp; Hospice.</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of Departmental cars, internet and phones</li> </ul>
6. Interpersonal relationships between other stakeholders and WBOTs	<ul style="list-style-type: none"> <li>• Poor relationship</li> </ul>	
7. Management processes	<ul style="list-style-type: none"> <li>• Irregular unequal payments of stipends from Social services R1500 and Health R1900. District manager and WBOTs coordinator have no control on the payment of stipend.</li> </ul>	<ul style="list-style-type: none"> <li>• DOH have capacity to pay as the system is available</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>No training for the management</li> <li>One Registered nurse trained on WBOT resigned, other one took pension, other one transferred to hospital</li> </ul>	<ul style="list-style-type: none"> <li>No retention and unavailability of Professional nurses interested in the district.</li> <li>No team leaders for WBOTs</li> <li>Available OTLs are facility based</li> <li>Community supervision rate: nil20.</li> </ul>
<ul style="list-style-type: none"> <li>Lack of coordination amongst managers</li> <li>Poor communication amongst managers</li> </ul>	<ul style="list-style-type: none"> <li>Disruption to the services</li> <li>Confusion to WBOTs and clinic where they report</li> </ul>
<ul style="list-style-type: none"> <li>Not giving full attention on WBOT due to gross shortage</li> </ul>	<ul style="list-style-type: none"> <li>Shortage of staffUnavailability of OTLs</li> </ul>
<ul style="list-style-type: none"> <li>No proper introduction of WBOT to councillors</li> </ul>	<ul style="list-style-type: none"> <li>No cooperation and enough support from councillors</li> </ul>
<ul style="list-style-type: none"> <li>District coordinator with multi task as managing care and support and WBOTs. No dedicated manager focusing solely to WBOTs</li> </ul>	<ul style="list-style-type: none"> <li>Uncoordinated services Late communication</li> </ul>
<ul style="list-style-type: none"> <li>Other stakeholders lack knowledge of the programme</li> </ul>	<ul style="list-style-type: none"> <li>No response when there are referrals to other stake holders.</li> </ul>
<ul style="list-style-type: none"> <li>Late submission of report by Hospice quarterly in order for WBOTs to receive their stipend at regular identified date.</li> </ul>	<ul style="list-style-type: none"> <li>Payments of WBOTs are under health but via Hospice.WBOTs performing the same job but different benefits (training and reimbursement)</li> </ul>

# WBOT RAPID APPRAISAL: TSHWANE DISTRICT, GAUTENG PROVINCE

Map of Tswane District - Gauteng Province





# 1. OVERVIEW

The rapid appraisal of the Ward Based Outreach Teams (WBOT) is a national project conducted by the Albertina Sisulu Executive Leadership Programme in Health (ASELPH) at the request of the NDOH. Gauteng is one of the seven provinces selected for the study. The purpose of the research is to review the current status of WBOT and to identify factors that impact the effective and efficient functioning of the WBOTs in Gauteng

The research team:

- Dr. Armelia Chaponda
- Mr. Masilo Malema
- Sr. Lilian Shehanke
- Mrs. Pauline Ngobeni - CHW
- Mrs. Nonhlanhla Nthete - ENA
- Mrs. Virginia Nchere - CHW

University of Pretoria

On 5th March 2015 a preparatory meeting was held at the Gauteng Department of Health.

The methodological approach, based on documentary reviews, structured interview questionnaires and direct field observations were outlined and the relevant documents and forms were shared with the senior management team of the district. Senior management officials were requested to complete the forms and there after return them to the research team during field visits.

Sub-districts Tshwane 1 (Soshanguve) and Tshwane 2 (Hammanskraal) were identified as study sites.

A peer from each sub-district was identified to join the research team. Below is the report of the five-day rapid appraisal conducted in these two sub-districts between 11-15 May, 2015.



## 2. WORK PLAN AND IMPLEMENTATION

<b>Day 1:</b>	A discussion of the WBOT programmes in each sub-district was followed by a debrief session on expectations of all for the week. The week's activities were planned and meetings with facility managers and CHWs were confirmed.
<b>Day 2:</b>	The research team divided into two and visited each sub-districts. Interviews were conducted with all 12 CHWs. The clinics visited were large and had sufficient space where the interviews were held.
<b>Day 3:</b>	A number of interviews were conducted with individual households in isiZulu, Setswana or a combination a combination of the two as well as English.
<b>Day 4:</b>	Data was reviewed for completion and preliminary findings summarized for presentation.
<b>Day 5:</b>	Preliminary findings for the two sub-districts were presented and discussed with the District WBOT manager and OTLs.

## 3. FINDINGS

Findings from the fieldwork are presented in three sections

- 3.1. CHW Individual Interviews Analysis
- 3.2. Household Interviews Analysis
- 3.3. WBOT Management Thematic Analysis

### 3.1. WBOT Community Health Worker interviews

#### WBOT services

WBOTs work in the assigned community from Monday to Thursday from 8am to 2pm. Each household visit takes between 30-45 minutes depending on the nature of issues encountered. Friday is spent doing administration and in-service training.

Not all municipal wards within the district have WBOTs. The number of households assigned community health workers range from 200 to 310. OTLs supervise between 6 and 41 CHWs each. WBOT activities include individual health assessments, referrals to clinics and relevant departments and home based care, such as bed baths and dressings.

#### Partnerships

Referrals for social problems are made to the Department of Social Development. There has not been any interaction with environmental health officers (EHOs). Health promoters collaborate with WBOTs on health education campaigns in some areas. Some areas are not covered due to transport constraints. The district manager is active and coordinates information utilized for community health education campaigns.

### 3. FINDINGS

#### Data collection and reporting

Data is collected using both hard copies/forms supplied by the DoH and hand held devices. Not all CHWs were trained on the use of the device and the balance is yet to be procured. CHWs prefer the hand held device for data collection as it is fast and reliable (for data storage). However, they do encounter a few network problems.

Data collected on hard copies is cumbersome to file as there is insufficient space for filing in the support clinics and no lockable cupboards are available.

Meetings with team leaders are inconsistent - sometimes they are held weekly and not all CHWs attend WBOT meetings.

*"We hold meetings with the sister, but only sometimes"*

The method of reporting of information is also inconsistent. A few CHWs occasionally give oral reports to the team leader and others are given via hand written notes and short message service (sms).

#### Operational constraints and suggested improvements

Incomplete training of CHWs - not all CHWs were trained on WBOT short course. A few CHWs were recruited after the training was done and are currently working in the community without any training.

*"Top up training is needed due to the fact that no formal training was offered by WBOT, but there was a first group that had already been trained and joining the team I had to follow the footsteps of the first group of CHWs, whereas I feel even they are not competent with the WBOT programme"*

Selection criteria for additional top-up training may not be communicated to all and is causing unease.

*"I feel that we must be trained in other things like HIV/AIDS, TB, Nutrition and not only specific people be trained. When they train Joyce, the next training they should send Rebecca. Not one person for all the courses"*

#### Shortage of CHWs - not all wards have WBOTs.

*"Yes there are vacancies, the community needs more CHWs and need us more with regard to giving them information, referrals to relevant place. I feel the workload is too much. It would be better if there are more CHWs in the field"*

No name tags and uniform - CHWs would like to be identified by means of a name tag and uniform because they experience resistance in the community for not wearing proper identification.

*"Some community members don't gain trust that we are from the Department of Health. They feel that we are there to rob them"*

*"We must be given name tags to identify us because even the community wants to see the name tag when we introduce ourselves"*

Regular payments of stipends - Inconsistent payments of stipends cause uncertainty of employment.

*"Sometimes we are not paid every month. Last time we got paid after 3 months and when that happens we get backdated and they pay all the money owed to us. Yes it is a lot of money for that month when it comes like that. But in the mean time you are struggling. You can't come to work when your family does not have food. Better you stay and look for other work to feed your family"*

A few barriers raised are those of mistrust, lack of interest in the programme, cultural preferences of not having females care for males who are bedridden and require palliative care.

Some CHWs are currently doing health assessments and find it challenging as community members prefer that they perform the same functions as home based care givers who assess their vital signs.

*“But some give us a hard time as now we are doing household registration and not taking their vital signs anymore and I think if we can get working resources it will be fine in the community”*

Community is unprepared for WBOTs - Certain communities were not familiar with the programme, hence community members do not cooperate with teams.

*“I think this programme affected them negatively, because they did not understand what we were doing, asking questions, wanting their identity documents and stuff”*

## 3.2 Household interviews

### Experience with WBOT and what they do

People interviewed in the communities were generally satisfied with the WBOTs They reported that CHWs give advice on health related matters, assess immunization records of children, assess adherence to treatment and do referrals to the clinic and assess whether the household requires social assistance.

*“They ask if there is anyone who is ill and taking treatment and also assist them. Teach us about cleanliness and behaviour and how we care for HIV positive persons”*

Feelings about the services provided by WBOTs in the community.

There are mixed views. Some people prefer the previous Home Based Care programme where CHWs were providing tangible health services.

*“I prefer the first programme where they were doing home base care, to see how my blood pressure is doing. They assisted me with pills and the rub-rub when my body was not good.”*

Others are generally satisfied with the services provided. Community members stated that they get their medication delivered to them and have their vital signs taken.

### Recommendations to improve WBOT:

Additional training in health

*“Take the nurses to school so that they can know more about health. Give them cars, because when it rains we do not get medication”*

Deliver medication - Not all areas have medication delivered by CHWs

*“To bring medication, because I am in a wheelchair and my mother is old. Every time I go to the clinic I have to hire someone. I would be glad if the CHW brings my medication”*

*“To bring me medication when I am unable to come to the clinic, because also at the clinic we are waiting a long time for long queues. I think to avoid these long queues they should bring us medication at home and check our blood pressure”*



# WBOTS MANAGEMENT INTERVIEWS: THEMATIC ANALYSIS

TOPICS	RESPONSES	STRENGTHS
1. Knowledge about WBOTs	<ul style="list-style-type: none"> <li>• Taking PHC from facilities to the community</li> <li>• Visiting households to identify problems and refer to relevant stakeholders</li> <li>• Individual health assessments, assess families holistically</li> </ul>	<ul style="list-style-type: none"> <li>• Commendable understanding of WBOT concept</li> <li>• A few OTLs are trained in computer literacy</li> </ul>
2. Services rendered by WBOT	<ul style="list-style-type: none"> <li>• Register patients and do health assessments</li> <li>• Provide holistic care</li> <li>• Early detection of illnesses</li> <li>• Do health promotion</li> <li>• Do referrals to relevant stakeholder</li> </ul>	<ul style="list-style-type: none"> <li>• Determinants of health responded to (social issues)</li> </ul>
3. Interpersonal relationships between facility Registered Nurses and WBOTs	<ul style="list-style-type: none"> <li>• Engage all ward counsellors more-some are not available ('even when you make an appointment, they don't turn up')</li> </ul>	<ul style="list-style-type: none"> <li>• A few ward counsellors are supportive</li> </ul>
4. Interpersonal relationships between WBOTs and other stakeholders	<ul style="list-style-type: none"> <li>• Require sensitizing of community members, ward counsellors, other municipal leaders</li> <li>• Education department provides for room as WBOT meeting place (classrooms)</li> <li>• Religious sector active</li> <li>• Facility managers require in-service training in WBOTs and operations</li> </ul>	<ul style="list-style-type: none"> <li>• Support from education department commendable. Collaborative relationship has resulted in WBOT using classroom at school as health post</li> </ul>
5. Interpersonal relationships between WBOTs Managers and District Coordinators	<ul style="list-style-type: none"> <li>• Community not well informed on the initiation of WBOT</li> <li>• Pressure to implement and expand the programme</li> <li>• Appointment and placement of personnel took significant time</li> <li>• Storage of paper based statistics in the clinics problematic</li> <li>• Require more CHWs</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of Departmental cars, internet and phones</li> </ul>
6. Training of CHWs	<ul style="list-style-type: none"> <li>• 6 team leaders trained as trainer of trainers and assessors</li> <li>• 70% of CHWs were trained in phase 1-90% of OTLs were trained</li> <li>• CHW accredited course commenced in May 2015-Some team leaders were trained in computer literacy</li> <li>• Training support partner contract ended</li> <li>• Training was put on hold</li> </ul>	<ul style="list-style-type: none"> <li>• Training done by FPD</li> <li>• Standards utilized</li> <li>• Training evaluation done</li> </ul>



WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>No management training</li> </ul>	<ul style="list-style-type: none"> <li>Lack of management training result in poor CHW management and supervision</li> </ul>
	<ul style="list-style-type: none"> <li>Ward based outreach programme's support system (stakeholders) are weak</li> </ul>
<ul style="list-style-type: none"> <li>Weak political support. Could have used the opportunity of gaining more support for the programme</li> </ul>	<ul style="list-style-type: none"> <li>Ward based outreach programme's support system (stakeholders) is weak. Programme cannot be successful as stand-alone activity</li> <li>Community and health system factors may affect programme effectiveness</li> </ul>
<ul style="list-style-type: none"> <li>Community cooperation may be wanting if not properly sensitized</li> <li>Facility managers should have been prepared prior to programme implementation</li> </ul>	<ul style="list-style-type: none"> <li>Poor community acceptance of WBOTs</li> <li>Community factors may affect programme effectiveness</li> <li>WBOT link to the clinic needs</li> </ul>
<ul style="list-style-type: none"> <li>Programme started prior to sensitization of the community and health fraternity</li> <li>Infrastructure insufficient</li> <li>Wards are not all covered with WBOT</li> </ul>	<ul style="list-style-type: none"> <li>Community buy-in and collaboration slow</li> <li>Potential health and social problems go undetected</li> <li>Teams affected by low morale caused by insufficient space and CHWs</li> <li>Despondent teams</li> </ul>
<ul style="list-style-type: none"> <li>No support in training therefore slow progress</li> <li>Computer literacy training for team leaders outstanding</li> </ul>	<ul style="list-style-type: none"> <li>CHWs and team leaders are currently working without the requisite skills</li> <li>Risk poor programme progress</li> <li>Trainer of trainers (TOT) numbers not up</li> <li>Team confidence a concern</li> </ul>

TOPICS	RESPONSES	STRENGTHS
7. Operational challenges	<ul style="list-style-type: none"> <li>• Difficulties procuring hand held devices</li> <li>• Require suitable health posts</li> <li>• Integration with the City of Tshwane was challenging</li> <li>• Poor stock replenishment in CHW bags</li> <li>• Infrastructure challenges - space in clinics</li> <li>• Information Technology challenges with hand held devices</li> <li>• CHWs still require training in order to receive hand held device</li> <li>• Some team leaders still require laptops</li> <li>• Team leaders are also required to work in the clinics</li> <li>• Not all CHWs are confident with use of hand held device</li> <li>• Require transport</li> </ul>	<ul style="list-style-type: none"> <li>• DOH have capacity to pay as the system is available</li> </ul>
8. WBOTs success	<ul style="list-style-type: none"> <li>• Implementation of hand held devices with trained CHWs</li> <li>• Procurement of bags and uniform in process</li> <li>• Expansion of WBOTs (from 7 to 70)</li> <li>• Recruited initially 7 OTLs</li> <li>• currently 55-VIT A indicators increased</li> <li>• Defaulter tracing element strong</li> </ul>	<ul style="list-style-type: none"> <li>• Data collection system implemented is more reliable (data storage)</li> <li>• Coverage of wards increased</li> <li>• Rates of patients defaulting on treatment decreased</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Poor programme planning</li> <li>• Stakeholder analysis not done</li> <li>• Working space lacking</li> <li>• WBOTs met under trees and car ports</li> <li>• Equipment shortages</li> </ul>	<ul style="list-style-type: none"> <li>• Programme not efficiently run, therefore not yielding value for money-Poor administration of programme-Data collection and analysis potentially flawed (poor confidence of use of hand held device and no computer training of OTLs)</li> </ul>
	<ul style="list-style-type: none"> <li>• Procurement and maintenance of stock for the bags</li> <li>• Maintaining the usability/functioning of the hand held device</li> <li>• Strengthening contact tracing of TB defaulters</li> </ul>

## WBOT RAPID APPRAISAL: VHEMBE DISTRICT, LIMPOPO PROVINCE

*Vhembe District: Limpopo Province*



# 1. OVERVIEW

The rapid appraisal of the Ward Based Outreach Teams (WBOT) is a national project conducted by the Albertina Sisulu Executive Leadership Programme in Health (ASELPH), at the request of the NDOH. Limpopo is one of the seven provinces selected for the study. The purpose of the research is to review the current status of WBOT and to identify factors that impact the effective and efficient functioning of WBOTs in Limpopo.

The research team:

- Dr. Armelia Chaponda
- Mr. Masilo Malema
- Sr. Alina Motlapa
- Sr. Mikateko Khosa
- Mr. Raphalalani Lufuno
- Sr. Netshivhongweni Elizabeth

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A WBOT preparatory meeting was held on 9th March 2015 at Vhembe District, Limpopo Province. The meeting was attended by the NHI District management team and other senior managers. The two sub-districts identified for the rapid appraisal were Thulamela B and Makhado B. Management identified a peer from each sub-district to join the research team. The research was conducted in the week of 22nd of March 2015.

In the field



The research team with CHWs

## 2. WORK PLAN AND IMPLEMENTATION

<b>Day 1:</b>	The research team met with the PHC manager and the nominated peer reviewers to discuss expectations for the Rapid appraisal and to plan the week's activities. The team leaders from the WBOTs were the same peer reviewers and therefore made planning relatively easy. Appointments with CHWs, facility managers and CBO managers were confirmed.
<b>Day 2:</b>	The research team split into two and visited the two sub-districts. Interviews were conducted with CHWs as well as the facility manager.
<b>Day 3:</b>	Interviews were conducted with CBO managers and individual households.
<b>Day 4:</b>	Data was reviewed for completion and preliminary findings summarized for presentation.
<b>Day 5:</b>	Preliminary findings for the two sub-districts were presented and discussed with senior officials including the PHC manager.

Community health workers, outreach team leaders in Hammanskraal- Tshwane District





## 3. FINDINGS

Findings from the fieldwork are presented in 3 sections:

- 3.1 CHW Individual Interviews Analysis
- 3.2 Household Interviews Analysis
- 3.3 WBOT Management Thematic Analysis

### 3.1 WBOT Community Health Worker one on one interviews

#### WBOT coverage and activities

Ward Based Outreach Teams (WBOTs) are formed in a limited number of villages in Vhembe district. The teams are comprised of 1 team leader (TL) who is a Professional nurse and 6-12 community health workers (CHWs). Some of the OTLs are also trainers recruited to train CHWs on WBOT phase 1.

Between two hundred and fifty (250) and two hundred and seventy (270) households were allocated per team for registration over 12 months from inception of the programme (2011). Most of the teams have not reached their registration targets.

The activities WBOTs perform in individual households vary from doing health assessments, providing health education and health promotion, doing referrals and follow ups and providing home based care (HBC) with activities such as bed baths and dressings. Support groups and education campaigns are also facilitated by WBOTs.

Community health workers trained for WBOTs are individuals who previously worked with neighbouring community based organizations (CBOs) providing HBC. They currently work as both HBC and WBOTs staff and report to both the CBO and the Ward based outreach team leader. They report primarily to the CBO because it pays their stipend. This arrangement causes confusion for both CHWs and community members.

*“Community is also confused as she comes today for HBC and tomorrow for WBOT”.*

The CBO manager allows CHWs 1 to 2 days a week to do WBOT activities and the rest of the week is spent doing HBC activities for the CBO. This affects coverage of ward based activities. Furthermore, a few CHWs are required to work over weekends to meet set targets. CHWs are finding the work difficult to complete in 1-2 days.

*“One day provided to do WBOT activities is not sufficient, as HBC and WBOT activities must be done by the same CHW”.*

CHWs identify a health, social or economic concern from the community and inform the team leader. The ‘case’ is reported to the team leader who refers the matter to the relevant department. There is a working referral system between the WBOT and the clinics. Patients are consulted immediately at the clinic and feedback is provided to the WBOT via the team leaders who also have nursing duties in the clinics.

Referrals to other departments are done, however no feedback mechanism is employed and as a result, no follow up is made. There is no ‘back referral’ due to a missing reference number on referral forms. This matter has been reported.

*“Good working relationship with Department of Social Development. But with other departments it is not so. There is no down referral to the clinic because they say there is no reference number to respond to. The TL has visited these departments at the municipality to explain the referral process, but does not get feedback. The WBOT coordinator was informed and she will take it up. There are other forms used in the community and these forms have reference numbers, therefore the WBOT programme was also expected to have these reference numbers.”*

## **Intersectoral collaboration with stakeholders**

The relationships between WBOTs and stakeholders vary. CBOs do not allow CHWs to spend more than 2 days doing WBOT activities. The CBO requires the CHWs to complete HBC work first before doing WBOT. Practically this means visiting a minimum of 20 patients per day providing HBC, prior to doing WBOT activities.

*“It is not easy working in the community because we are sometimes not allowed by the CBO manager to go and do WBOT activities”*

Collaboration with Departments of Social Development and Water Affairs, traditional healers, ward councilors and the local clinic ranges from good to great.

Traditional leaders are the gatekeepers to the communities and were involved in sensitizing on the advent of the ward based outreach programme. In areas where this did not happen, CHWs were not permitted to enter the communities.

The ward councilor also actively refers cases from WBOT to relevant departments.

The district manager supports the WBOT by supplying team leaders with stationery. However, the district manager does not visit WBOTs.

*“District managers only hold monthly report (meetings). They only go to the teams when they need something or are pressured by the province or national to provide a report”.*

## **Data collection and reporting**

Data is collected using forms supplied by the Department of Health (DoH) and are kept in a lockable cupboard at the clinics. Teams meet monthly to compile statistical reports which are submitted to team leaders. Meetings with team leaders are held when necessary to report on urgent matters.

Data is collected for both the CBO and WBOT. There are instances when data is collected on one form for the CBO and on another for WBOT, resulting in duplication. ‘Double referral’ occurs when a patient is recorded as being referred under the WBOT programme as well as CBO HBC programme. There is also a possibility of ‘double counting’ of beneficiaries to services as reports are prepared independently for both CBO and WBOT leaders/managers.

## **Operational constraints**

CHWs do not have the resources to do ward based outreach activities. Key constraints are

- Insufficient time to complete WBOT responsibilities

The current one to two days is insufficient resulting in them working weekends to complete their activities.

- Lack of identifying name tags and uniforms

Because the CHWs also work as home based carers and wear the uniform supplied by the CBO, the communities confuse them with HBC who perform mostly HBC activities. A few CHWs were not permitted entry into the community because they were not properly identified.

- Communication with OTLs

CHWs currently communicate with the team leader by sending “please call me” messages. When this does not work they have to go meet the team leader at the clinic. This is ineffective for urgent matters and is very time consuming.

*“I use my cell phone to contact the team leader and other staff at the clinic. If no cell phone, I walk to the clinic and report”.*

The team leaders also use their own air time to return calls.

- Equipment

CHWs are not properly equipped with bags files and forms and other resources they need to do their work.

- Inadequate pay

The stipend is inadequate. A few CHWs are working on more than one job in order to make ends meet.

*“I have increased workload as I have a dual job that makes it difficult to reach all the households allocated for HBC and WBOT”*

- Insufficient stationery

There is a shortage of ‘maternal’ forms thus these could not be registered.



## 3.2 Household interviews

### Experience with WBOT

WBOTs are said to provide health education and promote the health of those on treatment by discussing the importance of adherence. Referrals are made to the clinic for consultation and other relevant government departments and screening of TB is done. Condoms are also distributed for health promotion.

People in the community were positive about CHWs.

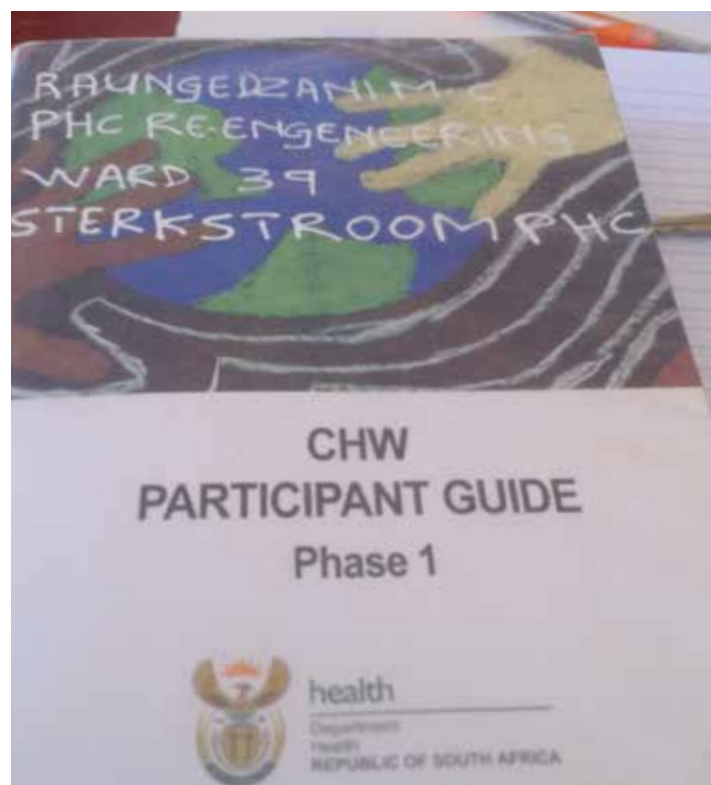
*“CHWs have confidentiality as I never heard anyone talking about the information I gave them in the village”.*

### Feelings about the services provided by WBOTs in the community

People in the community are generally satisfied with the services provided by the WBOTs. They said that the WBOT programme is a sign that the Department of Health wants to look after their health.:

*“I feel happy about this programme. The department of health is taking care of the health of Tshamavhodzi community”*

*“I was a defaulter on TB- it became MDR- but I got counseling from the CHW and I am taking treatment every day. ARVs- I am collecting my ARV monthly at the clinic and viral load has subsided...”*





# WBOTS MANAGEMENT INTERVIEWS: THEMATIC ANALYSIS

TOPICS	RESPONSES	STRENGTHS
1. Knowledge about WBOTs	<ul style="list-style-type: none"> <li>• Team comprising 1 Professional nurse and 6 or more CHWs, Environmental health officer, Health promoter and district specialist team</li> <li>• Do health, psychosocial assessments in the community</li> <li>• Early diagnosis, management, referral and rehabilitation</li> <li>• Health promotion</li> <li>• Health services taken to the people</li> </ul>	<ul style="list-style-type: none"> <li>• Professional Nurse as leaders of WBOT</li> <li>• Commendable understanding of WBOT</li> </ul>
2. Services rendered by WBOT	<ul style="list-style-type: none"> <li>• Household registration, health promotion and prevention, home based care</li> <li>• Screening and referral</li> <li>• Social support services (housing, social assistance, environmental-sanitation, documentation)</li> </ul>	<ul style="list-style-type: none"> <li>• Cater for community needs other than health</li> <li>• Employs referral network</li> </ul>
3. Interpersonal relationships between facility Professional nurses and WBOTs	<ul style="list-style-type: none"> <li>• Conflicts arise due to tensions between clinic staff and WBOTs</li> </ul>	<ul style="list-style-type: none"> <li>• Provides opportunity to learn on the job conflict management skills</li> </ul>
4. Interpersonal relationships between ward councillors and WBOTs	<ul style="list-style-type: none"> <li>• Ward committees formed through collaboration of ward counsellor</li> </ul>	<ul style="list-style-type: none"> <li>• Commendable intersectoral collaboration</li> </ul>
5. Interpersonal relationships between WBOTs and other stakeholders	<ul style="list-style-type: none"> <li>• CBO prevents CHWs to do WBOT duties - told to do that afterhours</li> <li>• Training of CHWs interrupted</li> <li>• CBO manager not supportive - required for CBO duties</li> <li>• WBOT not formally introduced to CBO and other partners</li> <li>• Traditional healers involved in sensitizing communities re WBOT</li> <li>• Referral forms not returnedDCST not introduced</li> <li>• Municipality does not understand WBOT concept</li> <li>• Dept. of home affairs not responsive to WBOT referrals (letters missing referral number, therefore no assistance)</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional medicine sector involved - gatekeepers of the community to some extend</li> </ul>

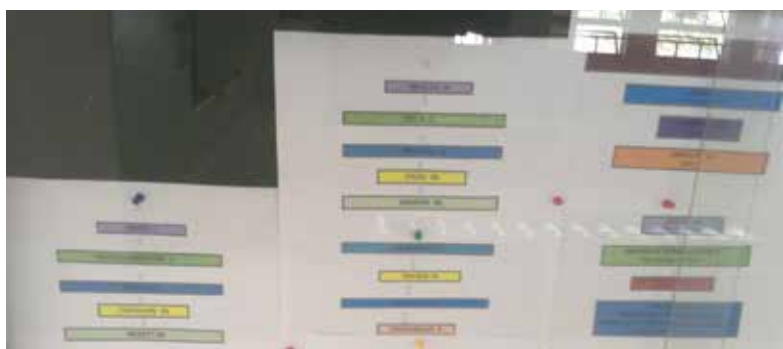


WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• WBOT leadership restricted to Prof. Nurses only</li> <li>• Professional nurses not trained in management</li> </ul>	<ul style="list-style-type: none"> <li>• Shortage of Professional nurses results in thin management/ supervision of CHW teams</li> </ul>
<ul style="list-style-type: none"> <li>• Too much time spent catering for social needs</li> <li>• Referral network weak</li> </ul>	<ul style="list-style-type: none"> <li>• Social welfare department needs to be more active in meeting social needs to allow WBOT to focus on health related matters</li> <li>• Interventions need to be focused, CHWs cannot provide comprehensive care for all</li> </ul>
<ul style="list-style-type: none"> <li>• Slows responses to community needs</li> <li>• Interpersonal skills training lacking</li> <li>• Communication disrupted</li> <li>• Distrust and lack of understanding</li> </ul>	<ul style="list-style-type: none"> <li>• Unresolved conflict will result in ineffective and inefficient WBOTs</li> <li>• Hierarchical relationship exists between facility nurses and WBOTs</li> <li>• Community needs, beliefs and expectations will only be known by CHWs and not rest of health</li> </ul>
	<ul style="list-style-type: none"> <li>• Accountability system put in place for community- concern is its sustainability</li> </ul>
<ul style="list-style-type: none"> <li>• CBO and municipality misunderstanding of WBOT concept</li> <li>• Same CBO staff used as WBOT</li> <li>• WBOT and CBO action plans not harmonised</li> <li>• Weak referral system due to unresolved operational/management matters</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT and CBO terms of reference not clear</li> <li>• WBOT and other stakeholders not communicating re resolving management/operational obstacles</li> </ul>

TOPICS	RESPONSES	STRENGTHS
6. Management concerns	<ul style="list-style-type: none"> <li>• Lack policy guidelines on WBOT</li> <li>• Own resources used to initiate WBOT (transport), raining materials</li> <li>• No support from managers</li> <li>• DSCT not appointed</li> <li>• Team leaders not consulted in management of WBOT</li> <li>• Do support visits inconsistently</li> <li>• Team leaders - not appointed - clinic staff deployed</li> </ul>	
7. Resource constraints	<ul style="list-style-type: none"> <li>• CHWs not allowed into certain areas due to poor identification (no name tags)</li> <li>• No dedicated budget for WBOT</li> <li>• No recruitment criteria for CHWs</li> </ul>	
8. Training of OTL/CHWs	<ul style="list-style-type: none"> <li>• WBOT not clear on how to perform duties</li> <li>• CHWs not provided with correct community information</li> </ul>	
9. Operational challenges	<ul style="list-style-type: none"> <li>• Lack of equipment and stationery</li> <li>• Transport constraints</li> <li>• Dedicated offices and furniture for WBOT management</li> </ul>	
10. WBOTs success	<ul style="list-style-type: none"> <li>• Assisting with securing houses</li> <li>• Assisting with securing ablution facilities, water tanks, social and child support grants, birth certificates, wheel chairs, food parcels, crutches</li> <li>• Being able to send statistical reports monthly</li> </ul>	<ul style="list-style-type: none"> <li>• Social support provided</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Management training lacking</li> <li>• Leadership skills required</li> <li>• WBOT is not considered part of the clinic</li> <li>• Weak management support</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT poorly introduced and managed</li> <li>• Requires dedicated staff and resources</li> <li>• Poor CHW support, due to lack of transport</li> <li>• Creating staff shortages in the clinic</li> <li>• Team leaders' roles are shared between WBOT and PHC clinics</li> </ul>
<ul style="list-style-type: none"> <li>• Resource constraints will negatively affect WBOT success</li> </ul>	<ul style="list-style-type: none"> <li>• Poor strategic planning for WBOT results in resource constraints which may become bottlenecks to forming strong teams and programmes</li> <li>• Important determinant to programme success</li> </ul>
<ul style="list-style-type: none"> <li>• Poor training of operational management of WBOT/daily implementation of WBOT</li> <li>• Not trained to interpret statistics</li> <li>• Trust of CHWs from the community is poor</li> </ul>	<ul style="list-style-type: none"> <li>• Training of daily WBOT activities for the CHWs is the team leaders' responsibility - because of no management skills they are unable to train CHWs on activities that fall outside of the clinic</li> <li>• Community profiling system based on incorrect information which will discredit the programme</li> <li>• Risk of poor planning for WBOT activities if statistics are not considered</li> </ul>
<ul style="list-style-type: none"> <li>• Demotivated WBOTs</li> </ul>	<ul style="list-style-type: none"> <li>• Ineffective teams which will result in ineffective programme</li> <li>• Important determinant to programme success</li> </ul>
<ul style="list-style-type: none"> <li>• No health related success of WBOTs was raised by team leaders</li> </ul>	<ul style="list-style-type: none"> <li>• Social health needs in the community are overwhelming WBOTs</li> <li>• Health prevention and promotion activities may become secondary to meeting social needs</li> </ul>

*Dr. Kenneth Kaunda District:  
North West Province*



# 1. OVERVIEW

The rapid appraisal of the Ward Based Outreach Teams (WBOT) is a national project conducted by the Albertina Sisulu Executive Leadership Programme in Health (ASELPH), at the request of the NDOH. North West is one of the seven provinces selected for the study. The purpose of the research is to review the current status of WBOT and to identify factors that impact the effective and efficient functioning of the WBOTs in North West.

The research team:

- Dr. Armelia Chaponda
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On 4th March 2015 a preparatory meeting was held at Dr. Kenneth Kaunda District, North West Province. The meeting was attended by Directors, Chief Directors, Deputy Directors and the DDG of PHC. Self-assessment forms were distributed, together with copies of WBOT documents. The methodological approach, based on documentary reviews, structured interview questionnaires and direct field observations was outlined and the relevant documents and forms were shared. Senior management officials were requested to complete the forms and to submit them to the research team during field visits. The field research was undertaken in the week of May18-22, 2015.



Kgakala Clinic –Wolmaransstad with mobile unit used by WBOT

## 2. WORK PLAN AND IMPLEMENTATION

<b>Day 1:</b>	A discussion of the WBOT program in each sub-district was followed by a debrief session on expectations of all for the week. The weeks activities were planned and meetings with facility managers and CHWs were confirmed.
<b>Day 2:</b>	The research team divided into two and visited the two sub-districts. Interviews were conducted with all CHWs.
<b>Day 3:</b>	Interviews were conducted with individual households.
<b>Day 4:</b>	Data was reviewed for completion and preliminary findings summarized for presentation.
<b>Day 5:</b>	Preliminary findings for the two sub-districts were presented and discussed with the chief Director of PHC, OTLs and facility managers, who were at a two day operations meeting in Klerksdorp.

## 3. FINDINGS

Findings from the fieldwork are presented in three sections

- 3.1. CHW individual Interviews Analysis
- 3.2. Household Interviews Analysis
- 3.3. WBOT Management Thematic Analysis and

### 3.1 WBOT Community Health Worker one on one interviews

#### WBOT services provided

Ward based outreach teams consist of one professional nurse as team leader and 6-12 CHWs. The numbers of households the WBOTs are responsible for vary between 250 and 275. Some teams are allocated households but find these unoccupied and hence they are responsible for less. Other wards fall within farming areas that are difficult to reach because of logistical constraints. The population in the province is migrant and therefore difficult to trace.

The activities conducted include

- Health education and facilitating health education campaigns in the community.
- Performing household registrations.
- Performing health assessments.
- Referrals to the clinic and relevant department.
- Creating support groups.
- Conduct home based care activities such as cleaning homes.



### 3. FINDINGS

- Delivering medication to residents living in farming areas.

*“We fetch their books from home, collect medication at the clinic and deliver to their homes. This prevents them to be in long queues at the clinic”*

WBOTs in this district work an eight (8) hour day.

Medical and other referrals is done by team leaders as well as CHWs. Nursing staff do not provide back referrals.

*“...I need support from the professional nurses working in the clinic because most of the time, I don't get back referrals. Professional nurses sometimes, don't fill them in saying they don't know how to fill them. It's like they don't take their job seriously.”*

Referrals are also made to the Departments of Social Development and Basic Education. They do refer back, although often after a long time.

#### Partnerships

Relationships with local stakeholders are good. The district manager is supportive. The Department of Basic Education is supportive of WBOTs and refers non-school going children to the Department of Social Department as well as schools. However, the relationship with clinic staff is strained.

*“The managers' manner of approach towards us is not professional. No respect for our age. You want to get up and feel like going to work, but sometimes not.”*

*“We should be treated well in the clinic. We know we are not nurses but we should be accepted and don't get attitudes from nurses.”*

The environmental health officer does not form part of the WBOT.

*“I have never met an environmental health officer”*

NGOs play an active role in that a few CHWs report to them as well as the team leader of the WBOT.

#### Data collection and reporting

Data is collected by completing forms supplied by the Department of Health (DoH). Updates are done verbally to the OTL and monthly statistics are completed. CHW meetings with the team leaders are held as and when required depending on the nature of the problem. Urgent issues are discussed telephonically, at the end of the day or the next day when the team meets at the clinic. Others use a messaging system, which requires the team leader to call them back. The team leader uses her own resources to return all the calls.

*“I write on an individual follow-up sheet and tick sheet and report the next day when I meet the OTL. I cannot get in touch with the OTL in emergencies because my phone is lost. I come to the clinic to report to her”*

Weekly WBOT management meetings are held to discuss the weeks' activities and challenges. Most of the team leaders accompany CHWs into individual homes and record matters requiring further action into a diary. Monthly meetings are conducted with the respective operational managers. Team leaders do in-service training on any topic after the Friday WBOT meetings.

## Operational constraints

The CHWs and team leaders interviewed raised the following issues that if addressed would assist in making their duties easier.

- Communication

A few CHWs are given R100 a month towards communication, others do not. Reasons for this discrepancy are not known. Team leaders communicate at their own cost.

Identification – CHWs have nothing that enables the community to recognize them as health workers

*“We don’t get uniform and name tags so that the community may recognize us - to take our job seriously because even government will take our jobs seriously”*

- Value and regularity of stipend payment

Stipends are not paid regularly.

*“Last month I was the last one paid”*

Stipends are low.

*“Money to be increased because we are doing most of the things but the stipend is too small. But every time work is increased...”*

- Transport

Transport to the farms is limited. Team leaders use their own vehicles to transport CHWs working in those wards. Often the vehicles are open and unsuitable for carrying passengers. The travelling distances amount to 60 kilometers per day. Expenses incurred for fuel are never reimbursed because of unresolved administration challenges.

*“Claiming money for our travelling is a nightmare. Our forms are always returned for small mistakes”*

- Reporting to clinics

WBOTs are required by the facility manager to report to clinics before and after going to work. Facility managers use this system to monitor the teams’ working hours. This creates operational challenges for teams working a long distance from the local clinic. Less time is spent in the community doing WBOT activities because CHWs have to get back to the clinic in order to be there before closure at 16h00. A few WBOTs have resorted to meeting at a central place in the community. They have met with some resistance from facility managers who say they cannot supervise teams if they do not know where they are.

*“We found a place to ‘clock in’ rather than coming to the clinic, because you find it closed when you arrive”*

Left: Kgakala Clinic –Wolmaransstad with mobile unit used by WBOT



There is some community resistance to WBOT that arises from traditional beliefs, concerns regarding confidentiality or misunderstanding about the program.

*“Resistance is from people that believe in traditional healers, they refuse to visit the clinic claiming that they have been given ‘muti’”*

*“Most of the resistance in black households is confidentiality. They feel like we are discussing their issues with their neighbours”*

*“Access into the households is not good. Communities don’t want us to enter the houses. They get mad when seeing us time and time again. People thought that reengineering was to give them medication from clinics, not to come to their houses bare hands and make them sign after the visit ends”*

Some people also believe that the program only caters for people without medical insurance or black people.

*“The other resistance is from white people, claiming that it is a Zuma thing and they have not seen it on television”.*

## 3.2 Household interviews

### 3.2.1 Experience with WBOT and what they do

Most people interviewed in the community are familiar with WBOTs and with CHWs in particular. Some are not. The people who know about WBOT say CHWs move from house to house delivering medication to those who are unable to collect from the clinic, help people them avoid the long lines at the clinic, do individual health assessments and registrations, screen for TB, give supplements such as Vitamin A to children and do referrals to the clinic for HIV testing.

### 3.2.2 Feelings about the services provided by WBOTs in the community

Community members are generally satisfied with the services rendered by WBOTs, but they want CHWs to help with problems as well as ask questions.

*“I thought that the interview would help my problem”.*

## Recommendations

- Medication is delivered to some communities living farms and not to others.
- Medication should be carried by all CHWs and delivered in the community to those who cannot reach the clinic.
- Additional CHWs should be appointed to continue with the services they provide in the community.
- Stipends should be raised.
- CHWs should visit all the households in the community and not be selective.
- CHWs need training to improve the programme.

# WBOTS MANAGEMENT INTERVIEWS: THEMATIC ANALYSIS

TOPICS	RESPONSES	STRENGTHS
1. Knowledge about WBOTs	<ul style="list-style-type: none"> <li>• Primary health care approach</li> <li>• Taking health services to the people</li> <li>• Working collaboratively with other service providers</li> <li>• Assess, diagnose and refer to clinic</li> </ul>	<ul style="list-style-type: none"> <li>• Collaborative approach</li> </ul>
2. Services rendered by WBOT	<ul style="list-style-type: none"> <li>• Household registration, health promotion and prevention, home based care, DOTs support,</li> <li>• Collection and dispensing of medication especially in very remote areas</li> <li>• Trace and facilitate transfer of very ill foreign patients home, facilitating getting of documentation, social assistance</li> </ul>	<ul style="list-style-type: none"> <li>• Community health profile</li> <li>• Meeting social needs</li> </ul>
3. Interpersonal relationships between facility Professional nurses and WBOTs	<ul style="list-style-type: none"> <li>• Poor relationship between WBOTs and facility managers</li> </ul>	
4. Interpersonal relationships between ward councillors and WBOTs	<ul style="list-style-type: none"> <li>• Ward counsellor is not very active/ supportive</li> </ul>	
5. Interpersonal relationships between WBOTs and other stakeholders	<ul style="list-style-type: none"> <li>• Department of social development has poor relationship with WBOT</li> <li>• Departments of home affairs and social development very slow to act when required</li> <li>• No relationship with the district specialist team</li> <li>• No down referral from partner organizations</li> </ul>	
6. Management concerns	<ul style="list-style-type: none"> <li>• WBOT programme not properly introduced with guidelines and policies</li> <li>• There is a difference of R8000 between professional nurses doing WBOT in N/W</li> <li>• Team leaders are also utilised in the clinic when there are staff shortages</li> <li>• Have own management structure and be run independent of clinic</li> <li>• Costs incurred for field work not reimbursed (claim forms are always returned)</li> <li>• WBOT should have been planned properly with its own budget</li> </ul>	<ul style="list-style-type: none"> <li>• Team leaders assist with clinic responsibilities when required</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• Diagnosing and not referring</li> </ul>	<ul style="list-style-type: none"> <li>• Utilizing working knowledge of WBOT and collaborating with stakeholders to provide service at the PHC level</li> <li>• WBOTs should not diagnose medical conditions, but refer to secondary level of care</li> </ul>
<ul style="list-style-type: none"> <li>• Not referring cases to respective agency</li> <li>• CHWs taking on the responsibilities of social worker, dietician, nurse and psychologist</li> </ul>	<ul style="list-style-type: none"> <li>• A significant amount of WBOT time is spent on social issues - teams are overwhelmed</li> <li>• Poor referral network, not utilised optimally</li> </ul>
<ul style="list-style-type: none"> <li>• Clinic staff unsupportive of WBOT</li> </ul>	<ul style="list-style-type: none"> <li>• No base for WBOT to operate from</li> <li>• WBOT not linked to DCST</li> </ul>
<ul style="list-style-type: none"> <li>• Missing link from the community to other departmental/government structures</li> <li>• Missed opportunity to maintain contact with the community it represents</li> </ul>	<ul style="list-style-type: none"> <li>• Community representation may be politically motivated</li> </ul>
<ul style="list-style-type: none"> <li>• Weak referral and feedback system</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT incomplete, health continuum cut due to poor referral system</li> </ul>
<ul style="list-style-type: none"> <li>• WBOT duties are neglected over clinic responsibilities</li> <li>• Unsupervised CHWs</li> <li>• Remuneration not standardized</li> </ul>	<ul style="list-style-type: none"> <li>• Poor planning for WBOT programme</li> <li>• Team leaders' expectations are not clear</li> <li>• WBOTs Team leaders not motivated and have poor morale</li> </ul>



TOPICS	RESPONSES	STRENGTHS
7. Recruitment/appointment of WBOT members	<ul style="list-style-type: none"> <li>• CHWs live and work in the same ward</li> <li>• Recruitment procedures for CHWs varied</li> <li>• CHWs recruited from CBOs</li> <li>• Standard of CHW education poor</li> </ul>	<ul style="list-style-type: none"> <li>• Know the community</li> </ul>
8. Operational challenges	<ul style="list-style-type: none"> <li>• Structural - insufficient space for WBOT administration and management duties</li> <li>• Insufficient stationary and other logistics such as transport to do WBOT activities</li> <li>• WBOTs are told PHC reengineering does not have a budget</li> <li>• Transport arrangements are outstanding and hampering productivity. Some OTLs work in remote areas and use their own vehicles</li> </ul>	
9. WBOT success	<ul style="list-style-type: none"> <li>• Identify TB cases in the community</li> <li>• Assist with social needs</li> <li>• Identify very ill patients requiring hospitalization</li> </ul>	<ul style="list-style-type: none"> <li>• Early identification of communicable diseases</li> </ul>





WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• No respect and trust from community - regarded as 'friends'</li> <li>• Poor English comprehension</li> </ul>	<ul style="list-style-type: none"> <li>• Low levels of education may result in WBOT not considered a professional health service body</li> </ul>
<ul style="list-style-type: none"> <li>• WBOT documents not secured</li> </ul>	<ul style="list-style-type: none"> <li>• Challenges result in poor administration of WBOT programme</li> <li>• Sustainability of the WBOT programme questioned</li> <li>• Uncertainties created</li> </ul>
	<ul style="list-style-type: none"> <li>• Poor linkages with department of social development</li> </ul>



# 6 WBOT RAPID APPRAISAL: GERT SIBANDE DISTRICT, MPUMALANGA PROVINCE

Gert Sibande District: Mpumalanga Province





# 1. OVERVIEW

The rapid appraisal of the Ward Based Outreach Teams (WBOT) is a national project conducted by the Albertina Sisulu Executive Leadership Programme in Health (ASELPH) at the request of the NDOH. Mpumalanga is one of the seven provinces selected for the study. The purpose of the research is to review the current status of WBOT and to identify factors that impact the effective and efficient functioning of the WBOTs in Mpumalanga

The research team:

- Dr. Armelia Chaponda
- Mr. Masilo Malema
- Sr. Gabie Kubheka
- Sr. Stellar Shabalala
- Sr. Zandile Mabuza
- Mr. Welcome Mabila

University of Pretoria

On 12th March 2015 a preparatory meeting was held at Gert Sibande District, Mpumalanga Province. The meeting was attended by Deputy Directors of PHC and NHI and WBOT team leaders. Self-assessment forms were distributed, together with copies of WBOT documents. The methodological approach, based on documentary reviews, structured interview questionnaires and direct field observations was outlined and the relevant documents and forms were shared. Senior management officials were requested to complete the forms and to submit them to the research team during field visits. The two sub-districts identified for the rapid appraisal were Chief Albert Luthuli and Dr Pixley Ka Isaka Seme.



## 2. WORK PLAN AND IMPLEMENTATION

The following is a table reflecting the two sub-districts and respondents interviewed

<b>Day 1:</b>	A brief orientation meeting was held on Monday at the district office in Ermelo. This was attended by the PHC manager as well as PHC coordinator, WBOT manager, NHI coordinator and four peer reviewers. The introduction to the WBOT assessment was a good discussion point of the challenges encountered in Gert Sibande district. The rest of the day was spent orientating the teams to the assessment process, assessment material and their responsibilities throughout the week. The weeks activities were planned and meetings with facility managers and CHWs were confirmed.
<b>Day 2:</b>	The research team divided into two and visited the two sub-districts. Interviews were conducted with all CHWs.
<b>Day 3:</b>	Interviews were conducted with individual households.
<b>Day 4:</b>	Data was sorted and reviewed on Thursday and a presentation for the feedback discussion compiled.
<b>Day 5:</b>	Preliminary findings for the two sub-districts were presented and discussed with the deputy and assistant directors of PHC.

Daggakraal Clinic



## 3. FINDINGS

Findings from the fieldwork are presented in three sections

- 3.1. CHW Individual Interviews Analysis
- 3. 2. Household Interviews Analysis
- 3.3. WBOT Management Thematic Analysis

### 3.1 WBOT Community Health Worker one on one interviews

#### Teams and Services

Ward based outreach teams (WBOTs) comprise of one team leader who supervises between 6 to 11 CHWs. Not all wards are covered with WBOTs. There are outlying areas which raises the need for additional CHWs and teams in general. A few WBOTs overlap with wards not covered by teams and feel compelled to offer services to those vulnerable households as well. Each CHW visits 3 houses in very rural area and 5 in others. Activities include, performing health assessments, health promotion and education talks, conducting referrals, tracing patients on treatment and performing follow-up visits.

The Environmental Health Officer gives health education talks.

In certain areas, team leaders supervise two teams of 12 CHWs in total and travel long distances for transport as well as supervision. Working hours are from 08h00 to 14h00.

WBOTs have a good relationship with the School Health Programme and have managed to plan and implement an effective referral system.

*“We work well with the school health programme. We give HPV at the school to school going children. Also the schools assist us when we have campaigns such as Vitamin A which we also give in the schools. The school health programme refers children who do not have birth certificates to the WBOT to get documents as well as those requiring grants”*

#### Partnerships

The Department of Social Development accepts all referrals made by the CHWs. The Department of Basic Education assists with letters from the local school for application of identity documents. The School Health Programme supports WBOT by participating in education campaigns and WBOTs take referrals made for the application of birth certificates and those requiring social support.

They share community information through a NGO on a regular basis. For example, community education on traditional medicine is provided by the NGO. It strengthens the education and information CHWs already provide. They also work together to provide services, for example when male home based care givers are requested to provide care in households with male patients.

Collaboration with traditional healers needs to be intensified. Bringing all traditional healers on board will be beneficial to individual families and communities at large.

*“...Sometimes we have problems with patients who are HIV positive, they go to traditional healers, then when we see them it's too late”*

Collaboration with the district manager could be better. Irregular support visits are made to the OTLs. In certain cases, the district manager is not seen.

*“I don’t know because the district manager don’t visit us”*

The general relationship between team leaders and facility managers or other clinic nurses is poor and could be strengthened.

*“My superior support to WBOT is poor, she doesn’t value my duties in the WBOT- since I have been take from the clinics and this has caused a shortage of staff. She needs more in-service on WBOT until she understands the importance of the programme”*

## **Operational constraints**

Supervising large groups of CHWs is challenging for OTLs. A contributing factor is that the teams are physically dispersed.

*“I supervise two groups of CHWs in separate areas. I drive for 27 kilometres from one area to the next. I can’t cope with my workload because I am in meetings some times, or I am taken away other times, then my reports are incomplete. I compile weekly and monthly reports and transport CHWs between the wards in the farms. Sometimes I work in the clinic when there are staff shortages...”*

CHWs work without uniforms or any form of identification. This affects the response of the community and it impacts on their security.

*“With the uniform, the community can identify me. At least they won’t refuse me to enter their households. Also they won’t rob me. They will identify me as a CHW”*

CHWs are exposed to people with infectious disease. They also need counseling support to share their worries.

*“This work is risky. I went to someone and they were coughing. They did not say they had XDR TB. So they coughed and I fell ill after a few weeks. Now my family at home is also sick because of my work. We need someone to counsel us when this happens.”*

They work hard and over weekends.

*“The work does not stop. We work overtime and sometimes over weekends. When I am at home, someone comes and tell me their problems. I leave my house and go and see what the problem is.*

CHWs dissatisfied with stipend amount:

*“I like to help people that is why I am doing this for many years (interviewer was a home based care giver for 10 years). But the only problem is this stipend. I am willing to do more work. But if someone can give me work in the week as a cleaner, I will take it. We are struggling at home. I wash and clean other people’s homes on Saturday”*

A few CHWs are working far from home and are required to catch public transport to the clinic.

*“The support we need as a team is incentives or stipend because I have to take transport to come to the clinic. Sometimes I become absent because of shortage of money and uniform too. Last time we got jackets only, we don’t have shoes and other stuff”*

Team leaders are delegated to supervise CHWs yet they are required to work in the clinics when the need arises. This causes situations where CHWs work in the community without supervision.



Team leaders are unhappy about this and wants to be appointed in order to focus on strengthening WBOTs.

*“The shortage of medication means you go to other facilities to get them. You are a jack of all trades. If there are many patients the OTL work stops - you do nursing work in the consulting rooms”*

*“OTL case load is very high and demanding - because firstly I am not appointed as an OTL. I am delegated from the clinic and expected to do extra miles, working as an OTL and also as a professional nurse in the clinic”.*

WBOTs are sometimes turned away from households. The community wants assistance with tangible health issues and does not see the short term benefit of individual health assessments.

*“Some households refuse you to enter, they say you always filling forms and nothing is happening and they say you don't keep the promise.”*

## 3.2 Household interviews

### Experience with WBOT and what they do

Community experiences with WBOTs are mostly positive. Access to the clinic is hampered by the lack of finances for transport. As a result consultations are not made particularly for follow up of chronic medication.

According to community members WBOTs provide health education and do health promotion activities such as education campaigns. They are polite and ask for permission prior to speaking to anyone. They enquire about their individual health status and do referrals to the local clinic as well as to the Department of Social Development and Social Services.

*“I wish the programme will remain in the community as it helps us a lot to improve our lives. People are afraid of going to disclose their problems, but with the assistance of the CHWs, they can.”*

### Feelings about the services provided by WBOTs in the community

Some members of the community said that the WBOTs have had a positive influence in their lives and changed their health seeking behavior for the better. They are encouraged to adhere to and monitor their medication and visit the clinic before their prescribed medication runs out.

Some expressed a preference for more services other than doing health assessments. This suggests that people want to see tangible health care.

### Recommendations to improve WBOT

- Ensure sufficient medication in the clinics and to deliver chronic medication to the homes.
- Expedite the 'referred cases' to the professional nurses at the clinic.
- Procure vehicles for CHWs working in farming areas, so that the communities can be visited regularly.
- Fix the roads to improve accessibility to farming and other hard to reach areas.
- Increase the number of CHWs and OTLs in order to cover all the wards with WBOTs to prevent teams travelling long distances to work.
- Remunerate CHWs consistently every month.

# WBOTS MANAGEMENT INTERVIEWS: THEMATIC ANALYSIS

TOPICS	RESPONSES	STRENGTHS
1. Knowledge about WBOTs	<ul style="list-style-type: none"> <li>• One of the streams of PHC</li> <li>• Team comprising 1 Professional nurse</li> <li>• Team leader and 6 or more CHWs, Environmental health officer and Health promoter</li> <li>• Prof. nurses supervisor's team</li> <li>• Promote health and prevent illness</li> </ul>	<ul style="list-style-type: none"> <li>• Professional Nurse as leaders has health background and can intervene to promote health at community level</li> </ul>
2. Services rendered by WBOT	<ul style="list-style-type: none"> <li>• Household registration/individual health assessments, health promotion and prevention, home based care, DOTs support,</li> <li>• Screening and referral/follow up of referrals</li> <li>• Social support services</li> <li>• WBOTs also responsible for clinic duties</li> </ul>	<ul style="list-style-type: none"> <li>• Consider social needs as well</li> </ul>
3. Interpersonal relationships between facility Professional nurses and WBOTs	<ul style="list-style-type: none"> <li>• Poor support received from clinic nurses/operational managers-No back referral from clinics</li> </ul>	
4. Interpersonal relationships between ward councillors and WBOTs	<ul style="list-style-type: none"> <li>• Ward councillor was met once</li> </ul>	<ul style="list-style-type: none"> <li>• Was involved in the introduction/ sensitization of WBOT in the community</li> </ul>
5. Interpersonal relationships between WBOTs and other stakeholders	<ul style="list-style-type: none"> <li>• Poor support from partner organizations like social development</li> <li>• Home based carers from CBO do not assist freely with referrals</li> <li>• No back referrals received from other partners</li> <li>• CBO carers do not work collaboratively with WBOT - refuse to do dressings, bed baths etc.</li> </ul>	

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>Professional nurse does not have management training</li> <li>Only one leader of WBOT may cause a bottle neck if away or unavailable</li> <li>Team leaders require computer literacy training</li> </ul>	<ul style="list-style-type: none"> <li>Shortage of Professional nurses to strengthen WBOTs</li> </ul>
<ul style="list-style-type: none"> <li>Each WBOT renders different services</li> <li>May not render health services effectively due to time spent on meeting other needs</li> <li>WBOTs not dedicated to community service only</li> </ul>	<ul style="list-style-type: none"> <li>Uncoordinated services</li> <li>Social department should take a more active role in identifying social issues (part of WBOT)</li> <li>WBOT activities neglected</li> </ul>
<ul style="list-style-type: none"> <li>Poor relationships create factions between clinic and WBOT</li> <li>Do not work together collaboratively</li> </ul>	<ul style="list-style-type: none"> <li>Break in health care continuum</li> <li>WBOT not considered an extension of clinical care to preventative care in the community</li> <li>Will have a negative impact on the programme</li> </ul>
<ul style="list-style-type: none"> <li>Could be more supportive and involved in community mapping with WBOTs</li> </ul>	<ul style="list-style-type: none"> <li>Political leadership is required to support programmes affecting communities, but this support has alternative implications</li> </ul>
<ul style="list-style-type: none"> <li>PHC approach incomplete</li> <li>Home based care activities left for WBOT to do</li> <li>Weak linkages with other stakeholders</li> </ul>	<ul style="list-style-type: none"> <li>Strategic meetings should be held with department of social development and partnering CBO to strengthen poor relationships to allow each to work against clear terms of reference in the same community</li> <li>Department of social development should play a more active role in meeting social needs</li> <li>Back referral system requires urgent attention. WBOTs are unable to move on to the next 'case' because no feedback/ resolution is reached in the former</li> <li>PHC approach not fully integrated</li> </ul>

TOPICS	RESPONSES	STRENGTHS
6. Management concerns	<ul style="list-style-type: none"> <li>• Need dedicated WBOT staff - not delegated</li> <li>• Team leaders not remunerated according to advertised scale</li> <li>• Poor management of CHWs because team leaders performs nursing duties in clinics</li> <li>• Stipend paid to CHWs not consistent- Poor support from District office and other supervisors</li> <li>• CHWs report both to CBO and WBOT</li> <li>• Insufficient time to complete WBOT duties because of clinic responsibilities</li> </ul>	<ul style="list-style-type: none"> <li>• Team leaders working in clinics can assist in cases of staff shortages</li> </ul>
7. Training of CHWs	<ul style="list-style-type: none"> <li>• Training not effective</li> <li>• CHWs can't articulate what WBOTs are - too short time period for training health issues</li> </ul>	
8. Operational challenges	<ul style="list-style-type: none"> <li>• No office space for WBOT in the clinic</li> <li>• No lockable cupboard to store files</li> <li>• Require transport to farm areas</li> <li>• Require stationery</li> </ul>	
9. WBOTs success	<ul style="list-style-type: none"> <li>• Securing identity documents for patients-tracing Tuberculosis patients who default on their treatment</li> <li>• Secure grants</li> <li>• Reached target of VIT A distribution</li> <li>• Referrals to different services</li> </ul>	<ul style="list-style-type: none"> <li>• Tracing defaulters is a strong element of community based care</li> <li>• Same applies to making immunizations available to those who do have poor access</li> </ul>

WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>• No management, data management and computer training</li> <li>• WBOT reports not submitted on time and are incomplete</li> <li>• Poor collaboration with District office</li> <li>• WBOT staff are not permanently employed</li> </ul>	<ul style="list-style-type: none"> <li>• Tasking shifting for OTLs result in shortages</li> <li>• Unsupervised teams risking CHWs wondering around the community unsupervised</li> <li>• Dedicated WBOT staff is required for programme success</li> <li>• Appointment of the right numbers of WBOTs following correct recruitment criteria will aid better working conditions</li> <li>• WBOT policy should incorporate recruitment criteria, terms of reference/job specifications and remuneration specifications in for all to be standardized</li> </ul>
<ul style="list-style-type: none"> <li>• Forms not completed correctly</li> <li>• Training programme may be too comprehensive and a lot of material is covered in a short time period - result is basics are not comprehended</li> <li>• CHWs struggle to piece WBOT training and realities in the community together</li> <li>• Demotivated staff resulting in poor morale</li> </ul>	<ul style="list-style-type: none"> <li>• WBOT training not equipping CHWs to 'use reason' when in the community</li> <li>• Require continuous structured training</li> </ul>
<ul style="list-style-type: none"> <li>• Demotivated staff resulting in poor morale</li> </ul>	<ul style="list-style-type: none"> <li>• Team leaders not included in resource planning for clinic and WBOT operations</li> <li>• Risk poor implementation of WBOT duties</li> </ul>
<ul style="list-style-type: none"> <li>• Time spent on meeting social needs and not referring as WBOT model suggests</li> </ul>	<ul style="list-style-type: none"> <li>• WBOTs are not referring matters to social department or home affairs - rather they are getting caught up in meeting social needs which are the responsibility of other stakeholders. Terms of reference and responsibilities are not clear</li> <li>• WBOT not value for money</li> <li>• WBOT results will not be commensurate with programme cost</li> <li>• Stakeholders not meeting their responsibilities - may be due to social problems now being identified by CHWs therefore increasing workloads which differs from the past which was social development waiting for cases to be reported</li> </ul>

# WBOT RAPID APPRAISAL: PIXLEY KA SEME DISTRICT, NORTHERN CAPE



*Pixley Ka Seme  
District: Northern  
Cape Province*

The rapid appraisal of the Ward Based Outreach Teams (WBOT) is a national project conducted by the Albertina Sisulu Executive Leadership Programme in Health (ASELPH) at the request of the NDOH. The Northern Cape is one of the seven provinces selected for the study. The purpose of the research is to review the current status of WBOT and to identify factors that impact the effective and efficient functioning of the WBOTs in Northern Cape.

The research team:

- Prof N Jinabhai
- Prof DT Goon
- Mrs. N Rala
- Mrs. NM Vellem
- Mrs. Jack
- Ms M Hlabahlaba - Ms Thompson - CEO Hospice
- Ms N Parkies - NCDoh- WBOT Co-ordinator

University of Fort Hare



## 2. WORK PLAN AND IMPLEMENTATION

On the 3rd March 2015 a preparatory meeting was held at Pixley Ka Seme district, Northern Cape. In consultation with the District Management Team, Siyancuma and Emthonjeni sub districts were identified as study sites.

Self-assessment forms were distributed to all the Senior Management Team members, together with copies of WBOT documents. Dates for field research were set. The methodological approach based on documentary reviews, structured interview questionnaires and direct field observations was outlined and the relevant documents and forms were shared with the Senior Management Team of the district. They were requested to submit these to the research team during their field visits.

Below is the report of the five-day rapid appraisal conducted between the 4th-8th May 2015 in the two sub-districts in Northern Cape.

### 2. Work Plan and Implementation

WORK PLAN	
<b>Day 1:</b>	The research team met with the WBOT Manager and coordinators in the two sub-districts to strategize and plan weekly activities pertaining to the WBOT Rapid appraisal. Documentation requested prior to field research was collected (Appendix A) in addition to the WBOT self-assessment questionnaires (Appendix B). Two peers from each sub-district were identified to join the research team.  The team interviewed 12 community health workers working in WBOTs in Emthonjeni sub-district (face-to-face).
<b>Day 2:</b>	10 household interviews were conducted at Emthonjeni sub-district.
<b>Day 3:</b>	Four focused group discussions were held with community health workers in Bristown, (Emthonjeni) (n=1) and Douglas, (Siyancuma) (n=3).
<b>Day 4:</b>	Eleven Interviews were conducted at Siyancuma sub-district (the WBOT team leader, district WBOT coordinator, the CEO of Hospice and at eight households).
<b>Day 5:</b>	Preliminary findings from the data collected in the two sub-districts were presented and discussed in a peer learning workshop with the WBOT district Manager, district coordinator and others.

Findings from the fieldwork are presented in four sections –

- 3.1 CHW Individual Interview Analysis
- 3.2 CHW Group Discussion Analysis
- 3.3 Household Interviews Analysis
- 3.4 WBOT Management Thematic Analysis

## 3.1 WBOT Community Health Workers

### WBOT services

The respondents reported that WBOT serves to help the community in handling their health issues. Broadly, WBOT provides are home-based care, maternal neo-natal care and women's health (MNCWH), non-communicable diseases screening, assistance with social services, counseling and support.

Community health workers visit people in their homes. During household visits they promote health, prevent illness, offer referrals to healthcare facilities, perform health status assessments for children under the age of 5, do ante and post-natal care, care for chronically ill patients, do home base care for immobile and elderly patients, assist with registrations of births at the Department of Home Affairs, secure food parcels and provide TB treatment through direct observed treatment supports (DOTS) services. Additionally, health talks on teenage pregnancies, contraceptives and HIV/AIDS are conducted.

The CHWs find providing health services to their community rewarding.

*"I feel good to help the people. It made me proud to help my community. I do feel happy when my clients are helped and are better"*

The CHWs enjoy interacting with the community on health issues and say they gain new knowledge.

*"We like working with the children and poor people in our communities. " We feel proud when they call us nurses."*

### Partnerships

Relations between WBOTs and facility staff vary. Some CHWs reported that their professional nurse team leader at the sub-district hospital is good.

*"The team leader gives us good guidance, talk freely to us, makes us part of the team, treats us with dignity. They are supportive and provide mentoring to us".*

Some reported that registered nurses were condescending and sometimes even hostile. There does not appear to be much of a relationship between the WBOTs and ward councilors with only one of five working cooperatively with teams.

## Operational constraints and suggested improvements

There is a sense that the Department of Health (DoH) does not plan adequately .

Some CHWs say they would prefer it if Hospice rather than government manages WBOT.

*“The management of WBOT is poor, they do not recognize our work and there is poor communication. They are not supportive when we are bereaved”.*

Although CHWs state that the quality of training received is good, the courses are non-credit bearing. Furthermore, CHWs have only had Phase 1 WBOT training.

They made the following recommendations:

- consistency in the training of CHWs
- increase in the number of outreach team leaders
- more campaigns to educate the community about health issues
- improve communication between the district coordinator and the team leader
- provide more ambulatory and EMS services in the community
- increase the value, align and regularly pay stipends
- pay salaries directly through the DoH and rather than indirectly through NGOS.

*“Our stipends are owned for three months and we do not have a clue on when it shall be paid. This is not good, as we are having family and working every day.” We don’t have an office. We need an office to share our challenges, experiences and achievements before starting the day’s work. We need transport so that we can extend our services to the farm community too.”*

In addition to the above, the following main challenges were identified:

1. The difficulty with TB patients and TB defaulters, MDR TB
2. Poverty and the development
3. Community Care Givers and their role in WBOT

## 3.2 Community health workers (CHW) – Group discussions

The Northern Cape Department of Health (DOH) has initiated as a policy to manage and operate the CHW Programme through the NGO Sector. The Nightingale Hospice, originally an organization that offered home based care (HBC), was identified as a channel through which to operate WBOTs and a formal contract was signed with the organization to employ, manage, monitor and evaluate all the CHWs.

### Scope of practice

The first task mandated to CHWs is household registration. Each household was identified through mapping in their respective wards. Household data was captured using the registration forms that cover detailed socio-demographic and health information for each member of the household. The registration forms were then shared with the WBOT team leaders based at the local PHC clinic. The team leader and the nursing staff reviewed the forms in order to identify appropriate interventions and treatments. Depending on the nature of the health problems, the CHWs are guided on how to perform these interventions at household level.

CHWs then are required to visit households identified as “in need” for specific interventions and make referrals to the primary clinic or Community Health Centre’s (CHCs).

Follow up visits are conducted to ensure that the identified health, social and other problems have been satisfactorily addressed and resolved.

CHWs also assist with “awareness days and health campaigns”.

After the referral to the clinic, the PHC Clinic staff identify appropriate interventions. Households identified as “not in need” are visited every six months to confirm the registration details and establish any change in status.

### WBOT Data Collection and reporting

In nearly all wards, information is collected manually by CHWs who record and submit the forms to the WBOT Team Leaders.

There is an electronic capture system pilot in Britstown. There CHWS use Lenovo tablets to capture data. All 14 CHWs in the Britstown WBOT have been trained the Health Systems Trust (HST) to use the tablets. During household visits, information is entered directly onto the tablets. It is uploaded onto servers when CHWs return to the clinic where it is accessed by the OTL on a desktop computer for review and to plan interventions, referrals and recommendations. All recommendations from the OTL are then uploaded directly to the respective CHWs tablet. Actions are implemented the following day, under OTL supervision.

It is envisaged that CHWs and data capturers based at the clinic will be able to collate, analyze and report on household registraton data as part of their tasks. Despite literacy constraints, with training and support the CHWs have been able to navigate the pre-loaded registration forms on the tablets and accurately enter the relevant data.

## **Career pathing, progression & further education & training**

Currently the 297 CHWs in the Northern Cape (NC) have all completed Phase I / Level I (ten days). To move to Phase II, they have to undertake a competency assessment followed by a six-month practice period. On completion of the practical they are expected to undergo another competency assessment to enter Phase III. A fast track option of completion of these training in one year also exists.

Regarding career progression the WBOT coordinator was not sure how and when this may happen or whether the CHWs will join the permanent establishment. ITEC is developing the curriculum materials and the CHW qualifications framework. Consultations have been undertaken with the Department of Public Service and Administration (DPSA) regarding the creation of an appropriate level in PERSAL for the CHWs.

## **3.3. Household Interviews**

### **WBOT experience**

Interviews with household members revealed that WBOT are seen working in the community and helping the sick.

*"We also see them at the clinic. They help us in health issues (TB treatment, HIV, Chronic medication), take care of our under 5 children, bath, clean and do our o washing when we are very ill".*

Community members say that CHWs care about them, inquire about their health and medical problems and ask if they are taking their chronic medications regularly. chronic medication are taking their medications regularly . CHWs also collect the medications from the clinic for patients in the community.

*"WBOT CHW educates us about health issues like diet, cleanliness, checking under 5s for immunisations. When they come, they ask whether we are sick or not, check for TB by screening us, DOTs us. Without the care-givers (WBOT), we will be lost in the community."*

### **Feelings about the services provided by WBOTs in the community**

Community respondents are positive and value the services provided by the WBOT.

*"I feel comfortable and happy. They help us to get birth certificates for our children. I had a broken back in 2013. They were cooking for me and doing everything in the house for me until I became better. They would call the ambulance to take me to the clinic."*

## **3.4 WBOT MANAGEMENT INTERVIEWS**

# WBOTS MANAGEMENT INTERVIEWS: THEMATIC ANALYSIS

TOPICS	RESPONSES	STRENGTHS
1. Knowledge about WBOTs	<ul style="list-style-type: none"> <li>• Team working hand in hand with the community and are the helping hands of the clinic, ears and eyes of the clinic</li> <li>• Promote, prevent illnesses before they occur and refer to clinic, and reduce the load</li> <li>• 297 CHW</li> <li>• 38 wards</li> <li>• 240 Assessed for the career pathing</li> </ul>	<ul style="list-style-type: none"> <li>• Knowledge of Palliative care</li> <li>• Manual as a guide</li> <li>• One manager has been trained as WBOT.</li> <li>• An enrolled nurse who works as a team leader worked with the WBOT leader who was trained before pension.</li> </ul>
2. Services rendered by WBOT	<ul style="list-style-type: none"> <li>• Focus in more palliative, TB, HIV/AIDS adherence, home base, MNCWH</li> <li>• Household registration</li> <li>• Promotion and prevention</li> </ul>	<ul style="list-style-type: none"> <li>• Provide equipment for service</li> </ul>
3. Interpersonal relationships between facility Registered Nurses and WBOTs	<ul style="list-style-type: none"> <li>• There is good relationship because of the good statistics from the facilities.</li> </ul>	<ul style="list-style-type: none"> <li>• Each facility got CHW's manuals as the guide</li> </ul>
4. Interpersonal relationships between Ward Councillors and WBOTs	<ul style="list-style-type: none"> <li>• No relationship except ONE ward councillor who support</li> </ul>	
5. Interpersonal relationships between WBOTs Managers and District Coordinators	<ul style="list-style-type: none"> <li>• No clear lines of communication, poor coordination between District and facility managers who act as OTLs, Area managers &amp; Hospice.</li> </ul>	<ul style="list-style-type: none"> <li>• Availability of Departmental cars, internet and phones</li> </ul>
6. Interpersonal relationships between other stakeholders and WBOTs	<ul style="list-style-type: none"> <li>• Poor relationship</li> </ul>	
7. Management processes	<ul style="list-style-type: none"> <li>• Irregular unequal payments of stipends from Social services R1500 and Health R1900.</li> <li>• District manager and WBOTs coordinator have no control on the payment of stipend.</li> </ul>	<ul style="list-style-type: none"> <li>• DOH have capacity to pay as the system is available</li> </ul>



WEAKNESSES	CHALLENGES
<ul style="list-style-type: none"> <li>No training for the management</li> <li>One Registered nurse trained on WBOT resigned, other one took pension, other one transferred to hospital</li> </ul>	<ul style="list-style-type: none"> <li>No retention and unavailability of Professional nurses interested in the district.</li> <li>No team leaders for WBOTs</li> <li>Available OTLs are facility based</li> <li>Community supervision rate: nil.</li> </ul>
<ul style="list-style-type: none"> <li>Lack of coordination amongst managers</li> <li>Poor communication amongst managers</li> </ul>	<ul style="list-style-type: none"> <li>Disruption to the services</li> <li>Confusion to WBOTs and clinic where they report</li> </ul>
<ul style="list-style-type: none"> <li>Not giving full attention on WBOT due to gross shortage</li> </ul>	<ul style="list-style-type: none"> <li>Shortage of staff</li> <li>Unavailability of OTLs</li> </ul>
<ul style="list-style-type: none"> <li>No proper introduction of WBOT to councillors</li> </ul>	<ul style="list-style-type: none"> <li>No cooperation and enough support from councillors</li> </ul>
<ul style="list-style-type: none"> <li>District coordinator with multi task as managing care and support and WBOTs.</li> <li>No dedicated manager focusing solely to WBOTs</li> </ul>	<ul style="list-style-type: none"> <li>Uncoordinated services</li> <li>Late communication</li> </ul>
<ul style="list-style-type: none"> <li>Other stakeholders lack knowledge of the programme</li> </ul>	<ul style="list-style-type: none"> <li>No response when there are referrals to other stakeholders.</li> </ul>
<ul style="list-style-type: none"> <li>Late submission of report by Hospice quarterly in order for WBOTs to receive their stipend at regular identified date.</li> </ul>	<ul style="list-style-type: none"> <li>Payments of WBOTs are under health but via Hospice. WBOTs performing the same job but different benefits (training and reimbursement)</li> </ul>

## Recommendations

- Increase recruitment of CHWs to perform more frequent and regular visits
- Considering the vast area WBOTCHWs cover, the transport should be provided to the WBOTs by the government
- WBOT team leaders should go on the community visits with the CHWs to guide, motivate and train them
- VCT counselors are not going to perform household visits. Therefore, management should consider providing training CHWs to perform VCT as potential patients are being lost because they are not identified
- Some community clinics are too small - the space, resources and equipment for CHWs is limited in quantity and scope
- CHW kits are inadequate and poorly replenished. In some wards the CHWs are given SurgiPacks with basic essentials
- Ideally all the data collection and entry should be computerized on tablets, with dedicated Data capturers and CHWs formally trained in their use
- Further pilot studies should be undertaken to explore the feasibility of the CHWs also undertaking basic profiles of households
- Generally, the CHWs found good support from the Clinics and the Nursing staff.
- Stipends – late and irregular payments are a major issue for CHWs because of financial and other commitments that need to be honored
- CHWs want to be respected and valued for the work they do. They want to be recognized for their contributions to health improvement. Their preference is to be employed and paid directly by the DOH
- CCGs and CHW Programmes should be amalgamated into a single cohesive and comprehensive programme, with the same scopes of practice, remuneration and management
- Lines of accountability, reporting and monitoring would be simplified and the current duplication between the clinic WBOT Team Leader and the NGO Hospice CEO would be eliminated.
- There is a need to increase and improve relations with ward councilors - both to inform them of community health related needs as well as to provide community services and other interventions to address community needs.
- Proposed “War Rooms” and coordinating structures need to be established and functional so that the valuable information collected by the CHWs and CCGs could be channeled to the relevant authorities, so that targeted interventions can be implemented.
- Strong calls are made for the current scope of practice of the CHWs to be expanded to include VCT training, HIV, TB testing, Basic Nursing Care, First Aid etc.
- Based on an expanded scope of practice the CHW kit bags and other resources, equipment and medications need to be equipped for them to be able to fulfill these additional function.
- CHWs need recognition when government posts are available especially those who qualify (have grade 12).
- Transport is crucial for WBOTs to reach people on the farms.



## Case Study 1: Ward Based Primary Health Care in Tshwane – The City of Tshwane/ University of Pretoria COPC Intervention



This review of the City of Tshwane/ University of Pretoria COPC Intervention is based on document review, key informant interviews and field site visits (27-05- 215) undertaken during the rapid appraisal process.

The complexity of health in the primary care setting and the many needs of multiple partners requires a multi-dimensional approach to primary health that is built on cooperation. As part of national primary health reengineering, the University of Pretoria Department of Family Medicine (UP DFM) and the City of Tshwane have created a proactive ward based primary care intervention to address health and disease in the metro. This intervention implements community oriented primary care through WBOTs, drawing on experience gained from seven site pilot in 2011-2013 (Family Medicine UP/Tshwane District ,GDoH) and the Foundation for Professional Development). It is built through an active public-private-university-non-governmental partnership. Practically, it is operationalised through five interrelated components.

1. Developing a shared understanding and commitment to the practice and processes involved in delivering community oriented primary care with key government, non-government and private sector partners.
2. Delivering services through clinically and professionally supported ward based health care teams that are drawn from and function in defined geographical areas.
3. Using a purposively designed information and communication technology (ICT) platform to support high quality service, learning and research across all sectors and layers of service from the individual home to the highest level of institutional care.
4. Developing an integrated educational platform to support workplace learning for both practical and qualification purposes. In it, the chain of learning is designed to extend from community health workers through team leaders and facility, sub-district and district managers, to health and other professionals. It is also expected to articulate with qualifications from basic occupational (QTCO Health Promotion) and vocational (NC(V) Primary Health) education through undergraduate health and medical education (BCMP for ClinA's, BMChB etc) to postgraduate diploma, masters and doctoral degrees.
5. Integrating research into service and learning in order to monitor and evaluate performance. and to generate a better understanding of health, care and disease as it is played out in individual, family and community life in defined geographical areas.

The CoT/UP COPC ward based health intervention started in 2013. Beginning in Mamelodi and Daspoort, it is being expanded to all Tshwane regions in collaboration with Tshwane District (GDOH).

In the first two years of implementation the initiative has achieved the following:

Organisation governance and management structures have been created and function according to an agreed framework.

- There has been an orientation of and there is ongoing engagement with key stakeholders (inter alia the mayoral & oversight committee, PHC facility managers, health and other sector NGOs, ward councillors and community based organisations).

- WBOT personnel have been recruited and appointed on contracts (1 WBOT manager, 5 cluster managers, 46 team leaders, 473 community health workers).
- Health posts have been established, upgraded and equipped (furniture, office and other equipment including lap tops, modems and mobile phones, medical bags, CHW bags etc.)

## Education and training

Learning materials have been developed. Personnel have been oriented and are continuously trained to provide ward based health care. *Inter alia*

- All management has undergone short course orientation (Introduction to COPC and the model, NDoH 5 day team leader training, NDoH 10 day training).
- All management participates in UP bi-monthly/monthly masterclass seminars as part of work integrated learning.
- All community health workers have undergone NDoH Phase 1: short-course training.
- All CHWs have been trained on how to use the gadget and the Aita application.
- All CHWS have been trained on the content of household registration, assessment and triage.
- All CHWs have participated in continuous peer, work-integrated learning with MBChB students on a number of primary health topics.
- 18 CHWs are enrolled in the NC(V) Primary Health part-time pilot initiated in Mamelodi through a partnerships with DHET and Gert Sibande FET.
- Bsc Psychology interns provide both education and psychological counselling support to CHWs.
- Custom materials (3 books and 4 films ) have been completed to support ward based health care education and training.

## Services

Service delivery has been set up and is being implemented. *Inter-alia*

- Through a mapping exercise, WBOTS have been allocated to wards and CHWs to households based on stand/household verification (as stands have more than one households).
- The intervention is being implemented in 35 wards across the City (Region 1- 6; Region 3 & 4 - 11; Region 5 & 7 - 5; Region 6 -13. As at end May 2015, there were 103 functional WBOTS (50 CoT and 53 Tshwane District) i.e. teams with team leaders and community health workers. There were 1215 community health workers in Tshwane, averaging 10 -12 per team.
- Community health workers have registered households. On average each CHW has completed a household health status assessment and triage, done health promotion and disease prevention, made referrals to clinics as well as to other local service providers and undertaken follow up visit with 75 households and some 250 individual household members (end May,2015).
- Team leaders (Professional Nurses) and doctors support clinical care and when necessary accompany CHWs to attend to people in their homes.
- CHWs assist facilities with health promotion, wound care, chronic medication delivery, treatment defaulter tracing etc.

## Cooperation and collaboration

The intervention is built on collaboration between people and organisations across all sectors and disciplines that contribute to health at community, district and provincial level. Integration of services and care is actively engaged through a number of mechanisms.

- Multisectoral, inter-disciplinary COPC forums have been created to share knowledge and information as well as to improve coordination and cooperation in the field. They are not across all CoT sites. Of those that have been set up, some meeting intermittently (e.g. in the Inner City) while others meet routinely every fortnight (e.g. Mamelodi West).
- Facility – WBOT coordination and cooperation is in progress but uneven, ranging from monthly multi-facility- ward health management meetings (e.g Mamelodi, Daspoort) to single team/ facility interaction on a case-by-case basis (e.g Inner City).
- Regional Health Management Teams have been created in the Inner City and Mamelodi. These teams integrate care from the home to hospital and back, focussing on continuity of care, collaborative care and integration of services.
- CoT- Tshwane District integration is in progress but is slow. This has led to duplication of services and parallel support and functioning.

## Information

An ICT enabled platform is functional.

- It is created as a collaborative partnership between government, higher education and the private sector (CoT, Tshwane District, CSIR, UP, Mezzanine, Synaxon, Wellnicity, James1:27).
- ICT is managed by a data governance committee made up of all partners. The committee meets weekly.
- Applications developed for services take into consideration the information requirements of other levels of the health system as well as other sector needs (e.g indigent, Ntirisano, DHIS). The HHR is fully functional. The individual health status assessment is at an advanced stage of development and will be pilot and implemented by the end of 2015.
- System refinement and content and application development is continuous and on-going.
- Information is transmitted through secure, non-public routes and is available to team leaders and other relevant levels of management in real time on a web based platform that is accessed on all available technologies (computers, tablets and cells).

Ward Health Care (WHTs and RHTs)

- Cell phones are the field devices. Community health workers capture information electronically using a custom designed Aita application. The first component that has been developed is the HHR (Household Registration, Assessment and Triage). In the first week of October, 2015 some 80,000 households and 265,000 individual household members had been registered by WHTs across Tshwane .
- Current and historically collected information about their designated families is available to community health workers at all times on their cell phones.
- Custom reports are available and being developed to support team leaders and RHT management.
- System information and custom reports are used by managers to monitor and support performance and to plan and report.
- Technological support and training is ongoing.



# WORKFORCE PERFORMANCE REPORT: REGION 6 (MAMELODI) 2014-09-01- 2015-04-30

Team/Ward	Number of Registered Houses	Number of Registered Members	Number of Follow-up Visits Scheduled	Number of Follow-up Visits Completed
Jafer Mahlangu Team 1	298	1180	542	250
Jafer Mahlangu Team 2	248	1001	603	344
Mamelodi west team 1	379	1488	330	174
Mamelodi west team 4	487	1837	179	84
Recovery center team 1	362	1109	193	135
Recovery center team 2	366	1221	252	108
Rethabile SP Team 1	212	1041	399	100
Phahameng Team 1	733	2155	569	200
Phahameng Team 4	1403	5403	591	574
Ikageng Team 1	443	1410	207	24
Ikageng Team 2	652	2313	1040	446
Stanza 2 Team 3	1175	4337	350	210
Stanza 2 Team 6	1289	4551	384	205
Stanza 2 team 7	1083	3784	165	41
Stanza SP team 1	1096	4336	725	241
Stanza SP team 2	638	2069	604	251
Nellmapius Team 1	306	1128	258	11
Nellmapius Team 3	225	683	411	190
Nellmapius team 2	1117	3992	449	208

The ICT platform extends into facilities.

- An integrated patient record system at clinic and hospital levels (Daspoort, Sediba Hope, Stanza Bopape and Pretoria West respectively) has been put in place to support information and service continuity across facilities and with ward health teams.
- Technical training and support is ongoing.

Information collected through the ICT platform is used for multiple purposes.

- Data are used to support reporting and planning at local, regional, city and district level
- Data supports operational, applied and basic research. In June 2015, there were 16 ongoing research projects in the UP COPC Research Unit linked to this initiative. Most research projects include masters and doctoral students, thereby contributing knowledge and capacity to the national innovation system.
- Presentations and posters have been presented at national and international conferences, workshops and fora and papers have been published in peer reviewed journals.

These many achievements are the outcome of serious commitment and considerable purposive and sustained individual and collective hard work that stretches from community health workers and team leaders to senior CoT officials and COPC Living Lab academics and practitioners at UP Department Family Medicine.

## Challenges

This intervention conceives of ward based health services as a stand alone, geographically defined component of a locally integrated primary care system. While it has been possible to identify workable solutions to some key elements, ongoing sustainability and expansion depends on overcoming underlying systemic constraints. Critical amongst these is the status of community health in the health care system. Construed as an addendum of people and services of uncertain value and uncertain prospect, community based health has been gripped by problems of financing, management, education, recruitment and conditions of employment. These are made worse by the poor integration of services across systems, departments, divisions, tiers, sectors and people that lead to inefficiencies, undermine cooperation and result in avoidable direct and indirect economic and social costs to the system as well as to individuals and families.

It is clear that better solutions can be found to all these challenges. Notwithstanding the best efforts of individuals on the ground however, these are only likely to succeed when the status of community health is addressed systemically.

In Gauteng this is becoming a possibility as integrated COPC has been accepted as a model of community health. In the third quart of 2015, a provincial team began working on province wide implementation of best practice ward health care, under instruction of the MEC for Health (GP). The team is expected to address data and IT systems, the education of ward health teams and managers, integration of ward health teams into re-engineered primary care, human resources and management. It is anticipated that this work will lead to community based primary health care that is integrated into district health and across sectors and that is capable of providing quality services to individual and families in their homes and places of occupation.

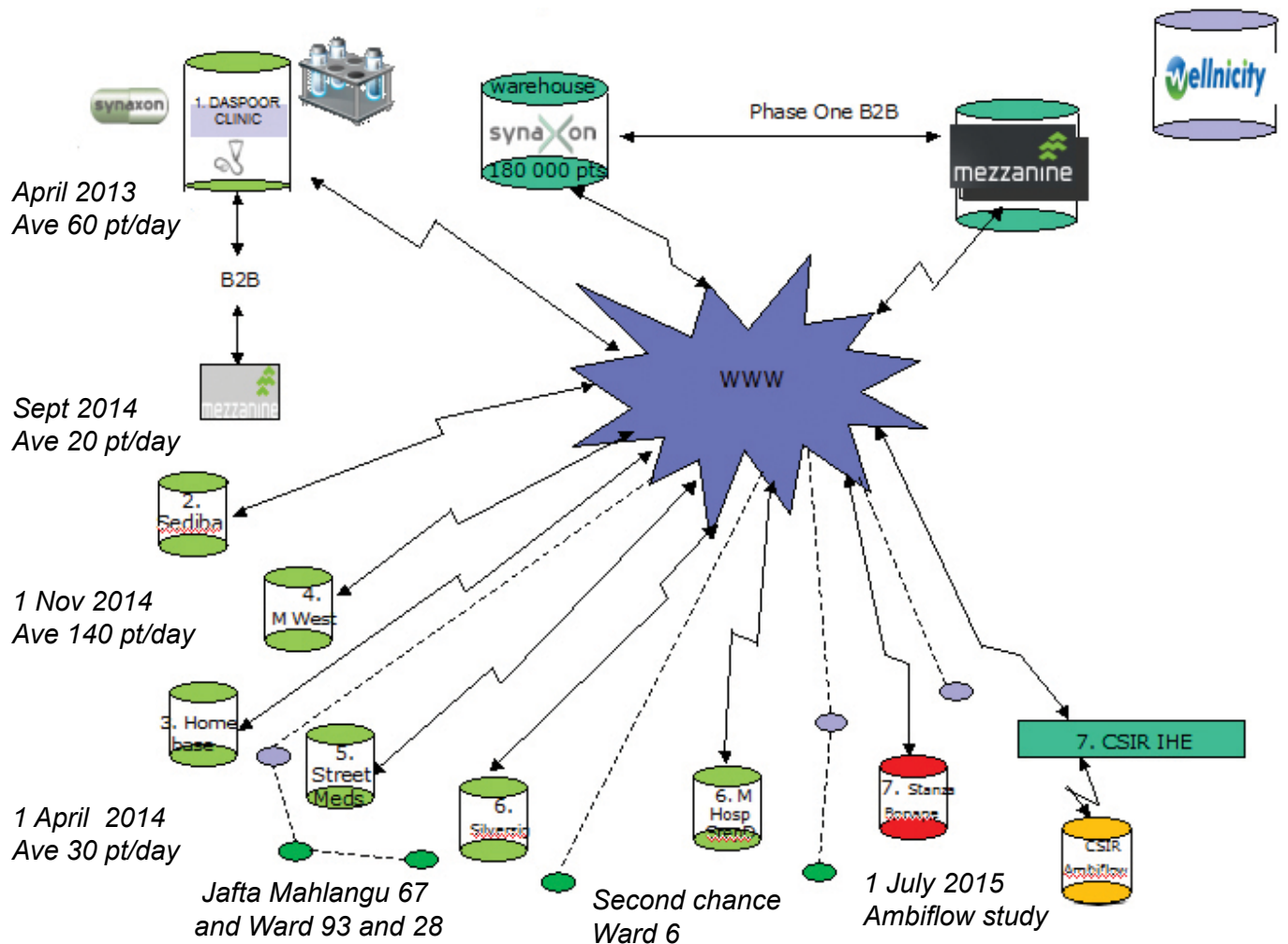


Aita Household visit



Aita Team Photo

### ICT Operational WBOT Clinics and Health Posts



## Case Study 2: Philani Maternal Child Health and Nutrition Project: Mentor Mothers in Zithulele and Coffee Bay Eastern Cape

The Philani Maternal, Child Health and Nutrition Project is a community health organization that focuses on family health



by supporting pregnant women and child nutrition through five inter-related programmes (Mentor Mother, Educare, Income Generation, Integrated Nutrition and Dental). It started in Crossroads and the surrounding informal settlements of Cape Town (Western Cape) in 1979. Through the Mentor Mothers programme, Philani MCHN expanded into OR Tambo District (Eastern Cape) beginning in Zithulele Village in 2010 and extending to Coffee Bay in 2012.

This review focuses on Philani MCHN in the Eastern Cape . It draws on a review of documents as well as interviews conducted in the field over two days (20-21 July 2015).

Philani MCHN activity in the Eastern Cape was initiated through the Mentor Mothers Programme. The MM Programme engages "capable women to improve the lives of families, within their own communities, prioritising mothers and children. In this way the programme takes family health, including the nutrition and rehabilitation of children, beyond clinics and institutions and directly into people's homes." It is an action-oriented health intervention with women in their homes. Women recruited to become Mentor Mothers are selected from their communities for their positive coping skills (positive deviants). They are trained (initial six weeks, ongoing work integrated learning) and actively supervised and supported in the field. Mentor mothers and their coordinators monitor performance and intervention outcomes.

### Services

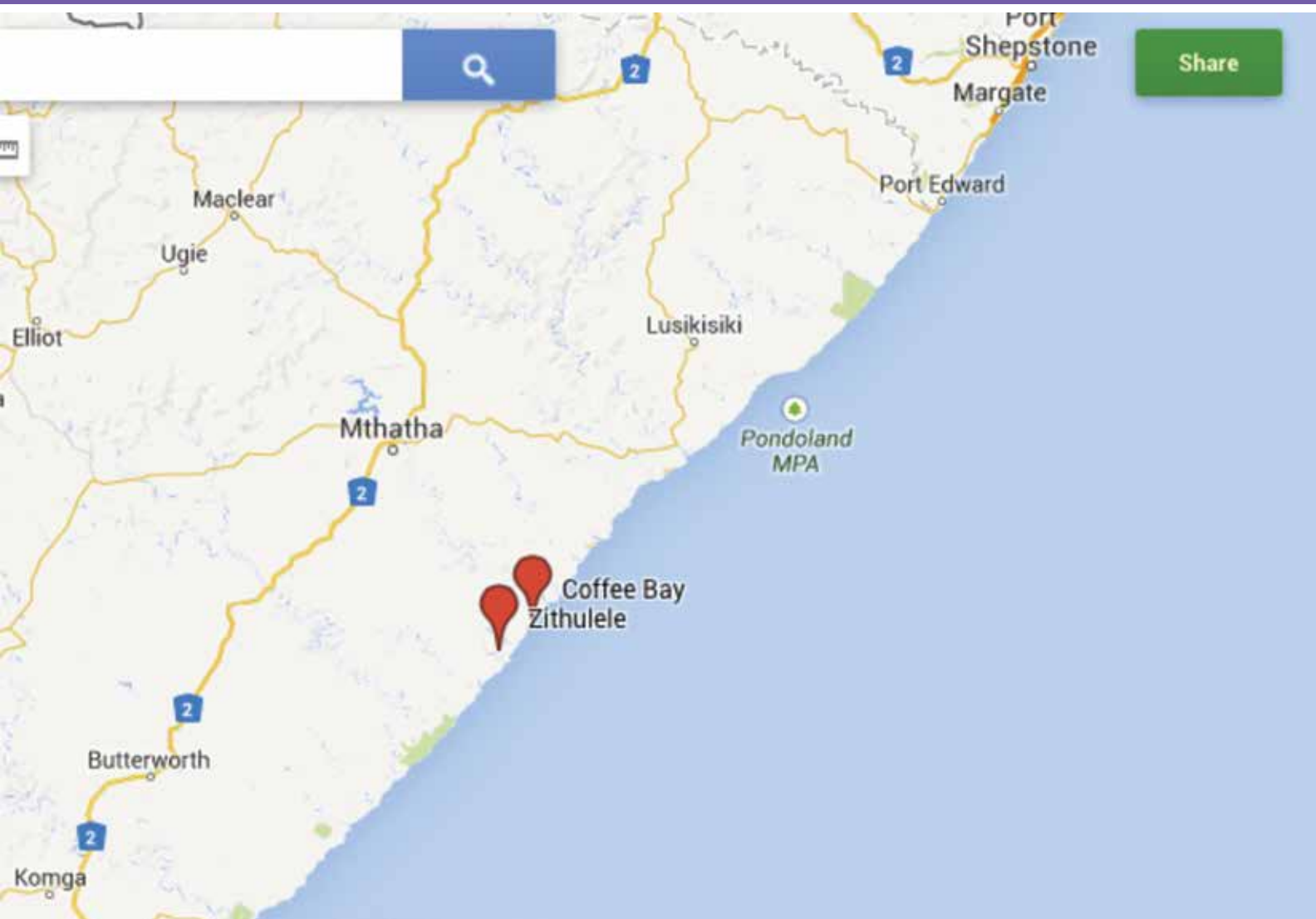
Philani MCHN is based at Coffee Bay and Zithulele, where some 74 staff, including professional nurses at each site, works in surrounding villages.

The Mentor Mothers Programme has become an umbrella programme for nutrition rehabilitation, breast-feeding and infant feeding, grant uptake, HIV transmission prevention, ECD, home based care etc. Each Mentor Mother visits 6-8 households a day in her catchment area to assess at risk children and pregnant mothers. Mentor Mothers have average caseloads of approximately 30 children and 40 pregnant women. In 2014, Mentor Mothers had an average of 3,000 cases at any one time. They undertook 53,000 household visits and weighed 46,000 children. ECD Mentor Mothers operated 10 remote rural playgroups.

### Partnerships

Philani MCHN entered into a formal partnership with the Eastern Cape Department of Health (ECDoH) in 2014 to support WBOT service integration. Drawing on its experience, Philani is responsible for training, supervising and supporting ECDoH CHWs in Ward 24.





## Zithulele and Coffee Bay

Philani MCHN works with traditional healers and other local stakeholders to identify and recruit Mentor Mothers and to get their help to promote health and prevent disease.

Philani MCHN Mentor Mothers work at ECDoH primary health clinics assisting with health promotion, disease prevention and defaulter tracing.

Philani MCHN works closely with the local ward counsellors and ward committees.

Philani MCHN works in partnership with the Universities of Stellenbosch, Cape Town, California & Los Angeles and Stanford to undertake research, do monitoring and evaluation and to support education and training.

Philani MCHN works with a number of faith based and other NGOs. All of their field staff is female, given its femi-centric focus on maternal and child health. It does however; indirectly try to collaborate with organisations like TAC to address men's health issues.

## Education and Training

In addition to training newly recruited Mentor Mothers and CHWs, Philani MCHN undertakes mental health, ECD and HCT and other training with staff. There is a Mentor Mother Training Manual that is used in the Mentor Mother 6 week training.

## Information and ICT

Mentor Mothers complete three folders for a household – one each for the pregnant woman, the child, and the rest of family. In October 2014, Mentor Mothers in Ward 24 piloted mHealth using cell phones. The cell phone application is used to collect household information simplify data collection and enable office-based supervision to compliment field support.

## Staffing

Professional and managerial staff are employed on one-year renewable contracts and are paid according to their level of education/qualifications. CHWs and Mentor Mothers are paid stipends.

## Challenges

Programme challenges include the nature and extent of social and economic distress, the inability of health care facilities to meet service demands, the need to have integrated service delivery and much greater involvement of government departments, the need to provide health care workers including Mentor Mothers with psychological support, and the need integrate into the DHIS, and the need to normalise Mentor Mom conditions of employment.





## Case Study 3: Community Action and Palliative Care



**COMMUNITY ACTION**

Community Action is a training and service support NGO (formerly the Palliative Care Institute

1998) in the City of Johannesburg. It originated as a response to the palliative care and general HIV/AIDS educational needs of parents of especially HIV positive terminally ill patients and the health professionals who provided services to them. It combines community based health education and care support, with palliative care education and support in facility as well as in-community. Community Action works primarily in Alexander.

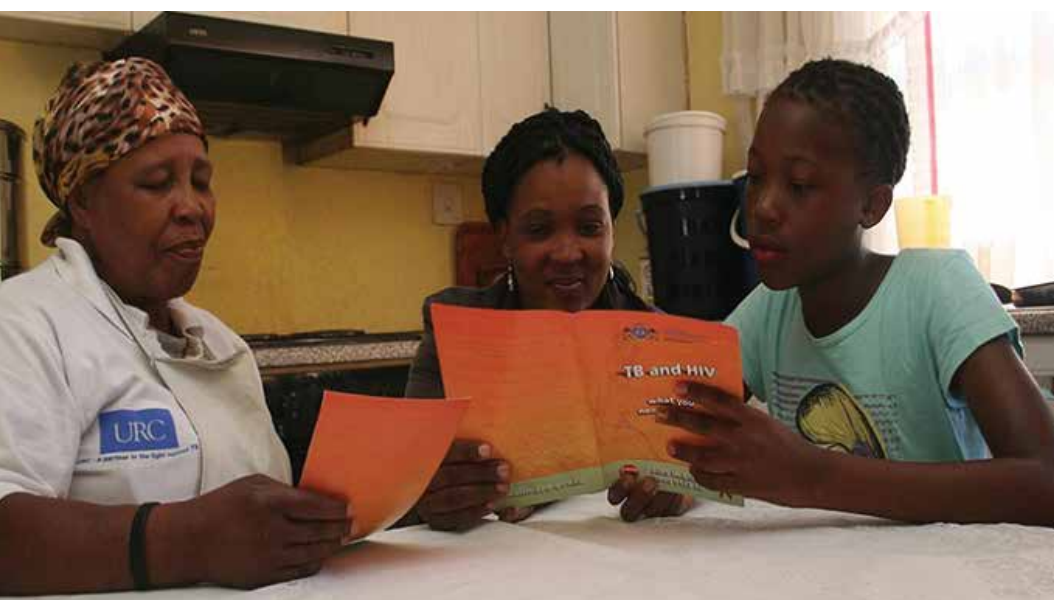
### Approach

Community Action empowers parents, care givers and other individuals to organise for health in communities by creating street or neighbourhood committees. Community Action uses a holistic approach to health and disease that is based on individual and family needs.

The Pan-Palliative Care Team (PPCT) promotes the integration of palliative care and curative medicine. Educationally it teaches professionals and care givers “to manage suffering of any patient with any condition at any stage” in any setting.

### Services

Like ward health teams, Community Action street committees work with all households in defined geographical areas. Each street committee member (SCM) is allocated 50 households. An education and needs assessment visit is done with each household. The SCM does follow up visits based on the social and health care needs until issues are resolved. A PPCT nurse based at Community Action offices provides clinical care to households with medical problems. The Pan Palliative Care Team at Charlotte Maxeke links street committees to patients who are discharged back into the communities.



*Education using own developed reading material in a home*

## Education

Education and training combines short course training (2-4 weeks) During the training period in addition to interactive classroom sessions, every SCM spends two days in the field with a member of the Community Action Demonstration Team. Post training SCMs are assessed and supported in weekly training sessions in the field until they are fully competent.

Community Action has created purposively designed educational material (Interview techniques for the SCMs, a training guide for the trainer of the SCMs, animated sequences demonstrating health and disease, A positive learning game, a resource list of community services, and own developed reading material). The learning model is one of “continuous repetition of material until information is successfully recalled”.

## Information

Community Action uses a paper data-collecting tool to collect individual demographic, socio-economic and health information. Completed forms are checked by the SCM monitor and captured electronically by a data capturer. Information is used by SCMs to educate and provide services and make and monitor referrals.

## Cooperation and Collaboration

Community Action’s starting point is integration across services. An initial stakeholder community mapping exercise implemented before the project began is continuously updated and forms the backbone of an active cooperation and referral system.

SCMs use the stakeholder list to make referrals using referral forms and to do active follow-up. Active partners do back referral.

Community Action partner and stakeholder organisations include:

- Government departments operational in Alexander (the Home affairs and Social Development as well as City of Johannesburg – Primary Health Care, Fourth Avenue Clinic);
- National and local non-governmental organizations (Operation Hunger, SANTA -South African National Tuberculosis Association);
- Community based organizations (Albert Luthuli Home Based Care, Bathuseng Home Based Care, Friends for Life, Itlokomeleng Old Age Home, Jozi Hlomile, Masakane Health Centre, Ncedo Home Based Care, Phuthaditshaba Old Age Home); and
- Civic associations and forums (Alexandra Renewal Project, GAPAA -Alexandra Umbrella Association).

## Organisation

Community Action has a four-tier management system – comprising the project manager, the trainer, the chief monitor and community monitors. Community monitors are permanent staff who coordinate, assist and monitor street committee members (SCMs).

All managers are appointed as permanent staff. SCMs are contracted ‘full-time’ on stipends. This means that do not have prescribed working hours and expected to be a resource to the community at any time.

Community Acton has specific criteria of SC member selection. To be eligible the person must have experience with HIV and AIDS as a parent or relative, live within the same community, be older than 18 years, have a grade 12 (matric qualification) and speak the local language.

The scope of practice of SCMs includes:

- Establishing a relationship and rapport with household members.
- Assessing the family or individual needs.
- Assisting with needs by linking the individual/family with community resources, (stakeholder list).
- Educating the individual/household on HIV and AIDS prevention and testing, TB, maternal and child health, etc.
- Educating and supporting healthy lifestyle and healthy living (E-pap - fortified maize meal as supplement).
- Supporting and monitoring treatment adherence (ART, DOTS).
- Involving traditional healers in the health education.
- Linking to social and health services.

SCMs do not provide counselling in any form. They do not diagnose or prescribe treatment. And they do not provide home-based care services such as bed baths etc.

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# ACRONYMS

Abbreviation	Description
AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante Natal Care
ARV	Antiretroviral
ASELPH	Albertina Sisulu Executive Leadership Programme in Health
BNurs	Bachelor Of Nursing
BP	Blood Pressure
CBA	Competency Based Assessment
CBO	Community Based Organisation
CCG	Community Care Givers
CEO	Chief Executive Officer
CHW	Community Health Worker
COPC	Community Oriented Primary Care
CoT	City of Tshwane
DCST	District Clinical Specialist Team
DDG	Deputy Director General
DHIS	District Health Information System
DHS	District Health System
DOTS	Directly Observed Treatment Support
DPSA	Department of Public Service and Administration
EC	Eastern Cape
EHO	Environmental Health Officer
EMS	Emergency Medical Services
EN	Enrolled Nurses
FS	Free State
GP	Gauteng
HBC	Home Based Care
HCT	HIV Counseling and Testing
HH	Household
HIV	Human Immunodeficiency Virus
HP	Health Promoters
HRH	Human Resources for Health
ID	Identity Document
IDP	Integrated Development Planning
INP	Integrated Nutrition Programme
km	Kilometers
KPI	Key Performance Indicators
KSD	King Sabata Dalindyebo
LP	Limpopo
MDR	Multi Drug Resistant
MNCWH	Maternal Neonatal Care and Women's Health
MP	Mpumalanga

<b>Abbreviation</b>	<b>Description</b>
<b>MRU</b>	<b>Monitoring Response Unit</b>
<b>NC</b>	<b>Northern Cape</b>
<b>NDoH</b>	<b>National Department of Health</b>
<b>NDP</b>	<b>National Development Plan</b>
<b>NGO</b>	<b>Non-governmental Organisation</b>
<b>NHI</b>	<b>National Health Insurance</b>
<b>NQF</b>	<b>National Qualifications Framework</b>
<b>NSDA</b>	<b>Negotiated Service Delivery Agreement</b>
<b>NW</b>	<b>North West</b>
<b>OTL</b>	<b>Outreach Team Leader</b>
<b>PERSAL</b>	<b>Personal and Salary System</b>
<b>PHC</b>	<b>Primary Health Care</b>
<b>PN</b>	<b>Professional Nurse</b>
<b>RA</b>	<b>Rapid Appraisal</b>
<b>RN</b>	<b>Registered Nurse</b>
<b>SAPS</b>	<b>South African Police Service</b>
<b>SASSA</b>	<b>South African Social Security Agency</b>
<b>SDG</b>	<b>Sustainable Development Goal</b>
<b>SDH</b>	<b>Social Determinants of Health</b>
<b>SLA</b>	<b>Service Level Agreement</b>
<b>STI</b>	<b>Sexually Transmitted Infection</b>
<b>TB</b>	<b>Tuberculosis</b>
<b>TL</b>	<b>Team Leader</b>
<b>UHC</b>	<b>Universal Health Coverage</b>
<b>UN</b>	<b>United Nations</b>
<b>VCT</b>	<b>Voluntary Counselling and Testing</b>
<b>WBOT</b>	<b>Ward Based Outreach Team</b>
<b>WBPHCOT</b>	<b>Ward Based Primary Health Care Outreach Team</b>
<b>WHO</b>	<b>World Health Organisation</b>

# RESPONDENTS

Province		
<b>Eastern Cape</b>	Community health workers	17
	Community members	11
	Outreach team leaders	112
	Non-Governmental Organization managers	0
	Self-Assessment Questionnaires	8
<b>Free State</b>	Community health workers	25
	Community members	31
	Outreach team leaders	-
	Non-Governmental Organization managers	-
	Self-Assessment Questionnaires	8
<b>Gauteng</b>	Community health workers	12
	Community members	8
	Outreach team leaders	2
	Non-Governmental Organization managers	
	Self-Assessment Questionnaires	6
<b>Limpopo</b>	Community health workers	12
	Community members	8
	Outreach team leaders	2
	Non-Governmental Organization managers	2
	Self-Assessment Questionnaires	5
<b>Mpumalanga</b>	Community health workers	12
	Community members	8
	Outreach team leaders	2
	Non-Governmental Organization managers	2
	Self-Assessment Questionnaires	4
<b>Northern Cape</b>	Community health workers	42
	Community members	10
	Outreach team leaders	-
	Non-Governmental Organization managers	-
	Self-Assessment Questionnaires	10
<b>North West</b>	Community health workers	12
	Community members	8
	Outreach team leaders	2
	Non-Governmental Organization managers	-
	Self-Assessment Questionnaires	4



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