Rapid Assessment of the Implementation of the Ward-based Primary Health Care Outreach Team (WBPHCOT) Policy Framework and Strategy

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Background

- Primary Health Care remains the backbone for comprehensive health care services in resource constraint settings.
- The PHC paradigm as adopted in the Alma Ata Declaration (1978) also emphasizes on redefining health, beyond disease and sickness through emphasizing on prevention, community empowerment and development,
- Community Health Care workers are considered a key towards bridging the gap between PHC facilities and communities.
- CHWs key in achieving Universal Health Coverage for all citizens, regardless of their socio-economic status or geographic location
- The Ward Based Primary Health Care Outreach Teams in model was adopted by South Africa as part of the “re-engineering” of the country’s PHC services

AIM & OBJECTIVES

Overall Aim

To undertake a rapid assessment to gain an understanding of the WBPHCOT implementation context in South Africa including best practices, enabling factors, challenges, and recommendations from the existing literature and primary data collection in selected sites

Objectives

- To conduct a desktop review exploring best practices based on the existing literature and other relevant reports
- To conduct a policy review of all the WBPHCOT implementation documents and protocols, including training manuals, tools as well as reports and data
- To gain an in-depth understanding of the implementation models, including training, accreditation, remuneration, conditions of employment, and other labour-related issues.
- To explore the enabling factors, barriers, challenges, and other implementation-related issues
- To provide recommendations for future modifications and improvements to strengthen the implementation of the WBPHCOT program based on existing literature and the findings from the empirical data that will be collected in the current study

METHODOLOGY

Qualitative study

[Open-ended interview guides]

Key informant interviews
- Provincial program/DHS manager
- District and subdistrict managers

In-depth interviews
- PHC officials
- OTLs
- Key stakeholders

Focus group discussions
- CHWs

Mixed-method sampling approach
- Random and Purposive sampling

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SAMPLING

Random sampling

- 12 Districts were sampled across 9 provinces: 2 districts for Limpopo, Eastern Cape, and KwaZulu Natal; 1 district for other provinces
- 2 subdistricts randomly sampled for each district [only subdistricts with >6 CHWs]
- 6-10 CHWs were randomly selected in each subdistrict for FGDs

Purposive sampling

- KIIs: 9 provincial program and 9 DHS managers; 12 district, 24 subdistrict managers were selected through consultation with NDoH/PDoH
- IDIs: 44 PHC officials, 24 OTLs, and 24 key stakeholders

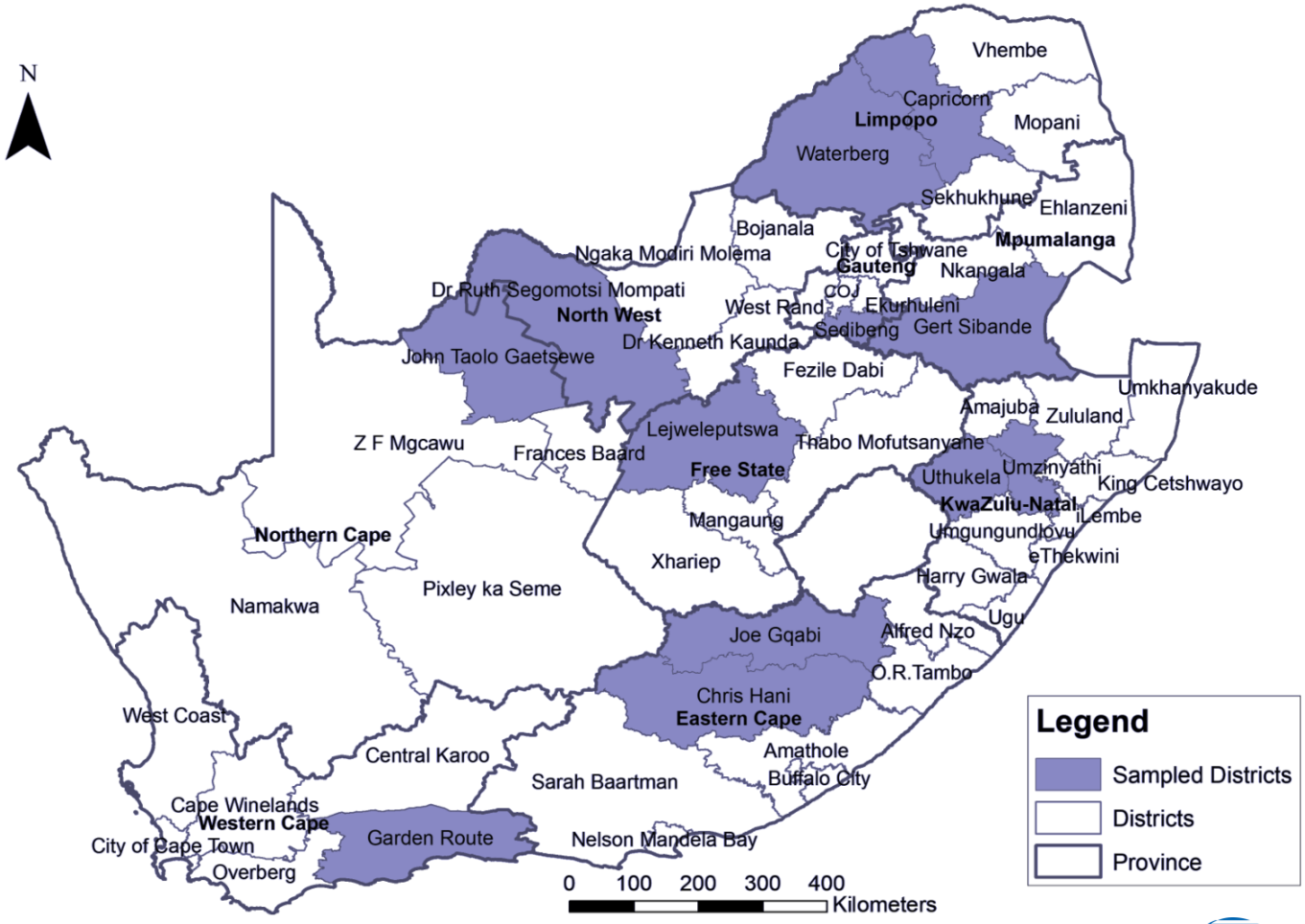
Key Informant Interviews Sample

Province	District Managers	Subdistrict Managers
Western Cape	1	2
Eastern Cape	2	4
Northern Cape	1	2
Free State	1	2
North West	1	2
Gauteng	1	2
Mpumalanga	1	2
Limpopo	2	4
KwaZulu-Natal	2	4
Total	12	24

In-depth Interview and FGD sample

Province	Facility managers or designated managers	CHWs (FGDs)	OTLs	Relevant stakeholders
Western Cape	4	2	2	2
Eastern Cape	4 (2 Districts)	4	4	4
Northern Cape	4	2	2	2
Free State	4	2	2	2
North West	4	2	2	2
Gauteng	4	2	2	2
Mpumalanga	4	2	2	2
Limpopo	4 (2 Districts)	4	4	4
KwaZulu-Natal	4 (2 Districts)	4	4	4
Total	**36**	**24**	**24**	**24**

SAMPLED DISTRICTS



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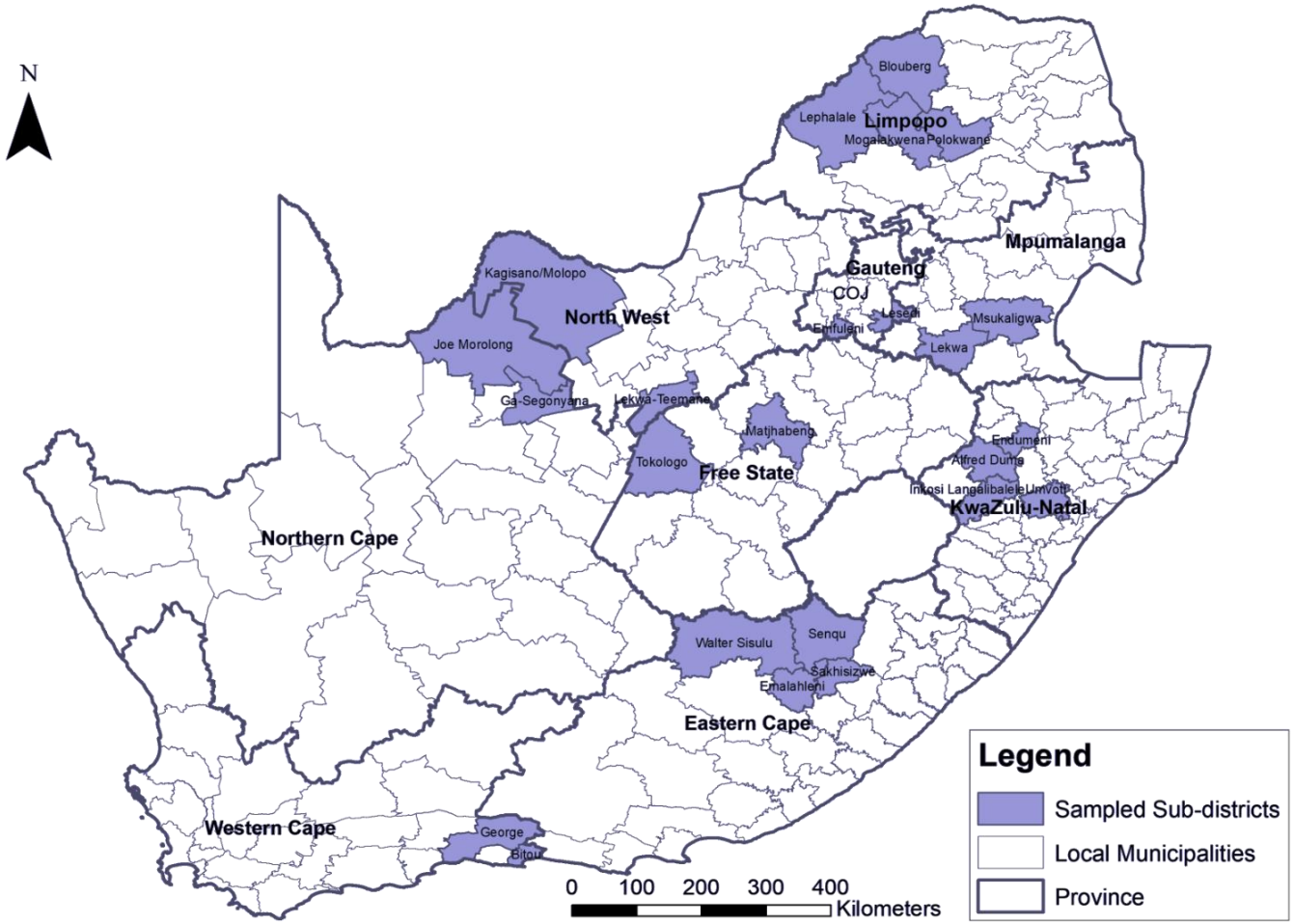
SAMPLED SUB-DISTRICTS



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Key findings

Response Rate

	Provincial Managers	Provincial DHS Managers	District Managers	Subdistrict Managers	PHC facility manager	OTL	Key stakeholders	FGDs
Eastern Cape	1	1	2	4	6	4	4	4
Northern Cape	1	1	1	2	2	**	2	2
Free State	1	1	1	2	3	2	2	2
North West	1	1	1	2	4	2	2	2
Gauteng	1	1	1	2	2	2	1	2
Mpumalanga	1	1	1	2	4	2	2	2
Limpopo	1	1	2	4	8	4	4	4
KwaZulu-Natal	1	1	2	4	8	4	4	4
Total	8	8	11	22	37	20	21	22

DESKTOP REVIEW ON BEST PRACTICES

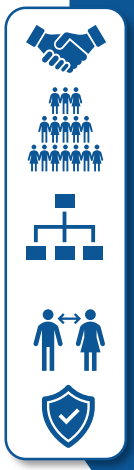
Demographic and personality characteristics of CHWs

- Eligibility requirements for CHWs of 18 or older
- A resident of the community and well-accepted by the community
- Familiar with local customs and habits
- Strong desire to volunteer and positive interpersonal skills
- Community involvement in the selection and recommendation of CHWs

Compensation models for CHWs

- A comprehensive legal framework is essential for the high-quality implementation of compensation models
- Long-term funding and politics remain barriers
- Expressed discontent with low wages, lack of permanent employment and absence of benefits like health insurance and pension funds

DESKTOP REVIEW ON BEST PRACTICES



Strengthen the relationships between CHWs and other healthcare professionals

A strong and cordial relationship between CHWs and healthcare workers is crucial

Healthcare workers often feel overwhelmed by the high number of patients referred by CHWs

CHWs to feel supported in their role rather than perceived as lay workers, the social hierarchy of healthcare facilities needs to be overcome

Better working conditions and supportive supervision for CHWs are among the strategies to foster workplace trust

Building interpersonal and institutional trust

DESKTOP REVIEW ON BEST PRACTICES

Monitoring tools used by CHWs to inform the planning and evaluation of the program

Capturing of household and individual data using digital platforms [mHealth and cell phone technology]

Constant verification and checking of data quality purposes

Setting quantitative targets for WBPHCOTs [number of HIV test follow-ups, supervisory visits, and plan formulation]

Functional District Health Information System

DHS needs to have a functional and regularly updated data management system; this will allow the policymakers and implementors to fully understand and determine the need and identify the gaps in human resources

DESKTOP REVIEW ON BEST PRACTICES

Ongoing training of CHWs

- Structured, supportive, and experiential ongoing training should be adopted into everyday COPC practice to build capacity
- Foundation phase training should be offered to all newly recruited CHWs and OTLs
- Refresher courses to ensure continuous learning
- Training should cover data administration, competencies to compile and analyse data to help improve data quality, organisational and clinical competencies
- Certification of completion or competency upon completion of training

National summit to share experiences and best lessons

- There is a need for the establishment of a feedback mechanism to provide guidance and share experiences when implemented in different settings and alternative contexts
- Encourage community and key stakeholder participation in such summits

DESKTOP REVIEW ON BEST PRACTICES

Resources for outreach purposes

Non-provision of necessary equipment and supplies was the biggest challenge

CHWs use their finances to buy stationery and make copies of necessary forms

NDOH must compile a list of required materials and resources

Resources should include a nametag-adorned uniform, an umbrella for rainy weather, a designated workspace and meeting area, files for paperwork storage, stationery, and a phone for communication

Transportation needs to be considered

WBPHCOT POLICY IMPLEMENTATION and STRATEGIES (Empirical Data)

Differences in supervision models

- There are differences in the CHWs supervision models, and training, highlighting the lack of a standardized approach in the WBPHCOT program across provinces
- CHWs are supervised differently across provinces.
- Variation in supervision models due to an insufficient number of OTLs
- Some districts utilise PHC managers for supervision

Disparities in resource availability

- Varied availability of funding, human resources, infrastructure, and training
- Impact on scope and quality of WBPHCOT policy framework and strategy

District-level understanding

- Most managers are knowledgeable about WBPHCOT policy implementation
- Recognised as a holistic approach to extend healthcare services

IMPLEMENTATION MODELS

Employment conditions for CHWs

- CHWs operate on renewable one-year contracts
- Low compensation leading to job insecurity and financial instability
- Some districts offer permanent contracts, e.g. Gauteng

Role of OTLs

- OTLs crucial for supervising and supporting CHWs.
- Some face challenges fulfilling duties due to clinical roles

Reporting and supervision challenges

- Daily check-ins at facilities leading to time wastage
- Potential for work beyond normal hours

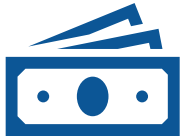
Utilisation of Technology

- In-person support groups and WhatsApp are used for communication
- Facilitates collaboration and problem-solving

CONDITIONS OF SERVICES FOR CHWs

Entry requirements for CHWs

- Completion of matric or grade 12
- Some districts consider individual CHW experience
- Good social standing in the community is valued



Funding challenges

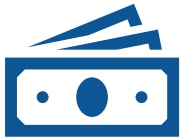
- Inadequate funding in certain districts
- Impacts remuneration and resource availability
- Delays work and reports for OTLs and CHWs

Remuneration models for CHWs

- Employed on one-year renewable contracts
- Monthly stipend around R4000.00
- Job insecurity and financial instability
- Some districts offer permanent contracts

CONDITIONS OF SERVICES FOR CHWs

Remuneration models for CHWs



- Employed on one-year renewable contracts
- Monthly stipend around R4000.00
- Job insecurity and financial instability
- Some districts offer permanent contracts

Working hours

- Typically 8 hours a day, Monday to Friday
- Occasional overtime and weekend work based on client needs
- Varied based on demands and urgency of follow-up tasks

SCOPE OF WORK AND OTHER ACTIVITIES BEYOND THE SCOPE OF WORK

Defined scope of work:

Community and individual profiling: Assessing health needs and demographics

Campaigns: Organising and participating in health awareness campaigns

Counselling: Guiding on health-related issues to individuals and families

Identification of support services: Referring community members to social support services

Communication and administration: Facilitating communication between community members and healthcare facilities, as well as administrative tasks

Duties beyond scope:

Facility-requested tasks: CHWs often find themselves performing duties outside their defined scope at the request of facility officials

Examples of additional tasks:

Patient queue management: Organising and directing patient flow within the clinic

Vital sign monitoring: Taking and recording patients' vital signs

Clinic administrative work: Handling patient medical records, including capturing, sorting, and filing

Facility cleaning: Maintaining cleanliness and hygiene within the healthcare facility

Water fetching: Addressing water shortages by procuring water for clinic use

SCOPE OF WORK AND OTHER ACTIVITIES BEYOND THE SCOPE OF WORK

Common practices:

Working beyond normal hours: CHWs frequently work outside their designated hours to fulfill demands

Weekend work: Weekend shifts are common, especially during urgent situations or follow-ups

Personal resource utilisation: CHWs often use personal resources, such as time and transportation, to meet their responsibilities

TRAINING AND ACCREDITATION

Training delivery model:

Training cascades from regional training managers to master trainers, who then train OTLs.
OTLs are responsible for training CHWs and facilitating work-integrated learning

Training scope:

Training covers various health conditions, including HIV, TB, maternal and child health, communicable and non-communicable diseases, substance use, violence, and injury

Identified concerns:

Lack of training on mental health, depression, and managing mentally incapacitated clients.
Shortcomings in training regarding recent health policies, such as Universal Test and Treat and Pre-exposure prophylaxis for HIV.
Inconsistent training sessions and inadequate frequency reported.
Challenges related to certification and recognition of training completion.
Financial burdens associated with training for both CHWs and the health system.

SUPERVISION MODEL

Dual responsibilities:
OTLs serve as both healthcare providers and supervisors for CHWs
They manage a dual role, shifting between providing healthcare services and supervising CHWs in community outreach activities

Supervision and training:
OTLs train and supervise CHWs to ensure competence and adherence to policy guidelines
They align CHWs with policy implementation objectives through training and supervision

Meeting structures and digital support:
OTLs conduct regular meetings with CHWs to provide support and guidance.
Utilisation of digital platforms for remote support and communication, enhancing efficiency and accessibility

SUPERVISION MODEL

Challenges faced:

High workload due to dual responsibilities of healthcare provision and CHW supervision

Inadequate OTL coverage leads to some teams lacking supervision, affecting CHW performance and policy implementation

In instances where OTLs are unavailable, CHWs report directly to Primary Healthcare (PHC) managers, who may lack specific mentoring and coaching skills for CHW teams

APPROACHES TO LINKING CHWS TO PHC FACILITIES AND THE COMMUNITIES, INCLUDING REFERRAL MECHANISMS

Recruitment from communities:

- CHWs are often recruited from the communities they serve, facilitating quick establishment of trust and rapport
- Shared Cultural Background: Similar cultural backgrounds enable CHWs to better understand community needs and concerns
- Collaborative Engagement

Partnership with traditional leaders:

- CHWs collaborate with traditional leaders to gain community trust and support
- Participation in Community Events: Engagement in community events provides platforms to disseminate health-related information and address social issues

APPROACHES TO LINKING CHWS TO PHC FACILITIES AND THE COMMUNITIES, INCLUDING REFERRAL MECHANISMS

Health and social awareness:

- Disease Outbreak Awareness: CHWs inform communities about disease outbreaks and preventive measures
- Vaccination Advocacy: Conducting talks on child vaccination to promote immunization coverage and prevent diseases

Addressing social issues:

- CHWs raise awareness on social issues like malnutrition, gender-based violence, substance abuse, and teenage pregnancy

FACILITATORS OF POLICY IMPLEMENTATION

Comprehensive training:

CHWs and OTLs undergo thorough training before and during their roles.

Training equips them with essential skills for delivering healthcare services in their communities effectively

Multisectoral collaborations:

Collaboration between CHWs, the community, and various stakeholders strengthens policy implementation

Stakeholders from sectors such as Social Development, Agriculture, Education, and Home Affairs contribute different roles to support healthcare initiatives

FACILITATORS OF POLICY IMPLEMENTATION

Digital data collection and reporting:

Implementation of digital platforms like mHealth facilitates real-time data capturing and reporting

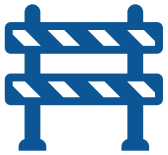
Benefits include minimizing transcription errors, loss of records, and enabling real-time monitoring of health and social patterns for timely interventions

Effective communication:

In-person support groups and instant messaging platforms like WhatsApp foster a collaborative approach to problem-solving and communication

These platforms facilitate quick information sharing and coordination among healthcare workers and stakeholders

BARRIERS TO EFFECTIVE IMPLEMENTATION OF WBPHCOT POLICY



Inadequate provision of resources:

- Insufficient budgets hinder policy implementation, resulting in a lack of human, infrastructure, and financial resources
- Underfunding leads to a shortage of CHWs and OTLs, impacting service delivery to disadvantaged communities
- Task shifting of OTLs between clinical duties and CHW supervision further strains resources and limits community outreach

Inadequate training:

- CHWs face challenges in dealing with daily patient interactions and varied issues due to insufficient training
- Lack of knowledge, capacity, and resources hinder CHWs' effectiveness in addressing community health needs

BARRIERS TO EFFECTIVE IMPLEMENTATION OF WBPHCOT POLICY

Unfulfilled training opportunities:

- Promises of training opportunities often go unmet, with CHWs expressing frustration over the absence of accreditation and certificates
- Some CHWs rely on informal learning from colleagues due to inadequate formal training

Paper-based data collection:

- Time-consuming paper-based data collection and reporting systems cause delays in reporting to the District Health Information System (DHIS)
- Prone to transcription errors and loss of documents, hindering planning and implementation of interventions

Safety challenges:

- CHWs face safety concerns dealing with mentally challenged individuals, aggressive dogs, and drug addicts during community interactions

RECOMMENDATIONS

The implementation of the WBPHCOT policy framework and strategy

Offer training, especially Foundation phase training to all CHWs and OTLs

Enhance the OTL supervision and mentoring models and approach across provinces

Invest in comprehensive and ongoing training programs for CHWs, addressing gaps identified by participants. Facilitate collaboration among CHWs, communities, and local stakeholders through targeted initiatives

Allocate additional resources to districts to overcome budget constraints hindering the effective implementation of the policy

Ensure the availability of essential resources, such as standardized uniforms for CHWs, to facilitate community trust and identification

Prioritize funding to underfunded districts implementing the policy, focusing on sufficient CHW deployment and resources to serve disadvantaged communities effectively.

RECOMMENDATIONS

Conditions of service for CHWs and OTLs

Consider revising CHWs' employment contracts, establishing standardized employment contracts for CHWs across districts, and providing clarity on job security and benefits

Review and enhance the compensation packages for CHWs to address concerns about low remuneration, limited benefits, job insecurity, and financial instability, ensuring a more equitable and supportive arrangement

Allocate additional funds to districts facing financial constraints, specifically targeting remuneration for OTLs and CHWs to prevent resource shortages and work delays

Ensure CHWs can access essential work resources such as workspaces, uniforms, health kits, and transportation to enhance their effectiveness

Implement safety protocols and training for CHWs to address challenges related to safety

RECOMMENDATIONS

Scope of work and activities beyond CHWs and OTLs scope of work

Develop advanced training programs for CHWs to further equip them with the skills needed for their diverse responsibilities

Provide additional support, resources, and incentives to CHWs, including adequate workspaces, tools, and safety measures, to enhance their working conditions and overall well-being

Encourage collaboration between CHWs and other healthcare professionals to streamline efforts and ensure a more coordinated approach to community health, maximizing the impact of their diverse responsibilities

RECOMMENDATIONS

Training for CHWs and OTLs and issues of accreditation for CHW training

Review and update the training curriculum for CHWs to address identified gaps, ensuring comprehensive coverage of essential topics such as HIV and TB management, home-based care, and health promotion

Allocate sufficient budgetary resources to training programs, address financial implications and certification concerns, and ensure all CHWs have access to necessary training

Establish a regular and consistent schedule for training sessions to ensure that CHWs and OTLs receive ongoing education and updates, improving their capacity to address evolving health challenges

Establish an information cascade dissemination system to update CHWs and OTLS on revised/updated policies related to their work

RECOMMENDATIONS

Supervision model for CHWs and OTLs

Clearly define and communicate the roles and responsibilities of OTLs in both their supervisory capacity for CHWs and their clinical roles within the facility to avoid conflicts and ensure effective task management

Recognize the dual role of OTLs and provide additional support, such as adequate resources, training, and staffing, to help them manage their supervisory and clinical responsibilities effectively

Standardise training and capacity-building programs for OTLs to enhance their skills in supervision, mentorship, and clinical roles

Develop and standardize the functional and accessible digital platforms used for support, such as Datafree systems, to enhance communication between CHWs and OTLs

RECOMMENDATIONS

Approaches to linking CHWs to PHC facilities and the communities, including referral mechanisms

Enhance the strategic engagement of CHWs with communities, introducing them to key stakeholders and community members and clarifying their roles to improve cooperation during home visits

Data collection and reporting on CHW work and other existing reporting systems, including mobile health systems

Standardize digital data collection and reporting system to enhance the efficiency and accuracy of information gathered by CHWs

Foster a structured reporting schedule to maintain effective communication and progress tracking between CHWs and their supervisors

LIMITATIONS

- Qualitative research is subject to bias and may not be fully generalizable
- Conducting KIIs and IDIs via phone may have impacted data quality due to connectivity issues
- Data collected relied on self-reporting, introducing potential recall bias
- Multiple rescheduling of interviews due to work commitments affected data collection
- Difficulties in accessing purposively sampled participants due to non-functional contact details
- Absence of direct involvement from patient advocacy groups may have limited insights into specialized services
- Ethics approval was received late for the Western Cape province

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