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 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

Desktop review

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

Mixed-method sampling approach
- Random and Purposive sampling

Focus group discussions
- CHWs

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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

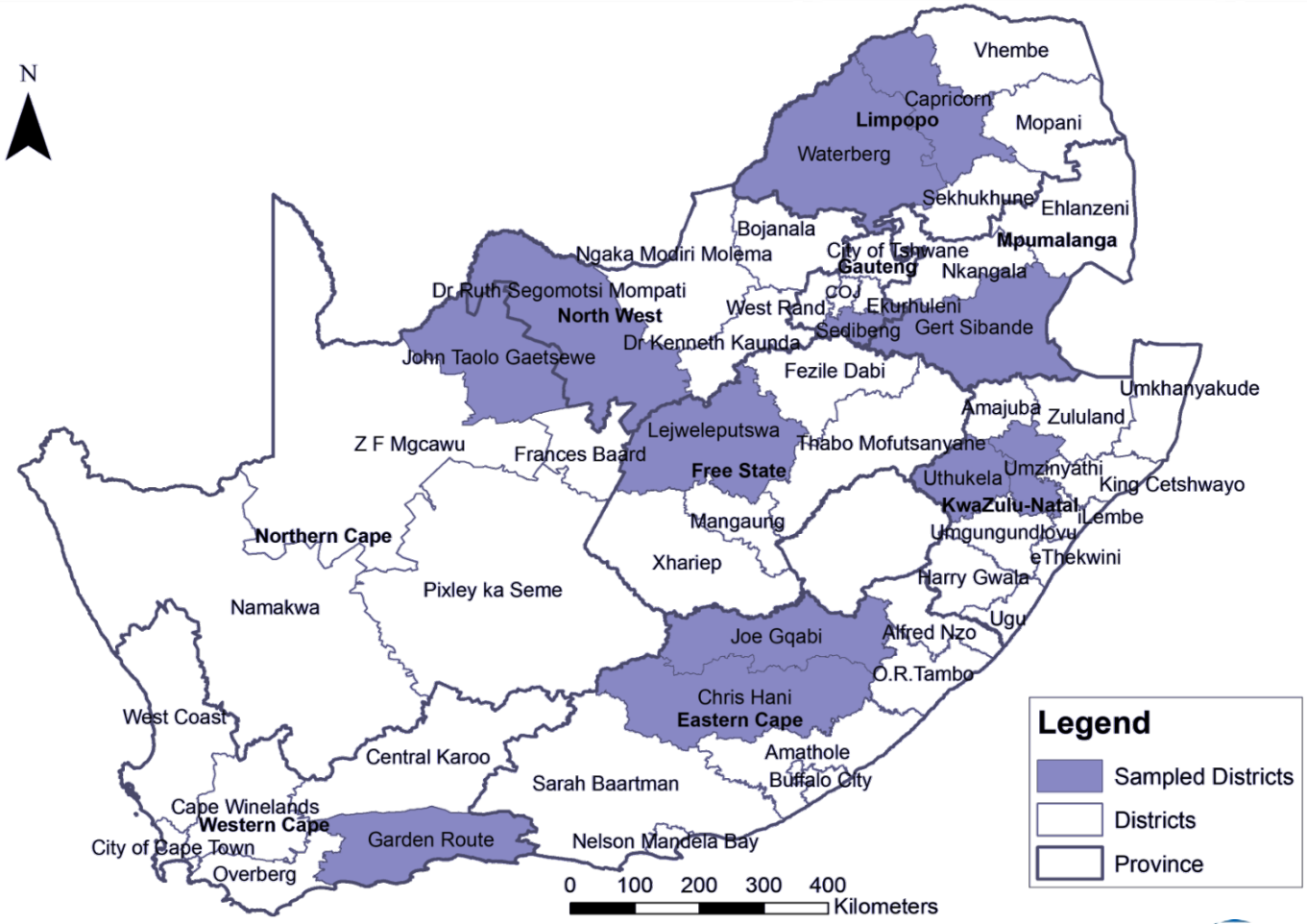
Key Informant Interviews Sample

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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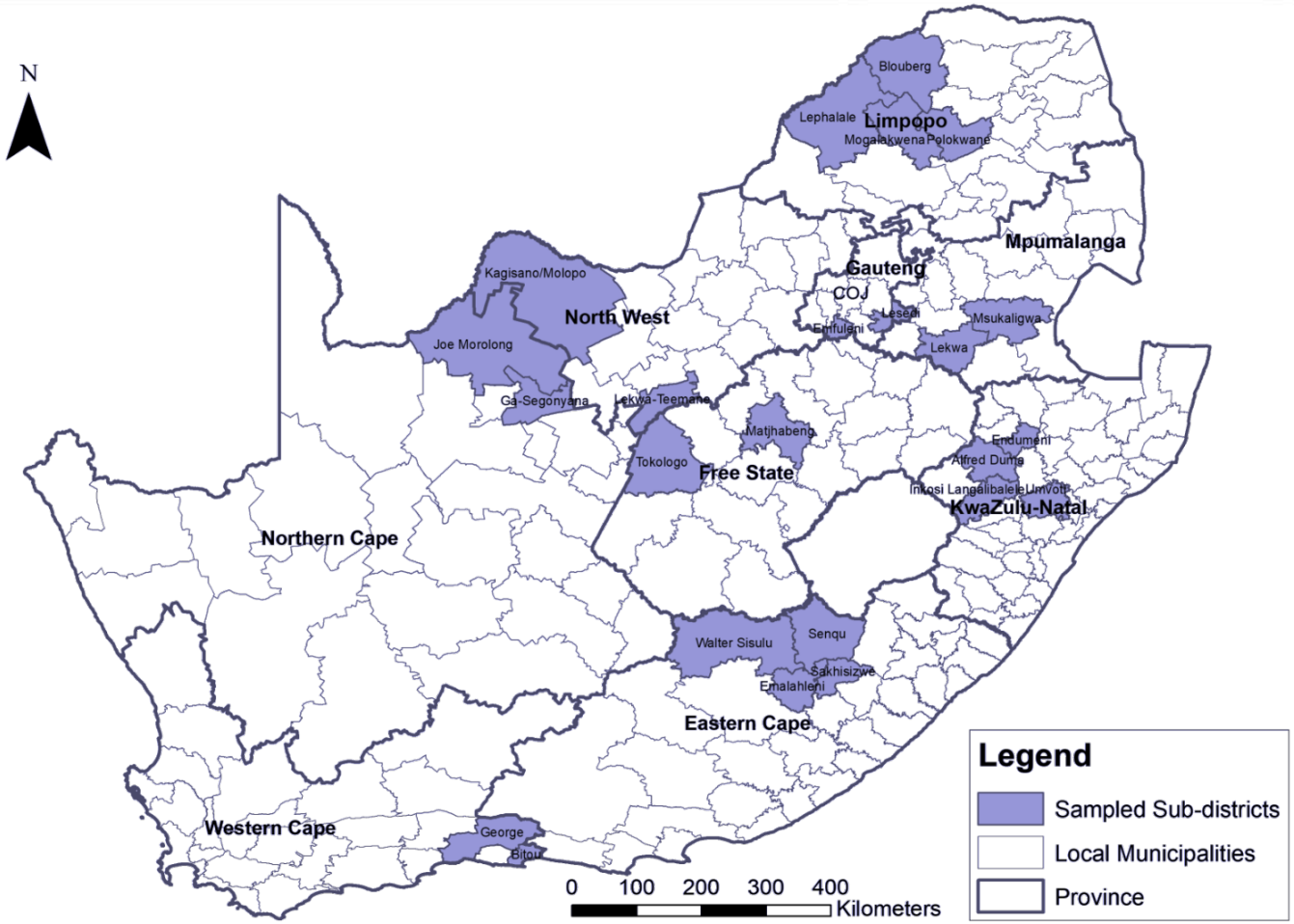
SAMPLED SUB-DISTRICTS



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Key findings

from primary data collection

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

CONDITIONS OF SERVICES FOR CHWs

Entry requirements for CHWs

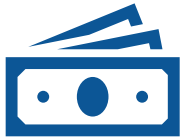
- Completion of matric or grade 12
- Some districts consider individual CHW experience
- Local resident and familiar with customs
- Good social standing in the community is valued

Contracting

- 7/8 provinces – CHWs are employed on 12 months renewable contracts
- Gauteng – CHWs are permanent contracts
- Job insecurity
- Poor retention in service

CONDITIONS OF SERVICES FOR CHWs

Remuneration models for CHWs



- Monthly stipend ~ R4000.00
- Financial instability

Working hours

- Typically 6-8 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

TRAINING

Training delivery model:

Classroom-based, followed by work-integrated learning in the community

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:

Need for regular training/ refresher training

Lack of training on mental health

Shortcomings in training regarding recent health policies, such as Universal Test and Treat and Pre-exposure prophylaxis for HIV.

Challenges related to certification and recognition of training completion.

Inadequate funding for training

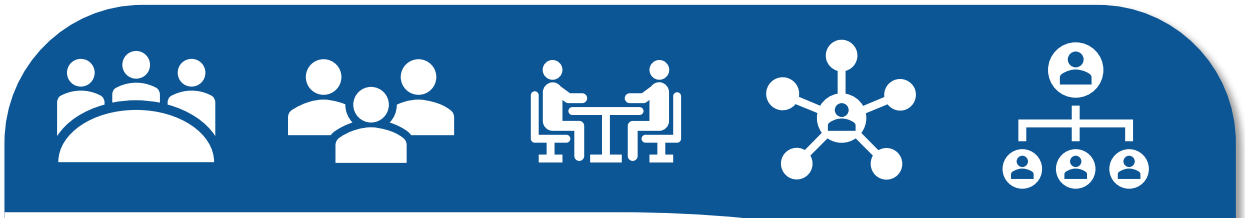
SUPERVISION MODEL

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
- Nutrition related issues (Malnutrition)

Addressing social issues:

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

Data collection, recording and reporting

Paper-based data collection system

Submitted to the district office for capturing

FACILITATORS OF POLICY IMPLEMENTATION

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

Collaborations:

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

Stakeholders from sectors such as Social Development, Agriculture, Education, Home Affairs, Mines, Power stations and NGOs 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

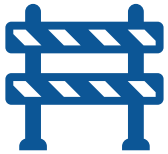
Benefits include minimizing transcription errors, loss of records, and enabling real-time monitoring of health and social patterns for timely interventions

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



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

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

Data collection and reporting:

- 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 individuals with mental health challenges, aggressive dogs, and people who abuse substances during community interactions

DESKTOP REVIEW ON BEST PRACTICES

Recruitment and selection

Eligibility requirements for CHWs of 18 or older

Have secondary level education in some countries;

Literate in most countries

No gender preference in most countries but others prefer females, couples or family members

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

DESKTOP REVIEW ON BEST PRACTICES

Conditions of service

Written employment agreement outlining:

- Roles and responsibilities
- Working conditions
- Worker's rights

Fulltime-employment and paid

Volunteers are part-time, unpaid, or paid less

CHW: Population ratio, ranges from 1:1200 to 1:6000

CHW: Household ratio, ranges from 1:10 to 1:100

Working hours: 10-20 hrs/month to 160 hrs/month

DESKTOP REVIEW ON BEST PRACTICES

Compensation models for CHWs

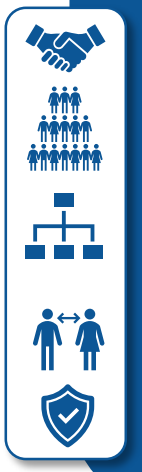
Financial compensation equivalent to their job demands, hours, training, and role

Balances both financial and non-financial incentives, including employee benefits [housing allowances, medical insurance, and vacation leave]

Compensation models vary by country and are dependent on programmatic models and population coverage

Non-financial compensation: transportation, government-sponsored leisure trips, parties, vacations, free medical care, uniforms, and bicycles

DESKTOP REVIEW ON BEST PRACTICES



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

Supervision models

Building relationships, teamwork, collaborative problem-solving, two-way communication, mentoring, feedback, and participatory decision-making

CHWs being supervised by health workers or medical professionals

Monthly meetings, refresher training, report reviews, distribution of health kits, and observation of household activities

CHWs are accountable to the community

Community provides support and participates in performance evaluations

DESKTOP REVIEW ON BEST PRACTICES

Data collection tools

mHealth solutions can improve patient-provider communication, patient education, clinical decision-making, CHW supervision, monitoring, and evaluation

In South Africa, Mobenzi and CommCare were piloted for large-scale surveillance and CHW program

Feasibility, cost-effectiveness, and long-term financial implications of using mHealth for CHW programs

DESKTOP REVIEW ON BEST PRACTICES

Training approaches

Training duration should be country-specific, considering health and social needs, and CHWs' pre-existing skills and experience

The curriculum should cover core competencies

Pre-service training should be offered within six months of recruitment

Practical time in public health facilities and the community

Continuous professional development (CPD) fortnightly or quarterly

Training duration varies by country, ranging from 43 hours to 3 years

Consist of 2- (classroom-field) and 3-phase approaches (classroom-filed-classroom-base)

DESKTOP REVIEW ON BEST PRACTICES

Resources for outreach purposes

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

Integrating CHW equipment into the facility procurement system for smooth ordering and stock monitoring

National supply management provides supplies through an official request system

Supplied through medical facilities

Use their own finances for stationery and forms

RECOMMENDATIONS

Program implementation

- Ensure full compliance with the WBPHCOT policy framework and strategy implementation guidelines
- Promote visibility of CHWs and the role of WBPHCOT within the health system
- Facilitate collaboration between WBPHCOT, communities, and other community stakeholders
- Encourage collaboration between CHWs and other healthcare professionals to streamline efforts and ensure a more coordinated approach to community health

RECOMMENDATIONS

Conditions of Service

- Establish standardized employment contracts that include clarity on job security
- Review compensation packages to address concerns about low remuneration and limited benefits
- Compensate CHWs for additional hours worked (overtime)
- Allocate additional funds to districts facing financial constraints, specifically targeting remuneration for CHWs to prevent resource shortages and work delays
- Implement training and safety protocols to address safety challenges in the community

RECOMMENDATIONS

Scope of work

- Revise the CHW training curriculum on an ongoing basis to address skills gaps
- Address human resource needs for other cadres (healthcare professionals) in the PHC facilities to avoid CHWs undertaking roles beyond their work scope

Supervision

- Clearly define and communicate the roles and responsibilities of OTLs in both their supervisory capacity
- Recognize the dual role of OTLs and provide additional support, such as adequate resources, training, and staffing
- Develop and standardize the functional and accessible digital platforms used for support
- Establish a structured reporting schedule for effective communication and progress tracking

RECOMMENDATIONS

Training

- Ensure that all CHWs and OTLs are offered Foundation Phase training before commencing their work.
- Establish a regular and consistent schedule for training sessions

Data collection tools

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

RECOMMENDATIONS

Resources

- Allocate adequate financial resources to overcome budget constraints hindering the effective implementation of the policy
- Recruitment of more CHWs and OTLs to improve coverage in all communities
- Ensure the availability of essential resources, such as standardized uniforms for CHWs, to facilitate community trust, branding and identification
- Ensure CHWs can access essential work resources such as workspaces, office equipment and stationery, health kits, and transportation to enhance their effectiveness

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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