



Ward-based PHC Outreach Team Leader Orientation Programme Facilitator Guide

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This Ward-based Primary Health Care Outreach Team Leader Orientation Programme Facilitators Guide is designed to give Facilitators the necessary guidance and skills required in order to carry over the Primary Health Care Outreach Team Leader Orientation Programme material to the Learners. This document does not include an Acronym List or Glossary of Terms. However, both can be found in the Ward-based Primary Health Care Outreach Team Leader Orientation Programme Learner Guide which should be read in conjunction with this document.

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1. Introduction

Primary Health Care (PHC) is an approach that provides access to good quality health care as well as preventive and promotive services for priority health needs, inter-sectoral action at local level to address the root causes of ill-health, and enhanced community participation and accountability.

Over time, evidence supporting the PHC approach has been accumulating. This evidence shows that PHC results in better health outcomes, has lower costs and leads to greater equity in health.

In South Africa, the case for focusing on PHC is compelling and is a critical component of National Health Insurance (NHI), with many of the health problems being linked to the social determinants of health such as education and water. These determinants require inter-sectoral collaboration, one of the pillars of the PHC approach.

The National Department of Health (NDOH) is focused on delivering quality Primary Health Care. To this end, the PHC Re-engineered model has been developed. This model involves a 3-stream approach:

1. District-based clinical specialist teams
2. Strengthening school health services
3. Ward-based PHC Outreach Teams for every ward

Within the PHC Re-engineered model, the NDOH has made it an urgent priority to reduce the quadruple burden of disease which includes:

1. High rates of HIV, AIDS and TB
2. High maternal and child mortality
3. High rates of chronic non-communicable diseases (e.g. heart disease, diabetes and mental illness)
4. High rates of violence and injuries (e.g. abuse, substance abuse)

The NDOH priority to deal with the quadruple burden of disease aligns with the Millennium Development Goals which is a list of 8 goals, agreed by 189 countries, including South Africa, to cut poverty in the world by half by the year 2015.

The Ward-based PHC Outreach Team (hereafter referred to as the Outreach Team) is the focus of this Ward-based Primary Health Care Outreach Team Leader Orientation Programme. The NDOH will deploy Outreach Teams in every ward in the country, including in rural areas, informal urban settlements as well as townships. Each ward will have 1 or more Outreach Team(s), depending on the size and geographic spread of the ward. The Outreach Team will offer integrated health services to the households (HHs), individuals and communities within the team's catchment area.

Each Outreach Team will be made up of 1 professional nurse (the Outreach Team Leader) and 6 (or sometimes more) Community Health Workers (CHWs). They will be supported by a Health Promoter and an Environmental Health Practitioner. The Outreach Team Leader (OTL) is primarily responsible for managing and supervising the Outreach Team. Their core responsibility is service delivery at the community level. The CHWs are primarily responsible for household engagement and service delivery to individuals within HHs. The Health Promoters and Environmental Health Practitioners will focus on health promotion and environmental issues, respectively, at the community level.

As part of the PHC Re-engineered model, the NDOH has, for the first time, included CHWs into the formal health sector and will report to an OTL. All CHWs will receive training so as to standardise the services delivered by them.

The OTL is a professional nurse who has both clinical knowledge and experience. More often than not, he/she will already work in a PHC clinic as a professional nurse and possibly other roles. The additional OTL responsibilities will result in a transition from clinical duties in the clinic to clinical duties in the community and HHs as well as managing the Outreach Team.

A 5-day Ward-based PHC OTL Orientation Programme* has been developed for the OTL in order to provide them with the necessary skills and tools to manage the Outreach Team. This Ward-based PHC OTL Orientation Programme Facilitator Guide* is intended to assist the Facilitator with all aspects of the training so that the OTLs are enabled and empowered to take on the role of OTL.

**Throughout the rest of this document, the Ward-based PHC OTL Orientation Programme will be referred to as 'Orientation Programme' and the Ward-based PHC OTL Orientation Programme Facilitator Guide will be referred to as the 'Facilitator Guide.'*

2. Objectives of the Orientation Programme

There are 3 objectives of the *Orientation Programme*:

- To help OTLs understand their role in the Outreach Team
- To help OTLs understand the services which need to be delivered to the community, HHs and individuals
- To provide OTLs with skills required to manage and lead the Outreach Team

There are already many operational Outreach Teams and it is the intention of the *Orientation Programme* to ensure consistency across all teams across all provinces, all using the same guidelines and the same reporting tools.

This *Facilitator's Guide* is designed to teach and guide the Facilitator with the implementation of the *Orientation Programme*. The *Orientation Programme* is intended to equip the OTLs with the knowledge and skills to lead and manage their Outreach Teams in their assigned communities. The end result is successful Outreach Team(s) which deliver quality services to communities and HHs according to NDOH guidelines.

3. Facilitator Role

A Facilitator is someone who makes learning happen, not through lecturing, but by facilitating learning; that is, by creating the conditions that make learning happen. The Facilitator's task is to understand the Learners and their needs and create conditions for learning to take place through a combination of methods including discussion, exercises and more. It is definitely not to stand in front of the class and deliver a lecture.

Facilitation is a way of working with people. Facilitators should have a dynamic ability to work well leading a group, and also should be comfortable and able to conduct one-on-one discussions with the OTLs.

Behaviour of the Facilitator must mirror the behaviours we are seeking to develop among the OTLs.

3.1 Principles and Values of Facilitation

Facilitators should demonstrate, verbally and non-verbally, their commitment to the following principles:

- **Listening:** Facilitation means listening to what people are saying and tuning in to what they are not saying. This includes being aware of verbal and non-verbal means of communication
- **Confidentiality:** In order to participate fully, people must be confident that everything of relevance can be discussed freely without inappropriate reporting outside the group. Group members will normally decide what level of detail can be reported to those not in the group
- **Respect:** A Facilitator must acknowledge and respect each individual and prevent other group members from undermining the basic respect that should be accorded to each individual in the group
- **Equality:** Each person is regarded as having an equal right to contribute, to influence, to determine the direction of the group as another. Equality also relates to respect, valuing of personal experience and participation
- **The value of personal experience:** Each member's contribution to a discussion/skill-sharing activity is equally valid and valuable. Frequent usage of examples that are relevant and applicable can help Learners understand and learn content
- **Agreed goals:** Members must share an agreed goal if they are to develop a belief in and sense of ownership of the group. The Facilitator must ensure the group remain focused and don't stray too far from the subject at hand
- **Group process:** Facilitation requires giving attention to how the group operates. This includes attempting to resolve conflict or any other difficulty that might arise in the group
- **Trust:** To ensure maximum participation, the Facilitator must encourage the development of trust
- **Inclusion and encouragement:** Everyone in the group must be included and encouraged to participate, to share ideas, suggestions and solutions and to take the initiative. This includes making sure that quiet participants have an opportunity to speak and get involved and overly vocal and enthusiastic participants are managed as necessary

- **The importance of a positive/beneficial experience:** The Facilitator must recognise that everyone is entitled to positive experience in the group. The Facilitator must therefore as far as possible, meet realistic individual needs and be aware of and manage unrealistic expectations
- **Participation:** Facilitation succeeds when there is a genuine belief in the value of responding to stated needs in relation to the work of the group. Consultation with group members on direction, pace, content and method with an openness to change is vital
- **Neutral:** The learning process is best served when the Facilitator remains neutral in discussions

3.2 The CPR Approach

For every 90 minutes of new information, the average adult typically only retains the first 20 minutes. A useful tool for managing this issue is to employ the CPR Approach, which involves breaking down learning objectives into:

- **Content** – used to introduce a topic, share key information and/or give instructions for an activity
- **Participation** – used to allow the Learners time to work with the topic introduced in the content section
- **Review** – used to manage Learner feedback from the activity and provide important space for the Facilitator to summarise and bring out key learnings and to make links with other topics

This approach is useful to break down each learning objective into digestible chunks of information, allow the participants time to reflect on what they've learned, and allow the Facilitator, to emphasise key learning points and reference information previously covered.

Furthermore, adults learn best by doing. Learning increases in direct proportion to the amount of participation that occurs. Therefore, involving the Learners as much as possible by, for example asking as many questions as time will permit, will promote increased retention.

Throughout this *Facilitator Guide*, the following icon is used for Review Activities which follow the CPR Approach.



4. Orientation Programme Curriculum

The *Orientation Programme* has been structured and includes materials and tools to ensure the most value for the OTL.

4.1 Format of Orientation Programme

The *Orientation Programme* consists of 5-days of theory and practical application with a competent Facilitator to guide the process. The *Orientation Programme* material and curriculum have been designed to teach and guide OTLs to understand and implement:

- The PHC package of services
- Team management
- Community entry, assessment and involvement
- Household engagement
- Monitoring, evaluation and reporting

4.2 Components of the Orientation Programme Curriculum

The following items form part of the *Orientation Programme* curriculum and should not be utilised in isolation but as an integral part to the same curriculum:

- *Facilitator Guide* (i.e. this document)
- Ward-based PHC OTL Orientation Programme Facilitator Toolbooks 1 to 5*
- Ward-based PHC OTL Orientation Programme PowerPoint Slides*
- Ward-based PHC OTL Orientation Programme Learner Guide*
- Team Leader Job Aid
- CHW Household Tools

These items are all described in more detail below.

**For the remainder of this Facilitator Guide, the words 'Ward-based PHC OTL Orientation Programme' will be assumed but not included when referring to the Facilitator Toolbooks, PowerPoint Slides and Learner Guide.*



4.2.1 Facilitator Guide

This *Facilitator Guide* is a tool to help you, the Facilitator, deliver the *Orientation Programme* curriculum. It provides an account of what material to cover, how to present the material and how to run the activities in each Lesson.

Overall, Lessons present information, generate discussion, and give OTLs opportunities to practice skills and information learned during the *Orientation Programme*. While it is important to cover basic content, discussions and activities are designed to help Learners understand and learn the content and place it in contexts relevant to their own work.

Ultimately OTLs need to gain skills in the *Orientation Programme* that they can apply immediately in their day-to-day work. As the Facilitator, you should encourage Learners to think of the *Orientation Programme* content as tools they can use in everyday situations by using real-life challenges as examples. When the OTLs ask questions throughout the *Orientation Programme*, you should (as often as possible) challenge them to answer their own questions within the group. This will enhance ownership, understanding and the ability to resolve problems or concerns, in line with the skills they are learning.

The content of this *Facilitators Guide* has been designed to encourage, by the use of various teaching methodologies, participatory learning.

These methodologies include:

- **Brief Lecture:** Lectures are intended to be utilised for the purpose of simply disseminating relevant and important information. The *PowerPoint Slides* are provided to help assist sharing theoretical knowledge
- **Brainstorm:** Facilitator solicits ideas from the Learners and charts them on flipchart paper. This may include asking probing questions or initiating a discussion
- **Working in Pairs:** Learners are instructed to pair up with another Learner and perform an activity
- **Individual Activity:** Learners are guided by the Facilitator to work by themselves. During activities when the Learners will be working alone, the Facilitator will need to build in sufficient pause time for Learners to process information and complete any necessary writing tasks
- **Group Activity:** Learners break up into between 2 and 5 groups. During group activities, it is critical that the Facilitator make efforts to equalise participation among the group members. The activity may take the form of a role play

Each Lesson also ends with a Review Exercise.

4.2.2 Facilitator Toolbook

For each programme, you will be given 5 *Facilitator Toolbooks*. This is a perforated book that contains the following items which are described further below:

Facilitator Toolbook 1:

- Learner Materials Acceptance Register
- Attendance Register
- Role-play descriptions for delegation activity in Lesson 2 and team meeting activity in Lesson 4
- Assessment Register
- Programme Evaluations for each Learner
- Facilitator Incident Log

Facilitator Toolbook 2:

- Lesson 1 Pre Assessments for all Learners
- Lesson 1 Post Assessments for all Learners
- Lesson 2 Pre Assessments for all Learners
- Lesson 2 Post Assessments for all Learners

Facilitator Toolbook 3:

- Lesson 3 Pre Assessments for all Learners
- Lesson 3 Post Assessments for all Learners
- Lesson 4 Pre Assessments for all Learners
- Lesson 4 Post Assessments for all Learners

Facilitator Toolbook 4:

- Lesson 5 Pre Assessments for all Learners
- Lesson 5 Post Assessments for all Learners
- Lesson 6 Pre Assessments for all Learners
- Lesson 6 Post Assessments for all Learners

Facilitator Toolbook 5:

- Lesson 7 Pre Assessments for all Learners
- Lesson 7 Post Assessments for all Learners

4.2.2.1 Learner Materials Acceptance Register

The *Learner Material Acceptance Register* is a register that will require all Learners of the *Orientation Programme* to tick which materials have been given to them and sign in acknowledgement of receipt. It can be found in *Facilitator Toolbook 1*.

4.2.2.2 Attendance Register

It is essential that each Learner sign the *Attendance Register* each day. Learners who have not attended all 5 days of the *Orientation Programme* will not receive a *Certificate of Attendance*. The *Attendance Register* can be found in the *Facilitator Toolbook 1*. (At the end of day 1, the Facilitator should check the *Attendance Register* to ensure that names have been spelt correctly for *Certificates of Attendance*. In the event that there is a mis-match, the Facilitator should inform the Training Coordinator).

4.2.2.3 Role-play Descriptions

There are 2 activities that will require a few Learners to act out a role-play whilst the others observe/perform a task. The first is a delegation activity which can be found in Lesson 2 and the second is a team meeting activity which can be found in Lesson 4. These role-play descriptions have been included in *Facilitator Toolbook 1* as they should only be distributed to the 'actors' prior to the activity itself.

4.2.2.4 Programme Evaluations

A *Programme Evaluation* can be found for each Learner in the *Facilitators Toolbook 1*. This evaluation is to be given to each Learner at the end of the *Orientation Programme*. *Programme Evaluations* request Learner feedback on the content, the Facilitator and the *Orientation Programme* as a whole. Please note that the *Programme Evaluation* is 4 pages. Therefore you should remove them from the *Toolbook* and staple the pages prior to distribution.

At the end of the *Orientation Programme*, you will need to summarise these evaluations, using the *Facilitator Report* (see below) as well as your own evaluation of the *Orientation Programme* and submit it to the Training Coordinator.

4.2.2.5 Facilitator Incident Log

In the event of any incidents related to venue, material or learners, as Facilitator, you must record this on the *Facilitator Incident Log* which can be found in *Facilitator Toolbook 1*. This must be returned to the Training Coordinator at the end of the training. It will also need to be summarised and included in the *Facilitator Report* (see below).

4.2.2.6 Pre and Post Assessments for all Learners

The objective of these assessments is to assess knowledge prior to the training and after the training has been completed. This serves 2 purposes:

- To provide a baseline to ensure that learning has occurred
- To evaluate the quality of the training and the training material

The assessments are multiple-choice. Each assessment will indicate how many marks are available. For each correct choice made, the Learner is awarded 1 point.

As Facilitator, you will be required to capture the average results per *Pre and Post Assessment* on the *Assessment Register*.

The average can be calculated as follows:

- Add up all the scores for the particular assessment. Then divide by what the score was out of and the number of Learners
- Then multiply the result by 100
- Example: if there are 5 Learners and the assessment is out of 30, the results are as follows:

| | |
|-----------|----|
| Learner 1 | 30 |
| Learner 2 | 26 |
| Learner 3 | 15 |
| Learner 4 | 20 |
| Learner 5 | 20 |

The average % = $(30+26+15+20+20) / 5 / 30 * 100 = 74\%$

Only this average may be shared with the group.

More information on how the *Pre and Post Assessments* will be administered is provided in Section 6.1.3.

4.2.2.7 Assessment Register

The *Assessment Register* is a register on which the average results for each *Pre and Post Assessment* can be found. It can be found in *Facilitator Toolbook 1*. You will need to capture these average results into the *Facilitator Report* at the end of the *Orientation Programme* for submission to the Training Coordinator.

4.2.2.8 Facilitator Report

The *Facilitator Report* is included on the CD with the *PowerPoint Slides*. It is a report which you will be required to complete and submit, electronically, to the Training Coordinator, at the end of each *Orientation Programme*. In this report, you will summarise:

- The *Programme Evaluations* as well as your own evaluation of the *Orientation Programme*
- The *Facilitator Incident Log*
- The *Assessment Register*

4.2.3 PowerPoint Slides

PowerPoint Slides have been prepared for you to use as part of the *Orientation Programme* delivery. These *PowerPoint Slides* will be provided on a CD to each Facilitator. Most *PowerPoint Slides* have notes to assist you with delivery.

The *PowerPoint Slides* content and order should not be changed. However it may be possible that the following require adjustment:

- Introduction with date and presenter
- *Orientation Programme* Agenda
- Notes – each Facilitator may want to add onto the notes or make minor changes. (Remember, any changes that you make should not alter the message of the *PowerPoint Slide*)



4.2.4 Learner Guide

The *Learner Guide* is a document specifically developed and distributed to the Learners at the beginning of the *Orientation Programme*. It has been designed to encourage the Learner to participate in the learning process. Its content is divided into Lessons and every Lesson has both a theoretical and practical component. Practical sessions include the methodologies mentioned earlier: brainstorms, individual activities, group activities and working in pairs.

The Lessons are as follows:

- Lesson 1: Introduction to the Role of the PHC Outreach Team Leader
- Lesson 2: Skills Required to be an Effective Outreach Team Leader
- Lesson 3: Service Delivery
- Lesson 4: Team Management
- Lesson 5: Community Entry, Assessment and Involvement
- Lesson 6: Household Engagement
- Lesson 7: Monitoring, Evaluation and Reporting
- Lesson 8: Summary of Orientation

The beginning of each Lesson clearly states the role of the OTL within the specific topic. This will assist you to focus the Learner/group on the specific Lesson at hand. This is an example of a role description in the *Learner Guide*:

EXAMPLE:

Your Role as an Outreach Team Leader

Your role as the Ward-based Primary Health Care (PHC) Outreach Team Leader (OTL) is central to the successful implementation of the PHC Ward-based Outreach Team.

The OTL will be expected to:

- manage the work of the Outreach Team
- engage with the community in the catchment area serviced
- deliver and manage health services to the catchment population

This training programme will provide you with the tools and skills required to perform your role effectively and efficiently.

Each Lesson covers specific learning objectives that the OTLs need to master within the Lesson. These learning objectives are aligned with the successful fulfilment of their role. This is an example of the learning objectives in the *Learner Guide*:

EXAMPLE:



Learning Objectives

This Lesson has 4 main learning objectives:

1. To understand how the PHC Re-engineered model aims to strengthen the delivery of PHC to support the implementation of the National Health Insurance (NHI)
2. To understand the role of the Outreach Team
3. To understand the roles and responsibilities of the Outreach Team members
4. To understand how the Outreach Team interacts with other services within the community

The *Learner Guide* and *PowerPoint Slides* make use of various icons to help the Learner identify key points. These icons are:



You will already have seen this icon above, used to illustrate an objective.



This icon can be found in all places where a key question is posed to the Learner.



This icon is used when a definition is given.



The Learner will see this icon when there is an activity.



This icon represents a think point. It is intended to invite the Learner to think about the topic at hand.

4.2.5 Team Leader Job Aid

The *Team Leader Job Aid* forms part of the items utilised by the OTL when engaging with CHWs, HHs, communities and service providers. The *Team Leader Job Aid* provides the OTL with a quick and easy reference instrument and should become the single most important resource in the OTL's toolkit. All tools within the *Team Leader Job Aid* are designed to assist the OTL achieve the objectives required. Where necessary, instructions on how to use the tool have also been included.

For ease of use, the tools have been broken down into the following groups:

- CHW Forms
- Team Management
- Individual Team Member Management
- Team Leader Reporting Forms
- General Information

OTLs must know how and when to use all tools. Therefore, it is important that you emphasise the need to make use of these tools at the appropriate time and place. Therefore, each time a tool is referred to in the *Learner Guide* or *PowerPoint Slides*, you should guide them to open the specific tool in the *Team Leader Job Aid*.

To further embed the necessity and use of these tools, specific exercises have been developed to familiarise Learners with the tools during the *Orientation Programme*.

4.2.5.1 Exercises

At the back of the *Team Leader Job Aid* is an Exercise section containing extra forms, simulated data and other material that the Learner will require during the *Orientation Programme* in order to complete various activities. The contents of this section are outlined below:

For Lesson 4:

- 1 completed *Household Registration Form* for each Learner
- 1 completed *Individual Adult Health Record* for each Learner
- 1 completed *Maternal and Child Health Record* for each Learner
- 1 completed *Referral Form* for each Learner
- 1 blank *Evaluation of Household Registration Form* for each Learner
- 1 blank *Evaluation of Postnatal Home Visit Form* for each Learner

For Lesson 5:

- 1 blank *Community Resource List* for each Learner
- 2 blank *Referral Forms* for each Learner
- 1 completed *Community Profile* for each Learner

For Lesson 6:

- 1 scenario for each Learner (to be used to complete a *Household Registration Form*)
- 1 blank *Household Registration Form* for each Learner
- 1 completed *Referral/Back-referral Form* for each Learner

For Lesson 7:

- 3 completed *CHW Household Visit Tick Sheets* for each Learner
- 1 blank *CHW Household Visit Monthly Summary Form* for each Learner
- 1 completed *CHW Household Visit Monthly Summary Form* for each Learner
- 1 completed *Outreach Team Monthly Summary Form* for each Learner

4.2.6 CHW Household Tools

The *CHW Household Tools* were distributed at the CHW training. It comprises all tools that the CHW will use as part of their role. It is essential that the OTL understands what all these tools are and how they are used, as the OTL will have to coach CHWs in the use of these tools so as to ensure they are accurately and appropriately utilised. These tools are available in a set of books, one for the CHW Phase 1 skills training and the other covering CHW Phase 2.

Please note that all CHW Forms in the *Team Leader Job Aid* are included in the *CHW Household Tools*.

5. Preparation for the Orientation Programme

There are 2 types of preparation required by you, the Facilitator, for the *Orientation Programme*:

1. Logistical preparation
2. Content preparation

5.1 Logistical Preparation

Each *Orientation Programme* will be scheduled in the relevant area and can accommodate up to 25 Learners per *Orientation Programme*. Invitations must be sent in advance by the relevant District Training Coordinator. (Please note that the person performing this role may have a different job title). He/she will also send out an SMS and/or email reminder and will take responsibility for ensuring that the *Registration Forms* (described below) are completed and returned. The Training Coordinator will ensure that you are kept abreast of all logistical details.

Ideally the relevant District Manager will also attend the *Orientation Programme* to address any Human Resource (HR) issues that will arise. Should this not be the case, you should ensure that you have the contact details of the District Manager so that any District specific queries can be forwarded to him/her. You should make contact with the District Manager at the end of each day so that feedback can be provided to Learners the following day. (You should contact the District Manager in advance and agree on this arrangement).

5.1.1 Training Venue

The *Orientation Programme* should take place at a venue that is central to all Learners and satisfies the requirements outlined in the *Training Venue Guideline* in **Appendix A**. The Training Coordinator will determine whether transport and accommodation are provided and the logistics related to that. However, the Facilitator will need to check the venue on the afternoon/evening before training commences to ensure all needs are satisfied. He/she will also need to communicate with the venue staff regarding tea and lunch times.

5.1.2 Training Material Guideline

As Facilitator, you must make sure that all the material required for each *Orientation Programme* is available, as per the guideline below. This guideline is also included in **Appendix B**.

Preparation for the Orientation Programme

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Table 1: Training Materials Guideline

| Item |
|--|
| <i>Facilitator Guide</i> |
| <i>Facilitator Toolbooks 1, 2, 3, 4 and 5 for each Orientation Programme*</i> |
| <i>PowerPoint Slides</i> |
| <i>Laptop and projector*</i> |
| <i>Learner Guide for each Learner attending the Orientation Programme*</i> |
| <i>Facilitator Report (electronic report)</i> |
| <i>Team Leader Job Aid for each Learner attending the Orientation Programme*</i> |
| <i>CHW Household Tools for each Learner attending the Orientation Programme*</i> |
| Sticky name tag labels* (if not available, get Learners to write their name on a piece of paper and place it in front of them) |
| 1 book of flipchart paper* |
| 6 coloured pens for writing on the flipchart |
| A signed copy of the Certificate of Attendance for each Learner plus a few blanks* |
| Prestick |
| A hole punch |
| A stapler and staples |
| A book of sticky tabs |
| Index Cards for each OTL attending the Orientation Programme* (if not available, use paper) |
| 1 notepad and 1 pen for each Learner attending the <i>Orientation Programme*</i> |
| 5 x A1 municipal maps for activity in Lesson 5 (if not available, draw a map) |
| 2 small soft coloured balls that can be used inside (if not available, scrunch up a piece of paper and use it as a ball) |
| <i>*Ideally these items will be delivered to the training venue or provided by the training venue for each Orientation Programme. All other items will be given to you at your training and can be re-used for each Orientation Programme.</i> |

You should check that you have all materials and that all items are working (e.g. laptop and projector connection) the afternoon/evening before training commences.

Preparation for the Orientation Programme

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It should be noted that in addition to the above, you should have a list of all attendees and have reviewed all *Registration Forms* (as outlined below).

In the event that an OTL who has not registered arrives at the training, you should try and accommodate them. You will need to notify the Training Coordinator who will arrange for additional materials to be delivered to the venue.

NB: There may be 1 or 2 Learners who are not official OTLs. So long as there is adequate communication around their attendance, the training should move forward unchanged.

5.2 Content Preparation

Every Facilitator has personal preferences in preparation and delivery. A useful way to begin preparing is to review the material without trying to prepare it. Such a review might consist of:

- Thorough read through of the *Learner Guide*
- Review of the *Facilitator Guide* (this document) and *Facilitator Toolbooks*
- Simultaneously review the *PowerPoint Slides*
- Cross reference the *Learner Guide* and *Team Leader Job Aid*

This review provides most Facilitators who are new to the material with an understanding of how each Lesson's methods and materials support the specified objectives. Having such an understanding can save on preparation time.

As you use this *Facilitator Guide*, it will become apparent which method works best for you. In addition, as you become versed in delivering the *Orientation Programme*, the need to rely heavily on this guide will fade. Highlighting key words in this guide is often one of the best ways to support delivery.

As Facilitator, you should resist the temptation to rewrite substantial portions of activities because the resulting material may not:

- Fit within the time allotted
- Serve the objectives specified for the Lesson or subsequent activities
- Be consistent with the NDOH guidelines and protocols

If there are any questions regarding the *Orientation Programme* material, the Training Coordinator should be contacted.

NB: It should be noted that this Orientation Programme has been designed to be delivered by 2 Facilitators, in the language that you both speak. It is essential that 1 Facilitator assumes the role of 'core Facilitator'. He/she will need to maintain the relationship with the Learners and control the structure and timing of the Orientation Programme at all times. The 2 Facilitators should plan the week in order to optimise resources (e.g. 1 could be marking assessments whilst the other is presenting). From time to time, the case may also exist when an expert is brought in to deliver a particular Lesson or part thereof.

5.2.1 Programme Framework

You should use the Programme Framework, which can be found in Section 8 of the *Facilitator Guide*, as a tool for delivering the *Orientation Programme*. The Programme Framework is broken down by Lessons and *PowerPoint Slides* where the Lessons are aligned with that found in the *Learner Guide*. The Programme Framework for each Lesson includes:

- Name of Lesson, duration of Lesson and Lesson objectives
- Material necessary for that Lesson
- Overview of Lesson plan
- Process for facilitation
- Notes to Facilitator and key points to specific *PowerPoint Slides* which includes:
 - References to core content
 - Guidelines to certain *PowerPoint Slides*
 - Specific tips or background/supplementary information
 - Practical examples that may be utilised to help clarify the content within those *PowerPoint Slides*
 - Questions to ask or activities to perform before or during the *PowerPoint Slide* presentation

5.2.2 Registration Forms

It is intended that all Learners will have completed a *Registration Form*. You must review these forms prior to facilitating each *Orientation Programme*. This will allow you to know the following about the group:

- The nurses experience, specifically within NDOH and also within PHC
- If he/she has attended the CHW training (in which case they will be required to bring their copy of the *CHW Household Tools* with them)
- If he/she already has CHWs assigned, how many and whether or not household registrations have begun
- What position he/she currently holds and therefore the distribution of their time

With this information, you will be able to adapt your training methodology accordingly. Those Learners who have not attended the CHW training will require more emphasis placed on the CHW requirements incorporated into their *Orientation Programme*.

Furthermore, the *Registration Forms* will indicate what their field of experience in PHC is, what are their needs in terms of the *Orientation Programme*, and help you, the Facilitator, to provide more relevant examples based on their current environment.

A copy of the *Registration Form* that will be completed by Learners can be found in **Appendix C**.

5.2.3 Running an Activity

For every activity, you are given instructions on how the activity should proceed. As Facilitator, you need to read these instructions in advance as part of your preparation. By knowing the instructions in advance, you will be able to be more enthusiastic in guiding the Learners through the activity. You will also be available to assist the Learners that are experiencing difficulty in understanding what they are supposed to do.

Whilst each activity has specifically been designed to enhance learning at a particular point, they may be altered depending on the size and experience of the group.

6. Running the Orientation Programme

There are various functions that you, the Facilitator, will need to ensure are addressed on the first day of the *Orientation Programme*, during the *Orientation Programme* itself and then at the end of the *Orientation Programme*.

6.1 First day of the Orientation Programme

Below is a list of all items to address at the beginning of the first day of the *Orientation Programme*.

6.1.1 General

- Greet each person as they arrive
- Welcome Learners and introduce yourself (let them know your current role and experience). Remember that as a Facilitator of the *Orientation Programme*, you are representing NDOH. Therefore you must introduce yourself as a representative of NDOH
- Ask each Learner to fill out a name tag and to wear it (you and any other attendees, such as staff from the District Office, should also wear a name tag)
- Discuss the ground rules/group agreements and write these on a flipchart. You can ask the group to come up with the list of ground rules. Pin the flipchart up in the front of the room so that it is visible to everyone for the duration of the *Orientation Programme*. Try to ensure that all of the items listed below are included in the list:
 - Switch cell phones to “silent” or “vibrate”
 - If calls must be taken it must be outside
 - Respect confidentiality
 - Respect of others’ comments, opinions and questions
 - Quiet during presentations
 - Listen without interrupting when other Learners have questions and comments
 - Punctuality (start each session on time and let latecomers know upfront that each session will be starting on time, every time)
 - Speak by raising their hands
 - Anything else Learners would like to add
- Use the Introductory *PowerPoint Slides* to give a brief overview of the content of the Lessons and agenda for the 5 days and various definitions that are used in the *Orientation Programme*
- Ask Learners about their expectations. Write these expectations on a flipchart and stick to the wall to refer to at the end of the *Orientation Programme*
- Explain that this training will not be lecture-based but rather facilitative – Learners will get out as much as they put in

6.1.2 Understanding the Learners

From time to time, not all *Registration Forms* will be available/completed. In such instances, you should ask Learners the following questions after you do introductions on the first day of the training session:

1. How many of you are currently acting as Outreach Team Leaders?
 - Does anyone play more than one role aside from OTL (e.g. Operational Manager)?
2. How many of you have already attended the CHW training?
3. How many CHWs are you managing:
 - How many people are managing 6 – 10 CHWs?
 - How many people are managing 10 – 5 CHWs?
 - How many people are managing more than 15 CHWs?

This knowledge will enable you to adapt your training methodology accordingly. Those Learners who have not attended the CHW training will require more emphasis placed on the CHW requirements incorporated into their *Orientation Programme*. Furthermore, understanding the Learners current working environment will help you to provide more relevant examples.

6.1.3 Pre and Post Assessments

Discuss the *Pre and Post Assessments* which exist for Lessons 1 to 7.

Learners should be informed that individual results will not be used or published. Data will only be used in aggregate to demonstrate overall effectiveness of the *Orientation Programme*. Learners will get to keep both assessments which will be handed back so they can see their level of improvement.

As the Facilitator, you will need to ensure that the Learners answer the *Pre Assessment*, before the training for each Lesson commences. Similarly, at the end of each Lesson, after the training has been completed, ensure that the Learners complete the *Post Assessment* for that same Lesson.

Pre and Post Assessments can be found in *the Facilitator Toolbooks 2 to 5* and will need to be marked by you, the Facilitator, at the end of each day. *Assessment Model Answers* can be found in **Appendix D**.

6.1.4 Certificates of Attendance

Clarify the requirements for receiving a *Certificate of Attendance*:

- Attendance at all Lessons (Learners must be sure to sign the *Attendance Register* daily)
- Completed *Pre and Post Assessments* for Lessons 1 to 7
- Completed *Programme Evaluation*

(NB: The Orientation Programme does not involve technical training and is intended to orientate the OTL into his/her position. Therefore there is no formal certification or CPD points applicable).

At the end of each *Orientation Programme*, you need to identify which of the Learners qualify for a *Certificate of Attendance*. Ideally, a member of the Province will deliver a handover presentation but should no-one from the Province be available, you will need to conduct this presentation. (Blank Certificates will be made available for any non-registered Learners that attend the *Orientation Programme* and qualify).

In the event that the Certificates of Attendance are not available (if the final list of Learner names is not made available prior to the Programme), the printed certificates will be delivered directly to the District.

6.1.5 Material

Give each Learner a training box which comprises the *Learner Guide*, *Team Leader Job Aid* and *CHW Household Tools*. Learners will be required to sign the *Learner Material Acceptance Register* for each item in the box. This register can be found in *Facilitator Toolbook 1*.

6.1.6 Introductory Icebreaker

Before you start the training, a great way to relax the group is to break the ice with an exercise that will help Learners get to know each other.

Ask the group to pair up with another Learner and ask each other the following questions:

- How were you given your name?
- Did you like your name as a child? Why or why not?
- What is the meaning of your name?
- Do you have any nicknames, either as a child or an adult?

Each Learner must write down their partner's answers. Once the exercise is complete, each Learner should introduce their partner and share their findings with the rest of the group.

6.2 During the Orientation Programme

At the beginning of each training day, including the first day of the *Orientation Programme*, where appropriate, you will need to ensure certain protocol is followed.

As Facilitator, in the first day or 2, you should try and interact at least once with every Learner, and encourage interaction. This will help them to overcome their shyness, and they will be more likely to interact with you and the group for the remainder of the *Orientation Programme*.

6.2.1 At the beginning of each training day, before the Learners arrive

- Be fully prepared, in the training room, at least 15 minutes before the session is due to start
- Be sure to have all the training materials for the day's session, that the computer and projector are set up, and that the chairs and tables are set up
- Go through each Lesson before the start to ensure knowledge of what the Lesson entails
- Know what tools and activities are found in each Lesson. Identify the page numbers that these tools and activities will be found on. You will have to tell Learners where to find these resources during the Lesson

6.2.2 When Learners arrive

- Greet Learners as they walk in
- Ask them to sign the *Attendance Register*
- Return marked *Pre and Post Assessments* and go through the correct answers. Invite Learners to discuss any queries they may have about them
- Provide any feedback obtained from the District Manager
- Review the agenda for the day
- Ask Learners to complete the *Pre Assessment* for the appropriate Lesson
- Begin training

6.2.3 During the day

- Motivate Learners. The OTLs are critical in the PHC Re-engineered model. Without them, the third stream of the PHC Re-engineered model would not be possible. The Learners must know how important they are. For example, say: 'You are part of history in the making. This is the first time that something like this is rolling out in South Africa. You are changing and improving access to health care for individuals in every community.'
- Encourage interaction
 - Make an effort to learn Learners' names early in the *Orientation Programme*, and use their names whenever it is appropriate. Use names when asking Learners to speak, or to answer questions, or when referring to their comments

- Be readily available at all times. Remain in the room, and look approachable. For example, do not read magazines or talk constantly with only one group of Learners. Talk to Learners during tea breaks, and be available after a session has finished. Get to know the Learners and encourage them to engage at any time, to ask questions, or to discuss any difficulties, or even to share what they are interested in and enjoy themselves
- Reinforce Learners efforts
 - Take care not to seem threatening or dismissive
 - Be careful not to use facial expressions or comments that could make Learners feel ridiculed
 - Do not be in a hurry, whether asking or answering questions
 - Show interest in what Learners say. For example, say: 'That is a good question or suggestion'
 - Praise, or thank Learners who make an effort. For example, when they try hard, ask for an explanation, do well on an exercise, participate in a group discussion or help other Learners (without distracting them by talking about something irrelevant)
- Be aware of language difficulties
 - If necessary and you are able to, communicate with Learners and lecture in their first language
 - If you are not able to speak the local language, try to identify Learners who have difficulty understanding or speaking English. Speak slowly and clearly so that they can more easily understand. Ask other Learners to help you explain to Learners who may have problems understanding English
 - Encourage Learners in their efforts to communicate

6.2.4 At the end of each training day

- Summarise the learning's for the day using the provided activity. Learners should leave the *Orientation Programme* each day energised and positive
- Ask Learners if they have any concerns that have not been addressed
- Ask them to complete the *Post Assessments*
- Remind them to complete any homework (if applicable)
- Thank all Learners for their participation
- Contact the District Manager, if necessary, to deal with any District specific questions so that feedback can be provided the following day
- Mark the *Pre and Post Assessments* for that day. The *Assessment Model Answers* can be found in **Appendix D**

6.3 At the end of the Orientation Programme

- Summarise the key learnings for the entire *Orientation Programme*
- Compare what has been achieved with the Learner expectations that were provided at the start of the *Orientation Programme* and written on the flipchart
- Ask Learners to complete the *Programme Evaluations*
- Outline the way forward by explaining that all Facility Managers have or will be communicated with in order to ensure that the Outreach Team is provided with the necessary resources and support and is managed appropriately. They will therefore be able to provide on-going guidance and mentorship to the OTLs
- Congratulate Learners, thank them for their participation and issue *Certificates of Attendance*. Ideally this will be presented by someone in the Province. However if that is not possible, you should take on this role
- Submit the following to the Training Coordinator:
 - Signed *Attendance Register*
 - Completed *Learner Materials Acceptance Register*
 - Completed *Programme Evaluations*
 - Any left over and/or blank *Certificates of Attendance*
 - Any leftover *Learner Guide, Team Leader Job Aids* or *CHW Household Tools*
 - Completed Facilitator Incident Log
 - Completed Facilitator Report (electronic)

Orientation Programme Planning Guide

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7. Orientation Programme Planning Guide

The table below shows the number of *PowerPoint Slides* and activities per Lesson as well as an estimated time for each. You should use this as a guideline when presenting each Lesson.

| Lesson | No of PowerPoint Slides | Total time for PowerPoint Slides | No of Activities (incl review) | Total time for activities | Total time for Lesson |
|--|-------------------------|----------------------------------|--------------------------------|---------------------------|-----------------------|
| Introduction to the Orientation Programme (this excludes the welcome, group agreements and icebreaker) | 8 | 30 mins | 0 | 0 | 30 mins |
| Introduction to the Role of the PHC Outreach Team Leader | 31 | 80 mins | 2 | 40 mins | 120 mins |
| Skills Required to be an Effective Outreach Team Leader | 33 | 40 mins | 7 | 110 mins | 150 mins |
| Service Delivery | 66 | 227 mins | 9 | 115 mins | 342 mins |
| Team Management | 51 | 160 mins | 7 | 165 mins | 325 mins |
| Community Entry, Assessment and Involvement | 33 | 50 mins | 6 | 90 mins | 140 mins |
| Household Engagement | 25 | 40 mins | 3 | 50 mins | 95 mins |
| Monitoring, Evaluation and Reporting | 36 | 40 mins | 5 | 50 mins | 90 mins |
| Summary of Orientation and closing | 30 | 110 mins | 1 | 20 mins | 130 mins |

7.1 Agenda

Below is an outline of the intended agenda for the 5-day Orientation Programme. You will need to keep time and ensure adherence to the timelines. Adjustments may need to be made to the timings of these sessions in some circumstances, including if the sessions take longer to complete. This may be as a result of:

- Learners taking a longer time to understand the concepts or principles being taught to them
- Activities taking longer to complete than stated

As a result it may be necessary to:

- Start earlier in the morning
- Finish later in the day
- Reduce the amount of time allocated for the tea breaks
- Reduce the amount of time allocated for the lunch break

It is important to finish the work scheduled for completion every day.

Orientation Programme Planning Guide

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Figure 1: Orientation Programme Agenda

| Time | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
|---------------|--|---|--|---|--|
| 08:30 – 10:15 | <ul style="list-style-type: none"> Welcome and Introductions Overview of Orientation Programme Pre Assessment for Lessons 1 Lesson 1: Introduction to the role of the PHC Outreach Team Leader | <ul style="list-style-type: none"> Welcome Review of Day 1 incl Assessments Pre Assessment for Lessons 3 Lesson 3: Service Delivery | <ul style="list-style-type: none"> Welcome Review of Day 2 incl Assessments Pre Assessment for Lessons 4 Lesson 4: Team Management | <ul style="list-style-type: none"> Welcome Review of Day 3 incl Assessments Pre Assessment for Lesson 5 Lesson 5: Community Entry, Assessment and Involvement | <ul style="list-style-type: none"> Welcome Review of Day 4 incl Assessments Pre Assessment for Lesson 7 Lesson 7: Monitoring, Evaluation and Reporting |
| Tea | | | | | |
| 10:30 – 12:00 | <ul style="list-style-type: none"> Lesson 1: Introduction to the role of the PHC Outreach Team Leader Post Assessment for Lesson 1 | <ul style="list-style-type: none"> Lesson 3: Service Delivery | <ul style="list-style-type: none"> Lesson 4: Team Management | <ul style="list-style-type: none"> Lesson 5: Community Entry, Assessment and Involvement Post Assessment for Lesson 5 | <ul style="list-style-type: none"> Lesson 7: Monitoring, Evaluation and Reporting Post Assessment for Lessons 7 |
| Lunch | | | | | |
| 13:00– 14:30 | <ul style="list-style-type: none"> Pre Assessment for Lesson 2 Lesson 2: Skills Required to be an Effective Outreach Team Leader | <ul style="list-style-type: none"> Lesson 3: Service Delivery | <ul style="list-style-type: none"> Lesson 4: Team Management | <ul style="list-style-type: none"> Pre Assessment for Lesson 6 Lesson 6: Household Engagement | <ul style="list-style-type: none"> Lesson 8: Summary of Orientation incl: <ul style="list-style-type: none"> Wrap up and summary Programme Evaluations Certificates of Attendance |
| Tea | | | | | |
| 14:45 – 16:30 | <ul style="list-style-type: none"> Lesson 2: Skills Required to be an Effective Outreach Team Leader Post Assessment for Lessons 2 | <ul style="list-style-type: none"> Lesson 3: Service Delivery Post Assessment for Lessons 3 | <ul style="list-style-type: none"> Lesson 4: Team Management Post Assessment for Lessons 4 | <ul style="list-style-type: none"> Lesson 6: Household Engagement Post Assessment for Lesson 6 | |

8. Programme Framework

The *Orientation Programme* framework below outlines what you, as the Facilitator, will need to be aware of in order to deliver each Lesson.

It includes the CPR logo as a reminder of when this approach should be adopted.

8.1 Introduction to Orientation Programme

The first set of slides that you will talk through includes a brief (30 minutes) introduction and overview of the *Orientation Programme*. These slides include:

- Overview of the *Orientation Programme* and teaching methods that will be used
- Brief description of acronyms and terms that are used in the *Orientation Programme*
- Overview of the materials that all Learners will receive
- Overview of the *Learner Guide* and icons
- Orientation Agenda

Emphasise to the Learners that the agenda is just a guideline and the times may change throughout the week.

8.2 Lesson 1 – Introduction to the Role of Ward-based PHC Outreach Team Leader

| | | |
|---|---|---|
| Lesson 1 Learning Objectives 120 minutes | ✓ | To understand how the PHC Re-engineered model aims to strengthen the delivery of PHC to support the implementation of the National Health Insurance (NHI) |
| | ✓ | To understand the role of the Outreach Team |
| | ✓ | To understand the roles and responsibilities of the Outreach Team members |
| | ✓ | To understand how the Outreach Team interacts with other services within the community |

8.2.1 Training Material

- *PowerPoint Slides* for Lesson 1
- *Facilitator Toolbook 1 and 2*
- Lesson 1 in the *Learner Guide*
- Flipchart paper and 6 coloured flipchart pens
- Name tags

8.2.2 Overview of Lesson Plan

- South Africa and Burden of Disease
- National Health Insurance (NHI)
- What is Primary Health Care?
- PHC Re-engineering
- The Ward-based PHC Outreach Team
- Outreach Team Members
- Outreach Team Leader
- Community Health Workers
- Health Promoters
- Environmental Health Practitioners
- Outreach Team interaction with other services
- Brief Summary of Outreach Team member roles

8.2.3 Process for Teaching

- Brief Lecture
- Brainstorm

8.2.4 Notes to Facilitator

- This Lesson sets the tone for the *Orientation Programme*. It is therefore critical that all Learners understand the purpose of the Outreach Team and their importance as OTL
- If the group is not made up of Learners with CHWs reporting to them and/or have not yet attended the CHW training, extra time will need to be taken to ensure that the OTL understands the roles and responsibilities of the CHW

8.2.5 Key points related to specific PowerPoint Slides

| Slide 13 | District Health Model |
|---|-----------------------|
| It is important that the Learners understand all aspects of the model and how they link to one another. | |

| Slide 15 | Ward-based PHC Outreach Team |
|--|------------------------------|
| <p>The diagram shows that the OTL will manage 6 CHWs who will each have 250 HHs. You <u>must</u> emphasise that this is a guideline and that every Outreach Team is different and that the OTL may manage more or less CHWs and that CHWs may be responsible for more or less HHs depending on the size of the catchment area.</p> <p>Furthermore, there may be more than 1 Outreach Team per clinic.</p> <p>Some OTLs may be acting in dual roles at the same time. This is not something for us to resolve. We must just acknowledge that every clinic and staffing situation is different. For now, we may have OTLs having dual functions. Eventually, all clinics will have a designated OTL for each Outreach Team but we might not be there just yet. We must recognise that having a part-time OTL is better than having no OTL at all. This is just a guideline and every situation is different.</p> | |

| Slide 20 | From the clinic to the community |
|--|----------------------------------|
| <p>Highlight that most people fear change. Change to expectations, deliverables, duties, tasks or team structures. It may be simple, it may be complicated. But ultimately even the most basic change within a team requires adjustments.</p> <p>The OTLs will be required to move from working in the clinic within a structure to working in the community on their own. This will be daunting. In order to get the most out of the change so that the OTL, Outreach Team and community benefit, the OTL must plan for it.</p> | |

Slide 21

Brainstorm

Explain to the Learners what 'brainstorming' is - it involves gathering ideas by all people involved in an activity in order to find a solution to a problem or find an answer to a question.

Explain that brainstorming will be used throughout the *Orientation Programme* so that Learners can get as much input as possible and expand their learning.

Guide Learners through the following brainstorm.

20 minutes

Invite the group to share their concerns with regard to their transition from clinic-based professional nurse to community-based Outreach Team Leader and note each on a flipchart.

Then together, get them to start thinking about some ways that they can manage the transition with their manager and the other staff within the clinic. Similarly, note these on the flipchart.

Slide 22

Role of the CHW

You should emphasise that some CHWs may have been previously acting as community-based workers who were volunteers or employees of local organisations. The primary role of most community-based workers is/was to provide home-based care (HBC). It is important for the CHWs (who came from being a community-based worker) to understand that their primary role within the Outreach Team is not to provide HBC but rather provide the PHC package of services and refer household members to the clinic or social services.

Slide 28

Summary of Outreach Team Member Roles

You should emphasise here that the OTL is responsible for service delivery at the community level and the CHW is primarily responsible for service delivery at the household/individual level.

Slide 29

Review Exercise

20 minutes

In order to help increase retention of new material and simplify the subject matter, you should end every Lesson with a review exercise.

Ask the Learners to form teams of 3. Each team must write a short paragraph that summarises the Lesson. Then they should reduce it to a sentence and then to 3 words that accurately captures the content of the Lesson.

Once they have their 3 words, each team should share their words with the larger group and explain how they decided on their 3 words.



8.3 Lesson 2 – Skills Required for be an Effective Outreach Team Leader

| | | |
|---|---|---|
| Lesson 2 Learning Objectives 150 minutes | ✓ | To practice effective communication |
| | ✓ | To practice effective listening skills |
| | ✓ | To understand the basic steps in problem solving |
| | ✓ | To understand the definition and methods for motivating team members |
| | ✓ | To understand the importance of and how to delegate |
| | ✓ | To understand the importance and necessity for coaching and mentoring |

8.3.1 Training Material

- *PowerPoint Slides* for Lesson 2
- *Facilitator Toolbook 1 and 2*
- Lesson 2 in the *Learner Guide*
- Flipchart paper and 6 coloured flipchart pens

8.3.2 Overview of Lesson Plan

- Communication
- Listening
- Problem solving
- Delegation
- Motivation
- Mentoring/coaching
- Pulling it all together

8.3.3 Process for Teaching

- Brief Lecture
- Brainstorm
- Working In Pairs
- Individual Activity
- Group Activity

8.3.4 Notes to Facilitator

- This Lesson introduces some general skills to the OTL. These skills will be used throughout and therefore it is essential that you:
 - a. Ensure that the group grasp these skills and remind the Learners to use opportunities throughout the *Orientation Programme* to practice these skills
 - b. Refer to them and reinforce their use throughout the *Orientation Programme*

8.3.5 Key points related to specific PowerPoint Slides

| Slide 9 | Individual Activity |
|---|---------------------|
| <p>15 minutes</p> <p>Ask all Learners to imagine that they are pregnant (if they are a woman) or have a long term disability (if they are a man). Ask them to think about how they would feel about that situation in their current place in life. It is important to get them to think about this from an emotional point of view. Then, ask them to think about sharing this information and take 10 minutes to write 3 brief letters to the following people to share the news:</p> <ol style="list-style-type: none">i. Their sisterii. Their Facility Manageriii. A woman who has just had a miscarriage at 5 months into her pregnancy or a man with a disability worse than yours <p>Once they finish writing their letters, ask the group to share some of the differences they noticed between the 3 letters. It is important to use this opportunity to illustrate to the group different types of communication and language. (The letter to the Facility Manager would have been more formal than to their sister. The letter to the woman who has had a miscarriage would be more sensitive).</p> | |

Slide 11

Group Activity

15 minutes

Invite 6 volunteers to come to the front of the room. Whisper to each one an emotion that they will be required to illustrate to the group without using words. They must act out the emotion whilst the group tries to guess the emotion. The 6 emotions are:

- i. Happiness
- ii. Excited
- iii. Sadness/tender
- iv. Anxious
- v. Scared/fear
- vi. Shame/guilt

Once all 6 acts are complete, ask the group to share what they learnt about non-verbal communication. It is important that Learners understand that there are many forms of non-verbal communication and it is important to understand:

- a. Their own non-verbal communication
- b. When it will be important for them to observe other people's non-verbal communication (e.g. when communicating with members of the community, when communicating with CHWs and almost every aspect of their job)

Slide 18

Problem Solving continued

You should highlight that we prioritise by identifying the most important work on which we should focus on now. When we have a large workload or many important items that we need to deal with, we can often not do everything we need to do; we may need to decide what has to be done first.

We need to find:

- What things are more important to do, or
- Which items we can do that will have the best or biggest immediate impact on our desired outcomes

For example, after a party, we can first go around and throw all the paper plates, cups and rubbish away – immediately that small job has made a very big impact on the space and cleanliness of the room.

Ask the group to give other examples.

Slide 19/20

Working in Pairs

15 minutes

Ask the Learners to pair up with someone in the group. Ask them to imagine that the problems listed below are occurring at the same time:

- Their CHWs have run out of condoms for distribution at household visits (2)
- There is no printer paper available in the office (3)
- There is no tea or coffee in the staff kitchen (4)
- You need a new pair of shoes for a party and don't have time to shop (5)
- 1 of their CHWs has been on leave for 2 weeks and nobody is visiting her assigned HHs (1)

In their pair, ask them to list the problems in order of priority, remembering to think about how urgent and how important each problem is. (The suggested priority order is indicated in brackets after each point but it should be noted that this is subjective).

Once they have prioritised each problem, ask them to use the '7 steps to problem solving' to decide how they will deal with the problem.

Once each pair has completed the activity, ask some to share their priority list and also the problem solving process. Talk through the process to ensure learning amongst all and encourage interaction.

Slide 24

Group Activity

20 minutes

Before or after going through the delegation slide, organise a role-play session with 6 Learners. 3 of them will need to act as OTLs and 3 of them will need to act as CHWs. Pair up 1 OTL with 1 CHW and give them a role-play description as outlined below which describes how they should behave. (The role-play description for the actors can be found in *Facilitator Toolbook 1*. You can tear it out the Toolbook and give to the actors to prepare).

One by one, ask them to act out their role-play in front of the rest of the group. After each role-play, ask the group for feedback and ask what they identified. Write it down on the flipchart. Ensure you highlight skills previously learnt, specifically communication, listening and problem solving – what was used, what was not, what worked and what did not.

Each role-play should take no more than 3 or 4 minutes.

Role-play 1: The OTL must be very strict, forceful and bossy; and insist the CHW invites a community leader to a meeting by the next day. The employee must come and receive the task and then make some valid reasons for not being able to deliver. This boss must not take these issues into consideration and merely remain bossy and strict (poor delegation)

Role-play 2: A CHW comes to receive the delegated task of completing the *Community Resource List* from a weak, insecure, begging manager. Basically the employee must “walk all over the manager” and not agree to complete the delegated task (poor delegation)

Role-play 3: A moderate and considerate OTL delegates the task of setting up a team meeting correctly and wisely to a CHW. They have a common and fair understanding as to what gets completed; when and how (good delegation)

Slide 26

Motivation

Motivation is the force that compels persons to complete work and act on deliverables required for the function of a team as a whole. Greater motivation results in greater productivity within the team.

You must emphasise that most of the time OTLs are going to have to use non-financial motivators. OTLs will not have control over salary increases, promotions and other financial motivators so they will need to be creative in motivating their team through praise/acknowledgement, fun awards, leaving work an hour early and other similar benefits.

Slide 27

Brainstorm

5 minutes

Get the group to discuss what role they need to play in motivating members of their team. Ask them to give examples of what they have done that has worked and what has not been very successful. If they have not managed staff, ask them to think about what would motivate them.

Slide 30/31

Working in Pairs

15 minutes

Ask all Learners to pair up with someone they have not paired up with before. As a pair, they should answer the following questions:

- What are the possible challenges around communication in their community?
- If someone in the community or in a household is aggressive, how would they deal with it?
- If one of their CHW's HHs has an older woman who refuses to speak to her, how would they handle this?
- Their team continuously encounters a drunken man at one of the HHs in their catchment area. All of the female CHWs are afraid of him and don't want to go to that house. How would they handle this situation?

Once they have answered all the questions they should list which skills are needed for each scenario.

Give each team 10 minutes to answer the question and then invite a handful of teams to present their answers.

This exercise is intended to illustrate how all the different skills can be used together. Highlight this by asking Learners to indicate what skills they employed during this exercise.

Slide 32

Review Exercise

25 minutes

In order to review this Lesson, ask the Learners to split into 5 groups. Each group must be given a flipchart page and pen. Each page should have a different title:

- i. Communication
- ii. Problem Solving
- iii. Delegation
- iv. Motivation
- v. Mentoring and Coaching



Each group will get 3 minutes to write as many things on the flipchart as possible as it relates to the topic. After the 3 minutes is up, they must move to the next flipchart and add their ideas to that one. This must keep going until each group has had an opportunity to add their ideas to each topic. Once finished, each group shares the ideas that are listed on each flipchart.

Ensure that all concerns are resolved and relevant clarification provided relating to any of aspects in each topic

8.4 Lesson 3 – Service Delivery

| | | |
|---|---|---|
| Lesson 3 Learning Objectives 342 minutes | ✓ | To understand the services to be provided to the community by the Outreach Team |
| | ✓ | To understand the services that need to be provided to individual HHs by the Outreach Team |
| | ✓ | To understand the Ward-based Outreach Team’s responsibilities in delivering antenatal services |
| | ✓ | To understand the Outreach Team’s responsibilities in delivering postnatal services |
| | ✓ | To understand the Outreach Team’s responsibilities in delivering services for the management of non-communicable diseases |
| | ✓ | To understand the Outreach Team’s responsibilities in delivering treatment adherence support |
| | ✓ | To understand the Outreach Team’s responsibilities in supporting the delivery of social services |
| | ✓ | To understand the package of school health services to be provided by the school health team with the Outreach Team’s support |
| | ✓ | To understand the Outreach Team’s role in providing emergency health services |

8.4.1 Training Material

- *PowerPoint Slides* for Lesson 3
- *Facilitator Toolbook 1 and 3*
- Lesson 3 in the *Learner Guide*
- Flipchart paper and 6 coloured flipchart pens
- 2 soft coloured balls

8.4.2 Overview of Lesson Plan

- Services to the community
- Services to HHs
- Antenatal care
- Postnatal care
- Child health
- Chronic non-communicable diseases (NCDs)
- Violence and injury

- Integration and treatment adherence support
- School health services
- Emergency services

8.4.3 Process for Teaching

- Brief Lecture
- Brainstorm
- Working in Pairs
- Individual Activity

8.4.4 Notes to Facilitator

- It is important that the OTLs are familiar with the PHC package of services, specifically ANC, PNC, child health, chronic disease and geriatric care, mental health and substance abuse, abuse and violence and treatment adherence regimes
- The PHC package of services is part of the District Health Services. Therefore, there is no separate Outreach Team or PHC budget. All services that the team provides are funded by the current/existing District health budget

8.4.5 Key points related to specific PowerPoint Slides

| Slide 8 | Services to the Community |
|--|---------------------------|
| Remind the OTLs again that their primary responsibility is to the community and that of the CHW is the individual. The Health Promoter and Environmental Health Practitioner also largely deal with the community. | |

| Slide 9 | Working in Pairs |
|--|------------------|
| 10 minutes | |
| Ask Learners to pair up with someone in the group that they have not yet paired with. Then together, ask them to list the barriers for people to access health care services within their communities. Then using the problem solving skills they learnt in Lesson 2, they should be creative and identify how they would address 1 of those barriers. | |
| Use this exercise to guide the Learners to think outside the box. Many of the problems OTLs are faced with will not be easily solved. They will need to be creative. | |
| Once this exercise is complete, select a few pairs to share some of the barriers identified and their solutions with the larger group. | |
| In addition to sharing the barriers and solutions, ask the group what it was like to pair up with someone new? What skills did they have to employ? | |

Slide 15

ANC Visit Checklists

Ask the Learners to open their *Learner Guide* at the ANC Visit Checklists in Lesson 3 and talk them through these checklists.

Slide 16

Brainstorm

15 minutes

Facilitate a discussion about which ANC checklists are to be used for the following scenarios, with the group.

- Scenario 1: CHW identifies a pregnant woman who is 17 weeks pregnant and has never been visited before. Which checklist must the CHW complete? (Answer is: Checklist for visit 2)
- Scenario 2: CHW identifies a pregnant woman who is 24 weeks pregnant and has been visited once before. Which checklist must the CHW complete? (Answer is: Checklist for visit 1 and 2)
- Scenario 3: The CHW visits a HH where there is a 36 week pregnant woman who has never been visited before. Which checklist(s) must the CHW complete? (Answer is: all of them)

It is very important that Learners understand that the checklist is not linked to weeks of pregnancy (e.g. if no visits have occurred and the household member is already 30 weeks pregnant, they cannot jump to the visit 4 checklist, 1, 2 and 3 must also be completed). In fact all 4 will need to be done at once and discretion will need to be applied in terms of what is and is not relevant to ensure that the same questions are not asked in the same visit more than once.

Once they have answered the above correctly, ask the group to suggest ways in which they would train their CHWs on how and when to use these checklists. Invite them to share any challenges they may face and what skills they would use to train them.

Slide 20

PNC Visit Checklists

Ask the Learners to open their *Learner Guide* at the PNC Visit Checklists in Lesson 3 and talk them through these checklists.

Slide 21/22

Brainstorm

15 minutes

Refer to the PNC Visit Checklists in Lesson 3 of the *Learner Guide* and facilitate a discussion about which PNC checklists are to be used for the following scenarios, with the group.

- Scenario 1: The HH member has delivered her baby at 2:00AM this morning. Which checklist must the CHW complete? (Answer is: Visit 1 checklist)
- Scenario 2: The HH member has delivered her baby 5 days ago and she has not been visited at all since delivery. Which checklist must the CHW complete? (Answer is: Visit 1 and 2 checklists)
- Scenario 3: The client has had a spontaneous abortion (i.e. miscarriage) at 18 weeks into the pregnancy. Will you still visit this client? What checklist would you use? What are the most important services to provide? (Answer is: Yes. Use the *Postnatal checklist for women who have had a still birth or miscarriage*. Psychosocial care is critical at this stage)
- Scenario 4: The client has delivered a dead baby at full term. Will you still visit this client? What checklist would you use? What are the most important services to provide? (Answer is: Yes. Use the *Postnatal checklist for a woman who has had a still birth or miscarriage*. Psychosocial care is critical at this stage)

It is important that Learners understand that although there are tools and guidelines, there are times when they will have to assess the relevance of those guidelines and use their initiative. For instance, if a woman has lost her baby, they should not ask the questions in the 'Care of Newborn' component of the checklist. However, additional psychosocial support will be necessary.

Once they have answered the above correctly, ask the group to suggest ways in which they would train their CHWs on how and when to use these checklists. Invite them to share any challenges they may face and what skills they would use to train them.

After the previous activity, you may need an energiser. Try the one below. It should not take you longer than 20 minutes.

Split the Learners into 2 groups. Give each group a soft coloured ball.

Have each group stand in a circle. Request that everyone in each circle state their name to the rest of the Learners in their circle. Request they do this 2 or 3 times. Then, give 1 Learner in each circle the ball. He/she is to call out the name of another person in the circle and then throw him/her the ball. The Learner who receives the ball must make eye contact with another Learner in the circle, call out his/her name and toss the ball to them. If a Learner forgets someone's name and wants to be reminded of it, they can ask him/her to repeat it. The game carries on until everyone has thrown to everyone else in the circle.

This is an excellent game for Learners to learn each other's name while learning a simple metaphor for communication skills.

Slide 43**Child Health Checklist**

Ask the Learners to open their *Learner Guide* at the Child Health Checklist in Lesson 3 and talk them through these checklists.

Slide 47**Chronic Non-Communicable Diseases****15 minutes**

Ask Learners to divide into three groups. Assign one scenario to each group.

- Scenario 1: CHW identifies a HH where the family is not following a healthy lifestyle
- Scenario 2: CHW identifies a HH where the grandmother has diabetes
- Scenario 3: CHW identifies a need for an exercise programme in the community

As part of the group discussion each group should consider:

- the approach that the CHW has to take when dealing with the issues specific to the HH
- other organisations their CHWs will need to work with
- challenges that may be faced when approaching or working with these organisations
- what role the OTL can play to help CHWs overcome these challenges

Facilitate a discussion about the role that CHWs play in promoting health and preventing ill-health, generally, and with regard to NCDs specifically.

It is critical that Learners understand the important role they play in ensuring that healthy lifestyle messages are communicated at both household and community level.

Slide 50**Violence and Injury****5 minutes**

Working on their own, ask Learners to consider the impact of any form of violence and injury on individuals and communities.

Slide 53

Treatment Adherence Support Checklist

Ask the Learners to open their *Learner Guide* to the Treatment Adherence Support Checklist in Lesson 3 and talk them through this checklist.

Initially, CHWs will only be trained to provide treatment adherence support for TB and HIV. Once they are familiar with the treatment adherence support process and methods, they should apply the same process and methods to treatment for other chronic diseases or conditions (e.g. diabetes, high blood pressure).

Slide 56

Individual Activity

10 minutes

Ask all Learners to answer the following questions about their Ward:

- What do they know about their community's school(s)? Does the school(s) have a school health nurse?
- What are the ways their Outreach Team could assist the school health programme in their community? Ask them all to provide an example of a situation where they would have to assist a school health nurse or principal with providing services

Give the group 5 minutes to do this activity on their own. It is important to encourage thinking. Then allow 5 minutes of group discussion. Facilitate the process so that the group has lots of practical ideas.

An example might be if a child has scabies and the school health nurse wants to give the child medicine to take home. If the child is small, they should not be handed medication to take home but rather someone should deliver the medication to the child's family and provide instructions for the use of the medication. The school health nurse may call upon the OTL to ensure that a CHW delivers the medication to the child's family and explains the instructions on how to use the medicine.

Slide 59

Working in Pairs

5 minutes

Ask the Learners to pair up with someone new in the group. In their pair, request they list as many emergencies as they can think of.

Slide 64

Working in Pairs

10 minutes

Ask the Learners to get back into the pairs they were in for the previous exercise. Ask them to take the list of emergencies previously created and identify for each emergency, whether it is an:

- Individual emergency (examples would include anything that requires first aid or an ambulance)
- Household emergency (examples would include a fire, flood, electrical problem where there is live wiring and any other house safety issue)
- Community emergency (examples would include social and environmental emergencies)

For each one, they should also consider who they would contact regarding the emergency. Once complete, get the larger group to discuss.

Slide 65

Review Activity

30 minutes

Split the Learners into 2 groups. Give each group a flipchart. The first flipchart paper will have the letters A to M and the second with the letters N to Z. Give the groups 10 minutes to write down 1 word that starts with each letter of the alphabet in their list that is related to Lesson 3. At the end of the time, the group with the most letters used wins.

As a group, review all the letters.



8.5 Lesson 4 – Team Management

| | | |
|---|---|---|
| Lesson 4 Learning Objectives 295 minutes | ✓ | To understand the importance of team work within the Outreach Team |
| | ✓ | To understand the basics of planning an activity for their team or in the community |
| | ✓ | To plan and manage the Outreach Team schedule |
| | ✓ | To understand how to organise and conduct meetings (including agenda setting, minute taking, attendance registers) |
| | ✓ | To understand how to manage the individual team member (including induction, human resource matters and performance management) |
| | ✓ | To understand your responsibilities in administering the Community Health Worker Phase 1 Competence Assessment |
| | ✓ | To maintain clear records to manage team supplies and materials |

8.5.1 Lesson Material

- *PowerPoint Slides* for Lesson 4
- *Facilitator Toolbook 1* and 3
- Lesson 4 in the *Learner Guide*
- *Team Leader Job Aid – Exercises* and *CHW Forms* section
- Flipchart paper and 6 coloured flipchart pens

8.5.2 Overview of Lesson Plan

- Managing the team
- Managing the individual
- Performance management
- Administering the CHW Phase 1 Competency Assessment
- Managing team supplies

8.5.3 Process for Teaching

- Brief Lecture
- Individual Activity
- Group Activity

8.5.4 Notes to Facilitator

- You must emphasise that the performance of each individual team member is a reflection on the OTL and the entire Outreach Team. Therefore it is important that the OTL emphasises the need for a high level of

performance from each and every Outreach Team member

- You should ensure that OTLs understand that they play a vital role in assisting CHWs successfully complete the CHW Phase 1 Competency Assessment. This will, by extension, will help ensure effective service delivery for the Outreach Team as a whole

8.5.5 Key points related to specific PowerPoint Slides

| Slide 5 | Team Work |
|---------|--|
| | <p>Teamwork is a joint effort of a group of people toward a common purpose. In the PHC setting a team is “A group of people who may come from different backgrounds to work together as a team to support the healthcare services for the community.”</p> <p>Any group of staff or people can be considered a team when they work closely together for the same specific deliverable(s). It is important to note that even if reporting structures are different, a group whose goal is the same may still be part of the same team. Give examples.</p> <p>Examples include:</p> <ul style="list-style-type: none">• The entire community wants to make the community cleaner and remove rubbish from the streets. The Ward councillor is in charge of the initiative but many people are involved and team work is required to clean up the community• Consider a District immunisation campaign. It is likely to be headed up by a District person yet all Outreach Teams and PHC clinics will need to get involved. It will be a massive team effort to get everyone in the District immunised |

| Slide 9/10 | Group Activity |
|------------|---|
| | <p>15 minutes</p> <p>Request the Learners to divide into 3 groups for a scavenger hunt. Once they have divided, instruct them that:</p> <ul style="list-style-type: none">• 1 group will be silent and not allowed to use verbal or written communication at all• 1 group will be allowed to communicate with each other in whatever form they wish• 1 group must agree up front on who will and will not be allowed to communicate (it must be 50:50) <p>Explain to the group that on your instruction, each group must collect 1 each of the following items (be sure to check that all the items are available and adjust the list if necessary), all of which can be found in the training room (i.e. they do not need to go outside):</p> <ul style="list-style-type: none">• A driver’s license• A family photo• A red pen |

| Slide 9/10 | Group Activity (continued) |
|---|----------------------------|
| <ul style="list-style-type: none">• A pair of glasses• A tube of lipstick• A R2 coin <p>They may not get more than 1 item from any 1 person. The teams must shout 'hunt over' when they have collected all items at which point you must check they have all the items and where they got them from (at this point they can be returned).</p> <p>Once the hunt is complete, ask the groups for feedback about what they experienced participating in that exercise? Were those who worked as a team more successful than those who were not? Did the manner in which they communicated with one another make a difference?</p> <p>The intention of this exercise is to illustrate the importance of teamwork. Working together and communicating properly with one another is much more effective than the alternative.</p> | |

| Slide 13 | Individual Activity |
|--|---------------------|
| <p>15 minutes</p> <p>Ask Learners to answer the following questions individually:</p> <p>It was mentioned in Lesson 3 (Service Delivery), that all CHWs in their team are required to have basic first aid training. They must make an activity plan to ensure that the CHWs in their team receive the training.</p> <ul style="list-style-type: none">• What actions are required to get all CHWs trained?• Who is responsible for doing each action?• When should each action be completed by?• When should all CHWs be trained by?• What is the expected outcome of the activity? <p>Walk around the room making sure each OTL is able to complete this activity and help where necessary.</p> | |

Please note that if the team are using the Work Calendar, then show slides 16 – 26. If not, they will be using the Weekly HH Visit Schedule. In which case you will show slides 27 – 28 instead. At the time of going to print, the Work Calendar was being piloted in North West and all other districts are using the Weekly HH Visit Schedule.

Slide 27

Weekly HH Visit Schedule

Talk Learners through this form and refer to it in the *Team Leader Job Aid* under *CHW Forms*.

The *Weekly Household Visit Schedule* will keep a record of all HHs that were visited by the CHW, including when they visited a household and nobody was home.

This schedule may also be used to cross check CHW reporting forms which are discussed further in Lesson 7 when we talk through monitoring, evaluation and reporting.

Slide 30

Types of Meetings to be Planned and Conducted by OTL

Ask all Learners what activities are completed before, during and after a meeting.

It is important that the OTL understands that meetings are very important to communicate needs and expectations within any team. Meetings should NOT be used to do work, but rather used to communicate what needs to be done, confirm who is doing what and communicate on plans and steps. Specific workshops can be organised to assist in completing work that requires substantial brainstorming, planning and organising by the whole team.

Emphasise that when calling a meeting, they must make sure they know who they need in that meeting; who will be there; and what is expected as the outcome for the meeting. What exactly is the purpose for calling the meeting?

- Is it to report back on activities?
- Is it to make specific decisions?
- Is it to update all on new plans?
- Is it to review results and emphasise new needs and work focus?

During a meeting, it is important to:

- Adhere to the circulated agenda points
- Stick to the time allocations decided prior to the meeting
- Manage all delegates' participation
- Ensure someone is taking minutes
- Summarise all points according to the key minute taking entries
- Ensure everyone signs an attendance register

After the meeting, it is important to get the minutes out within 2 days of the meeting and make sure they reach everyone; especially those people who have specific tasks that have been decided upon during the meeting. These tasks and deadlines need to be recorded in the minutes so that everyone knows who is expected to deliver what, and by what date.

Slide 30

Types of Meetings to be Planned and Conducted by OTL (continued)

It is the responsibility of the OTL to ensure that the decisions from the meeting are being implemented. These tasks need to be tracked and enforced to ensure all projects and deliverables keep on track.

Slide 34

Group Activity

15 minutes

Request 6 volunteers to come to the front of the room. These volunteers are going to be part of a mock meeting. When the meeting is finished, the group will discuss what was good in the meeting and what was bad in the meeting.

Give each volunteer a copy of the role-play description outlined below. It can be found in *Facilitator Toolbook 1*. The scenario is as follows: a weekly team meeting is being held by the OTL, with his/her 6 CHWs.

Each of the volunteers will need to take on 1 of the following roles of CHW 1 to CHW 6 (as the Facilitator, you will take on the role of OTL/chairperson so that the group can see an example of how best to run such a meeting):

- OTL – chairperson (this should be you, the Facilitator)
- CHW 1 – difficult and disruptive person (always interrupting, always knows better)
- CHW 2 – easy going, minute taker
- CHW 3 – very quiet, does not contribute
- CHW 4 – has a very difficult household where a child is being neglected and needs support
- CHW 5 – proactive and has identified a need in the community (weight loss) and wants to take action
- CHW 6 – easy going

The team is established and knows each other quite well. This is their regular weekly team meeting. As Facilitator, you are to act at the OTL and lead the meeting, following the Agenda below. 20 minutes is assigned for the role-play.

Agenda for team meeting to be held on 26 June 2012

Venue: Spades Executive Conference

Time: 14h00 to 14h20

Attendees: OTL, CHW1, CHW 2, CHW3, CHW 4, CHW5, CHW6

Apologies: None

| | | | |
|---|---|-------------|-----------|
| 1 | Welcome, apologies and attendance register | Chairperson | 2 minutes |
| 2 | Confirmation of minutes of previous meeting and any matters arising from previous meeting | Chairperson | 2 minutes |
| 3 | Feedback on previous weeks activities | All CHW's | 2 minutes |
| 4 | General including all problems and concerns | Chairperson | 2 minutes |
| 5 | Next meeting | Chairperson | 2 minutes |
| 6 | Closing | Chairperson | 2 minutes |

NB: Please note that the meeting agenda above has been adjusted from that of a real team meeting to allow for the time limit of the Orientation Programme.

Once the role-play is complete, facilitate a discussion amongst the whole group. Get them to answer the following questions:

- How did the meeting chairperson manage the meeting? What did he/she do well and what could he/she have done differently?
- How did the meeting attendees participate in and contribute to the meeting? What did they do well and what could they have done differently?
- What skills were demonstrated (e.g. communication, listening, problem solving, delegation, motivation, coaching and mentoring)?

After the previous activity, you may need an energiser. The one outlined below will help Learners understand the importance of team work and should only take 10 minutes. You may use one of your own if you prefer.

Have all Learners form one circle. Stand in the circle with them. To introduce the exercise, say: 'I am going to face and make eye contact with the person on my left, and we will try to clap our hands at the same moment (demonstrate). Then, he/she must turn to the left and clap hands at the same time with person to his/her left. The intention is to "pass the beat" around the circle. One by one, each Learner makes eye contact with the person to their left and the claps with them.

The rhythm builds up and as Facilitator, you can call out 'faster' or 'slower' to increase the speed. Once the handclaps have passed around the circle send additional rounds of handclaps around the circle, chasing the first.

Remind people to keep it going, even if it stops for a moment when someone misses the beat. When the first round of handclaps is well established, start a new round. Eventually there might be 3 or 4 beats going around the group at the same time. This will often result in an enjoyable, high-energy chaos with lots of laughter.

Remind the group that, to get the best results when working as a team, everyone depends on the other team members.

Slide 43

Individual Activity

40 minutes

Direct Learners to the following completed forms (one by one), which can be found in the *Team Leader Job Aid* under *Exercises*:

- *Household Registration Form*
- *Individual Adult Health Record*
- *Maternal and Child Health Record*
- *Referral Form*

For each form, ask the Learners to list the errors they identify on the completed form.

Give them 5 minutes to look through each form and after each one, ask them to share with the larger group their findings. Use the opportunity to assist with any queries regarding the forms.

Use this opportunity to point out to the OTLs that if a situation occurs when they have to complete 1 of these forms, they simply put their own name in the box.

The completed *Household Registration Form* with the errors can be seen below.

Please note that all errors in the forms below have been circled in red and the reason for the error is described in red. When discussing in the larger group, ensure that all errors have been covered and the reason that it is an error is explained.

Household Registration Form



health

Department: Health
REPUBLIC OF SOUTH AFRICA

Official Household registration number

THIS IS NOT A RECEIPT - THIS WILL NOT HAVE AN OFFICIAL NO. AS YET

| Clinic name (DHIS name) | STEVE TWSETE CLINIC | | Ward (DHIS #) | 2-6 | CHW household identifier number | 376 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---------------------------------------|---|---------------------------------------|---|---|---------------------------------|---|--|---------------------------------------|----------------------------|-----------------------------|-----------------------------|--|--|--|--|--|--|--------------------------------|--|---------|-------------------------------|-----------------|-----------|--|--|--|--|--|---|---|---|---|---|---|---|---|---|---|---|--|---|-------------------|--------------|---|--|---------------------------------|-------------------------------------|---------------------------------------|----------------------------|--|---|------------------|------------|----|--|---------------------------------|--|---------------------------------------|----------------------------|--|---|---|--|--|--|--|--|--|---------------------------------------|----------------------------|--|---|--|--|--|--|--|------------------------------------|---------------------------------------|----------------------------|--|---|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|---|---|--|--|---|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|--|--|--|--|--|--|
| Name of household head/contact | MUZI RAMALIKO | | | Date of visit (dd/mm/yyyy) | 06/12/2012 <i>DATE MUST BE WRITTEN DD/MM/YYYY</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Household street address/descriptive location | | | | CHW name | ZUKI <i>CHW NAME ABBREVIATED & INCOMPLETE</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 25A STEVE BIKO PLACE <i>ADDRESS IS INCOMPLETE</i> | | | | Team name (DHIS name) | MW STEVE TWSETE CLINIC OTI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | Household respondent | <input checked="" type="checkbox"/> A | <input type="checkbox"/> N/A | <input type="checkbox"/> R | A = available, N/A = not available, R = refused | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A DUPT OF THE CELL, NO IS MISSING | | | | Were all household members registered in this visit? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | <table border="1"> <thead> <tr> <th rowspan="2">Household head phone number</th> <th colspan="7">1. Household member details</th> <th colspan="2">2. Information about the house</th> </tr> <tr> <th>a. Name</th> <th>b. Date of birth (dd/mm/yyyy)</th> <th>c. Age in years</th> <th colspan="2">d. Gender</th> <th colspan="2"></th> <th colspan="2"></th> </tr> </thead> <tbody> <tr> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td>9</td> <td>0</td> </tr> <tr> <td></td> <td>1</td> <td>VIRGINIA RAMALOKO</td> <td>2-310712-008</td> <td>4</td> <td><input checked="" type="checkbox"/> male</td> <td><input type="checkbox"/> female</td> <td>a. Does the house have electricity?</td> <td><input checked="" type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td></td> <td>2</td> <td>CYNTHIA RAMALOKO</td> <td>05/06/1979</td> <td>32</td> <td><input checked="" type="checkbox"/> male</td> <td><input type="checkbox"/> female</td> <td>b. Is there piped water in the house or in the yard?</td> <td><input checked="" type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td></td> <td>3</td> <td colspan="5"><i>THE HEAD OF THE HOUSEHOLD, MUZI, IS NOT INCLUDED</i></td> <td></td> <td>c. Is there a working fridge in the house?</td> <td><input checked="" type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td></td> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>d. Is there a toilet in the house?</td> <td><input checked="" type="checkbox"/> Y</td> <td><input type="checkbox"/> N</td> </tr> <tr> <td></td> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>e. Total number of rooms in the house?</td> <td colspan="2">2</td> </tr> <tr> <td></td> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>f. How many grants does the household receive in total?</td> <td colspan="2">0</td> </tr> <tr> <td></td> <td>7</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>g. How many people in the house are currently working?</td> <td colspan="2">1</td> </tr> <tr> <td></td> <td>8</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>h. Name of school(s) for learners</td> <td colspan="2"></td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>e. Totals</td> <td><input checked="" type="checkbox"/> 0</td> <td><input type="checkbox"/> 2</td> </tr> </tbody> </table> | | | | | | | Household head phone number | 1. Household member details | | | | | | | 2. Information about the house | | a. Name | b. Date of birth (dd/mm/yyyy) | c. Age in years | d. Gender | | | | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 | | 1 | VIRGINIA RAMALOKO | 2-310712-008 | 4 | <input checked="" type="checkbox"/> male | <input type="checkbox"/> female | a. Does the house have electricity? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | 2 | CYNTHIA RAMALOKO | 05/06/1979 | 32 | <input checked="" type="checkbox"/> male | <input type="checkbox"/> female | b. Is there piped water in the house or in the yard? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | 3 | <i>THE HEAD OF THE HOUSEHOLD, MUZI, IS NOT INCLUDED</i> | | | | | | c. Is there a working fridge in the house? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | 4 | | | | | | d. Is there a toilet in the house? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | 5 | | | | | | e. Total number of rooms in the house? | 2 | | | 6 | | | | | | f. How many grants does the household receive in total? | 0 | | | 7 | | | | | | g. How many people in the house are currently working? | 1 | | | 8 | | | | | | h. Name of school(s) for learners | | | | | | | | |
| Household head phone number | 1. Household member details | | | | | | | 2. Information about the house | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | a. Name | b. Date of birth (dd/mm/yyyy) | c. Age in years | d. Gender | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 1 | VIRGINIA RAMALOKO | 2-310712-008 | 4 | <input checked="" type="checkbox"/> male | <input type="checkbox"/> female | a. Does the house have electricity? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 2 | CYNTHIA RAMALOKO | 05/06/1979 | 32 | <input checked="" type="checkbox"/> male | <input type="checkbox"/> female | b. Is there piped water in the house or in the yard? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3 | <i>THE HEAD OF THE HOUSEHOLD, MUZI, IS NOT INCLUDED</i> | | | | | | c. Is there a working fridge in the house? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4 | | | | | | d. Is there a toilet in the house? | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 5 | | | | | | e. Total number of rooms in the house? | 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 6 | | | | | | f. How many grants does the household receive in total? | 0 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 7 | | | | | | g. How many people in the house are currently working? | 1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 8 | | | | | | h. Name of school(s) for learners | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | e. Totals | <input checked="" type="checkbox"/> 0 | <input type="checkbox"/> 2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. General household screening questions for all households | | | | | | | | Write HH member # in the last column | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If YES to any of following questions, refer for further care | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Does anyone in the household have any of the following: (circle all that apply) (refer for sputum test for TB) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cough that won't go away? | | Night sweats | | Weight loss | | Fever | | Loss of appetite? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. It is very important to know your HIV status. Would anyone in the household like to have an HIV test? (refer for HCT) | | | | | | | | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Is there anyone who does not use a family planning method but wants to? (refer for family planning services) | | | | | | | | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Is there anyone in the household who cannot get out of bed or needs help with daily living activities? (refer for home-based care) | | | | | | | | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| e. Do any household members need help applying for social grants? (refer for social services) | | | | | | | | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| f. Is this a child (<18 years) headed household? (refer for social services) | | | | | | | | <input type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Household screening questions for CHW follow-up | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If any of the answers below are YES, this household will need follow-up. Complete page 2 of this form | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Is anyone in the household currently pregnant or has not had a menstrual period in the last 6 weeks and may be pregnant? | | | | | | | | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Has there been a delivery (baby) in the last 6 weeks? | | | | | | | | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Are there any children under the age of 5 in the household? | | | | | | | | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Is anyone in the household taking daily medication (like TB/ARV/diabetes medication/high BP medication)? | | | | | | | | <input checked="" type="checkbox"/> Y | <input type="checkbox"/> N | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Notes: | | | | | | | | ***DOES THIS HOUSEHOLD NEED FOLLOW-UP?*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | YES Complete page 2 of this form | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | NO Write date for next HH re-assessment visit | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| 5. Further assessment and screening questions for all households to be followed by CHW | | | | | HH member number(s)* | Number of Referral Forms Issued |
|---|-----|---------------------------------------|---------------------------------------|---|----------------------|---------------------------------------|
| <p>For each question: If the answer is YES, write the household member number(s) from the list of household member names and details on page 1.</p> <p>For any other problems you have identified, write this in the last box in detail and indicate HH member number.</p> <p>For questions b-g: check RTHB.</p> <p>If a referral is needed, write the total number of clients referred to the clinic for each line.</p> <p>If the client was referred elsewhere – indicate the reason, the place of referral and number of referral forms issued in box j.</p> | | | | | | |
| a. If someone in the house is pregnant, what is the estimated delivery date (EDD)? <i>Check the ANC card if available or ask mother when her LNMP was and use pregnancy wheel to estimate. (Write unknown if delivery date is not known)</i> | | EDD (dd/mm/yy) | | | 2- | 1 |
| b. If there was a birth in the last 6 weeks, what was the date? <i>Check the RTHB or ask mother for the date of births.</i> | | Date of Birth (dd/mm/yy) | | NO EDD IS WRITTEN HERE. IF UNKNOWN, WRITE 'UNKNOWN' | | |
| i. Was the baby's birth weight under 2500 grams? <i>Refer to clinic for monitoring. Schedule further home visits</i> | | Y | <input checked="" type="checkbox"/> N | | | 0 |
| c. Are there any children under 5 in the house whose immunisations are not up to date? <i>Refer for catch-up EPI at clinic</i> | | <input checked="" type="checkbox"/> Y | N | | 1 | 2- |
| d. Are there any children under 5 who have not had a dose of vitamin A in the last 6 months? <i>Refer for vitamin A supplement at clinic</i> | | Y | <input checked="" type="checkbox"/> N | THIS SHOULD BE 1 - ONLY 1 CHILD IS REGISTERED | | |
| e. Are there any children who have not been weighed according to the growth-monitoring schedule or who show signs of malnutrition/growth faltering? <i>Refer for growth monitoring. Complete a nutritional assessment and schedule follow-up visits if needed</i> | | Y | <input checked="" type="checkbox"/> N | | | 0 |
| f. Are there any children with suspected illness or does mother/caregiver have concerns about any child's current or recent health status? <i>Assess and refer to clinic if needed. Schedule follow-up visits</i> | | Y | <input checked="" type="checkbox"/> N | | | 0 |
| g. Are there any HIV exposed children in the household 6 weeks or older who have not had a PCR test? <i>Check the RTHB. Refer to clinic for PCR test. Schedule follow-up visit</i> | | Y | <input checked="" type="checkbox"/> N | | | 0 |
| h. If anyone in the HH is taking medication for the following, write their HH member number in the box(es) below. | | | | | | |
| TB | HIV | Hypertension | Diabetes | Other (Specify) | Y | <input checked="" type="checkbox"/> N |
| i. Has someone defaulted from treatment? <i>Write HH member # of defaulter. Refer to clinic for further care and schedule follow-up visit for treatment adherence support.</i> | | Y | <input checked="" type="checkbox"/> N | | | 0 |
| j. Any other problems identified (state). | | | | | | |
| Comments/Notes | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

* NOTE: It is expected that an Individual Health Record is complete for every client that is being followed in the household.

CHW Signature THE FORM IS NOT SIGNED Verified by Team Leader _____ on _____ (date)

NB: The Household Registration Form is the only form that looks at the HH profile. Even if the HH is not vulnerable, the CHW must identify future requirements (e.g. if there is a woman of reproductive age in the house, a follow-up visit to discuss family planning should be scheduled).



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

The completed Individual Adult Health Record with the errors can be seen below.

| Individual Adult Health Record ***Private and Confidential*** | | | | | | | | | | | |
|--|--|-------------------------------------|--------------------------|--|--|-----|---|--------------|-------------------|------------------------------------|--|
| CHW household identifier no. | Date of first visit assessment | CHW (dd/mm/yyyy) DATE OF ASSESSMENT | CHW name | Ward no. | Clinic name | | | | | | |
| 131 | | 04/08/2012 | ZUKISWA MSEBEZA | 2-6 | STEVE TSWETE | | | | | | |
| Name of individual | Household Street Address/Location | | | | | | | | | | |
| WANGO MATSILA | KATLEGO MATSILA | | | | | | | | | | |
| Contact no. | Age | Gender | Grant | Relationship to individual | Contact no. of next of kin | | | | | | |
| SHE IS 70 & PROBABLY DOES NOT HAVE A CONTACT NUMBER OF HER OWN | 70 | F | | NO RELATIONSHIP IS INDICATED - SHOULD BE SON | 0 8 1 2 2 2 2 2 2 2 | | | | | | |
| Date of birth (dd/mm/yyyy) | Age | Gender | Grant | Relationship to individual | Categories for case* | | | | | | |
| SHE MAY NOT KNOW HER DOB | 70 | F | | OLD AGE | LEFT OF CATEGORIES OR CASE - SHOULD BE DB/DP | | | | | | |
| Individual record of care | | | | | | | | | | | |
| Visit no. | Date (dd/mm) and time (00:00) of visit | Health screen conducted | Health status monitoring | Health promotion | Adherence support | HbC | Care and/or interventions provided (include any relevant findings or notes) | Referral Y/N | CHW signature | Consultation date with Team Leader | |
| 1 | 2-5/06/2012 (14.30) | ✓ | ✓ | ✓ | ✓ | | PATIENT OFTEN FORGETS TO TAKE MEDICATION NO OTHER PROBLEMS REPORTED | NO | Patient signature | (dd/mm/yyyy) | |
| 2 | 2-2/07/2012 | | | | | | | | | | |
| 3 | | | | | | | | | | | |
| 4 | | | | | | | | | | | |
| 5 | | | | | | | | | | | |

Category of care codes*

RV = anti-retrovirals
 TB = tuberculosis medications
 DB = medication for diabetes control
 MH = mental health medications
 BP = blood pressure medication
 CHR = other chronic medications

*If yes, fill out information in Record of Referral on page 2



Version 1.2
 August 2012

REPUBLIC OF SOUTH AFRICA

The completed *Maternal and Child Health Record* with errors can be seen below.

| Maternal and Child Health Record ***Private and Confidential*** | | | | | | | | | | | |
|---|--|--|-----------------------------|--------------------------------------|--|---|-----|---|--------------|---|--|
| CHW household identifier no. | 132- | Date of first visit/assessment | dd/mm/yyyy 2-5/06/12-012 | CHW name | ZUKI <i>FULL NAME OF CHW NOT USED</i> | Ward no. | 2-6 | Clinic name | STEVE TSWETE | | |
| Name of mother/caregiver | HANAI <i>MOTHERS LAST NAME NOT INCLUDED</i> | | | Household Street Address/Location | | Name of child | | THABISO MATSILA | | | |
| Contact no. | 0 8 1 2 3 4 5 6 7 8 9 | Date of birth of child (dd/mm/yyyy) | | 5 MORAY PLACE, POTCHEFSTROOM, MWP | | Date of birth of child (dd/mm/yyyy) | | Exposed? | | Gender | |
| Age of mother/caregiver | 32- | Grant(s) | | MM EXPOSURE STATUS NOT INDICATED | | Yes | | No | | Birth weight (grams) | |
| Visit no | | Date (dd/mm) and time (00:00) of visit | | ANC (#) PNC (#) Under 5 LBW | | Maternal health | | Child health | | Individual record of care | |
| 1 | | 2-5/06/12-012 (14:30) <i>NO FOLLOW-UP DATE DECIDED ON</i> | | UNJERL 5 | | Health promotion/nutrition Delivery plan/danger signs Feeding counseling Family planning | | Health/growth screen done Home-based treatment Counseling/support | | Care and/or interventions provided (include any relevant findings or notes) | |
| 2 | | | | | | | | | | SICK <i>NO DESCRIPTION PROVIDED</i> | |
| 3 | | | | | | | | | | Referral Y/N | |
| 4 | | | | | | | | | | Y | |
| 5 | | | | | | | | | | NO SIGNATURE INCLUDED | |



*If yes, fill out information in Record of Referral on page 2.

Individual record of care

| Visit no. | Date (dd/mm) and time (00:00) of visit | ANC (#) PNC (#) Under 5 LBW | Maternal health | | | | Child health | | | | Care and/or interventions provided (Include any relevant findings or notes) | Referral Y/N | CHW signature | Consultation date with Team Leader | |
|-----------|---|--------------------------------------|----------------------------|----------------------------|--------------------|-----------------|--------------|---------------------------|----------------------|--------------------|--|--------------|---------------|------------------------------------|--|
| | Date scheduled for follow-up visit (dd/mm/yyyy) | | Health promotion/nutrition | Delivery plan/danger signs | Feeding counseling | Family planning | Checked RTHB | Health/growth screen done | Home-based treatment | Counseling/support | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | |


Record of Referrals

| Visit no. | Referred to | Reason for referral | Back referral received (dd/mm/yyyy) | Outcome of referral |
|-----------|-------------|---------------------|-------------------------------------|---------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

NO REFERRAL INFORMATION INCLUDED

If yes, fill out information in Record of Referral

The completed Referral Form with errors can be seen below.

|  health Department of Health REPUBLIC OF SOUTH AFRICA | | Referral Form (from Outreach Team to Provider) | | |
|---|---|--|---|---------|
| A person has been referred to your service by a member of the Outreach Team working in your ward. Community Healthcare Workers are mandated by the National Department of Health to identify community members in need of primary health and social services. Thank you for seeing this client, we look forward to working together for improved health and welfare for all South Africans. | | | | |
| Client referred to (facility name) | | Date referral is made | | Ward No |
| STEVE TSWETE CLINIC | | 2-5/06/2012 | | 2-6 |
| Name of CHW referring client | | Outreach Team Leader name | | |
| DO NOT KNOW WHO HAS REFERRED THE CLIENT | | VIRGINIA NO SURNAME GIVEN | | |
| Contact number for CHW | Team Leader contact number | | | |
| NO NUMBER GIVEN | NO NUMBER GIVEN | | | |
| Client details | | | | |
| Client address | | Client name and surname | | |
| BOTCHESTROOM FULL ADDRESS NOT GIVEN | | BONGANI NO SURNAME GIVEN | | |
| Client contact telephone number | | Date of Birth (dd/mm/yyyy) | Age | Gender |
| NO CONTACT NUMBER GIVEN | | NO DOB GIVEN | NO AGE GIVEN | M |
| Referred to clinic (Tick all that apply) | | | | |
| MCHW | Under 5 | Treatment related problems | Other | |
| <input type="checkbox"/> Antenatal care <input type="checkbox"/> Postnatal care <input type="checkbox"/> Pregnancy test <input type="checkbox"/> Family planning <input type="checkbox"/> Emergency contraception <input type="checkbox"/> Cervical cancer screen <input type="checkbox"/> PCR test for infants | <input type="checkbox"/> Newborn care <input type="checkbox"/> Low birth weight <input type="checkbox"/> Immunisation <input type="checkbox"/> Vitamin A <input type="checkbox"/> Persistent diarrhea <input type="checkbox"/> Pneumonia <input type="checkbox"/> Nutritional/growth problems | <input type="checkbox"/> TB symptoms <input type="checkbox"/> STI testing <input type="checkbox"/> Mental health <input type="checkbox"/> Treatment adherence <input type="checkbox"/> Chronic health problem <input type="checkbox"/> HCT <input type="checkbox"/> CD4 test <input type="checkbox"/> Ots | <input checked="" type="checkbox"/> Other health problems (Specify below) | |
| Referred to Social Services (Tick all that apply) | | | Referred for home-based care (Please write condition that needs home care) | |
| <input type="checkbox"/> Child-headed household <input type="checkbox"/> Food support <input type="checkbox"/> Other (Specify in box below) | | | <input type="checkbox"/> Protection services <input type="checkbox"/> Grant support <input type="checkbox"/> Mental health <input type="checkbox"/> Support groups <input type="checkbox"/> Housing <input type="checkbox"/> Vital documents | |
| Provide a brief explanation for the referral (Include place client is being referred if not above and reason for referral) | | | | |
| COMPLAINS OF PAIN THE EXPLANATION IS VAGUE. IT DOES NOT GIVE A BACKGROUND TO THE PATIENT OR DESCRIBE WHERE THE PAIN IS, HOW LONG IT HAS BEEN GOING ON OR ANY OTHER INFORMATION THAT WILL HELP | | | | |
| Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care. Please contact the Outreach Team Leader noted on this form if you have any further questions regarding this referral. | | | | |
| Signed <i>W. J. J. J.</i> | | Date | | |

Slide 53

Group Activity

30 minutes

Request 4 volunteers in the group to perform 2 separate role-plays.

The first role-play will require one person to act as a CHW and one to act as a community member. The CHW is to conduct a household registration visit.

Whilst role-play is being performed, everyone in the larger group should act as OTL and each complete the *Evaluation of Household Registration* which can be found in the *Team Leader Job Aid* under *Exercises*. Once the role-play is complete and all Learners have completed the form, you should go through the form asking the group their responses.

This role-play has 2 purposes:

- i. To check that the OTL understands how to conduct a household registration visit (after all, he/she will have to guide their CHWs on how to perform this role)
- ii. To ensure that the OTLs understand how to complete the *Evaluation of Household Registration* form

The second role-play will require one person to act as a CHW and one to act as a community member. In this scenario, the CHW will be conducting a postnatal home visit where the community member lost the baby in child birth. You are going to need to be extremely skilled in this scenario. If there is someone in the group who has lost a baby, they may not be comfortable with this situation.

Again, whilst the role-play is being performed, everyone in the larger group should act as OTL and each complete the *Evaluation of Postnatal Home Visit* which can be found in the *Team Leader Job Aid* under *Exercises*. Once the role-play is complete and all Learners have completed the form, you should go through the form asking the group their responses.

This role-play has 2 purposes:

- i. To check that the OTL understands how to conduct a postnatal home visit (after all, he/she will have to guide their CHWs on how to perform this role). Furthermore, because the baby did not survive childbirth in this scenario, it highlights the need for sensitivity (e.g. there is no need to go through the **Care for the Newborn** section). Lastly, it also highlights that your own perceptions of a situation (e.g. if you have lost a baby) will affect your behaviour and you need to be impartial
- ii. To ensure that the OTLs understand how to complete the *Evaluation of Postnatal Home Visit* form

Slide 46

CHW Phase 1 Competency Assessment

30 minutes

Ask the Learners to open the CHW Phase 1 Competency Assessment Master Guide and, using the Master Guide, talk them through how to administer and evaluate CHW Phase 1 Competency Assessment.

Slide 51

Review Exercise

20 minutes

Split the Learners into groups of 3 and each group must come up with 1 question they still have about the content that was just delivered in Lesson 4.

Once each group has come up with their question, they must:

- First ask the other groups their question to see if they can answer
- Only if they are unable to answer the question, should you answer
- If you are unable to answer the question there and then, compliment the group on their question and commit to getting back to them with the answer



8.6 Lesson 5 – Community Entry, Assessment and Involvement

| | | |
|---|---|--|
| Lesson 5 Learning Objectives 140 minutes | ✓ | To understand the steps for community entry |
| | ✓ | To understand how to conduct a community assessment which includes community mapping and conducting a community profile |
| | ✓ | To understand the importance of and steps for community consultation |
| | ✓ | To understand how to use the community assessment in consultation with the community to design a community health improvement plan |
| | ✓ | To understand how to involve the community in implementing solutions or interventions for health issues |

8.6.1 Lesson Material

- *PowerPoint Slides* for Lesson 5
- *Facilitator Toolbook 1 and 4*
- Lesson 5 in the *Learner Guide*
- *Team Leader Job Aid – Exercises, CHW Forms and Team Management* section
- Flipchart paper and 6 coloured flipchart pens
- 5 x A3 maps
- 1 soft coloured ball

8.6.2 Overview of Lesson Plan

- Community entry
- Community assessment
- Community health improvement plan
- Community involvement

8.6.3 Process for Teaching

- Brief Lecture
- Working in Pairs
- Individual Activity
- Group Activity

8.6.4 Notes to Facilitator

- Good community relationships are essential for the OTL. The CHW is largely responsible for providing services to individuals and HHs but the OTL is responsible for providing services to the community.

8.6.5 Key points related to specific PowerPoint Slides

| Slide 10 | Individual Exercise |
|--|---------------------|
| 10 minutes | |
| Ask each of the Learners to think of the various community stakeholders (including service providers) in their Ward. | |
| They must start completing the <i>Community Resource List</i> for their Outreach Team. This template can be found in the <i>Team Leader Job Aid</i> under <i>Exercises</i> . (They will also find a copy in the <i>Team Leader Job Aid</i> under <i>Team Management</i>). | |

| Slide 12 | Working in Pairs |
|--|------------------|
| 20 minutes | |
| Ask the Learners to pair up with someone they have not paired with thus far in the <i>Orientation Programme</i> . They must familiarise themselves with the <i>Referral Form</i> found in the <i>Team Leader Job Aid</i> under <i>CHW Forms</i> . Then for each of the case studies below, they must complete the form using the copy found in the <i>Team Leader Job Aid</i> under <i>Exercises</i> . | |
| Case study 1: Mavis is a girl of 18 months. She has been attending monthly screening sessions regularly for the past 4 months. For the past 2 months, Mavis's weight has been in the yellow zone. This month, her MUAC dropped. Her mother says she has had diarrhoea for the past 3 days. Her MUAC is in the Red Zone. | |
| Case study 2: Mathew is a boy of 18 months. He lives with his mother, Portia. She does not work but qualifies to receive a child support grant. She has no idea how to go about getting one. | |
| The correctly completed forms can be found below. Go around the room and check that the Learners are completing the form correctly for each case study. (Please note that the only information you are looking for is the information filled out on the forms below. Correctly completed forms would obviously include the CHW, clinic and household member details.) | |
| After 10 minutes, ask all of the pairs to discuss their completed forms with the larger group. Ensure that the form is completely correctly for each case study using the forms below as a guide. | |
| Learners must understand that: | |
| <ul style="list-style-type: none">• The fields Client name and surname and DOB must always be that of the patient who requires the treatment, regardless of whether or not they are a minor or unable to care for themselves. This will ensure that regardless of who assists the patient, the service provider will always have the details related to the treatment required• When it comes to services, the Client name and surname and DOB entered on the <i>Referral Form</i> should always be for the person who is receiving the benefit. For example, although child support is in fact for the child, the recipient is the parent/guardian and therefore it is his/her details that should be captured on the form and then details of the child would be given in the notes section | |

Referral Form (from Outreach Team to Provider)

A person has been referred to your service by a member of the Outreach Team working in your ward. Community Healthcare Workers are mandated by the National Department of Health to identify community members in need of primary health and social services. Thank you for seeing this client, we look forward to working together for improved health and welfare for all South Africans.

| | | | | | | | | | | | |
|------------------------------------|--|--|--|----------------------------|--|--|--|---------|--|--|--|
| Client referred to (facility name) | | | | Date referral is made | | | | Ward No | | | |
| Name of CHW referring client | | | | Outreach Team Leader name | | | | | | | |
| Contact number for CHW | | | | Team Leader contact number | | | | | | | |

Client details

| | | | | | | | |
|---------------------------------|--|--|--|----------------------------|--|-----------|--------|
| Client address | | | | Client name and surname | | | |
| | | | | MAVIS | | | |
| | | | | Date of Birth (dd/mm/yyyy) | | Age | Gender |
| Client contact telephone number | | | | | | 18 MONTHS | F |

Referred to clinic (Tick all that apply)

| MCHW | Under 5 | Treatment related problems | Other |
|--|---|---|---|
| <input type="checkbox"/> Antenatal care | <input type="checkbox"/> Newborn care | <input type="checkbox"/> TB symptoms | <input checked="" type="checkbox"/> Other health problems (Specify below) |
| <input type="checkbox"/> Postnatal care | <input type="checkbox"/> Low birth weight | <input type="checkbox"/> STI testing | |
| <input type="checkbox"/> Pregnancy test | <input type="checkbox"/> Immunisation | <input type="checkbox"/> Mental health | |
| <input type="checkbox"/> Family planning | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Treatment adherence | |
| <input type="checkbox"/> Emergency contraception | <input checked="" type="checkbox"/> Persistent diarrhea | <input type="checkbox"/> Chronic health problem | |
| <input type="checkbox"/> Cervical cancer screen | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> HCT | |
| <input type="checkbox"/> PCR test for infants | <input checked="" type="checkbox"/> Nutritional/growth problems | <input type="checkbox"/> CD4 test | |
| | | <input type="checkbox"/> Oils | |

Referred to Social Services

(Tick all that apply)

| | |
|---|--|
| <input type="checkbox"/> Child-headed household | <input type="checkbox"/> Protection services |
| <input type="checkbox"/> Food support | <input type="checkbox"/> Grant support |
| <input type="checkbox"/> Other (Specify in box below) | <input type="checkbox"/> Mental health |
| | <input type="checkbox"/> Support groups |
| | <input type="checkbox"/> Housing |
| | <input type="checkbox"/> Vital documents |

Referred for home-based care

(Please write condition that needs home care)

Provide a brief explanation for the referral (Include place client is being referred if not above and reason for referral)

MUAC IN RED ZONE, DIARRHEA FOR 3 DAYS

Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care. Please contact the Outreach Team Leader noted on this form if you have any further questions regarding this referral.

Signed _____ Date _____



Referral Form (from Outreach Team to Provider)

A person has been referred to your service by a member of the Outreach Team working in your ward. Community Healthcare Workers are mandated by the National Department of Health to identify community members in need of primary health and social services. Thank you for seeing this client, we look forward to working together for improved health and welfare for all South Africans.

| | | | | | | | | | | | |
|------------------------------------|--|--|--|----------------------------|--|--|--|---------|--|--|--|
| Client referred to (facility name) | | | | Date referral is made | | | | Ward No | | | |
| Name of CHW referring client | | | | Outreach Team Leader name | | | | | | | |
| Contact number for CHW | | | | Team Leader contact number | | | | | | | |

Client details

| | | | | | | | |
|---------------------------------|--|--|--|----------------------------|--|-----|--------|
| Client address | | | | Client name and surname | | | |
| | | | | PORTIA | | | |
| | | | | Date of Birth (dd/mm/yyyy) | | Age | Gender |
| Client contact telephone number | | | | | | F | |

Referred to clinic (Tick all that apply)

| MCHW | Under 5 | Treatment related problems | Other |
|--|--|---|---|
| <input type="checkbox"/> Antenatal care | <input type="checkbox"/> Newborn care | <input type="checkbox"/> TB symptoms | <input checked="" type="checkbox"/> Other health problems (Specify below) |
| <input type="checkbox"/> Postnatal care | <input type="checkbox"/> Low birth weight | <input type="checkbox"/> STI testing | |
| <input type="checkbox"/> Pregnancy test | <input type="checkbox"/> Immunisation | <input type="checkbox"/> Mental health | |
| <input type="checkbox"/> Family planning | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Treatment adherence | |
| <input type="checkbox"/> Emergency contraception | <input type="checkbox"/> Persistent diarrhea | <input type="checkbox"/> Chronic health problem | |
| <input type="checkbox"/> Cervical cancer screen | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> HCT | |
| <input type="checkbox"/> PCR test for infants | <input type="checkbox"/> Nutritional/growth problems | <input type="checkbox"/> CD4 test | |
| | | <input type="checkbox"/> OIs | |

Referred to Social Services

(Tick all that apply)

| | |
|---|---|
| <input type="checkbox"/> Child-headed household | <input type="checkbox"/> Protection services |
| <input type="checkbox"/> Food support | <input checked="" type="checkbox"/> Grant support |
| <input type="checkbox"/> Other (Specify in box below) | <input type="checkbox"/> Mental health |
| | <input type="checkbox"/> Support groups |
| | <input type="checkbox"/> Housing |
| | <input type="checkbox"/> Vital documents |

Referred for home-based care

(Please write condition that needs home care)

| | |
|--|--|
| | |
|--|--|

Provide a brief explanation for the referral (Include place client is being referred if not above and reason for referral)

PORTIA HAS AN 10 MONTH OLD BABY, MATTHEW. SHE REQUIRES A CHILD SUPPORT GRANT. SHE DOES NOT WORK

Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care. Please contact the Outreach Team Leader noted on this form if you have any further questions regarding this referral.

Signed _____ Date _____

Slide 16

Group Activity

10 minutes

Ask the group to split into groups of 5. Give each group an A1 copy of the map below. They must take a look at the municipal map they have been given and identify geographic features, infrastructure resources and landmarks of the area.

Some of their observations may include:

- A national road serves as a boundary on the left side of the ward
- A railway serves as a boundary on the right side of the ward
- Mokgosi Primary
- Bopaganang Secondary School
- Retlaadira Primary School
- Pule Leeuw Secondary
- Huhudi Community Health Centre
- Thuto-Lesedi Primary
- John Frylinck Secondary School

Remember that you will be re-using these maps per programme and therefore Learners must not write on the map itself.

Slide 20

Working in Pairs

10 minutes

Ask the group to team up with another member of the *Orientation Programme* that they have not yet paired with. Direct them to the *Team Leader Job Aid* under *Exercises* where they will find a completed copy of the *Community Profile*. From the information in the completed profile, they must identify at least 3 key health issues within this community.

Once they have completed this activity, get each group to discuss their findings.

All issues that may be identified are circled in red in the completed community profile below.

Ensure that all circled issues on the form below are identified during the group discussion.

| Community Profile Template | | | |
|--|---|------------------------------|---------------------------------------|
| Team Leader name | JACKIE SHEBA | | Clinic (DHIS name) |
| | | | VISCHKUIL PHC |
| District | LESEDI | | Team (DHIS name) |
| | | | VISCHKUIL |
| Ward (DHIS number) | ENDICOTT 23 | | |
| Geographic information | | | |
| (Obtain this information by observation, talking to people, the internet) | | | |
| Please describe the geographic area of the catchment area in the space below. When you are writing the description, please consider some of the following: | | | |
| <ul style="list-style-type: none"> • Is it an urban or a rural area? • Is it a township? • How far is the area from the nearest major city and the nearest hospital? | | | |
| <ul style="list-style-type: none"> • PRIMARILY A RURAL AREA • COMMUNITIES ARE LOCATED FAR APART • MAJOR ROADS: N17, R29, R42 | | | |
| Once you have described the area, try to fill in the information in the boxes below. If you don't know the information and cannot access the information, leave it blank. That way, if you get this information at a later stage, you can fill it in then. | | | |
| Closest major city | Distance (km) from clinic to major city | Closest hospital | Distance (km) from clinic to hospital |
| DEVON | 21KM | HEIDELBERG | 36KM |
| Number of clinics | Number of Community Health Centres | Number of district hospitals | Number of regional hospitals |
| 6 | 2 | 1 | 0 |
| Number of primary schools | Number of high schools | Number of police stations | Number of informal settlements |
| 1 | 1 | 1 | 2 |



Demographic data

(Obtain this information by observation, talking to people, Stats SA, the PHC clinic, government documents)

Try to describe the people living in the catchment area. When you are describing the people, some factors to consider are:

- Are the people mostly old or mostly young?
- Are the people mostly employed or unemployed?
- What is the primary race of most people in the area?
- What is their ethnicity (e.g. Zulu, Xhosa, Tswana, Venda)?
- What languages do people speak?

- MOST MEN ARE EMPLOYED AT THE MINES *MIGHT INDICATE MIGRANT LABOUR FORCE - HIV/STIs*
- MOST OF THE FEMALES TRAVEL TO NIGEL OR DEVON FOR WORK
- THERE ARE LOTS OF TEENAGE PREGNANCIES - MANY YOUNG WOMEN LIVE OFF SOCIAL + CHILD GRANTS *CAUSE FOR CONCERN*

Once you have described the people, try to fill in the information in the boxes below. If you don't know the information and cannot access the information, leave it blank. That way, if you get this information at a later stage, you can fill it in then.

| | | |
|---|-----------------------|---|
| Total number of households | Total ward population | Total number of child headed households |
| 1251 | 3110 | 9 |
| Primary sources of income | Languages spoken | |
| MINING, GRANTS <i>NO INDUSTRY IN AREA</i> | ENGLISH, TSWANA | |

Health status data

(Obtain this data from the PHC clinic, Stats SA, NDOH website, World Health Organisation website, talking to people in the community)

Describe the health of the people in the area. When you are describing their health, consider the following factors:

- What are the major health problems in the community (e.g. HIV, TB, diabetes, obesity)?
 - What is the number one cause of death in infants? In adults?
 - What are the major infectious diseases found in the community?
 - What are the major chronic diseases found in the community?
- HALF OF THE HOUSEHOLDS HEADED BY A PERSON OVER 65 YRS
RECEIVE HBC OUTREACH TEAM NEEDS TO WORK WITH HBC OWNERS
- INFANT DEATHS ARE INCREASING AS MOTHERS DO NOT BRING NEWBORNS TO THE CLINIC FOR IMMUNISATIONS EDUCATION REQUIRED
- A MAJOR CAUSE OF DEATH IN CHILDREN IS DIARRHEA

EDUCATION, HEALTH PROMOTION,
SCREENING & TREATMENT
ADHERENCE SUPPORT REQUIRED

Once you have described the health issues in the community, try to fill in the information in the boxes below. If you don't know the information and cannot access the information, leave it blank. That way, if you get this information at a later stage, you can fill it in then.

| | | | | |
|---|--|--|--|--------|
| Infectious diseases: Tick the box if you think people in your community suffer from any of these illnesses | HIV <input checked="" type="checkbox"/> | TB <input checked="" type="checkbox"/> | STI | |
| Chronic diseases: Tick the box if you think people in your community suffer from any of these illnesses | Heart disease <input checked="" type="checkbox"/> | Cancer | Diabetes <input checked="" type="checkbox"/> | Asthma |
| List any other diseases that may be in your community | CHILDREN WITH DIARRHEA HYPERTENSION PREVENTABLE. MAY ALSO POINT TO WATER/SANITATION ISSUES | | | |



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Other aspects of the community

(Obtain this information by observation, talking to people, the internet)

Write any other information about the community here. This could include information about the gatekeepers of the community, politics, or anything else.

- PUBLIC TRANSPORT DOES NOT EXIST + THE TAXI SERVICE IS VERY EXPENSIVE
- WARD COUNCILLOR, MR. MONALEDI, HAS BEEN IN THE JOB FOR 6 MONTHS + DOES NOT KNOW ABOUT ALL THESE ISSUES

Slide 31

Group Activity

20 minutes

Divide the Learners into 4 groups. Assign each group 1 of the following health issues for their community:

- High teenage pregnancy rate
- High HIV prevalence
- Poor sanitation: the community has garbage all over the streets and around the HHs
- High drug and alcohol abuse

Give each group 10 minutes to agree on the way that their team will respond to their community issue and come up with 3 possible interventions to address the issue and how to involve the community.

For each of the 3 interventions to address the health issue, they must give the following details:

- What is the activity that will get the community involved and how will it work?
- Who will be involved?
- How will community involvement be encouraged?

Once complete, they must present their approach to the larger group. Generate group discussion to ensure that all OTLs are thinking practically and creatively about community interventions. Highlight skills used as indicated in Lesson 2.

Slide 32

Review Exercise

20 minutes

Summarise this Lesson by dividing the Learners into 2 groups. Have the teams form 2 lines facing each other. Announce 1 of the following themes:

- Community entry
- Community assessment
- Community health improvement plan
- Community involvement



Once the theme is announced, throw the ball to a team member who must immediately name an item within the declared theme. Once named, they should immediately throw the ball to a member on the opposite team, who must also name an item, and so on. No duplicates are allowed and the ball is thrown between the 2 teams until someone fails to name a new item or the theme is exhausted.

8.7 Lesson 6 – Household Engagement

| | | |
|-------------------------------------|---|--|
| Lesson 6 Learning Objectives | ✓ | To understand how to allocate HHs to CHWs |
| 95 minutes | ✓ | To understand the HH registration, screening and assessment process |
| | ✓ | To understand how to establish and maintain a referral system for the catchment area |
| | ✓ | To understand the importance of and how to supervise CHW home visits |

8.7.1 Lesson Material

- *PowerPoint Slides* for Lesson 6
- *Facilitator Toolbook 1 and 4*
- Lesson 6 in the *Learner Guide*
- *Team Leader Job Aid – Exercises* section
- Flipchart paper and 6 coloured flipchart pens

8.7.2 Overview of Lesson Plan

- Allocation of HHs to CHWs
- HH registration, screening and assessment process
- Referral system
- CHW home visit supervision

8.7.3 Process for Teaching

- Brief Lecture
- Brainstorm
- Individual Activities

8.7.4 Notes to Facilitator

- Form completion is a critical component of the Outreach Team. The OTL must understand how all forms are to be completed regardless of whether or not it is their responsibility to do this

8.7.5 Key points related to specific PowerPoint Slides

| Slide 14 | Individual Activity |
|--|---------------------|
| <p>20 minutes</p> <p>Guide each Learner to look at the scenario and information provided in the <i>Team Leader Job Aid</i> under <i>Exercises</i> that will enable them to complete a <i>Household Registration Form</i>. (They will find a blank Form in the <i>Team Leader Job Aid</i> under <i>Exercises</i> and must complete it accordingly).</p> <p>The scenario is as follows.</p> <p><i>You are visiting a household for the first time in your area. Fill out the Household Registration Form according to the information below.</i></p> <p><i>You are a CHW named Zukiswa Msebeza. You work in Ward 26 based from Steve Tswete Clinic and your Outreach Team name is NW Steve Tswete Clinic Outreach Team 1.</i></p> <p><i>Your team leader has given you the Official Household registration number of your HH and this one is 6850026. You have made a map of the area you work and this house is number 132 on your map.</i></p> <p><i>You approach this house on the 25th of June, 2012. You knock at the door and explain who you are, the role of the Outreach Team and purpose of the visit. You request to be allowed to proceed with the registration. The door is answered by a woman who invites you in.</i></p> <p><i>This household is located at Number 5 Moray Place, Potchefstroom in the North West Province. The postal code is 2520. The head of the household is not there as he is currently at work but the rest of the family is there. The head of the household is Katlego Matsila. His cell number is 0812228192.</i></p> <p><i>You ask about household members living in the house. The woman says it is herself, her 4 children, her mother-in-law and her husband. Her sister is also there visiting from Cape Town for a few weeks.</i></p> <p><i>The children are two girls Jenny, born August 7, 2008 and Vundli born February 2, 2003, and two boys, Thabiso, born May 27, 2010 and Pshasha born March 16, 1998.</i></p> <p><i>The woman who answered the door says her name is Hanani Matsila. She says she is 32 but reports her date of birth as Feb 5, 1979.</i></p> <p><i>The mother-in-law is Wangamatsilia, she says she is 70 years old and does not remember her true birthdate. She is receiving an old age grant. This is the only grant being received in the household.</i></p> | |

Slide 14

Individual Activity (continued)

The head of household is not there but according to his wife, his date of birth is May 30, 1974. He has a regular job at the local Spar that brings income into the house. This is the only wage earner in the house.

The sister is Anne Ramaloko and she is 19. She lives in Cape Town and will return to Cape Town in a few weeks.

The house has a pipe for water in the yard and a pit latrine. There is a gas fridge in the corner and no electricity. The house has 3 rooms, excluding the bathroom.

The children all go to Nelson Mandela Primary and Secondary School in Potchefstroom.

You inform them that you are going to ask some screening questions that you ask every household to help identify some important health needs.

The woman reports that no one in the house has any of the TB symptoms that you list. She is on contraceptive injections. She says no one wants an HIV test in the house because she says “they do not need it.” She states she would like to apply for a child support grant because her husband’s income is not very much. The mother-in-law is able to move around and take care of herself.

You ask if anyone is taking medication and she reports that mother-in-law is taking blood pressure control medication and tablets for diabetes. She also says her husband has an infection that he is taking antibiotics for but is almost finished with the medication.

You ask to see the children’s Road To Health Booklet (RTHB). Thabiso has not received his latest immunisations. He has also not had vitamin A supplementation in the last 6 months. Furthermore, he has not been weighed in over a year. Jenny has missed her latest immunisations but her vitamin A supplementation is up to date as well as her growth-monitoring chart.

You ask the mother about the health of the children. She states that child Thabiso has had a cough for a few days and fever. The other children are fine she says. You assess the children and see that they are fine except for Thabiso who looks unwell and is coughing.

None of the children have been exposed to HIV according to their RTHB.

The grandmother is taking medication for high blood pressure and diabetes. She does not report any problems with these though Hanani states her mother-in-law is often forgetful.

There are no other major problems reported.

Allow them 10 minutes to complete the Household Registration Form and 10 minutes for group discussion. The correctly completed form is shown below. Ensure that all Learners have completed the form correctly. If something is missing or incorrect, ensure that the Learners understand what was missing or why it was incorrect.

Household Registration Form



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REPUBLIC OF SOUTH AFRICAOfficial Household
registration number

685 002-6

| | | | | | | |
|--|---------------------|--------------|----------------------------------|---|---------------------------------------|--|
| Clinic name (DHIS name) | STEVE TWSETE CLINIC | | Ward (DHIS #) | 2-6 | CHW household identifier number | 132- |
| Name of household head/contact | KATLEGO MATSILA | | | Date of visit (dd/mm/yyyy) | 2-5/06/2012 | |
| Household street address/descriptive location | | | | CHW name | ZUKISWA MESEBENZA | |
| 5 MORAY PLACE | | | | Team name (DHIS name) | NW STEVE TWSETE CLINIC OTI | |
| POTCHEFSTROOM | | | | Household respondent | <input checked="" type="checkbox"/> A | <input type="checkbox"/> N/A |
| NW PROVINCE | | | | Were all household members registered in this visit? | <input type="checkbox"/> Y | <input checked="" type="checkbox"/> N |
| Household head phone number | 0 | 8 | 1 | 2 | 2 | 2 |
| 1. Household member details | | | b. Date of birth (dd/mm/yyyy) | c. Age in years | d. Gender | 2. Information about the house |
| a. Name | | | | | male | female |
| 1 | JENNY MATSILA | 07/08/2008 | 4 | | <input checked="" type="checkbox"/> | a. Does the house have electricity? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| 2 | VUNDLI MATSILA | 02/10/2003 | 10 | | <input checked="" type="checkbox"/> | b. Is there piped water in the house or in the yard? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| 3 | THABISO MATSILA | 2-7/05/2010 | 3 | <input checked="" type="checkbox"/> | | c. Is there a working fridge in the house? <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| 4 | PSHASHA MATSILA | 16/03/1998 | 14 | <input checked="" type="checkbox"/> | | d. Is there a toilet in the house? <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| 5 | HANANI MATSILA | 05/02/1979 | 32 | | <input checked="" type="checkbox"/> | e. Total number of rooms in the house? <input type="checkbox"/> 3 |
| 6 | WANGA MATSILA | | 70 | | <input checked="" type="checkbox"/> | f. How many grants does the household receive in total? <input type="checkbox"/> 1 |
| 7 | KETLEGO MATSILA | 2-01/05/1974 | 38 | <input checked="" type="checkbox"/> | | g. How many people in the house are currently working? <input type="checkbox"/> 1 |
| 8 | | | | | | h. Name of school(s) for learners |
| | | | | e. Totals | 3 | 4 |
| 3. General household screening questions for all households If YES to any of following questions, refer for further care | | | | | | Write HH member # in the last column |
| a. Does anyone in the household have any of the following: (circle all that apply) (refer for sputum test for TB) | | | | | | |
| Cough that won't go away? <input checked="" type="checkbox"/> Night sweats <input type="checkbox"/> Weight loss <input type="checkbox"/> Fever <input checked="" type="checkbox"/> Loss of appetite? <input checked="" type="checkbox"/> | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> 3 |
| b. It is very important to know your HIV status. Would anyone in the household like to have an HIV test? (refer for HCT) | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| c. Is there anyone who does not use a family planning method but wants to? (refer for family planning services) | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| d. Is there anyone in the household who cannot get out of bed or needs help with daily living activities? (refer for home-based care) | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N <input type="checkbox"/> 1 |
| e. Do any household members need help applying for social grants? (refer for social services) | | | | | | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| f. Is this a child (<18 years) headed household? (refer for social services) | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| 4. Household screening questions for CHW follow-up If any of the answers below are YES, this household will need follow-up. Complete page 2 of this form | | | | | | |
| a. Is anyone in the household currently pregnant or has not had a menstrual period in the last 6 weeks and may be pregnant? | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| b. Has there been a delivery (baby) in the last 6 weeks? | | | | | | <input type="checkbox"/> Y <input checked="" type="checkbox"/> N |
| c. Are there any children under the age of 5 in the household? | | | | | | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| d. Is anyone in the household taking daily medication (like TB/ARV/diabetes medication/high BP medication)? | | | | | | <input checked="" type="checkbox"/> Y <input type="checkbox"/> N |
| Notes: | | | | ***DOES THIS HOUSEHOLD NEED FOLLOW-UP?*** | | |
| HH HEAD NOT AT HOME AT TIME OF VISIT | | | | YES Complete page 2 of this form | | NO Write date for next HH re-assessment visit |
| | | | | <input checked="" type="checkbox"/> | | |

| 5. Further assessment and screening questions for all households to be followed by CHW For each question: if the answer is YES, write the household member number(s) from the list of household member names and details on page 1. For any other problems you have identified, write this in the last box in detail and indicate HH member number. For questions b-g: check RTHB. If a referral is needed, write the total number of clients referred to the clinic for each line. If the client was referred elsewhere – indicate the reason, the place of referral and number of referral forms issued in box j. | | | | | HH member number(s)* | Number of Referral Forms Issued |
|--|--------------------------|--------------|----------|-----------------|----------------------|---------------------------------|
| a. If someone in the house is pregnant, what is the estimated delivery date (EDD)? <i>Check the ANC card if available or ask mother when her LNMP was and use pregnancy wheel to estimate. (Write unknown if delivery date is not known)</i> | EDD (dd/mm/yy) | | | | | |
| b. If there was a birth in the last 6 weeks, what was the date? <i>Check the RTHB or ask mother for the date of births</i> | Date of Birth (dd/mm/yy) | | | | | |
| i. Was the baby's birth weight under 2500 grams? <i>Refer to clinic for monitoring. Schedule further home visits</i> | Y | N | | | | |
| c. Are there any children under 5 in the house whose immunisations are not up to date? <i>Refer for catch-up EPI at clinic</i> | ✓ | N | 1,3 | 2 | | |
| d. Are there any children under 5 who have not had a dose of vitamin A in the last 6 months? <i>Refer for vitamin A supplement at clinic</i> | ✓ | N | 3 | 1 | | |
| e. Are there any children who have not been weighed according to the growth-monitoring schedule or who show signs of malnutrition/growth faltering? <i>Refer for growth monitoring. Complete a nutritional assessment and schedule follow-up visits if needed</i> | ✓ | N | 3 | 1 | | |
| f. Are there any children with suspected illness or does mother/caregiver have concerns about any child's current or recent health status? <i>Assess and refer to clinic if needed. Schedule follow-up visits</i> | ✓ | N | 3 | 1 | | |
| g. Are there any HIV exposed children in the household 6 weeks or older who have not had a PCR test? <i>Check the RTHB. Refer to clinic for PCR test. Schedule follow-up visit</i> | Y | ✓ N | 0 | 0 | | |
| h. If anyone in the HH is taking medication for the following, write their HH member number in the box(es) below. | | | | | | |
| TB | HIV | Hypertension | Diabetes | Other (Specify) | Y | N |
| | | 6 | 6 | | | |
| i. Has someone defaulted from treatment? <i>Write HH member # of defaulter. Refer to clinic for further care and schedule follow-up visit for treatment adherence support.</i> | Y | ✓ N | | | | |
| j. Any other problems identified (state). | | | | | | |

| Comments/Notes |
|----------------|
| |
| |
| |
| |
| |
| |

* NOTE: It is expected that an Individual Health Record is complete for every client that is being followed in the household.

CHW Signature *Zenzebeza* Verified by Team Leader _____ on _____ (date)



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Slide 14

Individual Activity (continued)

Once they have completed the forms, discuss what further forms need to be completed.

They should identify that:

- 2 *Maternal and Child Health Records* for both children under 5 need to be completed
- 1 *Individual Adult Health Record* for the mother-in-law for diabetes and high blood pressure medication needs to be completed
- 1 *Referral Form* for Hanani (mother of children) to Social Services for child support grant application needs to be completed
- 1 *Referral Form* for child, Thabiso, for cough and fever and for immunisation, Vitamin A catch up, and Growth Monitoring needs to be completed
- 1 *Referral Form* for child, Jenny, for immunisation catch up needs to be completed

Furthermore, other issues that should be discussed include:

- The husband was not home on this visit. This is a vulnerable household and the CHW will be following up. Therefore the CHW can screen husband for HIV/TB and other issues at subsequent visit and can write this at the bottom of the page
- The CHW should discuss the issue of HIV testing and how to encourage HCT for Hanani and Katlego sensitively. This would be best approached at a later visit when trust is established

The sister is only visiting and planning to leave within a few weeks so does not need to be added on the form. However, what would the OTL do if she was planning to stay for 6 months and was pregnant?

Slide 18

Brainstorm

10 minutes

Guide each Learner to the completed *Referral/Back-referral Form* in the *Team Leader Job Aid* under *Exercises*. Ask them to individually review the form and then as a group, get them to discuss:

- i. Has the form been completed correctly? If not, what is not correct?
- ii. Does that referral service appear to be conducted properly? If not, why not?

This activity is intended to highlight again how to complete a *Referral Form*, illustrate to the OTLs how to identify a poorly completed form and most importantly, illustrate the implications of an incomplete or poorly completed form (i.e. the service not being provided).

The completed form with errors highlighted can be found below.

Please note that all errors in the forms below have been circled in red and the reason for the error is described in red. When discussing in the larger group, ensure that all errors have been covered and the reason that it is an error is explained.



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Referral Form (from Outreach Team to Provider)

A person has been referred to your service by a member of the Outreach Team working in your ward. Community Healthcare Workers are mandated by the National Department of Health to identify community members in need of primary health and social services. Thank you for seeing this client, we look forward to working together for improved health and welfare for all South Africans.

| | | | | | | | | | | | | | | | | | | | | | |
|------------------------------------|---|---|---|---------------------------|---|---|---|---------|---|---|----------------------------|---|---|---|---|---|---|---|---|---|---|
| Client referred to (facility name) | | | | Date referral is made | | | | Ward No | | | | | | | | | | | | | |
| STEVE TSWETE CLINIC | | | | 2-5/06/2012 | | | | 2-6 | | | | | | | | | | | | | |
| Name of CHW referring client | | | | Outreach Team Leader name | | | | | | | | | | | | | | | | | |
| ZUKISWA MSEBEZA | | | | VIRGINIA MPANE | | | | | | | | | | | | | | | | | |
| Contact number for CHW | 0 | 8 | 6 | 1 | 5 | 5 | 1 | 7 | 9 | 0 | Team Leader contact number | 0 | 7 | 2 | 6 | 7 | 8 | 7 | 0 | 8 | 9 |

| Client details | | | | | | | | | | | | | |
|---|---|---|---|---|----------------------------|---|-----|--------|---|-------------|--|----|---|
| Client address | | | | | Client name and surname | | | | | | | | |
| 240 SECTOR 3 MANTHE GREATER TANG NWP | | | | | LUCAS MAMPE | | | | | | | | |
| Client contact telephone number | | | | | Date of Birth (dd/mm/yyyy) | | Age | Gender | | | | | |
| 0 | 7 | 2 | 5 | 5 | 5 | 5 | 5 | 5 | 4 | 2-3/06/1972 | | 40 | M |

| Referred to clinic (Tick all that apply) | | | |
|--|--|---|--|
| MCHW | Under 5 | Treatment related problems | Other |
| <input type="checkbox"/> Antenatal care | <input type="checkbox"/> Newborn care | <input type="checkbox"/> TB symptoms | <input type="checkbox"/> Other health problems (Specify below) |
| <input type="checkbox"/> Postnatal care | <input type="checkbox"/> Low birth weight | <input type="checkbox"/> STI testing | |
| <input type="checkbox"/> Pregnancy test | <input type="checkbox"/> Immunisation | <input type="checkbox"/> Mental health | |
| <input type="checkbox"/> Family planning | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Treatment adherence | |
| <input type="checkbox"/> Emergency contraception | <input type="checkbox"/> Persistent diarrhea | <input type="checkbox"/> Chronic health problem | |
| <input type="checkbox"/> Cervical cancer screen | <input type="checkbox"/> Pneumonia | <input checked="" type="checkbox"/> HCT | |
| <input type="checkbox"/> PCR test for infants | <input type="checkbox"/> Nutritional/growth problems | <input type="checkbox"/> CD4 test | |
| | | <input type="checkbox"/> OIs | |

| Referred to Social Services (Tick all that apply) | Referred for home-based care (Please write condition that needs home care) |
|---|---|
| <input type="checkbox"/> Child-headed household <input type="checkbox"/> Food support <input type="checkbox"/> Other (Specify in box below) | |
| <input type="checkbox"/> Protection services <input type="checkbox"/> Grant support <input type="checkbox"/> Mental health <input type="checkbox"/> Support groups <input type="checkbox"/> Housing <input type="checkbox"/> Vital documents | |

Provide a brief explanation for the referral (Include place client is being referred if not above and reason for referral)

Please complete Back-referral Form on the other side of this paper so we can ensure follow-up care. Please contact the Outreach Team Leader noted on this form if you have any further questions regarding this referral.

Signed Virginia Mpane Date _____

**Back-referral Form
(from Provider to Outreach Team)**

| | |
|---|-------------------------------|
| This client was seen by (Provider name) | Date client seen (dd/mm/yyyy) |
| Facility name <i>NO INFORMATION REGARDING WHO SAW THE CLIENT OR WHEN</i> | Facility telephone number |
| Name of referring CHW | Name of Team Leader |

Client details

| | |
|---|------------------|
| Client name and surname <i>NO NAME GIVEN</i> | Telephone number |
|---|------------------|

Findings (include diagnosis with patient consent)

PATIENT HAS HIGH BLOOD PRESSURE

THIS HAS NOTHING TO DO WITH THE OUTCOME OF THE REFERRAL. THE CLIENT WAS REFERRED FOR HCT

Actions taken (including medicines given/prescribed if relevant)

GIVEN MEDICATION

Follow-up actions to be monitored or completed by CHW

SEND TO CLINIC AFTER 6 MONTHS

NO INDICATION WHY

Please send client back to this provider on/by _____ for further follow-up
(dd/mm/yy)

| | |
|--|-----------------|
| Signature <i>NO IDENTIFYING INFORMATION FOR FOLLOW-UP</i> | Date (dd/mm/yy) |
|--|-----------------|

Slide 24

Review Exercise

20 minutes

Invite the group to select 1 person as the note-taker. He/she is to write on the flipchart everything the group says. Together, the group are to share with him/her all the major points of this Lesson.



8.8 Lesson 7 – Monitoring, Evaluation and Reporting

| | | |
|--|---|--|
| Lesson 7 Learning Objectives 90 minutes | ✓ | To understand the importance of monitoring and evaluating all Outreach Team activities, including all services delivered |
| | ✓ | To understand how to complete all required Outreach Team reports |
| | ✓ | To understand how to organise and file all Outreach Team documents and store them in a secure location |
| | ✓ | To understand what happens to all the information that is captured by the Outreach Team |

8.8.1 Lesson Material

- *PowerPoint Slides* for Lesson 7
- *Facilitator Toolbook 1* and 5
- Lesson 7 in the *Learner Guide*
- *Team Leader Job Aid – CHW Forms, Team Leader Reporting Forms* and *Exercises* section
- Flipchart paper and 6 coloured flipchart pens

8.8.2 Overview of Lesson Plan

- Monitoring and evaluation
- Reporting
- Where do I keep all required documentation?
- What happens to the information I submit in the monthly reports?

8.8.3 Process for Teaching

- Brief Lecture
- Brainstorm
- Individual Activities

8.8.4 Notes to Facilitator

- In order to identify whether or not the Outreach Team is having a positive effect on the community, data must be collected and stored

8.8.5 Key points related to specific PowerPoint Slides

| Slide 10 | CHW Household Visit Tick Sheet |
|--|--------------------------------|
| <p>The <i>CHW Household Visit Tick Sheet</i> is intended for the CHW to record the activities of their day.</p> <p>Talk the Learners through the <i>CHW Household Visit Tick Sheet</i> which can be found in the <i>Team Leader Job Aid</i> under <i>CHW Forms</i>.</p> <p>It is critical that Learners understand that each tick relates to an activity (e.g. the CHW should only tick the children under 5 block if they provided a service to a child under 5, not because there is a child under 5 in the HH). The <i>Household Registration Form</i> is the only form that looks at the HH profile, the rest all look at the activity/service provided.</p> <p>Another example would be if the CHW scheduled a follow-up with a pregnant woman. Even if the CHW went to the house, the tick should only be made if the CHW conducted an antenatal visit with the pregnant woman. So if the pregnant woman was not home, there is no tick applicable.</p> <p>NB: If the OTL provides a service instead of the CHW, he/she must also complete all the CHW forms and simply write his/her name in the form in the block titled CHW name.</p> | |

| Slide 11 | CHW Household Visit Monthly Summary Form |
|---|--|
| <p>Talk the Learners through the <i>CHW Household Visit Monthly Summary Form</i> which can be found in the <i>Team Leader Job Aid</i> under <i>CHW Forms</i>.</p> <p>NB: If the OTL provides a service instead of the CHW, he/she must also complete all the CHW forms and simply write his/her name in the form in the block titled CHW name.</p> | |

| Slide 12 | Individual Activity |
|--|---------------------|
| <p>15 minutes</p> <p>Guide each Learner through the completed <i>CHW Household Visit Tick Sheets</i> found in the <i>Team Leader Job Aid</i> under <i>Exercises</i>. Ask them to then complete the <i>CHW Household Visit Monthly Summary Form</i>, a copy of which can also be found in the <i>Team Leader Job Aid</i> under <i>Exercises</i>.</p> <p>Allow each Learner to complete the form and then discuss. Ensure that all Learners have done this correctly.</p> <p>The correctly completed form is shown below. Ensure that all Learners have completed the form correctly. If something is missing or incorrect, ensure that the Learners understand what was missing or why it was incorrect.</p> | |

**CHW Household Visit
Monthly Summary Form**


| | |
|---|--|
| CHW name <i>ZUKISWA MSEBEZA</i> | Reporting month/year <i>06/2012</i> |
| Clinic (DHIS name) <i>STEVE TSWETE</i> | Ward (DHIS #) <i>2-6</i> |
| Team (DHIS name) <i>MW STEVE TSWETE OT 1</i> | |

| Tick sheet no. | Tick sheet end date (dd/mm) | Household visit details (totals) | | | Household activity (totals) | | | | | Referral Forms given (totals) | | | Activity head count (totals) | | Support groups facilitated (total) |
|---|-----------------------------|----------------------------------|-----------------|------------------|-----------------------------|-----------|---------|-------------------|-----------------|-------------------------------|-----------------|-----------------|------------------------------|---------------------------|------------------------------------|
| | | Type of visit | | Supervised visit | Pregnancy | Postnatal | Under 5 | Adherence support | Home-based care | Clinic | Social Services | Home-based care | Clients UNDER 5 years | Clients 5 years and older | |
| | | Household registration visit | Follow-up visit | | | | | | | | | | | | |
| 1 | 12/06 | 9 | 16 | 3 | 3 | 3 | 11 | 6 | 0 | 10 | 4 | 0 | 18 | 15 | 0 |
| 2 | 22/06 | 7 | 18 | 3 | 2 | 0 | 14 | 12 | 0 | 11 | 7 | 1 | 22 | 16 | 0 |
| 3 | 29/06 | 5 | 8 | 0 | 0 | 0 | 6 | 7 | 0 | 5 | 1 | 0 | 8 | 8 | 0 |
| 4 | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | |
| Monthly Total | | 21 | 42 | 6 | 5 | 3 | 31 | 25 | 0 | 26 | 12 | 1 | 48 | 39 | 0 |
| Total community campaigns this month | | | | | | | | | | | | | | | 0 |

CHW signature *Mashale* Date 29/06/2012
 Verified by Team Leader *Mashale* on 29/06/2012 (date)

Slide 13

Keeping Data Clean

One important role is for the OTL to support the accurate reporting to DHIS by the Outreach Team. This will ensure that the data submitted at the end of each month is accurate and “clean”.

There are a few tricks that OTLs can quickly use to scan the forms and see that there are no mistakes which you must explain to the OTLs. These are included in the notes of the *PowerPoint slides* and include:

- The first trick is that under **Type of Visit**, **Household registration visit** AND **Follow-up visit** cannot be ticked at the same time. It is ALWAYS one or the other
- When a HH is first registered using the *Household Registration Form*, this is recorded as a **Household registration visit**. Any following visit is recorded as a **Follow-up visit**, even if the CHW finds someone new in the household and must update the *Household Registration Form*. If you add the total number of Household registration visits to the total number of follow-up visits you will get 25 if every line of the *CHW Household Visit Tick Sheet* is filled out. If it is more than 25, there is a problem
- Another thing to remember is that the Activity ticks must be reflected in the **Activity head count**
 - Let's say the CHW ticks **Under 5** for her **Household activity**, you MUST then see at least the number 1 written in the **Clients under 5** years given service box under **Activity head count**. You could see more than 1 in this box if the CHW has given service to more than one child under 5 in that household, but the minimum would be 1
 - Most **Adherence support** ticks will be for adults so you should see a number '1' or more written for **Clients 5 years and older** for that household
 - A CHW may have seen a child under 5 and ticked **Under 5** and written '1' for **Clients UNDER 5 years**. The CHW may also have referred this child to the clinic. She might also refer another household member. For example, she may have referred the father to the clinic as well for TB symptoms. Then she would write '2' under **Clinic** referrals. She would then count the father in the **Clients 5 years and older** box for that household
 - If a CHW ticked **Postnatal** they must write at least '1' for **Clients under 5 years** given service and '1' for **Clients 5 and older** given service to show they saw both the mother and the baby
 - If they tick **Pregnancy**, they must also count this person in the **Clients 5 years and older** given service box
 - The **Activity head count** always applies to the person for whom the treatment is intended. For example, if **Adherence support** was required for a child under 5 years, you would put a 1 in the **Clients under 5 years**, even though realistically you would have had this discussion with the parent/guardian

Slide 14

Questions to Think About

Here are some circumstances to think about:

- Under what circumstance could you see only a '1' written for Clients 5 years and older when **Postnatal** household activity is ticked?
Answer: If the baby has died and the mother is still being followed for PNC
- If a CHW visits a house for a 2 year old HIV-positive child on ARVs, what should be ticked under **Activity**? What should be written in **Activity Headcount**?
*Answer: Both **Under 5** and **Adherence Support Household** activity should be ticked. Only the number '1' should be written under **Clients under 5 years** given service under Activity head count*
- If a CHW records visiting only 1 child but then she records 2 **Clinic Referral Forms issued**, what could this mean?
*Answer: This could mean that she gave one form to the child and one form to someone else in the household for something else such as HCT or TB screening. This is not wrong. However, the other person should be reflected in the **Client 5 years and older** box. If however the activity was for treatment of STI's for example, this would not be reflected in activity type.*

Remember, If something does not make sense to you, you can always check the individual health records to see what has happened at the household.

Slide 16

Outreach Team Monthly Summary Form

Talk the Learners through the *Outreach Team Monthly Summary Form* which can be found in the *Team Leader Job Aid* under *Team Leader Reporting Forms*.

Slide 18

Individual Activity

15 minutes

Guide Learners to a completed *CHW Household Visit Monthly Summary Form* in the *Team Leader Job Aid* under *Exercises*. Then ask the Learners to use this form and the *CHW Household Visit Monthly Summary Form* completed in the previous exercise to add to and complete the *Outreach Team Monthly Summary Form* which can be found in the *Team Leader Job Aid* under *Exercises*.

Once all Learners have completed the form, discuss with the larger group to ensure that they all have the same completed form.

The correctly completed form is shown below. Ensure that all Learners have completed the form correctly. If something is missing or incorrect, ensure that the Learners understand what was missing or why it was incorrect.

Outreach Team Monthly Summary Form



| | |
|--|---|
| Team Leader name <i>VERONICA MAKABE</i> | Reporting month/year <i>06/2-012</i> |
| Clinic (DHIS name) <i>STEVE TSWETE</i> | Ward (DHIS number) <i>2-6</i> |
| Team name (DHIS name) <i>NW STEVE TSWETE OT 1</i> | |
| Total number of HHs allocated to team <i>1500</i> | Number of CHWs per team <i>6</i> |

| CHW name | Number households allocated | Household visit details | | | Household activity | | | | | Referral Forms given | | | Activity head count | | Community activity | |
|---|-----------------------------|-------------------------|------------------------------|-----------------|--------------------|-----------|------------|------------|-------------------|----------------------|-----------|-----------------|---------------------|-----------------------|---------------------------|----------------------------|
| | | Type of visit | Household registration visit | Follow-up visit | Supervised visit | Pregnancy | Postnatal | Under 5 | Adherence support | Home-based care | Clinic | Social services | Home-based care | Clients UNDER 5 years | Clients 5 years and older | Support groups facilitated |
| <i>CYNTHIA</i> | <i>250</i> | <i>42</i> | | | | | | | | | | | | | | |
| <i>ALICE</i> | <i>250</i> | <i>20</i> | <i>57</i> | <i>5</i> | <i>0</i> | <i>6</i> | <i>36</i> | <i>28</i> | <i>0</i> | <i>18</i> | <i>8</i> | <i>1</i> | <i>54</i> | <i>34</i> | <i>0</i> | <i>0</i> |
| <i>GRACE</i> | <i>250</i> | <i>33</i> | <i>40</i> | <i>3</i> | <i>4</i> | <i>2</i> | <i>34</i> | <i>15</i> | <i>0</i> | <i>22</i> | <i>17</i> | <i>2</i> | <i>38</i> | <i>23</i> | <i>0</i> | <i>0</i> |
| <i>PRECIOUS</i> | <i>250</i> | <i>27</i> | <i>25</i> | <i>6</i> | <i>2</i> | <i>0</i> | <i>20</i> | <i>5</i> | <i>8</i> | <i>31</i> | <i>4</i> | <i>0</i> | <i>23</i> | <i>11</i> | <i>0</i> | <i>0</i> |
| <i>ZUKISWA MSEBEZA</i> | <i>250</i> | <i>21</i> | <i>42</i> | <i>6</i> | <i>5</i> | <i>3</i> | <i>31</i> | <i>25</i> | <i>0</i> | <i>26</i> | <i>12</i> | <i>1</i> | <i>48</i> | <i>39</i> | <i>0</i> | <i>0</i> |
| <i>VIRGINIA MASHALE</i> | <i>250</i> | <i>35</i> | <i>40</i> | <i>3</i> | <i>3</i> | <i>3</i> | <i>30</i> | <i>19</i> | <i>0</i> | <i>22</i> | <i>4</i> | <i>4</i> | <i>48</i> | <i>23</i> | <i>0</i> | <i>0</i> |
| Total | <i>1500</i> | <i>178</i> | <i>242</i> | <i>24</i> | <i>20</i> | <i>14</i> | <i>174</i> | <i>109</i> | <i>8</i> | <i>143</i> | <i>52</i> | <i>10</i> | <i>236</i> | <i>156</i> | <i>0</i> | <i>0</i> |
| Total number of Back-referral Forms received from clinics this month | | | | | | | | | | | | | | | <i>0</i> | |

Signature of Team Leader *V Makabe* Date (dd/mm/yyyy) *30/06/2012*

Signature of Facility Manager _____ Date (dd/mm/yyyy) _____

Signature of Data Capturer _____ Date (dd/mm/yyyy) _____

Comments:

Slide 19

Data Accuracy and Cross Checking Records

One way that the OTLs can check that the CHWs in their team are doing their work and are reporting their work accurately is to cross check their records. It is also good for the OTLs to go back to these forms when things on the *CHW Household Visit Tick Sheet* do not make sense.

If all CHW forms are filled in completely and correctly, they should give the OTL a good picture of the work each CHW is doing. In this way the forms 'speak' to each other.

The key CHW forms that speak to each other are:

The Individual Health Records (IHRs), including the *Maternal and Child Health Record* and the *Individual Adult Health Record*, the *CHW Household Visit Weekly Tick Sheet* and the *Weekly Household Visit Schedule*.

The Individual Health Records will capture key information about each household visited. If a CHW has written on their *CHW Household Visit Tick Sheet* that they saw one child under 5 and one person 5 and older in a household, you can check the IHRs for both of these clients.

The IHR will also keep a record of the Referrals that were made to the clinic or other service providers and this can be cross-checked with the *CHW Household Visit Tick Sheet* numbers as well.

Finally, the OTLs can check to see that the number of *Back-referral Forms* that they have counted corresponds with the number of *Back-referral Forms* received that are documented on the back of the IHR for the month.

The *Weekly Household Visit Schedule* is a tool that plans the forward visits for the coming weeks. If a visit to a household was successfully made, the CHW can tick the box on the *Weekly Household Visit Schedule*. This should also be reflected on the IHRs and the *CHW Weekly Household Visit Tick Sheet*.

If the CHW went to a household but was unable to make the visit, the box should be left empty on the *Weekly Household Visit Schedule*. This way, you can see that the CHW spent the time traveling to the household but the visit was not successful.

This way you can track the workload and ensure that the reporting forms are being filled out accurately. The *CHW Household Visit Tick Sheet* records the type of visit, activity given at household, referrals made and number of clients seen for each household visited.

Check this periodically with the IHRs for each HH. The IHRs will tell you the date of visit, the type of visit, and if a referral was made and you can check the *CHW Household Visit Tick Sheet* to see if these are accurately recorded for each household.

The *Weekly Visit Schedule* will help keep a record of HHs that were visited but the CHW found that no one was there. The HHs without a tick in the box will show this.

| | |
|--------------------|-------------------------------------|
| Slide 20/21 | Outreach Team Reporting Tool |
|--------------------|-------------------------------------|

Talk the Learners through the *Outreach Team Reporting Tool* which can be found in the *Team Leader Job Aid* under *Team Leader Reporting Forms*.

| | |
|-----------------|---|
| Slide 22 | Outreach Team Supplies Management Form |
|-----------------|---|

Talk the Learners through the *Outreach Team Supplies Management Form* which can be found in the *Team Leader Job Aid* under *Team Leader Reporting Forms*.

| | |
|-----------------|-------------------|
| Slide 25 | Brainstorm |
|-----------------|-------------------|

5 minutes

Ask the Learners to look the examples on screen of how 2 clinics have stored their documents. Get them to think about the differences between the 2 approaches and facilitate a group discussion.

Clearly Example 1 is accessible to anyone. Furthermore, trying to find a document in the piles would be very difficult. Example 2 however is secure and structured. You can see labels on the cabinets indicating an organised filing system.

The intention of this exercise is to illustrate the importance of a filing system. In addition, safe storage of documentation should be strongly linked to maintaining confidentiality of information.

| | |
|-----------------|----------------------------|
| Slide 31 | Individual Activity |
|-----------------|----------------------------|

5 minutes

Ask the Learners to think about how documents are currently stored in their clinic? Where will Outreach Team documents be stored? Do they need to order a filing cabinet or filing boxes?

| | |
|-----------------|-------------------------|
| Slide 33 | Information Flow |
|-----------------|-------------------------|

It is important the OTLs understand the importance of all paperwork. From the forms they submit, DHIS will be able to generate information to illustrate:

- a. If they are delivering service in their ward and
- b. What the health outcomes are

Slide 35

Review Exercise

10 minutes

Invite each Learner, one by one to share with the group 1 word about this Lesson.
Go around the whole room until each Learner has shared a different word.



8.9 Lesson 8 – Summary of Orientation

| | | |
|-------------------------------------|---|-------------------------------|
| Lesson 8 Learning Objectives | ✓ | Summary points of all Lessons |
| 70 minutes | | |

8.9.1 Lesson Material

- *PowerPoint Slides* for Lesson 8
- *Facilitator Toolbook 1*
- Lesson 8 in the *Learner Guide*
- Flipchart paper and 6 coloured flipchart pens
- 1 Index card for each Learner

8.9.2 Overview of Lesson Plan

- The intention of this Lesson is to summarise the entire *Orientation Programme*

8.9.3 Process for Teaching

- Brief Lecture

8.9.4 Notes to Facilitator

- This Lesson is intended to pull together the entire programme and summarise the key learnings for the Learners

8.9.5 Key points related to specific PowerPoint Slides

| Slide 25 | Individual Exercise |
|---|---------------------|
| 20 minutes | |
| Hand out 1 index card to each Learner and ask them to reflect on the entire <i>Orientation Programme</i> and write down on the 1 side card, their top 3 takeaways from the <i>Orientation Programme</i> . | |
| On the other side, they are to list, in order of priority, top 5 things they will address next week and how they will implement these. | |
| Explain that this card is their action list and should be displayed in full view when they return to their offices to act as a reminder. | |



Slide 27

Orientation Programme Conclusion

You should invite the Learners to sum up what has been covered in the past five days. Ask them to review the initial expectations of the group, and also reflect on the many flipchart sheets which cover the walls of the training room. Make sure you give the Learners the opportunity to share their thoughts. You should add important points not mentioned.

Ask Learners to provide feedback on what they view as the highlights of this training, what was not achieved, and what topics require further training. Remind Learners of the importance of continuing to practise and utilise the skills they learnt during the *Orientation Programme*.

Give them *Programme Evaluations* (which can be found in *Facilitator Toolbook 1*) and request that they complete with their feedback of the *Orientation Programme*.

Allow enough time for a well-planned closing ceremony, which should include a congratulatory speech by a member of the Provincial Health Department, as well as yourself. In addition, ensure that the *Certificates of Attendance* are distributed. These certificates should be viewed as a reward for the Learner's hard work during the *Orientation Programme*.

Finally, reinforce the valuable role the OTLs will play in the effective and efficient delivery of Primary Health Care services to individuals, HHs and communities.

9. Appendices

The following appendices can be found in this section:

Appendix A: Training Venue Guideline

Appendix B: Training Material Guideline

Appendix C: Registration Form

Appendix D: Assessment Model Answers

Appendix A

Training Venue Guideline

9

9.1 Appendix A: Training Venue Guideline

The training room must:

Accommodate 25 people at a desk and chair, both of which must be in good condition and can be arranged in a “U” or horseshoe arrangement, with sufficient surface to post flipcharts within comfortable view for the Learners. There must also be adequate space for the Facilitator at the front of the room and space for a materials table to the side or back of the room

Have enough floor space for small group exercises and for the Facilitator to move around the room. Alternatively break away rooms will be necessary

Meet all electrical requirements, specifically: electricity supply; adequate lighting; working plug points; fans or air conditioning; heating

Have audio-visual equipment – the *Orientation Programme* material requires a projection wall or screen and a projector on which to utilise the PowerPoint Slides. Additional adaptors and extension cords may also be required

Have a flipchart board on which to attach flipchart paper

Have proper ventilation in order to help assure the health of Learners. The space should be well ventilated and large enough to minimise the risk of anyone contracting airborne pathogens

Be available for 5 consecutive weekdays exclusively to this *Orientation Programme*, without disruptions or cross bookings

Be locked at night so that equipment/material can be secured

Be cleaned regularly (e.g. at the end of each day)

The training venue must be able to provide the following:

Adequate ladies and gentleman’s toilet facilities with toilet paper

Emergency exits available and usable (e.g. not chained or padlocked closed)

Visible health and safety signage

Fire fighting equipment in good order (e.g. fire extinguisher)

Wheelchair accessibility

Cellular phone reception

Ideally accessible by public transport

Kitchen/serving facilities

Meet the following catering requirements:

- Provide for morning tea/coffee and snack
- Provide hot lunch and cater for special dietary requirements such as Diabetic, Vegetarian, Halaal, Other
- Provide afternoon tea/coffee and snack
- Have crockery, cutlery and glassware
- Have a suitable space, outside of the meeting room in which to eat meals
- Have the personnel to serve food and clear up at the end of each day
- Provide food at the required times to coincide with the *Orientation Programme*
- Provide water to all Learners in the training room
- Provide a certificate from the Health Department that they can provide perishable foods to the public

Appendix B

Training Material Guideline

9


9.2 Appendix B: Training Material Guideline

| Item |
|--|
| <i>Facilitator Guide</i> |
| <i>Facilitator Toolbooks 1, 2, 3, 4 and 5 for each Orientation Programme*</i> |
| <i>PowerPoint Slides</i> |
| <i>Laptop and projector*</i> |
| <i>Learner Guide for each Learner attending the Orientation Programme*</i> |
| <i>Facilitator Report (electronic report)</i> |
| <i>Team Leader Job Aid for each Learner attending the Orientation Programme*</i> |
| <i>CHW Household Tools for each Learner attending the Orientation Programme*</i> |
| Sticky name tag labels* (if not available, get Learners to write their name on a piece of paper and place it in front of them) |
| 1 book of flipchart paper* |
| 6 coloured pens for writing on the flipchart |
| A signed copy of the Certificate of Attendance for each Learner plus a few blanks* |
| Prestick |
| A hole punch |
| A stapler and staples |
| A book of sticky tabs |
| Index Cards for each OTL attending the Orientation Programme* (if not available, use paper) |
| 1 notepad and 1 pen for each Learner attending the <i>Orientation Programme*</i> |
| 5 x A1 municipal maps for activity in Lesson 5 (if not available, draw a map) |
| 2 small soft coloured balls that can be used inside (if not available, scrunch up a piece of paper and use it as a ball) |
| <i>*Ideally these items will be delivered to the training venue or provided by the training venue for each Orientation Programme. All other items will be given to you at your training and can be re-used for each Orientation Programme.</i> |

Appendix C Registration Form

9

9.3 Registration Form

| | | | | | | | |
|---|--|---|---------------------------|--|-----------------|-----------|----|
|  | | Ward-based Primary Healthcare Outreach Team leader Orientation Programme Registration Form | | | | | |
| | | Date | | | | | |
| <i>This registration form must be completed by all PHC Outreach Team Leaders before they can participate in the PHC Outreach Team Orientation Programme</i> | | | | | | | |
| Title | First Name | Surname | | | | | |
| Preferred Name | | Gender (mark with x) | | Male | Female | | |
| YOUR PERSONAL DETAILS | ID Number | Please check that ID number entered is correct | | | | | |
| | Persal Number | SANC No/MP No | | | | | |
| | Ward Name | Ward No | | | | | |
| | What year did you qualify as a nurse? | | | | | | |
| | How many years have you worked for the Department of Health? | | | | | | |
| | Date employed at current establishment: | Day | Month | Year | | | |
| | Contact Details | Landline | | | | | |
| | Cell | | | | | | |
| | Email | | | | | | |
| Dietary Requirements (please mark preference using x) | Diabetic | Vegetarian | Halaal | Other (please specify) | None | | |
| ALL ACCOMMODATION IS SHARING (2 SINGLE BEDS PER ROOM) | | | | | | | |
| YOUR WORK DETAILS | Province | | | | District | | |
| | Sub-District | | | | Hospital System | | |
| | Name of Clinic (PHC) | | | | | | |
| | Position held over the last 3 months (mark with an x) | Ward Based PHC Outreach Team Leader | Ward Based Facility Nurse | Ward Based PHC Outreach Team Leader AND Facility Nurse | | | |
| OUTREACH TEAM INFORMATION | Do you have a General Nursing Qualification? if yes, state year completed | Yes | | | | | No |
| | Do you have a Midwifery Qualification? if yes, state year completed | Yes | | | | | No |
| | Do you have a General Nursing Qualification? if yes, state year completed | Yes | | | | | No |
| | Do you have a Community Health Qualification? if yes, state year completed | Yes | | | | | No |
| | Do you have a Mental Health Qualification? if yes, state year completed | Yes | | | | | No |
| | Did you attend the Community Health Worker training? if yes, please bring the CHW Household Tools to this training programme | Yes | | | | | No |
| | Number of Community Health Workers assigned to you (leave blank if none assigned yet) | | | | | | |
| Household registration process begun for your team | Yes | | | No | | | |
| Declaration | | | | | | | |
| <p>BroadReach Healthcare in cooperation with the Department of Health and USAID are committed to the training and capacity building of South African medical and nursing staff. As part of this commitment, BroadReach Healthcare, under its cooperative agreement with USAID, provides training to designated medical and nursing staff. In order to ensure the mutual commitment of all parties involved each participant will be required to sign this agreement.</p> <p>As a participant you undertake to:</p> <ul style="list-style-type: none"> Notify BroadReach Healthcare in writing no less than seven (7) working days prior to the start of the training if you will not be able to attend. Communicate any amendments, requests and communications pertaining to travel, accommodation and attendance directly with the BroadReach Healthcare offices no less than seven (7) days prior to departure. Not communicate with any service providers (conference facilities, accommodation establishments, transport companies, etc.) directly, but rather direct any queries to BroadReach Healthcare. Attend the full 5 days of site training and submit feedback to BroadReach Healthcare as requested. Should you fail to comply with the conditions above you will be held liable for all costs incurred on your behalf to attend the training which are, but not limited to, the costs of the training course, transportation, accommodation etc. | | | | | | | |
| AUTHORISATION | Learner Signature | | | | | | |
| | CEO/PHC Manager | Full Name | | | | Signature | |
| PLEASE FAX THIS COMPLETED FORM TO (000)123 4567 | | | | | | | |

Appendix D

Assessment Model Answers

9

9.4 Assessment Model Answers

Lesson 1: Introduction to the Role of the PHC Outreach Team Leader

Perfect Score =
9/9

1. The PHC re-engineering will help SA to reach the MDGs. What do PHC and MDG stand for?
 - a. Primary Heart Centre; Multiple Discovery Goals
 - b. Paediatric Heart Care; Millennium Development Goals
 - c. Primary Health Care; Millennium Development Goals
 - d. Primary Health Care; Many Deliverable Goals
2. Of the three streams of PHC Re-engineering, which one is this programme focussed on:
 - a. District-based clinical specialist teams with an initial focus on improving maternal and child health
 - b. Strengthening school health services
 - c. Ward-based PHC Outreach Team
3. The PHC Outreach Team will be:
 - a. Nationally-based
 - b. Ward-based
 - c. Provincially-based
 - d. City-based
4. The PHC Outreach Team will be responsible for approximately _____ households.
 - a. 1500 – 1700
 - b. 3500 – 4000
 - c. 200 – 300
 - d. 10000 – 15000
5. Who will be in the PHC Outreach Team?
 - a. One doctor, one nurse and five community health workers
 - b. One Facility Manager and six nurses and one Environmental Health Practitioner
 - c. One professional nurse and approximately six community health workers
 - d. One Facility Manager, one doctor, one nurse

Appendix D

Assessment Model Answers

9

6. True or False:

The PHC Outreach Team Leader will spend approximately 70% of their time outside of the facility serving the community, supervising and evaluating CHWs and liaising with other service providers. Administrative tasks will make up the remaining 30%.

7. Which of the following is the responsibility of the Team Leader?

- a. Manage the work of the PHC Outreach Team
- b. Visit households in the catchment area
- c. Engage with the community in the catchment area
- d. Perform all referrals in the catchment area
- e. Identify vulnerable households
- f. Manage health services to the catchment area

Appendix D

Assessment Model Answers

9

Lesson 2: Skills Required to be an Effective Outreach Team Leader

Perfect Score =
9/9

- The following are examples of non-verbal communication, except for:
 - Shrugging shoulders
 - Rolling your eyes
 - Hand gestures
 - Writing reports
 - Having a discussion
- The techniques for active listening include:
 - Daydreaming
 - Reflection
 - Summarising
 - Asking questions
 - Looking at things other than the person speaking to you
- The seven steps to problem solving include:
 - Tell everyone at the clinic about the problem, who is involved, when it happened, how it happened and ask the facility manager to resolve it
 - Identify the parts of the problem, identify possible reasons for problem, think about possible solutions, select the best solution, develop an action plan, implement the solution, evaluate the solution
 - Complain about the problem to your team members, report the problem in your monthly report, report the problem to the Facility Manager, ask your team members to resolve the problem, forget about the problem
 - Define who caused the problem, think about why they caused the problem, identify possible solutions, implement the solution, report the solution to the Facility Manager, continue with day-to-day work, write the problem in your diary
- Delegation is when:
 - You raise a work concern with your Facility Manager
 - Deliver services to households and communities
 - The responsibility to perform a task is given from one person to the next
 - The authority and responsibility to perform a task is given from one person to the next
- Examples of ways to motivate staff include:
 - Salary increase
 - Praise/acknowledgement
 - Monthly employee awards

Appendix D

Assessment Model Answers

9

d. Training opportunities

e. All of the above

6. True or False

A team member may have a learning need that does not require a formal training but instead requires mentoring or coaching. This is part of your role as the Outreach Team Leader.

Appendix D

Assessment Model Answers

9

Lesson 3: Service Delivery

Perfect Score =
11/11

- The types of services that will be delivered by the Outreach Team include:
 - Implementing interventions
 - Non-clinical services
 - Physical fitness classes
 - Referrals to and collaboration with service providers
 - Hair and beauty services
- Which of the following are barriers to accessing health care?
 - Friendly health care providers
 - Facility location
 - Cost of travel
 - Negative attitude of health care providers
 - Free health care services
- Which one of the services below does the Outreach Team not need to cover:
 - Women's reproductive health
 - Disease prevention by immunisation
 - Sexually Transmitted Infections
 - Management and treatment of HIV and AIDS
 - Preparation of food
 - Mental health and substance abuse
 - Oral health
 - Chronic disease and geriatric care
- Which one of these is not a key area of service delivery:
 - Antenatal Care
 - Postnatal Care
 - Child Health
 - Treatment adherence support
 - Oral health
- True or ~~False~~

The CHW must visit a pregnant woman two times during her pregnancy.

Appendix D

Assessment Model Answers

9

6. True or False

The CHW must visit a new mother and the new born baby four times after delivery.

7. Identify the non-emergency service:

a. Local EMS

b. Local hospital

c. Local restaurant

d. Local SAPS

e. Local fire brigade

Appendix D

Assessment Model Answers

9

Lesson 4: Team Management

Perfect Score =
11/11

1. When an activity needs to get done, you must always consider:
 - a. The actions required to get the job done
 - b. The people responsible for each action
 - c. The age of the people responsible
 - d. The due date for the entire activity
2. Types of meetings to be planned and conducted by the Team Leader include:
 - a. Outreach Team meetings
 - b. Patient meetings
 - c. Facility Manager and Team Leader meetings
 - d. Doctors meetings
 - e. Community meetings
3. For every Outreach Team meeting, you should:
 - a. Adequately prepare
 - b. Ensure everyone signs an attendance register
 - c. Make sure someone takes minutes
 - d. Make sure someone keeps time
 - e. All of the above
4. True or False

All team members, current and new, must go through a formal induction process to ensure they fully understand their roles and responsibilities.
5. You should discuss all of the following topics with a new team member during induction, except:
 - a. Health status of the team member
 - b. Expectations toward other team members
 - c. Materials available
 - d. Roles and responsibilities
 - e. Personal history
 - f. HR related topics

Appendix D

Assessment Model Answers

9

6. True or False

Performance management is an on-going process that should be happening all of the time.

7. A formal performance management review session should include:

- a. Evaluation of household visits
- b. Review of team member reporting
- c. Assessment of team member learning needs
- d. Review of team member's attendance and punctuality

e. All of the above

Appendix D

Assessment Model Answers

9

Lesson 5: Community Entry, Assessment and Involvement

Perfect Score =
10/10

1. Traditional healers, business leaders, chiefs and ward councillors are examples of:
 - a. Stakeholders
 - b. Gatekeepers
 - c. Community members
 - d. All of the above

2. The Team Leader is expected to:
 - a. Hold monthly community meetings
 - b. Hold an annual nurses conference
 - c. Gain buy-in from community stakeholders
 - d. Liaise with service providers

3. True or False

It is the Outreach Team Leader's responsibility to familiarise service providers with the Referral/ Back-referral Form.

4. A community map is not:
 - a. Bought from the Shell Petrol Station
 - b. Created by the CHWs and Outreach Team
 - c. Used to allocate households to team members

5. A community profile is very useful for you to:
 - a. Make friends
 - b. Identify potential work opportunities
 - c. Understand what problems your community are facing and where these problems are
 - d. Know your community

6. Examples of community interventions that the Outreach Team may implement or assist to implement include:
 - a. Support group for people living with HIV/AIDS
 - b. Measles campaign
 - c. Posters to remind people to throw rubbish in bins
 - d. All of the above

7. Resource mobilisation is:
- a. When you move team resources and supplies from one clinic to another
 - b. When money is transferred from the District hospital to the Outreach Team
 - c. The process of getting financial and/or non-financial resources together to implement an intervention
 - d. Mobilising CHWs to assist with your work load

Appendix D

Assessment Model Answers

9

Lesson 6: Household Engagement

Perfect Score =
7/7

1. Ideally, you will allocate the households to each CHW based on the households in the area where they reside or is closest to them. Should this not be possible, other techniques that could be used include:
 - a. Where their friends live
 - b. Align the background, experience and training of the CHW to the needs of the households in a particular area
 - c. Use a lottery system to decide which households they will get
 - d. Let the CHW choose their favourite area in the community
2. True or False
Household identification and numbering is necessary to ensure that every household in the catchment area is identified, accounted for and allocated to a CHW.
3. When a household is registered:
 - a. A Household Registration Form must be completed
 - b. Vulnerable household members must be further assessed
 - c. A follow-up visit must be scheduled if a household vulnerability is identified
 - d. A Referral Form must be completed if necessary
 - e. All of the above
4. True or False
Once every household in the catchment area is registered, you may re-allocate the households to CHWs based on the number of identified vulnerable households.
5. As the Team Leader, which of these is not your responsibility regarding referrals:
 - a. See all household/individuals before they see a service provider
 - b. Follow-up on the referrals made to facilities, based on the CHW Household Visit Monthly Summary Form to ensure that the referral system is effective
 - c. Follow-up on any referrals not processed by the service provider or inadequate quality of service rendered
 - d. Monitor and assess performance and functioning of the referral system
6. As a supervisor, what should you not do:
 - a. Provide CHWs with a clear mandate regarding home visits
 - b. Guide CHWs with clinical issues related to screening and assessment
 - c. Support CHWs by attending to or escalating issues beyond their scope of practice
 - d. Do the CHWs job all of the time

Appendix D

Assessment Model Answers

9

7. As the Team Leader, you can monitor and assess the performance of CHW home visits through:
- a. Checking that the forms from the CHW have been properly completed
 - b. Ensuring that appropriate follow-up action has been done in response to screening and assessment outcome
 - c. Assessing household referrals based on the completion of the Referral Form and the collection of the Back-referral Form
 - d. All of the above

Appendix D

Assessment Model Answers

9

Lesson 7: Monitoring, Evaluation and Reporting

Perfect Score =
8/8

- Monitoring and evaluation are necessary to:
 - Track progress
 - Compare expected outcome to actual outcome
 - Make adjustments
 - Analyse impact
 - All of the above
- True or False

The CHW is not responsible for completing any reporting forms.

- At the end of each month, the Team Leader will have to submit the following reports to the Facility Manager:
 - Outreach Team Monthly Summary Form
 - Outreach Team Reporting Tool
 - Outreach Team Supplies Management Form
 - All of the above
- True or False

All reports completed by the Facility Manager are sent to the District Health Information Officer who puts the data into the District Health Information System.

- Of the following information, which is not a formal measure that can be applied to ensure confidentiality of household information?
 - Storing documents in a cabinet that is under lock and key
 - Talk to all of your friends and family about the household information
 - Not leaving household documentation lying around
 - Ensure that all household documentation does not get misplaced
 - Keep all household documentation in a safe place
- In order to keep a filing system, as Team Leader, you must have which skills?
 - People skills
 - Nursing skills
 - Organisational skills
 - Psychic skills

Appendix D

Assessment Model Answers

9

7. What material will not help you set up a filing system?
 - a. Filing cabinet and suspension files
 - b. Dividers
 - c. Plastic file carrying case
 - d. Kitbag

8. Why is confidentiality important for record keeping?
 - a. To ensure sensitive and personal information remains private
 - b. To ensure the community knows the health status of all its members
 - c. To ensure team members don't lose their jobs
 - d. To ensure all community members are happy

Disclaimers

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Disclaimers

Acronym List

| | |
|-------|--|
| ANC | Antenatal care |
| CBO | Community-based Organisation |
| CHW | Community Health Worker |
| DMT | District Management Team |
| DHIO | District Health Information Officer |
| DHIS | District Health Information System |
| DHS | District Health System |
| DOH | Department of Health |
| DOTS | Directly Observed Treatment, Short course |
| FBO | Faith-based Organisation |
| HAART | Highly Active Antiretroviral Therapy |
| HBC | Home-based Care |
| HH | Household |
| HIV | Human Immunodeficiency Virus |
| HR | Human Resources |
| IMCI | Integrated Management of Childhood Illnesses |
| ISHP | Integrated School Health Programme |
| MCWH | Maternal, child and women's health |
| MDGs | Millennium Development Goals |
| NCD | Non-communicable disease |
| NGO | Non-government Organisation |
| NHI | National Health Insurance |
| NPO | Non-profit Organisation |
| NSDA | National Service Delivery Agreement |
| ORT | Oral rehydration therapy |
| OTL | Outreach Team Leader |
| PHC | Primary Health Care |
| PMTCT | Prevention of Mother-to-Child Transmission |
| PNC | Postnatal care |
| SAPS | South African Police Service |
| SOW | Scope of Work |
| STIs | Sexually Transmitted Infections |
| TB | Tuberculosis |

Glossary of Terms

| | |
|--|--|
| Archiving | The collection of records that have been accumulated over a period of time and are stored in a secure location ²⁶ |
| Active listening | Listening with the intent to give feedback or to summarise what the listener heard. Active listening is meant to confirm that the listener heard and understood everything that was said ¹¹ |
| Activity | Any specific action that needs to get done. Some activities may require some planning while others may be straight forward to execute |
| Actual outcome | The actual result of the activity once you have completed all required actions |
| Client | Is another term that may be used throughout the orientation material and Team Leader Job Aid which refers to the household member |
| Coaching | Teaching or training process where an individual gets support while learning to achieve a specific result or goal |
| Community | A group of people living close to each other in the same area. They may share a similar way of living and may also share what is important to them. This common understanding of life and living give them a sense of belonging to the group ⁸ |
| Community assessment | A process of gathering and interpreting information from multiple sources in order to develop a deep understanding of a community. It is also a process that uses the se results to develop strategies to improve the health status of the community. The products or outcomes of a community assessment will include: a community map, a community profile and a community health improvement plan ²³ |
| Community health profile | A comprehensive compilation of information about a community. The information in a profile describes the health of a given community from many different angles ²³ |
| Delegation | The assignment of authority and responsibility, to perform a task, from one person to the next. This normally occurs from an OTL to their Team Member ¹³ |
| Evaluation | The comparison of how the team has done against what you planned to do. It looks at what you set out to do and what you actually accomplished and how you accomplished it ²⁵ |
| Expected outcome | The result you expect to have after completing an activity |
| Filing system | A method of organising and storing documents so that you can find information quickly and effectively |
| Impact | The mid to long term effect that the Ward-Based PHC Outreach Team has on the health of the community (especially in terms of the NSDA outputs and MDGs) |
| Incidence | The number of new cases of a disease in a population ¹ |
| Millennium Development Goals (MDGs) | In 2000, 189 countries, including South Africa, agreed to cut poverty in the world in half by the year 2015. Experts in this type of work looked at different problems that make and keep people poor. They came up with 8 targets that would help most people meet their basic needs. If these needs are met, these targets would get poor people out of poverty and into a better life, as well as help people to play a part in their society in a more useful way. These targets are known as the Millennium Development Goals (MDGs). The goals also help countries measure how much progress has been made in reducing poverty over the years ⁴ |

Glossary of Terms

| | |
|---|--|
| Mentoring | When a more experienced person guides a less experienced person. It is often a relationship of learning, dialogue and challenge ¹⁷ |
| Monitoring | The collection of information as the Outreach Team progresses. It is aimed at improving the efficiency and effectiveness of the team. Monitoring is an on-going process. It helps to keep the work on track and to let management know when things are going wrong. Monitoring also enables you to determine if the resources you have available are sufficient and appropriate ²⁵ |
| Morbidity | The occurrence of an illness or illnesses in a population ¹ |
| Mortality | The occurrence of death in a population ¹ |
| Motivation | The process of “stimulating a person’s interest in an activity” or “to cause a person to act in a particular way” ¹⁵ |
| Negotiated Service Delivery Agreement (NSDA) | A charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government. The government has agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010 – 2014. Each outcome area is linked to a number of outputs that inform the priority implementation activities that will have to be undertaken over the given timeframe to achieve the outcomes associated with a particular output ⁶ |
| National Health Insurance (NHI) | A financing system that will make sure that all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund ⁷ |
| Performance management | Includes all activities that ensure that goals are met in an effective and efficient manner. Performance management can focus on the performance of the OTL, of the team member or of the entire Outreach Team ²¹ |
| Prevalence | The number of existing cases of a disease or health condition in a population at some point in time ¹ |
| Resources | The financial and non-financial supplies that are required to implement a solution or intervention for a health issue. Resources may include money, skills, time contributions, services of people in the community, equipment and materials ²⁴ |
| Resource mobilisation | The process of getting the resources together that you need to implement the solution for a health issue. These may include both financial and non-financial resources ²⁴ |
| Service providers | Organisations or government departments outside of the hospital system that address specific community needs. Service providers are also stakeholders in the community ⁸ |
| Stakeholder | A person, group or organisation who affects the community or can be affected by issues in the community |

You will see some common icons throughout the Learner Guide.



This icon is representative of a learning objective. Each time a learning objective is addressed, it will be marked with this icon.



This icon is used for definitions of specific terms. All terms are also included in the glossary of terms.



This icon is used whenever there is a group discussion or activity that will happen in the learning session.



This icon is used whenever there is a ‘Think Point’ for you to consider.

Lesson 1

Introduction to the Role of Ward-based PHC Outreach Team Leader

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Your role as an Outreach Team Leader

Your role as the Ward-based Primary Health Care (PHC) Outreach Team Leader (OTL) is central to the successful implementation of the Ward-based PHC Outreach Team.*

The OTL will be expected to:

- manage the work of the Outreach Team
- engage with the community in the catchment area serviced
- deliver and manage health services to the catchment population

This training programme will provide you with the tools and skills required to perform your role effectively and efficiently.

* For the remainder of this Learner Guide, the 'Ward-based PHC Outreach Team' will mostly be referred to as 'Outreach Team.'

Learning Objectives

This Lesson has four main learning objectives:

1. To understand how the PHC Re-engineered model aims to strengthen the delivery of PHC to support the implementation of the National Health Insurance (NHI).
2. To understand the role of the Outreach Team.
3. To understand the roles and responsibilities of the Outreach Team members.
4. To understand how the Outreach Team interacts with other services within the community.





Learning Objective 1

To understand how the PHC Re-engineered model aims to strengthen the delivery of PHC to support the implementation of the National Health Insurance (NHI).

Throughout this orientation and in your role as OTL, you will see and hear the following terms. It is important that you remember and understand the meanings of these terms. These terms are also listed in the *Glossary of Terms*.



Key terms to understand:

Morbidity: The occurrence of an illness or illnesses in a population. ¹

Mortality: The occurrence of death in a population. ¹

Incidence: The number of new cases of a disease in a population. ¹

Prevalence: The number of existing cases of a disease or health condition in a population at some point in time. ¹

1. South Africa and its burden of disease

South Africa currently faces a quadruple burden of disease. The burden of disease is the number of people in a community that are affected or ill with a certain disease and may die from the disease. ²

The quadruple burden of disease includes: ^{2,3}

1. High rates of HIV, AIDS and TB
2. High maternal and child mortality
3. High rates of chronic non-communicable diseases (NCDs), heart disease, diabetes, high blood pressure and mental illness
4. High rates of violence and injuries (e.g. abuse, substance abuse)

It is an urgent priority for the South African National Department of Health (NDOH) to reduce the quadruple burden of disease and also to meet the Millennium Development Goal targets by 2015.



What are the Millennium Development Goals?

In 2000, 189 countries, including South Africa, agreed to cut poverty in the world in half by the year 2015.

Experts looked at different problems that make and keep people poor. They came up with 8 targets that would help most people meet their basic needs. By achieving these targets, people would get out of poverty and into a better life. These targets are known as the Millennium Development Goals (MDGs).

The goals also help countries measure how much progress has been made in reducing poverty over the years. ⁴

Figure 1: Millennium Development Goals ⁵



For South Africa especially, the immediate priorities are to **improve maternal health** and to **reduce child mortality**. In order to reduce the burden of disease and to achieve these MDGs, the government has recognised the need to improve health care delivery and access to health care.

In an effort to make sure this happens, the South African Minister of Health has made a commitment to the President and to the country called the Negotiated Service Delivery Agreement, which has identified four strategic outputs that the health sector must achieve.



What is the NSDA? ⁶

The Negotiated Service Delivery Agreement (NSDA) is a charter that reflects the commitment of key sectoral and intersectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government. Two examples of these partners include the Department of Social Development and the Department of Women, Children and People with Disabilities.

The government has agreed on 12 key outcomes as the key indicators for its programme of action for the period 2010 – 2014. Each outcome area is linked to a number of outputs that inform the priority implementation activities that will have to be undertaken over the given timeframe to achieve the outcomes associated with a particular output.

To this end, the government has identified four strategic outputs which the health sector must achieve. These include:

- Output 1:** Increasing life expectancy
- Output 2:** Decreasing maternal and child mortality
- Output 3:** Combating HIV and AIDS and decreasing the burden of disease from tuberculosis
- Output 4:** Strengthening health system effectiveness

One reason for South Africa's quadruple burden of disease which led to the creation of the NSDA was poor access to health care by the majority of South Africans. In order to achieve the NSDA outputs and to improve access to health care, the South African government has proposed a National Health Insurance programme.

Notes

2. National Health Insurance (NHI)



National Health Insurance ⁷

NHI is a system that will make sure that **all** citizens of South Africa (and legal long-term residents) are provided with essential health care, whether or not they are able to pay for it.

In preparation for NHI, the DOH must:

- Improve existing health infrastructure (e.g. buildings and equipment)
- Ensure that national core standards of all health institutes are implemented and followed
- Refocus the health system on primary health care

Note: From April 2012, DOH is piloting NHI roll out in 10 districts. Part of this pilot includes assessing access to health care through the primary health care system.



3. What is Primary Health Care?

Primary Health Care (PHC) is a way of offering health care that helps everyone in the community live healthy and productive lives. This type of health care looks after the well-being of people and their families, their living conditions and the surroundings. PHC services are meant to be preventive, promotive, curative and rehabilitative.⁸

PHC is health care that is essential, ethical, accessible, equitable, affordable, and accountable to the community.⁸

Essential health care means basic health care and services that are necessary and important for most people.

Accessible health care means that the health service is available and easy for community members to find and use.

Equitable health service means all community members who have the same need for the care and services will be able to use them no matter who they are (e.g. community leader or labourer) or how much money they have.

Affordable health services means that most community members have enough money to pay for the services and those community members who cannot pay will be allowed to use the service anyway.

An **accountable** health service must be offered according to people's needs. Communities must be involved and have a say in how these services are offered and what services are available to them.



4. PHC Re-engineering

The South African system of delivering health services to the people has changed over the years. The district health system (DHS), which is the way of providing health services to local communities, was introduced in 1996. Although this way of providing health care has been running since 1996, our country is still facing many challenges with how health services are made available to communities. The government has taken another look at how health services should be offered to individuals and communities in order to improve on how health services are delivered. A strategy called the PHC Re-engineered model was developed to strengthen district-based PHC services and to improve local community access to health services.^{8,9}

Why is PHC Re-engineering a priority now?

- The focus of NDOH is shifting to a holistic health care system that is based on disease prevention and health promotion rather than curing disease
- NHI needs a strong DHS driving effective PHC
- Health system needs to re-find its focus to:
 - Be service and outcome oriented
 - Have a motivated, enthusiastic committed workforce
 - Maximise all available resources

PHC Re-engineering aims to:

1. Strengthen the current DHS
 - The district management team (DMT) needs to be given the responsibility and held accountable for managing the district and for the health of the population
2. Strengthen interaction between the health services and the users of the health service by:
 - Pro-actively reaching out to families with an emphasis on health promotion and preventive activities
 - Early identification of individuals within families at high risk of certain diseases or health problems
 - Greater interaction with communities to get their support in maintaining and improving their own health
 - Offering a team approach to health care

This will create a stronger DHS on which NHI can be based and increase its potential to achieve better health outcomes.⁹

PHC Re-engineering will be addressed through focusing on strengthening three streams of the current PHC system which will include: ¹⁰

1. District-based clinical specialist teams with an initial focus on improving maternal and child health
2. Strengthening school health services
3. **Ward-based PHC Outreach Team for each electoral ward**

These streams are described in further detail below:

- i. The first stream is the deployment of District Specialist Teams to each of the 52 districts in the country to strengthen clinical governance of district-based maternal and child health services at hospitals, community, PHC facilities and home based levels, in order to promote the well-being of the population within a geographical catchment area. A district team will comprise of:
 - a. 4 medical specialists (family physician, obstetrician and gynaecologist, a paediatrician and an anaesthetist)
 - b. 3 advanced nursing professionals (an Advanced Primary Health Care nurse, an Advanced Midwife and an Advanced Paediatric Nurse)

This strategy aims to address the country's unacceptably high infant, child and maternal mortality in the effort to achieve NSDA Outcome 2 (Decreasing maternal and child mortality) and MDGs 4 (Reduce child mortality) and 5 (Improve maternal health). ¹⁰

- ii. The second stream is the revitalisation and strengthening of the School Health Policy of 2003 in partnership with the Department of Basic Education and Social Development. In the short to medium term it is not going to be possible to have a school health nurse in every school.

For this reason a selected range of basic health services will be provided by a school health nurse to a group of schools, targeting schools with the greatest need first. These initial services will focus on:

- Screening of learners in grade R and grade 1, ensuring that all learners are fully immunised
- Strengthening life skills programmes in secondary schools; with specific focus on sexual and reproductive health as well as prevention of substance and alcohol abuse

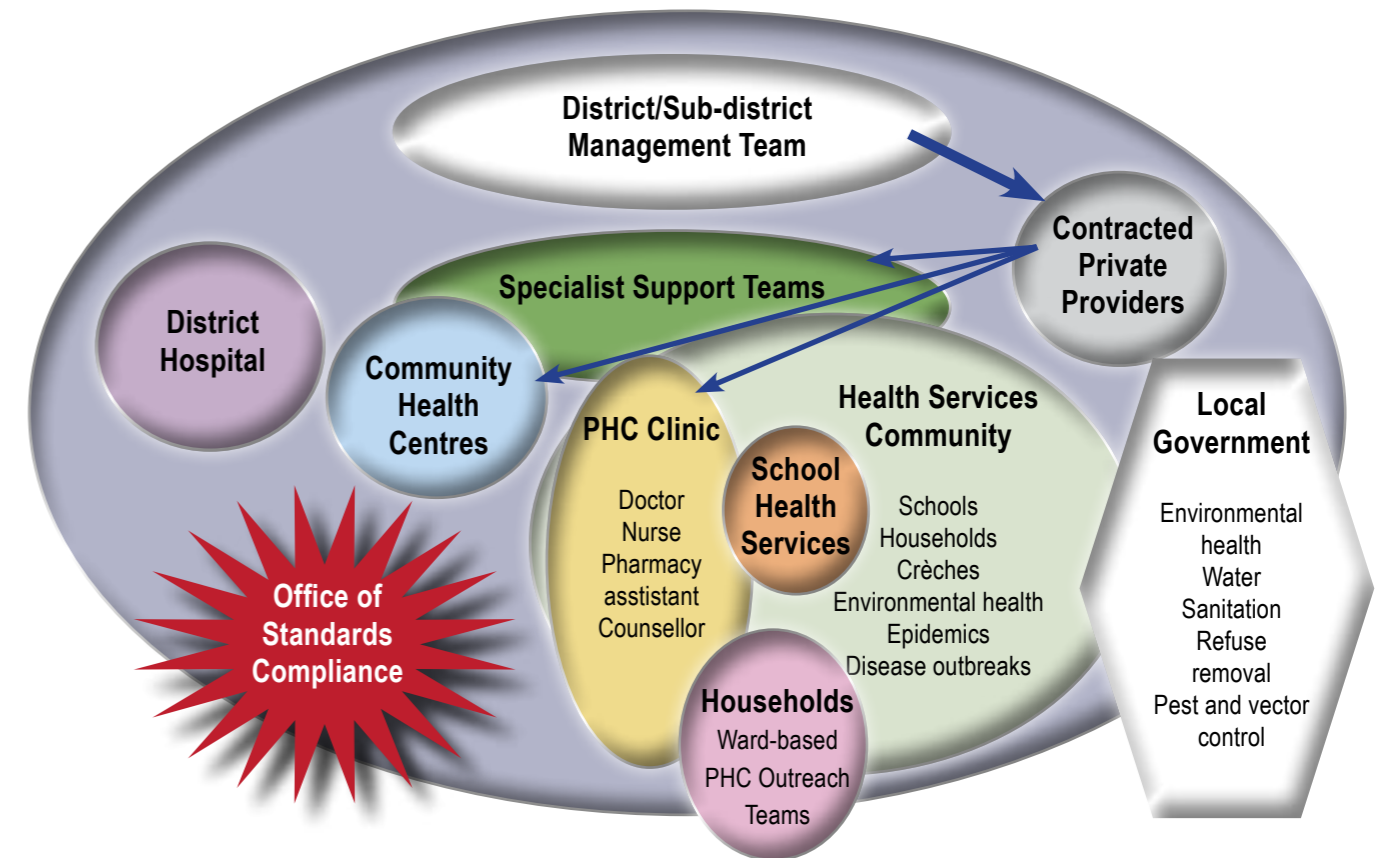
School nurses will be sourced by districts that will look at staff efficiencies and the redeployment of nurses and hiring retired nurses with the immediate priority of providing a limited range of services. ¹⁰

- iii. The third stream is the Ward-based PHC Outreach Team. Each ward will have one or more Outreach Teams depending on the catchment area size. Outreach Team(s) will be community-based and understand the needs of a community at a household level. They will then be able to determine how best to link identified needs to care. The roles of the Outreach Team are described further in the next section. Introduction of these Outreach Teams is hoped to strengthen health care, improve access to health care and health outcomes. ¹⁰

Outreach Teams will also work together with district specialist teams and school health services. It is possible that in some areas, the Outreach Team will provide or assist in the provision of school health services.

Figure 2 below is a diagram of the District Health Model which includes the three streams.

Figure 2: District Health Model ¹⁰





Learning Objective 2

To understand the role of the Outreach Team.

5. The Ward-based PHC Outreach Team

Each Outreach Team will offer an integrated health service to the households (HHs) and individuals within its catchment area. The core components of the integrated services are to: ¹⁰

1. Promote health (child, adolescent and women's health)
2. Prevent ill health
3. Ante and postnatal community-based support and interventions that reduce maternal mortality
4. Provide information and education to communities and HHs on a range of health and related matters
5. Offer psychosocial support and refer to other service providers when necessary
6. Screen for early detection and intervention of health problems and illnesses
7. Provide follow-up and support to persons with health problems including adherence to treatment
8. Provide treatment for minor ailments
9. Basic first aid and emergency interventions

The NDOH will deploy Outreach Teams in rural areas, in informal urban settlements as well as in townships. Each ward will have one or more Outreach Team(s). Each Outreach Team will be responsible for an average of 7660 persons or 1620 HHs (with an average of 4.7 persons per HH). Each CHW will be allocated an average of 270 households.⁸

These numbers are not set in stone and may differ by area. The numbers of HHs and individuals that the Outreach Team is responsible for may depend on the total population in the area, the demographic profile of people in the area and the burden of disease in that area.

5.1. Outreach Team Members

Each Outreach Team will be made up of: ¹⁰

- 1 professional nurse (the OTL)
- 6 (on average) Community Health Workers (CHWs)

All Outreach Teams will be supported by a Health Promoter and an Environmental Health Practitioner. While some districts may already have someone acting in these roles, other districts may still need to hire a Health Promoter and an Environmental Health Practitioner.

In addition, every Outreach Team is different and every catchment area is different. On average, an OTL will manage 6 CHWs (sometimes more). Each CHW will be responsible for approximately 270 households in the defined Outreach Team's Ward. If the PHC clinic catchment area is very large, there will eventually be more than one Outreach Team reporting to that clinic.

Figure 3: Ward-based PHC Outreach Team ¹⁰

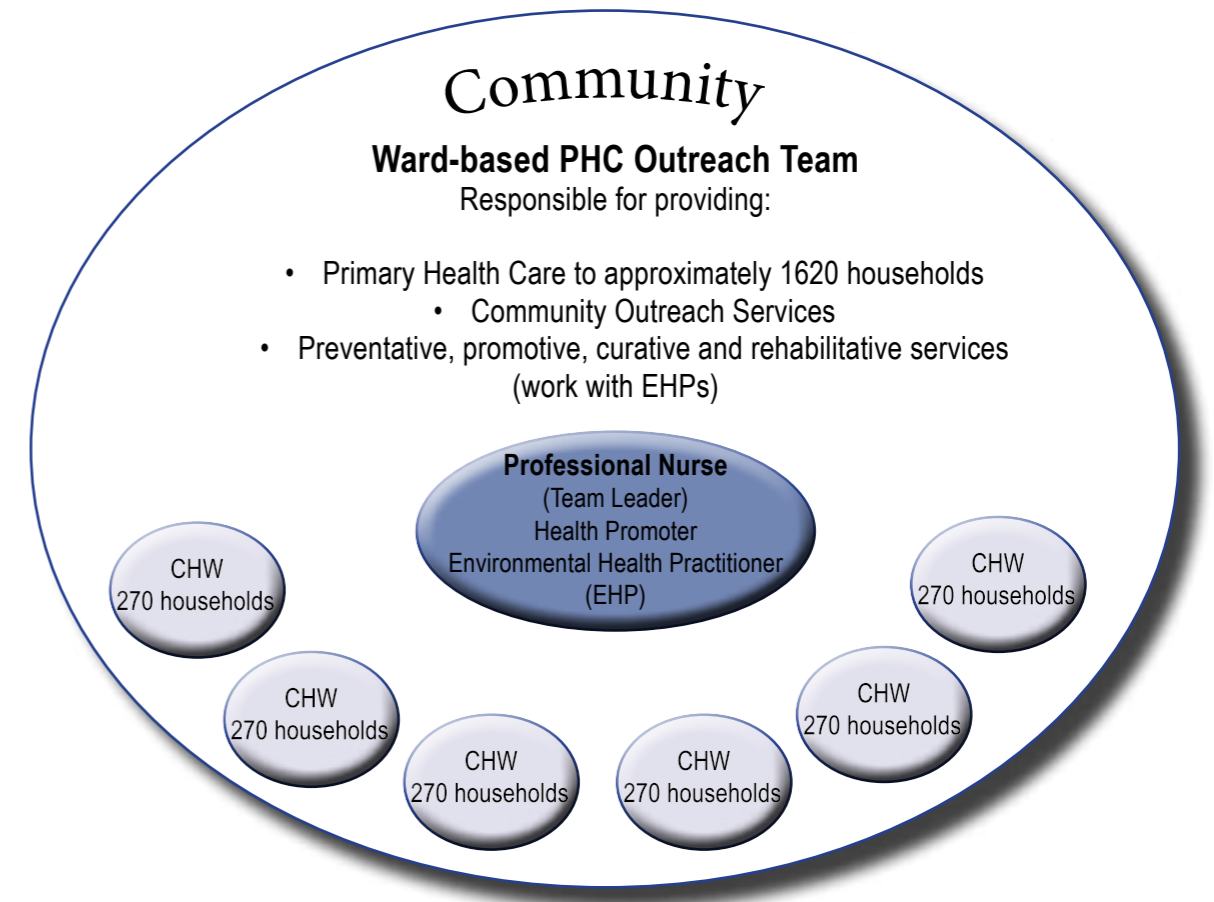
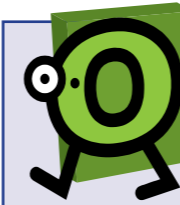
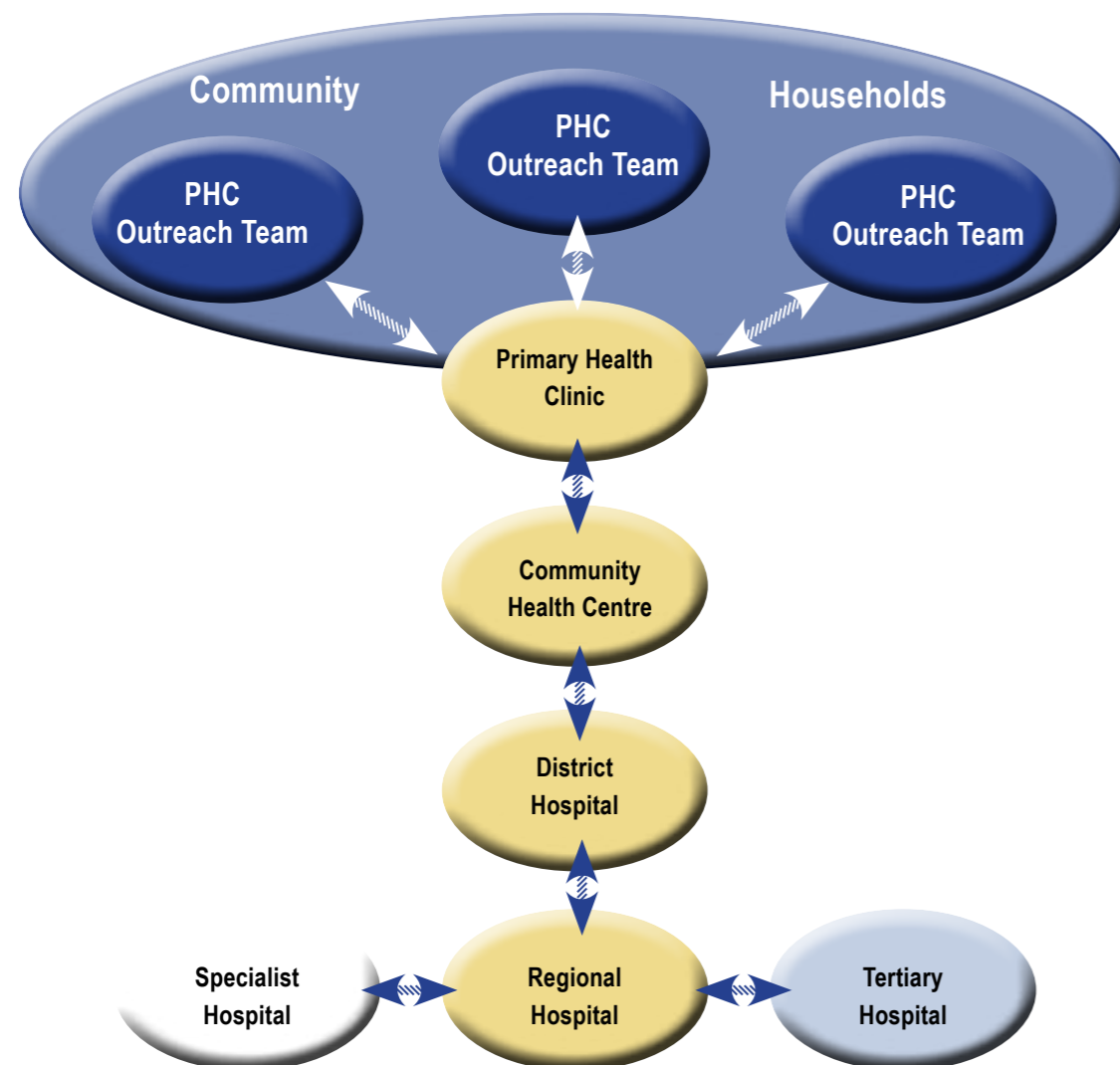


Figure 4 outlines how the Team fits into the DHS and the overall health system.

As seen in Figure 4 below the Outreach Team(s) acts as an extension to the PHC clinic and household members seen by the Outreach Team are referred (when necessary) to the PHC clinic. When required, clients from the PHC clinic are referred to the Community Health Centre; from the Community Health Centre to the District Hospital. If client is not able to be assisted at the District Hospital, they are referred to the regional, Specialist and Tertiary Hospital in that district or province.

Figure 4: PHC Outreach Team and Continuum of Care ⁸



Learning Objective 3

To understand the roles and responsibilities of the Outreach Team members.

6. Outreach Team Leader

Each Outreach Team will be linked to a PHC clinic. You, the professional nurse, will fulfil the role of OTL. You are responsible for ensuring that the work of the Outreach Team is linked to service delivery targets and that team members are adequately supported and supervised to meet these. ¹⁰

6.1. Reporting Line

Each OTL has been or will be appointed by the district or sub-district manager and will report to the Manager of the PHC clinic.

6.2. Roles and responsibilities of OTL

Each OTL will be delegated the responsibility to: ¹⁰

- i. **Deliver and manage health services to a defined geographic area according to the PHC package of health services.** These services are described further in Lesson 3 [Service Delivery]. In order to meet the NSDA and MDG targets around maternal and child health, the key health services will include antenatal care, postnatal care and treatment adherence counseling, support and education.
- ii. **Manage the work of the Outreach Team** to ensure that quality services are delivered to the community and to each HH within the designated catchment area.
- iii. **Manage the supplies allocated to the team** to ensure that the team is able to function efficiently and effectively to deliver quality services.
- iv. **Initiate and establish the community-based outreach services with the team members.** This includes ensuring that the community is aware of the Outreach Team and the services that you, as a team, will provide.
- v. **Ensure clear links and relationships are established with all other service providers within the catchment area.** An integral part of the PHC Re-engineering model includes linkages between service providers. This requires established relationships and clear expectations between service providers such as the Outreach Team, home-based care workers and palliative care workers and other sector community-based workers.
- vi. **Report on progress of Outreach Team through the appropriate reporting channels** in order to monitor the performance of the Outreach Team.

A breakdown of the roles and responsibilities of the OTL is provided in table 1:

Table 1: Activities and Roles of OTL ¹⁰

| Activities | Role of Team Leader |
|--|--|
| Community | |
| Community assessment of structure, demographics, cultural practices | Facilitate entry into the community for the PHC Outreach Team |
| | Conduct a community assessment, including a community map and a community profile |
| | Assess and diagnose health needs of the community |
| | In consultation with the community, prioritise identified needs |
| Assessment of community resources, including service providers | Keep local community informed of health related matters and potential health threats |
| Identify resource constraints, potential and actual risks facing the community | Identify, establish and maintain collaboration and liaison with local community and local service providers |
| Develop and implement community-based interventions, including inter-sectorial action | Identify service gaps |
| Household | |
| Screening, assessment and referral of HHs within catchment area | Community consultation and involvement (where possible) |
| | Identification of HHs in the defined geographic catchment area that team is working in |
| Provide information and support for healthy behaviours and home-based care | Identify catchment area for each CHW, allocate HHs to CHW and determine where to commence HH registration process based on need |
| | Provide practical skills training to CHWs |
| Provide psychosocial support (including adherence support for HIV, TB and other chronic disease treatment) | Provide support to CHW on how to use job aids, share information; teach and coach CHWs on how to use the tools and assess their competency |
| | Ensure CHWs conduct regular support visits to HHs where HH members are on HIV/TB or chronic disease treatment (note: this needs to be coordinated during the scheduling of visits) |
| | Ensure CHWs have the knowledge and skills required to provide this support |
| | Deploy the right CHW(s) to provide the support |
| | If person is at high risk and CHW cannot provide service then OTL should provide the service |

| Activities | Role of Team Leader |
|--|--|
| Identify and manage common conditions and health problems | Provide support of how to use screening tools and job aids, share information, teach and coach CHWs on how to use the tools and assess competency on chronic diseases including HIV/AIDS, TB, child health, antenatal and postnatal visits |
| Identify and support HH to access social and other related services | Provide guidance to CHWs to understand how to identify and appropriately refer patients to relevant services |
| Schools and early childhood centres | |
| Screening, assessment and referral | Provide support to school health services, as required |
| Targeted interventions (e.g. educational programmes, vitamin A, de-worming and immunisation campaigns, teenage pregnancy) | Ensure team liaises with school health team or school principal and responds to common health problems that may arise at schools (i.e. scabies, lice, worms, measles outbreak) and immunisations |
| Other health and social providers (through referral and linking) | |
| Referral and coordination of services provided in HH with other sectors (in particular social development and early childhood development), non-profit organisations, community care centres and any other service providers | Facilitate and coordinate referral process across sectors to ensure that HH needs are addressed |
| Focus on: orphaned and vulnerable children, elderly, mental health and substance abuse services, step-down care | Liaise and establish areas of responsibility between the Outreach Team and social services, community-based workers to ensure no overlap in roles |
| Service delivery | |
| Deliver services to the community and provide oversight and assistance to the CHW delivery of services to HHs | Plan, implement and evaluate health and wellness services to the catchment population of the Outreach Team including promotion, prevention, early detection, curative, rehabilitative and palliative service |
| | Develop services for the catchment area in line with needs of the community and HHs |
| | Develop a targeted plan to address the health needs of those that are vulnerable (children, women, elderly, disabled persons affected by TB, HIV, chronic diseases) |
| | Act as an advocate for improving health services |
| | Deliver the community component of the PHC Re-engineering package of services |
| | Provide health services according to local and national guidelines |

| Activities | Role of Team Leader |
|---|---|
| | Ensure that health services delivered are comprehensive and integrated |
| | Render emergency health services during disasters and disease outbreaks |
| | Conduct home visits to pregnant women, postnatal women, sick children and people in need of treatment adherence support |
| | Develop an effective referral system to ensure that follow-up on referrals and linkage to care takes place |
| | Improve access to health care services for catchment population based on community's needs |
| Team management | |
| Management of Outreach Team CHWs (CHWs, Health Promoters, Environmental Health Practitioners) | Induction of new team members into Outreach Team and community |
| | Inform Outreach Team members of their roles and responsibilities and ensure clarity |
| | Understand employment contract of Outreach Team members |
| | Develop and manage <i>Weekly HH Visit Schedule</i> |
| | Escalate payment problems of Outreach Team to Facility Manager or HR when necessary |
| | Organise and conduct team meetings |
| | Communication with and between Outreach Team members |
| | Liaise with other Outreach Team Leaders, Facility Managers, clinic committees and other structures |
| | Allocate and assign tasks, supervise and manage team members |
| | Develop capacity of Outreach Teams to deliver services (i.e. competence, skills, knowledge and appropriate ethical conduct) |
| | Promote teamwork amongst Outreach Team members |
| | Train, mentor and coach Outreach Team members |
| | Manage performance of team members (set performance requirements, assess, evaluate, correct and improve performance) |
| | Monitor and evaluate team performance |
| | Conduct the CHW Phase 1 Competency Assessment |
| Manage team resources and materials (i.e. stationery) | |

| Activities | Role of Team Leader |
|---|--|
| Manage Team Conduct | Manage leave, absenteeism, punctuality, resignation of Outreach Team members |
| | Manage discipline according to NDOH policy |
| | Manage and deal with grievances |
| | Manage and deal with complaints regarding Outreach Team members |
| Monitor Quality of service provided by Outreach Team | Monitor the conduct of Outreach Team members to ensure that their behaviour is ethical, maintains confidentiality and do not violate the rights of community members |
| | Monitor and evaluate services rendered, quality of care and health outcomes |
| | Develop solutions for improving service delivery and health outcomes |
| Record keeping and reporting | |
| File and maintain records and provide reports to facility manager | Maintain HH and individual health records |
| | Maintain an updated register and database of HHs and profile of its inhabitants |
| | Manage and file all team documents related to the team, the community, individual team members and reports in a secure location |

6.3. From clinic-based professional nurse to OTL

It is envisaged that you will spend 70% of your time outside the facility serving the community, supervising and evaluating the CHWs and liaising with other service providers. Administrative tasks will make up the remaining 30% of your time.

As you can see from Table 1 above, your role as the OTL is a job on its own. You might be asking yourself: How do I go from spending 100% of my time in the clinic to only spending 30% of my time in the clinic?

Tips to manage the transition from clinic-based professional nurse to OTL

1. Ensure that you are clear about your roles and responsibilities as the OTL.
2. Schedule time with your Facility Manager to discuss your new roles and responsibilities. Every Facility Manager is scheduled to attend a one day workshop to give them an overview of the Outreach Team, your role as the OTL and of the CHWs role within the community. While your Facility Manager may or may not have attended this workshop, it is important for you to schedule some time with them to discuss a plan for your transition.
3. Set timelines for when the transition should take place.
4. Suggest a phased approach while the Facility Manager is managing the workload in the clinic so that your time in the clinic (from 100% to 30%) does not have such a harsh impact on the rest of the clinic staff.

Table 2: Scope of work for the Community Health Worker¹⁰

| Scope of work for the Community Health Worker | | | | |
|---|---|---|--|--|
| Improve the quality of life of community members by mobilising for improved access to and delivery of Primary Health Care at local level within the context of an inter-sectoral environment. | | | | |
| <ol style="list-style-type: none"> Promote health and prevent illnesses Conduct community assessments and mobilise around community needs Conduct structured household assessment to identify their health needs Provide psychosocial support to community members Identify and manage minor health problems Support screening and health promotion programmes in schools and Early Childhood Development (ECD) centres Promote and work with other sectors and undertake collaborative community based interventions Support continuum of care through service co-ordination with other relevant service providers | | | | |
| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
| 1. Promote health and prevent illness <ul style="list-style-type: none"> Provide information Educate and support for healthy behaviours Facilitate appropriate home care | <ul style="list-style-type: none"> Promote key family practices: <ul style="list-style-type: none"> Infant and young child feeding Newborn care ORT, hand washing Nutrition Postnatal care for women | <ul style="list-style-type: none"> Promote HIV prevention including HIV testing, condom use, partner reduction, circumcision, STI treatment Promote voluntary counselling and testing for HIV Distribute condoms Advise on TB infection control in the home | <ul style="list-style-type: none"> Provide information on risk factors for chronic diseases | <ul style="list-style-type: none"> Provide information and motivational interviewing on substance abuse Provide information on prevention of injuries in homes |
| 2. Conduct community assessments and mobilise around community needs <ul style="list-style-type: none"> Compile a community profile Identify community resources Identify health and related services | <ul style="list-style-type: none"> Support immunisation, vitamin A and de-worming campaigns | <ul style="list-style-type: none"> Support HIV educational and treatment literacy campaigns Distribute condoms in non-traditional outlets | <ul style="list-style-type: none"> Support exercise, diet and smoking cessation campaigns | <ul style="list-style-type: none"> Support pedestrian safety initiatives Support campaigns to reduce the availability of drugs and alcohol |

| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
|--|--|--|--|--|
| 3. Conduct structured assessment to assess households to determine <ul style="list-style-type: none"> Biographical profile Information on health status Level of health and social risk facing households and individuals Need for services Identify vulnerable households Ease of access to health and social services | <ul style="list-style-type: none"> Identify households with children under 5 and women of reproductive age Assess need for and facilitate access to key preventive and care services <ul style="list-style-type: none"> Early ANC Immunisation Growth and development HIV screening and care in pregnancy and childhood Contraception, TOP and cervical cancer screening | <ul style="list-style-type: none"> Identify persons who at risk of contracting HIV or TB <ul style="list-style-type: none"> Refer for HCT and screen for TB symptoms Provide adherence support and counselling for those on TB or HAART treatment Facilitate early referral for CD4 testing | <ul style="list-style-type: none"> Identify adults with hypertension, diabetes and depression Identify persons with other chronic diseases and disabilities Facilitate access to facility or specialist care Provide adherence support and counselling for new and existing persons on treatment | <ul style="list-style-type: none"> Identify households affected by domestic violence and substance abuse Facilitate access to sexual assault and mental health services Motivate and refer persons to appropriate substance abuse treatment |
| 4. Provide psychosocial support | <ul style="list-style-type: none"> Support women with postnatal depression Support HIV affected and youth and child headed households | <ul style="list-style-type: none"> Provide an integrated approach to adherence support for TB, HAART and other chronic disease medication in close collaboration with facility-based counsellors | | <ul style="list-style-type: none"> Provide post-trauma psychosocial support |
| 5. Identify and manage minor health problems | <ul style="list-style-type: none"> Identify and treat diarrhoea (ORT and continuous feeding) Identify and refer pneumonia | <ul style="list-style-type: none"> Identify persons with opportunistic infections and refer Identify and refer persons with sexually transmitted infections Promote and support good nutrition and nutritional supplements | <ul style="list-style-type: none"> Provide basic stroke support and rehabilitation Support foot care in diabetics and elderly | <ul style="list-style-type: none"> Provide basic first aid in the home and community as required |

| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
|--|--|---|--|--|
| 6. Support screening and other programmes in schools and ECD centres | <ul style="list-style-type: none"> Support school screening programmes and campaigns | <ul style="list-style-type: none"> Support gender sensitive school and youth HIV prevention programmes | <ul style="list-style-type: none"> Support school children who are on treatment for chronic health problems (e.g. diabetes, asthma) | <ul style="list-style-type: none"> Identify, support and monitor children that are at high risk of child neglect, domestic violence and abuse, and refer to social development services |
| 7. Promote and work with other sectors and undertake collaborative community-based interventions <ul style="list-style-type: none"> Address inter-sectoral issues (e.g. water sanitation and food security) | <ul style="list-style-type: none"> Facilitate early birth and death registration Facilitate access to social grants child care, disability, old age and other social services (e.g. OVC, substance abuse) | <ul style="list-style-type: none"> Participate in inter-sectoral prevention campaigns (e.g. HIV and TB, measles) | <ul style="list-style-type: none"> Facilitate access to social grants, disability and old age benefits | <ul style="list-style-type: none"> Facilitate access to social services for substance abuse and victims of violence and neglect |
| 8. Support continuum of care through service co-ordination with other relevant service providers | <ul style="list-style-type: none"> Assist community members to access services (e.g. health and other required services) Identify and access resources Network and build coalitions with other service providers in the community Provide follow-up support and care Refer community members to health services and social and other community based services offered by other sectors Utilise health system, the services offered at various facilities and refer appropriately | | | |

Table 3: Core Competencies of Community Health Worker ¹⁰

A Community Health Worker requires the following competencies to function effectively as a member of the Ward-based PHC Outreach Team:

Core Competencies

1. Conduct a comprehensive household assessment
2. Promote health and prevent illness
3. Provide psychosocial support
4. Identify and manage minor health problems
5. Conduct community assessments and mobilise around community needs
6. Support screening and other programmes in schools and ECD centres
7. Offer basic first aid and treat minor ailments
8. Conduct a home visit
9. Interview community members and apply interpersonal communication skills
10. Assist community members to access services
11. Refer community members to health, social and other community-based services
12. Promote and work with other sectors and undertake collaborative community-based interventions
13. Advocate for improved health and community services
14. Conduct health promotion and education sessions for communities and its members
15. Understand the principles of PHC and the interventions and services supporting it
16. Understand the health system, the services offered at various facilities and the referral system

Generic Competencies

17. Communication
18. Health promotion and education
19. Team work
20. Problem solving
21. Self-management
22. Recording
23. Service co-ordination

| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
|--|---|---|--|--|
| <p>1. Conduct a comprehensive household assessment</p> <ul style="list-style-type: none"> • Biographical profile • Information on health status • Level of health and social risk facing households and individuals • Need for services • Ease of access to health and social services • Identify vulnerable households | <ul style="list-style-type: none"> • Conduct a developmental assessment for children • Understand basic integrated management of childhood illnesses and use of guidelines • Understand immunisation schedules and read <i>Road to Health Booklet</i> • Understand the nutritional requirements for infants (exclusive breast feeding), children and pregnant women • Knowledge of HIV screening and care in pregnancy and childhood • Knowledge and understanding of antenatal and postnatal care of pregnant women • Screen for reproductive health problems, sexually transmitted infections, family planning requirements and termination of pregnancy | <ul style="list-style-type: none"> • Understand HIV, TB, the presentation of illnesses, prevention, screening, treatment and support • Understand the requirements for treatment adherence support groups and promotion of treatment compliance • Conduct treatment adherence support groups | <ul style="list-style-type: none"> • Understand the manifestation of common chronic health problems and factors that promote and prevent these conditions • Use basic screening and assessment tools to screen for risk of chronic health problems • Understand the special needs of persons with chronic diseases, the disabled and elderly • Understand the service network and referral systems for service required to support persons with chronic diseases, the disabled and elderly • Provide education and support to persons with chronic diseases, the disabled and elderly | <ul style="list-style-type: none"> • Identify households affected by domestic violence and substance abuse • Facilitate access to sexual assault and mental health services • Motivate and refer persons to appropriate substance abuse treatment |

| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
|--|---|---|---|--|
| | <ul style="list-style-type: none"> • Conduct breast examination | | <ul style="list-style-type: none"> • Understand the requirements for treatment adherence support and promotion of treatment compliance for persons with chronic illness • Provide adherence support and counselling for new and existing persons on treatment | |
| <p>2. Promote health and prevent illness</p> <ul style="list-style-type: none"> • Provide information • Educate on and support for healthy behaviours • Facilitate appropriate home care | <ul style="list-style-type: none"> • Promote early childhood development and stimulation • Promote and prepare families for parenthood and effective parenting • Promote exclusive breastfeeding • Promote accident prevention and safety in the home • Facilitate basic hygiene and infection control | <ul style="list-style-type: none"> • Understand the principles of HIV and TB prevention programmes • Conduct health promotion and prevention campaigns for HIV and TB • Understand and promote infection control in the home | <ul style="list-style-type: none"> • Conduct health promotion and prevention campaigns for chronic diseases | <ul style="list-style-type: none"> • Provide information and motivational interviewing on substance abuse • Provide information on prevention of injuries in homes |
| <p>3. Provide psychosocial support</p> | <ul style="list-style-type: none"> • Psychosocial and supportive counselling • Coping mechanisms and emotional support • Knowledge of postnatal blues and depression management | <ul style="list-style-type: none"> • Understand the principles of providing integrated psychosocial and adherence support to persons on TB, HAART and other chronic disease treatment | | <ul style="list-style-type: none"> • Provide post-trauma counselling |

| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
|---|--|------------|---|---|
| 4. Identify and manage minor health problems | <ul style="list-style-type: none"> Integrated management of childhood illnesses Oral rehydration and continuous feeding Signs and symptoms of pneumonia | | <ul style="list-style-type: none"> Manage common health problems that affect persons with disability and the elderly including <ul style="list-style-type: none"> Foot care Mobility Dietary interventions | <ul style="list-style-type: none"> Render basic first aid in the home and community |
| 5. Conduct community assessments and mobilise around community needs | <ul style="list-style-type: none"> Knowledge and skills for compiling a community profile Resource identification Develop a service profile Formulate a community diagnosis Understand community safety strategies Understand the effects of and impact of drugs and alcohol abuse | | | <ul style="list-style-type: none"> Understand community safety strategies Understand the effects of and impact of drugs and alcohol abuse |
| 6. Support screening and other programmes in schools and ECD centres | <ul style="list-style-type: none"> Conduct basic health screening of children in ECD centres and primary schools Conduct a wellness campaign at school and ECD centres | | | |

| | Maternal, Child, Women's Health | HIV and TB | Chronic, non-communicable diseases | Violence and injury |
|--|--|------------|------------------------------------|---------------------|
| 7. Promote and work with other sectors and undertake collaborative community-based interventions | <ul style="list-style-type: none"> Facilitate early birth and death registration Facilitate access to social grants, child care, disability, old age and other social services (e.g. OVC, substance abuse) | | | |
| <ul style="list-style-type: none"> Address inter-sectoral issues (e.g. water sanitation and food security) | | | | |
| 8. Advocate for improved health and community services | | | | |
| 9. Conduct health promotion and education sessions for communities and its' members | | | | |
| 10. Conduct a home visit | | | | |
| 11. Offer basic first aid and treatment of minor ailments | | | | |
| 12. Understand the principles of PHC and the interventions and services supporting it | | | | |
| 13. Understand the health system, the services offered at various facilities and the referral system | | | | |
| 14. Interview community members and utilise effective interpersonal and communication skills | | | | |
| 15. Demonstrate the ability to assist community members to access services | | | | |
| 16. Refer community members to health services and social and other community-based services offered by other sectors | | | | |

| Community Health Workers Generic Competencies | |
|---|--|
| 17. Communication | <ul style="list-style-type: none"> • Demonstrate the ability to listen, comprehend, and effectively communicate information, both written and orally, to all individuals • Use communication and interpersonal skills to initiate, develop and maintain a supportive, caring relationship with community members • Use verbal and written communication appropriately to communicate with community members • Demonstrate empathy • Use appropriate, accurate and non-judgmental language • Actively listen and attend to client concerns (including body language) • Paraphrase (reframing) what client says to ensure a mutual understanding • Ask open-ended questions to solicit client information and give positive reinforcement • Describe and explain client rights and confidentiality in clear language • Elicit, document and appropriately use community members responses • Convey information that is easily understood and appropriate • Respond timeously and correctly to community member's questions, requests and problems • Communicate in a manner that promotes respect and dignity of community members • Maintain confidentiality of both written and oral communication with community members as well as written records |
| 18. Health promotion and education | <ul style="list-style-type: none"> • Demonstrate skills in presentation of health information • Provide and present information to community members in an appropriate and clear manner • Use written and visual materials that convey information clearly and respectfully to clients, as well as other service providers and community residents • Present information effectively to small and large groups of community members • Promote appropriate health information within the community |
| 19. Team work | <ul style="list-style-type: none"> • Identify the structure and purpose of the PHC Outreach Team • Establish and maintain a good working relationship with team members, supervisors and other community-based workers and other colleagues • Understand and respect the roles and skills of all members of the Outreach Team and health and social care teams • Demonstrate understanding of the role of other stakeholders in health care • Participate with members of the health and social care teams in decision-making pertaining to health care delivery • Disseminate information about area of responsibility to other team members • Develop and establish inter-sectoral relationships that promote health care • Function as an effective team member • Form alliances with key players when dealing with community health issues and needs • Work effectively in groups with other community workers to understand and promote change |

| Community Health Workers Generic Competencies | |
|---|---|
| 20. Problem solving | <ul style="list-style-type: none"> • Identify problems by recognising the difference between current and ideal situations • Determine possible causes of problems from given sources of information • Request guidance and assistance from others to identify root causes of problems where own analysis is insufficient • Respond to known information • Interpret information if clues are given • Identify several solutions when analysing a problem, under general supervision |
| 21. Self-management | <ul style="list-style-type: none"> • Demonstrate ability to manage and organise one's self, tasks and work environment • Display the skills necessary for effective personal planning • Have effective time management ability • Demonstrate the skills necessary for effective goal setting |
| 22. Recording | <ul style="list-style-type: none"> • Complete household registration forms • Ensure information recorded is legible, accurate and relevant • Update household and community records • Accurately record all interventions rendered • Complete weekly and monthly reports as required • Complete community, household and individual assessment forms |
| 23. Service Co-ordination | <ul style="list-style-type: none"> • Demonstrate ability to identify and access resources • Demonstrate ability to network and build coalitions with other service providers in the community • Demonstrate ability to provide follow-up |

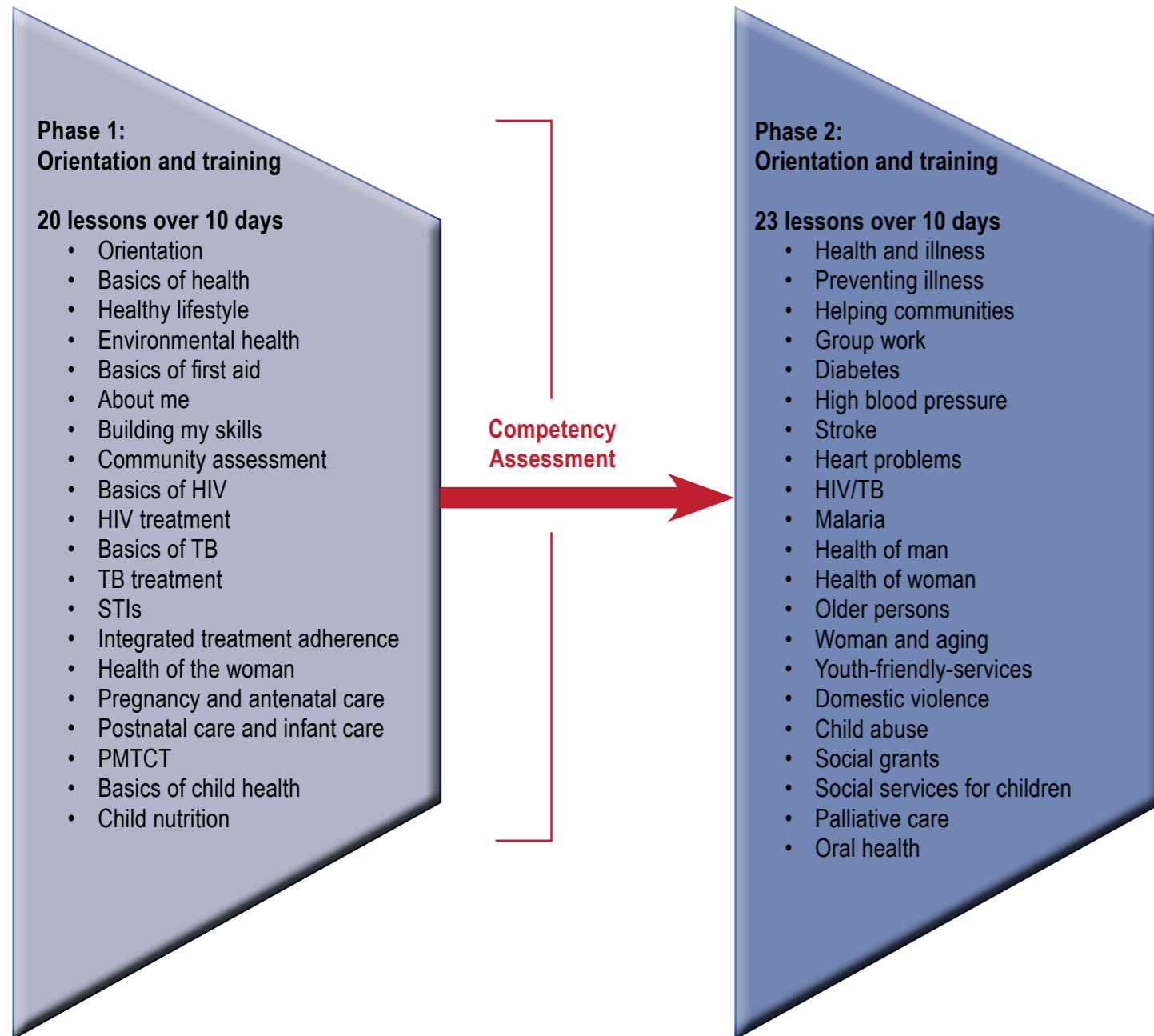
The tables above are also included in the *Team Leader Job Aid, General Information*.

7.3. What training will the CHW receive or have they received?

The CHWs who have been hired or will be hired to be in your team are not required to have passed matric or have any other formal qualifications.

The NDOH is responsible for training all CHWs and at times the training will be conducted with the support of partner organisations. Each CHW will receive comprehensive training in two phases. Prior to CHWs undergoing Phase 2 training, a Competency Assessment will be administered under your direct supervision. This training plan is outlined in Figure 5 below.

Figure 5: CHW Training Overview



8. Health Promoter

Ideally, the Health Promoter would provide technical support and assistance to the Outreach Team pertaining to health promotion activities at a community level based on local community needs.¹⁰

8.1. Roles and responsibilities of the Health Promoter

The roles and responsibilities of the Health Promoter are outlined in the table below.

Table 4: Role of Health Promoter in Communities¹⁰

| Community |
|--|
| <ul style="list-style-type: none"> • Plan, co-ordinate and implement Health Calendar events, activities and campaigns at a community level • Establish, facilitate and maintain support groups for persons with health related problems according to needs of the community • Co-ordinate health promotion activities and events at local schools, crèches, institutions and work places in the community • Provide information and education pertaining to health issues determined by local needs of the community <ul style="list-style-type: none"> ◦ One-on-one interaction with members of the community (information sharing and brief advice sessions, when necessary) ◦ Conduct group discussions with target audiences (youth, women, elderly) in the community ◦ Hold community health awareness days and health campaigns • Facilitate local drama, puppet shows, role-plays, song and dance sessions to encourage community involvement and participation in health issues |
| Outreach Team |
| <ul style="list-style-type: none"> • Provide overall support and technical assistance and support pertaining to health promotion to the Outreach Teams (each health promoter could support 2-3 Outreach Teams linked to a PHC clinic) • Support the members of the Outreach Team to: <ul style="list-style-type: none"> ◦ Develop and disseminate health promotion messages ◦ Identify appropriate and relevant health promotion material for use and distribution ◦ Use a range of health promotion tools • Assist and support CHWs by providing health information and updates on health promotion activities in accordance with the Health Calendar |
| School health |
| <ul style="list-style-type: none"> • Implement health education and promotion programmes in schools and crèches based on assessed needs • Support the school health nurse and the education team to develop and disseminate health promotion messages • Identify appropriate and relevant health promotion material for use and distribution • Use a range of health promotion tools • Participate in Health Calendar days |

Disease Outbreak Teams

- Run education campaigns (door-to-door) in high risk areas during disease outbreak (within the catchment area)
- Mobilise communities for specific health campaigns within the catchment area
- Provide health information, education and communication (IEC) materials (posters and pamphlets) for distribution to the community
- Present educational talks on local community radio and make local public service announcements and present health information

9. Environmental Health Practitioner

The Environmental Health Practitioner is an essential component of PHC at the community level. They will be responsible for providing all environmental health services that the community requires.¹⁰

9.1. Roles and responsibilities of the Environmental Health Practitioner

The services provided by the Environmental Health Practitioner are outlined in the table below.

Table 5: Services provided by Environmental Health Practitioner¹⁰

Community

- Control health hazards related to household and community waste disposal
- Control and manage unsafe sanitation
- Oversee waste water treatment
- Monitor waste management
- Vector control
- Prevent and control land pollution
- Monitor air quality management
- Establish an effective environmental health surveillance and information system
- Develop a community-based accident prevention programme
- Monitor and control retail food hygiene and safety (formal and informal)
- Develop environmental health measures associated with epidemics, emergencies, disasters and migrations of populations
- Monitor occupational health and safety in local businesses
- Manage environmental noise hazards
- Monitor environmental health in public and private accommodation establishments

**Learning Objective 4**

To understand how the Outreach Team interacts with other service providers within the community.

10. Outreach Team interaction with other services

You and your team are expected to liaise and collaborate with other services within your community. Your interaction with other services will include:

1. **Two-way referrals** where you refer your HH members to other services and other services may refer their clients to your Outreach Team.
2. **Quality improvement advocacy:** It is your responsibility as the OTL to recognise if and when household members are not receiving adequate or quality services from other service providers (including the clinic under which your team operates). If you recognise a gap or poor service, it is your responsibility to escalate the concern with the organisation manager or with your Facility Manager. In this way, you are an advocate for quality improvement in your community.

A list and description of the services you will liaise with and advocate for include, but are not limited to, the following:

Home-based care (HBC): A service that provides complete quality health services at home and in communities. HBC usually offers services to people with physical impairments or to people with chronic diseases, including TB and HIV/AIDS, who require support with the activities of daily living.

It is important for you to note that some CHWs in the Outreach Team might have previously worked as community-based workers who were providing HBC as their primary job. CHWs in the Outreach Team may provide limited HBC at times but this is not their primary role or function within the Outreach Team.

Palliative/hospice care: An approach that improves the quality of life of patients facing life-threatening illness, through the relief of suffering by means of early identification and treatment of pain and other distressing symptoms.

Geriatric (old age) care: These services are meant to assist elderly people in their final years in life. There may or may not be old age homes or facilities in your community.

Although these services are offered by organisations that are not part of the public sector, they are important partners that offer necessary support services to the community. It is therefore important for the Outreach Team to work in close collaboration with these services.

11. Brief summary of Outreach Team member roles

You, as the OTL, are primarily responsible for managing and supervising the Outreach Team. Your core responsibility is service delivery at the community level. This means you are responsible for community entry, assessment and involvement [to be discussed further in Lesson 5, Community Entry, Assessment and Involvement]. Your other core responsibility is the oversight of the CHWs and their service delivery to the HHs in your catchment area.

The CHWs are primarily responsible for HH engagement and service delivery and to assist you on community level efforts when necessary.

12. Overview of Learner Guide

The remainder of this Learner Guide includes the basic information and skills required to perform your role as OTL. The following lessons include:

- Lesson 2:** Skills Required to be an Effective OTL
- Lesson 3:** Service Delivery
- Lesson 4:** Team Management
- Lesson 5:** Community Entry, Assessment and Involvement
- Lesson 6:** Household Engagement
- Lesson 7:** Monitoring, Evaluation and Reporting
- Lesson 8:** Summary of OTL Orientation

Lesson 2

Skills Required to be an Effective Outreach Team Leader

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Your role as an Outreach Team Leader

Your role as the OTL will require you to have a set of general skills that you will utilise when:

- Managing the team
- Managing the individual
- Collaborating with other service providers within your community
- Liaising with your Facility Manager

While the skills in this Lesson may not include every skill that you might require, they include:

- Communication skills
- Listening skills
- Problem solving
- Delegation
- Motivation
- Mentoring and coaching

Learning objectives

This Lesson has six main learning objectives:

1. To practice effective communication.
2. To practice effective listening skills.
3. To understand the basic steps in problem solving.
4. To understand the importance of and how to delegate.
5. To understand the definition and methods for motivating team members.
6. To understand the importance of coaching and mentoring.





Learning Objective 1

To practice effective communication.

1. Communication

This section will take you through the basics of how to practice effective communication. The topics covered in this section include:

- Requirements for effective communication
- Different forms of communication
- Appropriate methods of communication

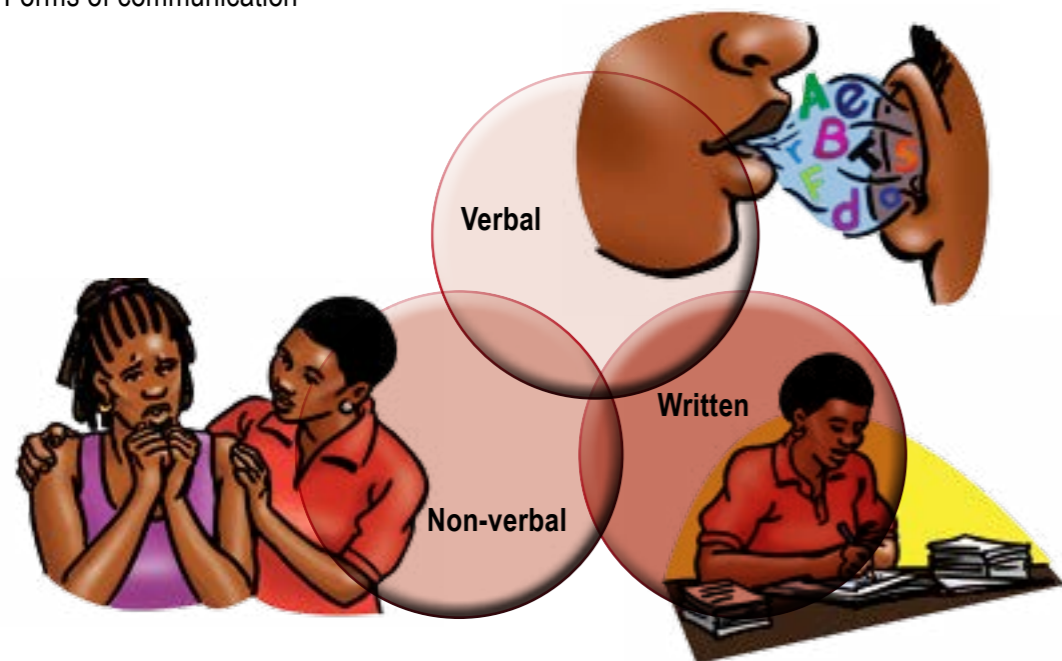
1.1. Requirements for effective communication

Effective communication is the core skill that is required for all of the work that you do and for all of the people that you will interact with. Effective communication requires you to:

- Respect each other's view points
- Use simple language
- Communicate in a clear manner

1.2. Different forms of communication

Figure 1: Forms of communication



1.2.1. Verbal communication

Verbal communication is when we speak to another person. This could be over the phone or in person. With verbal communication, we must think about our **tone**, which **words we emphasise** and **which emotions we use** when we communicate.

1.2.2. Written communication

As an OTL, you will be required to submit regular monthly reports and to write referrals. Both of these items require that you have good writing skills.

How to write well

- Think about who you are writing to
 - What is the main message that the person must understand?
 - Make sure that this is very clear in the writing
 - Only use words that you know the person will understand
- Use simple language
 - Use specific and tangible words and not ones that are vague (for example, don't say "We have assessed many houses this week" rather say, "We have assessed 4 houses this week")
 - Keep sentences short
 - Use only one idea per sentence
 - Avoid jargon that the other person may not know or understand
- Write neatly in a way that others can read what is written
- Write like you talk
 - Don't use big words or try and sound impressive
 - Use words like "me", "you", "us" and "I" to make it personal
- Use a positive tone
 - Replace negative words with positive ones; don't say "I can't see you tomorrow" rather say "I can see you on a different day"
- Be respectful
 - When you are talking about both male and female use "he/she" in your writing
 - Use the plural form (more than one) when you can (for example, talk about "their" instead of his or her)
 - Don't use words that could sound like they are disrespectful

Individual Activity

Imagine that you are pregnant (if you are a woman) or have a long term disability (if you are a man). In this current place in your life, how would you feel about it? Now imagine sharing this information. Please write three brief letters to the following people to tell them your news:

1. Your sister
2. Your Facility Manager
3. A woman who has just had a miscarriage at 5 months into her pregnancy OR a man with a disability worse than yours



What are some of the differences that you noticed between the three letters?

1.2.3. Non-verbal communication

Non-verbal communication is mostly about our body language. Non-verbal communication can have different effects or roles.

Group Activity

6 volunteers will each demonstrate an emotion to the group without using words. As a member of the group, you must try and guess the emotion.

Once all 6 demonstrations are complete, think about what you have learnt about non-verbal communication. Consider the following:

- Your own non-verbal communication
- When it will be important for you to observe other people's non-verbal communication



1.3. Appropriate methods of communication

Day to day methods of communication in the work place include:

- | | | |
|----------------|--------------|------------------------|
| • Face-to-face | • Phone | • Reports |
| • SMS | • Email | • Letters |
| • Meetings | • Non-verbal | • Educational material |

It is important that you choose the best and most appropriate method of communication every time that you communicate. In certain circumstances, one method of communication may be better than another.

No matter which method you choose, you must be in regular and open communication with your Outreach Team members at all times.

**Learning Objective 2**

To practice effective listening skills.

2. Listening**2.1. Why we listen**

Being a good listener is one of the best and most fundamental qualities of being a good leader and coach. Without the ability to really listen to other people, you cannot be good at either.

Other reasons why we listen include:

- We listen to obtain information
- We listen to understand
- We listen for enjoyment
- We listen to learn

2.2. Active listening**What is active listening?**

Active listening is listening with the intent to give feedback or to summarise what the listener heard. Active listening is meant to confirm that the listener heard and understood everything that was said. ¹¹

Assumptions, judgements, and beliefs can distort what we hear. As a listener, your role is to understand what is being said. ¹¹

Techniques for active listening:

- Pay attention
 - Give the speaker your undivided attention
- Recognise that non-verbal communication also “speaks” loudly
 - Look at the speaker directly
 - Put aside distracting thoughts; don’t mentally prepare how to challenge or respond
 - Avoid being distracted by external factors (e.g. the list of things you have to do)
 - Don’t interrupt or make counter arguments; allow the other person to finish
- Positive physical listening
 - Use your own body language and gestures to convey your attention
 - Nod occasionally
 - Smile and use other facial expressions
 - Note your posture and make sure it is open and inviting
 - Encourage the speaker to continue with small verbal comments like ‘yes’ and ‘uh huh’
- Ask questions to clarify and show that you are listening

- Paraphrasing/Summarising
 - Summarise what the other person has said so that an important aspect of the message can be highlighted, emphasised or explored
 - Take several themes and tie them together into a central theme
- Reflection
 - Try and understand the confidence level and emotional level of the other person; say things like “It doesn’t sound as though you are very confident about xyz”
- Do not judge
 - You are hearing someone else’s perspective and for this reason alone they cannot be wrong





Learning Objective 3

To understand the basics steps in problem solving.

3. Problem solving

It is important for you to understand that there are different kinds of problems which may be at different levels.

Examples of problems may include:

- Inadequate resources (e.g. no paper available to make copies of tools)
- Staff conflict
- Not meeting activity targets

There is no magic formula for problem solving. It typically takes place on a case by case basis. The following steps for problem solving can be applied in most cases. Please note that not all steps are required but it is especially important to document:

- The problem
- The solution implemented
- A reflection on how it worked out

3.1. Seven basic steps to problem solving ¹²

When you encounter a problem of any kind, there are seven basic steps that you can follow to resolve the problem.

First you must identify the problem and understand what caused the problem.

Next you must identify possible solutions to the problem and select the best option.

Some solutions may require an action plan but some solutions may be so simple that they do not require a plan. If the solution requires a plan, write up an action plan and implement your plan in order to achieve the solution.

Once the problem is solved, evaluate whether or not your solution was successful and reflect on the whole situation.

Problem solving does not have to be a formal process every time. The following steps are to help guide you whenever you do face a problem.

Figure 2: 7 Steps to problem solving ¹²



While you do not always have to write down all details in the problem solving process, the steps are there to provide guidance when you are not sure how to deal with a problem.

3.1.1. Raise problems that you cannot resolve with your manager

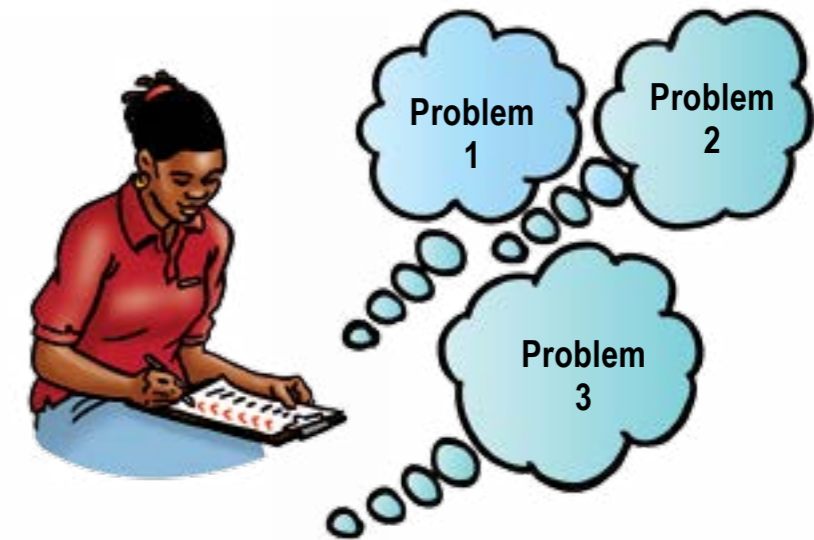
At times there may be problems that you have tried to resolve, but the problem remains the same or you cannot find the solution. In cases like this, it is important that you give the problem a time frame to be resolved within. If you are unable to resolve the problem within that time frame, you must raise the problem with the Facility Manager. It is recommended that all problems that are raised with the Facility Manager are documented and tracked.

3.1.2. Prioritising problems

At times you may have more than one problem and you may not feel like there is adequate time to think through the first five steps of problem solving. It is important that you prioritise your problems in order of urgency and importance, especially with respect to your team schedule and activity plans.

When you have to prioritise problems, ask yourself:

1. What is the implication of this problem and who will it affect? How urgent is it to deal with in comparison to the other problems?
2. How important is the task or activity in terms of service delivery and the entire team?



Working in Pairs

Pair up with someone in the group. Imagine that the problems listed below are occurring at the same time:



- Your CHWs have run out of condoms for distribution at household visits
- There is no printer paper available in the office
- There is no tea or coffee in the staff kitchen
- You need a new pair of shoes for a party and don't have time to shop
- One of your CHWs has been on leave for two weeks and nobody is visiting her assigned households

In your pair, list the problems in order of priority (remembering to think about how urgent and how important each problem is).

Once you have prioritised each problem, use the '7 steps to problem solving' to decide how to deal with each problem.

Share your priority list and also the solving process with the larger group.



Learning Objective 4

To understand the importance of and how to delegate.

4. Delegation



What is delegation?

Delegation is when the authority and responsibility to perform a task is given from one person to the next.¹³ This normally occurs from an OTL to their team member.

Key things to remember when delegating a task:

- The person being delegated to is responsible for that task being completed.
- The person receiving the responsibility must also have the authority to be able to complete the given task. This authority may need to be in writing from senior levels if the person with the given responsibility has to interact with other departments or staff of higher authority elsewhere.
- Delegating responsibility of a task to a team member does NOT free the OTL of the accountability for that task to be completed correctly and on time. It is in your own interest to ensure you brief the team member appropriately so that they may be able to complete the delegated task effectively and efficiently.
- Make sure that it is very clear what you are asking the team member to do and that the person is clear on what you expect from them.

4.1. Steps in effective delegation¹⁴

a. Define the goal concisely

Be brief about the goal that you want the CHW (or other team member) to achieve but make sure that you communicate this clearly and that they understand exactly what is expected of them.

b. Select the right person for the task

Consider what skills the task will require and make sure that the person you ask has the right skills for the job. If you have more than one person that you can ask, try and ask the most suitable person.

c. Solicit the team member's view about the suggested approaches

This is especially important when the delegation is part of your coaching process. Discuss the various options that are available and guide the team member in making the most appropriate decisions.

d. Give the selected team member the authority, time and resources

- The time that is allowed for the task to be completed will depend on the situation. If the time is limited then you will need to monitor the progress very quickly, however do not assign a task to someone if the time that is available is not suitable for this person's ability

- Ensure that the person knows what decisions they can make on their own and which they should discuss with you first
- If there are any resources (human or material), which will help the person achieve their goal, make sure that you mention to the person what they are and that they are available

e. Schedule checkpoints for reviewing progress

As your confidence in the person grows, the checkpoints and reviewing process can change, but initially ensure that you keep the review period as short as possible in case a wrong turn is taken. In this way rectifying any problems will be easy, quick and simple.

f. Follow through by discussing progress at appropriate intervals

- These will be longer discussions about the progress that is being made and the way forward
- This will be used mainly when the goal is a longer project that needs a lot of planning with more complex and complicated activities

Ultimately the responsibility of the delegated task remains that of the OTL who has delegated the task. It is in your interest to ensure the team member understands the task, and can actually perform it. Furthermore, you need to check on progress of larger tasks before the expected completion date of those tasks.

4.2. Advantages of delegation ¹⁴

- Permits getting work done through others
- OTL saves time
- OTL frees herself/himself to devote energy to other important, higher-level activities
- Provides team member with more responsibility
- Provides team member with the opportunity to develop new skills and to demonstrate potential
- From the organisation’s perspective, jobs are done more cost effectively

Group Activity

6 volunteers will role play three different scenarios around delegation. Write down your observations of each role play, noting what the acting CHWs and OTLs did well and didn’t do well in terms of effective delegation. Consider how communication, listening and problem solving skills were used within the interaction between the CHW and OTL. Discuss your findings with the larger group.



Learning Objective 5

To understand the definition of motivation and methods that can be used to motivate your team.

5. Motivation

Motivation is the force that makes people want to complete work and act on deliverables required for the function of a team as a whole. Greater motivation results in greater productivity within the team.



What is motivation?

Motivation is the process of “stimulating a person’s interest in an activity” or “to cause a person to act in a particular way.” ¹⁵

People are motivated by different things. The factors that motivate people are influenced by their interests, values, needs and desires.

Table 1: Examples of different incentives for motivation and demotivating factors ¹⁶

| Financial motivators | Non-financial motivators | Team motivators |
|---|---|---|
| <ul style="list-style-type: none"> • Bonuses • Salary increases • Training opportunities • Promotions | <ul style="list-style-type: none"> • Opportunities to grow and peer recognition • Being given challenging responsibility (e.g. effective delegation) • Public (or private) praise or acknowledgement • Create informal leadership roles | <ul style="list-style-type: none"> • Group lunch • Team building activities • Rewards for achieving team objectives • Monthly employee awards • End of year function |
| Demotivating factors | | |
| <ul style="list-style-type: none"> • Thinking that you are always right and have all the answers • Being negative and complaining often • Taking the team for granted • Tolerating poor performance and behaviour • Only acknowledging poor performance and not acknowledging good performance or achievements | | |

It is important to note that you do not have control over and will not be able to provide financial motivators for the Outreach Team.

Instead, you should use non-financial and team motivators.

It is important to give praise (privately or in a team meeting) whenever there is an opportunity. If you receive positive feedback about a team member from a service provider or someone in the community, you should always communicate this to the team member.

Brainstorm

In the larger group, discuss what role you need to play in motivating members of your team. Give examples of what you have done that has worked and what has not been very successful. If you have not managed any staff, think about what would motivate you. Be practical with your ideas (i.e. suggesting a bonus is not realistic if you are not in a position to authorise such a payment).



Four horizontal lines for writing notes.



Learning Objective 6

To understand the importance of coaching and mentoring.

6. Mentoring/Coaching

Mentoring and coaching are often used interchangeably and may be used interchangeably in the context of the Outreach Team.



What is mentoring?

Mentoring is when a more experienced person guides a less experienced person. It is often a relationship of learning and dialogue.¹⁷

What is coaching?

Coaching is teaching or training process where an individual gets support while learning to achieve a specific result or goal.¹⁸

Mentoring and coaching involve face-to-face communication over a period of time.

Sometimes a team member may have a learning need that does not require a formal training or course. In these instances, they may just require coaching and/or mentoring from you as their OTL. This is part of your role as the OTL!

Mentoring allows you to be a leader for your team members. You must remember that the performance of your CHWs reflects the performance and success of the entire Outreach Team. The CHWs ability to perform their role is a reflection on how well you've mentored or coached them in the necessary areas.

The key to mentoring is to ask questions. In order for your team member to grow it is important for them to find their own solutions. Your role as OTL is to guide that process of self-discovery through mentoring and coaching.

As a coach, you need to be able to identify your team member's level of competency in the area you intend to coach them on. Then you need to create a safe space where they realise that it is okay not to have all the answers. This will allow them to be coached.



7. Pulling it all together

Most of the time, you will have to use these skills in combination or apply different skills to one scenario. The following exercise is to help you think about how you might use different skills for various scenarios.

Working in Pairs



Pair up with someone you have not paired up with before.

Think about the following situations and consider how you would respond to them:

If someone in your community or in a household is aggressive, how would you deal with it?

If one of your CHW's households has an older woman who refuses to speak to her, how would you handle this?

Your team continuously encounters a drunken man at one of the households in your catchment area. All of your female CHWs are afraid of him and don't want to go to that house. How would you handle this situation?

Once you answered all the questions, list which skills are needed for each scenario.

Present your answers to the larger group.

Lesson 3

Service Delivery

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Your role as an Outreach Team Leader

Your role as an OTL is to plan, implement and evaluate health and wellness services to the catchment population of the Outreach Team.

This includes promotion, prevention, early detection, curative, rehabilitative and palliative services in line with the needs of the community and HHs which are outlined in PHC package of services.

Learning Objectives

This Lesson has ten main learning objectives:

1. To understand the services to be provided to the community by the Outreach Team.
2. To understand the services to be provided to individual HHs by the Outreach Team.
3. To understand the Outreach Team's responsibilities in delivering antenatal care services.
4. To understand the Outreach Team's responsibilities in delivering postnatal care services.
5. To understand the Outreach Team's responsibilities in delivering child health services.
6. To understand the Outreach Team's responsibility in delivering services for the management of non-communicable diseases.
7. To understand the Outreach Team's responsibilities in delivering treatment adherence support.
8. To understand the Outreach teams responsibilities in supporting the delivery of social services.
9. To understand the package of school health services to be provided by the school health team with the Outreach Team's support.
10. To understand the Outreach Team's role in providing emergency health services.



1. Introduction to Lesson

Now that you have a general understanding of who the Outreach Team includes, how the team fits into the PHC Re-engineering model and what skills you are required to have as the OTL, it is important to understand the team's role in service delivery.

Think Point

Think back to Lesson 1 [Introduction to Role as OTL] and remember:

The primary role of the OTL is to provide services to the community and to provide oversight of the CHWs in their delivery of services to HHs. The primary role of the CHW is to register, assess and provide services to the HHs within the catchment area.



As indicated from the outline of South Africa's quadruple burden of disease, the Outreach Team must deliver a wide range of services to the community and to HHs to respond to these diseases and to achieve the NSDA and MDG goals. These services include:

- **Clinical services**
These services may include any clinical services that can be provided in the HH without sending HH members to the clinic. Some examples of clinical services that the team will provide include: HIV rapid testing; taking blood pressure; screening for health conditions (e.g. TB, diabetes); calculating Body Mass Index (BMI).
- **Non-clinical services**
These services may include things like health education and health promotion.
- **Referrals to and collaboration with other service providers**
A large responsibility of you and the team is to link or refer HH members to other service providers when necessary. The team will use a standard *Referral Form* to refer HH members. (The *Referral Form* is discussed further in Lessons 4, 5 and 6.) For example, you or the CHW may not be able to provide certain clinical services in the HH so the HH member will need to be referred to the PHC clinic. The HH member would bring their *Referral Form* to the PHC clinic which will tell the clinic why they were referred.
- **Implementing interventions**
There may be times when a CHW encounters a problem that he/she is not capable of dealing with. This may require you to intervene in the problem and help them to resolve it. Your involvement may be considered an intervention in itself.

In other situations, your team may find that an entire area within your catchment area has never been tested for HIV. This may require an HIV testing campaign as the intervention. Your team would be responsible for planning such an intervention with the necessary support.

The following sections in this Lesson outline the Outreach Team's responsibility in delivering services to the community and to the HHs with an emphasis on the priority services to each HH. The last section discusses the team's responsibility with providing emergency services.



Learning Objective 1

To understand the services to be provided to the community by the Outreach Team.

2. Services to the community

The Outreach Team's priorities are to deliver services to both the community and to HHs within the community. It is your role to ensure that the Outreach Team improves access to health care services by providing community-based services and collaborating with other service providers.

2.1. Improve access to health care services

What is access to health care?

As described in Lesson 1 [Introduction to Role as OTL], a major priority of NDOH is to improve access to health care. Access to health care is not only limited to the physical access to care but may include other factors.

Some barriers to accessing health care might include:

- Facility location
- Cost of travel
- Cost of service
- Attitude of health care providers
- Positive or negative feelings you get when you receive care
- No services available

It is important to always look for opportunities to improve access to health care and to collaborate with other services providers whenever possible to ensure improvements are made.

Key steps to improve access to health care

1. First, you must identify which services are available in that community. More details and templates for collection of this information are described further in Lesson 5 [Community Entry, Assessment and Involvement].
2. At the HH level, what problems are individuals experiencing in terms of accessing health care services? What are the barriers to individuals in accessing health care services? (examples provided above and in brainstorm) More details around HH engagement are provided in Lesson 6 [Household Engagement].
3. Once all barriers are identified, it is your responsibility to find ways to address them. This may involve you talking to specific service providers. It may also require you to come up with creative solutions to the barriers. You should use the problem solving skills you learnt in Lesson 2.

Working in Pairs

Pair up with someone you have not yet paired with in the group. Together, list the barriers for people to access health care services within your community.

Using the problem solving skills that you learnt in Lesson 2, pick one barrier and identify how you would address it. Be creative in your solutions.

Discuss with the larger group.



2.2. Community components of PHC package of services

The community components of the package of services that the OTL should ensure are delivered are described in Table 1 below.

Table 1: Community components of the PHC package of services ³

| Health issue | Community-based services | Collaboration |
|------------------------------------|--|--|
| Women's reproductive health | <ul style="list-style-type: none"> Supporting the PHC clinic to promote positive outcomes for all pregnant women during and after delivery | <ul style="list-style-type: none"> Collaboration with social development/welfare for social assistance, as well as other role players to address women's reproductive health issues Cross collaboration with other role players to enhance health promotion of women's reproductive health |
| Child health | <ul style="list-style-type: none"> Ensuring that the management of child illness takes place in line with the Road to Health Booklet Ensuring the Outreach Team works in close cooperation with other health programmes like PHC clinic or care groups | <ul style="list-style-type: none"> Outreach Team collaborates with social workers, NGOs, CBOs, crèches and other sectors to improve child health |
| Disease prevention by immunisation | <ul style="list-style-type: none"> Communities participate in campaigns and national health days Ensuring the Outreach Team follow-up suspected patients of measles at home to determine extent of outbreak | <ul style="list-style-type: none"> Outreach Team collaborates with other government departments and sectors to promote immunisation and improve coverage |

| Health issue | Community-based services | Collaboration |
|--------------------------------------|--|---|
| Sexually Transmitted Infections | <ul style="list-style-type: none"> Facilitate liaison with traditional healers about signs, symptoms, prevention, referral and care of STI | <ul style="list-style-type: none"> Health care personnel collaborate with different departments such as schools, churches, traditional healers and community organisations implementing health promotion activities leading to the prevention of STI |
| Management and treatment of HIV/AIDS | <ul style="list-style-type: none"> Outreach Team has a working relationship with PHC facility, political leaders, ward councillors, NGOs and CBOs in the catchment area of the PHC clinic Health care personnel educate and train family and community groups in home-based care and seek to de-stigmatise HIV disease in communities through education Health care personnel assist in integrating home-based services and collaborate to understand guidelines used at facility on situational analysis and needs assessment in the community | |
| Oral Health | <ul style="list-style-type: none"> Oral health promotion should be integrated into PHC oral health promotion School oral health programmes consist of oral health education, tooth-brushing, fissure sealant application and A-traumatic Restorative Treatment | <ul style="list-style-type: none"> Collaboration with other departments: Education, Water Affairs, Forestry and other programmes within health such as Child Health, Health Promotion, Environmental Health, Nutrition, Communications |
| Chronic disease and geriatric care | <ul style="list-style-type: none"> Health care personnel work with any district NGO and CBO dealing with chronic conditions Health education and information on modifiable risk factors, early recognition of symptoms and regular check-ups to be provided to the patients and communities. Educational activities are culturally and linguistically appropriate Health care personnel facilitate the establishment and sustainability of active support groups | |

| Health issue | Community-based services | Collaboration |
|-----------------------------------|--|---|
| Mental health and substance abuse | <ul style="list-style-type: none"> Health care personnel participate in community awareness programmes for mental health according to the national and international calendar Health care personnel in the training of family and caregivers of patients to plan an active role in their rehabilitation Health care personnel encourage patient and caregiver support groups in communities | <ul style="list-style-type: none"> Health care personnel respect, and where appropriate, seek collaborative association with local traditional healers Health care personnel collaborate with all community services such as crisis counselling (lifeline, priests with counselling skills) and mental health groups, especially those for youth Health care personnel collaborate with the PHC clinic and hospital for planning discharges to the community Health care personnel collaborate with other sectors like education, correctional services, labour and welfare as well as other relevant NGPs and CBOs to improve mental health With community-based residential and day care mental health facilities that refer mental health care users to the facility for follow-up care |
| Rehabilitation services | <ul style="list-style-type: none"> Refer patients to community monitoring programmes, mobilise community support, where indicated by the patients' social circumstances to ensure compliance with treatment Needs analysis for rehabilitation in the community, to plan appropriate and effective intervention programmes Home visits to patients to gain insight into their social situation Devise home-based rehabilitation programmes for people requiring extended rehabilitation Maintain contact with HH members through follow-up visits Identify and mobilise community resources for groups and peer support, skills training and income generation. Supervise, advise and assist community therapy assistants Recommend and assist with implementation of adaptations to HH member's homes, communities, work areas, or schools | <ul style="list-style-type: none"> Develop a responsive disability information system and database in consultation with nurse, generalist doctor, disabled people's organisations and community |



Learning Objective 2

To understand the services to be provided to individual HHs by the Outreach Team.

3. Services to households

There are services you and the Outreach Team should provide to the HHs in your community on an on-going basis. These services include some clinical services you are qualified to provide as well as non-clinical services such as patient education and referrals.

Your main responsibility is to ensure the team provides these services, and to provide the services yourself where the team members are not qualified or capable to do so.

3.1. Provision of clinical services

The clinical services provided by the team should cover the PHC Re-engineering package of services in the following areas:

- Women's reproductive health, including family planning
- Child health, including the integrated management of childhood illness
- Disease prevention by immunisation
- Sexually Transmitted Infections
- Comprehensive management and treatment of HIV and AIDS
- Tuberculosis
- Mental health and substance abuse
- Oral health
- Victims of abuse and violence
- Chronic disease and geriatric care
- Rehabilitation services



The details of what services are required for each area are documented in Table 2.

Also at the HH level, there are six service delivery priorities which include:

- Antenatal care
- Postnatal care
- Child health
- Chronic non-communicable diseases (NCDs)
- Support for victims of violence and injury
- Treatment adherence support

More details around these service delivery priorities are provided in sections below.

Table 2: Household components of the PHC package of services ³

| Health issue | Patient education provided by Outreach Team | Other services provided by Outreach Team |
|------------------------------------|--|---|
| Women's reproductive health | <ul style="list-style-type: none"> • Booking for delivery • Child preventive care • Child feeding and the introduction of solid food | <ul style="list-style-type: none"> • More detail around antenatal and postnatal services provided by the Outreach Team are described further in sections 6 and 7 below |
| | <ul style="list-style-type: none"> • Care of breasts • Vaginal bleeding and scars • Signs of hypertension, diabetes, anaemia • Return to usual physical efforts • Labour rights • Rights of the child • Provider initiated family planning | |
| | <ul style="list-style-type: none"> • Using support groups, community forums or special meetings • Patient's relatives and community receive information about the importance of antenatal care and institutional deliveries | |
| Child health | <ul style="list-style-type: none"> • Mother or caregiver should be counselled in accordance with Road to Health counselling guidelines • Key family/HH practices to improve child health are promoted as described in the Road to Health Booklet | |
| Disease prevention by Immunisation | <ul style="list-style-type: none"> • Immunisation services available at the PHC clinic | |
| Sexually Transmitted Infections | <ul style="list-style-type: none"> • All patients receive health education on asymptomatic STI, misconceptions and rationale for treatment, compliance and return visit • Time is given for counselling and for discussion after treatment about the need for contacts to be treated • If pregnant, the complications for the baby (congenital syphilis, ophthalmia neonatorum, HIV, chlamydia) • The importance of condom use • Female condoms • Safe sex counselling | |

| Health issue | Patient education provided by Outreach Team | Other services provided by Outreach Team |
|--|--|---|
| Comprehensive management and treatment of HIV/AIDS | <ul style="list-style-type: none"> • Information on the harmful effects of ignorance, fear and prejudice regarding patients with HIV/AIDS • Increase acceptance and use of condoms among youth and other sexually active populations • Safer sexual practices messaging | |
| Tuberculosis | <ul style="list-style-type: none"> • General information about TB • Information about HIV/AIDS/STIs • Counselling and testing for HIV • Community-based DOTS | <ul style="list-style-type: none"> • Verbal screening for TB • Treatment adherence support • Defaulter tracing • Referrals to Department of Social Development/Social Welfare when necessary • Collaboration with health facilities, NGOs, schools, private practitioners and workplaces in catchment area |
| Mental health and substance abuse | <ul style="list-style-type: none"> • General information about mental health and mental illness • How to recognise predisposing factors and conditions to prevent relapse • Information about ignorance, fear and prejudice regarding patients with severe psychiatric conditions | |
| Oral health | <ul style="list-style-type: none"> • General information about oral health | |
| Abuse and violence | <ul style="list-style-type: none"> • Information about the importance of referrals to accredited health practitioner | <ul style="list-style-type: none"> • Referrals to appropriate health care facility or Department of Social Development/Social Welfare |
| Chronic disease and geriatric care | <ul style="list-style-type: none"> • Outreach Team member must ensure that all community members and caretakers are supported and their capacity developed regarding self-care, self-monitoring, compliance, prevention of complications and management of disease | |
| Rehabilitation services | <ul style="list-style-type: none"> • Prevention of bedsores in debilitated patients and patients with sensory loss | |

A table including the available supporting guidelines for the PHC package of services may be found in the *Team Leader Job Aid, General Information*.



Learning Objective 3

To understand the Outreach Team’s responsibilities in delivering antenatal care services.

4. Antenatal Care (ANC)

Think Point

Think point: Why are we focusing on ANC?

As you will remember from Lesson 1 [Introduction to Role as OTL], it is both a global and South African priority to **reduce maternal and child mortality**.

NSDA Output 2: Decrease maternal and child mortality

MDG 4: Reduce child mortality

MDG 5: Improve maternal health



What is the role of the OTL in ANC service delivery?

As the OTL, it is your role to ensure that the entire PHC ANC package of services is delivered according to guidelines. While the CHW is mainly responsible for delivering these services at the HH level, you must:

1. Fully understand what the package of services includes
2. Fully understand what is expected of the CHW at each scheduled ANC HH visit

In order to do this, you must be aware of the ANC visit schedule and which CHW ANC visit checklist must be used at each visit. Once you know all of the details of the ANC package of services, you can adequately train, coach or mentor your CHW on how to do their job effectively. As part of this training, you must ensure your CHWs understand the need for women to book early for ANC at the clinic.

In addition to the visits that the pregnant mother makes to the clinic, the CHW must visit the pregnant woman at least **four** times during her pregnancy. These visits are very important in making sure that the mother gets the care and support she needs to stay healthy.

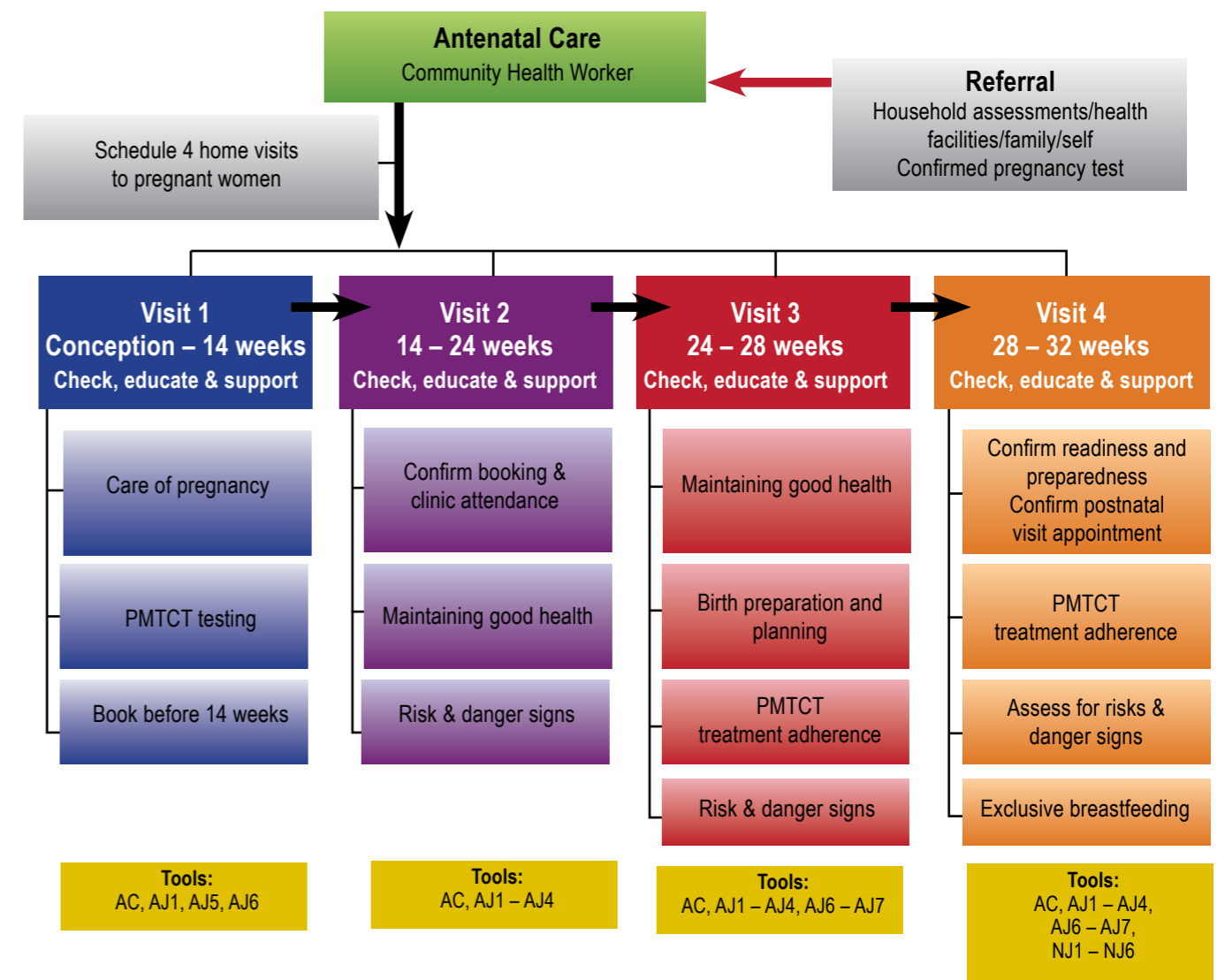
At each visit, the CHW will check if the mother completed her previous clinic appointment and if there were any specific instructions and that the mother followed these instructions. If the woman did not follow the instructions, the CHW must find out the reasons for this; discuss the importance of her keeping to the instructions and help her to make decisions and dates when she promises to complete the recommendations.



In addition, you must conduct at least one ANC visit yourself. If there are complications with the mother, you will have to conduct further visits based on her needs.

In Figure 1 below, you will find the comprehensive flow diagram of the CHW ANC visit process. For every visit, the CHW must check the HH member’s health, educate and support them. Thereafter, each visit includes different services and requires different checklists.

Figure 1: CHW ANC visit process ¹⁹



All tools specified in Figure 1 above may be found in the *CHW Household Tools*.

4.1. ANC visit checklists

At each ANC visit, the CHW must complete an ANC checklist to ensure that they have completed all required actions. You must be completely familiar with the items required at each visit so it is important that we talk through each checklist. All checklists may also be found in the *CHW Household Tools*.

Figure 2: ANC CHW Visit 1 checklist (conception – 14 weeks)¹⁹

| ANTENATAL VISIT 1 CHECKLIST | | |
|--|-------------|-----------------|
| At this visit, you will check if the mother went to the clinic to confirm her pregnancy. You should also check if there were any specific instructions and that the mother has followed them. If there were and she did not, find out the reasons for her not doing so and discuss the importance of her following these instructions. Help her to make up her mind about when she will complete the recommendations. You will then carry out the following specific actions for this visit: | | |
| Antenatal Visit 1 | | |
| Conduct this visit within the first 14 weeks of pregnancy | | |
| | Done | Not done |
| 1. Mother has booked at an ANC clinic | | |
| 2. If not booked, encourage her to book as soon as possible but before 14 weeks of pregnancy | | |
| 3. Educate mother on how to take care of herself during her pregnancy | | |
| a. Getting enough rest and doing basic exercises | | |
| b. Healthy eating during pregnancy | | |
| c. Not drinking alcohol and not smoking | | |
| d. Getting immunised against tetanus | | |
| e. Iron, folic acid and vitamin A | | |
| f. Micronutrient supplementation | | |
| g. Importance of going to the clinic for at least four ANC visits | | |
| 4. Prevention of mother-to-child transmission of HIV (PMTCT) | | |
| a. Educate the mother about | | |
| i. HIV infection | | |
| ii. How to prevent HIV infection | | |
| iii. How to prevent HIV infection from getting worse | | |
| iv. PMTCT | | |
| v. HIV testing | | |
| b. Discuss any concerns she may have | | |
| c. Encourage mother about the advantages of HIV testing | | |
| d. Refer the mother for further counselling and testing at the local PHC clinic | | |
| e. Discuss signs of Sexually Transmitted Infections (STIs) and the tests that are carried out to look for these | | |
| f. Explain the importance of her having full screening for STIs during ANC | | |

Figure 3: ANC CHW Visit 2 checklist (14 weeks – 24 weeks)¹⁹

| ANTENATAL VISIT 2 CHECKLIST | | |
|--|-------------|-----------------|
| At this visit, you will check if the mother completed her previous clinic appointment. You should also check if there were any specific instructions and that the mother has followed them. If there were and she did not, find out the reasons for her not doing so and discuss the importance of her following these instructions. Help her to make up her mind about when she will complete the recommendations. You will then carry out the following specific actions for this visit: | | |
| Antenatal Visit 2 | | |
| Conduct this visit during 14 – 24 weeks of pregnancy | | |
| | Done | Not done |
| 1. Check with the mother that she registered at the PHC clinic and that she has completed first ANC clinic visit | | |
| 2. Check if any tests were done and if any recommendations were made | | |
| 3. Remind and discuss with the mother | | |
| a. The importance of healthy eating and exercise during pregnancy | | |
| b. That she should cut back on doing very tiring exercises | | |
| c. To do suitable antenatal exercises during pregnancy that are shown at the clinic | | |
| 4. Educate family on the danger signs (i.e. lots of swelling or swelling that increases quickly; pale colour, bleeding; severe dizziness; headaches; she can't feel the baby move) | | |
| 5. Encourage mother to ensure that silent complications are checked for at the clinic (including blood pressure, testing urine, testing blood for haemoglobin and blood group and other tests for safety of baby, STIs, Hepatitis B) | | |



Figure 4: ANC CHW Visit 3 checklist (24 weeks – 28 weeks)¹⁹

| ANTENATAL VISIT 3 CHECKLIST | | |
|---|------|----------|
| At this visit, you will check if the mother completed her previous clinic appointment. You should also check if there were any specific instructions and that the mother has followed them. If there were and she did not, find out the reasons for her not doing so and discuss the importance of her following these instructions. Help her to make up her mind about when she will complete the recommendations. You will then carry out the following specific actions for this visit: | | |
| Antenatal Visit 3 | | |
| Conduct this visit during 24 – 28 weeks of pregnancy | | |
| | Done | Not done |
| 1. Check if the mother has completed the second antenatal clinic appointment and the recommended tests were done | | |
| 2. Check mothers card for any specific recommendations or abnormal observations | | |
| 3. Discuss with the whole family and encourage them to prepare for the birth and for any emergency, especially the importance of making sure that the baby is born at a hospital. Get the family to make suggestions about which clinic they would prefer the delivery to take place at and help them make arrangements for transport in case of emergency | | |
| 4. PMTCT | | |
| a. Make sure that HIV-positive mother is taking antiretroviral medicines exactly as prescribed by the health care workers. Encourage her to disclose her HIV status and talk to her partner about the importance of disclosing his HIV status as well | | |
| b. Discuss HAART with HIV-positive mothers and encourage them to take their medicines exactly as prescribed if they qualify, so that they can protect themselves and their babies | | |
| c. Ask mother if she has any genital discharge, ulcerations, sores or rashes | | |
| d. Encourage the partner to go for regular screening and testing for STIs and HIV (if possible) | | |
| 5. Infant care | | |
| a. Discuss infant feeding options | | |
| b. Encourage six months exclusive breastfeeding even for HIV-positive mothers and those of unknown status | | |
| c. Help HIV-positive mothers to think about what would be the best infant feeding option for her baby | | |
| a. Discuss infant immunisation | | |
| 6. Develop birth and emergency plan | | |
| a. Discuss birth plan | | |
| b. Place of birth | | |
| c. Support during labour | | |
| d. Homecoming arrangements | | |
| e. Plans to care for the baby if the mother is returning to work | | |

Figure 5: ANC CHW Visit 4 checklist (28 weeks – 32 weeks)¹⁹

| ANTENATAL VISIT 4 CHECKLIST | | |
|---|------|----------|
| At this visit, you will check if the mother completed her previous clinic appointment. You should also check if there were any specific instructions and that the mother has followed them. If there were and she did not, find out the reasons for her not doing so and discuss the importance of her following these instructions. Help her to make up her mind about when she will complete the recommendations. You will then carry out the following specific actions for this visit: | | |
| Antenatal Visit 4 | | |
| Conduct this visit during 28 – 32 weeks of pregnancy | | |
| | Done | Not done |
| 1. Check that mother has completed third ANC clinic visit | | |
| 2. Check if any tests were done and any recommendations were made | | |
| 3. Check mother's card for weight and blood pressure at last ANC clinic visit | | |
| 4. Check for any danger signs (e.g. genital discharge, ulcers or sores, rashes, bleeding, swelling, pale colour, the baby not moving, moving less than usual or moving a lot more than usual) | | |
| 5. Birth and emergency preparedness plans | | |
| a. Check that the plans have been agreed upon with family and key players | | |
| b. Make a note of any difficulty that may exist and discuss these your Team Leader | | |
| 6. Make appointment to see mother and baby on day (1) of delivery after they leave the health facility | | |
| 7. Encourage partner screening for STI and testing for HIV, regardless of the mother's HIV status | | |
| 8. PMTCT | | |
| a. Check if the HIV-positive mother has started on antiretroviral medicines and that she is taking them exactly as prescribed by health care workers | | |
| b. If HIV-positive mother has not qualified for antiretroviral medicines, check that arrangements and preparations have been made, including medicines, for preventing HIV from being passed from the mother to the baby | | |
| c. Encourage mother to disclose her HIV status to her partner | | |
| d. For HIV-positive mothers, ask about any problems she may have in following the recommendations made at the clinic and discuss and agree on how to fix them | | |
| 9. Infant care | | |
| a. Discuss and make sure that she has decided on infant feeding options | | |
| b. Encourage and motivate mother to exclusively breastfeed for six months | | |
| c. For HIV-positive mothers, help her to think about the best feeding option for her baby | | |
| d. Discuss infant immunisation and explain that immunisations will keep the baby safe and healthy | | |

Brainstorm

Discuss in the group which checklists are to be used for the following scenarios:

Scenario 1: CHW identifies a pregnant woman who is 17 weeks pregnant and has never been visited before. Which checklist must the CHW complete?

Handwritten lines for notes.

Scenario 2: CHW identifies a pregnant woman who is 24 weeks pregnant and has been visited once before. Which checklist must the CHW complete?

Handwritten lines for notes.

Scenario 3: You visit a HH where there is a 36 week pregnant woman who has never been visited before. Which checklist(s) must the CHW complete?

Handwritten lines for notes.

Consider ways in which you would train your CHWs on how and when to use these checklists. What challenges might you be faced with? What skills will you use to train them?

Handwritten lines for notes.



Learning Objective 4

To understand the Outreach Team's responsibilities in delivering postnatal care services.

5. Postnatal care (PNC)

Again, to reduce the maternal and child mortality as per the NSDA and MDGs, it is important that all women who have given birth are followed-up at home. This is another major service delivery priority for the Outreach Team.

The CHW must provide PNC for the mother and the new baby by visiting the new mother and baby at least four times in the first six months after delivery. This is important because most problems that occur with mothers and babies happen in the first six months after birth. The CHW must also make sure that the mother and the family know what danger signs to look out for in both the mother and the baby and make sure they get taken to the clinic as soon as possible if any of these danger signs are noticed.

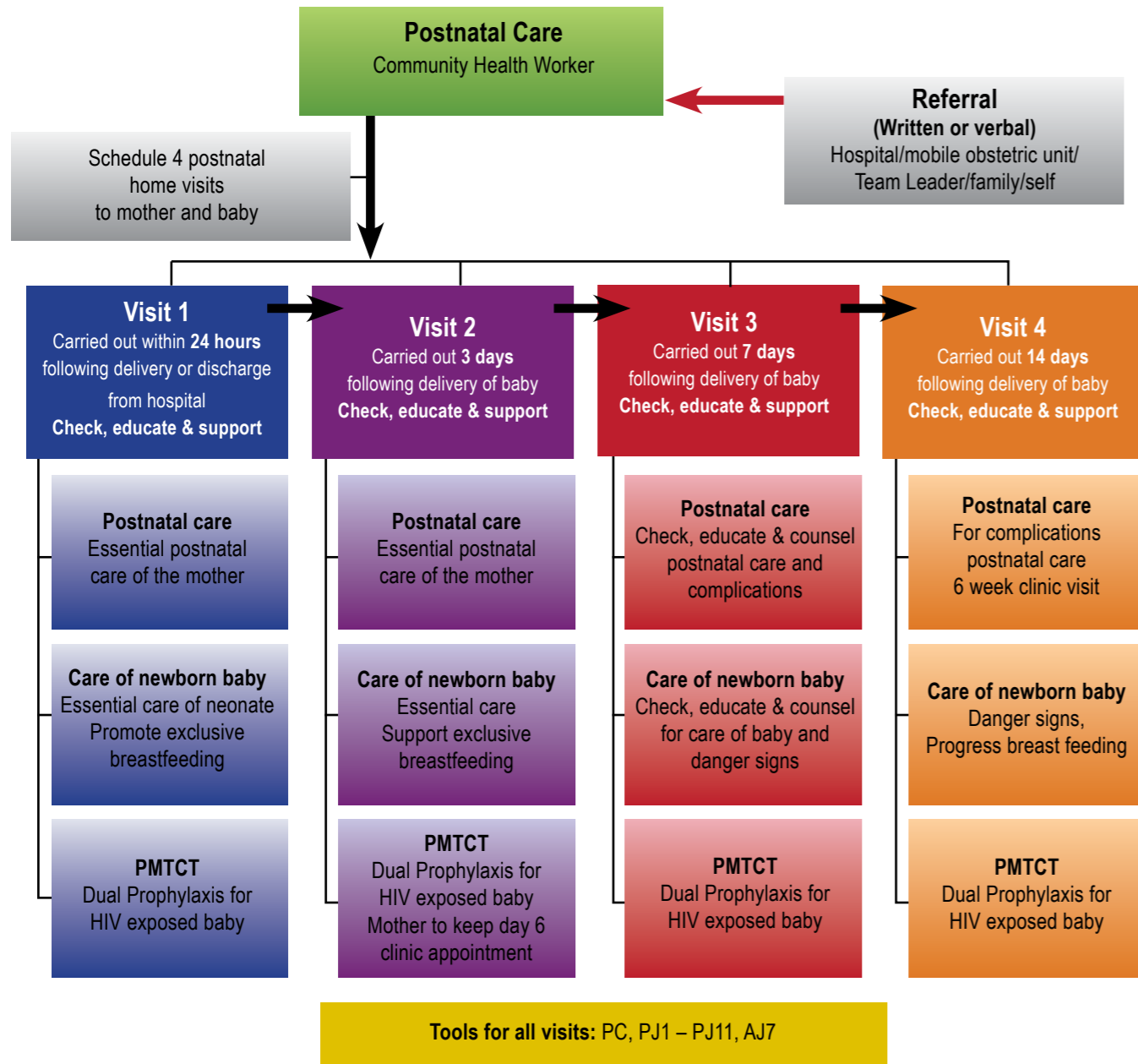


In Figure 6 below, you will find the comprehensive flow diagram of the CHW PNC visit process. For each visit, the CHW must check the HH member's health, educate and support them, provide postnatal care, care to the new born baby and PMTCT services when appropriate.

In addition, you must conduct at least one PNC visit yourself. If there are complications with the mother and/or baby, you will have to conduct further visits based on their needs.



Figure 6: CHW PNC visit process ¹⁹



All tools specified in Figure 6 above may be found in the *CHW Household Tools*.

5.1. PNC Visit Checklists

At each PNC visit, the CHW must complete a PNC checklist to ensure that they have completed all required actions. You must be completely familiar with the items required at each visit so it is important that we talk through each checklist.

There is an additional checklist for a woman who has had a miscarriage or stillbirth. All checklists may be found in the *CHW Household Tools*.

Figure 7: PNC CHW Visit 1 checklist (within 24 hours after delivery) ¹⁹

| POSTNATAL VISIT 1 CHECKLIST | | |
|--|------|----------|
| Most mothers are discharged the same day that they deliver their baby. It is important to visit mothers who have delivered with their babies the same day to help them settle in. It is also important to look for and tell the mother what the danger signs for both she and her baby are and that she needs to look out for these danger signs. The first 24 hours following delivery are the most important period for the safety of both mothers and babies because it is during this time that problems can happen. | | |
| Conduct this visit within 24 hours following delivery | | |
| | Done | Not done |
| Care of mother | | |
| 1. Check for bleeding | | |
| 2. Ask about signs of infection | | |
| 3. Look for engorged breasts or mastitis | | |
| 4. Ask about depression | | |
| 5. Tell the family what the danger signs are and the care that the mother will need | | |
| 6. Refer in case of any complications or if she has any of the warning signs | | |
| 7. Make sure that the family understands the importance of getting help if the mother or the baby have any of the danger signs | | |
| Care of newborn | | |
| 8. Conduct routine postnatal care of the newborn | | |
| 9. Check the breathing and colour; tell the mother what the danger colours are (i.e. pale look, grey, yellow, blue or darker than before) and show the mother on how to check the baby | | |
| 10. Teach mother how to bathe the baby; how to clean the baby's eyes and on how to care for the umbilical cord | | |
| 11. Teach mother on danger signs (i.e. discharge, bleeding, yellowness of eyes and skin, blue colour of skin and eyes, baby not moving, not responding or being very irritable) | | |
| 12. Show the mother how to keep the baby warm, even during feeding; encourage skin to skin contact and head cover | | |
| 13. Remind the mother that poor feeding, or the baby not feeding at all, are danger signs to be aware of | | |
| 14. Encourage exclusive breastfeeding; help mother to be comfortable with breastfeeding and help the working mother to continue exclusive breastfeeding | | |
| 15. Demonstrate how to encourage and talk to the baby | | |
| PMTCT | | |
| 16. Make sure babies of HIV-positive mothers are receiving their antiretroviral medicine | | |
| 17. Make appointment to see mother and baby again on day 3 | | |

Lesson 3

3 Postnatal care (PNC)

Figure 8: PNC CHW Visit 2 checklist (3 days after delivery)¹⁹

| POSTNATAL VISIT 2 CHECKLIST | | |
|--|------|----------|
| You conduct this visit on the third day after delivery. During the visit, you will carry out the following: | | |
| | Done | Not done |
| Postnatal care | | |
| 1. Ask how the last 3 days have gone | | |
| 2. Tell the family what the danger signs are and the care that the mother will need | | |
| a. Conduct basic routine postnatal care of mother | | |
| b. Check for bleeding | | |
| c. Ask about signs of infection | | |
| d. Look for engorged breasts or mastitis | | |
| e. Ask about depression | | |
| f. Refer in case of any complications or if she has any of the warning signs | | |
| g. Make sure that the family understands the importance of getting help if the mother or the baby have any of the danger signs | | |
| Care of newborn | | |
| 3. Conduct routine postnatal care of the newborn | | |
| 4. Check the breathing and colour; tell the mother what the danger colours are (i.e. pale look, grey, yellow, blue or darker than before) and show the mother on how to check the baby | | |
| 5. Check how the mother is managing with bathing the baby; cleaning the baby's eyes and caring for the umbilical cord | | |
| 6. Remind mother of danger signs (i.e. discharge, bleeding, yellowness of eyes and skin, blue colour of skin and eyes, baby not moving, not responding or being very irritable) and check if any of these have started since your last visit | | |
| 7. Check how the mother is managing with breastfeeding; help her sort out any problems that she may be having | | |
| 8. Encourage and support the mother to continue with exclusive breastfeeding | | |
| 9. Check that the mother maintains the warmth of the baby even during feeding; encourage skin to skin contact and head cover | | |
| 10. Remind the mother that poor feeding, or the baby not feeding at all, are danger signs to be aware of | | |
| PMTCT | | |
| 11. Make sure that babies whose mothers are HIV-positive are taking their antiretroviral medicine | | |
| 12. Remind mother that she needs to take the baby to the clinic when the baby is 6 days old | | |
| 13. Make appointment to see mother and baby again on day 7 | | |

Lesson 3

3 Postnatal care (PNC)

Figure 9: PNC CHW Visit 3 checklist (7 days after delivery)¹⁹

| POSTNATAL VISIT 3 CHECKLIST | | |
|---|------|----------|
| You will conduct this visit on the seventh day following delivery and carry out the following: | | |
| | Done | Not done |
| Postnatal care | | |
| 1. Ask how the last 7 days have gone | | |
| 2. Conduct basic routine postnatal care of mother | | |
| 3. Check for bleeding | | |
| 4. Ask about signs of infection | | |
| 5. Look for engorged breasts or mastitis | | |
| 6. Ask about depression | | |
| 7. Tell the family what the danger signs are and the care that the mother will need | | |
| 8. Refer in case of any complications or if the mother or baby have any of the warning signs | | |
| 9. Remind mother of danger signs and where to get help if she sees any of the danger signs | | |
| Care of newborn | | |
| 10. Conduct routine postnatal care of the newborn | | |
| 11. Check the breathing and colour; tell the mother what the danger colours are (i.e. pale look, grey, yellow, blue or darker than before) and show the mother on how to check | | |
| 12. Check how the mother is managing with bathing the baby; cleaning the baby's eyes and caring for the umbilical cord | | |
| 13. Remind mother of danger signs (i.e. discharge, bleeding, yellowness of eyes and skin, blue colour of skin and eyes, baby not moving, not responding or being very irritable) and check if any of these have started since your last visit | | |
| 14. Check how the mother is managing with breastfeeding; help her sort out any problems that she may be having | | |
| 15. Encourage and support the mother to continue with exclusive breastfeeding | | |
| 16. Check that the mother maintains the warmth of the baby even during feeding; encourage skin to skin contact and head cover | | |
| 17. Remind the mother that poor feeding, or the baby not feeding at all, are danger signs to be aware of | | |
| PMTCT | | |
| 18. Make sure that babies whose mothers are HIV-positive are taking their antiretroviral medicine | | |
| 19. Remind mother that she needs to take the baby to the clinic for the next clinic visit | | |
| 20. Make appointment to see mother and baby again on day 14 | | |

Lesson 3

3 Postnatal care (PNC)

Figure 10: PNC CHW Visit 4 checklist (14 days after delivery)¹⁹

| POSTNATAL VISIT 4 CHECKLIST | | |
|---|------|----------|
| You will conduct this visit on the fourteenth day following delivery and carry out the following: | | |
| | Done | Not done |
| Postnatal care | | |
| 1. Ask how the last 7 days have gone | | |
| 2. Conduct basic routine postnatal care of mother | | |
| 3. Check for bleeding | | |
| 4. Ask about signs of infection | | |
| 5. Look for engorged breasts or mastitis | | |
| 6. Ask about depression | | |
| 7. Tell the family what the danger signs are and the care that the mother will need | | |
| 8. Refer in case of any complications or if the mother or baby have any of the warning signs | | |
| 9. Remind mother of danger signs and where to get help if she sees any of the danger signs | | |
| Care of newborn | | |
| 10. Conduct routine postnatal care of the newborn | | |
| 11. Check the breathing and colour; tell the mother what the danger colours are (i.e. pale look, grey, yellow, blue or darker than before) and show the mother on how to check | | |
| 12. Check how the mother is managing with bathing the baby; cleaning the baby's eyes and caring for the umbilical cord | | |
| 13. Remind mother of danger signs (i.e. discharge, bleeding, yellowness of eyes and skin, blue colour of skin and eyes, baby not moving, not responding or being very irritable) and check if any of these have started since your last visit | | |
| 14. Check how the mother is managing with breastfeeding; help her sort out any problems that she may be having | | |
| 15. Encourage and support the mother to continue with exclusive breastfeeding | | |
| 16. Check that the mother maintains the warmth of the baby even during feeding; encourage skin to skin contact and head cover | | |
| 17. Remind the mother that poor feeding, or the baby not feeding at all, are danger signs to be aware of | | |
| PMTCT | | |
| 18. Make sure that babies whose mothers are HIV-positive are taking their antiretroviral medicine | | |
| 19. Remind mother that she needs to take the baby to the clinic for the next clinic visit | | |
| 20. Make appointment to see mother and baby again in 6 weeks | | |

Lesson 3

3 Postnatal checklist for woman who has had a stillbirth or miscarriage

Figure 11: Postnatal checklist for woman who has had a stillbirth or miscarriage

| POSTNATAL CHECKLIST FOR A WOMAN WHO HAS HAD A STILLBIRTH OR MISCARRIAGE | | |
|---|------|----------|
| It is very important that you provide support and care to a woman who has had a miscarriage or a stillbirth. Having a miscarriage or a stillbirth may be very difficult for women to cope with. Some women may experience physical symptoms from their emotional distress. These symptoms include: tiredness, trouble sleeping, problems concentrating, not feeling like eating, and crying very often. | | |
| The emotional effects can usually take longer to heal than the physical effects. It is your responsibility to help the woman understand these feelings are normal and to make sure she gets the care and support she needs. | | |
| Conduct first postnatal visit within 24 hours after discharge, and then on Days 3, 7 and 14 | | |
| | Done | Not done |
| 1. Check for bleeding | | |
| 2. Ask about cramping | | |
| 3. Ask about signs of infection | | |
| 4. Look for engorged breasts or mastitis | | |
| 5. Check that the flow of breast milk is getting less | | |
| 6. Tell the family what the danger signs are and the care that the woman will need | | |
| 7. Refer in case of any complications or if she has any of the danger signs | | |
| 8. Make sure that the family understands the importance of getting help if the woman has any of the danger signs | | |
| 9. Ask about depression | | |
| 10. Listen to what the woman says, provide psychosocial support | | |
| 11. Tell her it is OK to: | | |
| a. talk about how she is feeling | | |
| b. talk about the loss of the baby | | |
| c. cry if she feels sad and feels like crying | | |
| 12. Make sure the family is supportive of her feelings | | |
| 13. If the woman is very depressed refer her for counselling | | |
| 14. Make an appointment to see her on: | | |
| a. Day of discharge | | |
| b. Day 3 | | |
| c. Day 7 | | |
| d. Day 14 | | |

Brainstorm

Discuss in the group which checklists are to be used for the following scenarios:

Scenario 1: The HH member has delivered her baby at 2:00AM this morning. Which checklist must the CHW complete?

Scenario 2: The HH member has delivered her baby 5 days ago and she has not been visited at all since delivery. Which checklist must the CHW complete?

Scenario 3: The HH member has had a miscarriage at 28 weeks into the pregnancy. Will you still visit her? What checklist would you use? What are the most important services to provide?

Scenario 4: The HH member has had a stillbirth at full term. Will you still visit her? What checklist would you use? What are the most important services to provide?

Consider ways in which they would train your CHWs on how and when to use these checklists? What challenges might you be faced with? What skills will you use to train them?



Learning Objective 5

To understand the Outreach Team's responsibilities in delivering child health services.

6. Child health

In order to reduce childhood mortality, the third service delivery priority for the Outreach Team is child health and the integrated management of childhood illness. The CHW is primarily responsible for delivering these services to children under five within HHs and it is your responsibility, as the OTL, to ensure that all services are delivered at the highest standard possible and according to the PHC guidelines.

Child health services provided by the Outreach Team include:

1. Guide parents through the use of the Road to Health Booklet
 - a. Monitor growth and developmental milestones
 - b. Ensure baby/child has received all required immunisations
 - c. Check, educate and support mother on the need for Vitamin A supplementation, de-worming treatment
 - d. Provide guidance on parenting (e.g. safety, appropriate parenting methods)
2. Check, educate and support the mother with child nutrition
3. Integrated management of childhood illnesses, including:
 - a. TB
 - b. Fever
 - c. Cough
 - d. Vomiting
 - e. Diarrhoea
 - f. Pneumonia
 - g. Malnutrition



It is important to note that child nutrition and the integrated management of childhood illnesses are also included in the Road to Health Booklet, yet both are elaborated on further in sections 6.2 and 6.3.

6.1. Road to Health Booklet

The Road to Health Booklet (RTHB) gives the child's medical history, the list of immunisations the child has had, how the child should be developing and growing and the growth record of the child. Growth is plotted on a growth chart which is part of the RTHB. The RTHB could assist in improving health through making sure that the child gets all the necessary immunisations and finding out early if the child is not growing and developing as he/she should.⁸

The Road to Health Booklet (often referred to as the Clinic Card or Health of Baby Card), is given to the mother when a baby is born. For babies who are not born in clinics or hospitals, the mother or caregiver will be given a RTHB the

first time they take the baby to the clinic.⁸

Mothers must keep this RTHB safe and show it to the doctor or nurse every time the child is taken to the clinic or hospital. Remember this is not a hospital card, but it is needed every time the child goes to the clinic or hospital.⁸

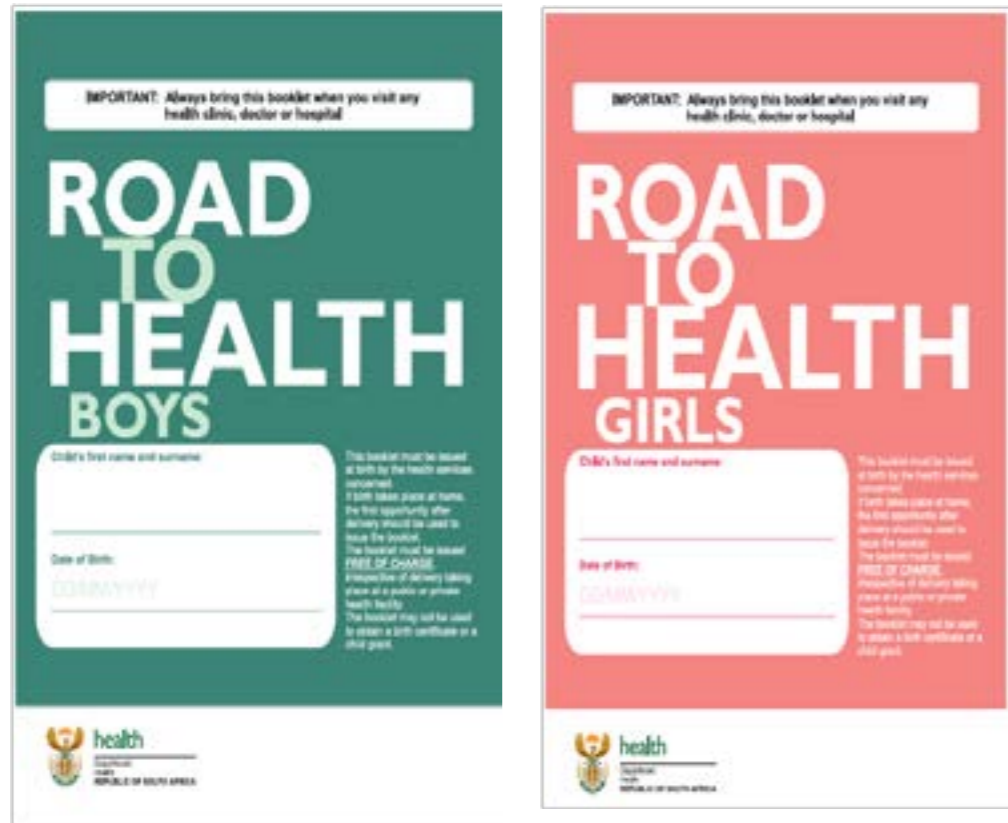
Doctors and nurses will check the RTHB to see:⁸

- If the child received the necessary immunisations
- If the child received the necessary Vitamin A supplementation and de-worming treatment
- The growth of the child
- The child's development according to the milestones for a growing child
- Whether the child requires additional care related to possible HIV infection

It is important to note that the CHWs are not responsible for completing the RTHB but rather to talk to the mother about the RTHB every time they have a scheduled home visit. The sections of the RTHB that are most relevant to the Outreach Team are described further below.⁸

The boy and girl child specific RTHBs shown in Figure 12 below were launched in 2011. Children born before 2011 will have the older RTHB. However, some children born in 2011 may still have the old RTHB.

Figure 12: Cover of RTHB²⁰



The first section of the RTHB includes well child visits for children under 5.

Figure 13: Pages 2 and 3 of RTHB – Well child visits²⁰

| WELL CHILD VISITS – RECORDING SHEET FOR CHILDREN LESS THAN 5 YEARS OLD | | | | | | | | | | |
|---|------|-------------------------|-------------------------------------|------------------|---|--|--------------------|--------------------|-----------------------|-----------------------|
| Record the following information for each visit on the spaces that are not shaded. Refer to the page numbers given in this booklet and complete the relevant section. | | | | | | Remember to check the following. Tick if done, and record details on the relevant page | | | | Date of next visit |
| Age | Date | Growth (IMCI) (page 14) | PMTCT/ HIV status (IMCI) (page 7&8) | TB status (IMCI) | Feeding (EBF/EFF/ mixed feeding for first 6 months) | Immunisations (page 6) | Vitamin A (page 9) | Deworming (page 9) | Development (page 13) | Oral Health (page 20) |
| 3 days | | | | | | | | | | |
| 6 wks | | | | | | | | | | |
| 10 wks | | | | | | | | | | |
| 14 wks | | | | | | | | | | |
| 4 mths | | | | | | | | | | |
| 5 mths | | | | | | | | | | |
| 6 mths | | | | | | | | | | |
| 7 mths | | | | | | | | | | |
| 8 mths | | | | | | | | | | |
| 9 mths | | | | | | | | | | |
| 10 mths | | | | | | | | | | |

| Age | Date | Growth (IMCI) (page 14) | PMTCT/ HIV status (IMCI) (page 7&8) | TB status (IMCI) | Feeding (EBF/EFF/ mixed feeding for first 6 months) | Immunisations (page 6) | Vitamin A (page 9) | Deworming (page 9) | Development (page 13) | Oral Health (page 20) | Date of next visit |
|---------|------|-------------------------|-------------------------------------|------------------|---|------------------------|--------------------|--------------------|-----------------------|-----------------------|--------------------|
| 11 mths | | | | | | | | | | | |
| 12 mths | | | | | | | | | | | |
| 14 mths | | | | | | | | | | | |
| 16 mths | | | | | | | | | | | |
| 18 mths | | | | | | | | | | | |
| 20 mths | | | | | | | | | | | |
| 22 mths | | | | | | | | | | | |
| 2 yrs | | | | | | | | | | | |
| 2.5 yrs | | | | | | | | | | | |
| 3 yrs | | | | | | | | | | | |
| 3.5 yrs | | | | | | | | | | | |
| 4 yrs | | | | | | | | | | | |
| 4.5 yrs | | | | | | | | | | | |
| 5 yrs | | | | | | | | | | | |

The next section is meant to ensure that the baby's birth has been registered.

Figure 14: Page 4 of RTHB – Details of Child and Family (to be completed at birth) ²⁰



| DETAILS OF CHILD AND FAMILY (To be completed at birth) | |
|---|---|
| Child's first name and surname: _____ | |
| Child's ID number: | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Mother's ID number: | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |
| Date of birth dd / mm / yyyy | Name of facility where child was born: |
| Child's residential address: | |
| Mother's name: | Mother's birth date: |
| Father's name: | Who does the child live with? |
| How many children has the mother had (including this child?) | |
| Number born (including stillbirths) <input type="text"/> | Reason(s) for death(s): |
| Number alive now <input type="text"/> | Date information given: / / / dd mm yyyy |
| Child in need of special care (mark with X) (Complete at delivery or at first contact with health services) | |
| Is the baby a twin, triplet, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No | Does the mother need additional support to care for the child? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Any disability present (including birth defects?) (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: (Specify) |

The information in the next section on neonatal care is important for the health care workers at the clinic. The only part that the CHW should look at during their home visits is how the mother is feeding the baby. The CHWs are required to give the mother support and to refer the mother to clinic if the CHW is unable to assist.



Figure 15: Page 5 of RTHB – Neonatal information ²⁰

| NEONATAL INFORMATION | | |
|--|--|------------------------------|
| Birth weight: | Birth length: | Head circumference at birth: |
| Gestational age (weeks) | Mother's blood group | Mother's RPR |
| Antenatal (Maternal history): | Intrapartum (including mode of delivery) | |
| APGAR | 1 min | 5 min |
| Neonatal problems: (identify high risk problems): | | |
| Neonatal Feeding: <input type="checkbox"/> Exclusive breast <input type="checkbox"/> Exclusive formula | | |
| Special care plan / input required (e.g. Kangaroo Mother Care) | | |
| Specify: | | |
| | | |
| | | |
| | | |
| | | |
| Post-discharge plan (if baby was admitted in a neonatal ward/premature): | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Next, CHWs must regularly check the RTHB to remind the mother to take the child to the clinic to be immunised, as per the immunisation schedule (refer to the RTHB for the full immunisation schedule). If a child has missed any of the immunisations, the mother must be told to take the child back to the clinic to catch up on the missed immunisation. It is important that the child gets these immunisations.



Figure 16: Page 6 of RTHB – Immunisation schedule ²⁰

| IMMUNISATIONS | | | | | |
|-------------------|-----------|---------------|---|---------------------|-----------|
| Name and surname: | | | ID number: | | |
| | | | [] | | |
| Age group | Batch no. | Vaccine | Site | Date given dd/mm/yy | Signature |
| Birth | | BCG | Right arm | | |
| | | OPV0 | Oral | | |
| 6 weeks | | OPV1 | Oral | | |
| | | RV1 | Oral | | |
| | | DTaP-IPV-Hib1 | Left thigh | | |
| | | Hep B1 | Right thigh | | |
| | | PCV 1 | Right thigh | | |
| 10 weeks | | DTaP-IPV-Hib2 | Left thigh | | |
| | | Hep B2 | Right thigh | | |
| 14 weeks | | DTaP-IPV-Hib3 | Left thigh | | |
| | | Hep B3 | Right thigh | | |
| | | PCV2 | Right thigh | | |
| 9 months | | RV2 | Oral | | |
| | | Measles1 | Left thigh | | |
| 18 months | | PCV3 | Right thigh | | |
| | | DTaP-IPV-Hib4 | Left arm | | |
| 6 years | | Measles2 | Right arm | | |
| 12 years | | Td | Left arm | | |
| | | | | | |
| | | | | | |
| | | | | | |

| <u>HEAD CIRCUMFERENCE AT 14 WEEKS AND AT 12 MONTHS</u> | |
|--|---------------------------------------|
| 14 Weeks: _____ (Range: 38 - 43 cm) | 12 Months: _____ (Range: 43.5 - 48.5) |
| REFER if head circumference is outside range | |

It is important that the mother has had an HIV test as soon as she finds out that she is pregnant.

- If she is HIV-positive, the CHW must ensure she knows how to give the baby ARVs
- If she is HIV-negative, the CHW must discuss the importance of her staying HIV-negative and engaging in safer sex
- If she does not know her HIV status, the CHW must talk to her about the importance of knowing her HIV status for her health and for the health of her baby

Figure 17: Page 7 of RTHB – PMTCT information ²⁰

| PMTCT/HIV INFORMATION | | | |
|---|---|--|---|
| Child's first name and surname: | | | |
| [] | | | |
| Child's ID Number: [] | | | |
| Fill in this section on discharge from Midwife Obstetric Unit (MOU) or obstetric ward or at first subsequent visit if not yet done | | | |
| Mother's latest HIV test result | <input type="checkbox"/> Positive | <input type="checkbox"/> Negative | <input type="checkbox"/> To be done |
| When did mother have the test? | <input type="checkbox"/> Before pregnancy | <input type="checkbox"/> During pregnancy | <input type="checkbox"/> At delivery |
| Is the mother on life-long ART? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| If yes, duration of life-long ART at time of delivery | <input type="checkbox"/> < 4 weeks | <input type="checkbox"/> > 4 weeks | <input type="checkbox"/> Before pregnancy |
| Document ARVs the mother received: | | | |
| Did the mother receive infant feeding counseling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Decision about infant feeding | <input type="checkbox"/> Exclusive breast | <input type="checkbox"/> Exclusive formula | |
| Document Nevirapine given: | | | |
| [] | | | |
| All HIV exposed infants should receive Nevirapine for a minimum of 6 weeks | | | |
| Has the mother disclosed to anyone in the household? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Has the mother's partner been tested? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Remember to offer testing for all the mother's other children if not yet done | | | |
| Offer a mother with unknown HIV status a rapid HIV test. | | | |
| If mother's HIV rapid test is positive, perform an HIV DNA PCR test on infant if ≥ 6/52 | | | |

HIV is a major cause of child mortality in South Africa. Some children may get infected with HIV from the mother during pregnancy, birth process or breastfeeding.

All infants who have been exposed to HIV should receive nevirapine every day to make breastfeeding safer. This should be continued until stopped by a health care worker. Page 8 of the RTHB is to be completed if the infant is exposed to HIV.

Figure 18: Page 8 of RTHB – If infant is exposed to HIV ²⁰

| Fill in this section if infant is HIV exposed | | | |
|---|--|---|--|
| 6 week visit | | | |
| What feeds has the infant received? <input type="checkbox"/> Exclusive breast <input type="checkbox"/> Exclusive formula <input type="checkbox"/> Mixed feeding | | | |
| HIV PCR test done? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Date: _____ | |
| Cotrimoxazole started? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Affix NHLS tracking barcoded sticker here | |
| Infant feeding discussed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Has the child received Nevirapine? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes: <input type="button" value="Stop now"/> <input type="button" value="Continue"/> | |
| Stop Nevirapine if the mother is on life-long ART or the child has stopped breastfeeding. If not, continue until breastfeeding stops | | | |
| 10 week visit, or earlier if ill | | | |
| PCR result <input type="button" value="Positive"/> <input type="button" value="Negative"/> | | | |
| Post test counseling done? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Referred for ART? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Stop Nevirapine if PCR is positive | |
| Cotrimoxazole given? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Has child received Nevirapine? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes: <input type="button" value="Stop now"/> <input type="button" value="Continue"/> | |
| Encourage a mother whose baby is HIV positive to continue breastfeeding | | | |
| Retest HIV negative children 6 weeks after cessation of breastfeeding, or if clinical suspicion. | | | |
| An HIV exposed child should be retested with a rapid HIV Antibody test at 18 months | | | |
| Repeat PCR test <input type="checkbox"/> Positive <input type="checkbox"/> Negative | | Date: _____ | |
| Post test counseling done? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Referred for ART <input type="checkbox"/> Yes <input type="checkbox"/> No | | Stop Nevirapine if PCR is positive | |
| Cotrimoxazole given? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Has child received Nevirapine? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If yes: <input type="button" value="Stop now"/> <input type="button" value="Continue"/> | |

Vitamin A has been found to reduce childhood illness so it is important that the CHWs discuss vitamin A supplementation with mothers.

Figure 19: Page 9 of RTHB – Vitamin A supplementation ²⁰



| VITAMIN A SUPPLEMENTATION | | | | | | | |
|--|------------|---------------------|-----------|---------|---------------------|-----------|-----------|
| | At age | Date given dd/mm/yy | Signature | At age | Date given dd/mm/yy | Signature | |
| 200 000 IU Mother at delivery (not later than 6-8 weeks) | | / / | | | | | |
| 100 000 IU | 6 mths | / / | | | | | |
| 200 000 IU every 6 months | 12 mths | / / | | 42 mths | / / | | |
| | 18 mths | / / | | 48 mths | / / | | |
| | 24 mths | / / | | 54 mths | / / | | |
| | 30 mths | / / | | 60 mths | / / | | |
| | 36 mths | / / | | | | | |
| ADDITIONAL DOSES: | | | | | | | |
| For conditions such as measles, severe malnutrition, xerophthalmia and persistent diarrhoea. Omit if dose has been given in last month. Measles and xerophthalmia: Give one dose daily for two consecutive days. Record the reason and dose given below. | | | | | | | |
| Date | Dose given | Reason | Signature | Date | Dose given | Reason | Signature |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Deworming is also important to ensure the baby/child is prevented from worms. The following is the deworming schedule which is included on the same page as the vitamin A supplementation schedule.

Figure 20: Page 9 of RTHB – Deworming treatment ²⁰

| DEWORMING TREATMENT (Mebendazole or Albendazole) | | | | | | |
|--|---------|---------------------|-----------|---------|---------------------|-----------|
| Dose | At age | Date given dd/mm/yy | Signature | At age | Date given dd/mm/yy | Signature |
| | 12 mths | / / | | 18 mths | / / | |
| | 24 mths | / / | | 48 mths | / / | |
| | 30 mths | / / | | 54 mths | / / | |
| | 36 mths | / / | | 60 mths | / / | |
| | 42 mths | / / | | | | |

Pages 10, 11 and 12 of the RTHB provide health promotion messaging around child feeding from birth up to five years of age. The CHW should explain the importance of exclusive breastfeeding children up to 6 months old and talk to the mother or caregiver about the need for complementary feeding in children over 6 months old.

In addition, information and directions on how to prepare and give a sugar/salt solution to children with diarrhoea is provided. It is important that the CHWs in your team understand these instructions and are able to help mothers follow these instructions should their children have diarrhoea.

It is important that the CHWs tell the mother to take the child to the clinic as soon as possible, and that the sugar/salt solution should only be used until they can get the child to the clinic.

Figure 21: Pages 10, 11 and 12 of RTHB – Health promotion messages ²⁰



| HEALTH PROMOTION MESSAGES | |
|---|--|
| Up to 6 months | |
| <p>Feeding:</p> <ul style="list-style-type: none"> Breastfeed <u>exclusively</u> (give infant only breast milk and no other liquids or solids, not even water, with exception of drops or syrup consisting of vitamins, mineral supplements or medication); Breastfeed as often as the child wants, day and night; Feed at least 8 to 12 times in 24 hours; When away from the child leave expressed breast milk to feed with a cup; Avoid using bottles or artificial teats (dummies) as this may interfere with suckling, be difficult to clean and may carry germs that can make your baby sick. | |
| Why is exclusive breastfeeding important? | |
| <ul style="list-style-type: none"> Other foods or fluids may damage a young baby's gut and make it easy for infections (including HIV) to get into the baby's body; Decreases the risk of diarrhoea; It decreases risk of respiratory infections; It decreases risk of allergies; | |
| If you have chosen to formula feed your baby, discuss safe preparation and use of formula with the health care worker | |
| <p>Play: Provide ways for your child to see, hear, feel, and move. Have colorful things to see and reach</p> | |
| <p>Communicate: Look into your child's eyes and smile at him or her. Talk to your child and get a conversation going with sounds or gestures.</p> | |

HEALTH PROMOTION MESSAGES

6 - 12 months

Feeding:

For all children start complementary foods at 6 months

- Continue breastfeeding;
- Always breastfeed first before giving complementary foods;
- Start giving 2—3 teaspoons of soft porridge and begin to introduce vegetables and then fruit. Give mashed dried beans and locally available animal foods daily to supplement the iron in the breastmilk. Examples include egg (yolk), minced meat, fish, chicken/chicken livers, mopani worms;
- Gradually increase the amount and frequency of feeds.
- Children between 6—8 months should have two meals a day. By 12 months this should have increased to 5 meals per day, whilst frequent breastfeeding continues;
- Offer your baby safe, clean water regularly;
- If the baby is not breastfed, give formula or at least 2 cups of full cream cow's milk (cow's milk can be given from 9 months of age);



Play: Give your child clean household things to handle, bang and drop.



Communicate:

Respond to your child's sounds and interests. Tell your child the names of things and people.

Encourage feeding during illness Suggest an extra meal a day for a week after getting better

Feeding recommendation for DIARRHOEA

- Follow feeding recommendations for the child's age, but give small frequent meals (at least 6 times a day);
- Give a sugar-salt solution (SSS) in addition to feeds. Give SSS after each loose stool, using frequent small sips from a cup (half cup for children under 2 years and 1 cup for children 2—5 years). If the child vomits, wait for 10 minutes then continue, but more slowly

How to prepare a sugar-salt solution (SSS) at home



HEALTH PROMOTION MESSAGES

Feeding: 12 months up to 5 years

- If the child is breastfed, continue breastfeeding as often as the child wants until the child is 2 years and beyond;
 - If not breastfeeding, give at least 2 cups of full cream milk, which could be maas, every day;
 - Encourage children to eat a variety of foods;
 - Feed your children five small meals a day;
 - Make starchy foods the basis of a child's main meals;
 - Children need plenty of vegetables and fruit every day;
 - Children can eat chicken, fish, eggs, beans, soya or peanut butter every day;
 - Give foods rich in iron and vitamins A and C;
- Iron-rich foods:** Liver, kidney, dark green leafy vegetables, egg yolk, dry beans, fortified cereal;
Remember that tea interferes with the absorption of iron. Iron is best absorbed in the presence of vitamin C;
- Vitamin A-rich foods:** Liver, dark green leafy vegetables, mango, paw paw, yellow sweet potato, full cream milk;
- Vitamin C-rich foods:** Citrus fruit (oranges, naartjies), guavas, tomatoes;
- If children have sweets, treats or drinks, offer small amounts with meals;
 - Offer clean, safe water regularly;
 - Encourage children to be active every day.



Play and communicate: 12 months to 2 years

Play: Give your child things to stack up, and to put into containers and take out.



Play and communicate: Above 2 years

Play: Help your child count, name, and compare things. Make simple toys for your child.



Communicate: Ask your child simple questions. Respond to your child's attempts to talk. Play games like "bye".






Communicate: Encourage your child to talk and answer your child's questions. Teach your child stories, songs and games.

ROAD TO HEALTH



Children develop mentally as well as physically and as a result they start learning and performing more difficult tasks as they grow. The CHW has to know what is expected of children at each stage so that problems with development can be noted and referred to the clinic. The CHW must notice if the child is learning as they are growing.

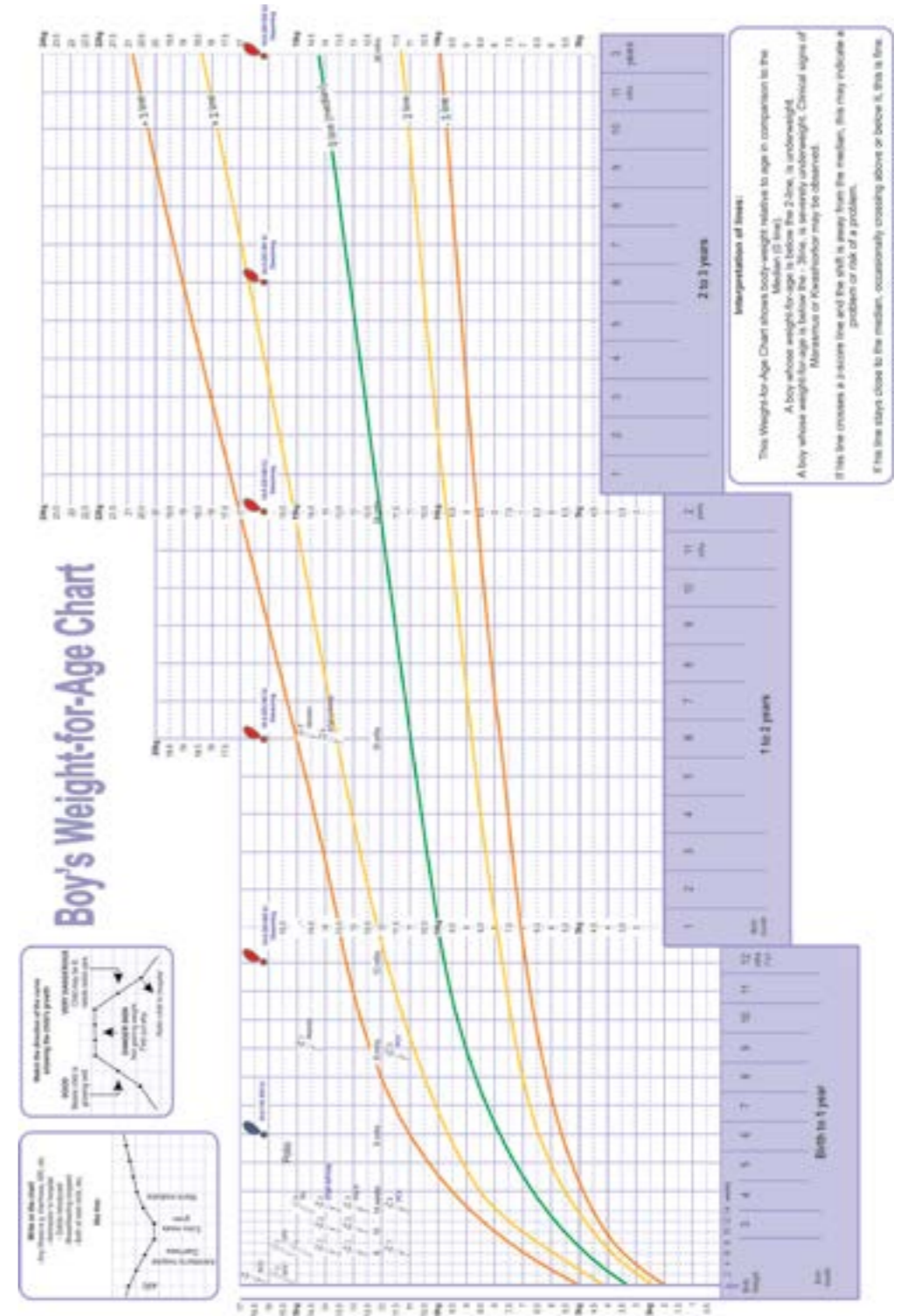
Figure 22: Page 13 of RTHB – Developmental screening ²⁰

| DEVELOPMENTAL SCREENING | | | |
|-----------------------------|--|---|---|
| | VISION AND ADAPTIVE | HEARING AND COMMUNICATION | MOTOR DEVELOPMENT |
| ALWAYS ASK | Can your child see? | Can your child hear and communicate as other children? | Does your child do the same things as other children of the same age? |
| 14 weeks | Baby follows close objects with eyes | Baby responds to sound by stopping sucking, blinking or turning | Child lifts head when held against shoulder  |
| 6 months | Baby recognises familiar faces | Child turns head to look for sound | Child holds a toy in each hand  |
| 9 months | Child's eyes focus on far objects Eyes move well together (No squint) | Child turns when called | Child sits and plays without support  |
| 18 months | Child looks at small things and pictures | Child points to 3 simple objects Child uses at least 3 words other than names Child understands simple commands | Child walks well  Child uses fingers to feed |
| 3 years | Sees small shapes clearly at 6 metres | Child speaks in simple 3 word sentences | Child runs well and climbs on things |
| 5-6 years: School readiness | No problem with vision, use a Snellen E chart to check | Speaks in full sentences and interact with children and adults | Hops on one foot  Able to draw a stick person |
| REFER | Refer the child to the next level of care if child has not achieved the developmental milestone. Refer motor problem to Occupational Therapist/Physiotherapist and hearing and speech problem to Speech therapist/Audiologist if you have the services at your facilities. | | |



Growth monitoring is used to check if a child is growing well. The RTHB is used to mark the weight to see if a child is growing well and according to what is expected. Pages 14 and 15 of the RTHB include a 'Weight-for-age Chart.' Below is the boy specific 'Weight-for-age Chart.'

Figure 23: Page 14/15 of the RTHB – Boy's Weight-for-age Chart ²⁰

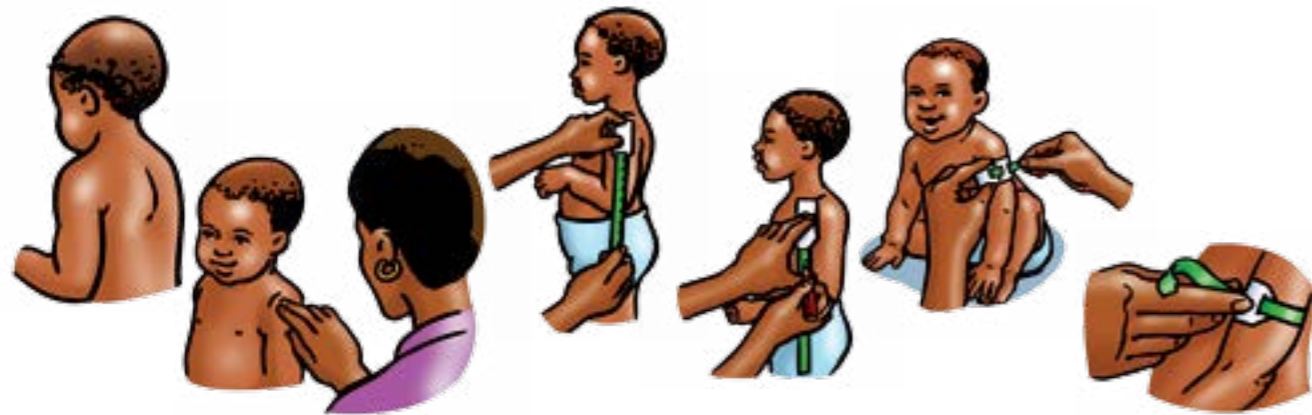


The CHWs must check every child for signs of malnutrition using the Malnutrition Screening Tool. The following table is included on page 19 of the RTHB to check for signs of malnutrition. Signs for malnutrition should be checked for on every child, every three months at the clinic.

Figure 24: Page 19 of RTHB – Mid-upper arm circumference (MUAC) ²⁰

| MID-UPPER ARM CIRCUMFERENCE (MUAC) (Every 3 months) | | | | | | | |
|---|------|---------------|------|---------------|------|---------------|------|
| Date of visit | MUAC | Date of visit | MUAC | Date of visit | MUAC | Date of visit | MUAC |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

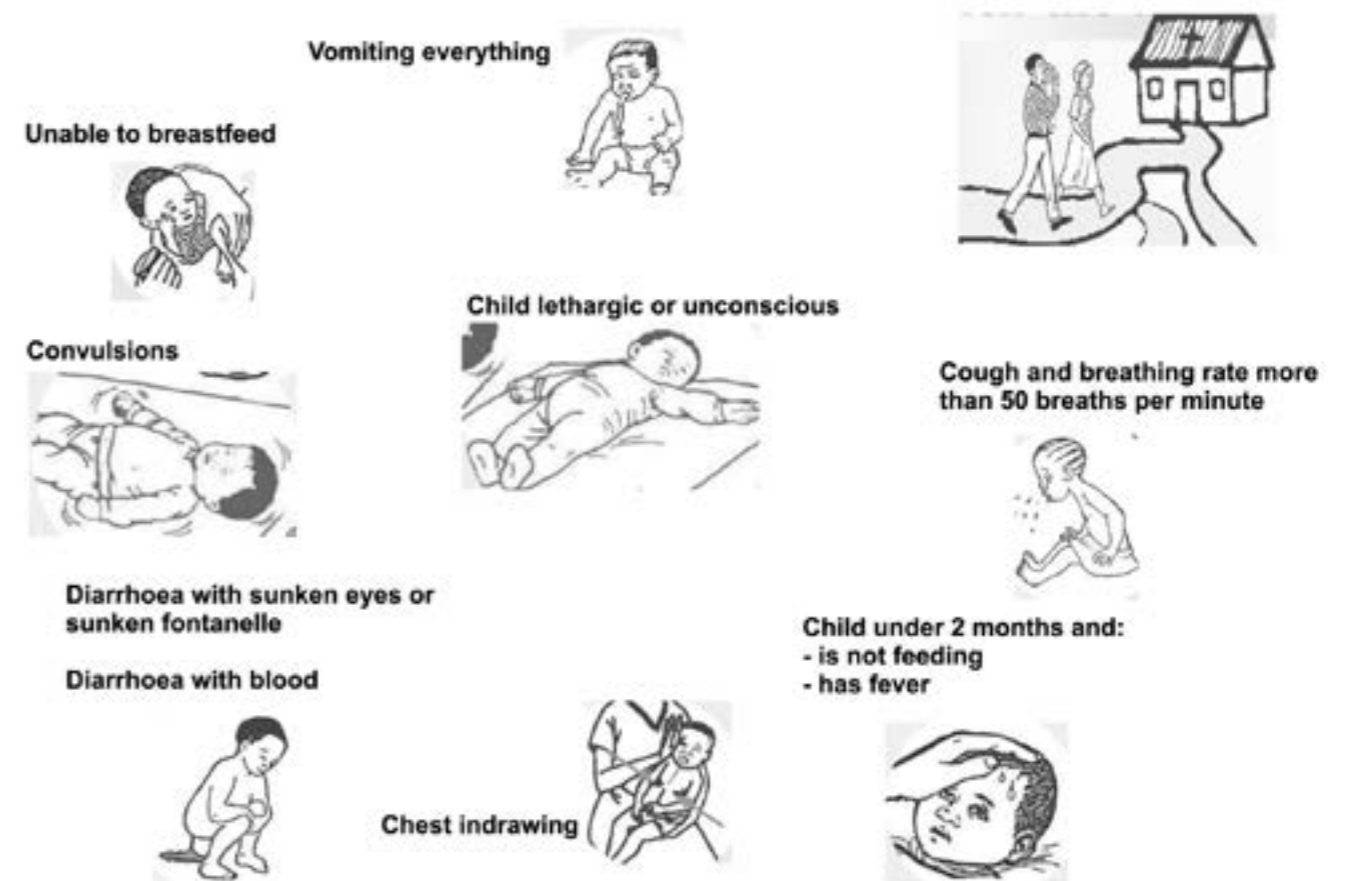
< 11.5 cm indicates severe acute malnutrition (REFER urgently)
 ≥11.5 < 12.5 cm indicates moderate acute malnutrition (Manage as in IMCI guide-lines)



Finally, the CHWs must check if any other danger signs are occurring and remind the mother or caregiver to take the child to the nearest clinic as soon as any danger signs occur.

Figure 25: Page 30 of RTHB – Danger signs ²⁰

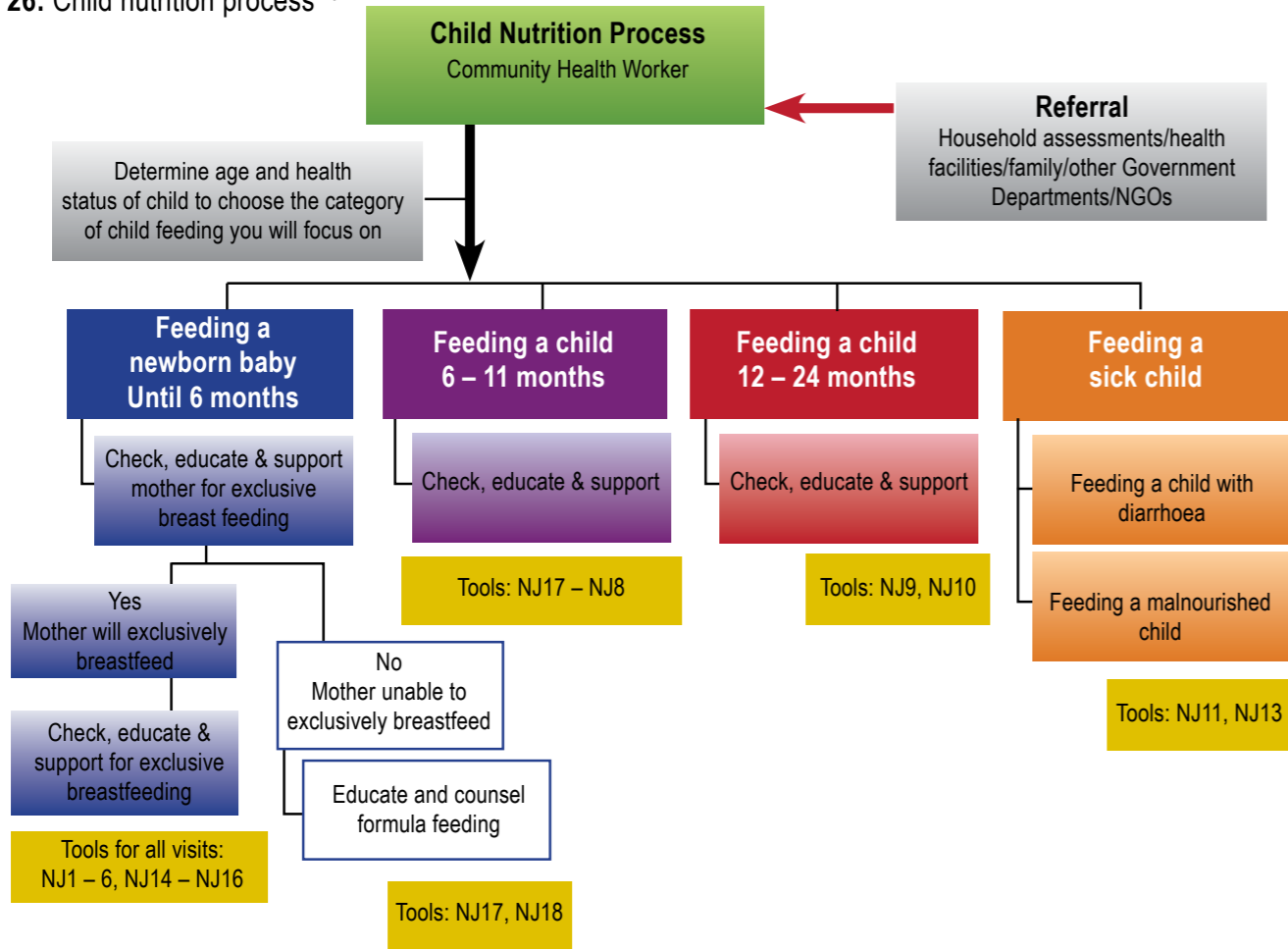
Take your child to the nearest clinic when any of these danger signs occur:



6.2. Child nutrition

As described above, the RTHB includes health promotion messages around child feeding up to five years of age (pages 10, 11, 12). In the *CHW Household Tools*, the following flow diagram is also provided to assist the CHW. It is important that you are familiar with the child nutrition process in order to adequately train and evaluate your team members' ability to provide support to mothers with children of different ages.

Figure 26: Child nutrition process¹⁹



All tools specified in Figure 26 above may be found in the *CHW Household Tools*.

6.3. Integrated management of childhood illness process

Aside from talking through the RTHB, the CHW must be aware of and check for other common childhood illnesses at each HH visit with a child under the age of five. The other common illnesses include:

- Fever
- Cough
- Vomiting
- Diarrhoea
- Pneumonia
- Malnutrition

The CHWs have or will be trained to provide home remedies for some of the illnesses listed above. It is important to note that these home remedies are not meant to treat or cure the child but rather to help the mother to reduce symptoms until the child is brought to the clinic.



6.4. Child health checklist

At every visit, the CHW must check that the mother has taken action on the advice given in the previous visit.

The following Child Health Checklist must be used when the CHW visits a HH with children under 5 years old. This will help them to remember the important topics that need to be checked and discussed with the family. It is your responsibility as the OTL to ensure that the appropriate checklist is used at the appropriate time.

Figure 27: CHW child health checklist¹⁹

| CHILD HEALTH CHECKLIST | | |
|---|------|----------|
| | Done | Not done |
| New born (birth to 1 month old) | | |
| 1. Visit HH with new born baby within 6 days of delivery | | |
| 2. Check that baby has a Road to Health Booklet | | |
| 3. Check that baby is suckling well | | |
| 4. Promote exclusive breastfeeding for the first 6 months | | |
| 5. Check baby's cord | | |
| 6. Check for jaundice and eye discharges | | |
| 7. Discuss cord care, eye care and hygiene with mother | | |
| 8. Discuss danger signs with mother | | |
| 9. Show mothers how to stimulate and talk to baby | | |
| 10. Ensure that baby's birth is registered | | |
| 11. For babies of HIV-positive mothers | | |
| a. Ensure baby has received ARV prophylaxis | | |
| b. Discuss the importance of a PCR test and cotrimoxazole at 6 weeks | | |
| Infants (2 to 12 months old) | | |
| 1. Check that baby has a Road to Health Booklet | | |
| a. Is baby growing well? | | |
| b. Are the immunisations up to date? | | |
| c. Are the Vitamin A supplements up to date? | | |
| 2. Promote complementary feeding from 6 months with freshly prepared home foods | | |
| 3. Promote breastfeeding up to at least 2 years | | |
| 4. Check that mother knows the danger signs of illness | | |
| 5. Encourage monthly clinic visits for growth monitoring | | |
| 6. For babies of HIV-positive mothers | | |
| a. Is baby getting cotrimoxazole every day? | | |
| b. Has baby had an HIV PCR test? | | |

| CHILD HEALTH CHECKLIST | | |
|---|------|----------|
| | Done | Not done |
| Children (1 to 5 years old) | | |
| 1. Check that child has a Road to Health Booklet | | |
| a. Is child growing well? | | |
| b. Are the immunisations up to date for child's age? | | |
| c. Are the Vitamin A supplements up to date? | | |
| d. Is child being de-wormed every 6 months? | | |
| 2. Ensure child is receiving adequate complementary feeds | | |
| 3. Promote breastfeeding up to 2 years and beyond | | |
| 4. Check that mother knows the danger signs of illness | | |
| 5. Encourage regular clinic visits | | |
| a. Every month up to age of 2 years | | |
| b. Every three months for 3 year olds | | |
| c. Every 4 months for 4 year olds | | |
| d. Every 6 months for 5 and 6 year olds | | |

The checklist above is also included in the *CHW Household Tools*.



Learning Objective 6

To understand the Outreach Team's responsibilities in managing non-communicable diseases.

7. Non-Communicable Disease Management

In order to reduce the growing burden of disease related to chronic non-communicable diseases (NCDs), the next service delivery priority for the Outreach Team is prevention of these chronic NCDs and/or prevention of the consequences of chronic NCDs. This is carried out primarily through the CHW providing education and information at HH level. As OTL, you should ensure that CHWs are providing accurate and relevant information depending on the needs of the HH, and in line with the PHC guidelines.

The chronic non-communicable diseases of focus include:

- Diabetes
- Hypertension
- Stroke
- Heart conditions, including heart attacks
- Malaria
- Prostate Cancer
- Testicular Cancer

The lifestyle elements of these chronic NCDs is emphasised and should form the focus of the education provided by the CHW. Your role is to ensure that, as the HH registration is conducted, either risk factors for these chronic NCDs are accurately identified in the HH and/or if any HH members have been diagnosed with chronic NCDs, the HH is categorised as vulnerable and the appropriate services are provided to the HH, e.g. education on lifestyle modification, support for integrated treatment adherence.

The role that CHWs play in supporting HHs where a HH member has been diagnosed with a chronic NCD members includes:

- promotion of a healthy lifestyle
- prevention of NCD
- early detection
- curative, rehabilitative and palliative service

In HHs where no there is no chronic NCD, the focus is the promotion of a healthy lifestyle and prevention on chronic NCDs.

A further role that you, as OTL play as regards chronic NCDs is the planning, implementation and evaluation of health and wellness services in the catchment population. Your CHWs and Health Promoters will play a key role in helping you identify what the health and wellness services should entail.

Brainstorm

Discuss in the group how to assist your CHWs in the following scenarios:

Scenario 1: CHW identifies a HH where the family is not following a healthy lifestyle.

Scenario 2: CHW identifies a HH where the grandmother has diabetes.

Scenario 3: CHW identifies a need for an exercise programme in the community. Consider other organisations you and your CHWs will need to work with. What challenges might you be faced with? How can you help your CHWs overcome these challenges?



Learning Objective 7

To understand the Outreach Team's responsibilities in dealing with violence and injury.

8. Violence and Injury

The Outreach Team play a vital role in helping to address the increasing problem of violence and injury in our communities. This violence and injury may take the form of road accidents, domestic violence or child abuse.

The role that your CHWs play is in identifying HHs where domestic violence, including against partners (whether or not they are married), older persons, children, etc, and abuse, including substance abuse, is occurring. Should your CHW suspect that violence or abuse is taking place, they need to report this to you as OTL. Your role is to assess your CHW's findings and report the violence or abuse to the South African Police Service.

In addition, another critical role that you play is in helping your CHWs create awareness in the community relating to the consequences of violence and injury both in the HH as well as in the community.



Learning Objective 8

To understand the Outreach Team's responsibilities in delivering treatment adherence support.

9. Integration of treatment adherence support

9.1. Integration of services

The core services that the Outreach Team should deliver to the community include: integration across all clinical and non-clinical aspects of health care and the continuous promotion and facilitation of adherence to long term treatment. Every possible opportunity should be used to promote integration and adherence with the team, and the community.

As the OTL, you should make sure that services are integrated as far as possible. You should illustrate this core service to your team not only by example, but also by asking them how they are practically integrating services.

Notes

What are possible ways your team can integrate services?

9.2. Treatment adherence support

HIV and TB together and non-communicable chronic diseases are two of the four conditions which contribute to South Africa's quadruple burden of disease that was discussed in Lesson 1 [Introduction to Role as OTL]. In an effort to assist people who are on long term treatment (e.g. people living with HIV, people infected with TB, people who have NCDs) the Outreach Team must prioritise treatment adherence support.

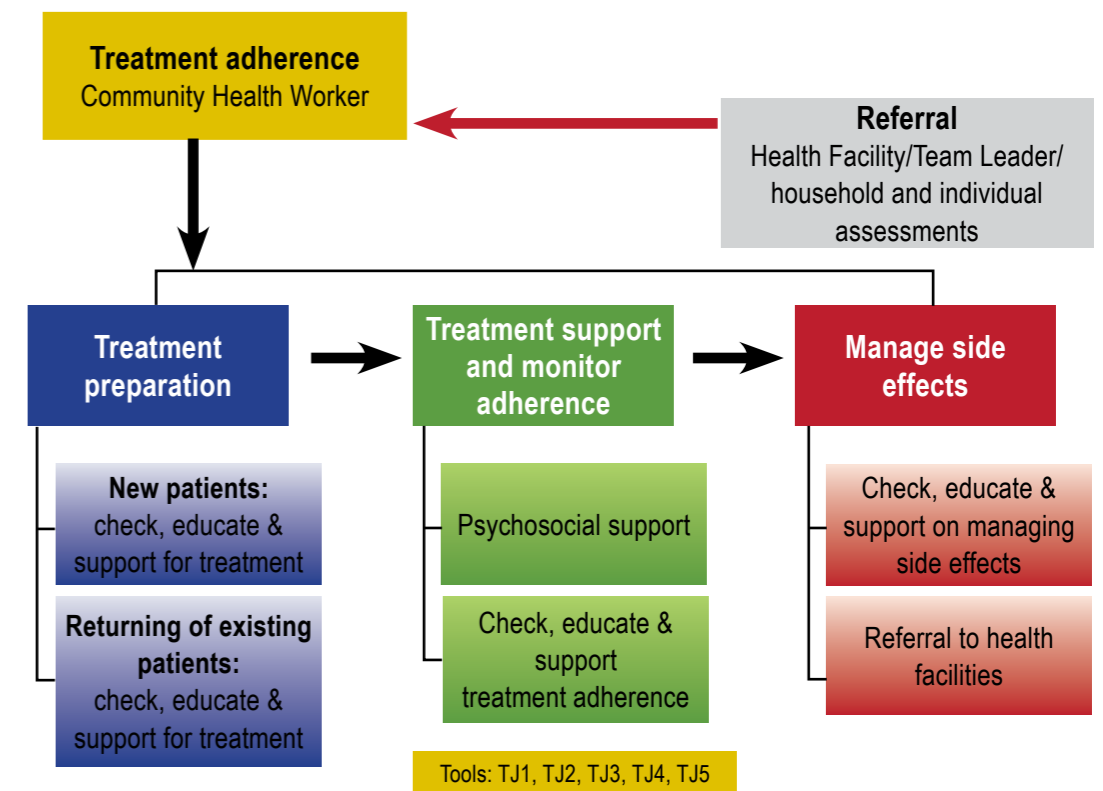
While HIV and TB treatment are the initial priority for adherence support by the Outreach Team, it is important that once the team becomes familiar with providing adherence support, that they also provide support for the treatment of other chronic conditions.

You should make sure that your team uses every possible opportunity to check whether all patients are on their treatment and following the regimes correctly. This can be done by reviewing the HH member's information before a visit and checking what treatment the HH member is on or by asking the people in the HH what treatment the HH member(s) is on.

As soon as a HH member is initiated on treatment, they should be referred to the Outreach Team and CHW for treatment adherence support. This includes preparation for treatment initiation, monitoring of adherence and managing side effects as outlined in the Figure 28 below.

When a CHW is providing treatment adherence support, there is a treatment adherence checklist that they should use at each support visit. You must be familiar with this checklist and what is required of your CHWs. You should also be able to train, mentor or coach your CHW as required on how to use this checklist correctly.

Figure 28: CHW treatment adherence support process¹⁹



All tools specified in Figure 28 may be found in the *CHW Household Tools*.

Figure 29: CHW Treatment Adherence checklist ¹⁹

| CHW TREATMENT ADHERENCE CHECKLIST | | |
|---|------|----------|
| Action Item | Done | Not done |
| Review treatment history, including: | | |
| • Current regimen | | |
| • Previous medications | | |
| • Side effects | | |
| • Other treatments | | |
| Discuss current health status with patient, including: | | |
| • Overall health and current problems | | |
| • Latest relevant laboratory tests (e.g. CD4 count) | | |
| • Goals for health | | |
| Assess patient's medication knowledge, behaviours and attitudes, including: | | |
| • Knowledge of HIV/TB/other medications | | |
| • Understanding of drug resistance and implications | | |
| • Criteria for evaluating medications | | |
| • Attitudes about taking medications | | |
| Review patient's/family's living situation, including: | | |
| • Daily activities: work, school and travel schedule | | |
| • Eating patterns | | |
| • Access to PHC clinic | | |
| • Special factors: disclosure of diagnosis, medication storage issues | | |
| Describe proposed medication regimen, including: | | |
| • Drug names | | |
| • Dosing | | |
| • Food requirements | | |
| • Special instructions/how to give | | |
| • Side effects | | |
| • Storage issue | | |
| • Assess patient's readiness for regimen | | |
| • Review with patient possible barriers to adherence (stigma, support system, work, living situation, travel to clinic to pick up medications side effects, depression, etc.) | | |
| • Counsel patient to identify strategies to overcome identified barriers | | |
| • Document treatment plan | | |
| • Give information on drug names, dosing, frequency, food and storage requirements | | |

| CHW TREATMENT ADHERENCE CHECKLIST | | |
|---|------|----------|
| Action Item | Done | Not done |
| • Discuss potential side effects and a plan for response, including prescriptions | | |
| • Review logistics of filling and refilling prescriptions | | |
| • Make plan for follow-up | | |
| • Schedule next appointment, discuss what should prompt an earlier visit | | |
| • Schedule support by other members of the health care team as appropriate (dietician, home visit, follow-up calls) | | |
| • Provide closure to adherence counselling session | | |
| • Ask patient to describe his/her treatment regimen, how to get refills, what to do if they experience any side effects, when is their next appointment, how to take meds, etc. | | |



Learning Objective 9

To understand the package of school health services to be provided by the school health team with the Outreach Team’s support.

10. School health services

10.1. Integrated School Health Programme

The revised National School Health policy made way for the comprehensive Integrated School Health Programme (ISHP) for grade 0 to 12 learners, implemented at sub-district level. This implementation strategy incorporates the principle of equity and human rights with specific consideration to the availability of resources required to cover all learners.

The goal of the ISHP is to contribute to the improvement of the general health of school-going children as well as the environmental conditions in schools and address health barriers to learning.

The general objective of the ISHP is to guide the provision of a comprehensive, integrated School Health Programme that operates within the PHC package of services.

10.2. Outreach Team and school health services

As the OTL, it is your role to support school health services and ensure your team liaises with schools and responds to health problems within schools by collaborating with other service providers.

Some schools will have an operating school health programme/school health nurse while others may not yet have their programme up and running. When there is no school health nurse, it is your responsibility as the OTL to liaise with the school principal to see how your team can assist. **Your team is NOT expected to implement the package of school health services but rather to assist and collaborate with the school as and when needed.**

- The Outreach Team and OTL should collaborate with, and involve officials from the departments of health, welfare, education and agriculture, as well as educators, learners, parents, community leaders, CBOs and NGOs
- School Health Promoting Teams are intra- and inter-sectoral



Individual Activity

Answer the following questions about your Ward:

What do you know about your community’s school(s)? Does the school(s) have a school health nurse?

What are the ways your Outreach Team could assist the school health programme in your community? Provide an example of a situation where you would have to assist a school health nurse or principal with providing services.

Discuss your answers with the larger group.

Example of Outreach Team and School Health Team collaboration:

One example might be if a child has scabies and the school health nurse wants to give the child medicine to take home. If the child is small, they should not be given medication to take home but rather someone should deliver the medication to the child’s family and provide instructions for the use of the medication. The school health nurse may call upon the OTL to ensure that a CHW delivers the medication to the child’s family and explains the instructions on how to use the medicine.

A table with the comprehensive package of school health services is included in the *Team Leader Job Aid, General Information*.



Learning Objective 10

To understand the Outreach Team’s responsibility in providing emergency health services.

11. Emergency Services

The Outreach Team should always be ready to provide emergency services should the need arise. It is in times of disasters and emergencies that communities rely on health workers and the services they can provide. Emergencies may occur at the individual, HH or community level. A brief description of the Outreach Team’s responsibility in dealing with each level of emergency is outlined below.

For all levels of emergencies, it is important that you and every person in the Outreach Team knows where to locate the contact details for the local emergency services in your catchment area. The following numbers should be included at the top of the *Community Resource List* which is discussed further in Lesson 5 [Community Entry, Assessment and Involvement]:

- Local EMS
- Local hospital
- Local SAPS
- Local fire brigade

Working in Pairs

Pair up with someone new in the group. In your pair, list as many emergencies as you can think of.



11.1. Emergencies at the individual level

At the individual level, the Outreach Team must provide basic first aid in an emergency involving one or more HH or community members.

All members of the Outreach Team should be trained and certified in basic first aid. As the OTL you should ensure that you and all of your team members have the necessary training. The training and certification should be provided by an accredited organisation or institution.

Renewal of certification

As the certification only lasts for a specific time period, it is the OTL’s responsibility to keep track of when all of the team members’ certification will end, and make sure the certification is renewed. You should ensure the renewal takes place before the current certification ends.

This is a requirement for all CHW in every Outreach Team. One of the first activities you must organise as the OTL is to ensure that all CHWs are scheduled to attend an accredited basic first aid course.

11.2. Emergencies at the household level

Emergencies at the HH level include any emergency that affects the entire HH. Examples of emergencies at the HH level include a HH fire or flood. If there is a HH level emergency that the Outreach Team is aware of or present for, the following are the responsibility of the Outreach Team members:

1. If necessary, evacuate the area where the emergency has occurred
2. If necessary, provide first aid to individuals within the HH
3. Contact the appropriate emergency services to alert them of the emergency (contact details of emergency services will be listed on the *Community Resource List*)
4. Contact the Facility Manager to make them aware of the emergency

11.3. Emergencies at the community level

If there is an emergency at the community level, the Outreach Team will work closely with the Facility Manager to respond to the needs of other sectors or emergency services (who are responsible and should be responding to the emergency).

Lesson 5

Community Entry, Assessment and Involvement

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Your role as an Outreach Team Leader

Your role as the OTL is to build relationships with and understand the needs of the community within the catchment area for which you and your Outreach Team are responsible.

By building a relationship with the community and working together to understand their needs, you and your team will be able to address those needs and involve the community.

Learning Objectives

This Lesson has five learning objectives:

1. To understand the steps for community entry.
2. To understand how to conduct a community assessment, including community mapping, conducting a community profile and developing a community diagnosis.
3. To understand the importance of and steps for community consultation.
4. To understand how to use the community assessment and diagnosis, in consultation with the community, to design a community health improvement plan.
5. To understand how to involve the community in implementing interventions for health issues.



1. Introduction to Lesson

Now you should have a clear understanding of:

- Your role as the OTL
- Roles and responsibilities of your team members
- Skills required to perform your role
- Services that the Outreach Team must deliver
- How to manage the team, the individual and the team supplies

The next step is to figure out how to use the knowledge and skills you have to start delivering the services to your community.



What is a community?

The term community refers to a group of people living close to each other in the same area. They may share a similar way of living and may also share what is important to them. This common understanding of life and living give them a sense of belonging to the group.

Each Outreach Team will be assigned a catchment area which is your team's 'community' that you are responsible for. This community will be defined by a ward or geographic area.

The Outreach Team will form the link between the community and the health facilities. The team's role is to make sure that the community members get the health services they need. To be able to do this, it will be important that the community is made aware of these services and the purpose of the Outreach Team. Similarly, the team will need to know and understand the community and its needs.

It is your responsibility as the OTL to make sure that this community awareness takes place. You will need to:

- Facilitate entry into the community for the Outreach Team
- Liaise with other service providers
- Identify community issues by conducting a community assessment and developing a community diagnosis
- Consult with the community to prioritise health issues found in the community assessment and diagnosis
- Design, plan and implement interventions to deal with the priority health issues in collaboration with community stakeholders and community members



Learning Objective 1

To understand the steps for community entry.

2. Community entry

In order to ensure that the community becomes aware of the Outreach Team, it is important to get the help of those people who have influence in the community. This may include:

- Ward councillors
- Traditional leaders
- Traditional healers
- Traditional health practitioners
- Priests or pastors
- South African Police Service (SAPS) and other local institutions
- Business leaders
- Clinic committees
- Chiefs
- Kings or Queens

People like those listed above may be the 'gatekeepers' to the community. Gatekeepers are also stakeholders. Therefore, it is important that they are notified first of the Outreach Team's existence and roles within the community in terms of service delivery.



What is a stakeholder?

A stakeholder is a person, group or organisation who affects the community or can be affected by issues in the community.

Examples of stakeholders: person in the community, person living with HIV/AIDS, an NGO, a church, a private business and many others.

Key steps for community entry:

1. Speak to your team members (as they should be from the community in which you work) and ask them who the main community leaders are.
2. Find out the best way to communicate with each community leader and gather their contact details. You may start populating a *Community Resource List* with this information. A template for this list is included in the *Team Leader Job Aid, Team Management*.

3. Organise one or more meetings with community leaders. Refer back to section 2.5 of Lesson 4 [Team Management] for guidelines on meeting preparation and conducting a meeting.
4. At each meeting, the agenda discussion topics should include:
 - a. Introduction of yourself and the Outreach Team members
 - b. Give a brief background to the Outreach Team
 - i. Why there is an Outreach Team
 - ii. How you will work with the local PHC clinic and other service providers
 - iii. Description of services that the team will provide to the community and to HHs
 - iv. Your team's commitment to respecting and keeping the confidentiality of all community members
 - c. Get commitment from community leaders for assistance with enabling the team's work in the community
Examples of this assistance may include making sure that CHWs are safe when visiting HHs, setting up community meetings and encouraging people to attend the meetings.
 - d. Explain your next steps in terms of community entry and community assessment (described further in next section)
 - e. Update your *Community Resource List* with names and contact details of any additional community leaders
 - f. Explain your commitment to ensuring ongoing communication about the Outreach Team's activities through monthly meetings

Once you have the support and buy-in from the community leaders and community members, you and your team may organise additional meetings with other community stakeholders, including local service providers. In each additional meeting, you will cover the same discussion topics (as above).

Also, an *Example Introduction of Outreach Team Letter* is included in the *Team Leader Job Aid* under *Team Management*.

2.1. Liaise with service providers



Who are service providers?

Service providers are those organisations or government departments that address specific community needs. Service providers are also stakeholders in the community. Some service providers may be specifically related to health while others are not.

Local **health** service providers may include (but are not limited to):

- PHC clinic, community health centres, tertiary hospitals
- Private health practitioners or practices
- School health nurse/team
- Home-based care workers
- Palliative care workers
- Old age homes
- Emergency Medical Services

Other local service providers may include (but are not limited to):

- Psychosocial support services
- Government departments, including but not limited to:
 - Basic Education
 - Economic Development
 - Environmental Affairs
 - Higher Education and Training
 - Home Affairs
 - Public Service and Administration
 - Social Development
 - South African Police Services
 - Women, Children and People with Disabilities
- Local NGOs, NPOs, CBOs, FBOs
- Crèches
- Early childhood development centres
- Schools, colleges, universities
- Fire brigade

Building relationships and defining how you will interact with the local service providers will greatly benefit the work of the Outreach Team and the impact on the community.

Interaction between the Outreach Team members and other service providers will typically include:

- Referrals from the Outreach Team of individual community members to specific service providers
- Collaboration to plan and implement interventions to address a community need

Individual Activity

Can you think of the various community stakeholders (including service providers) in your Ward?

Start completing the *Community Resource List* for your Outreach Team. This template can be found in the *Team Leader Job Aid* under *Team Management*.



2.1.1. Referrals to service providers

As the OTL, it is your responsibility to set up and coordinate the referral system between the Outreach Team, the community and service providers. You need to ensure that service providers know and understand their roles, responsibilities and services to be provided.

Example of a referral to a service provider:

An older person requires home-based care or financial assistance. For home-based care, the Outreach Team member would refer them to an organisation that provides home-based care as a service. For financial assistance, the Outreach Team member would refer them to the Department of Social Development to apply for a grant.

An effective referral system ensures a close relationship between all providers in the community and ensures that community members receive the best possible care closest to home. In this way:

- Access to needed services is faster than if someone had to go to the clinic, wait in a queue and be referred to another service
- Referrals between the organisations in the network can be tracked by the Outreach Team
- Referrals and their outcomes are documented by the Outreach Team
- Gaps in services can be identified and steps are taken to address them (e.g. increased demand for a particular service might require identification of additional providers)

Further details on individual client referrals are provided in Lesson 6 [Household Engagement].

Key steps to liaise with other service providers:

1. Populate *Community Resource List* with the details of all other local service providers
2. Set up meetings with service providers
3. Explain to each service provider the same discussion topics as listed in the section above
4. Explain the referral system in detail so that each service provider fully understands what happens when they see a referred client
5. Familiarise all service providers with the *Referral/Back-referral Form (Team Leader Job Aid, CHW Forms)* and give them a copy

Working in Pairs



Pair up with someone you have not paired with thus far in the orientation programme. Familiarise yourself with the *Referral Form* found in the *Team Leader Job Aid* under *CHW Forms*. Then for each of the case studies below, complete the form.

Case study 1: Mavis is a girl of 18 months. Her mother has been taking her to the clinic for her scheduled growth monitoring visits. For the past 2 months, Mavis's weight has been in the yellow zone. This month, her MUAC dropped. Her mother says she has had diarrhoea for the past three days. Her MUAC is in the Red Zone.

Case study 2: Mathew is a boy of 18 months. He lives with his mother, Portia. She does not work but qualifies to receive a child support grant. She has no idea how to go about getting one.

Share your discussion with the larger group.



Learning Objective 2

To understand how to conduct a community assessment, including community mapping, conducting a community profile and developing a community diagnosis.

3. Community assessment

For health care services to be effective, the services that are provided should be aligned to the community's need for health services. Part of your role is to make sure that the community and the community members get the services they need. To be able to do this, you will have to get know and understand the community that you will be working in.²³



What is a community assessment?

A community assessment is a process of gathering and interpreting information from multiple sources in order to develop a deep understanding of the challenges of a community. It is also a process that uses these results to develop strategies to improve the health status of the community.²³

The products or outcomes of a community assessment will include: a community map, a community profile and a community health improvement plan.²³

3.1. Community mapping

Community mapping is an activity that you and your team members will perform to understand the geography, infrastructure, resources and HHs of the catchment area that your team will serve.⁸

The Outreach Team's community map should (at minimum) include the location of:⁸

- PHC clinic and associated hospital (if applicable)
- All other local service providers
- Major shopping areas
- Churches or other religious facilities
- All HHs in the area

The CHW training will include a similar section on community mapping. Each CHW will be expected to draw a map which includes all of the HHs of the catchment area that they are working in.

In order to create one complete community map for your Outreach Team, you may use one or both of the following resources:⁸

- A municipal or ward map
 - This should be given to you by your facility manager or local area manager

- If you have access to a computer, you can source the map from Stats SA (www.statssa.gov.za) or the Demarcation Board (www.demarcation.org.za)
- HH maps drawn by CHWs and together with the CHWs combine each CHW's map into one large community map.

Remember! Informal settlements, townships and rural areas are generally not shown on municipal or ward maps. These areas must be added to your community map.

Community mapping, in particular, is a core responsibility of the CHWs in your team. Some of the information below is taken directly from the *CHW Learner Guide* so that you have a complete understanding of what the mapping process entails. Some of the preparation and techniques described below may be applied when you are drawing the community map with your CHWs.

3.1.1. Preparation to draw the map before the walkabout⁸

Decide on symbols for geographic features. Once the necessary information is collected, it is necessary to use some symbols to represent various features and landmarks of the area. These include:

- Rivers and roads
- Well-known community buildings

A rectangle/square will be used to represent each HH and a number will be applied to each house. The numbering system will be discussed further in Lesson 6 [Household Engagement]. Example:



3.1.2. How to draw the map⁸

Step 1: Take a large sheet of paper about 36cm by 50cm. The top of the paper will include the following details:

- Name of CHW (if it is a CHW's specific HH map)
- Name of the community
- Name of the catchment area
- Date of the community mapping walkabout

Step 2: Draw the general shape of the area in the lower three-quarters of the sheet of paper.

Step 3: Using the 'look, listen and learn' technique, identify and put in the major features or land markers in the area, such as roads, river, streams, schools, health centres, churches, shops, canals, bridges, hills and forests, or other recognisable land marks.

Step 4: On the bottom of the sheet, make a box for the key to explain the meaning of the symbols.

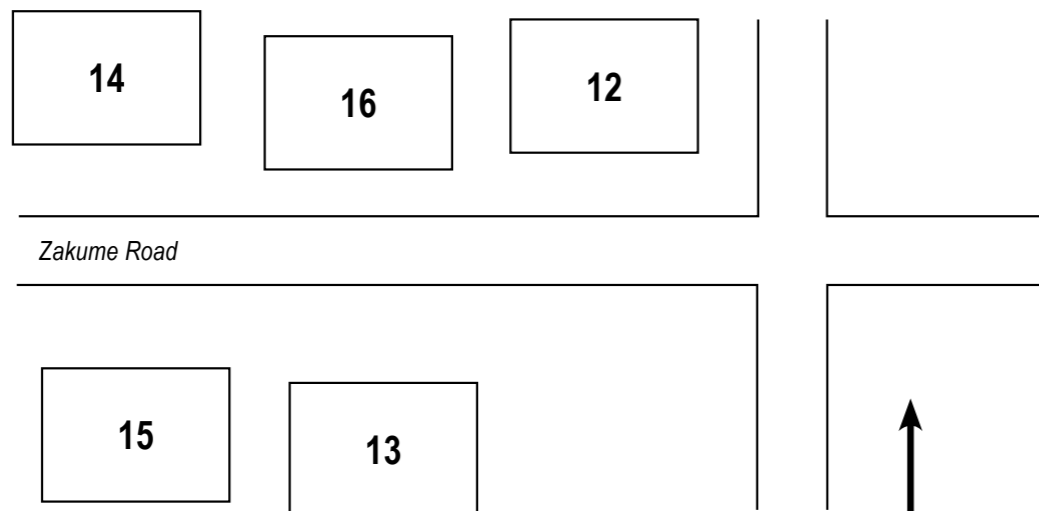
Step 5: Write in street names if available when drawing HHs.

Step 6: Draw HHs using the rectangular symbol above.

Step 7: Store community and HH maps in a safe and protected place so that they may be shared with and between Outreach Team members.

Below is an example of part of a community/HH map.

Figure 1: Example of community/HH map



Group Activity

Split into groups of five. Look at the municipal map you have been given. Identify geographic features, infrastructure resources (e.g. hospital, police station) and landmarks of the area.



3.2. Compile community profile



What is a community profile?

A community profile is a comprehensive compilation of information about a community. The information may include information already collected about a community or information collected by the Outreach Team.²³

3.2.1. What information is typically included in a community profile?²³

- A brief description of the community your team is working in
 - Geographic description (e.g. size, location, distances to major cities and health facilities)
- Demographic and economic data
 - Demographic data is a description of the population in the community you are working in. It may include the size, gender, age, race, ethnicity and languages spoken by the population.
 - Economic data is a description of the sources of income, the employment or unemployment rates and the average level of education of the population.
- Health status data
 - All health status data should come from the District Health Information System (DHIS) or DOH and should include information on:
 - » Maternal and child health indicators (e.g. total births, infant mortality rates, maternal mortality rates)
 - » General mortality (e.g. total deaths, deaths by gender and age)
 - » Leading causes of death in the community
 - » Chronic disease information (e.g. heart disease, cancer, diabetes, asthma, disability) including incidence and prevalence rates
 - » Infectious disease information (e.g. HIV, TB, STIs) including incidence and prevalence rates
 - » Environmental health information including information about available food, the water quality in the community, air quality
 - » Injury, violence and substance abuse information (e.g. violent deaths, abuse or neglect, unintentional injury, substance abuse)



- Community resources, including service providers
 - What services exist and for whom (*use Community Resource List*)?
 - What influences community access to health services for different people in the community?
 - Who utilises existing services?
 - Are there any existing support groups in the community?
- Summary of community profile and overall interpretation

3.2.2. How do I collect all of the information for the community profile?

There are various methods to collect all of the information for the community profile. These include, but are not limited to:

- Observations
- Informal discussions with CHWs, community leaders, community members or service providers, including support groups
- Record reviews: Review all existing material that you can find within the community and within the PHC clinic.
- Internet: There are some websites that are always useful to find health information:
 - National Department of Health (www.doh.gov.za)
 - World Health Organisation (www.who.int)
 - UNAIDS (www.unaids.org)
 - Stats SA (www.statssa.gov.za)
- District Health Information System (ask your Facility Manager to access information from the District Health Information Officer)



A template for a *Community Profile* is included in the *Team Leader Job Aid, Team Management*. The template provided is just to give you an idea of how a community profile may look. You may have to add or remove certain parts of the profile in order for it to make sense for your team and your community. The template provides space for statistics as well as for you to write a description of what you observe or understand about your community. There are also probing questions to assist you.

3.3. Developing a community diagnosis

What does all of the information in the community profile mean for you and the Outreach Team?

When you are summarising and interpreting all of the data collected for the community health profile, you are trying to determine the major issues within the community. This enables you to develop a community diagnosis.

In order to do this, you may consider the following questions:

- **Who is affected most by this issue?** What are their race, ethnicities, and gender? What are their socio-economic levels? Where do they live? What other information do you have on this population?
- **What is the impact of this issue on the community?** For the individuals most affected? For their families? For this community?
- **What are the barriers?** Are there barriers to addressing this issue in the community (social, political, economic)? Can they be overcome and if so, how?
- **What are the resources?** What types of resources are available within the community to address the issue? Where and how can these resources be acquired?
- **What has been done in the past to eliminate similar issues in this community?** Who was involved? Have efforts been ongoing? If efforts already exist can those who are already involved be enlisted to help? What are the results?
- **What does the community know about this issue?** What are the myths and beliefs surrounding this problem, if any? How can these perceptions be changed, if necessary?
- **What is the community's attitude toward this issue?** Do they see it as an important problem? If not what will make it important? What do they (the community) recommend?

Some of the questions above can only be answered by discussing the issues with the community. This is why community consultation is necessary!

Working in Pairs

Pair up with another member of the orientation programme that you have not yet paired with.

Locate the completed *Community Profile* in the *Team Leader Job Aid* under *Exercises*. From the information in the completed profile, identify at least 3 key health issues within this community.

Present your identified health issues to the larger group.





Learning Objective 3

To understand the importance of and steps for community consultation.

3.4. Community consultation

A critical component in the community assessment process is involving the community and consulting them about the community health profile. This is necessary to ensure that the community agrees on the Outreach Team community diagnosis and have the same understanding of the major issues facing the community.²³

Key steps for community consultation:

1. Organise one or more meetings [use meeting guidelines provided in Lesson 4, Team Management]
2. Ensure the following people attend one or all of the meetings:
 - a. All Outreach Team members
 - b. Community leaders
 - c. Service providers
 - d. As many members of the community as possible
You can notify the community by writing a letter to various religious organisations, distributing flyers and putting up posters in the local stores and at the community centre, schools, crèches and day care centres
3. Meeting agenda items should include:
 - a. Introductions
 - b. OTL presentation on community profile
 - c. OTL presentation on summary and key interpretation of the community profile and community diagnosis including a list of what the Outreach Team finds are the major issues in the community (these could be direct health issues or issues that affect the health of the community, e.g. no rubbish collection which leads to rubbish lying in the streets and in people’s gardens, which causes illness)
 - d. Open the discussion for community/meeting participants to give their interpretation of the community profile and for them to list the community priorities
 - e. Discussion about possible interventions to deal with the identified priorities
4. Report back major highlights or decisions of the community meeting to your Facility Manager. This should happen within one week of the community meeting

The initial community consultation meeting may last longer depending on the community and any sensitive issues that may be discussed. It is important that you allocate enough time in the community meeting agenda to allow the community to share their views. Community meetings that follow may take less time.



Learning Objective 4

To understand how to use the community assessment and diagnosis, in consultation with the community, to design a community health improvement plan.

4. Community health improvement plan

Once the Outreach Team and the community leaders, community members and other service providers have agreed on the priority health issues, you must think about how the Outreach Team can assist with designing and implementing possible interventions to the issues.²³

4.1. Key steps to develop community health improvement plan²³

1. Prioritise list of health issues
Prioritise in terms of what issues are possible to tackle in the next 6 months to one year. For issues that cannot be resolved quickly, refer them to the appropriate government department or service provider. This can be communicated through the Facility Manager if necessary
2. Brainstorm possible interventions to deal with the priority issues that can be tackled
3. Select the best and most feasible intervention
4. Make an activity plan to implement the intervention. The plan should include:
 - a. Action items to implement the intervention
 - b. People responsible for each action item
 - c. Timelines for action items and implementation
 - d. Expected outcomes for the intervention
5. Involve community members and other service providers as much as possible

A *Community Health Improvement Plan Template* is provided in Figure 2 below and is included in the *Team Leader Job Aid, Team Management*.

Figure 2: Health Improvement Plan Template

| Priority issue | Identified intervention | Action items to accomplish intervention | Person(s) responsible for each action item | Other service provider involvement | Timeline/due date for each item | Comments |
|----------------|-------------------------|---|--|------------------------------------|---------------------------------|----------|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

4.2. Examples of community interventions

Every community is different and will require different interventions for priority issues. Below is a list and description of example interventions which may take place once or may be on-going.

- **Information campaign**

Information campaigns may be implemented by the Outreach Team or by the community. These campaigns are meant to provide information that responds to an issue that was identified. For example, if the issue is that there is rubbish all over the community, some community members may want to make signs or posters which remind community members to use rubbish bins and not to litter.

- **Support groups**

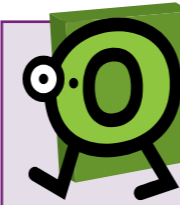
Support groups may also be implemented by the Outreach Team or by the community. Support groups are meant to provide a space or opportunity where people with the same problem can come together to receive support from one another. More information about setting up a support group is included in the *Team Leader Job Aid, General Information, 'Support Groups and Steps for Start-up.'*

- **Health campaigns or programmes**

Health campaigns or programmes are typically implemented by health service providers, such as the Outreach Team. A health campaign is often a once-off event that happens over a short period of time. A health programme is typically on-going over an extended period of time.

A health campaign is required when there is an identified health issue that can be dealt with on a large scale and quickly. For example, if an entire area within your ward has never been tested for HIV, you may want to have a HIV testing campaign. Another example is if there is a measles outbreak, the Outreach Team may work with the PHC clinic to organise an immunisation campaign to get children immunised against measles.

Health programmes such as TB programmes and others can be initiated within the community. As the OTL, you will need to identify where a gap exists for such a programme and help initiate it. This does not mean that it will be your responsibility to manage the programme but rather to mobilise other resources to do it.

**Learning Objective 5**

To understand how to involve the community in implementing interventions for health issues.

5. Community involvement

How can the Outreach Team involve the community in the actual implementation of interventions?

1. Regular community meetings for consultation
2. Resource mobilisation

5.1. Regular community meetings

The best way to involve the community in carrying out the health improvement plan is to meet with them on a regular basis. At community meetings you can provide information and give on-going feedback.

How often should community meetings occur?**Think Point**

Ideally, your first community meetings will be the community entry meetings with community leaders, community members and service providers.

Your second set of community meetings will be for community consultation around the community profile and diagnosis and to prioritise community health issues.

Please note that you may have other meetings in between the first and second set of meetings.



After your initial community entry and consultation meetings, it is recommended and ideal that community meetings take place on a **monthly** basis. Try to link up with other community meetings or events where there is already some community attendance.

Where should community meetings take place?

Community meetings may take place in any hall (church, school or community centre) or open space that can accommodate a large group of people.

Who should attend community meetings?

The same people who attended the community entry and community consultation meetings should be invited to attend the monthly community meetings. Again, these should include:

- Outreach Team members
- Facility Manager (if possible)
- Community leaders
- Service providers
- As many members of the community as possible

What should be discussed at community meetings?

The following is an example community meeting agenda. This is included in the *Team Leader Job Aid, Team Management*.

Figure 3: Example Community Meeting Agenda

| Community Meeting Agenda | | |
|------------------------------|---|-------------|
| Date and time: | | |
| Location: | | |
| Apologies (if any): | | |
| Minute taker: | | |
| Supporting documents: | | |
| Time | Topic | Responsible |
| 09h00 – 09h05 | Welcome <ul style="list-style-type: none"> • Introduce self • Welcome everyone • Thanks to sponsors of venue | Chairperson |
| 09h05 – 09h35 | Outreach Team (initial meeting) <ul style="list-style-type: none"> • Introduce each CHW • Describe purpose of team and what team will be doing | Chairperson |
| 09h35 – 10h05 | Provide feedback on issues raised in previous meeting (if applicable) | Chairperson |
| 10h05 – 10h25 | What the community can expect to see in the next month (e.g. household registrations, health campaigns) | Chairperson |
| 10h25 – 10h55 | Feedback from other service providers on community issues | Chairperson |
| 10h55 – 11h15 | Question from the community | Chairperson |
| 11h15 – 11h20 | Closing <ul style="list-style-type: none"> • Thank everyone for taking the time to attend. Invite people to come chat to you after if they have concerns | Chairperson |

While meeting minutes are not necessary for community meetings, it is important that you record when the meeting took place and write down the main highlights, decisions or next steps made in each community meeting.

5.2. Resource mobilisation



Who are resources?

Resources are the financial and non-financial supplies that are required to implement an intervention for a health issue. Resources may include money, skills, people's time, services of people in the community, equipment and materials.²⁴

What is resource mobilisation?

Resource mobilisation is the process of getting the resources together that you need to implement the intervention for a health issue. These may include both financial and non-financial resources.²⁴

Steps in resource mobilisation:²⁴

1. Identify what resources you need to implement the identified intervention for the issue
2. Ensure that all stakeholders, service providers and community members (who you will be requesting the resources from) are fully aware of all information about the intervention and why the resources are required
3. If the intervention requires volunteers:
 - a. Identify tasks that need to get done, outline a job description, duration of the volunteer service, and skills required
 - b. Depending on your needs, recruit volunteers from the community, including schools, churches or health facilities
4. If the intervention requires materials or skills from other local service providers, ensure that you:
 - a. Set up a meeting with the service provider to discuss resource requirements and what they are able to provide
 - b. Discuss clear roles and responsibilities for the implementation of the intervention



Group Activity



Divide into 4 groups following which each group will be assigned a different health issue for their community.

As a team, you will need to agree on the way you will respond to your community issue and come up with three possible interventions to address the issue and how to involve your community.

For each of the three interventions to address the health issue, you must give the following details:

- What is the activity that will get your community involved and how will it work?
- Who will be involved?
- How will community involvement be encouraged?

Present your approach to the larger group.

Lesson 6

Household Engagement

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Your role as an Outreach Team Leader

Your role as the OTL is to link, build and supervise relationships between the CHW, the HH and service providers. You will provide support, supervision and guidance to the CHW and implement interventions when necessary.

Learning objectives

This Lesson has four main learning objectives:

1. To understand how to allocate HHs to CHWs.
2. To understand the HH registration, screening and assessment process.
3. To understand how to establish and maintain a referral system for the catchment area.
4. To understand the importance of and how to supervise CHW home visits.



1. Introduction to the Lesson

Now that you understand your role and your team's role at the community level, you need to understand the Outreach Team's role, specifically the CHWs, with the HHs in the community. As you will remember from the Service Delivery Lesson (Lesson 3), there are a range of services that the team will provide to HHs.

Ideally, you will have already conducted your community entry and community consultation meetings so that the HH members are aware of the Outreach Team in general and they know what to expect when, in particular, the CHWs come to their home.

So how do we get started with service delivery to HHs?

As the OTL, you must ensure that:

1. Every HH in your catchment area has been assigned to a CHW in your team
2. Every HH is registered, screened and assessed in accordance to the HH registration process
3. The needs of the HH are met by referring them to service providers when appropriate
4. The CHW home visits are conducted at the highest standard and all processes, protocols and forms are completed as per the guidelines

**Learning Objective 1**

To understand how to allocate HHs to CHWs.

2. Allocation of Households to CHWs

It is your responsibility as the OTL to allocate HHs to each CHW in the team. The CHWs will be responsible for:

- HH registration, screening and assessment
- Conducting follow-up HH visits
- Administering services as required

HH allocation is not set in stone. All HHs must be allocated initially to ensure that all HHs have been registered, screened and assessed. Once all HHs are registered, you may have to re-allocate HHs based on the number of vulnerable HHs that require immediate follow-up.

Key steps in HH allocation:

1. Use the community map/individual CHW HH maps to determine the number of HHs in the catchment area and where the HHs are located
2. Allocate HHs to CHWs in a way that all CHWs will have a fairly equal work load
3. Identify HHs using a clearly defined numbering system

2.1. Step 1: Determine the number of HHs in the catchment area

The first step in HH allocation is to determine the number of HHs in the catchment area.

The method for creating a community map has been described in the community lesson (Lesson 5, Community Entry, Assessment and Involvement). Once you have added all the individual maps from each CHW's contributions you will know exactly how many HHs are in your catchment area.

Remember that it is still possible that you may have missed mapping some HHs and your CHWs must be aware of this as they start the registration process. For this reason, the community map must be continuously updated.



2.2. Step 2: Allocate HHs to each CHW

Having determined the total number of HHs in your catchment area, you now need to allocate or assign the HHs to each CHW, so that they know which HHs they will be responsible for. This should be done before the CHWs can enter the community.

1. Get an estimate of the number of HHs to be covered by each CHW

- Divide the total number of HHs in the community by the total number of CHWs in your team to get the average number of HHs to be covered by each CHW

For example:

The CHWs have identified 2000 HH in the community.

You have 10 CHWs in your team.

$2000 / 10 = 200$ HHs per CHW

As discussed in Lesson 1, every Outreach Team is different and every catchment area is different. Some OTLs may manage more than 6 CHWs. If the PHC clinic catchment area is very large, there will eventually be more than one Outreach Team reporting to that clinic.

2. Using your community assessment, demarcate HH coverage areas for each CHW based on:

- Land marks in your catchment area (e.g. mountains, rivers, major roads, buildings)
- Number of villages, townships or communities in your catchment area
- Even or balanced distribution of workload amongst the CHWs. This means that each CHW HH area should contain a mix of HHs (e.g. if you know of a particular area with a high number of HHs that are vulnerable, this entire area should not be allocated to a single CHW)



The actual number of HHs allocated to each area might not be the same and will depend on the:

- Size of the catchment population; the larger the size, the greater the number of HHs in the area
- How far the HHs are from each other; the closer they are to each other, the greater the number of HHs to be covered in an area
- Geography of the area; natural landmarks such as mountains and rivers could serve as a boundary between HH coverage areas

3. Allocate the HHs to each CHW. Ideally, CHWs should be allocated to the HHs in the area where they reside or is closest to them. Should this not be possible, other techniques that could be used include:

- Compare the background, experience and training of the CHW to the needs of the HHs in a particular area
- Look at personal safety of CHWs, especially in rural areas and areas lacking proper roads (it might be necessary to assign 2 CHWs to this area)
- Time planning and management; CHWs must have sufficient time to adequately meet the needs of the HHs. This would be particularly relevant in:

- Rural areas where HHs are far apart and the distance that a CHW must travel is greater
- HHs with large families where the CHW would have to serve many people on a visit and where there may be more than one vulnerable person
- HH coverage areas lacking access to basic services such as health care, social services, home-based care, etc., since more time might be required and follow-up visits might need to be more frequent

All HHs in your catchment area must be allocated to a CHW. You need to ensure that there is no overlap in the allocation of HHs to CHWs and that **no HH in your catchment area is unaccounted for**.

Once you have completed steps 1 and 2, you will fill in the total number of HHs allocated to each CHW on the *Team Leader Record of CHWs in Outreach Team*. This will be discussed further in Lesson 7 [Monitoring, Evaluation and Reporting] and has been included in the *Team Leader Job Aid, Team Management*.

2.3. Step 3: HH identification and numbering

It is important that you have a numbering system to identify the HHs in your catchment area. For now, it is the responsibility of the OTL to work out this numbering system. The numbering system should be clearly documented and systematic.

Eventually, all HHs in South Africa will be numbered in a way that aligns with the Stats SA numbering system. You will be notified when this change will take place.

For now, you will see one or both of the following on the *CHW Forms* in the *Team Leader Job Aid*:

- **'CHW HH Identifier No.':** This is the number that you will decide on with CHWs in your team; must be systematic and documented.
- **'Official HH Registration No.':** This is the number that will be allocated to each HH once the Stats SA numbering system is adopted.

Once you have a numbering system in place, you will list each HH number on the *Team Leader Record of HHs per CHW*. This sheet will be discussed further in Lesson 7 [Monitoring, Evaluation and Reporting] and has also been included in the *Team Leader Job Aid, Team Management*.





Learning Objective 2

To understand the HH registration, screening and assessment process.

3. HH registration, screening and assessment process

Now that you have clearly identified all HHs on the community map and have allocated all the HHs to the CHWs, the CHWs must start the HH registration process. The following section outlines the steps for HH registration, screening and assessment.

3.1. Determine where to start with HH registration process

When deciding where to start with HH registration and assessments, the most important tool to use is the community profile. Factors that you will need to take into consideration include:

- Consider which areas are most vulnerable
 - Burden of disease
 - Number of pregnant women
 - Number of women who have given birth in the last 6 months
 - Number of children under 5
 - Unemployment
 - Poverty
- Consult with the community to ensure that the vulnerable areas that you identified match with the community identified vulnerable areas

This information can be obtained from the community assessment process, the Facility Manager or even from community leaders and ward councillors.

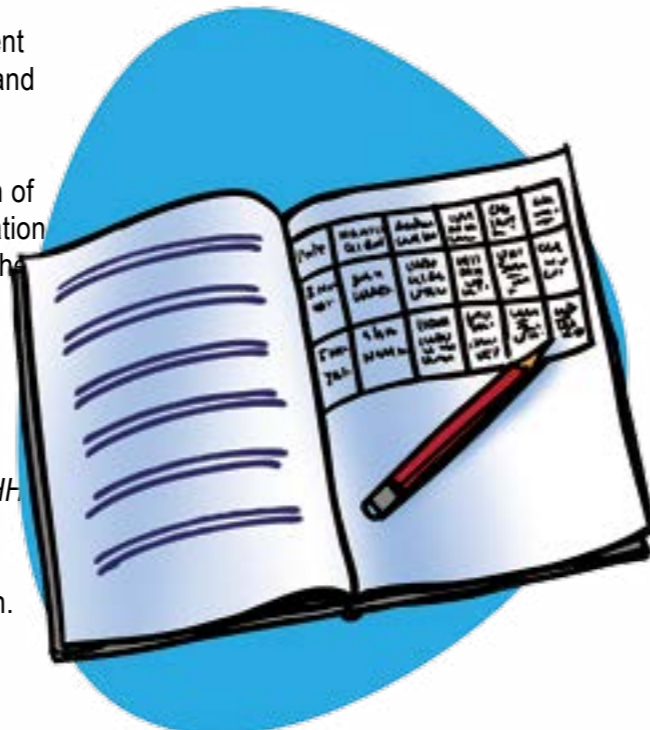
In the absence of specific community needs or a specific burden of disease, the easiest and most practical point to start the registration process would be at the HHs furthest from the clinic or facility. The municipal map could be used for this purpose.

3.2. CHW preparation for HH registration

Once the CHW has been allocated their initial HHs for HH registration, you will help them to set targets using the *Weekly HH Visit Schedule* discussed in Lesson 4 [Team Management].

The CHW must be adequately prepared for each HH registration. They should:

1. Have all of the forms needed, pen, pencil and eraser



2. Introduce themselves to the HH and explain their role within the Outreach Team
3. Confirm that it is a good time to visit or if they should rather make an appointment for another time
4. With the HH member's permission, proceed with filling in the *HH Registration Form*

You must ensure that your team members wear their uniform (badge, shirt, cap) at every HH visit. Also, the CHW should have a letter from the Facility Manager at each HH registration visit which explains what the Outreach Team and CHW is doing.

3.3. HH Registration Form

The *Household Registration Form* serves four purposes.

1. **To collect data to be captured electronically and collated to provide a picture about the community the Outreach Team serves.** This data includes numbers that summarise age groups, living conditions and basic health and referral information. This data will provide baseline information about HHs and communities at ward, sub-district, district and provincial levels. This will help programmers at all levels to plan, compare and monitor this program.
2. **To collect and keep a record of information about each HH** that is useful for the Outreach Team when planning services and following HHs. The *Household Registration Form* can give a "snapshot" picture of all the HH members, their ages, genders, grant and employment conditions as well as key features of their living conditions such as access to a working fridge or piped water in the HH. It also has a space to keep notes on extra information that might be useful for service planning but is not written on the form.
3. **To act as a screening tool to guide CHW care at this initial HH visit and form a record of this process.** This includes basic screening questions for TB symptoms, family planning services, HCT, and others. It identifies HH need to be followed-up and guides towards immediate identification of problems in HH that may require referrals.
4. **To register all HH, and individuals living in those HH, with a health facility as part of the NHI registration process.**

3.4. HH assessment process

As the OTL, you must ensure and reinforce that the CHWs are following the HH assessment process. The CHW steps for HH assessment are included below.

Step 1: Every HH will be registered using the *HH Registration Form* (see *CHW Household Tools and Team Leader Job Aid*) from the NDOH.

Step 2: Once a HH has been identified as 'vulnerable' a full HH assessment will be conducted. Questions to check if a HH is 'vulnerable' are found on the *HH Registration Form*.

Step 3: Once a 'HH vulnerability' due to a health issue has been found, the CHW will then carry on with individual health assessments.

Step 4: Schedule the next HH visit and complete the *Referral Form* (if necessary)

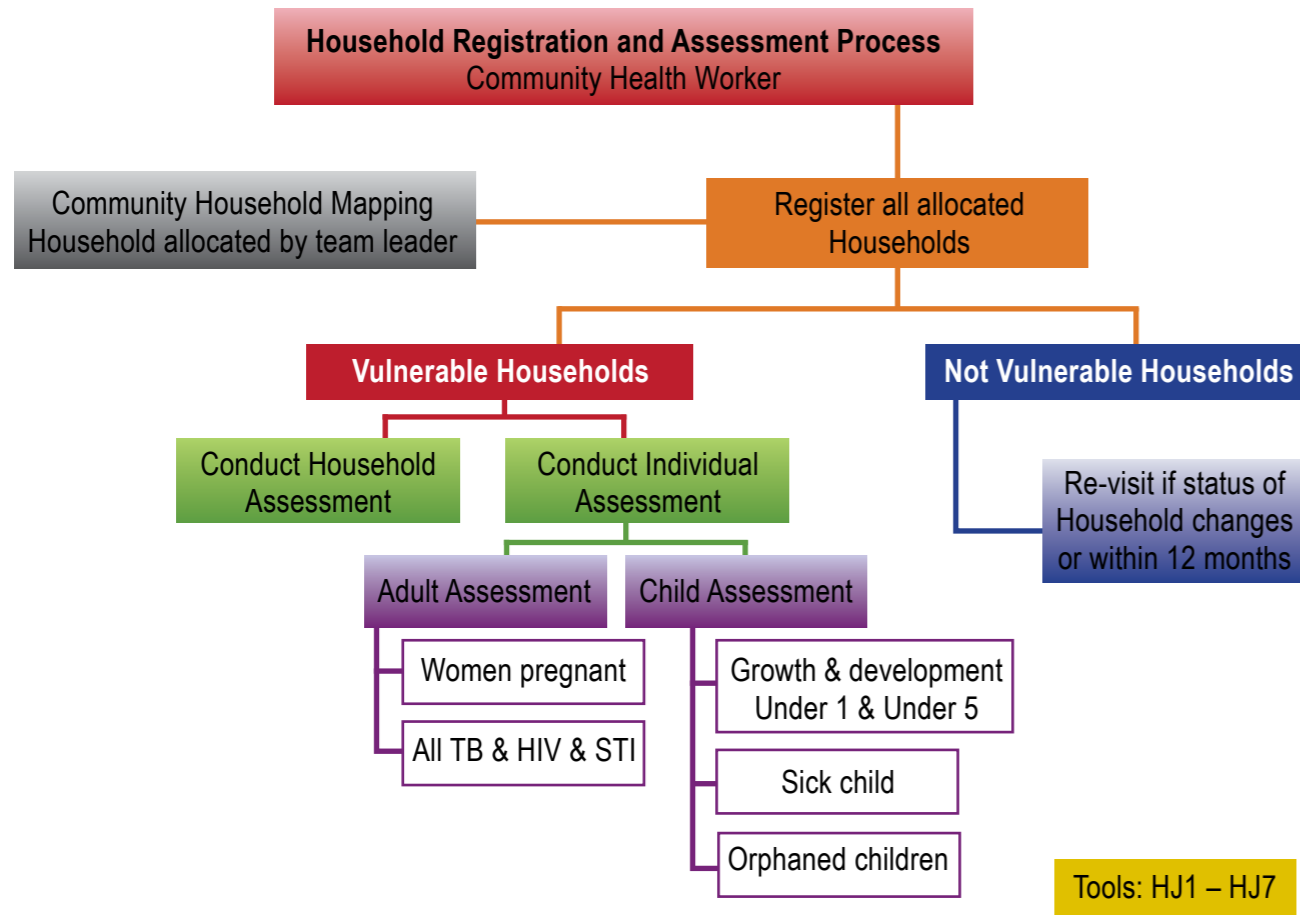
Some community members may be suspicious about the reason for a HH assessment, and may worry that it may create problems for them. The CHW must explain why the HH assessment is being done and advise them that it is part of the job of the Outreach Team. Their intention is to make sure that every 'vulnerable' person within a HH has contact with a CHW. The CHW should also assure HH members that all information provided is confidential and will not be shared with anyone outside the Outreach Team.

When a CHW registers the 'family unit' he/she will collect the following information:

- Details of the head of HH
- Details of where the HH is located
- Details of any socioeconomic grants that the HH may be receiving
- Details of HH members
- Details of type of HH vulnerability and services required

The diagram below sets out the process for registering and assessing HHs in your community. This process is the responsibility of the CHWs.

Figure 1: HH registration and assessment process ¹⁹



The tools referenced in Figure 1 above may be found in the *CHW Household Tools*.



Individual Activity

Using the scenario and information included in the *Team Leader Job Aid* under *Exercises*, complete a *Household Registration Form*. If the household is vulnerable, what are the next steps and what other forms would need to be completed.

Discuss in the larger group.

3.5. Re-allocate workload after HH registration

Once the registration and assessment of HHs has taken place, priority is placed on the vulnerable HHs. Not all HHs that are registered will be vulnerable and this will mean that a re-allocation of HHs will have to be done to balance the workload among all the CHW's in your team.

During this re-allocation process, the principles described in the section 'Allocation of HHs to each CHW' above, must once again be applied.



Learning Objective 3

To understand how to establish and maintain a referral system for the catchment area.

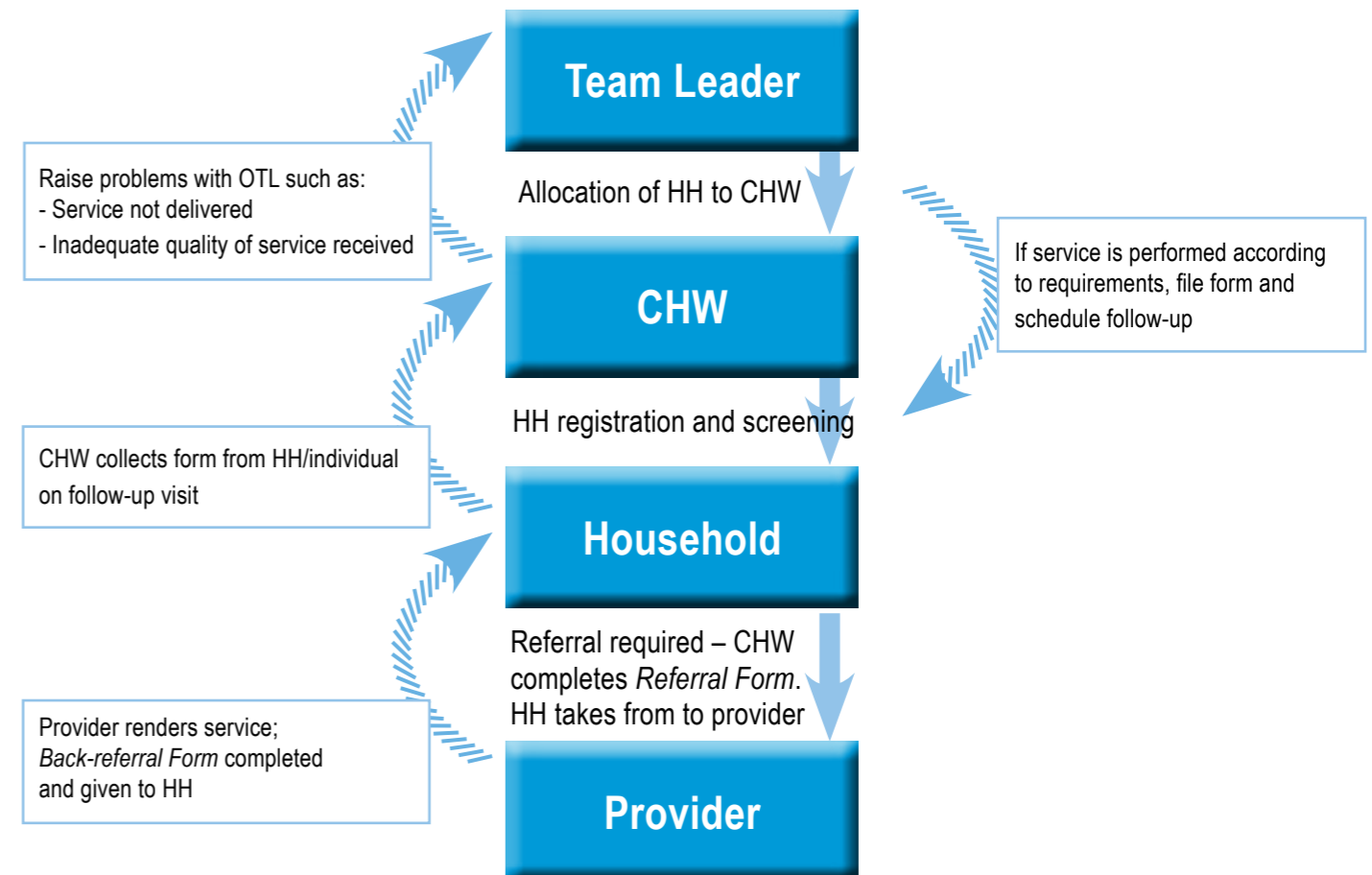
4. Referral system

As discussed, the next steps after HH registration and assessment include the CHW providing whatever services they can within the HH and referring clients to other service providers when necessary.

Referrals have been discussed in previous Lessons but you should now understand what the referral system looks like:

1. Based on a HH screening and assessment, the CHW may identify an individual for referral to either health services, social services or home-based care and/or identify the HH in need of basic services such as water, electricity, sanitation, telephone and refuse collection.
2. The CHW completes the *Referral Form (Team Leader Job Aid, CHW Forms)* and gives the form to the individual who requires the service or individual responsible for the HH if the individual who requires the services is unable to go, to take to the relevant facility/clinic/organisation.
3. The OTL must follow-up on the referrals made to facilities, based on the *CHW Household Visit Monthly Summary Form (Team Leader Job Aid, CHW Forms)* to ensure that the referral system is effective.
4. The facility/clinic/organisation provides the requested service or care. At the end of the consultation, the service provider completes the *Back-referral Form* and gives it back to the individual who they provided the service to.
5. The CHW collects the *Back-referral Form* on the next follow-up visit to the HH. If the service has been provided, the form can be filed by the CHW. If not, the *Referral Form* is then given to the OTL to follow-up. The follow-up may include:
 - a. Making contact with the relevant service provider
 - b. Visiting the HH
 - c. Finding a new service provider
6. In the case of home-based care or a referral to other institutions such as orphanages or old age homes, no formal *Back-referral Form* or feedback is needed. However the OTL must follow-up and ensure that the required services are being provided to the individual.

This process is outlined in Figure 2 below.



4.1. Role of the OTL in the referral system

The OTL coordinates and oversees the entire referral system. He/she is responsible for its performance and ensuring that the referrals are linked to care and service delivery.

1. Using the *Community Resource List (Team Leader Job Aid, Team Management)*, the OTL must identify and liaise with service providers for the catchment area
2. The OTL must ensure service providers know and understand their roles, responsibilities and services to be provided
 - Notify service providers that there will now be an increase in their workload due to the referral system
 - Referral procedures must be agreed upfront
 - Every service provider must have a designated person who helps HHs gain access to needed services and is responsible for processing, managing and documenting referrals
 - All service providers must be familiarised with the necessary *Referral/Back-referral Form* and how it should be completed
3. The OTL must put systems in place to develop and support service providers
 - Set up regular meetings (monthly) to promote collaboration and commitment; you should work with service providers to address gaps, new service requests, individual/HH issues, catchment area issues, updating the

- Support CHWs by attending to or raising issues beyond their scope of practice
 - Act as a channel through which CHW concerns can be raised through to the referral system

5.1. Supervisory duties and responsibilities

Supervising CHWs means that you need to encourage and help them achieve their objectives relating to the home visits. This can be done by acknowledging work done well, praising them for their efforts or supporting them when they experience difficulties. Support also involves sharing information, providing advice, arranging for training and making time to assist CHWs in their day-to-day activities. Support and assistance to CHWs can be provided via telephone calls and regular meetings.

As the OTL, you would need to:

- Set targets for home visits
- Monitor and assess performance of home visits
- Provide clinical guidance, support and practical skills training

Think Point

In Lesson 4 [Team Management], we discussed how performance management is an on-going process. As the OTL you must supervise and monitor the CHW performance on a daily basis. This may happen through setting targets and observing home visits. The target goals and home visit observations may be points of discussion in the twice yearly formal performance reviews.



5.1.1. Set targets for home visits

You will work with your team to set targets for the week and for the month. Targets may be based on the HHs to be registered, assessed or followed-up. As the OTL, you must ensure that the CHWs understand what their targets are and then you must follow-up at weekly team meetings to ensure that the targets were met, and if not, why.

5.1.2. Monitor and assess performance of home visits

The best way to see whether a CHW is performing well is to observe him/her conducting a home visit. As described in the performance management section of Lesson 4 [Team Management], you will evaluate each CHW in your team conduct each type of HH visit at least twice a year using the appropriate evaluation forms. These forms were discussed in Lesson 4 and are in the *Team Leader Job Aid, Individual Team Member Management*. Note as well that this is a requirement for successful completion of the CW Phase 1 Competency Assessment.

You may also observe or accompany CHWs on home visits at **any time**. You are encouraged to accompany CHWs whenever you have the opportunity, especially if you have any concerns about a particular team member. Any time

that you observe a CHW home visit, you should take note on whether or not the CHW:

- Is able to recognise visible signs and symptoms
- Takes the necessary health and safety precautions
- Is sensitive and understanding towards the HH members

The OTL should NOT interrupt a home visit unless a serious error is being committed, but should note their observations and the issues they want to discuss in their notebook during the home visit.

Examples of serious errors include:

- Acting beyond CHW scope of work (e.g. diagnosis of a HH member)
- Failure to follow set procedures (e.g. not using gloves during an assessment)
- Breach of confidentiality or ethical issues (e.g. talking to one HH about what is going on at another HH)

In the event that the error being committed is serious and requires immediate intervention, the supervisor would need to correct the behaviour in a manner that would contribute to the assessment process, so that the HH or HH member does not feel the CHW is inferior or incompetent.

5.1.3. Provide feedback about HH visit

As discussed in Lesson 4 [Team Management], it is important to discuss supervised HH visits with the CHW. You may use the *Post Evaluation Discussion Questions* to guide your discussion.

You and the CHW must reach an agreement on any problems identified and the solutions proposed. It may be necessary to supervise the next HH visit or schedule another visit to observe whether the suggested solutions have been implemented.

In this way, positive outcomes are reinforced and negative outcomes can be dealt with immediately. If necessary schedule a skills training follow-up session with the CHW.

5.1.4. Provide clinical guidance, support and practical skills training

Identification of areas requiring clinical guidance, support and practical skills training can arise from many sources such as requests from individual CHWs, your observation as OTL or feedback from community members or service providers.

Clinical guidance, support and practical skills training are on-going and can be provided via:

- One-to-one sessions with CHWs
 - Discuss personal issues and concern (e.g. emotional support)
 - Discuss work related issues and concerns (e.g. advice on assessments done, how to improve assessment skills)
 - Specific catchment area problems (e.g. high TB defaulter rate)

Lesson 7

Monitoring, Evaluation and Reporting

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Your role as an Outreach Team Leader

Your role as the OTL is to monitor and evaluate all of the activities and services delivered by the Outreach Team.

You must ensure that all required reports are completed, filed and stored confidentially.

Learning Objectives

This Lesson has four learning objectives:

1. To understand the importance of monitoring and evaluating all Outreach Team activities, including all services delivered.
2. To understand how to complete all required Outreach Team reports.
3. To understand how to organise and file all Outreach Team documents and store them in a secure location.
4. To understand what happens to all of the information that is captured by the Outreach Team.



**Learning Objective 1**

To understand the importance of monitoring and evaluating all Outreach Team activities, including all services delivered.

1. Monitoring and evaluation

Monitoring and evaluation are terms that are often used together but they have slightly different meanings.

**What is monitoring?**

Monitoring is the collection of information as the Outreach Team progresses. It is aimed at improving the efficiency and effectiveness of the team. Monitoring is an on-going process. It helps to keep the work on track and to let management know when things are going wrong. Monitoring also enables you to determine if the resources you have available are sufficient and appropriate.²⁵

What is evaluation?

Evaluation is the comparison of how the team has done against what you planned to do. It looks at what you set out to do and what you actually accomplished and how you accomplished it.²⁵

You should use both monitoring and evaluation to see what you are doing and how well you are doing it. It is very similar to the performance management of an individual team member but instead we are now looking at the performance of the entire Outreach Team.²⁵

1.1. Why do we need to monitor and evaluate work activities?

- **Tracking progress**
 - Are all tasks happening on time and to the expected standards with regard to quality and accuracy?
 - Have the CHWs in the team registered all HHs in your community? Have all HHs been assessed? Are vulnerable HHs being cared for or referred as and when needed?
 - Is the Health Promoter working with the identified service providers?
- **Comparing expected outcome to actual outcome**

Think Point

Think back to Lesson 4 [Team Management, Activity Planning].
An expected outcome is the result you expect to have after completing an activity.

Example: All CHWs trained on basic first aid through an accredited training organisation.

**What is an actual outcome?**

The actual outcome is the actual result of the activity once you have completed all required actions.

Example: 9 out of 10 CHWs trained on basic first aid. The last CHW will be trained on next available course.

- Are the outcomes as we expected?
- Are they better or worse than expected?
- Do we need to adjust our expected outcomes now that we know what the actual outcomes are?
- **Making adjustments**
 - As you monitor how the team is doing, you are able to make adjustments when necessary.
 - » For example, if the Environmental Health Practitioner does not understand the needs in the community, you may have to adjust your team and assign a CHW to assist him/her.
 - » Another example, if the referral system is not working and it seems that you have to provide follow-up on every referral written, you may have to have an intervention where you bring all service providers and the entire Outreach Team together for a workshop on the referral system and *Referral/Back-referral Form*.
- **Analysing impact**

**What is impact?**

Impact is the mid to long term effect that the Outreach Team has on the health of the community (especially in terms of the NSDA outputs and MDGs).

Example: Reduction of maternal and child mortality in the district you are working in.

- It is important to understand that the impact of the Outreach Team cannot be measured over a short period of time. It might take years in order to analyse whether or not the team has had an impact on the access to and delivery of primary health care services in the community and district that you work.
- It is also the responsibility of the Facility Manager, the DHT and the NDOH to determine if the Outreach Teams in your district are having an impact on the NSDA outputs and MDGs in your district and in your province.

1.2. How do I monitor and evaluate the activities of the Outreach Team?

Individual Outreach Team members will be monitored and evaluated through the performance management process that has been described in previous lessons.

It is your responsibility as the OTL to monitor and evaluate the overall team's performance. This will be done informally and formally through record keeping.

1.2.1. Informal monitoring and evaluation

Informal monitoring and evaluation may happen in two ways:

- Weekly team meetings

In your weekly team meetings and monthly community meetings, you should get a good sense of how your team is performing within the community.

- Verbal feedback from community members and other service providers

All verbal feedback from community members and other service providers that are received through community meetings, one-on-one discussions with HH members or through letters should be taken seriously and responded to appropriately.

1.2.2. Formal monitoring and evaluation

Formal monitoring and evaluation will happen through specific reporting forms that will be submitted to your Facility Manager. These reports are described further in sections below.



Learning Objective 2

To understand how to complete all required Outreach Team reports.

2. Reporting

This section reviews the reporting forms that need to be completed by both the CHW and the OTL in order to monitor and evaluate the performance of the Outreach Team. Some of these forms were introduced or mentioned in previous Lessons.

2.1. CHW reports

As the CHWs are responsible for delivering services at the HH level, it is their responsibility to document:

- Which services are delivered
- How many HHs they registered
- How many HHs they delivered each type of service to

This information is captured by the CHW in two forms which were described in Lesson 4 [Team Management]:

1. *CHW Household Visit Tick Sheet*
2. *CHW Household Visit Monthly Summary Form*

The next section presents each form that is completed by the CHW and explains the:

- Purpose and importance of the form
- What it is intended to monitor
- When the form is completed
- Who it is submitted to
- Where the form can be located

2.1.1. CHW Household Visit Tick Sheet

Purpose and importance: The *CHW Household Visit Tick Sheet* is used to document every HH visit that the CHW conducts. This form is important to ensure that all CHW activities and services delivered to HHs/individuals are captured for monthly Outreach Team reporting.

What is the form monitoring?

The form monitors the daily progress made by the CHW so that they can summarise the information in the *CHW Household Visit Monthly Summary Form* which is discussed next.

When is the form completed?


The CHW records every HH visit that they conduct at the end of each day or at the beginning of the next day. The HH visits should be recorded as soon as possible after the visit is conducted so that the CHW does not forget to do so.

Who is the form submitted to?

This form is not submitted to anyone. The CHW uses this form to complete the *CHW Household Visit Monthly Summary Form*. Once they have completed the monthly summary form, they will file this form in their own filing system to ensure that they have their own record of HH visits.

Where is this form located?

This form is included in the *CHW Household Tools* and in the *Team Leader Job Aid*.

| | | | |
|--|--------------------------|---------------------|------------------------|
| CHW Household Visit Tick Sheet  Department: Health REPUBLIC OF SOUTH AFRICA | CHW name _____ | Month/Year _____ | Page no. _____ |
| | Clinic (DHIS name) _____ | Ward (DHIS #) _____ | Team (DHIS name) _____ |

| Visit no. | Visit date (dd/mm) | Official household registration number ¹ | Household visit details <i>(note: tick only ONE type of visit)</i> | | | Household activity <i>(note: tick only once per activity)</i> | | | | | Number Referral Forms given (total) | | | Activity head count (total) | |
|---|--------------------|---|---|-----------------|------------------|--|-----------|---------|-------------------|-----------------|-------------------------------------|---------------------------------------|---------------------------------------|-------------------------------------|---|
| | | | Household registration visit | Follow-up visit | Supervised visit | Pregnancy | Postnatal | Under 5 | Adherence support | Home-based care | Clinic Referral Forms issued | Social services Referral Forms issued | Home-based care Referral Forms issued | Clients under 5 years given service | Clients 5 years and older given service |
| 1 | | | | | | | | | | | | | | | |
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| 14 | | | | | | | | | | | | | | | |
| 15 | | | | | | | | | | | | | | | |
| 16 | | | | | | | | | | | | | | | |
| 17 | | | | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | | | | |
| 19 | | | | | | | | | | | | | | | |
| 20 | | | | | | | | | | | | | | | |
| 21 | | | | | | | | | | | | | | | |
| 22 | | | | | | | | | | | | | | | |
| 23 | | | | | | | | | | | | | | | |
| 24 | | | | | | | | | | | | | | | |
| 25 | | | | | | | | | | | | | | | |
| Total | | | | | | | | | | | | | | | |
| Total number of support groups facilitated this week | | | Notes: | | | | | | | | | | | | |

CHW signature _____ (date) _____ Verified by TL _____ (date) _____

¹ Use the CHW HH identifier number if an Official HH registration number has not yet been assigned to the household

Lesson 7

7 Reporting

2.1.2. CHW Household Visit Monthly Summary Form

Purpose and importance: The *CHW Household Visit Monthly Summary Form* is used to summarise all HH visits completed by the CHW in one month. Each CHW will complete an individual monthly summary form. This form is important to ensure that all CHW activities and services delivered to HHs/individuals are captured and summarised in one form so that the Team Leader can summarise all *CHW Household Visit Monthly Summary Forms* without reviewing every *CHW Household Visit Tick Sheet*.

What is the form monitoring?

The form monitors the monthly progress made by each CHW so that the OTL can summarise all HH visits conducted by the entire Outreach Team.

When is the form completed?


The CHW must complete and submit this form at the end of every month. It is the responsibility of the OTL to create a deadline for submission near the month end.

Who is the form submitted to?

This form is submitted to the OTL every month.

Where is this form located?

This form is included in the *CHW Household Tools* and in the *Team Leader Job Aid*.

| CHW Household Visit Monthly Summary Form | | CHW name | | | | | | | | | | | Reporting month/year | | |
|---|-----------------------------|------------------------------|-----------------|------------------|-----------------------------|-----------|---------|-------------------|-----------------|-------------------------------|-----------------|-----------------|------------------------------|---------------------------|------------------------------------|
|  Department: Health REPUBLIC OF SOUTH AFRICA | | Clinic (DHIS name) | | | | | | | | | | | Ward (DHIS #) | | |
| | | Team (DHIS name) | | | | | | | | | | | | | |
| Household visit details (totals) | | | | | Household activity (totals) | | | | | Referral Forms given (totals) | | | Activity head count (totals) | | Support groups facilitated (total) |
| Tick sheet no. | Tick sheet end date (dd/mm) | Type of visit | | Supervised visit | Pregnancy | Postnatal | Under 5 | Adherence support | Home-based care | Clinic | Social Services | Home-based care | Clients UNDER 5 years | Clients 5 years and older | |
| | | Household registration visit | Follow-up visit | | | | | | | | | | | | |
| 1 | | | | | | | | | | | | | | | |
| 2 | | | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | |
| 7 | | | | | | | | | | | | | | | |
| 8 | | | | | | | | | | | | | | | |
| 9 | | | | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | | | | |
| Monthly Total | | | | | | | | | | | | | | | |
| Total community campaigns this month | | | | | | | | | | | | | | | |

CHW signature _____ Date _____

Verified by Team Leader _____ on _____ (date)

Individual Activity

Using the *CHW Household Visit Tick Sheet*, which is included in the *Team Leader Job Aid* under *Exercises*, complete the *CHW Household Visit Monthly Summary Form*.

Once complete, discuss with the larger group.



Lined writing area for the individual activity.

2.2. Team Leader reports

Once a month you will need to complete three reports according to the schedule that you agree with your Facility Manager. All templates for these reports may be found in the *Team Leader Job Aid*.

1. *Outreach Team Monthly Summary Form*
2. *Outreach Team Reporting Tool*
3. *Outreach Team Supplies Management Form*

The next section presents each form that is completed by the OTL and explains:

- Purpose and importance of the form
- What it is intended to monitor
- When it is completed
- Who it is submitted to
- Where the form can be located

2.2.1. Outreach Team Monthly Summary Form

Purpose and importance: This form is used to capture data on all HHs visited by the entire Outreach Team. This is the most important reporting form as it is the only form from the Outreach Team which feeds into the DHIS to report on all HHs visited and all services delivered to HHs/individuals by the entire Outreach Team.

What is the form monitoring?

This form pulls together the information from all *CHW Household Visit Monthly Summary Forms* for the reporting month into one form.

When is the form completed?

This form is completed every month.

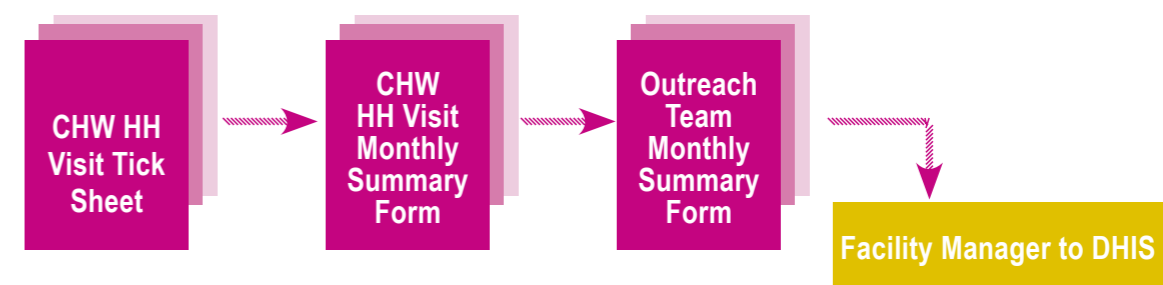
Who is the form submitted to?

This form is submitted to the Facility Manager every month. The Facility Manager submits the form to the District Health Information Officer (DHIO) to be captured on the DHIS.

Where is this form located?

This form is included in the *Team Leader Job Aid*.

Figure 1: Information flow for capturing information on HH visits



2.2.2. Outreach Team Reporting Tool

Purpose and importance: This tool is used to guide Facility Manager/OTL meetings. All items which should be discussed in these monthly meetings are included in this tool. This tool is the main form of communication and reporting between the Outreach Team and the Facility Manager. All Outreach Team issues, concerns and activities are communicated to the Facility Manager through this tool.

What is the form monitoring?

The form is used to monitor everything related to the Outreach Team including:

- CHW concerns and/or Outreach Team problems
- Planned or completed interventions by all team members, including the Health Promoter and Environmental Health Practitioner
- Total number of referrals made, *Back-referral Forms* completed and returned to the CHW by the client and feedback from specific referral cases
- Training completed by CHWs or conducted by the OTL
- Training required by team members
- General team management

When is the form completed?

This form is completed every month during or after the Facility Manager/OTL meetings.

Who is the form submitted to?

This form is submitted to the Facility Manager every month.

Where is this form located?

This form is included in the *Team Leader Job Aid*.

| Outreach Team Reporting Tool (to be used to guide meeting between Outreach Team and Facility Manager) | | | | |
|--|---|---|---|-----------------|
| Name of Team Leader | | Clinic | Name of Facility Manager | Date of meeting |
| Clinic/Outreach Team meeting checklist | | Comments (if YES, list major points, if NO, state why) | | |
| 1. Minutes from last meeting discussed including progress on actions decided upon at last meeting | Y | N | <i>Summarise progress on actions</i> | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 2. CHW concerns addressed and problems solved collectively | Y | N | <i>List of concerns raised and identified means to address these concerns</i> | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 3. Collective targets set with agreement of actions to help meet targets* | Y | N | <i>Targets and plans of action decided upon</i> | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

* Examples could include increased HCT, early antenatal booking, immunisation/Vit A coverage, postnatal clinic visit coverage, tracking treatment defaulters

| Clinic/Outreach Team meeting checklist | | | Comments (if YES, list major points, if NO, state why) | | | |
|--|---|---|---|--------------------------|----------------------|---------|
| 4. Community health campaigns discussed and planned | Y | N | Describe | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Referrals follow-up | | | Comments on issues of note regarding referrals and feedback through referral system | | | |
| 5. CHW referrals to clinic discussed | Y | N | | | | |
| | | | | | | |
| Total number of CHW referrals made this month | | | | | | |
| 6. Back-referral Forms completed and returned to CHW | Y | N | | | | |
| | | | | | | |
| Total number of Back-referral Forms received this month | | | | | | |
| Follow-up plans for clients | | | | | | |
| 7. Feedback given on CHW referral outcomes and follow-up of specific cases | Y | N | Client name | CHW HH identifier number | Reason for follow-up | Urgency |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Training completed (this month) | | | |
|--|----------------------------------|---|---------------------------------|
| How many CHWs on your team received ongoing training? | a | Proportion of Team CHWs given ongoing training this month? (box a/total # CHWs on team) | |
| How many of these CHWs completed the training satisfactorily? | b | Proportion of Team CHWs successfully completed training? (box b/box a) | |
| How many CHWs were newly trained for your team this month? | c | Proportion of new CHWs successfully completed training? (box c/box d) | |
| How many of these CHWs completed the training satisfactorily? | d | | |
| Training programmes conducted (specify program or content/area of focus) | Number of CHWs received training | Further identified training needs | Number of CHWs needing training |
| | | VCT | |
| | | IMCI | |
| | | Chronic care/adherence support | |
| | | HBC | |
| | | Antenatal/postnatal care | |
| | | TB screening/management | |
| | | Forms/reporting | |
| | | Other (specify) | |
| | | | |
| | | | |
| Overall management | | | |
| Is there a monthly plan to oversee each CHW at least once? (If YES, comment on the degree of implementation of the plan) | | | Y N |
| Comment | | | |
| Is there a need to run further training and support sessions in the following month? | | | Y N |
| Comment | | | |
| Have you co-ordinated with relevant structures for the timely delivery of supplies and pharmaceuticals necessary for the CHW? | | | Y N |
| Comment | | | |
| Data feedback from DHIS | | | |
| Have you received a summary on the HHs that were profiled by your team last month? | | | Y N |
| Have you received summary of data on Outreach Team activity last quarter? | | | Y N |
| | | | |
| Is there a plan to incorporate community feedback into CHW performance evaluation once annually? (If YES, comment on the degree of implementation of the plan) | | | Y N |
| Comment | | | |

2.2.3. Outreach Team Supplies Management Form

Purpose and importance: The purpose of this form is to help the OTL manage the team supplies. This form is necessary to ensure that the team is always adequately stocked with supplies that are required to deliver services to HHs and individuals.

What is the form monitoring?

This form is used to monitor and manage Outreach Team supplies that are required for the team to deliver services to the community and HHs. The form includes details of available supplies and supplies that must be ordered.

Who is the form submitted to?

This form is submitted to the Facility Manager every month. The Facility Manager uses the form to place any necessary orders for the Outreach Team. The supplies ordering process in each PHC clinic may be slightly different and may have a staff person who is responsible for ordering supplies.

When is the form completed?

This form is completed every month.

Where is this form located?

This form is included in the *Team Leader Job Aid* and was discussed in Lesson 4 [Team Management].

Figure 2: Outreach Team Supplies Management Form

| Outreach Team Supplies Management Form | | | | |
|--|-----------|--------------|------|--|
| Name of Team Leader | Team name | Clinic | Ward | Date |
| | | | | |
| <i>Please tick if the item is in stock, not in stock or is not applicable to your team. If the item is not in stock, please write how many you need for the entire team.</i> | | | | |
| Supplies | In stock | Not in stock | NA | If not in stock, how many you need for the entire team |
| Stationery | | | | |
| Pens | | | | |
| Paper | | | | |
| Notebook | | | | |
| Files | | | | |
| Filing boxes | | | | |
| Lever arch files | | | | |
| CHW kit bag supplies | | | | |
| Latex gloves small box | | | | |
| Roll plaster 2.5cm x 1cm | | | | |
| Antiseptic liquid 125ml | | | | |
| Gauze swabs medium box | | | | |
| Sanitary pads 10's | | | | |
| Linen savers 20's | | | | |
| N95 mask | | | | |
| Cotton wool | | | | |
| Small scissors | | | | |
| Tape measure | | | | |
| Mouth piece | | | | |
| Disposable nappies 10's | | | | |
| Disposable thermometer | | | | |
| Male condom (box) | | | | |
| Female condoms (box) | | | | |
| Hand sanitiser | | | | |
| Cover your couch tissues | | | | |
| Upper arm tape | | | | |
| Small torch | | | | |
| CHW uniform | | | | |
| Cap embroidered | | | | |
| Raincoat | | | | |
| Shirt | | | | |
| Name tags | | | | |
| Kit bag | | | | |
| Lanyard | | | | |

| From the list above, please outline how you will obtain the supplies needed. | | | |
|--|--------------------------------------|--------------|---------------|
| Items needed | Where/who you ordered the items from | Date ordered | Date received |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |
| 13 | | | |
| 14 | | | |
| 15 | | | |

Submit this form to your Facility Manager at the end of every month. Please ensure that you and the Facility Manager has signed off the form.

Team Leader Signature _____ Date _____
 Facility Manager Signature _____ Date _____

Lesson 7

7

Where do I keep all required documentation?



Learning Objective 3

To understand where and how to file all Outreach Team documents and store them in a secure location.

3. Where do I keep all required documentation?

All required documentation for individual and team management, including the reports described above must be kept in an organised and systematic way. It is important that someone else can find any document that they are looking for if you are not available. The best way to keep your documents is in a filing system.



What is filing system?

A filing system is a method of organising and storing documents so that you can find information quickly and effectively.

Think of the books stored in a library. Books in a library are stored using unique numbers and a location based on the topic of the book. The numbers are listed in a catalogue. This is a type of filing system. If the library *didn't* have a filing system, it would not be possible to find any books at all (or it would take you a very long time!). However, a library does have a system so that you can check if the book is listed in the library's catalogue. If the book is available you can use the number of the book to find it.

Setting up a filing system for your team will be like creating the catalogue for a library so that all the documents can be found easily. A key component of storing documentation is having **organisational skills**. Organisational skills are about 'having a place for everything and everything being in its place'.

| Category | Document name | Completed by | Submitted to | Filed by | Suggested filing system |
|-----------------------------------|---|--------------|---|----------|--|
| | Community Profile Template | OTL | Not submitted | OTL | Kept in file for all community documents |
| | Community Health Improvement Plan Template | OTL | Not submitted | OTL | Kept in file for all community documents |
| Individual Team Member Management | Team Leader Record of CHWs in Outreach Team | OTL | May submit copy to Facility Manager | OTL | This should be kept in the front of the filing box/cabinet/drawer where each individual team member file is kept |
| | Induction Process Checklist | OTL | Not submitted | OTL | You should have a completed induction checklist for each team member; once the checklist is complete, you would file it in the individual team member file |
| | Performance Management Review of CHW Form | OTL/CHW | May submit copy to Facility Manager | OTL | A review form for each team member should be kept in the team member's individual file |
| | Evaluation of Household Registration | OTL | Not submitted. Required for CHW Phase 1 Competency Assessment | OTL | Individual team member file |
| | Evaluation of Antenatal Home Visit | OTL | Not submitted. Required for CHW Phase 1 Competency Assessment | OTL | Individual team member file |
| | Evaluation of Postnatal Home Visit | OTL | Not submitted. Required for CHW Phase 1 Competency Assessment | OTL | Individual team member file |
| | Evaluation of Sick Child Home Visit | OTL | Not submitted | OTL | Individual team member file |
| | Evaluation of Treatment Adherence Support Visit | OTL | Not submitted | OTL | Individual team member file |
| | Post Evaluation Discussion Questions | OTL | Not submitted | OTL | Individual team member file |

| Category | Document name | Completed by | Submitted to | Filed by | Suggested filing system |
|-----------------------------|--|--------------|------------------|----------|-------------------------|
| Team Leader Reporting Forms | Outreach Team Monthly Summary Form | OTL | Facility Manager | OTL | Outreach Team file |
| | Outreach Team Reporting Tool | OTL | Facility Manager | OTL | Outreach Team file |
| | Outreach Team Supplies Management Form | OTL | Facility Manager | OTL | Outreach Team file |

*Ideally, each CHW would manage the filing of all of their HH and individual summary forms and you would manage all other documents. Initially, the CHW may not be capable of setting up an individual filing system for their HH documents. You may have to assist and file all CHW documents on their behalf. As the CHWs become more familiar with the concept of filing documents in a systematic way and you are confident with their ability to file documents, they will be responsible for filing all documentation for the HHs that they have been allocated.

There are a few things to note about the table above:

1. All documents in the *Team Leader Job Aid* are not listed in this table. This is because some documents in the *Team Leader Job Aid* are meant to provide general information for you to refer to when necessary but they don't necessarily require filing.
2. The preparation and post meeting checklists are to guide you before and after a meeting. You may choose to print and use these checklists for every meeting but eventually you may not need them. If you want to print and use these checklists, you may file them with all other meeting documents.
3. The last column in the table (on the right) is a suggestion. You must create a filing system that makes sense to you. The point of a filing system is to ensure that all documents are stored in a systematic way so that anyone can locate the necessary documents.

3.2. Materials to set up and maintain your filing system

The next section provides **examples** of stationery and filing equipment that you can use to set up your filing system.

Please note that these items may not be available from your facility. You must check with your Facility Manager to determine which stationery and equipment are available on the provincial procurement list.

If these materials are not available at your PHC clinic, you must order similar stationery that can be used to fulfil the same function.

- Filing cabinets (lockable)
- Suspension files to separate documents in filing cabinet. Order as many as necessary



If you cannot access filing cabinets and suspension files then use lever arch files and file dividers (see images below).



- One document wallet for each HH



- One set of transparent sleeves



- One plastic carrying case per CHW

- One punch, stapler (and staples) and calculator per OTL



Think Point

If you are not able to get all of the items listed above, be creative with the materials that you can access through your facility stationery list and order supplies using the *Outreach Team Supplies Management Form*. Most importantly make sure to use what you do have to organise and store your documents in a safe manner.



3.3. Missing documentation

If documentation for a HH goes missing, complete the following steps:

- Ask your District Health Information Officer (DHIO) to print out a copy of the electronically captured *Household Registration Form*
- Use this to create a new document wallet or the alternative method or material(s) the team members are using
- Make a note in the new record that it was previously lost (record on inner side of document wallet)
- Schedule a follow-up visit to the HH using the assigned CHW to create new individual health records
- Remind CHWs of the importance of Outreach Team documentation and that all documentation is government property

3.4. Archiving documentation



What is archiving?

Archiving is the collection of records that have been accumulated over a period of time and are stored in a secure location. When your filing system (drawers or boxes) is full, you may want to archive the Outreach Team's records.²⁶

3.5. Storing documents in a secure location

As the OTL, you are trusted with important and confidential information. Your Outreach Team will be working on cases with HHs that may be sensitive. Since you will be storing the confidential information of many HHs, you should take formal measures to protect this information.

Examples of measures to protect confidential information include:

- Discuss how you will maintain confidentiality with the Facility Manager and team and put this plan into action
- Store documents in a cabinet that is under lock and key
- Not leaving HH documentation lying around
- Avoid talking to friends or family about this information
- Ensure that any documentation in your possession does not get misplaced

It is also important that you reinforce this message with your CHWs when they are in possession of HH documentation.

For example, CHWs should:

- Not leave their filing case or documentation, including record books or diaries they may use, lying around
- Decide upon a safe place to keep their filing case and/or HH documentation at home where others will not access them
- Avoid talking to friends or family about the contents of HH documentation
- Ensure that the document wallet and/or its contents do not get lost

If there is any doubt that the CHWs will be able to appropriately handle and store HH documentation confidentially, please make arrangements to store their carry case in the clinic. The filing case may then be accessed and dropped off daily by the CHW.

Individual Activity

How are documents stored in your clinic currently? Where will Outreach Team documents be stored? Do you need to order a filing cabinet or filing boxes?





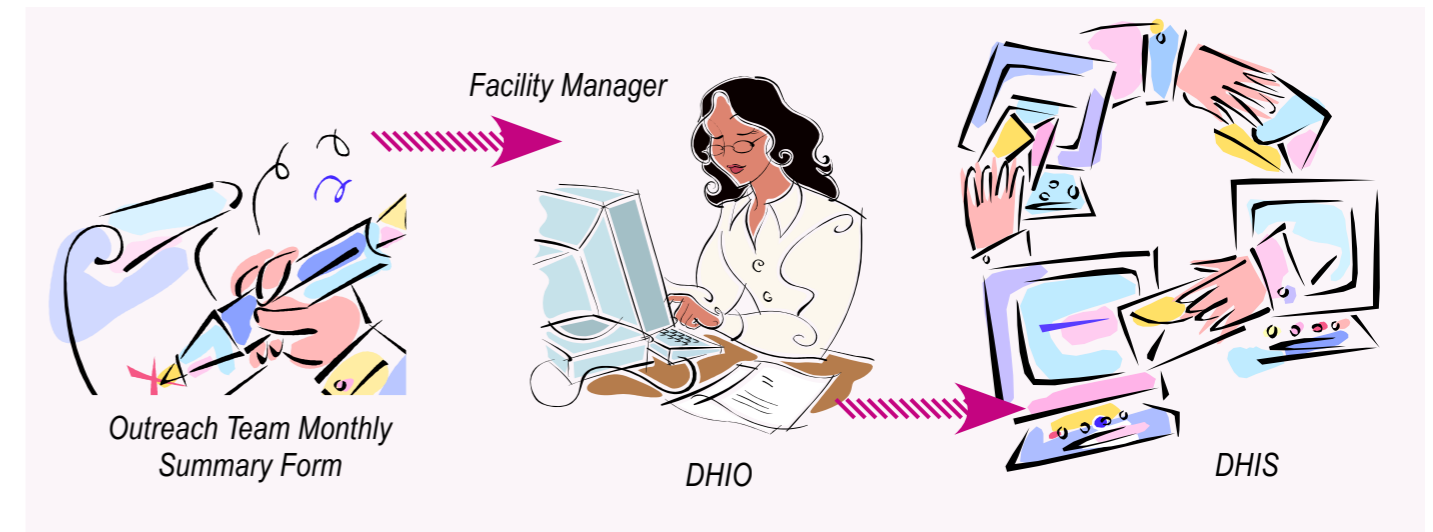
Learning Objective 4

To understand what happens to all of the information that is captured by the Outreach Team.

4. What happens to the information I submit in the monthly reports?

Of the three documents that you submit to the Facility Manager each month, only one document is submitted to the DHIO. This is the *Outreach Team Monthly Summary Form*. The other two documents are submitted to the Facility Manager to manage the Outreach Team supplies and activities.

Figure 3: Process flow of information from Outreach Team to DHIS



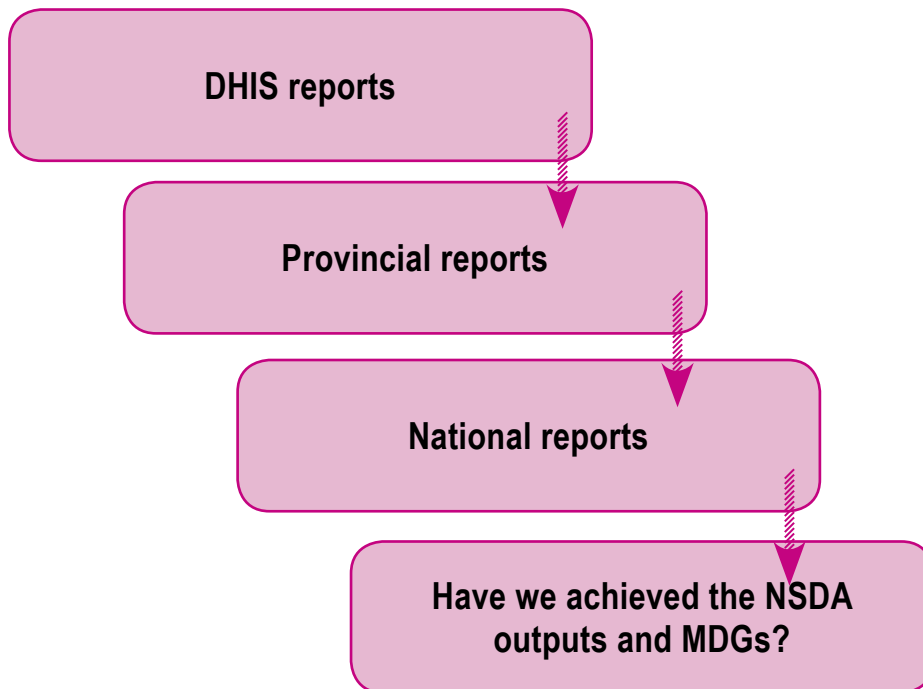
The DHIS will generate reports that you should receive on a monthly basis.

You may not currently be receiving these DHIS reports. If you would like to receive them, you must request them from your Facility Manager. Your Facility Manager will act as the link between the Outreach Team and the DHIO/DHIS.

4.1. What is the point of entering all of the HH visit data into the DHIS?

The long term vision for the NDOH is that all reports and forms from the Outreach Teams would feed into the DHIS, which would feed into provincial reports, which would feed into national reports. From the national reports, the NDOH employees could eventually see whether or not all of our work has led to the achievement of the NSDA outputs and the MDGs. This is outlined in Figure 4 below.

Figure 4: Big picture information flow



4.2. What does this mean for the Outreach Team?

Now that you understand the big picture of where the information from all of the team reports go, you should know how important it is to make sure all information on all forms is recorded and that the information is accurate to the highest standard possible.

Again, this is why it is of utmost importance for you to consistently make sure that you receive the required reports from your team members and that you monitor the quality of all the reports.

Lesson 8

Summary of Orientation

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Now that we've gone through the entire orientation, it is important to make sure that you understand the key points from each Lesson and your role as the OTL. The following sections include a brief summary of each Lesson.

1. Lesson 1: Introduction to the Role of the PHC Outreach Team Leader

The first Lesson in this orientation was meant to introduce you to the Re-engineered PHC system, explain how the Ward-based PHC Outreach Team fits into the changed PHC system and finally, how this fits into the overall health care system.

Key points from Lesson 1:

- South Africa has a quadruple burden of disease. These are high rates of HIV, AIDS and TB; high maternal and child mortality; high rates of chronic non-communicable diseases; and high rates of violence and injuries.
- To address this burden of disease, the NSDA has committed to 12 key outputs, 4 of which will aim to reduce the above mentioned diseases and conditions. The NSDA commitment will also help South Africa to reach the MDGs.
- One reason for the burden of disease is a lack of access to quality health care in South Africa. NHI is a system that the NDOH will continue to roll-out over the next few years to improve access to health care.
- PHC Re-engineering is meant to improve access to health care for all South Africans. The Re-engineered PHC system will help to prepare for NHI and to reach the NSDA and MDG targets.
- The Re-engineered PHC system has three streams which include:
 - District based clinical specialist teams with an initial focus on improving maternal and child health
 - Strengthening school health services
 - Ward-based PHC Outreach Team(s) for each electoral ward
- In each Outreach Team, your primary responsibility (as the OTL) is service delivery at the community level. This means you are responsible for community entry, assessment and involvement. Your other core responsibility is the oversight of the Outreach Team members and their service delivery to the community and individual HHs in your catchment area. The team members are primarily responsible for HH engagement and service delivery and to assist you on community level efforts when necessary.
- As the OTL, you are expected to spend 70% of your time in the community and only 30% of your time in the clinic.

Notes

2. Lesson 2: Skills Required to be an Effective Outreach Team Leader

To be an effective OTL, there are several basic skills that you will require for your interaction with other team members, community leaders, community stakeholders and the Facility Manager. Lesson 2 gave a brief description and key steps for some of these skills.

Key points from Lesson 2:

- Effective communication requires you to respect other people’s views, to use simple language and to communicate clearly.
- Different forms and methods of communication may be used in different circumstances and when communicating with different people. You must know how to choose the best form and method of communication for every situation and every person that you are communicating with.
- When you are communicating with another person, it is important that you actively listen to that person to ensure that you fully understand what is being said.
- As the OTL, you will experience different types of problems with different situations and people involved. The ‘7 steps to problem solving’ are there to provide guidance on how to deal with different problems.
- When you have more than one problem, make sure to prioritise the problems depending on how urgent the problem is and what the problem will have an impact on.
- Whenever you have a problem that you cannot solve, raise it to your Facility Manager.
- When you have too many tasks or activities to do, use the steps for effective delegation to help you work through your list.
- All people are motivated by different factors. Determine what motivates you and your team members to ensure greater productivity within the team.
- Each member of your team will have different skills that they need to develop. Mentor or coach team members on different areas as and when they need it. Document any formal mentoring or coaching so that you can follow-up with the team member at performance review time.

Notes

3. Lesson 3: Service Delivery

The entire purpose of your team is to ensure that the PHC package of services is delivered to the community, to HHs and to individuals at the highest standard possible and that all services are delivered according to the PHC guidelines. These services include clinical and non-clinical services, referrals and collaboration with other service providers and implementing interventions when necessary.

Key points from Lesson 3:

- Services to the community include:
 - Improved access to healthcare
 - Community involvement in proposed interventions or campaigns
 - Collaboration with other service providers
- Services to the HH include:
 - Patient education
 - Clinical services as per the PHC package of services
- In order to achieve the NSDA outputs and MDGs, the priority service areas include:
 - ANC
 - PNC
 - Child health
 - Treatment adherence support
- You are required to conduct at least 1 ANC visit to every pregnant woman in your catchment area and 1 PNC visit to every woman who has had a baby in the last 6 months
- The second stream of the PHC Re-engineering model includes the Integrated School Health Programme. The Outreach Team should liaise with the school health team or nurse whenever possible. If there is no school health team in your community, you must liaise with the school principal to see how your team can assist in the interim. It is not the job of the Outreach Team to deliver the package of school health services but rather to offer assistance as and when necessary.
- All members of your team must be familiar with where to locate all emergency service contact numbers.
- All members of your team must have their first aid certification from an accredited provider and must have this certification updated regularly.

Notes

4. Lesson 4: Team Management

In order to deliver services effectively and efficiently, you must be able to manage your team, the individual team members and the team supplies.

Key points from Lesson 4:

- Whenever you have an activity to plan, ensure that you have identified the tasks that need to be done to complete the activity, the people responsible for each task, the deadline for completion of each task and the expected outcome of the overall activity.
- You are expected to manage the team schedule. This means you must complete the *Weekly HH Visit Schedule* and ensure that all CHWs in your team are aware of which HHs need to be registered, assessed, screened or visited in the coming week.
- You are expected to organise and facilitate team meetings, Facility Manager/Outreach Team meetings, service provider meetings and community meetings. Use the *Meeting Preparation Checklist* and *Post Meeting Checklist* to adequately prepare for and document these meetings.
- You must always use an attendance register for team or clinic meetings.
- You must always document team meetings with meeting minutes. Be sure to follow-up on all activities or action items identified in meetings.
- All new team members should go through a formal induction process. Use the *Induction Process Checklist* to ensure all items in the induction are covered.
- It is important that you are familiar with the HR and contractual issues around the individual team member. Use all tools in the *Team Leader Job Aid* as and when necessary. Consult with your Facility Manager if you do not know how to deal with anything related to contractual issues.
- It is important and therefore required that you manage the performance of individual team members using the *Performance Management Review Form* and, specifically for CHWs, the evaluations of different types of HH visits. Discuss the performance management process with all team members including old and new members.
- You are responsible for the administration of the CHW Phase 1 Competency Assessment. Use the induction, practical skills training and ongoing performance management to help CHWs prepare for the Competency Assessment.
- Your team will have and require supplies to deliver services to the community and to HHs. You must manage these supplies and complete the *Outreach Team Supplies Management Form* on a monthly basis.

Notes

5. Lesson 5: Community Entry, Assessment and Involvement

In order for the Outreach Team to be successful in your assigned catchment area, you must have buy-in and support from the community leaders, community stakeholders and service providers. You must complete a comprehensive community assessment to understand the major concerns and health issues in the community.

It is extremely important the community agrees on the identified issues and which ones are to be prioritised. You should involve the community in implementing interventions whenever possible.

Key points from Lesson 5:

- You must organise and conduct a series of meetings with community leaders and community stakeholders to introduce yourself, the members of your team and to give a brief overview of the role of your team within the community.
- Once you have introduced the team to the community, you should start the community assessment. This includes a comprehensive community map (including all HHs) and a complete community profile.
- The community assessment should help you to understand what the major challenges are in the community and what the major issues that affect the health of the community are.
- Once you've completed the community assessment, you must present your findings to the community leaders, community stakeholders and service providers. When you present the findings, this is your opportunity to let the community help you to prioritise the health problems.
- With the list of priority health problems, develop a *Health Improvement Plan*. Use the guidelines and templates provided in the Lesson.
- Since a large part of service delivery is collaboration and linkages with other service providers, you must ensure that all service providers in the area are supportive of the Outreach Team and are familiar with the *Referral/Back-referral Form*.

Notes

6. Lesson 6: Household Engagement

Once the community members are familiar with and support the Outreach Team, your CHWs must start HH registration and assessments. As the OTL, you must understand how to allocate HHs to the CHWs, be familiar with the HH registration process, and the screening and referral system.

Key points from Lesson 6:

- In order to allocate HHs to the CHWs for registration, you must determine the total number of HHs in the catchment area using the community map. You should divide the total number of HHs in the catchment area by the number of CHWs in your team and ensure that all CHWs have an equal workload for HH registration.
- Your team should start the HH registration process in the most vulnerable area in the catchment area.
- CHWs must follow the HH registration and assessment process as outlined in the flow diagram in the Lesson. Once all HHs have been registered and assessed, you may have to re-allocate HHs based on the number of vulnerable HHs identified.
- CHWs must determine if any individuals within their allocated HHs require a referral to other service providers, including the PHC clinic. They must follow the referral system and correctly and consistently complete the *Referral Form*.
- The HH member will take the *Referral Form* to the service provider that they have been referred to. Once the service provider completes the *Back-referral Form*, they will give it back to the HH member to return to the CHW.
- It is your responsibility as the OTL to follow-up on all *Referral Forms* that are not received back from the individual HH members.
- In order to ensure that all HH visits are being conducted according to guidelines, it is your responsibility to supervise or observe CHWs conducting each type of HH visit. You may use the same evaluation forms used for performance management or you may just observe and take notes on your visit.
- You should only intervene in a supervised HH visit if there are serious errors (as outlined in the Lesson).

Notes

7. Lesson 7: Monitoring, Evaluation and Reporting

In order to measure the progress and success of the Outreach Team's efforts, you must monitor and evaluate all activities and HH visits. Monitoring and evaluation can be informal or formal. Formal monitoring and evaluation requires the completion of specific forms which are submitted either to you or to your Facility Manager.

Key points from Lesson 7:

- Monitoring and evaluation are meant to determine what the Outreach Team is doing and how you are doing it. It is very similar to performance management of an individual team member but instead we are now looking at the performance of the entire Outreach Team.
- We monitor and evaluate the Outreach Team activities to track progress, to make adjustments when necessary and to analyse the impact of the team.
- Informal monitoring and evaluation may happen in weekly team meetings or through feedback from community members or service providers.
- Formal monitoring and evaluation happens through a series of reports. Some reports are completed by the CHW and some reports are completed by the OTL.
- The CHW must complete two reporting forms:
 - *CHW Household Visit Tick Sheet*
 - *CHW Household Visit Monthly Summary Form*
- The OTL must complete three reporting forms:
 - *Outreach Team Monthly Summary Form*
 - *Outreach Team Reporting Tool*
 - *Outreach Team Supplies Management Form*
- All documents for the entire Outreach Team should be filed systematically to ensure that any document may be found at any time.
- It is your responsibility as the OTL to order the necessary supplies for your team filing system.
- Your filing system should be secure or in a secure location to ensure that all Outreach Team documents (including individual HH document wallets) are stored confidentially and only Outreach Team members and certain PHC clinic staff have access.
- The information collected on the *Outreach Team Monthly Summary Form* is submitted to the Facility Manager who submits it to the DHIO. The DHIO enters the information into the DHIS.
- You may access reports from the DHIS by requesting them through your Facility Manager.
- All information from all HH visits conducted by every Outreach Team in the country will help NDOH to understand if we have improved or achieved the NSDA outputs and the MDGs.

Notes

8. OTL next steps

Throughout the week, there were many activities mentioned which you must complete. Below is a 'to-do' list for you to complete when you return to work.

Table 1: Team Leader Priority Activity ('to-do') List

| Activity | Deadline | Tick when complete |
|---|----------|--------------------|
| Schedule a meeting time with your Facility Manager to discuss your roles and responsibilities as OTL; also discuss your transition from professional nurse in the clinic to OTL (70% time in community) | | |
| Team/CHW Management | | |
| Ensure all CHWs are familiar with roles, responsibilities and core competencies | | |
| Discuss induction topics with old and new CHWs | | |
| Complete <i>Record of CHWs in Outreach Team</i> (update whenever a new team member joins) | | |
| Organise first aid training (accredited course) for all CHW to attend | | |
| Schedule time for all evaluations of HH visits for each CHW in the team | | |
| Begin using <i>Weekly HH Visit Schedule</i> | | |
| Make photo copies of all forms/documentation/reports that will be used immediately by the team | | |
| Ensure all CHWs have enough copies of necessary forms to do their job | | |
| Service Delivery | | |
| Determine if school health team (school health nurse) has been appointed to school(s) in your area | | |
| Community entry, assessment and involvement | | |
| Create <i>Community Resource List</i> | | |
| Plan meetings with community leaders (e.g. gatekeepers) | | |
| Plan community meetings with other stakeholders/community members | | |
| Plan meetings with local service providers | | |
| Complete community map (ensure clear numbering system for all HHs in the catchment area) | | |
| Complete <i>Community Profile</i> | | |
| Present community assessment to community in one or more community meetings | | |
| Develop <i>Community Health Improvement Plan</i> | | |
| Familiarise local service providers on the <i>Referral/Back-referral Form</i> | | |
| Household engagement | | |
| Allocate HHs to CHWs (if this has not happened already) | | |
| Ensure all HHs in catchment area are registered | | |
| Ensure all HHs in catchment area are assessed | | |
| Schedule CHW home supervision visits with each CHW | | |



Individual Activity

With the index card that you receive from the Facilitator:

- On one side, write your top three take-away messages from the *Orientation Programme*
- On the other side, in order of priority, list the activities that you will address next week and how you will implement them

Use this card as a reminder when you get back to your clinic. Put the index card in a place that you can see every day.

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