Ward-based PHC Outreach Team Management Information

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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
STIs	Sexually Transmitted Infections
TB	Tuberculosis

Introduction

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1. Introduction

This Management Information Pack is intended to give a high level overview of the Ward-based Primary Health Care Outreach Teams as part of the Primary Health Care Re-engineered model developed by the National Department of Health.

The objective of this information overview is to:

- Ensure readers understand the value and purpose of the Outreach Team
- Ensure readers are aware of the various roles and responsibilities within the team and supporting the team
- Inform readers at a high level of the community and household engagement process
- Inform readers at a high level of the monitoring, evaluation and reporting process

2. The South African Health Care System

2.1 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. [1]

The quadruple burden of disease includes: [1,2]

1. High rates of HIV, AIDS and Tuberculosis (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.[3]

Figure 1: Millenium Development Goals [4]

The South African Health Care System

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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? [5]

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.

2.2 National Health Insurance (NHI)

National Health Insurance [6]

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 NDOH 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, NDOH is piloting NHI roll out in 11 districts. Part of this pilot includes assessing access to health care through the primary health care system.

2.3 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, promotional, curative and rehabilitating.[7]

PHC is health care that is essential, ethical, accessible, equitable, affordable, and accountable to the community.[7]

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.

2.4 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 new strategy called the PHC Re-engineered model was developed to strengthen district-based PHC services and to improve local community access to health services. [7,8]

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 Tteam (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. [8]

PHC Re-engineering will be addressed through focusing on strengthening <u>three streams</u> of the current PHC system which will include: [9]

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 Teams for each ward**

The strengthening of these streams is required for the successful implementation of NHI. Each stream is 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). [9]

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

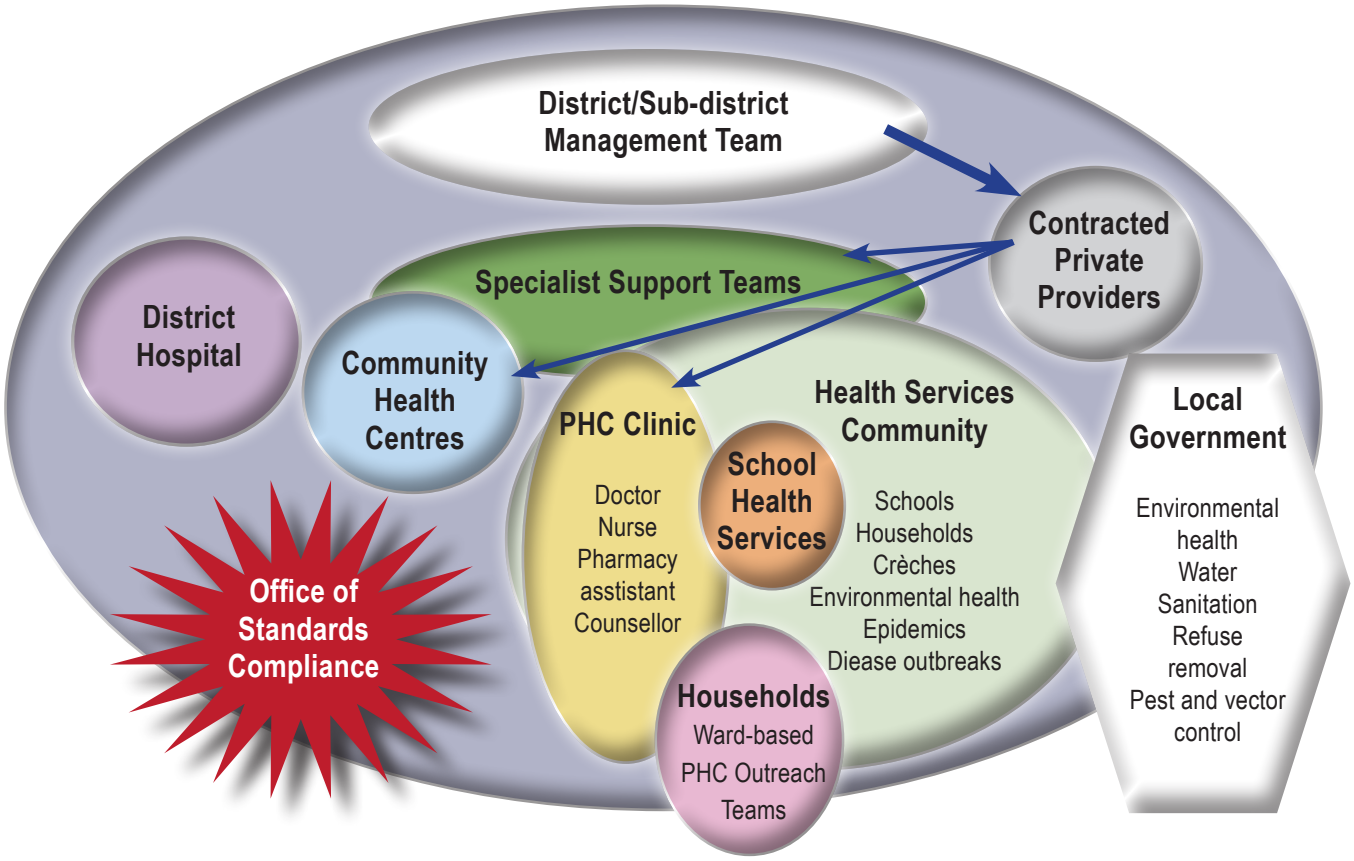
   School nurses will be sourced by districts that will look at staff efficiencies and the redeployment of nurses and hiring retired nurses with the immediate priority of providing a limited range of services. [9]

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 which will be an extension of the local PHC clinic and therefore another structure within the District Health Model and continuum of care. 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 in an effort to reduce the number of clients seen at the clinic. The roles of the Outreach Team are described further in the next section. Introduction of these Outreach Teams is hoped to strengthen health care and improve access to health care and health outcomes. [9]

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 [9]



3. The Ward-based PHC Outreach Team

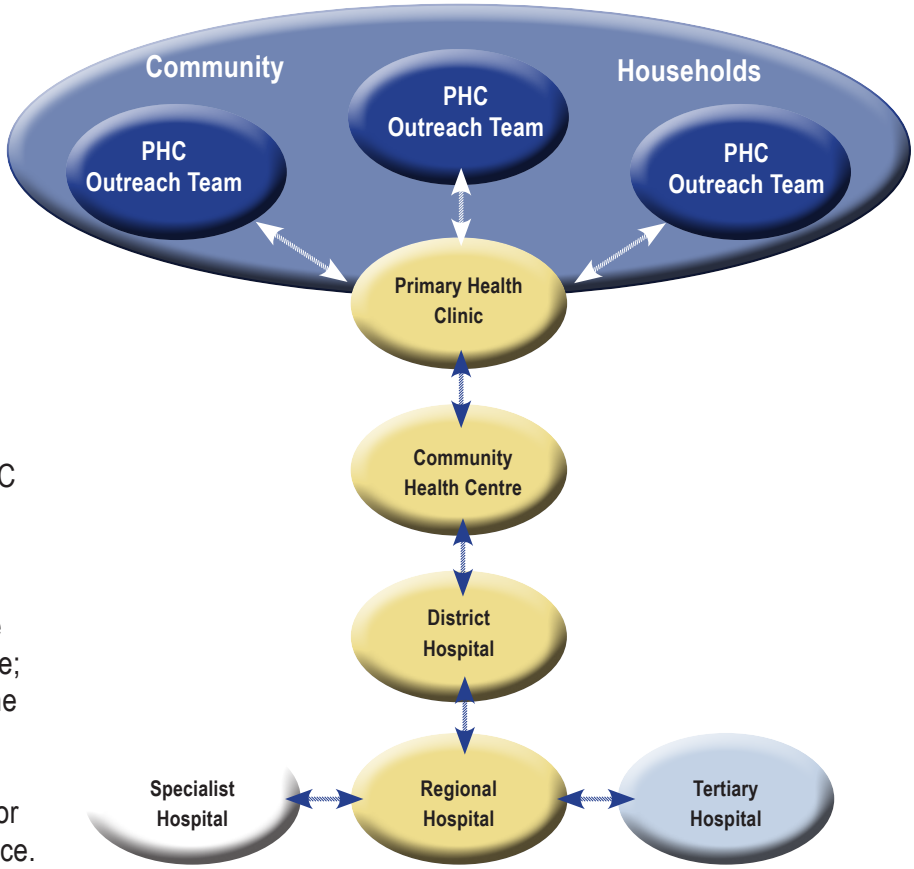
Each Ward-based Outreach Team will be linked to and report to a local PHC clinic. The person responsible for the facility will be responsible for managing and monitoring the Outreach Team. Some PHC clinics may have more than one Outreach Team operating under their facility depending on the population size, geography, demographics and disease profile.

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: [9]

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

Figure 3 below outlines how the Outreach Team fits into the DHS and the overall health system.

Figure 3: PHC Outreach Team and Continuum of Care [7]



As seen in Figure 3, 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 a client is not able to be assisted at the District Hospital, they are referred to the Regional, Specialist or Tertiary Hospital in that district or province.

The Ward-based PHC Outreach Team

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3.1 Outreach Team Oversight and Management

As Outreach Teams are part of the PHC Re-engineered District Health Model, their activities must be supported by the district, sub-district and facility management.

3.1.1 District and Sub-District Managers

All communication around PHC Re-engineering and the PHC Outreach Teams must be communicated via the district and sub-district management to the PHC clinics and Facility Manager which the Outreach Team(s) reports to and refers household members to. The district and sub-district managers are primarily responsible for ensuring that all Outreach Teams operating within their district (and sub-district) receive all communication around provincial and national guidelines for the operation and implementation of Outreach Team service delivery. They must support the persons responsible for each PHC facility in managing the Outreach Teams.

3.1.2 Facility Manager

Every PHC clinic has a different organogram with at least one person responsible for managing the facility. This person is often referred to as the Facility Manager or Clinic Manager. Whoever is responsible for managing the PHC clinic is also responsible for managing the Outreach Team Leader and for monitoring all Outreach Team activities. For the remainder of this document, the person responsible for managing the facility is referred to only as the Facility Manager.

With regards to the Outreach Team, the Facility Manager's core responsibilities are to:

- Conduct one-on-one meetings with each Outreach Team Leader (OTL) on a monthly basis
- Manage the performance of each OTL
- Deal with all human resource related matters (e.g. disciplinary, employment contracts) concerning members of the Outreach Team
- Provide adequate support for day-to-day activities of the Outreach Team
- Act as a liaison and communicator between the provincial/district/sub-district PHC Re-engineering staff and the Outreach Team
- Ensure the Outreach Team has adequate supplies for service delivery to the community and households
- Ensure all Outreach Team data is captured correctly and consistently on the monthly reporting forms*
- Ensure that the Outreach Team has adequate stationery and up-to-date copies of all required reporting forms*

*These items are discussed further in section 6.3.

A detailed checklist of all items for which the Facility Manager is responsible as it relates to the Outreach Team can be found in Appendix A.

3.2 Outreach Team Members

Each Outreach Team will be made up of: [9]

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

The Ward-based PHC Outreach Team

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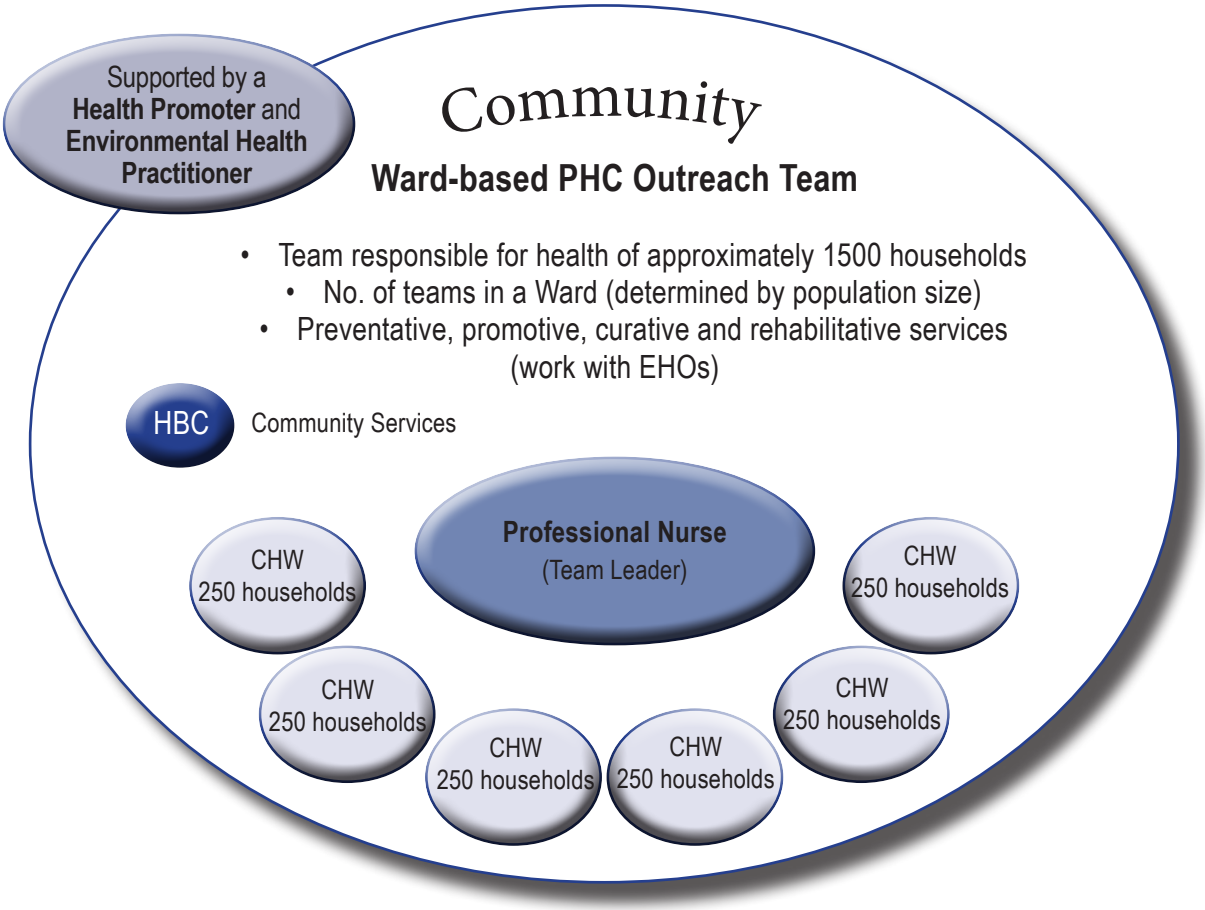
All Outreach Teams will be supported by a Health Promoter and an Environmental Health Practitioner. While some districts may already have someone acting in these roles, other districts may still need to hire a Health Promoter and an Environmental Health Practitioner.

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 250 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.

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. A diagrammatic overview of the Outreach Team is included in Figure 4 below.

Figure 4: Ward-based PHC Outreach Team [9]



The roles and responsibilities of the Outreach Team members and the supporting Health Promoter and Environmental Health Practitioner are described further in the next sections.

3.3 Outreach Team Leader

A professional nurse will fulfil the role of OTL. He/she will be 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. [9]

3.3.1 Reporting Line

Each OTL has been or will be appointed by the district or sub-district manager and will report to the Facility Manager of the PHC clinic. More often than not, he/she will be the existing clinic nurse.

3.3.2 Roles and Responsibilities of OTL

Each OTL will be delegated the responsibility to: [9]

i. **Deliver and manage health services to a defined geographic area according to the PHC package of health services.** 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 the 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 [9]

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
	Keep local community informed of health related matters and potential health threats
Assessment of community resources, including service providers	Identify, establish and maintain collaboration and liaison with local community and local service providers
Identify resource constraints, potential and actual risks facing the community	Identify service gaps
Develop and implement community-based interventions, including inter-sectorial action	Community consultation and involvement (where possible)
Household	
Screening, assessment and referral of HHs within catchment area	Identification of HHs in the defined geographic catchment area that team is working in
	Identify catchment area for each CHW, allocate HHs to CHW and determine where to commence HH registration process based on need
Provide information and support for healthy behaviours and home-based care	Provide practical skills training to CHWs
	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
Provide psychosocial support (including adherence support for HIV, TB and other chronic disease treatment)	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	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 *Weekly HH Visit Schedule*
	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
	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 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 Quality of service provided by Outreach Team	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

3.3.3 From clinic-based professional nurse to OTL

It is envisaged that the OTL will spend 70% of their 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 their time. OTLs who are existing nurses within the clinic will need to work with their Facility Manager to phase this transition so that the change does not have a harsh impact on the rest of the clinic staff.

3.3.4 What training will the OTL receive or have they received?

All OTLs have or will attend a 5-day Orientation Programme which has been developed for the OTL in order to provide them with the necessary skills and tools to manage the Outreach Team.

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

3.4 Community Health Workers

Currently, there are community-based workers who are like Community Health Workers (CHW) in most areas. Community-based workers are typically employed by local organisations and provide a varied range of services in communities including: home-based care, Directly Observed Treatment, Short course (DOTS) for TB, adherence counselling, lay counselling, peer education and tracing of treatment defaulters. [9]

3.4.1 Reporting Line

Overtime, the DOH will be taking over the employment of these community-based workers as CHWs and the OTLs will be managing the CHWs in their Outreach Team.

3.4.2 Roles and Responsibilities of CHW

As part of the formal Outreach Team, the CHWs' roles and responsibilities will include [9]:

- Conduct community, HH and individual level health assessments and identify if there are any potential or actual health risks and to assist the family or individual to seek the appropriate health service
- Promote the health of the HHs and the individuals within these HHs
- Refer persons for further assessment and testing after performing basic screening tests
- Provide limited health interventions in a HH (basic first aid, oral rehydration and any other basic intervention that she or he is trained to provide)
- Provide psychosocial support and manage interventions such as treatment defaulter tracing and adherence support

In the context of the quadruple burden of disease that was discussed earlier, the *Scope of Work for the CHW* and the *Core Competencies of the CHW* are outlined in the tables below.

Table 2: Scope of work for the Community Health Worker[9]

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.

1. Promote health and prevent illnesses
2. Conduct community assessments and mobilise around community needs
3. Conduct structured household assessment to identify their health needs
4. Provide psychosocial support to community members
5. Identify and manage minor health problems
6. Support screening and health promotion programmes in schools and Early Childhood Development (ECD) centres
7. Promote and work with other sectors and undertake collaborative community based interventions
8. 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 • Provide information • Educate and support for healthy behaviours • Facilitate appropriate home care	• Promote key family practices: ◦ Infant and young child feeding ◦ Newborn care ◦ ORT, hand washing ◦ Nutrition ◦ Postnatal care for women	• 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	• Provide information on risk factors for chronic diseases	• 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 • Compile a community profile • Identify community resources • Identify health and related services	• Support immunisation, vitamin A and de-worming campaigns	• Support HIV educational and treatment literacy campaigns • Distribute condoms in non-traditional outlets	• Support exercise, diet and smoking cessation campaigns	• 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 • 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	• Identify households with children under 5 and women of reproductive age • Assess need for and facilitate access to key preventive and care services ◦ Early ANC ◦ Immunisation ◦ Growth and development ◦ HIV screening and care in pregnancy and childhood ◦ Contraception, TOP and cervical cancer screening	• Identify persons who at risk of contracting HIV or TB ◦ 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	• 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	• 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	• Support women with postnatal depression • Support HIV affected and youth and child headed households	• Provide an integrated approach to adherence support for TB, HAART and other chronic disease medication in close collaboration with facility-based counsellors		• Provide post-trauma psychosocial support
5. Identify and manage minor health problems	• Identify and treat diarrhoea (ORT and continuous feeding) • Identify and refer pneumonia	• Identify persons with opportunistic infections and refer • Identify and refer persons with sexually transmitted infections • Promote and support good nutrition and nutritional supplements	• Provide basic stroke support and rehabilitation • Support foot care in diabetics and elderly	• 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	• Support school screening programmes and campaigns	• Support gender sensitive school and youth HIV prevention programmes	• Support school children who are on treatment for chronic health problems (e.g. diabetes, asthma)	• 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 • Address inter-sectoral issues (e.g. water sanitation and food security)	• 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)	• Participate in inter-sectoral prevention campaigns (e.g. HIV and TB, measles)	• Facilitate access to social grants, disability and old age benefits	• 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	• 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 [9]

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 it's 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

The Ward-based PHC Outreach Team

	Maternal, Child, Women's Health	HIV and TB	Chronic, non-communicable diseases	Violence and injury
1. Conduct a comprehensive household assessment • 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	• Conduct a developmental assessment for children • Understand basic integrated management of childhood illnesses and use of guidelines • Understand immunisation schedules and read *Road to Health Booklet* • 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	• 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	• 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	• 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
	• Conduct breast self-examination		• 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	
2. Promote health and prevent illness • Provide information • Educate on and support for healthy behaviours • Facilitate appropriate home care	• 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	• 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	• Conduct health promotion and prevention campaigns for chronic diseases	• Provide information and motivational interviewing on substance abuse • Provide information on prevention of injuries in homes
3. Provide psychosocial support	• Psychosocial and supportive counselling • Coping mechanisms and emotional support • Knowledge of postnatal blues and depression management	• Understand the principles of providing integrated psychosocial and adherence support to persons on TB, HAART and other chronic disease treatment		• 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	• Integrated management of childhood illnesses • Oral rehydration and continuous feeding • Signs and symptoms of pneumonia		• Manage common health problems that affect persons with disability and the elderly including • Foot care • Mobility • Dietary interventions	• Render basic first aid in the home and community
5. Conduct community assessments and mobilise around community needs • Compile a community profile • Identify community resources • Identify health and related services available	• 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
6. Support screening and other programmes in schools and ECD centres	• 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 • Address inter-sectoral issues (e.g. water sanitation and food security)	• 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)			
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	• 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	• 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	• 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	• 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	• 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	• 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	• 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

3.4.3 From NGO to DOH

In many cases, the CHW may have been assigned to the Outreach Team before the change in employment contract. This needs to be addressed at a district level but the teams need to continue as intended with a common purpose so that the community does not suffer.

3.4.4 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 DOH 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 which are outlined in Figure 5 below.

Figure 5: CHW training overview

Phase 1: Orientation and training

20 lessons over 10 days

- Orientation
- Basics of health
- Healthy lifestyle
- Environmental health
- Basics of first aid
- About me
- Building my skills
- Community assessment
- Basics of HIV
- HIV treatment
- Basics of TB
- TB treatment
- STIs
- Integrated treatment adherence
- Health of the woman
- Pregnancy and antenatal care
- Postnatal care and infant care
- PMTCT
- Basics of child health
- Child nutrition

Phase 2: Orientation and training

23 lessons over 10 days

- Health and illness
- Preventing illness
- Helping communities
- Group work
- Diabetes
- High blood pressure
- Stroke
- Heart problems
- Mental health
- HIV/TB
- Malaria
- Health of man/ woman
- Substance abuse
- Older persons
- Woman and aging
- Youth friendly services
- Domestic violence
- Child abuse
- Social grants
- Social services for children
- Palliative care
- Oral health

3.5 Health Promoter

Ideally, the district Health Promoter will provide technical support and assistance to the Outreach Team pertaining to health promotion activities at a community level based on local community needs.[9]

3.5.1 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 communities [9]

Community

• 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
  ◦ 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

• 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:
  ◦ 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
• 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

3.6 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. [9]

3.6.1 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 Practitioner [9]

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

3.7 Brief Summary of Outreach Team Member Roles

The OTL is primarily responsible for managing and supervising the Outreach Team. Their core responsibility is service delivery at the community level. This means they are responsible for community entry, assessment and involvement. Their 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 the OTL on community level efforts when necessary. The priority service delivery areas for the CHWs include:

- Antenatal care
- Postnatal care
- Integrated management of childhood illness
- Child nutrition
- Treatment adherence support

The Outreach Team service delivery responsibilities in these areas are included in the CHW Training and the OTL Orientation Programme.

An overview of how the Outreach Team engages with the community and households in order to deliver these services is provided below.

4. Community Engagement

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.

4.1 Community Entry

In order to ensure that the community becomes aware of the Outreach Team, it will be 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. It is the responsibility of the Facility Manager to assist the OTL with community entry by acting as a liaison between the OTL and the Clinic Committee.

Once the Outreach Team is known within the community, the OTL must liaise with health and local service providers.

4.2 Liaise with Service Providers

Service providers are those organisations or government departments that address specific community needs. 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 centres
- Schools, colleges, universities
- Fire brigade

The Outreach Team will need to build relationships and define how they will interact with the local service providers. 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

4.2.1 Referrals to Service Providers

The OTL will be responsible for setting up and coordinating the referral system between the Outreach Team, the community and service providers. They will 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.

4.3 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 the OTL role is to make sure that the community and the community members get the services they need. To be able to do this, the Outreach Team will have to get to know and understand the community that they will be working in.[10]

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.[10]

The products or outcomes of a community assessment will include: a community map, a community profile and a community health improvement plan.[10]

4.3.1 Community Mapping

Community mapping is an activity the Outreach Team will perform to understand the geography, infrastructure, resources and HHs of the catchment area that they will serve. [7]
The Outreach Team's community map should (at minimum) include the location of: [7]

- 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

4.3.2 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 profile. Typically, a community profile will include: [10]

- A brief description of the community the Outreach Team is working in
- Demographic and economic data
- Health status data
- Community resources, including service providers
- Summary of community profile and overall interpretation

All the information in the community profile will be used to identify the major issues within the community and thus develop a community diagnosis. This will be discussed with the community to ensure that the community agrees on the Outreach Team community diagnosis and have the same understanding of the major issues facing the community.[10]

4.3.3 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, the Outreach Team will assist with designing and implementing possible interventions to the issues.[10] The Outreach Team will need to involve the community in the actual implementation of interventions through:

1. Regular (monthly) community meetings
2. Resource mobilisation

5. Household Engagement

As mentioned previously, the CHWs are primarily responsible for HH engagement. Each CHW will be allocated HHs in the community which they will then have to register and assess. These processes are outlined further below.

5.1 Household Allocation

Every HH in a catchment area will be identified on the community map and assigned to a CHW in the respective team.

The Outreach Team will have a numbering system to identify the HHs in their 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.

For now, you will see one or both of the following on the CHW Forms:

- **'CHW HH Identifier No.':** This is the number that the team will decide on; it 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

The community profile will be used to assist in determining where to start the HH registration and assessment process. Factors such as 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 and poverty will be used to assist.

5.2 Household Registration

All HHs will be registered using one or both of the numbers described above. The HH registration process is designed to register and screen all HH members living in each HH. The registration process is documented on the *Household Registration Form* which has four purposes:

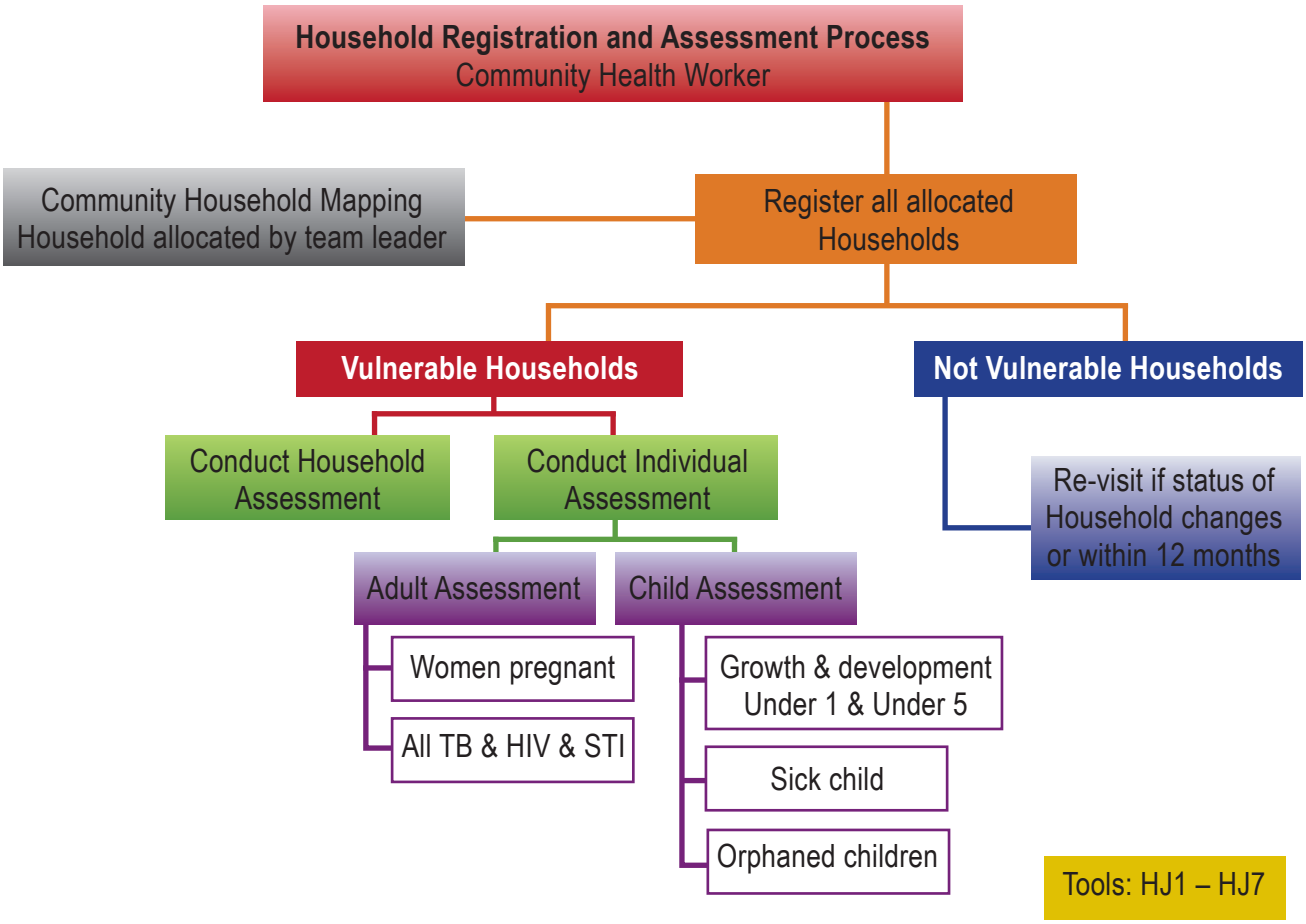
1. **To collect data to be captured electronically and collated to provide a picture about the community the Outreach Team serves.** This data includes numbers that summarise age groups, living conditions and basic health and referral information. This data will provide baseline information about HHs 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 HHs need to be followed-up and guides towards immediate identification of problems in HHs that may require referrals.

4. **To register all HHs, and individuals living in those HHs, with a health facility as part of the NHI registration process.**

The diagram below sets out the process for registering and assessing HHs in the community. This process is the responsibility of the CHWs.

Figure 6: HH registration and assessment process



5.3 Referral System

After HH registration and assessment, the CHW will provide whatever services they can within the HH and refer clients to other service providers when necessary. The steps in the referral system include:

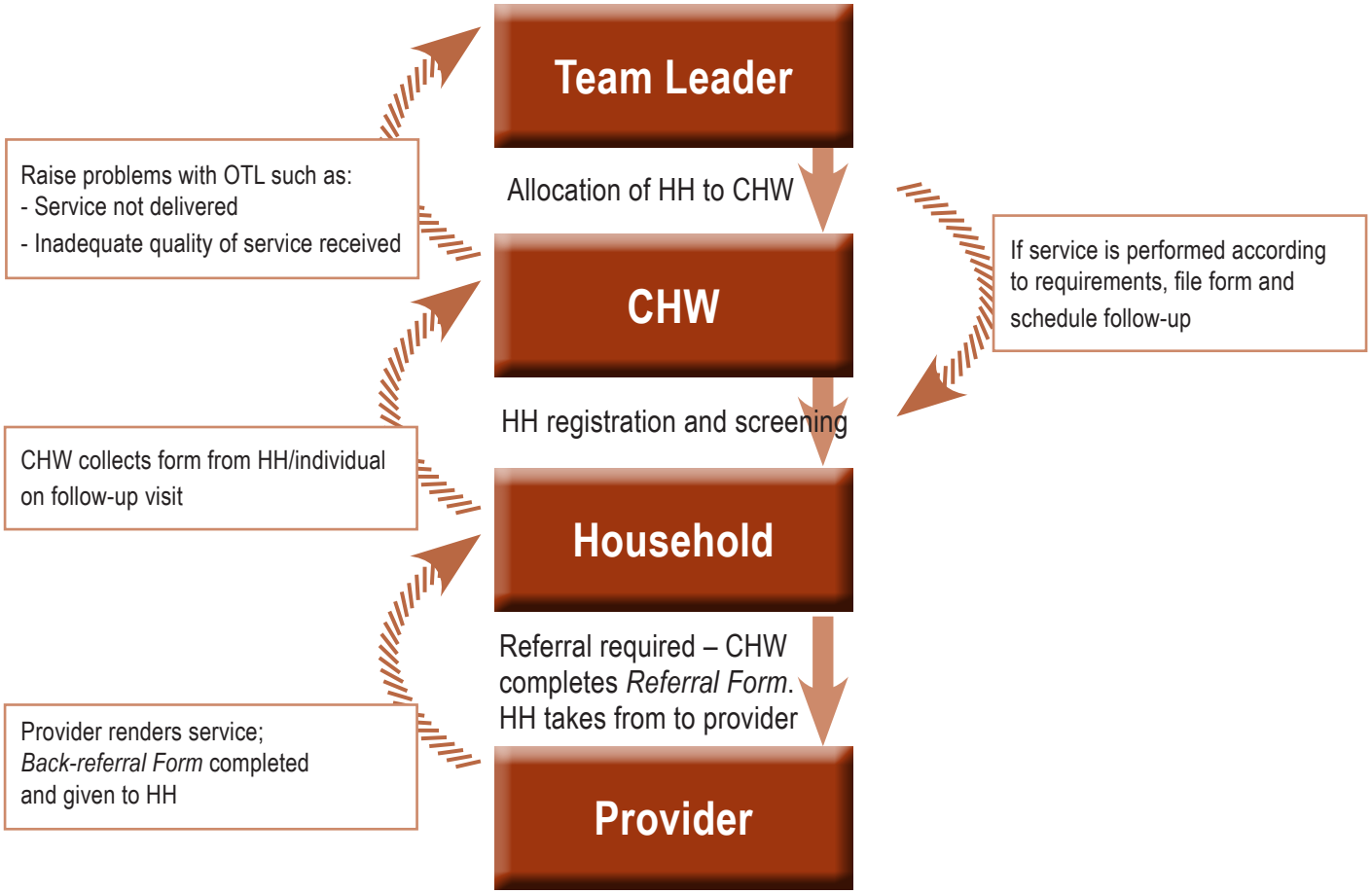
1. Based on a HH screening and assessment, the CHW may identify an individual for referral to either health services, social services or home-based care and/or identify the HH in need of basic services such as water, electricity, sanitation, telephone and refuse collection.
2. The CHW completes the *Referral Form* 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* 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 7 below.

Figure 7: Referral process



5.4 Home Visit Supervision

The success of the Outreach Team is dependent, largely, on the ability of the CHW to conduct a home visit and link the HH to appropriate care and services.

One of the main roles of the OTL is to ensure the competence of the CHW in conducting a home visit. This means that they will need to provide continuous support, guidance, mentorship and supervision in terms of HH registration, screening, assessment, referral and any other areas requiring additional assistance.

The main purpose of supervision is to develop the skills of CHWs, to guide and support them in their role so they can effectively meet the needs of HHs. The benefits of supervision are: increased accountability, improved efficiency and quality service delivery.

The OTL will need to set targets for home visits, monitor and assess performance of home visits and provide clinical guidance, support and practical skills training.

6. Monitoring, Evaluation and Reporting

In order to document the work and success of the Outreach Team to determine their impact on the NSDA Outcomes and the MDGs and in preparation for NHI, on-going monitoring, evaluation and reporting is required.

Individual Outreach Team members will be monitored and evaluated through the performance management process. The Facility Manager will monitor the performance of the OTL while the OTL will monitor the performance of the CHWs.

It will be the responsibility of the OTL to monitor and evaluate the overall team's performance. This will be done informally, through record keeping.

6.1 Informal Monitoring and Evaluation

Informal monitoring and evaluation may happen in two ways:

- Weekly team meetings
- Verbal feedback from community members and other service providers

6.2 Formal Monitoring and Evaluation

Formal monitoring and evaluation will happen through specific reporting forms that will be submitted to the Facility Manager. These reports are described further in the Reporting section below.

6.3 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.

6.3.1 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:

1. *CHW Household Visit Tick Sheet*
2. *CHW Household Visit Monthly Summary Form*

The CHW forms are not described in detail here because it is the responsibility of the OTL to monitor and summarise the information in their monthly reporting forms which are described further below.

6.3.2 Team Leader Reports

Once a month the OTL will complete three reports:

1. *Outreach Team Monthly Summary Form*
2. *Outreach Team Supplies Management Form*
3. *Outreach Team Reporting Tool*

All three reports are submitted to the Facility Manager.

6.3.2.1 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.

Figure 8: Information flow for capturing information on HH visits

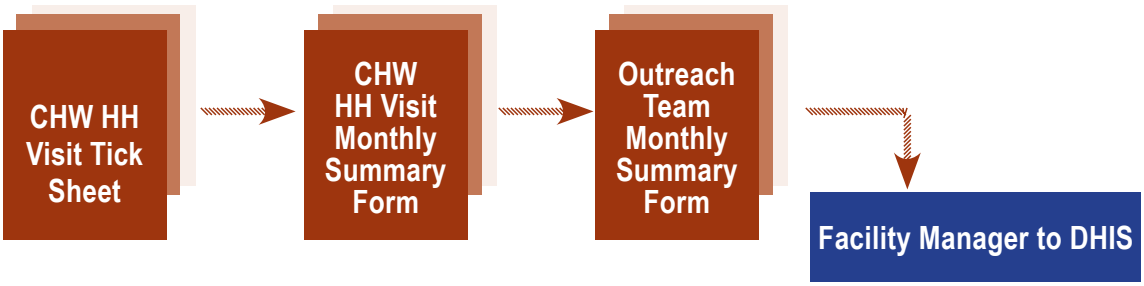


Figure 9: Outreach Team Monthly Summary Form

Outreach Team Monthly Summary Form	Team Leader name	Reporting month/year
	Clinic *(DHIS name)*	Ward *(DHIS number)*
	Team name *(DHIS name)*	
	Total number of HHs allocated to team	Number of CHWs per team

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CHW details		Household visit details			Household activity					*Referral Forms* given			Activity head count		Community activity	
		Type of visit														
CHW name	Number households allocated	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	Community campaigns
Total																
Total number of *Back-referral Forms* received from clinics this month																

Signature of Team Leader _____ Date *(dd/mm/yyyy)* _____

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

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

Comments:

Version 3

November 2012

6.3.2.2 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.

Figure 10: Outreach Team Supplies Management Form

Version 3
Date: November 2012

Outreach Team Supplies Management Form

Name of Team Leader	Team name	Clinic	Ward	Date

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.

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 suppplies				
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				

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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 _____

6.3.2.3 Outreach Team Reporting Tool

Purpose and importance:
This tool is used to guide monthly 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.

Figure 11: Outreach Team Reporting Tool

Version 3
Date: November 2012

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	*Summarise progress on actions*

2. CHW concerns addressed and problems solved collectively	Y	N	*List of concerns raised and identified means to address these concerns*

3. Collective targets set with agreement of actions to help meet targets*	Y	N	*Targets and plans of action decided upon*

* 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		

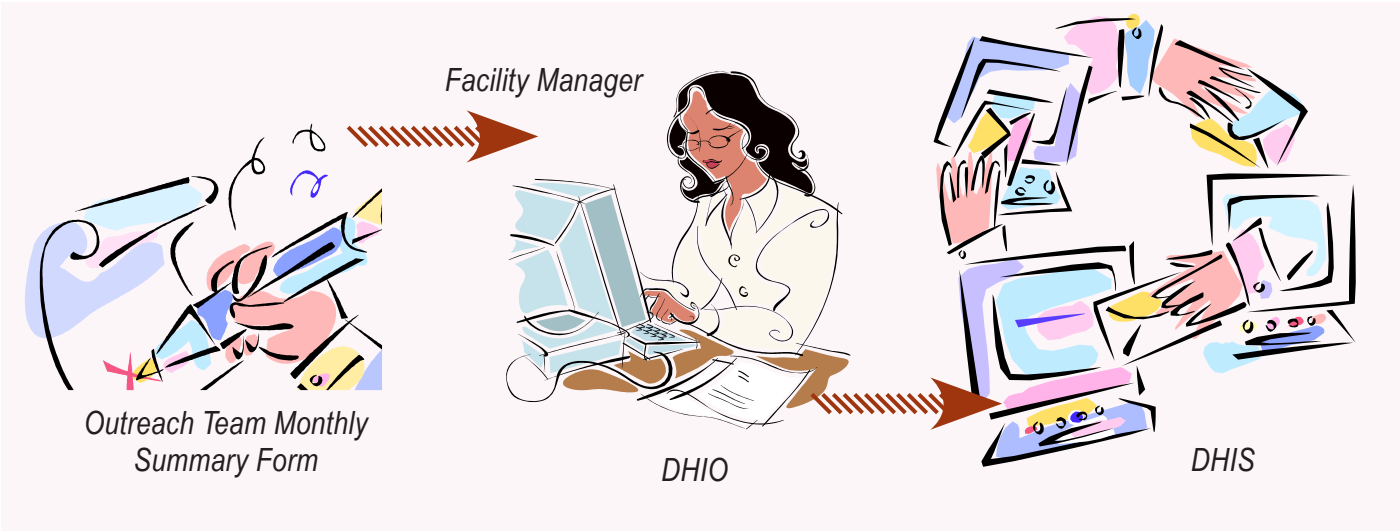
6.3.3 What happens to the information submitted in the monthly reports?

Of the three documents that the OTL submits to the Facility Manager each month, only one document is submitted to the District Health Information Officer (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.

Once the Facility Manager receives the *Outreach Team Monthly Summary Form*, they must submit it to the DHIO who will then enter the data into the District Health Information System (DHIS). The DHIS will generate reports that the OTL should receive on a monthly basis. The Facility Manager will act as the link between the Outreach Team and the DHIO/DHIS.

Note: It is the Facility Manager's responsibility to ensure that the Outreach Team has an adequate supply of copies of all required monthly forms and reports and they have the most up-to-date versions.

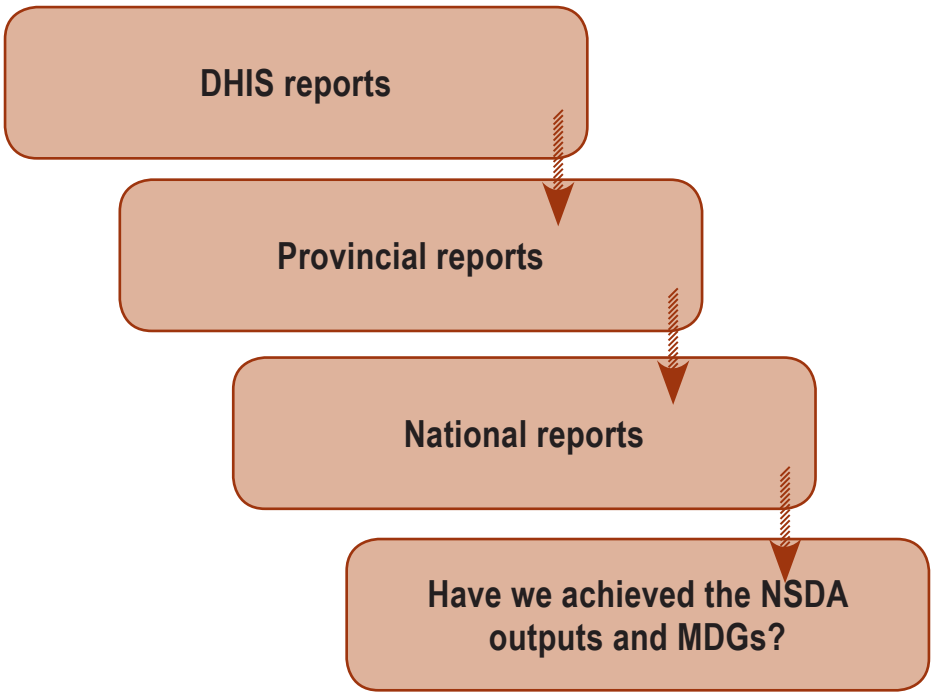
Figure 12: Process flow of information from Outreach Team to DHIS



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 this work has led to the achievement of the NSDA outputs and the MDGs. This is outlined in Figure 13 below.

Figure 13: Big picture information flow



6.4 Filing and Confidentiality

All required documentation for each Outreach Team, including the reports described above, must be kept in an organised and systematic way. It is important that anyone in the District Management Team (DMT) can find any document that they are looking for. The best way to keep documents is in a filing system.

It is the Facility Manager's responsibility to ensure that each OTL has a secure and confidential filing system in place for all Outreach Team documentation. All stationery supplies required for the Outreach Team(s) filing system must be ordered through the Facility Manager on the monthly Outreach Team Supplies Management Form.

6.5 Documentation that needs to be filed by Outreach Team

The Outreach Team are responsible for a great deal of documentation. The table below indicates which Outreach Team documents must be kept on record, who the document is completed by, submitted to, filed by and a suggested filing system. This table is provided to the OTL during their Orientation Programme and is included here for your information.

Table 6: Documentation that needs to be filed

Category	Document name	Completed by	Submitted to	Filed by	Suggested filing system
CHW Forms	Household Registration Form	CHW	OTL	CHW*	Each HH should have an individual document wallet where all of these documents are kept; all HH allocated to one CHW area should be stored in one location
	Individual Adult Health Record	CHW	OTL	CHW*	
	Maternal and Child Health Record	CHW	OTL	CHW*	
	Referral/Back-referral Form	CHW	OTL	CHW*	
	CHW Household Visit Tick Sheet	CHW	Not submitted	CHW*	Each CHW should keep their individual summary forms in an individual filing system; forms may be filed by month
	CHW Household Visit Monthly Summary Form	CHW	OTL	CHW/OTL	Both the CHW and the OTL should keep copies of this form which may be filed by month
Team Management	Record of Households per Community Health Worker	OTL	May submit copy to Facility Manager	OTL	This should be kept in the front of each filing box/cabinet/drawer where all HH document wallets are kept for each CHW
	Example Outreach Team Meeting Agenda	OTL	Not submitted	OTL	It is important to keep a record of all meetings that you facilitate; this should be kept in a file for all team meetings
	Outreach Team Meeting Minutes Template	OTL	May submit copy to Facility Manager	OTL	Kept in file for all team meetings
	Example Meeting Attendance Register	OTL	May submit copy to Facility Manager	OTL	Kept in file for all team meetings
	Community Meeting Agenda	OTL	May submit copy to Facility Manager	OTL	Kept in file for all community documents
	Community Resource List	OTL	Not submitted	OTL	Kept in file for all community documents

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	OTL	Individual team member file
	Evaluation of Antenatal Home Visit	OTL	Not submitted	OTL	Individual team member file
	Evaluation of Postnatal Home Visit	OTL	Not submitted	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
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

* The last column in the table (on the right) is a suggestion. Each team must create a filing system that makes sense to them. 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.

7. Facility Manager Checklist

Below is a list of all items for which the Facility Manager is responsible, as it relates to the Outreach Team:

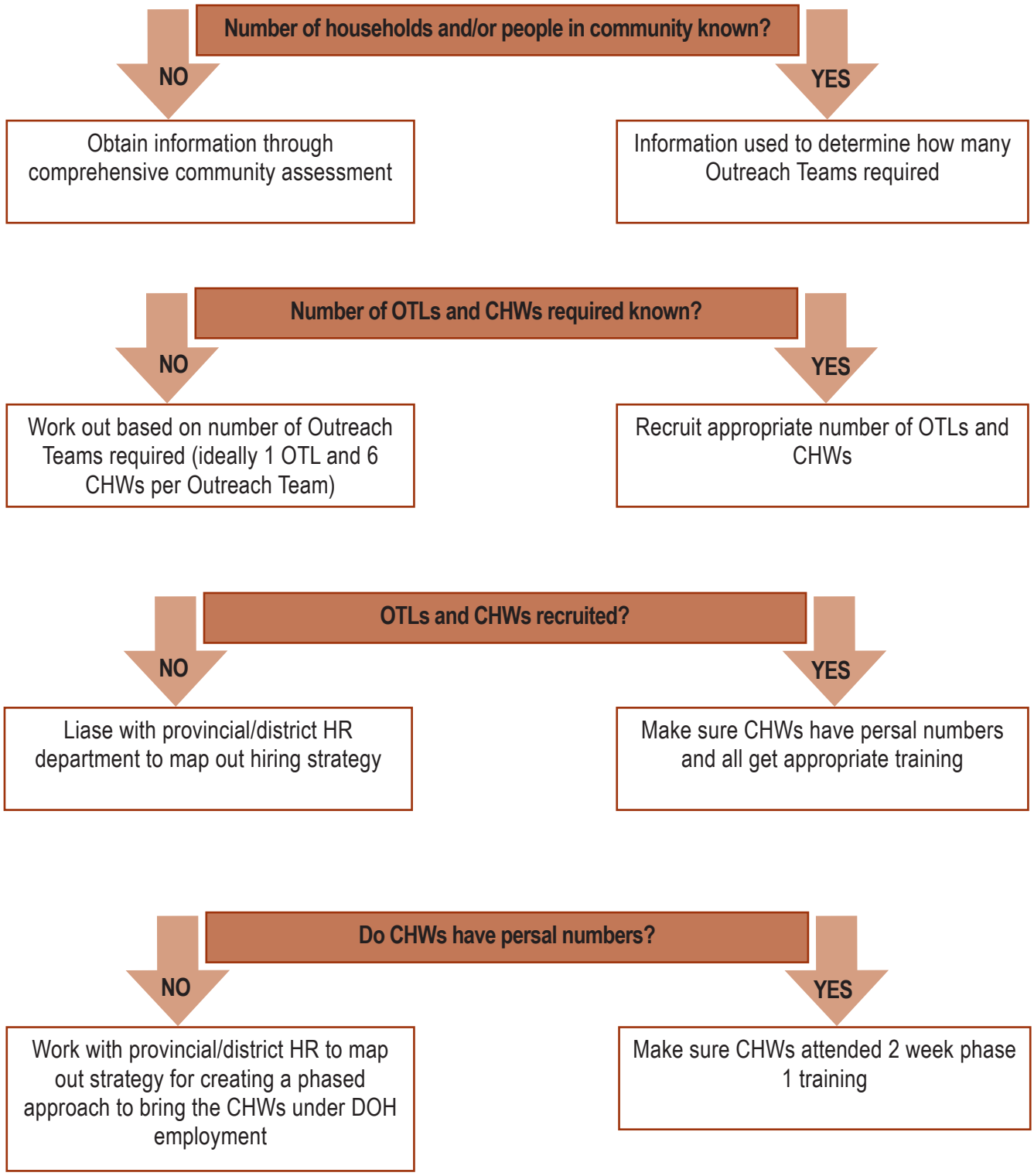
Item	Tick
Ensure all members of the clinic are kept informed of the activities and processes associated with the Outreach Team	
Assist the OTL with community entry by acting as a liaison between the OTL and the Clinic Committee	
Work with the OTL to ensure a smooth transition from clinic to community	
Conduct one-on-one meetings with each OTL on a monthly basis	
Manage the performance of each OTL	
Deal with all human resource related matters (e.g. disciplinary, employment contracts) concerning members of the Outreach Team	
Provide adequate support for day-to-day activities of the Outreach Team	
Act as a liaison and communicator between the provincial/district/sub-district PHC re-engineering staff and the Outreach Team	
Ensure the Outreach Team has adequate supplies for service delivery to the community and households (as requested on the *Outreach Team Supplies Management Form*)	
Ensure all Outreach Team data is captured correctly and consistently on the reporting forms and stored appropriately. This includes: • Ensuring the Outreach Team have an adequate supply of copies of all forms and reports and they have the most up-to-date versions • Ensuring the DHIO captures the *Outreach Team Monthly Summary Form* data on the DHIS • Ensuring any necessary reports are extracted from DHIS • Reviewing Record of *CHWs in Outreach Team, Record of Households per Community Health Worker*, Outreach Team Meetings Agenda, Minutes and Attendance Registers, Community Meeting Agendas, *Performance Management Review of CHW Forms, Outreach Team Reporting Tool* • Ensure that the Outreach Team has a secure and confidential filing system in place for all Outreach Team documentation	

Appendix B

8

Problem Management Tool

The Problem Management Tool below is intended to assist with the identification of what elements need to be in place for the success of the Outreach Teams.



Appendix B

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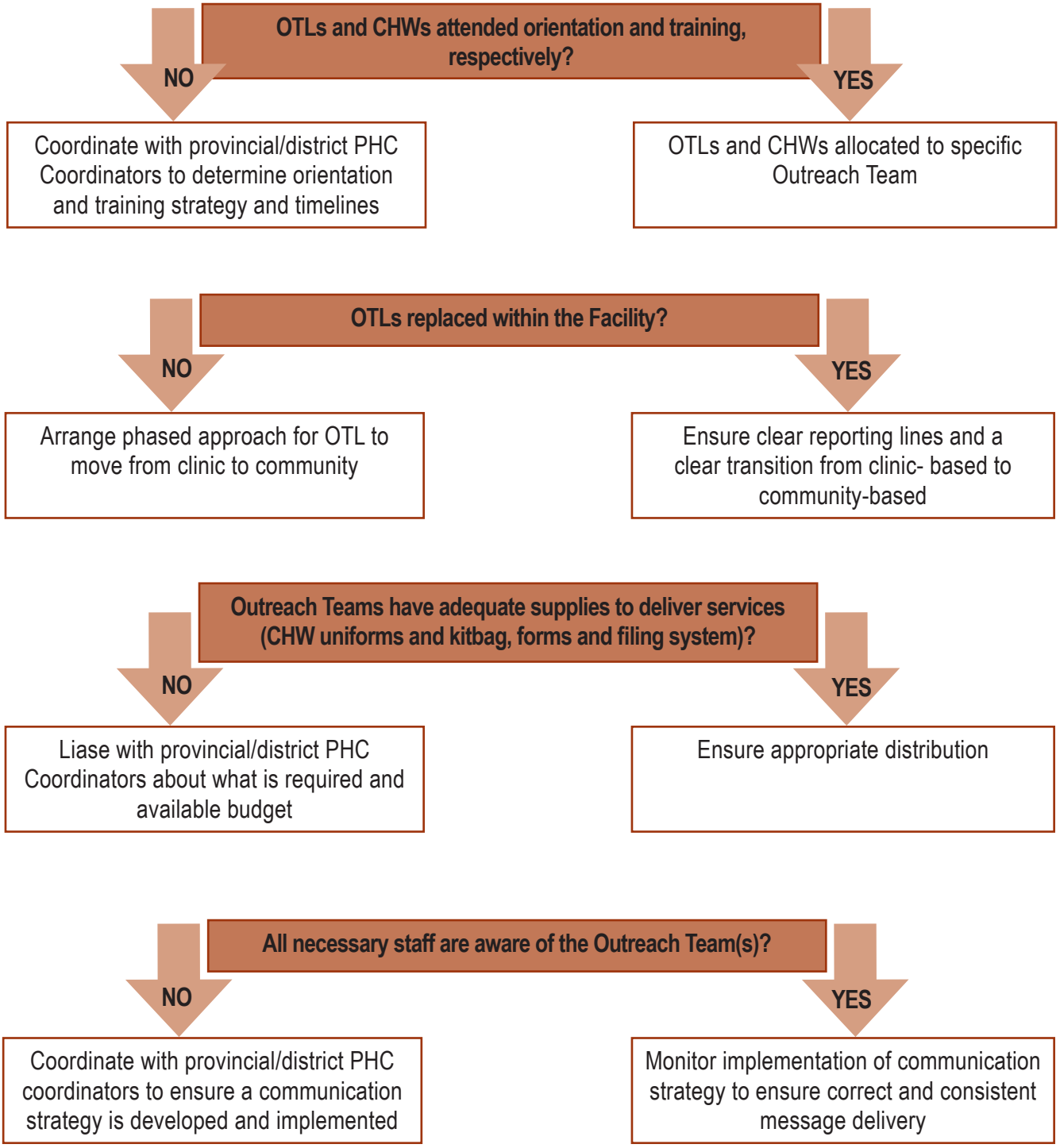
OTLs and CHWs attended orientation and training, respectively?
NO
YES
Coordinate with provincial/district PHC Coordinators to determine orientation and training strategy and timelines
OTLs and CHWs allocated to specific Outreach Team
OTLs replaced within the Facility?
NO
YES
Arrange phased approach for OTL to move from clinic to community
Ensure clear reporting lines and a clear transition from clinic- based to community-based
Outreach Teams have adequate supplies to deliver services (CHW uniforms and kitbag, forms and filing system)?
NO
YES
Liase with provincial/district PHC Coordinators about what is required and available budget
Ensure appropriate distribution
All necessary staff are aware of the Outreach Team(s)?
NO
YES
Coordinate with provincial/district PHC coordinators to ensure a communication strategy is developed and implemented
Monitor implementation of communication strategy to ensure correct and consistent message delivery

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Ward-based Primary Health Care Outreach Team Management Information Session Evaluation Form				
Name of Facilitator	Date			
Overall rating				
Overall rating of the Management Information Session	Poor	Average	Good	Excellent
Do you feel that you received the information you were looking for?	Yes	No	If no, explain why:	
Is there more you would like from the Management Information Session?	Yes	No	If yes, explain why:	
Facilitator(s)				
How well prepared was the Facilitator?	Poor	Average	Good	Excellent
Rate the Facilitator's knowledge of the subject matter	Poor	Average	Good	Excellent
Rate the Facilitator's response to questions	Poor	Average	Good	Excellent
Rate the standard of presenting	Poor	Average	Good	Excellent
Overall rating of the Facilitator	Poor	Average	Good	Excellent
Venue				
Rate the professionalism of the staff	Poor	Average	Good	Excellent
Was the venue comfortable and conducive to information sharing?	Poor	Average	Good	Excellent
Was the standard of the equipment in the venue satisfactory?	Poor	Average	Good	Excellent
Rate the refreshments and quality of food	Poor	Average	Good	Excellent
Was the accommodation clean and comfortable?	Poor	Average	Good	Excellent
General comments				

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