Province of KwaZulu-Natal

Operation Sukuma Sakhe

Integrated Community Caregiver Foundation Course

Ugu District Training Report

OPERATION Sukuma Sakhe

STAND UP AND BUILD

Published: July 2013

Contents

List of Tables

List of Figures

Acronyms and Abbreviations

Acronym/Abbreviation	Definition/Explanation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARV	Anti-Retroviral
BRHC	BroadReach Healthcare
CBO	Community-Based Organisation
CCG	Community Caregiver
CDW	Community Development Worker
CHF	Community Health Facilitator
DoH	Department of Health
DOTS	Directly Observed Treatment Short-Course
DSD	Department of Social Development
ECD	Early Childhood Development
EFT	Electronic Financial Transfer
FBO	Faith-Based Organisation
FG	Facilitator Guide
HAART	Highly Active Anti-Retroviral Therapy
HIV	Human Immunodeficiency Virus
KZN	KwaZulu-Natal
LG	Learner Guide
LO	Logistics Officer
MOA	Memorandum of Association
M&E	Monitoring and Evaluation
NGO	Non-Governmental Organisation
OSS	Operation Sukuma Sakhe
OTP	Office of the Premier
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother-To-Child Transmission

Acronyms and Abbreviations

Acronym/Abbreviation	Definition/Explanation
PPSTA	Provincial Public Service Training Academy
PT	Professional Trainer
QA	Quality Assurance
QAO	Quality Assurance Officer
STI	Sexually Transmitted Infections
TB	Tuberculosis
TOT	Train the Trainer
USAID	United States Agency for International Development
YA	Youth Ambassador

Introduction

1. Introduction

KwaZulu-Natal (KZN) is South Africa's most populous province and remains a predominantly rural province, with dependency ratios and poverty levels highest in the rural areas. The resulting challenges arising from poverty include malnutrition and poor health which are further exacerbated by social phenomena such as crime, violence against women and children, and substance abuse. Many of these challenges are inextricably linked to each other and therefore require an integrated response.

One such response has been the launch of Operation Sukuma Sakhe (OSS) as a beacon of hope. Through this initiative, government is calling on the people of KwaZulu-Natal to 'Stand Up and Build' KZN together to alleviate some of these challenges. This programme uses such strengths as the strong sense of community and Ubuntu within KZN to create a mutually beneficial relationship between government and communities; to ensure delivery of services and create healthy communities.

OSS is a programme of government that, according to Dr. Zweli Mkhize, Premier of the Province of KwaZulu-Natal, "Aims to integrate the services of Government in order to ensure that it enriches the lives of our citizens." OSS is about building a better life for communities with their help. Through this initiative, government works with many partners such as political and traditional leadership, civil society, community-based organisations and communities themselves, which come together in a 'War Room' based in the Wards. The War Room has members from political structures, traditional structures (amakhosi, izinduna and amagoso, etc.), business, youth groups, women's groups, religious and church leaders, sport, elderly and other cultural bodies. The Community Development Worker (CDW), the Community Caregiver (CCG), Youth Ambassador (YA) and other field workers are important members of the War Room.

The mandate given to OSS, the Provincial Public Service Training Academy (PPSTA), BroadReach Healthcare (BRHC) is to develop training materials that integrate the programmes of the Departments of Health and Social Development and to train Community Caregivers (CCGs) in the Province to perform their integrated scope of practice.

The Office of the Premier established a Provincial Training Task Team, led by Ms. Nirvana Simbhoo (PPSTA), consisting of members from the Department of Health (DoH), Department of Social Development (DSD) and BroadReach Healthcare (BRHC). Materials were developed in collaboration with the DoH and the DSD by January 2012 and approved by the respective Heads of Department in May 2012. Consequently, the Office of the Premier agreed to train CCGs in the Province starting with uThungulu District (21 July to 21 September 2012) and Ugu District (19 November 2012 to 15 February 2013).

2. About Ugu

The IsiZulu word 'Ugu' means 'coast' The Ugu District Municipality is 5 866 km² in extent and it is one of the eleven districts of KwaZulu-Natal; comprising approximately 7 percent of the population of KwaZulu-Natal (www.kznhealth.gov.za/ugu.htm). It is found in the lower South Coast of the Province of KZN and comprises of 81 municipal wards and boasts forty two (42) traditional authorities. Ugu District Municipality consists of six local municipalities: Umuziwabantu, Ezinqoleni and Vulamehlo are located inland, while Umzumbe, Umdoni and Hibiscus Coast; are located on the coast.

According to the Statistics SA (Census 2011), the estimated population is 722 484, of whom 91 percent are isiZulu speaking. The total number of households in the District is 179 440. The majority of the population (79 percent) resides in the rural areas. The Hibiscus Coast, makes up 36 percent of the population and 60 percent of the economic activity.

The following are the programmes that Ugu District uses to provide water services to the community:

- Free basic water and indigent support: An Indigent Support Policy entitles beneficiaries (indigent households) to 12kl of free water per month and 100 percent rebate on water and sanitation charges. To date, 5 844 households are benefitting from Indigent Support. In rural areas, households have access to 5 000 stand pipes in the whole district;
- Ground water programme which incorporates the use of boreholes and spring water; and
- Individual water schemes which seek to integrate the isolated individual water schemes into sustainable systems.

Currently, as per Statistics SA Census 2011, access to water services is as follows:

Table 1: Access to Water Services per Municipality (Percent of Households)

Municipality	Piped water	RDP level of service	Backlog
Hibiscus Coast Municipality	50	45	5
Ezinqoleni Municipality	17	68	15
Umuziwabantu Municipality	18	66	16
Umzumbe Municipality	14	40	46
Vulamehlo Municipality	17	49	34
Umdoni Municipality	53	44	3

Statistics SA Census 2011 shows that the backlog of households without a satisfactory level of sanitation services is estimated at 7 percent with 32 647 households having flush toilets connected to a sewerage system; 13 181 households with flush toilets connected to septic tanks; and the balance of households utilising other options such as pit latrines, chemical toilets and bucket toilets.

About Ugu

According to Statistics SA Census 2011, access to electricity services is as follows:

Table 2: Access to Electricity Services per Municipality (Percent of Households)

Municipality	Electricity	Backlog
Hibiscus Coast Municipality	85	15
Ezinqoleni Municipality	80	20
Umuziwabantu Municipality	80	20
Umzumbe Municipality	49	51
Vulamehlo Municipality	37	63
Umdoni Municipality	37	63

The major challenges in Ugu District are poverty and unemployment. The population is largely low-income. More than 44 percent of households earn less than R1 500 per month and almost 60 percent earn less than R2 500 per month. The unemployment rate for the district as a whole is estimated at 30 percent; urban areas tend to be wealthier and have access to better infrastructure, more economic opportunities and a greater range of municipal services than rural areas.

Rural households depend largely on external income sources, e.g. government grants and remittances from relatives working in urban areas across the country.

Rolling hills of Ugu near Gqayinyanga Clinic

3. About the Community Caregiver (CCG)

A Cabinet resolution has been passed in KZN endorsing the Integrated Programme for Community Caregivers led by the Department of Health and the Department of Social Development. Previously CCGs worked either as Community Health Workers, home and community-based carers or community caregivers under Non-Governmental Organisations (NGOs). CCGs have varying levels of skills and knowledge as a result of length of service and access to training. The Integrated Community Caregiver is a fieldworker contracted by DoH or DSD and reflected on their respective PERSAL systems. An integrated CCG is expected to connect households with service delivery units so as to allow for seamless service delivery while ensuring that services are available close to the homes of each citizen (PCA Presentation on Integrated CCG, March 2011).

The CCG is an important extension of the health and social development system at community level. The integration of CCGs allow for clients at household level to avoid receiving duplicate services from various organisations and departments. One CCG would visit one household offering a variety of services. CCGs are allocated specific households and offer services ranging from household profiling to access to service delivery.

The scope of practice of the Integrated Community Caregiver includes the following:

- Profiling of households using a household profiling form
- Health promotion to effect behaviour change and screen for high risk behaviour
- Basic environmental health assessment to identify health and manage health risk
- Assessment of all family health cards to identify existing illnesses for support
- Identification of early warning signs for outbreak of diseases and refer accordingly
- Manage emergencies and refer accordingly
- Provide HIV, AIDS, STI, TB, PMTCT and any other health and wellness information dissemination after screening using standardised screening tools
- Ensuring referral for early booking and registration for ANC (antenatal care)
- Adherence support for long term and chronic medication including DOTS support, adherence to ARVs and nutrition supplements
- Dispelling myths around HIV and encouraging more people to test and increase uptake on HAART
- Growth and development monitoring, including the Road to Health Chart which will increase vaccination rates, growth monitoring, nutrition and developmental assessments
- Conduct childhood nutritional assessment through the use of the tape measure for mid-upper arm circumference ensuring appropriate referrals
- Encourage one home one garden enhancement and support
- Mobilise communities on health, social and development issues
- Promote basic home-based care including palliative care
- Establish support groups (facilitate support groups and refer clients to them)
- Provide early identification of Orphans and Vulnerable Children for referral

About the Community Caregiver (CCG)

- Provision of material assistance in the form of food parcels, feeding schemes, assistance with laundry and school uniforms and after school recreation activities (NIP site)
- Referral of children under 5 to Early Childhood Development (ECD) (including partial care arrangements for children)
- Screen and refer family members to access social services DSD Service offices – Foster Care, Places of Safety, Substance Abuse, Child Abuse, Family Counselling, Care for the aged, victim empowerment, etc
- Screen and refer family member to access social grants and ID documents
- Monitor school attendance and assist with homework where necessary
- Development of care plans for children, addressing their emotional, social and health needs
- Refer clients to existing Child Care Forums, income generation projects
- Create linkages between households and government departments
- Prepare and submit reports using prescribed reporting tools

CCGs in the Integrated Programme report to structures within the Department of Health and the Department of Social Development. At the local level, in the Department of Health structure, the CCG reports to a Community Caregiver Supervisor (CCS) who in turn report to a Community Health Facilitator. Likewise, in the Department of Social Development structure, the CCG report to a CCS who in turn report to an HIV and AIDS Coordinator.

OSS relies on the work of Community Caregivers (CCG), a trusted partner who gathers information about the challenges that communities face and takes an active role in educating the community and supporting them in addressing some of these challenges.

For this reason, at ward level the CCG is allocated a set number of households and visit households door-to-door to:

- Understand the needs in the household
- Help people to get to the services that they need
- Educate household members to live in a healthy way and prevent diseases
- Screen and refer individuals to other services for treatment care and support
- Follow up with households to make sure that they received the services they needed

The Community Caregiver is an important member of the War Room. CCGs and Youth Ambassadors profile households and identify their needs. They bring the household profiles to the CDW or equivalent focal person in the War Room who collates the information and compiles a report for submission through the OSS structures.

About the Integrated Community Caregivers Foundation Course

4. About the Integrated Community Caregivers Foundation Course

To address varying skills and knowledge levels of CCGs, OSS was mandated to develop training material that will address all topics of the integrated programme. The Integrated Community Caregivers Foundation Course is a comprehensive 10-day training course aimed at building the capacity of CCGs in their role as the intermediary between the community and government and as champions in the roll-out of OSS in the integrated programme. The Integrated CCG Foundation Course is aligned to the integrated scope of practice of the CCG in KZN.

The aim of the Integrated CCG Foundation Course is to empower CCGs with the requisite knowledge and skills to educate, screen, and refer clients to appropriate service providers, empowering individuals and communities to take responsibility for their own health through positive health seeking behaviours. The training addresses needs of all types of individuals – new-born babies, infants, children, youth, adult males, adult females, pregnant mothers, people living with HIV and those living with disabilities.

The Integrated CCG Foundation Course consists of six modules. They are:

Module 1	The Role of the CCG	This module covers the purpose of the training, the role of the CCG, skills development and how to record, report and follow-up with households
Module 2	Healthy Living	This module covers all the ways to stay healthy and how to prevent diseases
Module 3	Maternal and Child Health	This module covers everything to do with the health and social needs of women and children
Module 4	Infectious Diseases	This module covers diseases and conditions that can spread from person to person and from animals to persons
Module 5	Chronic Conditions	This module covers diseases and conditions that are not infectious but will affect the client for a long time
Module 6	Care and Support	This module explains how to access services such as identity documents, social grants, support groups, food gardens and how to care for those living with sickness or disability

Learner materials for the Integrated CCG Foundation Course include:

- Learner Guide books 1 and 2 containing the ten-day course material in isiZulu and English. The Learner Guide is to be used for further training and as resource material following the training.
- Household Guide for use by CCGs at household level and is a summary of key points from the Learner Guide
- Screening Tools to assist the CCGs screen and refer clients to primary health care and social development service providers
- An OSS backpack for easy transportation of the Screening Tools and the Household Guide
- Stationery set for CCGs
- Facilitator Guide (English) is used by the Professional Facilitator during training
- Slides (English and isiZulu) is used by the Professional Facilitator during training
- A1 training posters of screening tools, checklists and care pathways displayed in the training session and used during training

The Aim and Objective of the Integrated Foundation Course Training

5. The Aim and Objectives of the Integrated CCG Foundation Course Training

The overall aim of the Integrated CCG Foundation Course is to empower CCGs with knowledge and skills to perform their scope of practice. The course is comprehensive and allows all CCGs an equal opportunity to acquire a basic level of knowledge and skills in health and social development topics. It creates the foundation knowledge and skills for future specialisation and career development.

Specifically, the objectives of the training are to provide:

- Basic education on health and psychosocial support to all CCGs on PERSAL
- Appropriate and relevant tools which will assist CCGs in the transfer of knowledge and to enable them to screen and refer their clients to appropriate services
- Skills development to enable CCGs to perform their scope of practice

6. Approach and Method for the Training Roll-Out

BroadReach Healthcare (BRHC), through its cooperative agreement with USAID and its Memorandum of Association (MOA) with the Office of the Premier (OTP), collaborated with OTP to develop the Integrated CCG Foundation Course and train all CCGs contracted in uThungulu and Ugu by DoH and DSD.

A partnership framework consisting of stakeholders from BRHC, OTP, DoH and DSD has been developed. The roles and responsibilities of each partner is defined and agreed upon. The role of BRHC is to perform project management tasks, develop and print all training materials, develop the advocacy and communication plan, offer technical assistance to the training task teams and to implement the training roll-out.

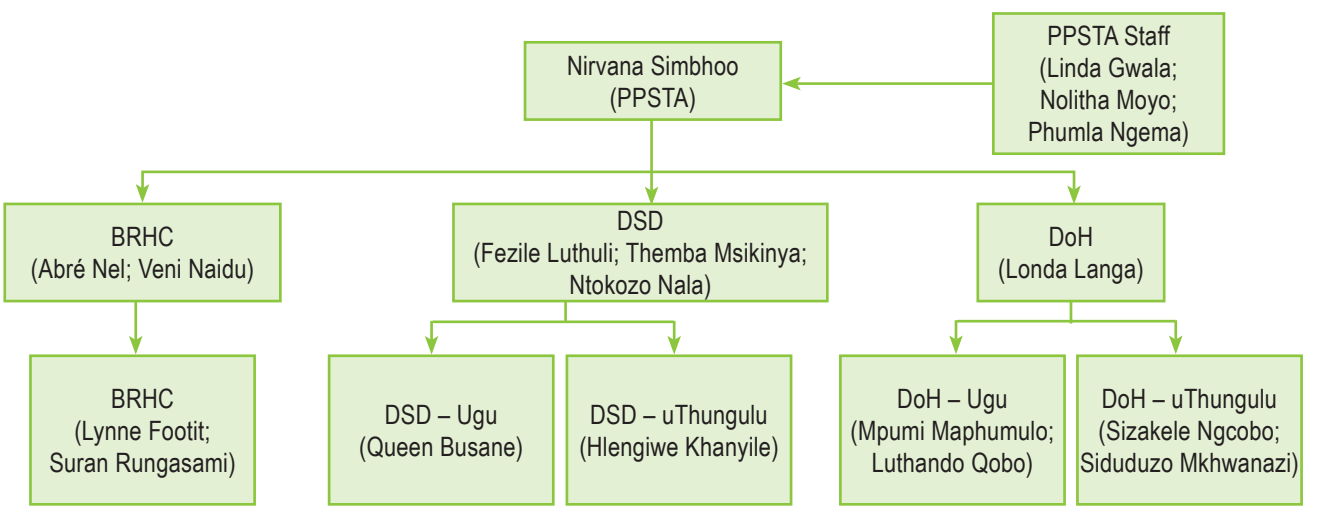
As part of the partnership framework, two task teams have been established – the Provincial Training Task Team and the District Training Task Team.

6.1 Provincial Training Task Team

OTP appointed Ms. Nirvana Simbhoo from the PPSTA to lead the Provincial Task Team (see Figure 1). Membership to the Provincial Training Task Team included members from PPSTA, DoH Province and District, DSD Province and District and BRHC. Meetings are hosted by the PPSTA, Durban and have been held bi-weekly from the start of the project, that is, from the planning phase. The roles and responsibilities of the Provincial Task Team are to:

- Approve the Stakeholder Advocacy and Communication Plan
- Approve the Training Roll-out Plan
- Present the progress of the training roll-out project deliverables to OSS and management structures within OTP
- Approve all project related communication
- Organise stakeholder site-visits to experience the training first-hand
- Approve training reports
- Disseminate training results to all stakeholders
- Provide direction to the District Training Task Team

Figure 1: Provincial Training Task Team Membership



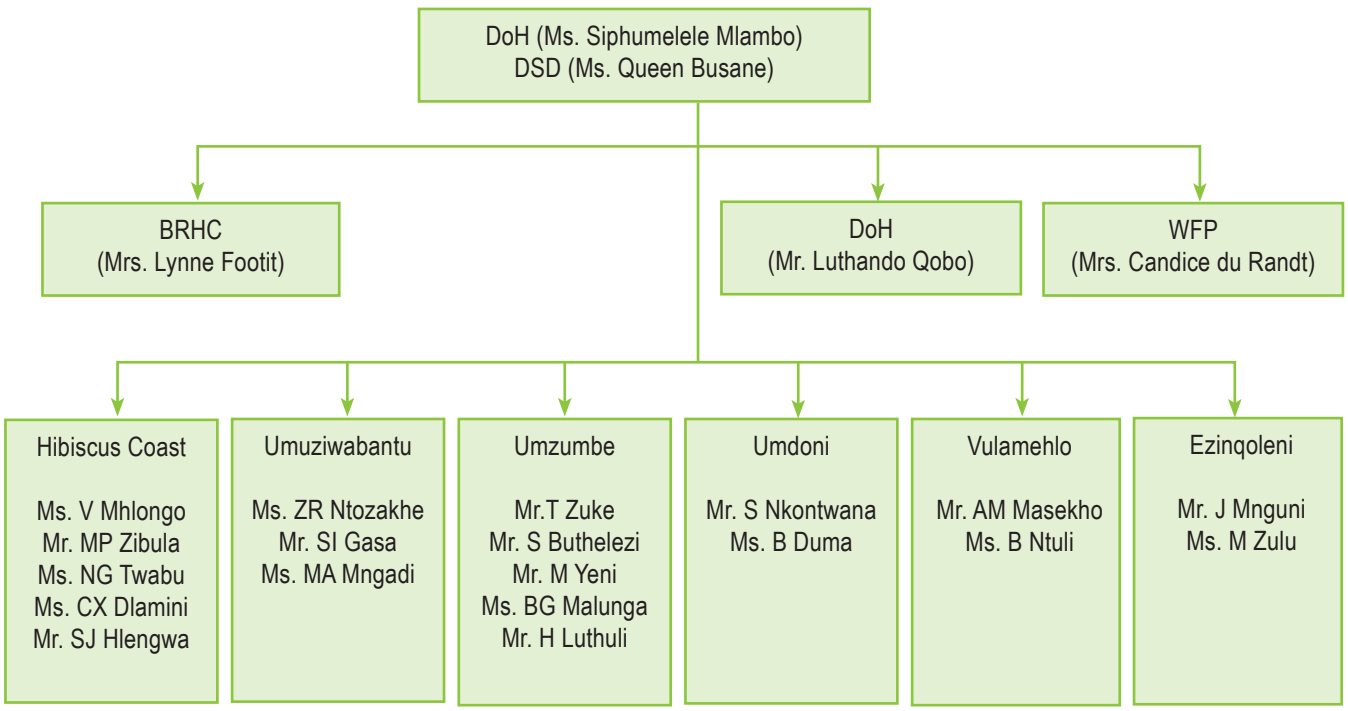
Approach and Method for the Training Roll-Out

6.2 District Training Task Team

The District Training Task Team in Ugu (see Figure 2) is chaired by Ms. Siphumelele Mlambo (DoH) with Ms. Queen Busane (DSD) as deputy chair. Meetings were held weekly before and during training and bi-weekly post-training. Meeting venues were provided by the Department of Health and/or Department of Social Development. Membership included district officials in charge of the CCG programme, HIV or AIDS Coordinator (DSD), Community Health Facilitator (CHF) from DoH, BRHC and Wildflower. The main role of the District Training Task Team is to facilitate the distribution of the invitation and attendance of CCGs and to plan the training logistics. Specific activities include:

- Approval of class lists and ward grouping of CCGs per training group
- Identification of suitable training venues and caterers within the wards, and assistance with booking of venues where required
- Pre-registration process, including update of CCG details and distribution of invitations and communiqué
- Reallocation and follow up of CCGs that missed classes
- Approval of certain logistical processes
- Communication of the training roll-out plan
- CCG communication and management during training roll-out
- Providing support to CCGs and motivate them to attend the training programme
- Troubleshooting and support during training roll-out

Figure 2: District Training Task Team Membership



Approach and Method for the Training Roll-Out

6.3 Training Approach

The training approach was outcomes and competency-based in order to achieve the overall aim of knowledge and skills transfer. The primary purpose of the training was to provide skills and knowledge needed to accomplish specific tasks, in this case, screening, education and referral of clients by trained CCGs.

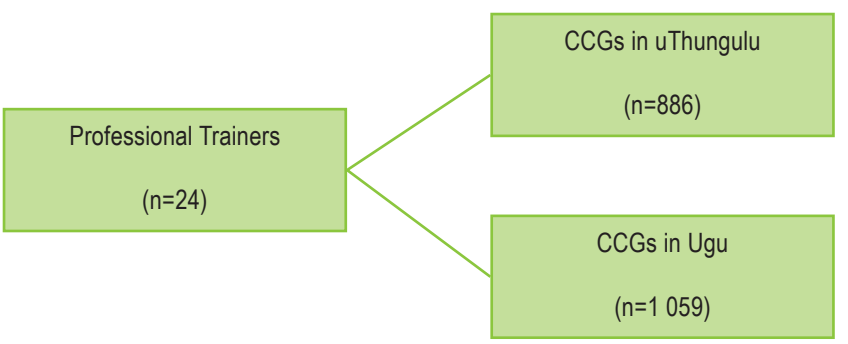
The training approach was participatory, interactive and based on adult learning principles. In this context, participants are given opportunities to interact within discussion groups, study groups, focus groups, work groups, and simulation groups. The following techniques and tools formed part of the training methodology:

- Self-paced written manual
- Peer learning
- Hands on practical sessions (buzz groups and small group sessions)
- Classroom lectures (PowerPoint presentations)
- Demonstrations
- Role-plays and case studies

A two-tier training approach is followed (see Figure 3), first being to up-skill Professional Trainers (PTs) who in turn will facilitate the ten-day training course in each of the Districts.

A team of professional trainers is recruited from within the districts wherever possible or from within the Province to receive training on the principles of OSS, Integrated CCG Foundation Course content, facilitator methodologies and training roll-out logistical and quality assurance tools.

Figure 3: Two-tier Training Approach



Approach and Method for the Training Roll-Out

6.4 Training Materials and Equipment

All training materials – the Facilitator Guide, the slides, the training programme – were approved by the Provincial Training Task Team. All material received by the CCG was translated into isiZulu by the same translator as the Learner Guides, and proof-read by one of the Professional Trainers who is isiZulu speaking and born in KZN. The following training tools were provided to each professional trainer:

- OSS Backpack
- Facilitator Guide with copies of slides in English and isiZulu (include slide notes)
- Training Programme
- Wax crayons
- Flip chart paper
- Baby doll
- Learner Guides (English and isiZulu)
- Household Guide (English and isiZulu)
- Screening Tools (English and isiZulu)
- Administrative files with copies of tools
- Name Badges for PTs and CCGs
- Extension cords
- Training posters of Checklists, Care Pathways, Screening Tools
- Laminated flashcards

As part of training roll-out, the following equipment was provided per training session (per class):

- Projection screens
- Flipchart stands
- Flash-drives
- Stationery
- Cameras x 5 (one for each LO and QAO)
- Laptops
- Data Projectors
- Portable Screens

Approach and Method for the Training Roll-Out

6.5 Quality Assurance

To support the training roll-out, a set of activities was carried out according to agreed quality standards to monitor and improve performance so that the training that was provided is as effective and safe as possible. Quality assurance tools have been used to support the project before training and during training.

Professional trainers were recruited according to the following pre-selection criteria to ensure that a minimum level of knowledge and competency was available:

- **Educational Qualifications:** Tertiary Education Level
- **Skills:** Training and facilitation skills in adult training, Training of Trainer (TOT) skills, communication skills, mentoring skills as well as evaluation/learner assessment skills
- **Core knowledge base:** Health, health policy and strategy
- **Generic knowledge base:** Counselling/Education/Welfare/Community Development/Primary Care; understanding community dynamics
- **Level of experience:** Minimum 5 years (training in a health and social development related context e.g., infectious disease management (HIV and AIDS; TB), home-based care; child and maternal health; orphans and vulnerable children)
- **Availability:** Not in current employment
- **Key requirements:** Willingness and ability to travel and work away from home
- **Language requirements:** Ability to speak, write and read isiZulu (essential)

During the planning phase, community and municipality venues were booked and caterers selected. Checklists were developed to ensure that venues were of an adequate minimum standard and caterers previously approved by the municipalities were appointed. To ensure that CCGs received the invitation and would attend they were expected to sign the pre-registration attendance register and supply their banking details.

Table 3 is a list of tools generated to provide quality assurance for the planning phase. An administrative file has been compiled with copies of these checklists.

Table 3: Quality Assurance Documents to Support the Planning Phase

Name	Purpose	Administered by
Venue Checklist	To ensure that appropriate venues for the training is sourced	Logistics Officer
Catering Checklist	To ensure that all catering requirements are met	Logistics Officer
Logistic Checklist	To guide the Logistic Co-ordinator to submit the required forms	Logistics Officer
Learner Pre-Registration Register	To obtain CCG's commitment to the scheduled training	Community Health Facilitators and HIV and AIDS Co-ordinators

Approach and Method for the Training Roll-Out

During training, the attendance register was used as a tool to monitor CCG attendance over the ten days. CCGs were expected to sign the time of arrival and departure so as to record times missed and to encourage CCGs to make up for the missed lessons. Assessments were developed to assess learning and competence at both the PT and CCG level.

Table 4 is a list of tools generated to provide guidance on quality during the training phase of both Professional Trainers and CCGs during their respective training sessions. An administrative file has been compiled with copies of these tools. All tools administered by the CCG were translated into isiZulu.

Table 4: Quality Assurance Tools to Support the Project During Training

Name	Purpose	Administered by
Professional Trainer Assessment	To assess the performance of Professional Trainers in the classroom	Quality Assurance Officers
Attendance Register	To monitor CCGs attendance	Facilitator
Pre-Assessment	To assess the level of all the CCGs prior knowledge to assist the trainer to address gaps and pitch the programme at the correct level	Facilitator
Post-Assessment	To assess transfer and retention of knowledge and to assist the learner to address gaps in knowledge	Facilitator
Role-play Checklist	To assess the CCGs practical application of their knowledge	Facilitator
CCG Learner Feedback	To obtain feedback with regard to the training	CCG
Facilitator Checklist	To guide Facilitator on processes and procedures required during the training	Facilitator

To measure success of the project, a Monitoring and Evaluation (M&E) Framework was developed covering three phases of the project – the training of Professional Trainers, training of CCGs and post-training assessment of CCGs in field 3 to 6 months after training. This report will focus on aspects of the M&E framework that have been completed to date, namely phase 1 and 2 as outlined above.

Pre- and Post-Testing of CCGs was conducted to determine the level of learning and the improvement in knowledge as a result of the training. Participants were asked a series of questions at both the beginning of a module (Pre-Test) and then again at the module's completion (Post-Test). Ten multiple choice questions were developed for each module except for the more extensive module 4 which had 15 questions. The questions, which were aligned with

the learning objectives, were designed to provide maximum coverage of the module. Facilitators were instructed to read out the multiple-choice options to the class to accommodate varying levels of literacy and facilitate common understanding amongst learners.

Professional Trainers are assessed in three ways:

- Pre- and Post-Test
- A practical test in a simulated training environment

Existing literature does not support any specific percentage improvement in knowledge between Pre- and Post-Test. However the literature does suggest that test scores in excess of 66 percent is appropriate for individuals needing to transfer knowledge. There were 65 questions for the Pre-and Post-Test covering all six modules. In keeping with selection criteria, PTs were required to have a high level of baseline knowledge.

CCGs are assessed in two ways:

- Pre- and Post-Test
- Practical role-play assessments simulating a household visit (they are expected to screen household members, educate them on relevant topics, refer them to appropriate service providers, as well as record and report the information)

CCGs have different levels of knowledge based on their employment history with DoH or DSD. It is expected that CCGs will increase their knowledge as measured by their Pre- and Post-Test scores. Whilst most literature supports a pass mark of 50 percent for learners, CCGs are expected to transfer knowledge to household members and the fact that they have educational tools at hand, a pass mark of 60 percent is a reasonable expectation. Their facilitation skills, however, were expected to be at a higher level so their expected role-play score was set at 66 percent.
A Post-Training Assessment will be conducted where CCGs will be assessed doing household visits three to six months post-training. They will be followed in the field by Professional Trainers and observed in terms of their skills to:

- Screen clients at home
- Educate clients on relevant topics
- Refer clients to appropriate service providers

The results for each indicator in Table 5 will be discussed under the relevant sections.

Approach and Method for the Training Roll-Out

Table 5: Monitoring and Evaluation Framework

Objective	Indicator	Numerator	Denominator	Source Document	Frequency
Training of Professional Trainers					
Train Professional Trainers to competently facilitate the Integrated CCG Foundation Course	Proportion of Professional Trainers with post-test score > 80%	Number of PTs with a post-test score > 80%	Number of Professional Trainers trained	Pre- and Post-test Questions	Once-off at the end of PT training
	Proportion of Professional Trainers who passed the facilitator test in a simulated environment (practical test) Target score = 80%	Number of Professional Trainers who passed the facilitator test > 80%	Number of Professional Trainers trained	Observation Checklist	Once-off at the end of PT training
Training of CCGs					
Train all CCGs in the District to competently transfer knowledge using skills gained during the Integrated CCG Foundation Course	Proportion of CCGs on PERSAL trained (Target = 80%)	Number of CCGs trained	Number of CCGs on PERSAL database	CCG Attendance Register	Every day during training
	Proportion of CCGs with post-test score > 60%	Number of CCGs with an increase in knowledge from pre- to post-test (Post-test score of 60%)	Total number of CCGs trained	Pre- and post-test questions	Before and after each module
	Proportion of CCGs who pass the role-plays with scores of 66% and above	Number of CCGs who attained scores of 66% and above	Total number of CCGs trained	Role-play Checklist	During days 8 and 9 of the training programme

Approach and Method for the Training Roll-Out

Objective	Indicator	Numerator	Denominator	Source Document	Frequency
Post-training Assessment					
Assess a sample of CCGs 3 to 6 months post-training	Proportion of sampled CCGs educating at household level using the tools provided (Target = 60%)	Number of sampled CCGs using the education tools at household level	Number of CCGs sampled	Research Report	Once off 3 to 6 months after training
	Proportion of sampled CCGs screening at household level using the tools provided (Target = 60%)	Number of sampled CCGs using the screening tools at household level	Number of CCGs sampled	Research Report	Once off 3 to 6 months after training
	Proportion of sampled CCGs referring clients at household level (Target = 60%)	Number of sampled CCGs referring clients to the appropriate service provider at household level	Number of CCGs sampled	Research Report	Once off 3 to 6 months after training

6.6 Professional Trainers

6.6.1 Resource Audit and Recruitment

A resource audit was conducted to assess the adequacy of the existing resources with regard to the number of Professional Trainers that were required to meet the needs of the planned training roll-out in Ugu District.

It was estimated that, for the training in Ugu District, 12 lead facilitators; 12 co-facilitators, and 6 reserves were needed. The existing resources available from the uThungulu District training were: 12 lead facilitators; 1 co-facilitator, and 6 reserves. This meant that eleven additional resources (Professional Trainers) needed to be trained as co-facilitators for Ugu District. All eleven trainees received their Professional Trainer Orientation (PTO) from Sunday 16th September to Thursday 20th September 2012. PTs resided at the venue which enabled them to practice during the evenings.

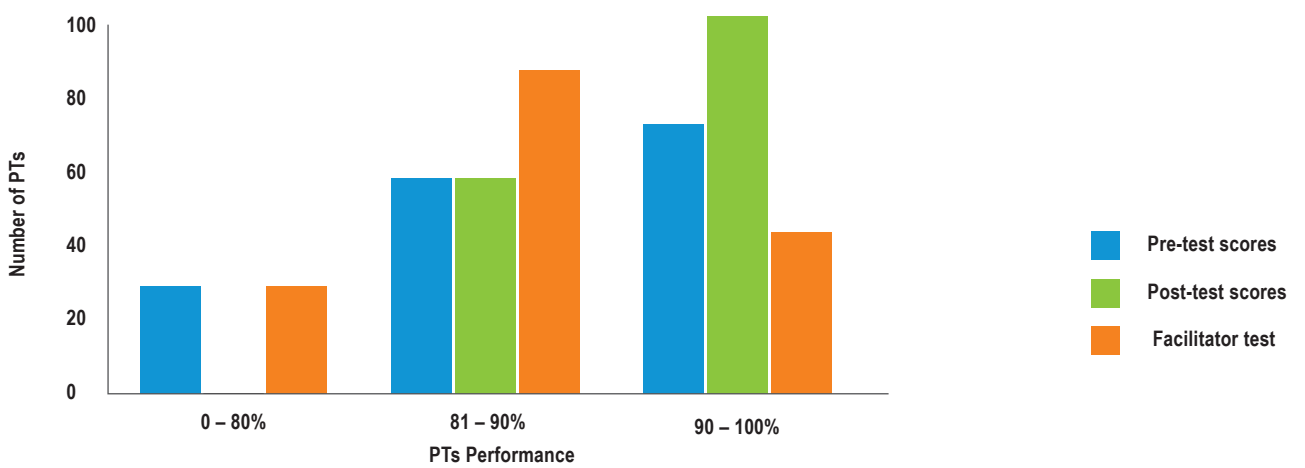
The orientation programme was designed to incorporate an orientation to the materials; an opportunity for knowledge and skills transfer, and an opportunity to test application of knowledge and skills at a practical level.

6.6.2 PT Performance

The results show that the level of knowledge of the PTs in health and social development was high prior to attending the orientation. Despite a high base, 11 PTs show increase in knowledge as evidenced in the Post-Test result. PTs attained on average 92 percent in the Post-Test with all PTs scoring higher than 80 percent in the Post-Test.

The average score of the facilitator test in a simulated environment (practical test) was 85 percent. As shown in Figure 18, there was a high level of trainer competency with nine of the eleven PTs attaining scores higher than 80 percent. There were two PTs who scored less than 80 percent; one with a score of 79 percent and the other 61 percent who received further coaching support.

Figure 4: Distribution of PT Scores



7. About the CCG Training

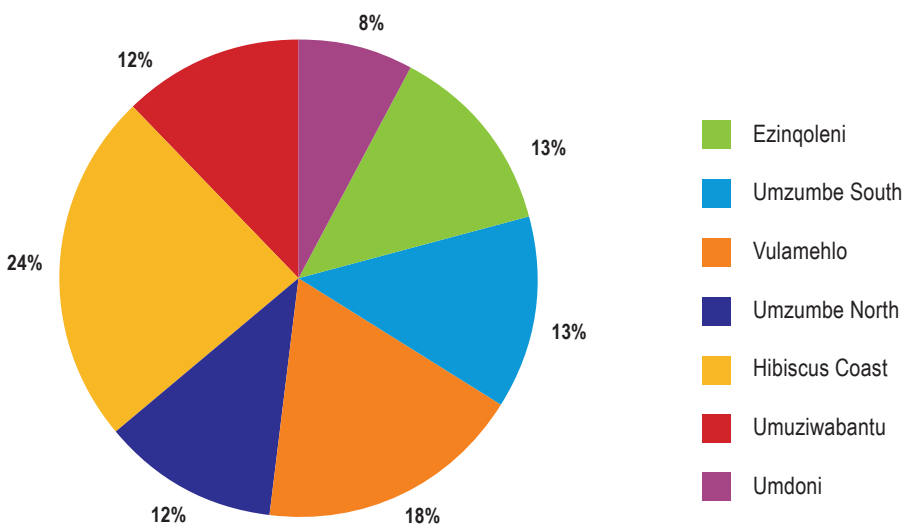
The CCG training will be discussed in five sections: Attendance, Communication with CCGs, CCG Disbursements, CCG Performance and CCG Feedback.

7.1 Attendance

7.1.1 Database

The Departments of Health and Social Development provided a PERSAL database with 1 102 names and contact details of the CCGs expected to undergo training in Ugu. During pre-registration, 4 CCGs were recorded as deceased, 10 left the programme before training commenced, 1 was on maternity leave, 2 were sick, 12 were promoted to become Nutritional Advisors and sent for specialised training and 10 remain unaccounted for.
The pre-registration database, categorised according to wards, was signed by 1 063 CCGs who were available, confirming their contact details or providing contact details of a relative or neighbour. Of these 1 063 CCGs, about a quarter were from Hibiscus Coast Municipality (HCM).

Figure 5: Origin of CCGs by Municipality



7.1.2 Number of CCGs Trained and Allocation to Training Sessions

Of the 1 063 that pre-registered, 1 059 actually attended. The 1 059 CCGs were divided into four training groups and 44 training sessions (see Table 6), based on their geographical location across the municipalities. The target number of training sessions per group was set at a maximum of 12 (see Table 6) consideration given to the number of acceptable training venues available. HCM had the highest number of classes. The number of classes per municipality and the number of CCGs that attended was as follows:

About the CCG Training

Table 6: Number of Training Sessions per Municipality

	HCM	Umzumbe South	Umzumbe North	Umdoni	Umuziwabantu	Vulamehlo	Ezinqoleni	Total no of classes	Total no of CCGs
Group 1:19 – 30 Nov 2012	2	4	1		2	2	1	12	292
Group 2: 3 – 14 Dec 2012	1		4		3	1	2	11	253
Group 3: 21 Jan – 1 Feb 2013	9		1	2				12	281
Group 4: 4 – 15 Feb 2013				1	1	6	1	9	233
Totals	**12**	**4**	**6**	**3**	**6**	**9**	**4**	**44**	**1 059**

A process was followed in allocating CCGs to training sessions. First, the database of CCGs was divided among wards. Second, an assessment was made on location of wards and number of CCGs in a ward to warrant a training session. In situations where there were more than 40 CCGs, the ward was split into two training sessions. In situations where there were insufficient CCGs in a particular ward, they were allocated to attend the training session nearest to their ward. In wards with no suitable training venues, a central training facility was used.

The average size per training session planned for was 20 CCGs, as this is regarded as the optimum training level. However, due to demographics and geographical location of wards, some class sizes were greater or smaller than this. Groups ranged in size from 10 to 37, with 24 learners being the average number per class (see Table 7). To mitigate against high numbers, 3 PTs were assigned to classes with numbers greater than 30 in a class.

Table 7: Number of CCGs per Training Session

Group	No of CCGs	Group	No of CCGs	Group	No of CCGs	Group	No of CCGs
1.01	24	2.01	34	3.01	27	4.01	34
1.02	22	2.02	17	3.02	23	4.02	24
1.03	34	2.03	26	3.03	21	4.03	31
1.04	26	2.04	19	3.04	23	4.04	26
1.05	26	2.05	25	3.05	30	4.05	24
1.06	22	2.06	22	3.06	21	4.06	16
1.07	20	2.07	21	3.07	15	4.07	31
1.08	18	2.08	23	3.08	14	4.08	37
1.09	25	2.09	27	3.09	24	4.09	10
1.10	27	2.10	15	3.10	35	4.10	
1.11	24	2.11	24	3.11	23	4.11	
1.12	24	2.12		3.12	25	4.12	

About the CCG Training

7.1.3 CCG Demographics

The overwhelming majority (96 percent) of CCGs were female (see Table 8) with the average age being 40 years.

Table 8: CCG Demographics by Municipality (Number)

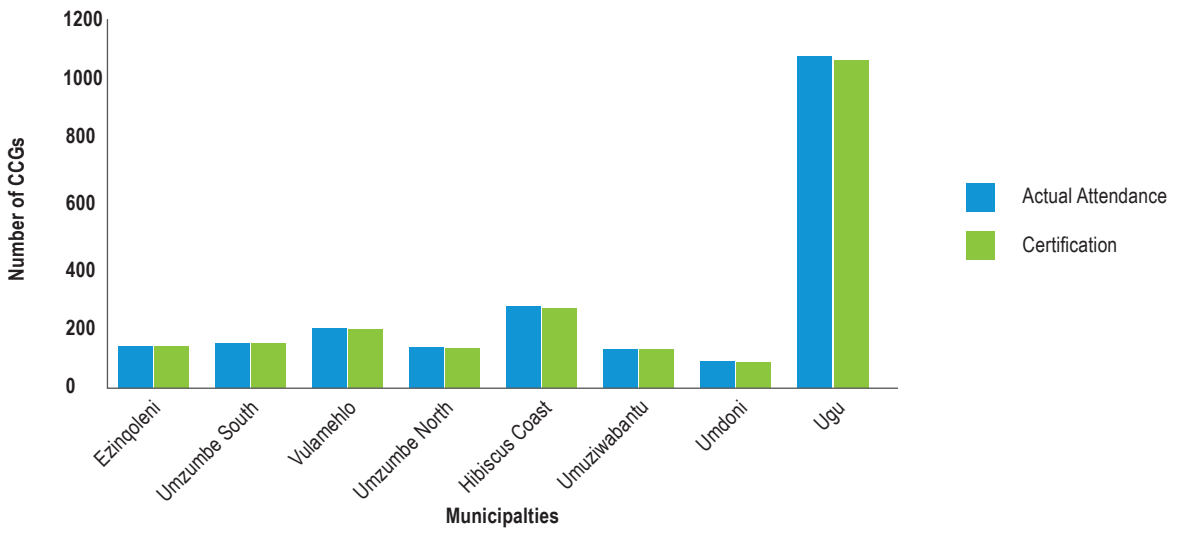
Municipality	Males	Females	Total	Avergage Age
Ezinqoleni	2	130	132	39
Umzumbe South	4	138	142	40
Vulamehlo	9	180	189	38
Umzumbe North	4	126	130	39
Hibiscus Coast	12	247	259	46
Umuziwabantu	8	115	123	38
Umdoni	2	82	84	38
Ugu	41	1 018	1 059	40

7.1.4 Certification of CCGs

Of the 1 059 CCGs who attended the training sessions, 1 047 are eligible to receive a certificate of attendance (see Figure 6). CCGs are eligible to receive a certificate of attendance provided they have attended the full ten days of training. CCGs who missed training days were given the opportunity to make up their lost time by attending training sessions of other groups. This ensured that they still qualified for the certificate of attendance. Due to non-attendance of the full training course, 12 CCGs did not qualify for certificate of attendance. Some of the reasons for their non-attendance included illness, family emergencies, severely inclement weather conditions, and in some instances death.

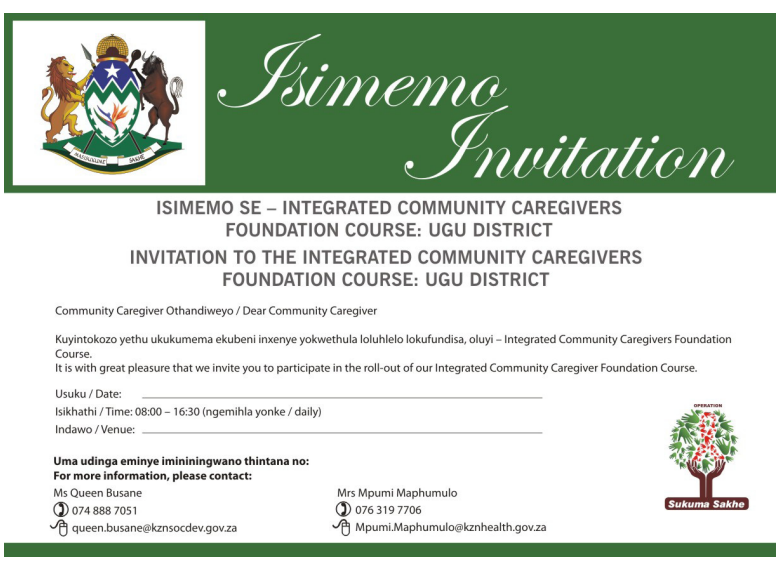
The high attendance rate of learners during the training roll-out is attributed to the level of consistency and effort that went into advocacy in all Municipalities by the District Training Task Team.

Figure 6: Number of CCGs Certified against Attendance by Municipality



7.2 Communication with CCGs

CCGs were invited to attend the training through a formal invitation and letter from the Office of the Premier signed by the Deputy Director General (DDG). Primary communication with the CCG was in the form of direct communication from the CHFs and HIV and AIDS Co-ordinators.



Isimemo Invitation

ISIMEMO SE – INTEGRATED COMMUNITY CAREGIVERS FOUNDATION COURSE: UGU DISTRICT

INVITATION TO THE INTEGRATED COMMUNITY CAREGIVERS FOUNDATION COURSE: UGU DISTRICT

Community Caregiver Othandiweyo / Dear Community Caregiver

Kuyintokozo yethu ukukumema ekubeni inxenye yokwethula loluhlelo lokufundisa, oluyi – Integrated Community Caregivers Foundation Course.
It is with great pleasure that we invite you to participate in the roll-out of our Integrated Community Caregiver Foundation Course.

Usuku / Date: _____
Isikhathi / Time: 08:00 – 16:30 (ngemihla yonke / daily)
Indawo / Venue: _____

Uma udinga eminye imininingwano thintana no:
For more information, please contact:

Ms Queen Busane
074 888 7051
queen.busane@kznsocdev.gov.za

Mrs Mpumi Maphumulo
076 319 7706
Mpumi.Maphumulo@kznhealth.gov.za

Sukuma Sakhe

CCGs thereafter received four SMS messages in isiZulu to remind them to attend training, and to bring with them vital information such as a copy of their identity document and a copy of their bank statement as proof of banking details. The SMS system allowed important information such as training dates, venues, time and other information to be communicated to CCGs instantly and simultaneously. Two SMS messages were sent two weeks prior to training, one was sent one week prior to training, and one was sent one day prior to training. Each SMS provided a call back number facility for CCGs who required more information. Where no cell number was provided for a CCG, an administrator communicated in isiZulu directly with the CCG via other communication methods such as a Telkom landline or via the CHFs and HIV and AIDS Co-ordinators.

CCG supervisors, CHFs, as well as HIV and AIDS Co-ordinators visited training sessions. In addition, there was a high level site visit that took place on 4th and 5th December 2012 attended by DDG Busisiwe Khuzwayo, Dr. Fikile Ndlovu, Mr. Fazal Safla, the US Consul-General Mr. Taylor Ruggles, Ms. Chalone Savant, the KZN PEPFAR Liaison Officer, Ms. Nomea Masihleho, Ms. Lessie Mnisi and Ms. Thobekile Finger from USAID. Training sessions visited

were: Marburg Library, Ezinqoleni Municipal Hall, Ezinqoleni Library, St. Andrews Hospital, and Umuziwabantu Stadium Hall, KwaHlongwa Hall, Nhlambamkhosi Training Centre, and Turton CHC. CCGs were given the opportunity to share feedback on their training experience, express challenges, and raise questions to representatives from DSD and DoH.

US Consul General Taylor Ruggles addressing CCGs accompanied by Ms. Mpumi Mlambo, Assistant Manager: Communicable Disease Control/Acting CCG Programme Manager, DOH

Ms. Busisiwe Kuzwayo, Deputy Director General: OSS in the Office of the Premier:KZN, addressing CCGs during a training session in Ugu

7.2.1 SMS Follow-up Survey

A selection of approximately two CCGs per classroom (10 percent of the total number of CCGs per classroom) received telephonic follow-up to determine the effectiveness of the SMS service to each group. CCGs were asked the following questions:

- Did you receive the SMS?
- Can you read the SMS?
- Do you understand the content of the SMS?
- Will you be attending the training session?

Ten percent of CCGs were surveyed and of those 98 percent confirmed receipt of the SMS and of their attendance. For the remaining CCGs in the survey, the correct telephone number was not listed or they did not receive the SMS. A list of these CCGs was compiled for the District Training Task Team who assisted in communicating with the relevant CCGs, and CCG information was updated where necessary. In addition, the Professional Trainer reported to the Quality Assurance Officer when a learner did not attend the first day of training. CCGs who failed to attend training from the first day were contacted directly and encouraged to attend.

7.3 CCG Disbursements

CCGs were given a contribution towards their travel costs through a travel disbursement. CCG attendance was tracked through a daily attendance register, and a travel disbursement was paid in arrears against the CCG's attendance. It was agreed by the Provincial and District Training Task Team that this travel disbursement be standardised at R50 per day.

CCGs were requested to provide their banking details for an electronic transfer of the disbursement. Banking details were collected and captured on a disbursement register. The option of using an "e-wallet" transfer to the CCGs was available as a back-up but not utilised as all electronic payments into the CCGs' bank accounts were successfully processed. This was as a result of CCGs having functional bank accounts listed on the Government PERSAL system. The success of the disbursement distribution can be attributed to both co-operation from the District in collecting and checking completed entity forms (which contained essential information needed to facilitate payment) prior to training; combined with immediate and effective communication from the project team directly with the CCGs where discrepancies arose. The project administrator was isiZulu speaking thereby ensuring smoother communication with the CCG which was critical to troubleshooting and ensuring all discrepancies were dealt with timeously.

7.4 CCG Performance

As per the Monitoring and Evaluation Framework, there were two indicators to assess CCG competency in respect of knowledge and application of training content namely a Post-Test score of at least 60 percent and a Role-Play score of 66 percent or higher.

7.4.1 Pre- and Post-Test Results

On average, the CCGs in each municipality exceeded the Post-Test target of 60 percent (see Figure 7). The average Post-Test score for Ugu was 80 percent. Furthermore, the results show an improvement between Pre- and Post-Test scores. The average improvement between Pre- and Post-Test for Ugu was 11 percentage points and these results are consistent across municipalities.

Figure 7: CCG Pre-and Post-Test Results per Municipality

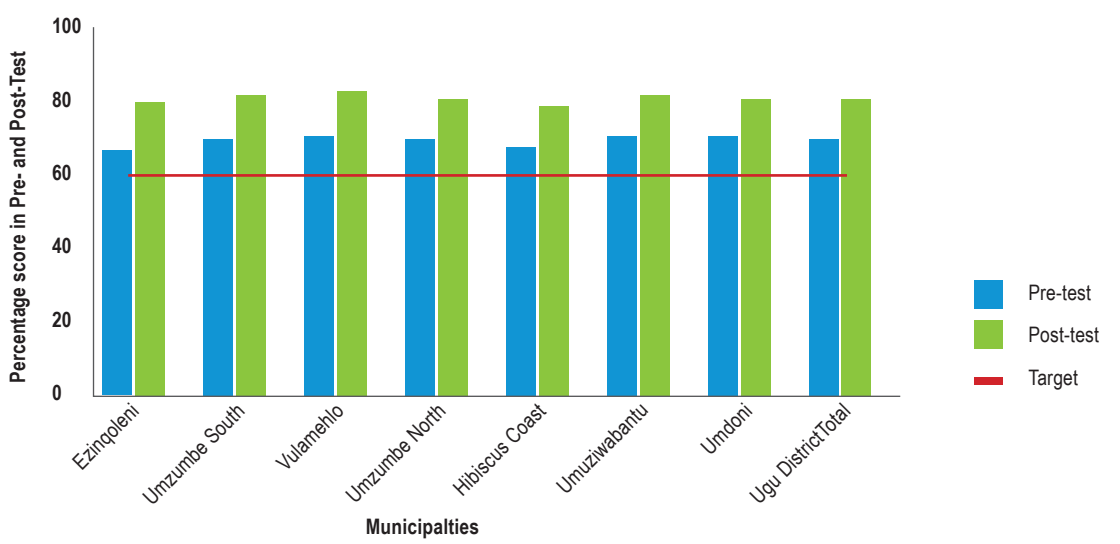
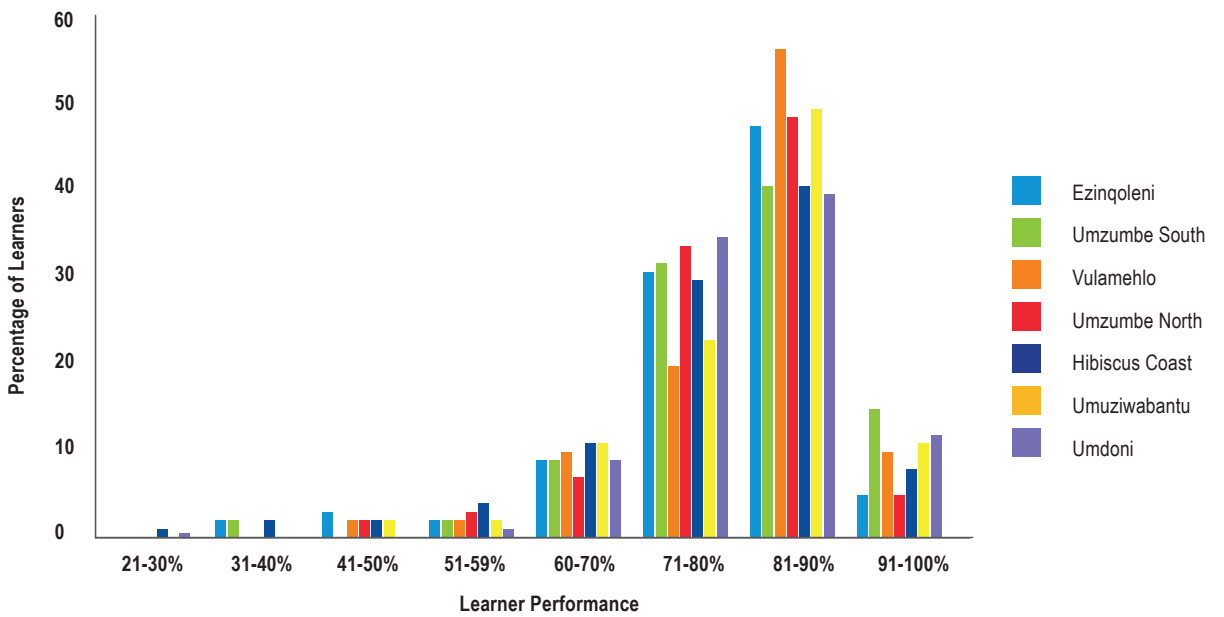


Figure 8 shows the distribution of performance scores across municipalities. The highest range of scores falls within the 81 – 90 percent band. A closer examination of the results shows that there were 59 CCGs (6 percent) with scores of less than 60 percent. A database of CCGs scoring less than 60 percent was generated and submitted to the municipalities for coaching and mentoring support. Overall the distribution of scores indicates high levels of knowledge retention amongst the majority of CCGs.CCG learner feedback.

Figure 8: Distribution of Post-Test Scores per Municipality



7.4.2 CCG Role-Play Assessment

The role-play proved to be a useful learning tool in measuring the preparedness of CCGs to deal with the diverse range of issues they may encounter during their household visits. Through this simulated activity, different learners in the class took on various roles and acted out scenarios they were likely to encounter, making it possible to assess their ability to apply the knowledge acquired in the classroom. CCGs were exposed to the material, Role-Play and other practical exercises in the first seven days of training. The Professional Trainers assessed CCGs in the classroom during days eight and nine of the programme. CCGs were assessed on their ability to meet the following ten criteria:

- Introduce themselves appropriately to the client
- Encourage client to feel comfortable
- Ask questions to profile the household
- Assess clients' needs appropriately
- Ability to select and use the appropriate Screening Tool
- Demonstrate competence in using the Care Pathways
- Provide clients with relevant and factual information
- Seek clarity where necessary
- Use the demonstration tools accurately
- Record information for follow-up

About the CCG Training

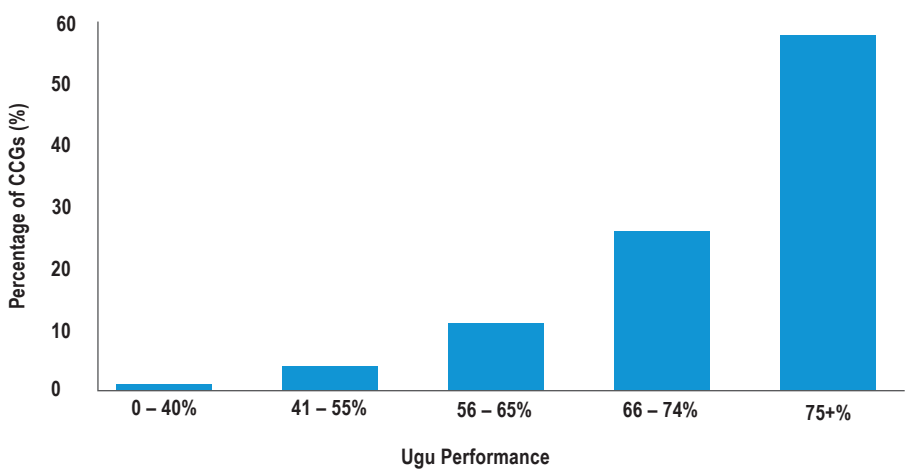
The results show that the average score achieved by CCGs in the Ugu District was 75 percent, with all municipalities on average exceeding the target score of 66 percent (see Table 9).

Table 9: Overview of Role-Play Scores per Municipality (Percent)

Municipality	Avergage Score per Municipality
Ezinqoleni	81
Umzumbe South	69
Vulamehlo	73
Umzumbe North	78
Hibiscus Coast	78
Umuziwabantu	75
Umdoni	71
Ugu (district total)	75

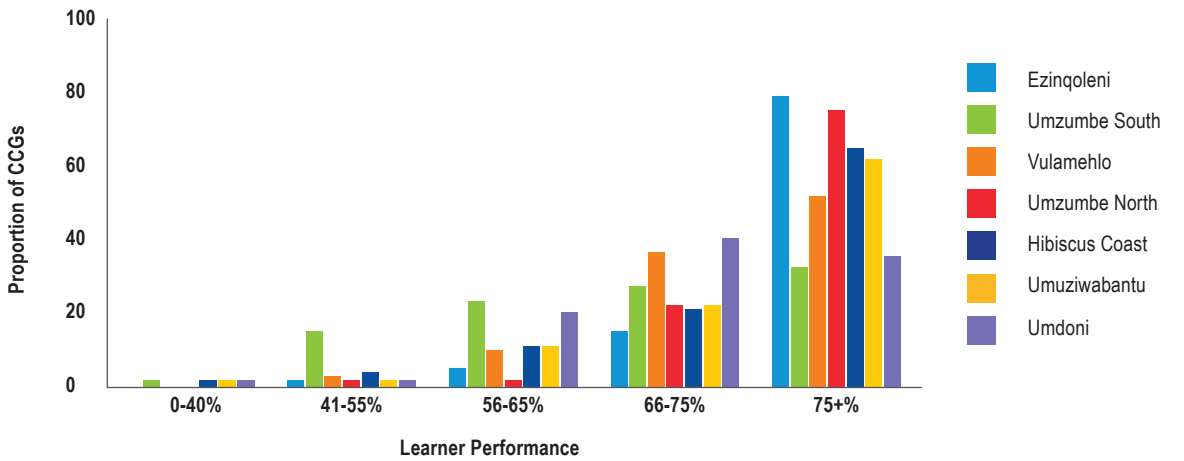
The distribution of Role-Play scores (see Figure 9) reveals that 84 percent of CCGs reached or exceeded the target score of 66 percent. A further 11 percent achieved scores between 56 and 65 percent and need a little coaching to meet the minimum criteria of being able to transfer knowledge to household members. There were 59 CCGs (5 percent) attained scores of less than 56 percent. These CCGs need further training to bring their knowledge and skills to the level that will allow them to perform their scope of practice.

Figure 9: Distribution of Role-Play Scores for Ugu



While Umzumbe South showed the lowest average score in the District (69 percent as indicated in Table 9), the majority of CCGs (82 percent) have scores of 56 percent and more (see Figure 10).

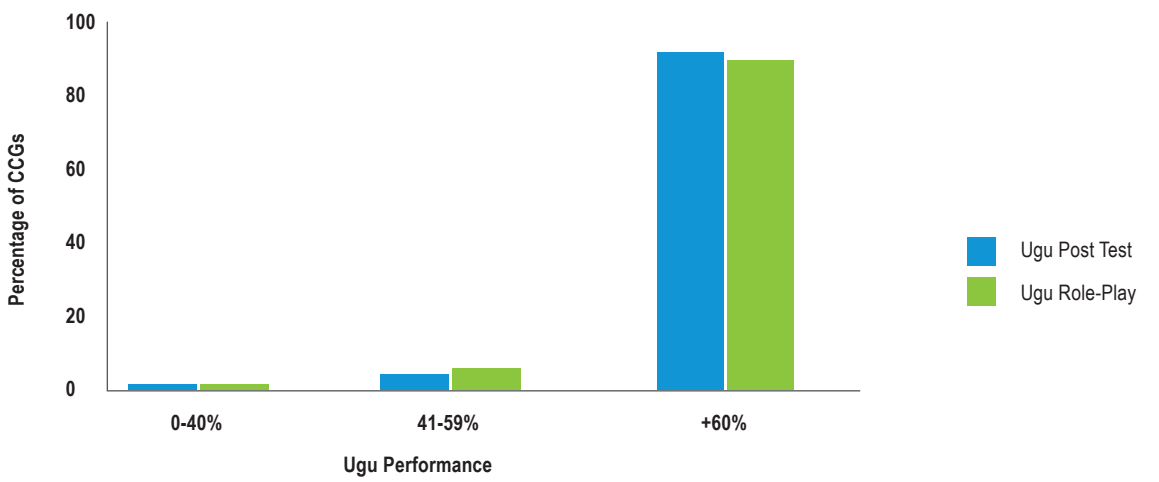
Figure 10: Distribution of Role-Play Scores within Municipalities



7.4.3 Summary of CCG Performance Results

In summary, a higher proportion of CCGs obtained 60 percent or more in their Post-Test results than in their Role-Plays (see Figure 11). Overall CCGs in Ugu performed well in their Post-Test and in their Role-Plays.

Figure 11: Distribution of Post-Test and Role-Play Scores for Ugu



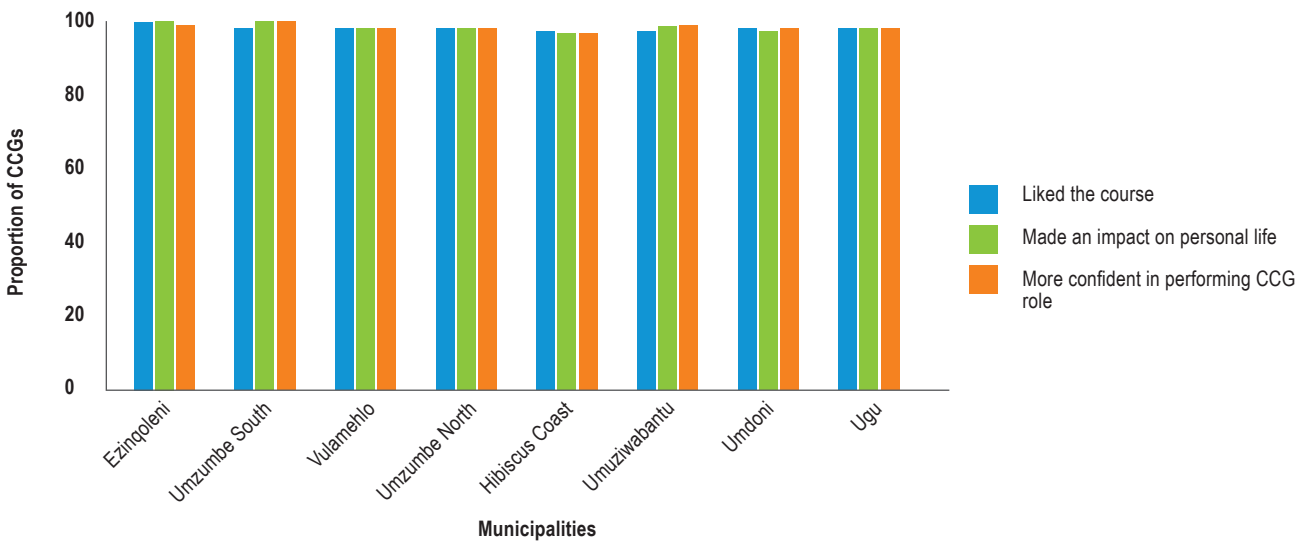
7.5 CCG Learner Feedback

Learner feedback was obtained through a self-completion questionnaire. Questions and answer choices were read out to assist learners who may have experienced difficulty. The feedback addressed learner confidence, facilitator presentation, training materials and logistics.

The overwhelming majority of CCGs across all municipalities liked the course. They felt it made an impact on their personal life and helped them feel more confident in performing their role as CCGs (see Figure 12).

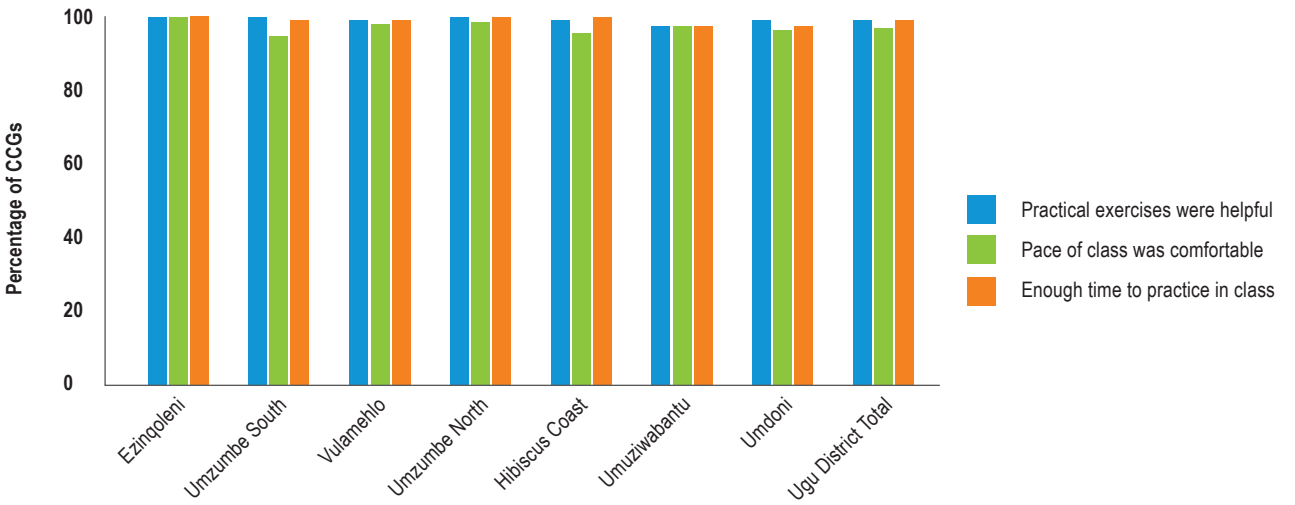
For some CCGs the Integrated CCG Foundation Course was the first formal training course they had attended. The training material was comprehensive and informative, covering topics from prevention, treatment to care and support.

Figure 12: Learner Feedback – CCG Learner Confidence



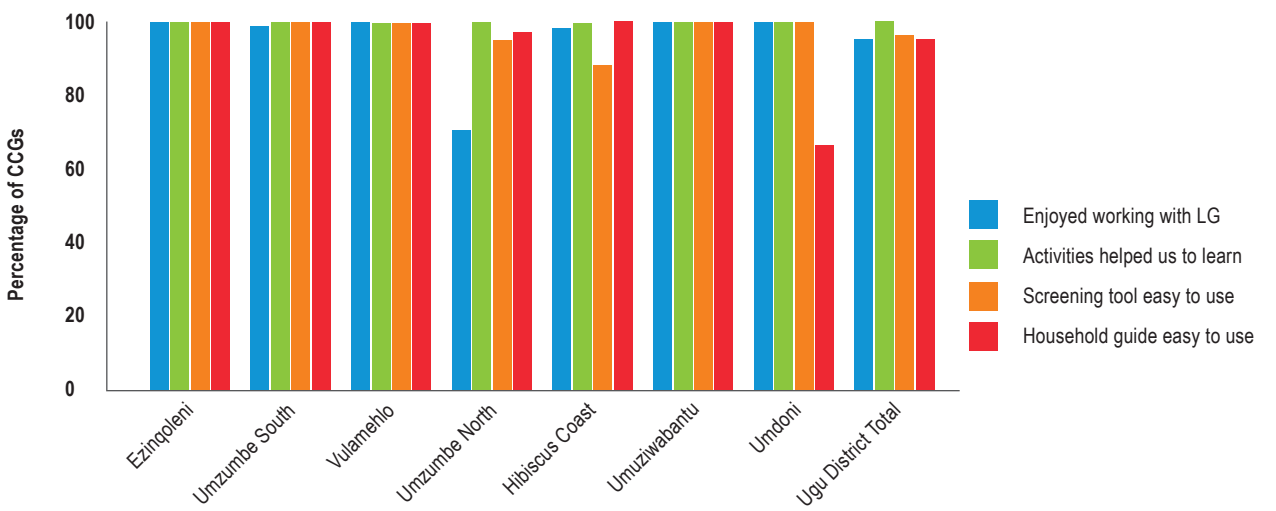
CCGs enjoyed the practical nature of the Integrated CCG Foundation Course, given that it covered the use of screening tools to screen individuals within the household, checklists to identify issues at individual and household level, case studies and individual and group work. Approximately 30 percent of the teaching was didactic while 70 percent was practical in nature. The majority of the CCGs across all municipalities found the practical exercises helpful, the pace of the class comfortable and that there was enough time to practice in class (see Figure 13.)

Figure 13: Learner Feedback – Course Presentation



The majority of CCGs enjoyed working with the learner materials (see Figure 14). However, a significant number in Umzumbe North experienced challenges with the Learner Guide and more than 30 percent in Umdoni found the Household Guide difficult to use. Almost all CCGs found the activities interesting and helpful in their learning. CCGs were appreciative of the Screening Tools which guide them to ask the right questions at household level so as to enable them to refer their clients to access appropriate services. Most importantly, CCGs found the materials suitable for their purpose. These results suggest that the CCGs are encouraged and feel empowered by having tools to assist them to carry out their daily functions.

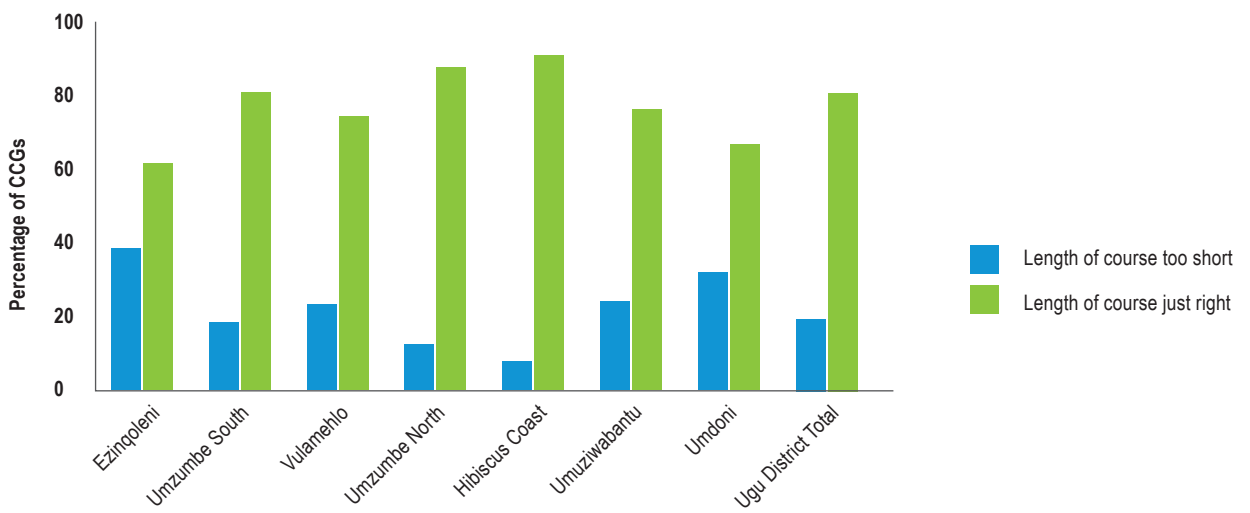
Figure 14: Learner Feedback – Training Materials



About the CCG Training

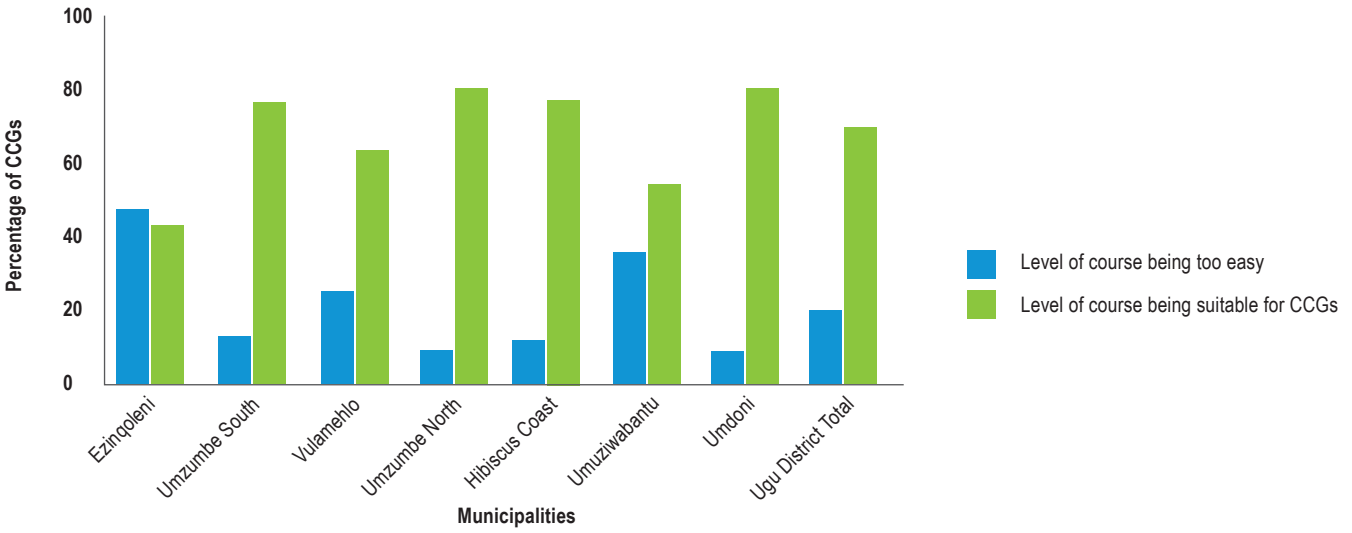
CCGs were asked about whether they felt the course duration was too long, too short or just right. The majority of CCGs across all municipalities felt that the length of the course, that is, ten days, was just right (Figure 15). In Ezinqoleni 38 percent of the CCGs felt that more time was required and in Umdoni, 32 percent of the CCGs concurred with this sentiment. In all Municipalities, there were some CCGs that experienced the course as being too short. It is recommended that time be made available during supervision and coaching sessions to give those who felt that the course was too short more time to practice their skills.

Figure 15: Learner Feedback – Course Duration



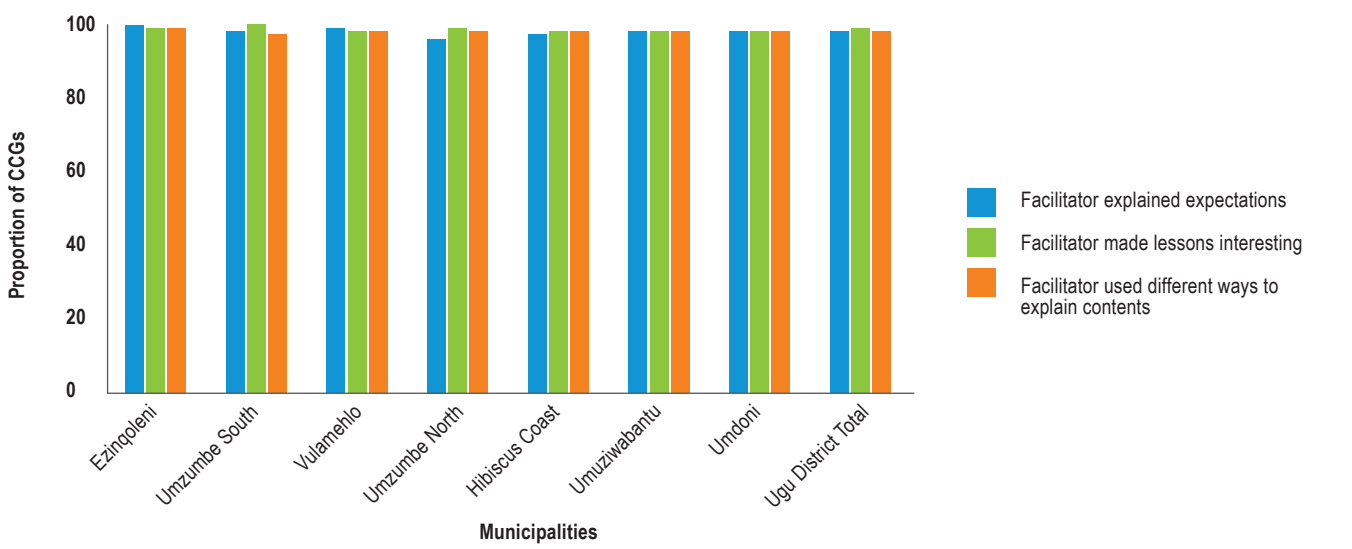
The majority of the CCGs found the level of the course suitable except for Ezinqoleni where 52 percent found the level of the course set too low and therefore experienced the course as being too easy (see Figure 16). This ties in with Ezinqoleni's overall performance as they attained an average of 79 percent in the Post-Test and the highest role-play average of 81 percent. It is recommended that these CCGs be exposed to more in-depth knowledge and skills during supervisory meetings to keep them stimulated and motivated.

Figure 16: Learner Feedback – Level of Difficulty



The vast majority of CCGs across all municipalities felt that the facilitator explained what was expected of them (Figure 17). CCGs felt the lessons were interesting and that the facilitator used different ways to explain concepts. At the end of each training day, CCGs showed appreciation to the facilitator by giving praise; offering thanks in prayer; or singing and dancing to acknowledge their joy and appreciation and at the end of the training session, some CCGs offered gifts such as home grown vegetables to the facilitator. Facilitators understood the vision of OSS and they effectively translated this vision and their belief in the role the CCG plays in communities to the learners.

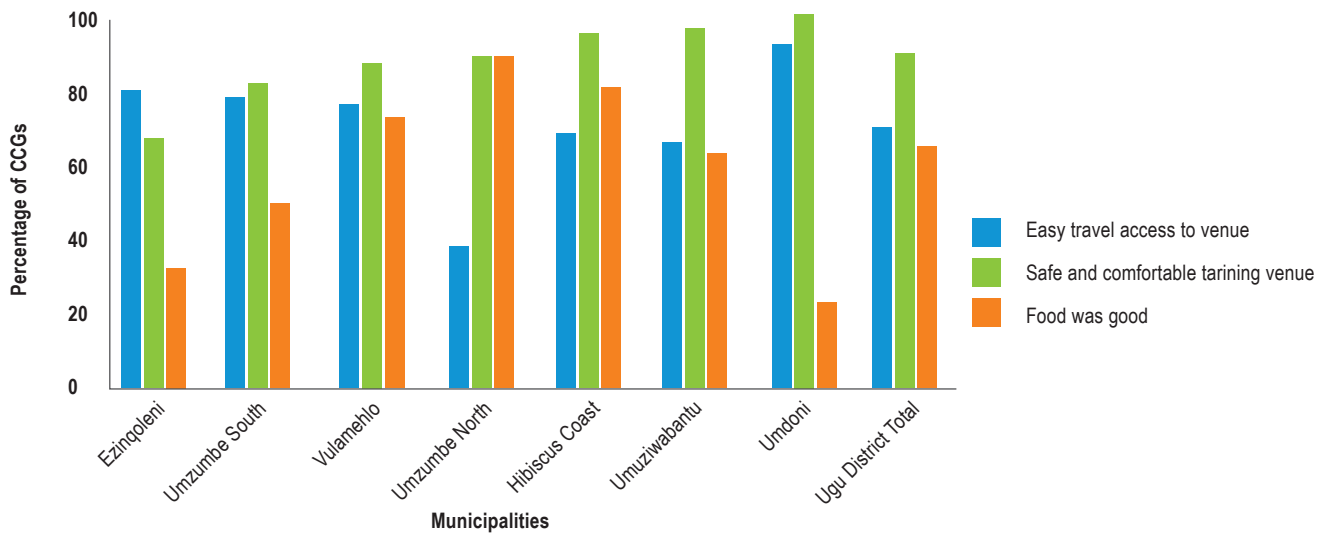
Figure 17: Learner Feedback – Facilitator Evaluation



About the CCG Training

The training venues were easily accessed by the vast majority of CCGs, the exception being Umzumbe North. The majority of CCGs found the venues comfortable and safe and the food acceptable (see Figure 18). Most CCGs from Ezinqoleni and Umdoni did not enjoy the meals that were provided. In instances where complaints were received they were immediately attended to and resolved to the satisfaction of learners wherever possible. Issues raised relating to meals were mainly due to inadequate spices and will be taken into consideration in planning for future endeavours.

Figure 18: Learner Feedback – Logistics



7.5.1 Interviews with CCGs

In all groups throughout the Ugu roll-out, attempts were consistently made to interview CCGs who were willing to be interviewed and photographed. The interviews were conducted by the Training Co-ordinator and the 2 Quality Assurance Officers. Some responses from CCGs are captured below:

Phumzile Mzizi
"This course was better than anything. I liked upgrading my knowledge and skills. My favourite thing was doing the role-plays. I feel much more confident now."
My message to the Premier is:
I like to work for the community and I want to see the community live healthy lives and have less diseases. I am excited that we can do something to help them to improve their lives."

Ntobezodwa Cele
"I have learned well in this course. I understood everything and really enjoyed the section on mother and child. The course was informative and will help me when I go out to do my job –especially the screening tools.
My message to the Premier is:
The course has opened my eyes and has answered my questions. Thank you. I am now more confident and I know I can make a difference".

About the CCG Training

Nomkhosi Mtenjwa
"I have been a CCG since 2007. The doubts I had as a CCG are no more and I see success ahead of me. The community members who undermined our services will change and those who welcomed our service will have more faith in us. I like the materials we were given; I'm getting familiar with it and am happy that I received more information than in the past.
My message to the Premier is:
Thank you – I appreciate having this opportunity to participate. I really feel honoured."

Paul Dube
"I have 13 years of experience as a CCG and I enjoy my job. My community will benefit from this training because it adds knowledge to us as CCGs. I have mastered the use of material.
My message to the Premier is:
I liked the training because now I feel more confident. The community welcomes the service and they see we are trying to improve service delivery."

CCGs consistently informed their PTs about what the training meant to them. For many, the Integrated CCG Foundation Course was the first formal training they had attended. For others, the way the training was conducted, the content and the intent behind the training boosted their morale and acknowledged the important role they are playing in the community.

Across all groups there were comments about how the training empowered CCGs with professional and personal skills. Many CCGs indicated that they felt more confident to communicate and more effectively fulfil their role as a result of the training. CCGs noted that not only did it impact on them professionally; it also built knowledge on how they should take care of themselves and follow a healthy lifestyle. More messages from CCGs:

"I learnt a lot of things that I hardly paid attention to before, especially children's rights and using screening tools."

"The training enhanced a lot of knowledge and our roles in the community."

"The training made a huge difference in me."

"Facilitators explained well."

"Our facilitators were very good and competent and would like them to teach us again."

"I feel confident about entering any household"

"I didn't know what I was saying to the clients for the past two years because I've never been trained now I am confident."

"I find the training so helpful and enjoyed it to the last minute and I am so glad that I managed to deliver my son and came back to the class."

"My knowledge has been added and I feel more comfortable now as I can answer questions from the clients."

"We are very thankful for this wonderful opportunity; we now have more confidence to go work with our clients."

About the CCG Training

"This is a great course, we learn a lot and received more tools to work with."

"I'm thankful for the training as I will be able to do my job and be more brave. I'm grateful for the working in hand with them and for the respect we were given."

All groups of CCGs made specific mention of the training material. CCGs found it useful and relevant. In particular, they valued the addition of the Screening Tools, which in many ways added a level of professionalism to what CCGs are already doing in communities. CCGs were impressed with the Learner Guides and enjoyed the activities and case studies. These clarified their understanding of daily activities in the community. CCGs commented positively on the layout of training material, especially the Care Pathways and the Screening Tools.

CCGs appreciated that the course caters for all levels of education/literacy. This means that those who cannot read and write in English are able to follow by listening to what the facilitator is saying and reading since the training material and delivery is in their mother tongue (isiZulu). Those CCGs who found the material difficult suggested that 10 days of training was not enough. They requested a follow-up where learners' progress with regards to implementation of what they learnt during the course is assessed.

7.6 CHF and HIV and AIDS Co-ordinators in Ugu

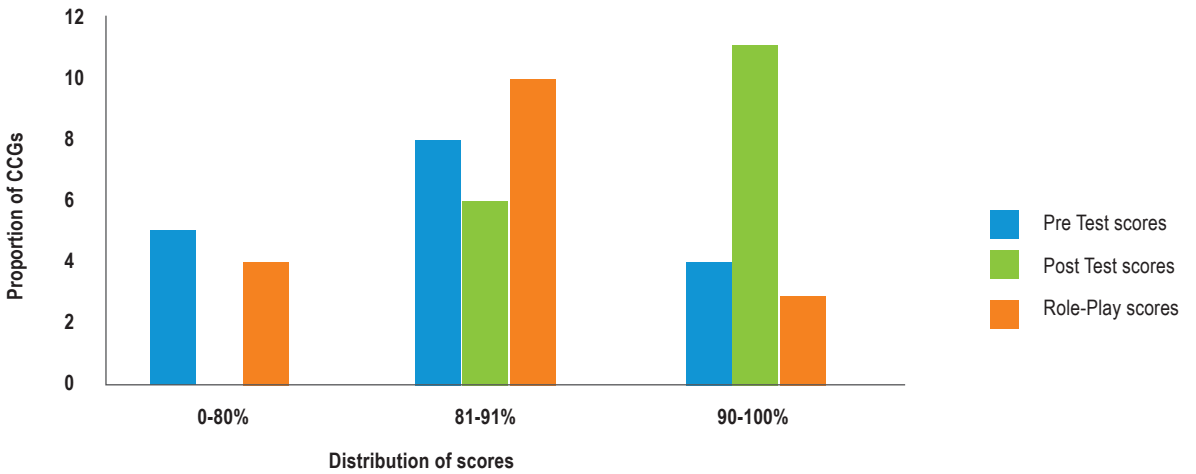
Over and above the 44 classes trained in Ugu, there was a specially convened class that comprised a group of Community Health Facilitators; and HIV and AIDS Co-ordinators. Of the 18 CHFs that pre-registered, 17 of the 18 attended all 10 days. In terms of gender there were 9 females (50 percent) and the average age of the group was 38 years.

The average Pre-Test score for this group was 82 percent which confirmed the expectation of a high level of baseline knowledge. The Post-Test average was 91 percent which was well above the target of 60 percent. With regard to the distribution of scores for the Post-Test, 6 attained scores between 81 and 90 percent, and 11 scored between 91 and 100 percent.

For the Role-Plays, the average for this group was 85 percent. 4 scored between 71 and 80 percent; 10 between 81 and 90 percent, and 3 between 91 and 100 percent (see Figure 19)

About the CCG Training

Figure 19: Distribution of Scores for CHFs and HIV and AIDS Co-ordinators



Some comments from the CHFs and HIV and AIDS Co-ordinators are listed below:

17 out of 18 commented that the “Time of the course was just right, materials easy” whilst 1 individual felt that more time was needed. In response to the question “What did the learner like best?", the most frequent response was that “The entire course was good”. Suggestions for additional modules included “Trauma Counselling” and “Delivery of Babies”.

Overall, it was useful that CHFs underwent the training that their supervisees were being exposed to. It will certainly enhance their capacity to supervise more effectively. It is recommended that this practice be incorporated into all future training initiatives.

8. Critical Success Factors for Training Roll-out

- Selecting competent and highly motivated Professional Trainers as facilitators
- Training an appropriate number of Professional Trainers as Facilitators or Co-Facilitators plus reserves for the number of training sessions planned
- A minimum of two facilitators per training session
- An updated Integrated CCG database with CCGs allocated by ward
- Dedicated individuals tracking movement on the database from group to group
- Provincial, District and Local level buy-in and support for the training programme
- Involvement of CHFs and HIV and AIDS Co-ordinators in advocacy and communication with CCGs
- Bi-weekly Provincial, District and local level meetings before, during and after training implementation
- Standardised materials, checklists and reports to streamline processes
- Standardised processes such as adherence to the daily programme
- Quality assurance and logistical support during planning and during training roll-out
- Funding to develop and print materials and to support the training roll-out

9. Conclusion and Recommendations

Provincial, District and Local Level Buy-in and Support

From the outset, all stakeholders contributed towards developing the partnership framework and the stakeholder advocacy and communication plan. This plan was adhered to and monitored on a bi-weekly basis at Provincial level. The result was strong buy-in and support for the training roll-out at all levels, ensuring continued and focused communication to CCGs, which resulted in high level of attendance. Regular and consistent messaging was provided to all stakeholders including CCGs before and during the training roll-out.

Professional Trainers

All PTs performed well in the Post-Test, indicating their readiness to transfer knowledge to CCGs. Professional Trainers required training not only on the CCG Integrated Programme, Operation Sukuma Sakhe and training content, but also on facilitator skills. PTs have differing levels of knowledge and skills as shown in their composite scores. On-going coaching and mentoring during training implementation is necessary. On-going administrative support of PTs during training implementation is also necessary since many PTs are not computer literate. The appropriate number of PTs is two per training session plus six additional PTs to be trained per District.

A key to the success of the training was that PTs understood their role in the training roll-out and displayed a commitment and passion which went beyond the classroom; their enthusiasm was infectious.

Attendance

Approximately 99.6 percent (n=1 059) of all CCGs on PERSAL have been trained on the Integrated CCG Foundation Course in 44 training sessions across Ugu District. The provision of a travel disbursement proved useful in providing CCGs with the means to travel to the training venue. The survey conducted with ten percent of the sample CCGs to ascertain whether they received the SMS and confirmed attendance was a useful gauge to guide attendance and plan and implement further action.

Database

The database was a useful tool to track non-registration, CCG attendance, and eligibility for certification. The CCG Integrated Foundation Course has informed the final database of CCGs on PERSAL for the District. CCGs who were on dual payrolls, (i.e. both NGO and government or in any other job) resigned during the pre-registration process; the training of CCGs provided this opportunity which otherwise would have been a difficult task. The integrated database also highlighted gaps in the number of CCGs allocated per ward. This has allowed the District Departments of Health and Social Development to submit requests for more CCGs to their respective Provincial Departments. It has also highlighted the gaps in terms of the number of CCG Supervisors required. CCGs will constantly be selected from the CCG database for career development in the manner in which Nutrition Advisors were selected from the database. A constant replacement of CCGs is therefore necessary.

Training Materials

Learner materials were received very well by CCGs, especially the Care Pathways and the Screening Tools which will help them screen, educate and refer clients more effectively. It is necessary to ensure that the high quality of the

training materials is maintained whenever CCGs are trained on this programme.

Number of CCGS Trained

Of the 1 059 CCGs trained in Ugu, 95 percent were African female. Attempts need to be made to recruit male CCGs and CCGs from wards where there are insufficient numbers of CCGs.

CCG Performance

The vast majority of CCGs (94 percent) scored over 60 percent in the Post-Test assessment. There are also 70 CCGs who achieved below 56 percent in the role-plays and below 60 percent in the Post-Test that require re-training to bring their knowledge and skills to the level that will allow them to perform their scope of practice. It is recommended that coaching support be provided via their peers and supervisors.

Learner Feedback

The ten-day Integrated CCG Foundation Course has empowered CCGs to perform their roles and responsibilities. There were a few learners who experienced difficulty and require additional coaching and mentoring support. The majority of CCGs feel more confident in performing their role after receiving the ten-day Integrated Foundation Course Training. The vast majority of the CCGs found the training materials suitable, the pace suitable, the facilitators very good and the training venues safe and comfortable. CCGs also feel more confident in their role in Operation Sukuma Sakhe.

CCG Supervision

There are insufficient numbers of supervisors appointed to supervise CCGs. The important role of the supervisor as a mentor and coach is a gap in the CCG structure. Supervisors themselves are appointed from the pool of CCGs and require further training in providing supervision and guidance to CCGs.

Policy Implications

The experience of the Ugu Integrated CCG Foundation Course has clearly demonstrated that there is a need to roll-out the training to all CCGs in the Province.

The Integrated CCG Foundation Course provides a strong platform for training all CCGs in the province who are on the PERSAL system. From this pool, it would be easier to select CCGs for further specialisation.

Although not strictly relevant to the training programme, it is important to note that many CCGs are concerned about having to compile various reports required by DoH, DSD, OSS and LCA (Local Council on HIV and AIDS). This reporting needs to define and incorporate only essential tools and the establishment of the Integrated CCG Programme provides an opportunity for a rationalisation and simplification of such reporting.

Conclusion and Recommendations

Overall

The CCG Integrated Foundation Course was a success due to the high level of commitment and passion of all Partners, the Professional Trainers, Provincial, District and Municipal Officials and staff from Wildflower Projects and BroadReach Healthcare. Shortcomings were identified and corrected as they arose due to the high level of presence and activity by all Partners. The short time allocated for pre-planning was made up by extra hours invested by the project team during the roll-out.

In this era of information sharing, the proverb “Knowledge is Power” was felt by CCGs who participated in the Integrated CCG Foundation Course. United by the programme of integration, they felt appreciated to serve their communities with one voice.

Notes

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