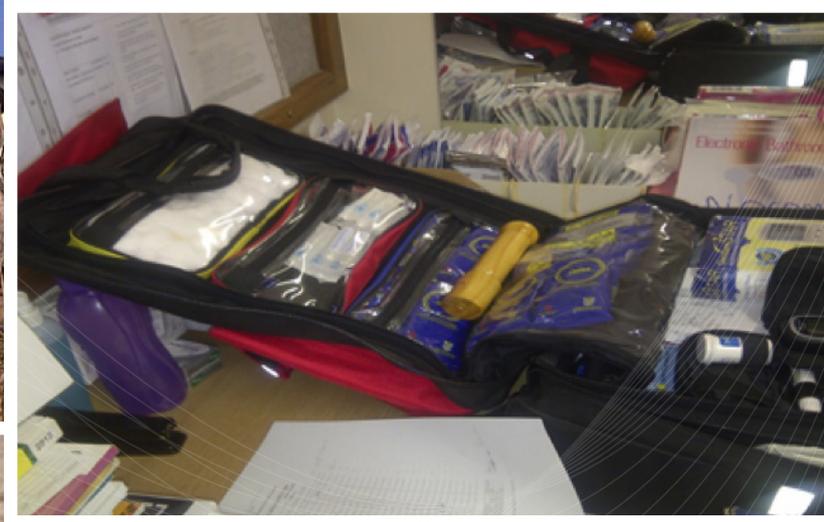


Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams

2018/19 - 2023/24



health

Department:
Health
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Foreword by the Minister of Health



Dr PA Motsoaledi, MP **Minister of Health**

The Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) form part of the streams of Primary Healthcare (PHC) Re-engineering and represents an important milestone in the ongoing efforts to transform healthcare in South Africa. This transformation should ensure that PHC is strengthened in line with the values and principles of the Alma Ata Declaration.

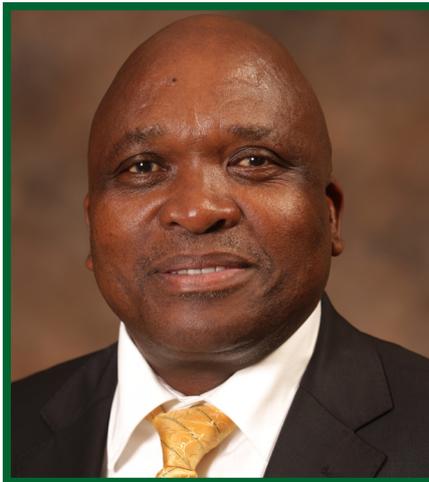
Implementation of this policy framework and strategy will ensure that community health workers within the WBPHCOTs, supported by different categories of health professionals, form the bridge between communities and healthcare service provision within health facilities. WBPHCOTs will bring healthcare closer to communities, families and individuals, even in the most rural and underserved areas. Implementing this policy framework and strategy will contribute enormously to building a sense of ownership in the public health system, with members of the community actively participating in keeping their families healthy and caring for those in need.

Formalising WBPHCOT teams will increase the number of much needed healthcare workers, as well as contribute to human resource development in the health sector. It is anticipated to lead to visible improvements, not only in equity and access to care, but also in managing the quadruple burden of disease with a strong focus on fostering the well-being of mothers, children and other vulnerable groups. The department will build the required capacity within WBPHCOTs and provide the necessary resources and support required by these teams for them to operate effectively and efficiently.

The successful implementation of this policy framework and strategy, together with several other initiatives that the department has embarked on, will contribute to the success of the National Health Insurance (NHI).

Dr PA Motsoaledi, MP
Minister of Health

Message from the Deputy Minister of Health



Dr M J Phaahla, MP
Deputy Minister of Health

The implementation of this Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) policy framework and strategy will do much to improve access to healthcare for poor and vulnerable communities in priority settings like the rural areas.

The WBPHCOTs have been established, registered and are reporting their activities in the District Health Information System (DHIS) since January 2012. This implementation is guided by the provincial Guidelines on the Implementation of the Three Streams of Primary Healthcare Re-engineering released by the national Department of Health in 2011.

Discussions with provincial health departments and constructive criticism from civil society and academic institutions on the implementation to date, have enabled the department to learn what works well and what needs to be improved. This learning has guided the content of this policy framework and strategy.

The implementation of this policy framework and strategy will bring healthcare closer to vulnerable communities, families and individuals especially in the rural areas of South Africa, thus building on our national culture of caring.

Dr M J Phaahla, MP
Deputy Minister of Health

Acknowledgement by the Director-General



M P Matsoso
Director-General of Health

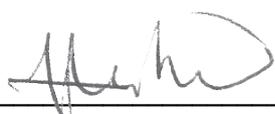
The success in achieving better health outcomes as a country depends on the collective ability to build relationships and to collaborate within government and across sectors to create cohesive communities and enabling environments that promote health. This Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams (WBPHCOTs) is an example of such collaboration with other government departments, development partners, universities, research institutions, civil society organisations and organised labour.

Community health workers organised into WBPHCOTs will play a pivotal role in improving access to primary healthcare for vulnerable communities.

The completion of this document was led jointly by three Deputy Directors-General namely, Ms J Hunter, Dr Y Pillay and Dr T Carter. They manage the areas of primary healthcare, health programmes and hospitals and health workforce respectively. I wish to express my gratitude to Mr R Morewane, Dr K Taole and Mr K Mahlako for their specific contributions toward the development of the document and Mr J Lazarus of the Hospice Palliative Care Association who reviewed the final draft.

I thank employees from BroadReach Healthcare, funded by the Centers for Disease Control and Prevention (CDC) South Africa, for the development of the first draft of the policy through conducting numerous interviews with specialists in this area. BroadReach also assisted with processing the document through several iterations through recording and incorporating discussions with colleagues in academic and non-governmental organisations (NGO) sectors as well as colleagues at provincial and district levels.

This document is intended to focus our efforts to establish and support WBPHCOTs in the community and in homes, provide health advice, do basic screening, effect early referral and offer basic home-based therapeutic, rehabilitation and palliative care services. I have confidence that health district management teams and PHC facility employees, supported by national and provincial managers will use this policy framework and strategy to build and sustain WBPHCOTs to form the required bridge between our vulnerable communities and much needed healthcare.



M P Matsoso
Director-General: Health

Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
BCEA	Basic Conditions of Employment Act
CBO	Community-based organisation
CDC	Centres for Disease Control and Prevention
CHW	Community health worker
COPC	Community-oriented primary healthcare
DHP	District Health Plans
DHS	District Health System
DHIS	District Health Information System
DHMIS	District Health Management Information System
DORA	Division of Revenue Act
EHS	Environmental health and safety
HiAP	Health in all policies
HIV	Human Immunodeficiency Virus
HRH	Human resource for health
IDP	Integrated Development Plan
M and E	Monitoring and evaluation
MTEF	Medium terms expenditure framework
NDHSC	National District Health Systems Committee
NDP	National Development Plan
NGO	Non-governmental organisation
NHC	National Health Council
NHI	National Health Insurance
NPO	Non-profit organisation
NQF	National Qualification Framework
OSS	Operation Sukuma Sakhe
OTL	Outreach team leader
PHC	Primary healthcare
RDP	Reconstruction and development programme
RPL	Recognition of prior learning
RTC	Regional Training Centre
SLA	Service level agreement
TB	Tuberculosis
TechNHC	Technical Committee of the National Health Council
WBPHCOT	Ward-based primary healthcare outreach team
WHO	World Health Organization

Glossary of terms

Accredited provider

A training or education service provider who is accredited in accordance with the requirements of the South African Qualifications Authority Act, 1995 (Act 58 of 1995).

Community health worker

Refers to any worker who is selected, trained and works in the community. They are the first line of support between the community and various health and social development services. They empower community members to make informed choices about their health and psychosocial wellbeing and provide ongoing care and support to individuals and families who are vulnerable due to chronic illness and indigent living circumstances.

Non-profit organisation

These organisations include non-governmental organisations (NGOs) and community-based organisations (CBOs) that are formally registered with the Directorate: Non-profit Organisations located at the national Department of Social Development. Registered NPOs receive a certificate of registration with a registration number and may apply for funding to employ CHWs.

Ward-based Primary Healthcare Outreach Team

Ward-based PHC Outreach Teams are based in PHC facilities and offers integrated services to households and individuals within its catchment area. The catchment area refers towards within municipalities. The team provides primary healthcare to families/households; community outreach services; preventative, promotive, curative, rehabilitative and palliative services.

Outreach team leader

Each WBPHCOT is led by an outreach team leader (OTL). The OTL is responsible for ensuring that the work of the WBPHCOT is linked to service delivery targets and that team members are adequately supported and supervised to meet these. OTLs are appointed by the district or sub-district manager and report to the operations manager at the primary healthcare facility to which the WBPHCOT is linked. In models where OTLs are employed by NGOs, the OTL must be linked to a clinic and report the team's activities to the clinic manager.

Rural-proofing

An approach to the development and review of government policies and strategic planning that recognises that the needs of rural areas and communities are different to those of their urban counterparts. Rural proofing is a process which ensures that all relevant executive policies are examined carefully and objectively to determine whether they have a different impact in rural areas from that of elsewhere, because of the characteristics of rural areas and where necessary, what policy adjustments need to be made to reflect rural needs and to ensure as far as possible that public services are accessible on a fair basis to rural communities.

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1. Introduction

The South African Government has pledged a 'Long and healthy life for all South Africans'. Since 1994, South Africa made its intentions clear to have a health system that provides universal access to healthcare. This system is based on the approach of keeping people healthy and caring for them when they are in poor health.

The district health system (DHS) is the unit for implementation of primary healthcare. South Africa has 52 health districts, the boundaries of which coincide with those of the municipal boundaries. Each health district offers a comprehensive package of services for all people living in the district.

The government has committed to, amongst others, 'strengthening the effectiveness of the health system' highlighting the need to overhaul the health services delivery platform from one that is based on a largely curative, high-cost care model, to one that promotes cost-effective PHC services that are delivered as close to communities and households as possible, and is centred around health promotion, prevention and community involvement. The South African Government in 2011 launched the model for re-engineering PHC through the following three streams:

- ward-based primary healthcare outreach teams (WBPHCOTs)
- school health teams
- district clinical specialist teams

The WBPHCOT stream in the PHC re-engineered model denotes the level of the health service which provides services in the community to families and individuals with the aim to facilitate improved population health outcomes. The content of this policy framework and strategy builds on the lessons learned during the implementation that was guided by the provincial Guidelines on the Implementation of the Three Streams of Primary Health Care Re-engineering released in 2011.

This policy framework and strategy sets the vision, mission, goals and objectives which provide direction for improving the implementation of community based health workers. The document starts by briefly describing the background to the community health worker (CHW) programme, continues to list the legislative and policy context, highlight the scope of the policy and the responsibilities at different levels, the expected outcome of the policy, budget implications, key risks and how the implementation of the policy will be monitored and reported on. This policy framework and strategy should be reviewed in the 2018/19 financial year against implementation successes and challenges.

2. Background

2.1 International experiences

Diverse community-based health worker models have been implemented across countries and in various settings, and in response to a range of disease profiles and health challenges. These models are dynamic and subject to change depending on political and social contexts. While the models are not necessarily easily transposed into different settings, there are however valuable lessons relating to their design and implementation that have been learned.

The Declaration of Alma Ata, signed by the world's global health leaders in 1978, reaffirmed the definition of health as: A state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. It emphasises that primary healthcare evolves from the economic, political and socio-economic status of a country and requires inter-sectoral coordination (e.g. housing, education, agriculture, social services) and promotes maximum community involvement and individual self-reliance. Local health workers, including community-based health workers and referral facilities together with other sectors, address the health needs of individuals and communities through promotive, preventive, curative, rehabilitative and palliative services.

Across many of the settings that have supported and equipped them, the evidence clearly demonstrates that CHWs can help improve health outcomes and increase the accessibility of health and social services. According to a 2010 Cochrane systematic review, the use of CHWs, when compared to the use of usual healthcare services, provide promising benefits in vaccination uptake and breastfeeding, improving TB treatment outcomes, and reducing child morbidity and mortality.

Further, a comprehensive review for the WHO and Global Health Workforce Alliance identified a wide range of services offered by community-based health workers, from counselling on birth preparedness, breastfeeding and postnatal care, management of uncomplicated childhood illnesses, preventive health education and in some settings, treatment for infectious diseases and chronic illness, as well as support for addressing common mental health problems.

2.2 Developments in South Africa

South Africa has a long history of community-based health workers engagement in the endeavour towards better health and social outcomes of communities. The first community-based health workers programmes were initiated in the 1920s to combat malaria, with innovative community-oriented primary healthcare (COPC) work continuing in the 1940s. After a period of low quality implementation and racialised services, community initiatives gained prominence again in pockets throughout the country in the 1970s and 1980s. These initiatives were largely undertaken by NGOs to address the gaps that resulted from the inequitable distribution of healthcare services in rural and peri-urban settings.

Post 1994, the DHS became the organisational unit for health service implementation to ensure accountability for service access and service quality close to where communities lived. The community-based health workers are intended to provide health promotion, primary prevention of disease, healthy behaviour counselling, treatment adherence counselling, secondary disease prevention through basic screening with appropriate referral and basic therapeutic, rehabilitative and palliative care services to vulnerable communities in close cooperation with facility-based health practitioners, other government departments, non-governmental organisations, community structures and the private sector.

3. Legislative and policy context

The following legislation and policy instruments guide the implementation of WBPHCOTs:

Key legislation

- a) **Constitution of the Republic of South Africa, 1996 (Act 108 of 1996)** - The Bill of Rights as enshrined in Chapter 2 of the Constitution of the Republic of South Africa, provides for the State/Department of Health to take reasonable legislative and other measures to ensure access and delivery of healthcare services to all citizens. Section 27 makes provision for the right to have access to healthcare services, food and water and social security whereas Section 24 enforces the right to an environment that is not harmful to health or well-being of all South Africans.
- b) **The Public Service Act, 1994 (Act 103 of 1994)** - The Public Service Act serves to regulate terms and conditions of employment within the public service of South Africa. As per Section 12A, it makes provision for the “Appointment of persons on grounds of policy considerations” such that “an executing authority may appoint one or more persons under a special contract, whether in a full-time or part-time capacity”.
- c) **Basic Conditions of Employment Act, 1997 (Act 75 of 1997)** - As per Section 23 (1) of the Constitution, “right to fair labour practices” this Act regulates the basic conditions of employment, contractual or permanent, in all sectors whilst making provision as per Section 50 (1) for the minister to “make a determination to replace or exclude any basic condition of employment provided for in this Act in respect of any category of employees or category of employers”.
- d) **National Health Act, 2003 (Act 61 of 2003)** - Considering the principles as contained in the Constitution, the Act provides a framework for a structured, uniform health system aimed at protecting, promoting and maintaining the health of the population. Chapter 5 establishes the “District health system based on the principles of primary healthcare, promoting universal access to quality, equitable, responsive

and efficient healthcare services that are accountable to the communities they serve.” Section 2 (b) “sets out the rights and duties of healthcare providers, health workers, health establishments and users” and Section 52(c) allows the Minister of Health to make regulations to “create new categories of healthcare personnel to be educated or trained”.

- e) **Intergovernmental Relations Act, 2005 (Act 13 of 2005)** - This Act serves to establish a framework for the national government, provincial governments and local governments to promote and facilitate intergovernmental relations; to provide for mechanisms and procedures to facilitate the settlement of intergovernmental disputes; and to provide for matters connected therewith.
- f) **Occupational Health and Safety Act, 1993 (Act 85 of 1993 as amended)** - It aims to create and enforce a safe and healthy working environment for all employees and outlines the roles and responsibilities of both employers and employees in this regard as per Section 8 and Section 14 of the Act respectively.
- g) **Non-profit Organisations Act, 1997 (Act 71 of 1997)** - This Act creates an administrative and regulatory framework within which NPOs can conduct their affairs, maintain standards of governance and create a spirit of cooperation and shared responsibility within government, donors and amongst other interested persons in their dealings with non-profit organisations.
- h) **The Skills Development Act, 1998 (Act 97 of 1998)** - This Act provides a framework to develop and improve the skills of the South African workforce. Learnerships, skills programmes and occupational qualifications fall within the ambit of this Act, which is of relevance to the CHWs career path design.
- i) **Promotion of Access to Information Act, 2000 (Act 2 of 2000)** - This Act gives effect to Section 32 “Access to information” of the constitution and allows for access to or request for information and data from the State or any other body for the purposes of protection of any right.
- j) **The Children’s Act, 2005 (Act 38 of 2005)** – This Act consolidates the law on matters related to children and gives effect to certain rights of children as contained in the Constitution; to set out principles relating to the care and protection of children, which is relevant to community-level service provision to households, including children.
- k) **Division of Revenue Act** - A list of indicators, financial and programmatic (health programmes and other), which provinces are expected to submit quarterly to the national Department of Health, 20 days after the end of each financial quarter. Indicator categories include antiretroviral therapy, post-exposure prophylaxis for sexual assault, prevention of mother-to-child transmission of HIV, programme management strengthening, regional training centres and HIV counselling and testing; some of which would fall within the scope of work of WBPHCOTs.

Key policies and strategies

- a) **World Health Organisation: Health in all policies (HiAP) framework – the HiAP framework**, to which South Africa is a signatory, seeks to highlight the connections and interactions between health and policies from other sectors. It recognises that causes of health and well-being lie mainly outside the health sector and are socially and economically formed. Thus, all sectors should include health and well-being as a key component of policy development.
- b) **National Development Plan (NDP) 2030** - Amongst the various goals contained in the NDP 2030, the following are applicable to the PHC re-engineering programme: (1) health systems reforms completed; (2) PHC teams deployed to provide care to families and communities, and (3) universal health coverage is achieved.
- c) **National Health Insurance (NHI) in South Africa White Paper** - The draft NHI white paper was released for public comment in December 2015 after the NHI green paper was published in August 2011 in terms of Section 3 of the National Health Act and Section 85 of the Constitution and provides for a comprehensive package of care underpinned by a re-engineered PHC system with a focus mainly on community outreach services. The white paper is envisaged to be completed soon for adoption to lead the implementation of the NHI. The white paper also describes the importance of community-based services as part of good primary healthcare services.

- d) **National Department of Health Human Resource for Health (HRH) Strategy: 2012/2013 – 2016/2017** – is described by the minister as a guide to action, outlining key strategies that will inform policies, programmes, operational plans and service strategies required to be undertaken by provinces, faculties of health sciences, labour organisations and healthcare managers and professionals, to ensure a sufficient, relevant, flexible and productive health workforce. The HRH Strategy sets out eight key strategies, all of which have relevance to this policy. Strategic Priority 3 – A workforce for new service strategies ensuring value for money – focuses on the needs of PHC re-engineering and makes specific reference to municipal ward-based structures.
- e) **National Department of Health Strategic Plan – 2014/2015 – 2018/2019**–provides a framework which guides the achievement of improved health outcomes through building relationships and working across sectors to creating cohesive communities and enabling environments that promote health. The document provides a strategic approach and strategic goals across programmes to facilitate the achievement of the vision of a healthy life for all South Africans is achieved.
- f) **Provincial guidelines for the implementation of the three streams of PHC re-engineering** - Developed in 2011 to aid implementation of the PHC re-engineering programme at provincial level. It contains the proposed PHC re-engineering model, outlines the roles and responsibilities of the WBPHCOT teams and proposes timelines for rollout and transition from skills programme to a qualification.
- g) **Ten Point Plan of the National Department of Health** - Released in 2009, as part of the Medium Term Strategic Framework, the 10-point plan sought to facilitate meeting the Millennium Development Goals and monitoring the improvements in the health system.
- h) **Whitepaper for the Transformation of the Health System, 1997** - The white paper was based on the principles of the Reconstruction and Development Programme (RDP) namely:
- (i) the health sector must play its part in promoting equity by developing a single, unified health system
 - (ii) the health system will focus on districts as the major locus of implementation, and emphasise the PHC approach
 - (iii) the three spheres of government, NPOs and the private sector will unite in the promotion of common goals
 - (iv) the national, provincial and district levels will play distinct and complementary roles
 - (v) an integrated package of essential PHC services will be available to the entire population at the first point of contact
- i) **District Health Management Information System (DHMIS) Policy** – This document presents an overarching policy for district health management information systems for South Africa. It details the requirements and expectations for users at national, provincial, district, sub-district and facility level.
- j) **National Environmental Health Policy of 2013** - As per Section 24 of the Constitution through this policy, government aims to create awareness and prevent and reduce health risks associated with environmental hazards by the promotion of inter-sectoral collaboration and community participation (Section 4.3.7) thereby influencing health outcomes to ensure “A long and healthy life for all South Africans”. Section 4.3.5 states that “Environmental health and safety (EHS) must be based on the decentralised model of the district health system for the promotion of equity, efficiency and effectiveness.”

4. The current community health worker programme

Informed by what was happening in South Africa and by lessons from other countries, South Africa developed the PHC re-engineering strategy which serves to strengthen the delivery of PHC services, in the context of the National Health Insurance (NHI). PHC re-engineering with a focus on WBPHCOTs, school health teams and district clinical specialist teams, aims to reorient a predominantly curative, vertical, individually orientated system to a proactive, integrated, and population-based approach to service delivery. The WBPHCOT programme was launched in 2011 as part of PHC re-engineering.

WBPHCOTs have been established, registered and are reporting their activities in the District Health Information System (DHIS) since January 2012. This implementation is guided by provincial guidelines

on the implementation of the three streams of primary healthcare re- engineering released by the national Department of Health in 2011. The implementation to date has allowed us to learn what works well and what needs to be improved.

The following is a summary of successes and challenges pertaining to the implementation of the CHW programme, from a report titled Rapid Appraisal of WBPHCOTs⁴:

4.1 Successes

The programme has been established such that CHWs work in defined areas with defined people and communities. The programme:

- extends healthcare beyond the individual patient and provides services to people in their homes
- extends healthcare to remote, rural and marginal populations, who find it difficult to access services at facilities because of their physical location or social position
- extends healthcare to people who are homeless, abuse substances, engage in sex work or are on the margins of society in other ways
- extends the care focus beyond health conditions and diseases
- education and training relevant to the work of CHW is essential
- increased cooperation with and acceptance of the CHWs by communities and clinic employees
- CHW participation in campaigns and health event days is viewed as useful by clinic employees and CHWs find this satisfying and motivating
- CHWs assist with formation of support groups in the community
- CHWs are successful in defaulter tracing, thus contributing positively to an increase in successful treatment completion

Information and data are an integral part of the implementation model of ward-based primary care. The national Department of Health has devised an information management system of forms and tick lists to support service monitoring and workforce management that is designed to report upwards into the system hierarchy. CHWs and team leaders put in much effort to ensure that the information that is fed into the system is quality controlled.

In certain areas, collaboration with other departments such as social development, water affairs, traditional healers and ward councillors ranges from good to great.

In most areas, CHW relationships with the clinics are good and allows for smooth referral from the community to clinics and for follow up. Patients identified in the community requiring healthcare are referred to the clinic and seen on arrival.

Partnerships are reported to play an important practical role in helping healthcare teams deliver services, variously assisting with community entry, education and training, problem identification and problem solving etc. In terms of organisational partnerships, all work extensively with government departments as well as faith-based and other not-for-profit organisations.

In one district, traditional healers are the gatekeepers to the communities and were involved in sensitising communities about the ward-based outreach team programme. CHWs are positively received by communities in all sites across the provinces. This, in large measure, is due to the hard and careful work done through WBPHCOTS as well as the still limited, but positive impact of taking healthcare to the people in their homes and communities.

Overall, the rapid appraisal shows unequivocal support for a primary healthcare model that takes healthcare to people in their homes. For every challenge identified, respondents have sought or proposed practical solutions.

4.2 Challenges

- Conditions in some geographical areas make it very challenging to cover the expected households.
- Teams often run short of stationery with no printing or copying facilities.
- Not all teams have uniforms and nametags. This makes it difficult for them to be identified and accepted by communities. There is also a lack of protective clothing, properly equipped kitbags and essential equipment. Transport is a major problem.

- No workspace and essential furniture for CHWs at some clinics.
- Team composition envisaged in the national implementation framework is difficult to establish since the shortages of professional nurses makes it difficult to find team leaders.
- Too large teams cannot be effectively managed.
- Functional authority and jurisdiction is a problem for both team leaders and community health workers working in WBPHCOTs. Locating WBPHCOTs in and under the supervision of primary healthcare facilities overburdens facility management and is onerous on CHWs. Outreach team leaders (OTLs) are expected to play a dual role, working both inside and outside the facility. Facility employees do not have control over CHWs deployed to WBPHCOTs by NGOs. This creates practical and organisational culture management problems.
- There are problems of understaffing, lines of authority, accountability, supervision and dual tasking, which are compounded by challenges of appointment and pay. Community-based health workers are neither workers nor volunteers. What this means is that the system does not accord them the status of an employee, with the rights and benefits that come with it under South African labour law. By entitling them to a stipend, government and non-government organisations acknowledge their labour and provide a form of compensation for their work, so they are not volunteers. This grey space leads to demotivation, hardship and attrition. It makes it very difficult to create a sustainable system of community-based healthcare.

Additional challenges that were not identified in the report are:

- differences in recruitment, appointment, working hours and remuneration of community-based health workers and between community-based health workers working in the health sector and community-based workers in other government departments causes dissatisfaction

4.3 Key lessons learned from the current implementation

The following are lessons learned from the current implementation. Resolutions based on these lessons will be taken forward in implementing this policy framework and strategy until new research evidence provides alternative insights.

- Based on the CHW per household norm in the 2011 WBPHCOT implementation framework, the country needs 9159 WBPHCOTs and 54956 CHWs to serve the entire South African population. In terms of the focus on health promotion and disease prevention within the scope of work of CHWs, their efforts are best applied to the poorer South African households since South Africans in higher income brackets have access to alternative health promotion media. Establishing WBPHCOTs for the entire country is thus not necessary. Because health service provision priorities compete for a share from a finite budget, a phased scale-up approach is advised such that CHW numbers are increased as more funding becomes available. Such an approach requires the selection of a population subset or wards where the service should be scaled up. Based on the important PHC principle of equity, poorest communities deserve to be served first. As a start the scale up will be focussed in municipalities with a multi-dimensional poverty index per Statistics South Africa's upper bound poverty line of $p \geq 0.6$. In addition, provinces should identify and service pockets of poor communities that reside in municipalities that fall below this poverty line.
- Each WBPHCOT will be responsible for approximately 6 000 individuals or 1 500 households. The actual number of households covered by each team in the WBPHCOT will be influenced by:
 - distance and travel time between households
 - demographic characteristics of the population
 - burden of disease

This ratio may be changed in the future based on evidence from research that is being conducted about the CHW/household ratio.

- Professional nurses are currently a scarce resource in South Africa in all areas of health service provision. This hampers the establishment and functioning of WBPHCOTs in many areas of the country. Provinces started using enrolled nurses as team leaders where it proves difficult to obtain professional nurses for this role. This “and/or” situation is however not good labour practice since it amounts to equating professional nurses with enrolled nurses. For this reason, the NHC approved that enrolled nurses who have been oriented to community health nursing should be the team leaders for the WBPHCOTs. This is a more cost-effective option since the training of an enrolled nurse is shorter than that of a professional nurse and it will serve as another stream of job creation for South Africans. The quality of the work delivered will be monitored by the PHC clinic manager. The status quo of “and/or” should however remain until sufficient enrolled nurses have been trained.
- Kinds and levels of competencies in WBPHCOTs differ. More generally, CHWs are inadequately prepared for their role because of low levels of basic education and knowledge and skills are limited to competencies relating to legacy vertical programmes. CHWs also fare differently with regard to mastering the training content. This is because the entry requirements for CHWs vary vastly. Going forward entry requirements for CHWs will be Grade 12. The service of CHWs who are already in the programme and who do not have Grade 12 will not be discontinued. During a transition phase, these workers will be, with their agreement, alternatively placed or phased out.
- The NDP 2030 states that households must have access to a well-trained community-based health worker. The plan describes the important role that community health workers can and should play with regard to addressing the social determinants of health through health education and prompt referral to health and other services. If community health workers are to be supported to fulfil these expectations and to become fully recognised members of multidisciplinary primary healthcare teams, their employment conditions must be improved uniformly across all provinces.
- The team composition of WBPHCOTs have been approved as six to ten community health workers, one data capturer and one team leader. CHWs must become part of the multi-disciplinary primary healthcare team within the district health system. Their health promotion, disease prevention, therapeutic, rehabilitative and palliative function must be supported by health practitioners in PHC facilities and by environmental health officers in the community.

Going forward, the implementation of the CHW programme should build on the strengths and lessons learned and address the challenges. This policy aims to provide a framework for improved implementation of the CHW programme.

5. Policy framework and strategy

This section briefly states the vision, values and desired outcomes of this policy framework and strategy.

5.1 Vision

An equitable distribution of a comprehensive community-based PHC service that will contribute to the improvement of health and well-being of individuals, households and communities being served.

5.2 Values

The WBPHCOT policy framework promotes the following values and principles:

- Community participation and empowerment
 - community members are considered as their own ‘agents of change’ and not as passive recipients of government services
 - communities gain the understanding and authority required to ensure that appropriate action is taken in addressing the issues that affect their health and well-being
- Inter-sectoral collaboration
 - health service employees plan jointly with all community-based structures and sectors to deliver services in an integrated manner
 - community structures are strengthened to ensure more effective participation in sustainable community development
- Context-specific implementation
 - to ensure effectiveness, equity with a special focus on rural underserved areas and sustainability, context specific factors such as the needs of rural communities should be considered
- Transparency
 - all stakeholders should function in an open and transparent manner

5.3 Key policy principles

5.3.1 Composition of WBPHCOTs

To achieve the aim of reduction of the mortality rates from the quadruple burden of disease through health promotion, prevention, early detection and appropriate referral, population coverage is critical. The WBPHCOT consists of six to ten community health workers (CHWs), one outreach team leader (OTL) who is an enrolled nurse and one data capturer.

An outreach team serves 6000 people. The wards with more than 6000 people will have more than one team and wards with less than 6000 people must be combined to create a team of more than one ward.

Professional nurses are currently a scarce resource in South Africa in all areas of health service provision. This hampers the establishment and functioning of WBPHCOTs in many areas of the country. Provinces started using enrolled nurses as team leaders where it proves difficult to obtain professional nurses for this role. This “and/or” situation is however not good labour practice since it amounts to equating professional nurses with enrolled nurses. For this reason, the National Health Council (NHC) approved that enrolled nurses who have been oriented to community health nursing should be the team leaders for the WBPHCOTs.

This is a more cost effective option since the training of an enrolled nurse is shorter than that of a professional nurse and it will serve as another stream of job creation for South Africans. The quality of the work delivered will be monitored by the PHC clinic manager. The status quo of “and/or” should however remain until sufficient enrolled nurses have been trained.

5.3.2 Distribution of WBPHCOTs

Because health service provision priorities compete for a share from a finite budget, a phased scale-up approach is advised such that CHW numbers are increased as more funding becomes available. Such an approach requires the selection of a population subset or wards where the service should be scaled up. Based on the important PHC principle of equity, poorest communities deserve to be served first. As a start the scale up will be focussed in municipalities with a multi-dimensional poverty index per Statistics South Africa's upper bound poverty line of $p \geq 0.6$. In addition, provinces should identify and service pockets of poor communities that reside in municipalities that fall below this poverty line.

5.3.3 Scope of work

The scope of work of CHWs is in line with South Africa's disease burden priorities and is attached as Annexure A.

5.3.4 Recruitment

A database of current CHWs must be developed and maintained by provincial departments of health. The national Department of Health will consolidate the information into a national repository. The recruitment of members making up the WBPHCOT must only be done after consideration of the community-based health workers who are on the database.

5.3.5 Key skills requirements

Kinds and levels of competencies in WBPHCOTs differ. More generally, CHWs are inadequately prepared for their role because of low levels of basic education and knowledge and skills are limited to competencies relating to legacy vertical programmes. CHWs also fare differently regarding mastering the training content. This is because the entry requirements for CHWs vary vastly.

The minimum requirements for CHWs should be matriculation (Grade 12) subject to training programme.

Where possible, recognition of prior learning principles will be applied to CHWs who are already in the system and who have undergone relevant training.

5.4 Desired policy outcome

The long-term impact of the WBPHCOT policy framework and strategy should be a long and healthy life for all within a supportive and cohesive community. The goal outlined below are aimed at ensuring efficient service delivery at community level.

Policy goal and objectives

Broad Goal: Efficient management and leadership of WBPHCOTs to support the delivery of primary healthcare services in South Africa

Goal 1: Improve the working conditions of WBPHCOTs

Objective 1:

- Standardise the WBPHCOTs management structures at provincial and district level.

Objective 2:

- Standardise roles and responsibilities of the following actors in the provision of community level services:
 - clinic manager
 - environmental health officer
 - facility-based health promoter
 - community health worker team leader
 - community health worker

Objective 3:

- Complete the CHW investment case to obtain the required budget over the MTEF period for a well-resourced and well-functioning institutionalised CHW programme.

Objective 4:

- Complete and maintain the national CHW information database and use the information to confirm existing CHWs in teams required to serve specific communities.

Goal 2: Improve Human Resource Recruitment, Selection, Placement, Development and Management pertaining to the WBPHCOT Programme**Objective 5:**

- Define an adequate ratio of WBPHCOTs to population and households allowing for differential geographic distribution, and considering problems with access in rural areas.

Objective 6:

- Ensure that WBPHCOTs are fully staffed and equitably distributed throughout South Africa.

Objective 7:

- Ensure appropriate implementation and management of recruitment, selection, appointment, placement, remuneration, skills development, dispute resolution and occupational health and safety processes for all members of WBPHCOTs.

Objective 8:

- Ensure adequate supervision and support for CHWs as well as for WBPHCOT leaders.

Goal 3: Standardize the WBPHCOT scope of work and ensure standardized application in all nine provinces of South Africa**Objective 9:**

- Ensure standardized implementation of the approved scope of work

Objective 10:

- Confirm training content and method for ensuring the WBPHCOTs are capacitated to provide the required services.

Objective 11:

- Ensure, as part of the Ideal Clinic programme, that WBPHCOTs have adequate physical space in clinics to prepare for their day in the field and to meet their data recording and reporting responsibilities.

Goal 4: Improve and maintain the monitoring and evaluation system for the WBPHCOT programme**Objective 12:**

- Review and standardise current indicators and data collection tools across all provinces.

Objective 13:

- Establish the required structures at national, provincial, district and PHC facility level for data collection and reporting.

Objective 14:

- Ensure submission of monthly activity data from PHC facilities into the DHIS, quarterly progress reports as well as a five yearly outcome and impact reports from NDoH and provinces.

6. Policy application and responsibilities of different levels of the health system

This policy framework is applicable to all provinces and health districts of South Africa and its implementation fall within the concurrent responsibility of the national Department of Health and provincial departments of health. The strategy implementation will consider the variation in contexts in the 52 health districts of the country. Roles and responsibilities of the different implementation levels are outlined below.

6.1 National level

The national level will provide strategic direction for implementation and will, in cooperation with provincial departments of health, monitor and evaluate the implementation of the WBPHCOT policy framework and strategy. Progress will be tracked in the National District Health Systems Committee (NDHSC) meetings and reported to the Technical Advisory Committee of the National Health Council to obtain further advice and direction. The national Department of Health, together with provinces, will do and report on an outcome and impact analysis of the WBPHCOT programme every five years.

6.2 Provincial level

Provincial health departments should have dedicated human resources tasked with ensuring the establishment and functioning of WBPHCOTs within the districts. Progress must be reported in the NDHSC on a quarterly basis.

Key responsibilities include:

- providing technical support for implementation
- approving the implementation plan for the WBPHCOT policy framework and strategy in the districts
- ensuring that the rural context is explicitly considered in the implementation
- assisting with the identification of possible barriers to policy implementation in rural areas
- developing a standardised service level agreement for implementation between the provincial department of health and NPO partners
- securing the required finance for human resources, equipment and process implementation
- ensuring that appropriate referral systems and processes are in place
- ensuring that appropriate and adequate training programmes for new and existing members of WBPHCOTs are in place
- ensuring that there is a set of clear indicators that are used to monitor progress in implementation
- monitoring implementation of the WBPHCOT policy in the province and provide quarterly reports to the provincial level
- supporting the national Department of Health in doing and reporting on a five-yearly outcome and impact analysis of the WBPHCOT programme

6.3 District level

District health management must ensure that finance for required human resources, equipment and process implementation is available. Each district must:

- develop an implementation plan for the CHW policy framework and strategy
- ensure that the implementation plan for the CHW policy framework and strategy is implemented and integrated into the district health plans
- ensure an equitable spatial distribution of WBPHCOTs for the district's catchment population
- strengthen existing systems for communication, transport and referrals
- develop, implement and maintain a capacity building system for all CHW team members within a multidisciplinary team context
- monitor implementation of the CHW policy framework and strategy and provide quarterly reports to the provincial level

6.4 PHC facility level

PHC facilities must ensure that WBPHCOTs perform their duty as required through training and supervision. All teams will report to a PHC facility via an WBPHCOT team leader (OTL).

- The PHC facility manager provides guidance and support to the OTL.
- The PHC facility manager must understand the scope of work of the WBPHCOT to ensure that the WBPHCOTs provide the services agreed on.

- The OTL is responsible for overseeing the day-to-day activities of the WBPHCOT and for ensuring that they are provided with uniform, equipment and the necessary logistical support. The OTL must:
 - ensure that statistical data generated from the work of WBPHCOTs is incorporated into the facility statistics and reported to the district, province and national levels monthly in line with the District Health Information Systems Policy
 - plan, together with the PHC facility manager, the allocation of WBPHCOTs to households within the catchment population
 - mobilise communities to support and cooperate with the WBPHCOTs and hold community dialogues to receive feedback on the work of the WBPHCOTs

7. Risk management

Table 2 serves as a guide. Specific risks to the successful implementation of this policy framework and strategy must be identified and mitigation strategies planned at provincial and district levels.

Primary risk	Risks	Root cause	Risk mitigation strategy
Not achieving the impact that health promotion and disease prevention should make on vulnerable communities	Inability to improve on the current implementation such that South Africans in need of this services are not reached	Insufficient funds to employ the required numbers of CHW, resource them with the required equipment and transport as well as ensure their support through appropriate supervision	Complete CHW investment case to obtain the funding to incrementally improve the programme
		Poor management of the CHW programme	Ensure appropriate management structures at national, provincial and district level
	Dissatisfaction from current CHW because of misunderstanding the prioritisation of lower-socio-economic geographic areas	Prioritising lower socio-economic geographic areas for cost-benefit purposes	Well documented harmonisation process ¹ approved by TechNHC that needs to be communicated well
	Dissatisfaction from current CHW because of new entry requirements	Entry requirements set at matric	Well documented harmonisation process approved by TechNHC that needs to be communicated well
	Inappropriate and ineffective interventions at community level	Lack of appropriate skills	Adopt and implement the work integrated training course with focus on local health needs for CHWs

8. Monitoring and reporting on progress pertaining to implementation of the policy framework and strategy

An operational plan with targets and timeframes must be completed within six months of approval of this policy framework and strategy. Progress reports will be presented to the NDHSC and TechNHC on a quarterly basis.

9. Conclusion

The National Development Plan 2030 states that households must have access to a well-trained community health worker. The plan describes the important role that CHWs can and should play regarding addressing the social determinants of health through health education and prompt referral to health and other services. Community-based health workers must be fully integrated into the health service delivery platform if they are to fulfil these expectations. This policy framework and strategy aims to give the direction required to do that.

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