PROVINCIAL GUIDELINES FOR THE IMPLEMENTATION OF THE THREE STREAMS OF PHC RE-ENGINEERING

health
Department:
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1. Introduction

1.1. The National Health Council has mandated that in order to improve health outcomes significant steps be taken to restructure the health system. This is one of the 10 points in the five year Health Sector 10 Point Plan, noted as 'overhauling the healthcare system'. It is also the fourth pillar of the Negotiated Service Delivery Agreement as 'strengthening the effectiveness of the health system'.

1.2. In order to learn lessons from other countries the Minister and MECs visited Brazil in 2010 and came back with a vision for the re-engineering of primary health care. Brazil was able to improve health outcomes by inter alia expanding the role of community agents working in teams with health professionals in designated catchment areas (La Forgia, 2009). Upon returning home the Minister established a small team to elaborate a South African model to strengthen primary health care. This team produced the first narrative document and presentation to an extended NHC meeting (Barron et al, 2010).

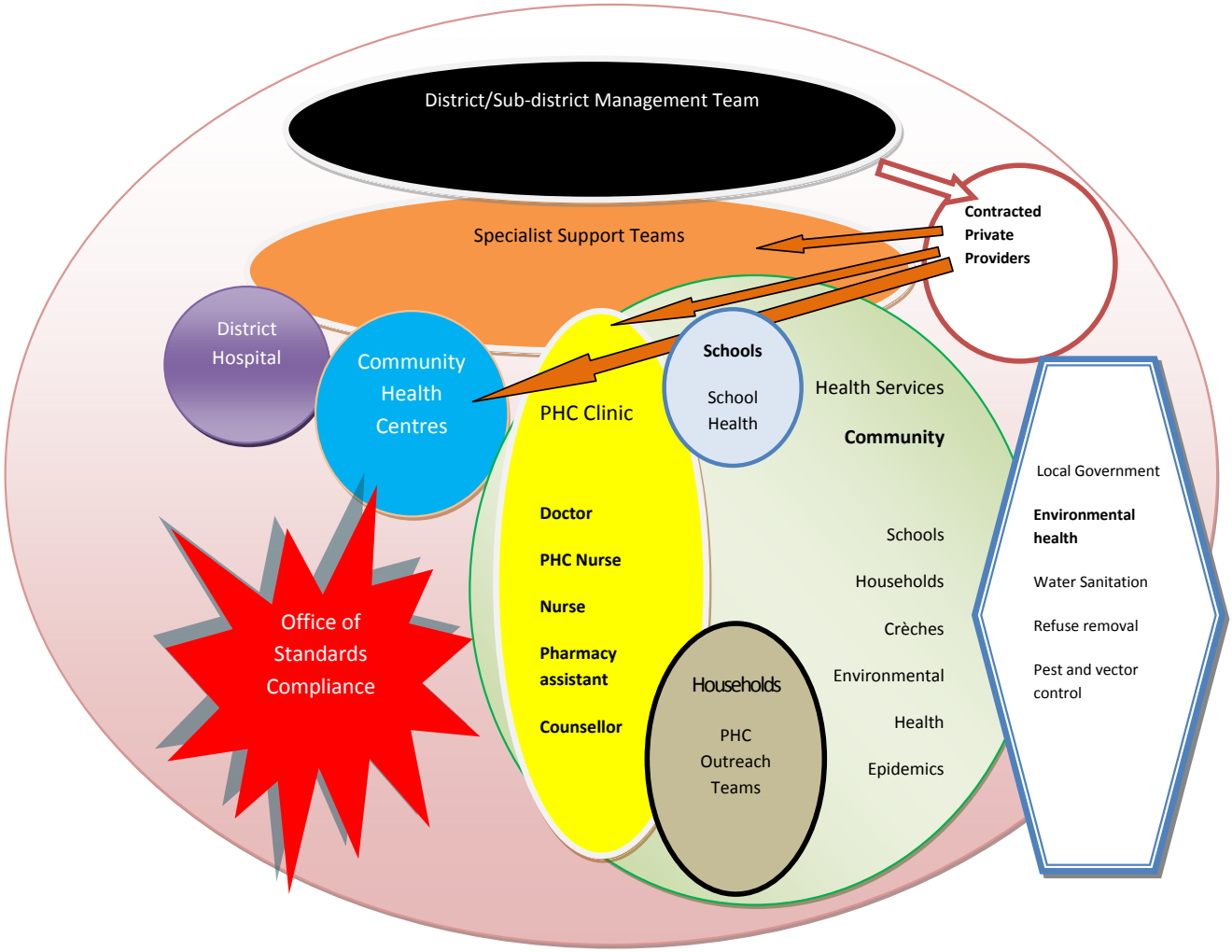
1.3. At the NHC meeting, the basic concept presented was adopted with the caveat that we build a South African model based on the ward system as had been started in KwaZulu-Natal. Since this meeting in November 2010 a number of innovations have been added to the basic model. These additions to the model will be described in the section below together with guidelines for their implementation.

1.4. ***The re-engineering process does not detract from the need to strengthen the district health system – which continues to be the institutional vehicle for the delivery of PHC and district hospital services.*** This means that district management, sub-district management as well as management of all facilities within the district must continue to be strengthened, that district health plans are developed (and strengthened) and that the DHIS amongst others is used to monitor and strengthen service delivery. It also means that quality of care must be improved through better supervision and clinical governance and paying attention to the basics, amongst other systemic interventions.

1.5. In particular it means DMTs, Sub-DMTs and district hospital CEOs being responsible and accountable for all the services that take place in all the facilities and communities in the districts. It means that district, sub-district and hospital plans must take into account the key ministerial priorities and focus on these, including improving the systems for PHC as well as the three focused streams. It means regular monitoring of all key performance indicators related to these and taking remedial action swiftly when these do not improve as planned

1.6. The diagrammatic presentation of the district model is shown below

Figure 1 Proposed PHC model



2. Three streams of PHC re-engineering

2.1 In discussion with the Minister and after debate in the National Health Council, a three stream approach to PHC re-engineering has been adopted by the Department of Health. This model was also part of the Minister's budget speech in the National Assembly early this year.

2.2 The model contains three streams: (a) a ward based PHC outreach team for each electoral ward; (b) strengthening school health services; and (c) district based clinical specialist teams with an initial focus on improving maternal and child health.

2.1 Ward based PHC outreach teams

2.1.1 Evidence from many countries suggests that provision of home and community based health services and their links with the fixed PHC facilities in particular are critical to good health outcomes, especially child health outcomes (Sepulveda et al, 2006). The role of community health workers in many countries has contributed to better health outcomes (WHO 2007). So why is it that with South Africa's 72 000 community based health workers (NDOH audit, 2011) at an estimated cost of R2.4b (Schneider) that we are unable to generate better health outcomes?

2.1.2 It is suggested that this is the result of a multiplicity of factors related to community based health workers. These include inadequate training; inadequate support and supervision; random distribution with poor coverage; no link between the community based services and services offered by fixed health facilities; funded through NGOs with inadequate accountability; limited or no targets for either coverage or quality to be reached (see also HST's report 'Community Health Workers: a brief description of the HST experience' and Lehman and Sanders, 2007 ' Community Health Workers: what we know about them') .

2.1.3 The impact of HIV on key impact indicators has also contributed considerably to the relatively poor health indicators and is independent of interventions made by CHWs or other health workers and interventions.

2.1.4 Many of these factors can be corrected if CHWs were part of a team, were well trained, supported and supervised with a clear mandate both in terms of what they are expected to do as well as catchment population that they are responsible for. The ward based -PHC outreach team is designed to correct these limitations in the way community based health services are currently provided in the country.

2.1.5 Each ward should have one or more PHC outreach teams. These teams are composed of a professional nurse, environmental health and health promotion practitioners as well as 4-5 community health workers and are expected to serve a population of about 7 660 people. The roles of the PHC outreach team will include (additional details are found in the separate documents dealing with the PHC outreach teams):

- Promoting health
- Preventing ill health
- Providing information and education to communities and households on a range of health and related matters
- Environmental health, especially those aspects impacting directly on households and communities
- Psychosocial support in collaboration with community care givers supported by the Department of Social Development
- Early detection and intervention of health problems and illnesses
- Follow-up and support to persons with health problems including adherence to treatment
- Treatment of minor ailments
- Basic first aid and emergency interventions

2.1. 5 Given the key role that CHWs will play, they should, over time be directly managed by the Department of Health (as opposed to NGOs). This has already happened in KZN. However, even as we finalise strategies for direct management by the Department, all districts should audit the number of community based workers in the district, who employs them and what they do, what impact they are making etc. This audit should result in a reorganisation of how community based workers function. Each group should also be linked to a PHC facility with a nurse in each facility, who is the team leader. The team leader is responsible for ensuring that their work is targeted and linked to service delivery targets and that they are adequately supported and supervised – this approach has been adopted in the Western Cape.

2.1.6 The roles of CHWs (as part of the PHC outreach teams) will include:

- Conduct community, household and individual health assessments and identify health needs and risks (actual and potential) and facilitate the family or an individual to seek the appropriate health service;
- Promote the health of the households and the individuals within these households
- Refer persons for further assessment and testing after performing simple basic screening
- Provide limited, simple health interventions in a household (e.g. basic first aid, oral rehydration and any other basic intervention that she or he is trained to provide)
- Provide psycho-social support and manage interventions such as treatment defaulter tracing and adherence support.

2.1.7 The NDOH is currently finalizing a curriculum for CHW training (and PHC outreach team orientation) and will make available the curriculum and training material by the

end of September 2011. The target is to train 5000 CHWs by December 2011. Those districts are ready to deploy the PHC outreach teams should indicate their readiness and identify the teams to be oriented and CHWs to be trained as part of the first batch.

2.1.8 Ideally each ward within the district should be covered with a PHC outreach team. There are 4,277 electoral wards in South Africa. The population sizes of wards are variable as is the geography and density of each ward. Urban wards are highly populated with high density whilst rural wards are sparsely populated and often with poor road and other infrastructure. This means that ward populations may range from less than 1000 in some wards to more than 20 000 in others. This means that district management must work out what is the best way to distribute the PHC outreach teams. As additional resources become available priority must be given to hard to reach areas, and vulnerable communities and homes within the district. Over time all wards should be covered.

2.1.9 Frequently asked questions and responses:

- Where will the additional professional staff come from?
    - Districts should identify staff that are under-utilised and increase efficiency of existing personnel in PHC and district hospitals; in addition, retired nurses and additional staff should be employed
- Where will be budget come from?
    - Efficiencies in district operations should be the first priority – noting that as community based services are improved, the number of referrals that can be dealt with at this level should decrease the volume of patients (even if increased case finding initially increases the load on facilities); secondly National Treasury has made additional funding for these teams available in the current MTEF
- What do we do about current contracts with NGOs who are employing CHWs?
    - We need to work with these NGOs to firstly improve the efficiency of how they work and how they work with the facility and sub-district management; secondly, we need to inform NGOs that their roles are changing and that over the next two years they will cease to be funded to employ CHWs as this will be done by the DOH, instead they should be funded to do social mobilisation and other community level activities which will complement the work of the PHC outreach teams

2.2 School health services

2.2.1 In 2003 the Department of Health adopted a national policy on school health services. However, the reality is that school health services are poorly resourced and therefore school health services are unevenly provided within and between provinces.

2.2.2 Working with the Departments of Basic Education and Social Development, the Department of Health has revised the School Health Policy and implementation guidelines. These will be jointly launched by the Ministers before the end of December 2011.

2.2.3 Whilst we would like to have a school health nurse in every school, the reality is that with 29 000 schools in the country, this is not possible in the short to medium term. It is therefore proposed that we focus on schools in quintiles 1 and 2 (the poorest schools) and also prioritise a selected range of services. For example we could prioritise screening of all grades R and grades 1, ensuring that all those that attend ECD and primary school are fully immunized, and that in secondary schools we prioritise strengthening the life skills programme with specific focus on sexual and reproductive health and the reduction of alcohol consumption.

2.2.4 As more resources become available the above package of services will be expanded to the full range of school health services as outlined in the revised policy.

2.2.5 In order to prepare for this formal launch, all districts should: (a) audit the current school health services (personnel, services offered); (b) plan to expand the services with additional personnel, again considering efficiencies and the redeployment of nurses and hiring retired nurses with the immediate priority of providing a limited range of services, with expansion as resources become available

2.2.6 District management must also ensure that the PHC outreach teams work in tandem with school health services. It is possible that in some areas, the PHC outreach team will provide or assist in the provision of school health services. The PHC outreach teams must also investigate home circumstances of children who do not attend school or are failing to thrive upon referral by the school health nurse.

2.3 District based specialist teams

2.3.1 Given the unacceptably high infant, child and maternal mortality in most of our districts, the National Health Council has agreed that every district should be supported by a team consisting of a gynaecologist, paediatrician, anaesthetist, family physician, advanced midwife and primary health care nurse.

2.3.2 A task team has been appointed to develop details around how the team will function but building on what exists in each province. Many provinces already have outreach specialist services provided by regional specialists. Also many provinces already have family physicians working in districts. The idea is to formalise the

composition and functionality of these teams, as well as to ensure that all districts have these teams.

2.3.3 The basic functions of the specialist teams are to: strengthen clinical governance at PHC level as well as in district hospitals; to ensure that treatment guidelines and protocols are available and are used; that essential equipment is available and that these are correctly used; that mortality review meetings are held, are of good quality and that recommendations from these meetings are implemented; support and supervise and mentor clinicians; and monitor health outcomes.

2.3.4 It is envisaged that posts for these teams will be advertised by the end of September with posts being filled towards the latter part of the year. Every district will appoint specialists. Those districts without any specialist support at present will be prioritized in appointing specialists. In addition universities will ensure that specialists employed by medical schools will rotate through the posts that provinces will create in each district.

2.3.5 District management teams, with provincial support, should begin to audit the specialist support they currently receive as well as its added value. Districts should start planning how to strengthen their current support and plan to expand this support over time, in line with the decisions of the NHC.

2.3.6 These teams will work closely with the PHC outreach teams.

3. Monitoring and evaluation

3.1 To obtain maximum value from the investments envisaged in implementing the three streams of PHC re-engineering, it is critical that proper systems for monitoring and evaluation are put in place early.

3.2 Currently the NDOH is busy designing new recording and reporting systems for CHW teams and school health services with appropriate indicators. These will be available from the beginning of October. The NDOH will develop a small set of indicators for inclusion in the DHIS that will be used to monitor outcomes and will also develop a set of input and process indicators to complement these for purposes of monitoring and evaluation.

3.3 As districts begin to develop 2012/13 District Health Plans, they should ensure that clear thought is given to how current resources will be re-prioritized and what new resources will be required to implement the three streams of PHC re-engineering.

4. Conclusions

4.1 The NHC mandates are clear. The health system must be overhauled to produce better health outcomes. The three streams of PHC re-engineering are also clearly defined by the NHC.

4.2 All provinces will be supported by the NDOH to implement the three streams.

4.3 These guidelines to provinces and districts will be augmented by specific guidelines around the three streams (e.g. detailed guidelines about employment and training of CHWs) as well as guidelines to development and other partners supporting districts. These additional guidelines will be distributed as and when they become available.

4. References

Barron P, et al (2010) Re-engineering Primary Health Care for South Africa *"*Suggestions for the way forward*" power point presentation to the extended NHC meeting, Umhlanga Rocks, Durban.*

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TOOLKIT

Ward Based Primary Health Care Outreach Teams

Implementation Toolkit

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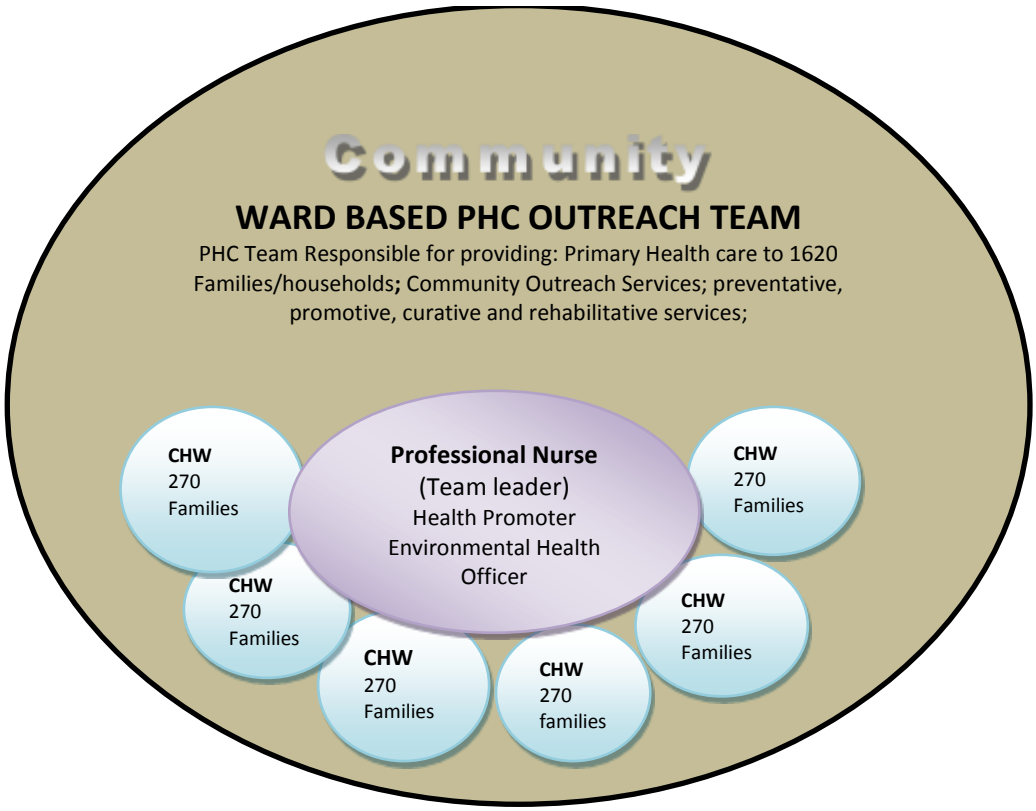
WARD BASED PHC OUTREACH TEAMS

1 Overview

The re-engineered approach to providing PHC services proposes a population based approach for the delivery of PHC outreach service to the uninsured population of South Africa 41 992 831 (84% of the total population). The PHC outreach service will be provided by an estimated 5 482 PHC outreach teams will be required to service the uninsured population. The department of health will deploy PHC outreach teams in rural areas, in informal urban settlements as well as in townships. The PHC re-engineering model will include for the first time CHWs as part of the formal structure of the health service.

The PHC outreach team (Figure 1) which is one stream of the re-engineered PHC model is the level of the health service which will provide services to communities, families and individuals at community-based institutions and at a household level in a ward. This service must be provided services in close association with facility based health services, other sectors and government departments, CBOs and NPOs providing community based services, and local communities. The ward based PHC outreach team is the cornerstone of community based PHC services, which will encompass activities in communities, households and educational institutions, and referral networks with community based providers (Table 1).

Figure 2 Ward Based PHC Outreach Services



1.1 Population and Household Allocation

Each primary health care outreach team will be responsible for an average of 7 660 persons or 1 619 households (with an average of 3.9 persons per household). Each community health worker will be allocated an average of 270 households. These thresholds are indicative and will depend on density, geography as well as burden of disease.

1.2 Composition

A primary health care outreach team will comprise of 1 professional nurse and 6 community health workers. Health promotion practitioners as well as environmental health practitioners will be added to the team over time and where these cadres already exist.

1.3 Role, Responsibility and Activity

Each PHC outreach team will offer an integrated health service to the households and individuals within its catchment. The core components of the integrated service are:

i. Promote health (child, adolescent and women's health)
ii. Prevent ill health
iii. Ante and post natal community based support and interventions that reduce maternal mortality
iv. Provide information and education to communities and households on a range of health and related matters
v. Offer psychosocial support
vi. Screen for early detection and intervention of health problems and illnesses
vii. Provide follow-up and support to persons with health problems including adherence to treatment
viii. Provide treatment for minor ailments
ix. Basic first aid and emergency interventions

Table 1: The PHC Outreach Team Community based PHC Activities according to Sites

	Sites	Activities
1	Community	Community assessment of structure, demographics, cultural practices
		Assessment of community resources, including service providers Identify resource constraints, potential and actual risks facing the community
		Develop and implement community based interventions, including inter-sectoral action
2	Household	Screening, assessment and referral across the life cycle (all age groups)
		Provide information and support for healthy behaviours and home care
		Provide psycho social support (including adherence support for HIV, TB and other chronic disease treatment)
		Identify and manage common health problems
3	Schools & early childhood centres	Screening, assessment and referral
		Targeted interventions (e.g. educational programmes, vitamin A, de-worming and immunisation campaigns, teenage pregnancy))
4	Other health and social providers: (through referral and linking)	Referral and coordination of services provided in households with other sectors (in particular social development & early childhood development), non-profit organisations, community care centres and any other service providers Focus on: orphaned and vulnerable children, elderly, mental health and substance abuse services, step down care

2 Responsibility and function of PHC Outreach Team Members

2.1 Role of Professional Nurse in PHC Outreach Team

To enable a professional nurse on the PHC outreach team to fulfil the role outlined in **Error! Reference source not found.** he/she must be comprehensively trained (i.e. registered as a general nurse, midwife, community and psychiatric nurse) with experience in working in a PHC setting. A driver's licence is an essential requirement.
The professional nurse will assume the role of team leader. A person in this position will be appointed by the district manager and he/she will report to the PHC clinic manager.
Each professional nurse will be delegated the responsibility to:

1. Deliver and manage health services to a defined geographic area according to the PHC package of health services;
2. Manage the work of the PHC outreach team
3. Manage the resources (financial, human and material) allocated to the team
4. Initiate and establish the community based outreach services with the team members

Table 2 : Role of Professional Nurses in PHC Outreach Team

Team
1. Assume responsibility as the team leader
2. Allocate and assign tasks and supervise and manage team members
3. Develop capacity of CHWs to deliver PHC outreach services
4. Promote teamwork amongst PHC outreach team members
5. Train, mentor and coach PHC Team members
6. Manage performance of team members (set performance requirements, assess, evaluate, correct and improve performance)
7. Monitor and evaluate team performance
Community
8. Facilitate entry into the community for the PHC outreach team.
9. Conduct a community assessment and compile a profile and diagnose the health needs of the community.
10. Initiate a community-based PHC outreach service to households, their inhabitants and to schools, crèches and day care centres in a designated geographic area.
11. Establish and maintain collaboration and liaison with local community and local service providers.
12. Assess health needs and priorities for the catchment population.
13. Map households, schools and crèches/day care centres in the geographic area serviced by the PHC outreach team.
14. Keep local community informed of health related matters and potential health threats
Services
15. Plan, implement and evaluate health and wellness services to the catchment population of the PHC outreach team including promotion, prevention, early detection, curative, rehabilitative and palliative service.
16. Develop a targeted plan to address the health needs of those that are vulnerable (children, women, elderly, disabled persons affected by TB, HIV, chronic diseases)
17. Act as an advocate for improving health services
18. Deliver the community component of PHC package of services
19. Conduct screening and PHC support services to crèches, old age homes and schools (where there no school health services
20. Conduct home visits to post natal women
21. Provide health services according to local and national guidelines
22. Ensure that health services delivered are comprehensive and integrated
23. Facilitate establishment of and oversee support groups
24. Render emergency health services during disasters and disease outbreaks

25. Develop an effective referral system to and from health services and services offered by other sectors
26. Improve access to health care services for catchment population
27. Monitor and evaluate services rendered, quality of care and health outcomes
28. Maintain household and health records
29. Maintain an updated register and database of households and profile of its inhabitants
30. Write monthly reports

2.2 Role of Health Promoters in PHC Outreach Teams and in Communities

Ideally a health promoter is required to support each PHC outreach team the availability of suitably qualified (B Degree in health promotion) persons may vary across provinces, districts, sub-districts and communities. A health promoter is required to support
The health promoter's role towards the PHC outreach team is to provide technical support and assistance pertaining to health promotion activities at a community level based on local needs. In order to fulfil the role (as detailed in Table 3) a health promoter could support 2-3 PHC outreach teams linked to a PHC clinic.

Table 3 : Role of Health Promoters in PHC Outreach Teams and in Communities

	1. Community
1.1	Plan, co-ordinate and implement Health Calendar events, activities and campaigns at a community level
1.2	Establish, facilitate and maintain support groups for persons with health related problems according to needs of the community
1.3	Co-ordinate health promotion activities and events at local schools, crèches, institutions and work places in the community
1.4	Provide Information and education pertaining to health issues determined by local needs of the community: a. One on one interaction with members of the community (information sharing and brief advice sessions, when necessary); b. Conduct group discussions with target audiences(youth, women, elderly) in the community c. Hold community health awareness days and health campaigns;
1.5	Facilitate local drama, puppets shows, role plays, song and dance sessions to encourage community involvement and participation in health issues
	2. PHC Outreach Team
2.1	The health promoter will provide overall support and technical assistance and support pertaining to health promotion to the PHC outreach teams (Each health promoter could support 2-3 PHC outreach teams linked to a PHC clinic).The health promoter will support the members of the PHC outreach team to: a. develop and disseminate health promotion messages; b. identify appropriate and relevant health promotion material for use and distribution c. use a range of health promotion tools
2.2	Assist and support CHWs by providing health information and updates on health promotion activities in accordance with the Health Calendar.
	3. School Health
3.1	Implement health education and promotion programmes in schools and crèches based on assessed needs.
3.2	Support the school health nurse and the education team to develop and disseminate health promotion messages; a. identify appropriate and relevant health promotion material for use and distribution b. use a range of health promotion tools c. participate in health calendar days
	4. Disease Outbreak Teams
4.1	Run education campaigns (door to door) in high risk areas during disease outbreaks, within the catchment area;
4.2	Mobilise communities for specific health campaigns within the catchment area;
4.3	Provide health information, education and communication (IEC) material (posters, pamphlets) for distribution

	to the community; and
4.4	Present educational talks on local community radio and make local public service announcements and present health information.

2.3 Role of Environmental Health Officers in PHC Outreach Teams and in Communities

Environmental health is a municipal competence and therefore environmental health officers are found employed by municipalities. Environmental health is an essential component of PHC especially at a community level. It is therefore important that the work of the PHC outreach team is closely linked to that of the environmental health officers. Table 4 outlines the environmental health services that communities require.

Table 4 : Services of Environmental Health Officers to Support PHC Outreach Teams

Community
1. Control health hazards related to household and community waste disposal
2. Control and manage unsafe sanitation
3. Oversee waste water treatment
4. Monitor waste management
5. Vector control
6. Prevent and control land pollution
7. Monitor air quality management
8. Establish an effective environmental health surveillance and information system
9. Develop a community based accident prevention programme
10. Monitor and control retail food hygiene and safety (formal and informal)
11. Develop environmental health measures associated with epidemics, emergencies, disasters and migrations of populations
12. Monitor occupational health and safety in local businesses
13. Manage environmental noise hazards
14. Monitor environmental health in public and private accommodation establishments

3 Community Health Workers Scope of Work, Roles and Competencies

For community health workers to fulfil the roles required of them as members of the PHC outreach team outlined in Table 5 they will need to have received the appropriate education training and acquired the requisite level of competence.

During the last two decades there was a proliferation of lay or community workers in the South African health and social development sectors, from an estimated 5,600 in the mid-1990s(Cruse, 1997) to 72,839 in 2011 (DOH, 2011). These community based health workers perform a wide range of functions with titles such as home community based care workers, VCT counsellors, ART adherence counsellors, DOTS supporters, child and youth care workers, home based carers and peer counsellors/educators and volunteers to name a few. The training received by these community based health workers ranges from 2 weeks to 4 years, some being skill based programmes and others formal qualifications registered on the National Qualifications Framework (NQF).

The most recent audit conducted by the National Department of Health found that these community based health workers offer a wide range of health services that are described by the title :

- 49 042 home based carers or community care givers (CCGs)
- 15 206 lay counselors
- 2 010 adherence counselors
- 2 740 DOTS supporters
- 3 478 peer educators
- TB defaulter tracers (93), High Transmission Area workers (109) and hospice workers (143) and mentors (18) found in only single provinces.

The audit also found that the aforementioned community based health workers were distributed across all provinces with the highest number in KwaZulu-Natal (17 677), Limpopo (8 443) and Mpumalanga (8 431) and the lowest in Northern Cape (2431), Free State (3194) and Western Cape (3816).

Table 5 : Role of Community Health Worker in the PHC Outreach Team Year 1 and 2

Household
1. Identifying and registration of households (Year 1 100% of households) 2. Conduct household assessments (35% of households in year 1) 3. Health promotion and prevention (Maternal and child health, HIV, TB (year 1) Chronic Diseases (year 2) will be an essential element of all home visits and other community based activities of the CHW. Specific functions include: 3.1 Health promotion 3.2 Provide health related information (immunisation, ante-natal and post natal care, HIV, TB and chronic diseases) 3.3 Conduct simple screen for potential health problems 4. Perform basic first aid 5. Adherence support and counselling 6. Provide supportive counselling 7. Refer to and receive referrals from health other services
Community Based Activities
1. Update Resource Profile of Community 2. Assist with conducting Support Groups 3. Participate in specific health days in the community 4. Attend community meetings 5. Assist with School health 6. Support and promote health at crèches, ECD institutions and other institutions like old age homes 7. Spend time in facilities to update records and prepare reports

3.2 Scope of Work

It is important for community health workers to have a clearly delineated scope that defines and sets parameters for their practice.

CHWs improve the quality of life and contribute to better health of communities and its members by providing an outreach service to promote and facilitate improved access to primary health care services.

3.2.1 The scope of the CHW is best encapsulated in the following 7 core generic roles:

I. Promote health and prevent illness
II. Conduct structured household assessment to identify their health needs
III. Provide psychosocial support to community members
IV. Conduct community assessments and mobilise around community needs

V. Identify and manage minor health problems
VI. Support continuum of care through service co-ordination with other relevant service providers
VII. Support screening and health promotion programmes in schools and ECD centres

The core competencies associated with each of these roles are unpacked in Table 6**Error! Reference source not found.**.

Special emphasis is made to ensure that the CHWs adopt an integrated approach in how they manage health problems. The integrated approach is applied to treatment adherence which includes:

- Treatment literacy, supported with good quality educational tools
- Practical adherence advice e.g. on scheduling doses
- Regular pill counts, particularly in early phases of treatment
- Identifying and briefing treatment buddies/supporters
- Provision of supportive tools such as pill boxes
- Availability of support groups
- Assistance with collection of tablets, negotiating with local clinics
- Early identification of individuals and households at risk of poor adherence

Table 6 : Core Competencies for Community Health Workers

Core Role of CHWs	Core Competences
1. Promote health and prevent illness	1.1 Conduct health promotion and education sessions for communities and its members
2. Conduct structured household assessment to identify their health needs	2.1 Carry out a comprehensive Household assessment 2.2 Conduct a home visit 2.3 Interview community members and use effective interpersonal communication skills
3. Provide psychosocial support to community members	3.1Use effective basic counselling and communication skills 3.2Provide psycho social support across the life cycle, including an integrated approach to adherence support for TB, HAART and other chronic disease treatment
4. Conduct community assessments and mobilise around community needs	4.1 Conduct a community assessment 4.2 Advocate for improved health and community services 4.3 Demonstrate skills required for entry and access into communities 4.4 Utilise effective advocacy and community mobilisation strategies
5. Identify and manage minor health problems	5.1 Offer basic first aid and treatment of minor ailments 5.2 Understand the principles of PHC and the interventions and services supporting it

6. Support continuum of care through service co-ordination with other relevant service providers	6.1 Demonstrate the ability to assist community members to access services (health and other required services). 6.2 Ability to identify and access resources 6.3 Ability to network and build coalitions with other service providers in the community 6.4 Ability to provide follow-up 6.5 Refer community members to health services and social and other community based services offered by other sectors 6.3 An overall understanding of the health system, the services offered at various facilities and the referral system
7. Support screening and health promotion programmes in schools and ECD centres	7.1 Conduct health assessments and use screening tools for identifying health problems

3.3 Employment of CHWs

Due to the complexity of the current situation with the employment of community based health workers, provinces are provided with hereunder guidance regarding the emplyment and inclusion of existing community based health workers into CHW positions on the PHC outreach teams.

3.3.1 Underlying Assumptions

a. All newly appointed CHWs will not necessarily fulfill all of the entry requirements to for the post of CHW (education and training, competence and skills required to fulfill the full range of responsibilities)
b. There is an existing pool of 72 839 community based health workers that are either directly or indirectly employed or whose employment is funded by the DOH.
c. There is not consistency in the education and training of the existing 72 839 community based health in-terms of knowledge, skills and competence and workers is not uniform there are vast variations from weeks to months duration and education levels.
d. Current categories community based workers vary from home based care, adherence counseling, lay counseling, DOTS support to community care givers, peer educators do not fulfill the full set of roles and responsibilities required by the CHW as member of the outreach team.

3.3.2 Principles guiding the employment of CHWs

a. The first phase of recruitment and appointment of CHW for the PHC outreach teams will be from amongst the existing CHW funded by the Department of Health or its funding partners.
b. The knowledge, skills competence of the new recruits will develop their skills and competence through an extensive orientation, training, mentorship and supervision programme.
c. The first cohort of CHWs will require close supervision and therefore they must be only be appointed onto an outreach PHC team where there is a team leader i.e. a Professional nurse to mentor and supervise their work.

d. All newly recruited CHW will not necessarily fulfill the full range of functions required of a CHW in the first two years.
e. CHWS that do not meet the job and competence requirements after two years of training, support and supervision will not be eligible to continue serving as a CHW.
f. All of the first cohorts of CHWs recruited will be appointed as contract workers

3.3.3 The Employment Contract

a. Community health workers contract of employment will be for a fixed period of one year. The National Department of Health developed a draft contract (Annexure III Employment Contract Community Health Worker (Training Post).
b. The basic benefits are provided for in terms of the BCEA
c. The contract also requires a basic security screen (this was recommended by the legal advisors so as to minimize risk and liability to the Department as the incumbents are required to enter and render services at a household level)

3.3.4 Job Description

a. A draft job description that can be used by provinces is attached Annexure IV Community Health Worker Job Description

3.3.5 Performance management

a. Each incumbent is required to sign a performance agreement that outlines the expected performance requirements
b. The supervisor the outreach team leader is responsible for setting the performance requirements as per the performance agreement and for reviewing performance
c. The team leader must record the performance reviews and file these for each CHW employed in a PHC Outreach.
d. The PHC facility managers will adjudicate the performance review.

3.3.6 Recruitment and selection

a. The provincial implementation teams will determine the number of PHC outreach teams and location of the teams and create the necessary employment mechanisms and posts
b. Delegations are required for the respective district /sub-district managers and the PHC facility managers regarding the establishment of PHC outreach teams, budgets and posts available. The human resource directorates will assist the facility managers with the recruitment and selection process.
c. The vacant CHW positions will be advertised locally and internally at local NPOs, CBO,s and health facility.

3.3.7` Minimum Entry Requirements for selection into PHC team as a CHW

a. Incumbent must be functionally literate and numerate (Tested through applicant completing the application form in their own writing without assistance)
b. Completed some training (un-accredited 59 or 69 day, or accredited NQF level 1-4)
c. Has at least 1 year experience as a community based health worker (2 years desirable)

d. Has a positive testimonial from previous employer (NPO or DOH)
e. Resides in the area that they will be serving (in areas where there is a shortage of CHWS the "area" could be more broadly defined)
f. Prepared to undergo orientation and training and sign a performance agreement
g. Meet basic competence requirements (assessment conducted after phase 1 orientation training before phase 2 training)

3.4 Education and Training of CHWs

3.4.1 Framing assumption

a. The current qualifications registered on the NQF (ancillary health care[1], and community health worker qualifications[2]) and the non-accredited (59-day and 69-day training programmes designed for home based carers) do not fully equip the CHW to fulfill the roles outlined in Table 5 Table 5 : Role of Community Health Worker in the PHC Outreach Team Year 1 and 2 in section 3.

b. A formal process with the Department of Health as implementing partner was initiated with the HWSETA and QCTO[3] using the Organising Framework for Occupations (OFO). The QCTO identifies the *"purpose of an occupational qualification is to specify the requirements that a learner must meet to be certified as competent to practice an occupation, or a specialisation related to an occupation, reflected on the Organising Framework for Occupations (OFO)."*[4]

c. The QCTO policy framework recognises that an occupational qualification requires theoretical conceptual knowledge / theory and information, practical / applied knowledge and skills and work experience and that a combination of all three components is important for attaining occupational competence. The OFO also makes provision for both occupational and educational progression which is ideally suited for progression of current cadre of CHWs.

d. The aforementioned review aims at developing revised/new national qualifications and career paths for CHWs and HCs that are aligned to the scope and occupational requirements for CHW, and HC. The process will include consultations with stakeholders and expert groups and QCTO has advised that the review will be completed during 2012.

e. Once the occupational qualifications become available, CHWs fulfilling the occupational role of CHW will be required to have their knowledge, skills and work based experience assessed against the registered occupational qualification using a RPL (Recognising Prior Learning) process. This will provide a formal process for addressing the differences in their existing competence of CHWs and the new occupational qualification will be identified and community based workers will be

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[1] General Education and Training Certificate: Ancillary Health Care (NQF Level 1)

[2] National Certificate: Community Health Work (NQF Level 2);National Certificate: Community Health Work (NQF Level 3); Further Education and Training Certificate: Community Health Work (NQF Level 4)

[3] Quality Council for Trades and Occupations (QCTO) was established in 2008 by the Skills Development Act to perform the functions set out in Chapter 6C – Section 26H, 26F and 26J of the SDA (Act No 97 of 1998

[4] Page 4 QCTO DRAFT CURRICULUM AND ASSESSMENT POLICY April 2011 accessed from SAQA Website http://www.saqa.org.za/list.asp?key=QCTO Policies

afforded the opportunity to advance their level of competence to fulfill the full range of functions of the CHW.

3.4.2 Guiding principle

a. The education and training of CHW will continue to utilise and build, on the national systems of training community health workers– like the National Qualifications Framework and the HWSETA as the quality assurance and accreditation body and align these to new developments such as the OFO and the QCTO.
b. The proliferation of unacknowledged courses that are a not part of the national system of training will be discouraged
c. In the interim on–the-job orientation, training and skills development will be offered to increase the capacity of community based health workers to fulfil the responsibilities of CHWs

3.4.3 Orientation and Training for the Interim Period

The main assumption is that the majority of CHWs will come from the existing cadres of CHWs and associated workers (lay counsellors etc.)

The underlying principles that will inform the orientation and training of CHWs in the interim period include:

i. **Accreditation** – while accreditation of training modules and training providers with the HWSETA is beneficial to both quality assurance and standardization of content, time does not allow this to be the only approach in the interim period.
ii. **Quality assurance** – while some training will not be accredited by the HWSETA and therefore not quality assured by them, it still needs to be of good quality – in both content and delivery.
iii. **Standardised** – all training – including the modules that comprise the top-up training - to be delivered through standard orientation and training materials throughout the country (possibly located on a central (electronic) 'hub'). Whilst this deviates from the outcomes-based approach which allows trainers to devise their own materials, it will save time and contribute to assuring quality.
iv. '**Baskets' of content** - addressed in more detail below, content to be bundled together into coherent groups, not offered in small itemised pieces.
v. CHWs to attend the full basket of orientation and training even if they are already proficient in some aspects of it, so that the competences needed in an aspect of the work are learned in an integrated way. There is no harm in some repetition, particularly where it serves to establish SOPs, approaches and protocols within a team.
vi. **Accessible and cost-efficient** - training programme for CHWs must ensure that it is self –sustaining and affordable in the long- run. Training must be geographically accessible - but also offered in ways that are cost-efficient. This will need provincial/district–level co-ordination (see Governance below).
vii. **Supervisors** – the PHC outreach team leader will supervise and manage CHWs and they will be active on-the-job coaches, both functionally and towards developing a team approach to work.
viii. **Language** of instruction and assessment - General approach is that multilingualism to be encouraged as a principle – but also within what is practicable.

ix. **Training providers** - The use of external training providers will only be used as an interim measure to fast track the training of the first cohort of 5000 CHWs.

x. **Training capacity -** A mechanism to capacitate a range of training providers RTC, supervisors and mentors must be in place to ensure that there is internal capacity within the Department of health at all levels (community, to provide on-going orientation and training, mentorship and supervision of CHWs and reduce the reliance on external training providers.

xi. **Work-based practical skills training** - The orientation and training programmes must include work-based activity exercises that will facilitate the achievement of competencies required to fulfill the responsibilities of CHWs. The PHC Outreach team leaders must closely supervise these practical activities in the workplace.

3.4.4 Governance and Oversight over Orientation and Training Programmes

In the interim period – provincial and districts levels governance and oversight and co-ordination is necessary. Issues will include, inter alia,

I. contracting of training providers
II. coordinating where and when training is held
III. keeping records of who has attended what training was completed
IV. monitoring provision and effectiveness and reviewing plans as needs arise or conditions change

3.5 National Orientation and Training Programme

Table 7 : Community Health Worker Orientation and Training Plan

Phase 1	**Phase 1 Output**
1. The Orientation and Training Programme Time frame: 2 Years (FY 2011-2012 2012-2013)	1. Orientate and Train the 33 000 community health workers appointed to work in PHC Outreach Teams 1.1 Year 1 : 10 000 CHWs will be trained (at least 5000 will be trained by 31 December 2011 and 5000 by 31 March 2012) 1.2 Year 2 : 23 000 CHWs will be trained by 31 March 2013 1.3 Competence assessment of CHWS trained and certificate of competence awarded to those found competent 1.4 Skill development support programme will be put in place for those that do not meet the competence requirement
2. Supervision, performance management, mentoring and coaching programme for outreach team leaders Time frame: 2 Years (FY 2011-2012 2012-2013)	2. Local level supervision and mentoring skills through: 2.1 Orientation and Training of 6426 professional nurses to supervise, coach, mentor and manage performance of CHWS to acquire skills and competencies (Year 1 and 2)
Phase 2	**Phase 2 Output**
1. Consolidation of skills learnt in Phase 1 2. Introduction of Protocols, guidelines and assessment and screening for: • Prevention, and management of chronic	1. Train 6426 PHC Outreach Team Leaders (Professional Nurses) 2. Train 33 000 CHWs in phase 2 training programme a. Competence assessment of CHWS trained and certificate of competence awarded to those found competent b. Skill development support programme for those that

diseases • Prevention and management of trauma and violence 2. Introduction to Group based interventions Timeframe: 1 Year (FY 2013-14)	do not meet the competence requirement
Phase 3	**Phase 3 Output**
Focus will be on Training that is aligned to registered occupation qualification that will facilitate CHWs to attain the full range of competencies required for fulfilling the job of CHW Time Frame: 4 Years Year 4 to Year 8 2014-15 to 2018-19	Competence assessments of CHWs against occupational qualification Vocational training programme for CHW to acquire the registered occupational qualification implemented 30% of CHWs to acquire vocational qualification in year 5 of the programme. 50% of CHWs to acquire vocational qualification by year 7 of the programme 70% of CHWs to acquire vocational qualification by year 8 of the programme

The orientation and training will take place in 3 phases the details for each phase of the training plan are outlined in Table 7 above.

3.5.1 Phase I Orientation and Training

Focus on the orientation of community health workers to the health services, the PHC re-engineering model and the role and function of the PHC outreach team. The content of the orientation and training programme is outlined in Table 8.

a. Included in phase 1 is the development of the pre-requisite skills for CHWs who will be appointed onto the PHC outreach teams.
   - basic skills such as community entry, how to conduct a household assessment and home visit, referral of community members to services in the community,
   - child and maternal health and HIV and TB.
b. Following Phase 1 the orientation and training the CHWs will be mentored and supervised by the PHC outreach team leader (professional Nurse).
c. Once the CHWs are found to be proficient and competent in the skills and knowledge of the phase 1 training and can apply these to their everyday work they will then progress to Phase 2 training.

3.5.2 Phase 2 Orientation and Training

Focus on management of the full range of Maternal and Child Health, TB and HIV and Chronic diseases and violence and injury.

3.5.3 Phase 3 Training

Support CHWs to attain formal training towards Registered Qualification for CHWs on the NQF

3.5.4 Criteria for selection of training of CHWs for inclusion into PHC Outreach team (Provinces)

a. Persons who are functionally literate and numerate (Tested through applicant completing the application form in their own writing without assistance)

b. Has at least 1 year experience as a community based health worker (2 years desirable)
c. Has a positive testimonial from previous employer (NPO or DOH)
d. Resides in the area that they will be serving (in areas where there is a shortage of CHWS the "area" could be more broadly defined)
e. Prepared to undergo orientation and training and sign a performance agreement
f. Meet basic competence requirements (assessment conducted after phase 1 orientation training)

Table 8 : Phase 1 Orientation and Training Programme Content

1. An introduction to the health care system including:
   - 1.1 What is PHC
   - 1.2 Services that promote PHC
   - 1.3 Roles of different structures providing PHC
   - 1.4 Referral systems
2. PHC Outreach Team Functioning
   - 1.1 Role of the CHW as a PC outreach team member
   - 1.2 Role of the PHC team
   - 1.3 Teamwork
   - 1.4 Performance, reporting and supervision requirements
   - 1.5 Inter-sectoral collaboration and co-operation
3. Core skills
   - 3.1 Communication and interpersonal skills
   - 3.2 Ethical code (confidentiality, mutual respect, dress code)
   - 3.3 Basic counseling and psycho-social support skills
   - 3.4 Interviewing skills
   - 3.5 Record keeping
     - 3.5.1 Forms, tools, registers, reports
   - 3.6 Problem solving
   - 3.7 Community Entry
   - 3.8 Community Assessment
   - 3.9 Household assessment
   - 3.10 Individual assessment and screening using basic comprehensive screening tools for selected range of health problems including: Developmental assessment (road to health chart), Maternal health (ante natal, postnatal care, PMTCT, breast feeding), NCD hypertension and diabetes
   - 3.11 Health promotion and education
   - 3.12 Basic knowledge and skills to promote Child Health, Maternal Health, and prevent and provide care and support for those households affected HIV and TB

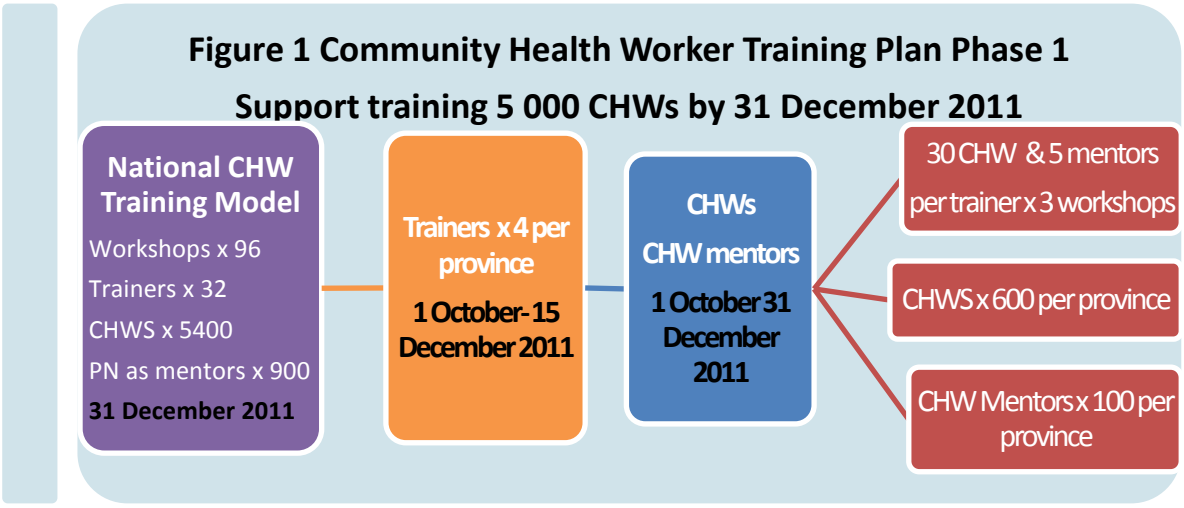
The orientation and training will also cover the use of:

1. National guidelines and protocols for delivery of primary health care outreach services by the CHW
2. Assessment and screening tools for communities, households and individuals (children, women and persons at risk for and or affected by TB and HIV.
3. Health promotion and information material
4. Treatment monitoring and adherence guidelines
5. Basic supportive and psychosocial interventions
6. Referral systems and forms (adapted for local situations)

4 Provincial Implementation Plan Phase 1 Orientation and Basic Foundation Training Programme

The National Department of Health has devised a plan to support provinces to meet the national training target of 5000 CHW by 31 December (outlined in **Error! Reference source not found.**). Provinces that do not have the infrastructure and resources to conduct their own orientation will be supported to reach the national target of 5 000 community health workers by 31 December 2011.

Figure 3 : Community Health Worker Training Plan Phase 1 Support training 5 000 CHWs by 31 December 2011



4.1 Provincial orientation and training plan

4.1.1 A template for implementing phase 1 of the orientation and basic foundation training programme in the provinces was developed to facilitate training of 5400 CHWs and 100 professional nurses distributed fairly across the 9 provinces.

4.1.2 The FPD will make available 4 trainers per province with each trainer committed to provide 2 training workshops per month for the months of October and November and 1 in December. The number of trainers available to each province will adjust to accommodate provincial contexts.

4.1.3 Twenty (20) orientation and training workshops are planned for per province.

4.1.4 The training workshop will be conducted over 10 days followed by 5 days of practical skills training at health facilities and community and household level.

4.1.5 The practical skills training will be facilitated by the PHC outreach team leader (Professional Nurse) who is expected to be part of the 10 day workshop conducted for members of his or her team.

4.1.6 For the training workshops to be conducted according to the schedule provinces will be required to select and identify 30 CHWs and 5 PN for each workshop, arrange a venue and catering. In addition depending on the proximity of training venue to where the CHWs reside the province will have consider accommodation and transport costs for the participants.

4.1.7 It is important for provinces to identify the resources they have available access to implement the programme and to inform CHWs what expenses will be covered.

4.1.8 There are some resources available to cover the cost of trainers, training material, basic equipment and supplies however the provinces will be liable for the cost of venues, catering, travel and accommodation for the participants. These costs will have to be paid by provinces through their training and skills development budget, recruitment budgets for orientation of the newly appointed CHWs.

Table 9 : Provincial Implementation Plan for Orientation and training Programme for Community Health Workers

	October 2011				October 2011				November 2011				November 2011				December 2011			
Workshop Dates	3-14 Oct				17-28 Oct				31 Oct - 11 Nov				14 -25 Nov				28 Nov- 9 Dec			
Training Workshop Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
No. of Days	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Trainers per workshop	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
No. of trainers available to each province	4				4				4				4				4			
Due date for identifying participants (CHWs and PN)	25-Sep 2011				10-Oct 2011				25-Oct 2011				10-Nov 2011				25-Nov 2011			
No. of Community Health Workers per workshop	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30
No. of CHWs for training period (2 weeks) per province	120				120				120				120				120			
No. of Prof Nurses per training workshop	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
No. of PN for training period (2 weeks) per province	20				20				20				20				20			
Venue	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Catering	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37

4.2 Provincial Action Plan for Implementing Phase 1 Orientation and Basic Foundation Orientation

4.2.1 A provincial action plan will be required from each province. To assist provinces an action plan with timeframes and outputs was developed to guide provinces especially to meet the timeframes and the training outputs .

4.2.2 Provinces will be required to submit an action plan to the NDOH by 5 September, present their action plans and report on the progress made with implementation at 14 of September workshop followed by weekly progress reports until 30 November.

4.2.3 In instances where provinces are unable to meet the targets within the specified time frames, provinces that are in a position to increase the number of CHWs available for training will be afforded the opportunity to do so. This will ensure that the set target of training 5 000 CHW is achieved by 31 December 2011.

4.2.4 To ensure that provinces develop their capacity to conduct their own training after 31 December it is important for provinces to identify and make available potential trainers for training. The CHW trainer training will be planned according to provincial needs. The trainers should be at least a professional nurse or a health professional, with some understanding or experience in training and they should be available to conduct training of CHWs.

Table 10 : Provincial Action Plan for Implementing Phase 1 Orientation and Basic Foundation Training 1 October - 31 December 2011

Provincial Actions Required	**TIME FRAME & OUTPUTS**				
	October	**October**	**November**	**November**	**December**
Identify a project manager for selecting and appointing PHC outreach teams by 5 September 2011					
1.Select and appoint CHWs for training	120 CHWs	120 CHWs	120 CHWs	120 CHWs	120 CHWs
2.Allocate CHWs to a training workshop	30 CHWs x 4 workshops	30 CHWs x 4 workshops	30 CHWs x 4 workshops	30 CHWs x 4 workshops	30 x 4 CHWs workshops
3.Select and appoint PN as PHC outreach team members	20 PN	20 PN	20 PN	20 PN	20 PN
4.Allocate PNs to a training workshop	5 PN x 4 workshops	5 PN x 4 workshops	5 PN x 4 workshops	5 PN x 4 workshops	5 PN x 4 workshops
5.Identify and book 4 Local venues suitable for training 35 participants for 10 days	4 local training venues	4 local training venues	4 local training venues	4 local training venues	4 local training venues
6.Finalise catering arrangements	4 catering orders x 10 days x 37 persons	4 catering orders x 10 days x 37 persons	4 catering orders x 10 days x 37 persons	4 catering orders x 10 days x 37 persons	4 catering orders x 10 days x 37 persons
Due dates	**26-Sept 2011**	**10-Oct 2011**	**25-Oct 2011**	**10-Nov 2011**	**25-Nov 2011**
7.Communicate details re: venue and confirmation of number of participants and arrangements made to coordinator at the NDOH for each training period	By 28 Sept 2011	By 12 Oct 2011	By 27 Oct 2011	By 12 Nov 2011	By 27 Nov 2011

ANNEXURE I

Annexure I Scope of Work Community Health Care Worker in providing Ward Based Outreach PHC Services

SUMMARY

Scope of Work for the Community Health Worker

Improve the quality of life of community members by mobilizing for improved access to and delivery of primary health care at local level within the context of an inter-sectoral environment.

1. Promote health and prevent illnesses
2. Conduct community assessments & mobilise around community needs
3. Conduct structured household assessment to identify their health needs
4. Provide psychosocial support to community members
5. Identify and manage minor health problems
6. Support screening and health promotion programmes in schools and ECD centres
7. Promote and work with other sectors & undertake collaborative community based interventions
8. Support continuum of care through service co-ordination with other relevant service providers

1. Promote health and prevent illness • Provide information, • Educate & support for healthy behaviours • Facilitate appropriate home care	**Maternal, Child, Women's Health***	**HIV and TB**	**Chronic, non-communicable diseases**	**Violence and injury**
	Promote key family practices: • infant and young child feeding, • newborn care, • ORT, hand washing, • Nutrition Postnatal care for women	• Promote HIV prevention including HIV testing, condom use, partner reduction, circumcision, STI treatment • Promote voluntary counseling and testing for HIV • Distribute condoms • Advise on TB infection control in the home	Provide information on risk factors for chronic diseases	Provide information and motivational interviewing on substance abuse Provide information on prevention of injuries in homes
2. Conduct community assessments & mobilise around community needs • Compile a community profile • Identify community resources • Identify health & related	Support immunisation, vitamin A and de-worming campaigns	Support HIV educational and treatment literacy campaigns Distribute condoms in non-traditional outlets	Support exercise, diet and smoking cessation campaigns	Support pedestrian safety initiatives Support campaigns to reduce the availability of drugs and alcohol

services				
3. Conduct structured assessment to assess households to determine: • Biographical profile • Information on health status • Level of health and social risk facing households and individuals • Need for services ease of access to health and social services • Identify vulnerable households	Identify households with children under 5 and women of reproductive age Assess need for and facilitate access to key preventive and care services: • early ANC, • immunisation, • growth and development, • HIV screening and care in pregnancy and childhood, • contraception, TOP and cervical cancer screening	Identify persons who at risk of contracting HIV or TB: • refer for HCT and screen for TB symptoms • Provide adherence support and counseling for those of TB and HAART treatment • Facilitate early referral for CD4 testing	Identify adults with hypertension, diabetes and depression Identify persons with other chronic diseases and disabilities Facilitate access to facility or specialist care Provide adherence support and counselling for new and existing persons on treatment	Identify households affected by domestic violence & substance abuse Facilitate access to sexual assault and mental health services Motivate and refer persons to appropriate substance abuse treatment
4. Provide psychosocial support	Support women with post natal depression Support HIV affected & youth and child headed households	Provide an integrated approach to adherence support for TB, HAART and other chronic disease medication in close collaboration with facility based counsellors		Provide post-trauma psycho-social support
5. Identify and manage minor health problems	Identify and treat diarrhoea (ORT and continuous feeding) Identify and refer pneumonia	Identify persons with opportunistic infections and refer Identify and refer persons with sexually transmitted diseases Promote and support good nutrition and nutritional supplements	Provide basic stroke support and rehabilitation Support foot care in diabetics and elderly	Provide basic first aid in the home and community as required
6. Support screening and other programmes in schools and ECD centres	Support school screening programmes and campaigns	Support gender sensitive school & youth HIV prevention programmes	Support school children who are on treatment for chronic health problems (diabetes, asthma)	Identify and support and monitor children that are at high risk of child neglect, domestic violence and abuse and refer to social development services

7. Promote and work with other sectors & undertake collaborative community based interventions • Address intersectoral issues: water sanitation & food security	Facilitate early birth and death registration Facilitate access to social grants child care, disability, old age) and other social services (e.g. OVC, substance abuse)	Participate in intersectoral prevention campaigns: HIV and TB, measles	Facilitate access to social grants, disability, old age	Facilitate access to social services for substance abuse and victims of violence and neglect
8. Support continuum of care through service co-ordination with other relevant service providers	6.1 Assist community members to access services (health and other required services). 6.2 Identify and access resources 6.3 Network and build coalitions with other service providers in the community 6.4 Provide follow-up support and care 6.5 Refer community members to health services and social and other community based services offered by other sectors 6.3 Utilise health system, the services offered at various facilities and refer appropriately			

ANNEXURE II

Annexure II : Competencies for Community Health Workers Providing Ward Based Outreach Services

SUMMARY

A community health worker requires the following competencies to function effectively as a member of the ward based PHC Outreach Team:

Core Competencies

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

Generic Competencies

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

1. Conduct a comprehensive household assessment :	Maternal, Child, Women's Health*	Communicable diseases	Chronic, non-communicable diseases	Violence and injury
• Biographical profile • Information on health status • Level of health and social risk facing households and	a. Conduct a developmental assessment for children b. Understand basic integrated management of childhood illnesses and use of guidelines	a. Understand HIV, TB, the presentation of illnesses, prevention, screening, treatment and support. b. Understand the	a. Understand the manifestation of common chronic health problem and factors that promote and prevent these conditions b. Use basic screening and assessment	h. Identify households affected by domestic violence & substance abuse i. Facilitate access to sexual assault and mental health

individuals • Need for services ease of access to health and social services • Identify vulnerable households	c. Understanding of immunization schedules and reading road to health cards. d. Understand the nutritional requirements for infants (exclusive breast feeding), children and pregnant women e. Knowledge of HIV screening and care in pregnancy and childhood f. Knowledge and understanding of antenatal, post natal care of pregnant women g. Screen for reproductive health problems, sexually transmitted diseases, family planning requirements and termination of pregnancy h. Conduct breast self-examination	requirements for treatment adherence support and promotion of treatment compliance. c. Conduct treatment support groups	tools to screen for risk of chronic health problems c. Understand the special needs of persons with chronic diseases, the disabled and elderly d. Understand the service network and referral systems for service required to support persons with chronic diseases, the disabled and elderly. e. Provide education and support to persons with chronic diseases, the disabled and elderly f. Understand the requirements for treatment adherence support and promotion of treatment compliance for persons with chronic illness. g. Provide adherence support and counselling for new and existing persons on treatment.	services j. Motivate and refer persons to appropriate substance abuse treatment
2. Promote health and prevent illness • **Provide information,** • **Educate & support for healthy behaviours** • **Facilitate appropriate home care**	2.1 Promote early childhood development and stimulation 2.2 Promote and prepare families for parenthood and Effective Parent 2.3 Promote exclusive breast feeding 2.4 Promote accident prevention and safety in the home 2.5 Facilitate basic hygiene and infection control	2.6 Understand the principles of HIV and TB prevention programmes 2.7 Conduct health promotion and prevention campaigns for HIV and TB 2.8 Understand and promote infection control in the home	2.9 Conduct health promotion and prevention campaigns for chronic diseases	2.10 Provide information and motivational interviewing on substance abuse 2.11 Provide information on prevention of injuries in homes
3. Provide psychosocial support	3.1 Psycho social and supportive counselling 3.2 Coping mechanisms and emotional support	3.4 Understand the principles of providing integrated psychosocial and adherence support to persons on TB, HAART and other chronic disease treatment.		3.5 Provide post-trauma counselling

	3.3 Knowledge of post natal blues and depression			
4. Identify and manage minor health problems	4.1 Integrated of childhood illnesses 4.2 Oral rehydration and continuous feeding 4.3 Signs and symptoms of pneumonia		4.4 Manage common health problems that affect persons with disability and the elderly including • foot care • Mobility • Dietary interventions	4.5 Render basic first aid in the home and community
5. Conduct community assessments & mobilise around community needs • **Compile a community profile** • **Identify community resources** • **Identify health and related services available**	5.1 Knowledge and skills for compiling a community profile 5.2 Resource identification 5.3 Develop a service profile 5.4 Formulate a community diagnosis			5.5 Understand community safety strategies 5.6 Understand the effects of and impact of drugs and alcohol abuse
6. Support screening and other programmes in schools and ECD centres	6.1 Conduct basic health screening of children in ECD Centres and primary schools 6.2 Conduct a wellness campaign at a school and ECD Centre			
7. Promote and work with other sectors and undertake collaborative community based interventions • **Address inter sectoral issues: water sanitation & food security**	7.1 Facilitate early birth and death registration 7.2 Facilitate access to social grants child care, disability, old age) and other social services (e.g. OVC, substance abuse)			
8. Advocate for improved health and community services				
9. Conduct health promotion and education sessions for communities and its members				

10. Conduct a home visit	
11. Offer basic first aid and treatment of minor ailments	
12. Understand the principles of PHC and the interventions and services supporting it	
13. Up-to-date knowledge and understanding of the health system, the services offered at various facilities and the referral system	
14. Interview community members and utilise effective interpersonal and communication skills	
15. Demonstrate the ability to assist community members to access services.	
16. Refer community members to health services and social and other community based services offered by other sectors	
Community Health Workers Generic Competencies	
17. **Communication**	17.1 Demonstrates the ability to listen, comprehend, and effectively communicate information both written and orally to all individuals. 17.2 Uses communication and interpersonal skills to initiate, develop and maintain a supportive, caring relationship with community members 17.3 Uses of verbal and written communication appropriately to communicate with community members 17.4 Demonstrates empathy 17.5 Uses appropriate, accurate and non-judgmental language 17.6 Actively listening and attending to client concerns (including body language) 17.7 Paraphrase (reframing) what client says to ensure a mutual understanding 17.8 Ask open-ended questions to solicit client information and give positive reinforcement 17.9 Describe and explain client rights and confidentiality in clear language 17.10 Elicit, document and appropriately use community members responses 17.11 Convey information that is easily understood and appropriate 17.12 Responds timeously and correctly to community member's questions, requests and problems. 17.13 Communicates in a manner that promotes respect and dignity of community members 17.14 Maintains confidentiality of both written and oral communication with community members as well as written records
18. Health Promotion and Education	18.1 Demonstrate skills in presentation of health information: 18.2 Provides and presents information to community members in an appropriate and clear manner. 18.3 Uses written and visual materials that convey information clearly and respectfully to clients, as well as other service providers

		and community residents
	18.4	Speaks and presents information effectively to small and large groups of community members
	18.5	Promote appropriate health information within the community
19. **Team work**	19.1	Identify the structure and purpose of the PHC outreach team
	19.2	Establishes and maintains a good working relationships with team members, supervisors and other community based workers and other colleagues.
	19.3	Understands and respects the roles and skills of all members of the outreach and health and social care teams.
	19.4	Understands the importance and consult with colleagues and other members of the PHC team and other community based workers.
	19.5	Demonstrate understanding of the role of other stakeholders in health care.
	19.6	Participates with members of the health and social care teams in decision making pertaining to health care delivery.
	19.7	Disseminates information on about area of responsibility to other team members.
	19.8	Develop and establish inter-sectoral relationships that promote health care.
	19.9	Functions as an effective team member.
	19.10	Forms alliances after networking with key players when dealing with community health issues and needs.
	19.11	Work effectively in groups with other community workers to understand and promote change
20. **Problem solving**	20.1	Identify problems by recognising the difference between current & ideal situations;
	20.2	Determine possible causes of problems from given sources of information;
	20.3	Request guidance & assistance from others to identify root causes of problems where own analysis is insufficient;
	20.4	Respond to known information;
	20.5	Interpret information if clues are given;
	20.6	Identify several solutions when analysing a problem, under general supervision are given;
	20.7	Identify several solutions when analysing a problem, under general supervision
21. Self-management	21.1	Demonstrates ability to manage and organize one's self, tasks and work environment
	21.2	Display the skills necessary for effective personal planning
	21.3	Has effective time management ability
	21.4	Knowledge and application of the skills necessary for effective goal setting is demonstrated
22. Recording	22.1	Complete household registration forms
	22.2	Information recorded is legible, accurate and relevant
	22.3	Household and community records are updated timeously
	22.4	All interventions rendered are accurately recorded

	22.5 Weekly and monthly reports completed as required 22.6 Complete community and household and individual assessment forms
23. Service Co-ordination	23.1 Ability to identify and access resources 23.2 Ability to network and build coalitions with other service providers in the community 23.3 Ability to provide follow-up

ANNEXURE IIII

Annexure III Employment Contract Community Health Worker (Training Post)

CONTRACT OF APPOINTMENT

Community Health Worker Training Post

AGREEMENT

ENTERED INTO BY AND BETWEEN

THE DEPARTMENT OF HEALTH:

_____

(PROVINCE NAME)

for and on behalf of the

PROVINCIAL DEPARTMENT
(Herein referred to as "Employer")

Represented by the Head of Department

_____

Name of HOD/Delegated Personnel

_____

Indicate portfolio or post

And

_____

(Full name of Community Health Worker)

_____

(South African Identity Number)

Hereafter collectively referred to as "Parties"

EMPLOYMENT CONTRACT FOR A FIXED TERM PERIOD IN ACCORDANCE WITH PART III, G OF CHAPTER 1 OF THE PUBLIC SERVICE REGULATIONS, 2001, READ TOGETHER WITH SECTION 18 OF THE PUBLIC SERVICE ACT OF 1994, AS AMENDED

WHEREBY IT IS AGREED AS FOLLOWS:

1. APPOINTMENT

1.1 The Employer hereby appoints the Employee, who agrees and accepts appointment as a Community Health Worker in terms of the relevant provisions of the Public Service Act, 1994, as amended (hereinafter referred to as the Act), for a period of 1 year (12 calendar months) commencing on the ___day of _____and terminating on the ___day of _____. The Employee's employment and conditions of service shall be governed by the Act, the Public Service Regulations, 2001, as amended (hereinafter referred to the Regulations) and any other legal provisions applicable to the Employee.

1.2 In terms of this Contract-

1.2.1 the Employee (**Community Health Worker**) shall serve the Employer in _____(name of Office, Department, Organisational Component or Provincial Department) at such place as may from time to time be directed by the Employer or any other officer duly authorised thereto in this respect;

1.2.2 the Employee will be responsible for the responsibilities as outlined in the attached Annexure A to this Agreement and shall comply with any statutory obligations applicable to the position;

1.2.3 the employment of the Employee is subject to –
a security clearance of _____ (state confidential, secret or top secret) - and subject **to section 2A. (1) (a) (b) of the National Strategic Intelligence Act, 39 of 1994;** and - the submission by the Employee of original certificates of her/his academic and professional qualifications, service certificates and proof of South African citizenship.

1.2.4 the Employee may be required to perform other duties or to work at other places that may reasonably be required by the Employer; and

1.2.5 any matter arising, which are not specifically provided for herein, shall be dealt with in accordance with the provisions of the Public Service Act, the Public Service Regulations and any other legal provisions applicable to the Employee.

2. REMUNERATION

2.1 The remuneration that the Employee shall receive as from the date of assuming duty as stated in clause 1 above, is a monthly salary of R2 500 per month (inclusion of 37% in lieu of benefits).

2.2 The salary will be payable in 12 equal monthly instalment.

2.3 The general conditions of service and benefits are determined in terms of PSCBC Resolution 3 of 1999 as well as collective agreements in the relevant bargaining council.

2.4 The Employee shall be refunded by the Employer for expenses incurred for travelling to households in the community.

3. TERMINATION OF EMPLOYMENT

3.1 The term of office of the Employee may be terminated in the following ways:

3.1.1 On completing the term of the stipulated contract period (i.e. 12 calendar months).

3.1.2 Discharge in terms of section 17 of the Act.

3.1.3 Death.

3.2 Subject to the provisions of the Act, and the *Labour Relations Act,* 1995, either party may, after consultation and agreement, terminate the Contract before the expiry of the original term of the contract, by giving to the other party one months' notice of termination, which notice shall –

3.2.1 be provided in writing; and

3.2.2 be submitted on or before the last day of a month and take effect on the first day of the succeeding month.

3.3 Should notice of termination be given as contemplated in clause 3.2, the Employer has the right to require the Employee to vacate the office occupied by her/him and to leave the premises of the Department before the expiry of the notice period on a day stipulated by the Employer and not to present herself/himself for duty any time thereafter.

3.4 Should the Employer invoke the provisions of clause 3.3 above, the Employee will still be entitled to all such benefits as contained in the relevant prescripts.

3.5 In the case of inefficiency and misconduct, the Employer may deal with the Employee in accordance with the applicable legislation and any directive issued by the Minister of Public Service and Administration.

4. CONDUCT

4.1 The Employee undertakes to the Employer that she/he-

4.1.1 shall not, without the applicable consent and during her/his employment or at any time thereafter, disclose any record, as defined in section 1 of the Promotion of Access to Information Act, 2000 (Act No. 2 of 2000), that must or may be refused upon a request for access to a record of a public body in terms of that Act, whether or not that Act is in force;

4.1.2 shall not, during her/his employment or at any time thereafter, use any record so defined and obtained as a result of her/his employment, to the detriment of the State, except if it is used in the exercise or protection of any right, or legitimate expectation, conferred by law;

4.1.3 shall-

(i) if so requested by the Employer during her/his employment or on the termination of her/his employment, submit to the Employer any record so defined and in the Employee's possession as a result of her/his employment; and

(ii) not retain any copies of or extracts from such record, except with consent of the Employer; and

4.1.4 she/he shall comply with the prescribed Code of Conduct (Copy of the Code of Conduct attached as Annexure B).

4.2 The Employee-

4.2.1 acknowledges that she/he has carefully considered the provisions of the clause;

4.2.2 agrees that this clause is, after taking all relevant circumstances into account, reasonable and necessary for the proper protection of the interests of the Employer and the Government of the Republic of South Africa and that if she/he should at any time dispute the reasonableness of this clause, then the onus of proving such unreasonableness will be upon her/him; and

4.2.3 acknowledges that she/he entered into this Contract freely and voluntarily and that no circumstances exist and/or existed for her/him alleging either now or at any future time that she/he was at a disadvantage in agreeing to the restraints set out in this clause or was other than in an equal bargaining position with the Employer in agreeing to such restraints.

5. ADDITIONAL TERMS AND CONDITIONS

5.1 The Employee shall enter into a Performance Agreement with the Employer, linked to the duration of the contract, which shall include at least the following:

5.1.1 A Performance Assessment tool that would outline the Key Performance Arrears in accordance with the Job Description of a Community Health Care Worker.

5.2 The Performance Agreement shall be revised if, at any time during the period, the work or environment of the Department (Unit, Directorate, Branch, Component) is so altered (whether as a result of Government or management decision or otherwise) that the contents of it are no longer appropriate.

5.3 This Contract is directly linked to the appointment period of the Employee;

5.4 In the event that the Employee does not perform satisfactorily in relation to the requirements of her/his performance agreement, the Employee acknowledges that the Employer may deal with her/him, in accordance with the procedure contained in the relevant labour legislation and any other directive issued by the Minister.

6. GENERAL

6.1 Good faith

In the implementation of this Contract, the parties undertake to observe the utmost good faith and they warrant in their dealing with each other that they will

neither do anything nor refrain from doing anything that might prejudice or detract from the rights, assets or interests of each other.

6.2 Applicability of the Act

Any matters arising from this Contract, which are not specifically provided for herein, shall be dealt with in accordance with the provisions of the Act, as amended, the aforesaid Regulations and other relevant legislation.

6.3 Interpretation of Agreement

The interpretation of this Contract shall be governed by the laws and legal principles applicable in the Republic of South Africa.

6.4 Jurisdiction of courts

6.4.1 The Employee submits to the jurisdiction of the Courts of the Republic of South Africa in the event of any legal proceedings arising from the provisions of this Contract.

6.4.2 It shall not be a breach of the Contract if a party to this Contract is prevented from or hindered in the performance or observance of its obligations hereunder by any Act of Parliament or other action of the State or by any cause or event outside the control of that party.

6.5 Variation

6.5.1 The Contract constitutes the whole of the agreement between the parties to this Contract relating to the subject matter of this Contract, and save as otherwise provided, no amendment, alteration, addition or variation of any right, term or condition of this Contract will be of any force or effect unless reduced to writing and signed by the parties to this Contract.

6.5.2 The parties agree that there are no other conditions, warranties or representations, whether oral or written and whether expressed or implied or otherwise, save those contained in this Contract, the Act, the Regulations and other relevant legislation (e.g. Government Employees Pension Fund Law).

6.6. Waiver

6.6.1. No waiver of any of the terms and conditions of this Contract will be binding for any purpose unless expressed in writing and signed by the party giving the same, and any such waiver will be effective only in the specific instance and for the purpose given.

6.6.2. No failure or delay on the part of either party in exercising any right, power or privilege precludes any other or further exercise thereof or the exercise of any other right, power or privilege.

7. Notice and Domicilium

7.1 The parties choose as their respective *domicilium citandi et executandi* for the purpose of legal proceedings and for the purpose of giving or sending any notice provided for or necessary in terms of this Contract, the following addresses-

	Employer	Employee
Physical address	_____	_____
Postal address	_____	_____
Telefax Number	_____	_____

provided that a party reports any change of her or his *domicilium* to any other physical address, postal address or telefax number by written notice to the other party. Such change of address will be effective seven days after receipt of notice of the change of *domicilium*.

7.2. All notices to be given in terms of this Contract will -

7.2.1 be provided in writing; and

7.2.2 be delivered or sent by prepaid registered post or by telefax; and

7.2.3 if delivered, be presumed to have been received on the date of delivery; or

7.2.4 if sent by prepaid registered post, be presumed to have been received within three business days of posting unless the contrary is proved; or

7.2.5 if sent by telefax, be presumed to have been received on the first business day following the date of sending of the telefax unless the contrary is proved.

SIGNED by the Employer at _____ on the ___day of

_____

AS WITNESSES:

1._____

2._____

EMPLOYER (EXECUTING AUTHORITY

ON BEHALF OF THE GOVERNMENT

OR HER/HIS DELEGATEE)

2. _____

SIGNED by the Employee at _____ on the ____ day of

_____

AS WITNESSES:

1. _____

2. _____

ANNEXURE IV

Annexure IV Community Health Worker Job Description

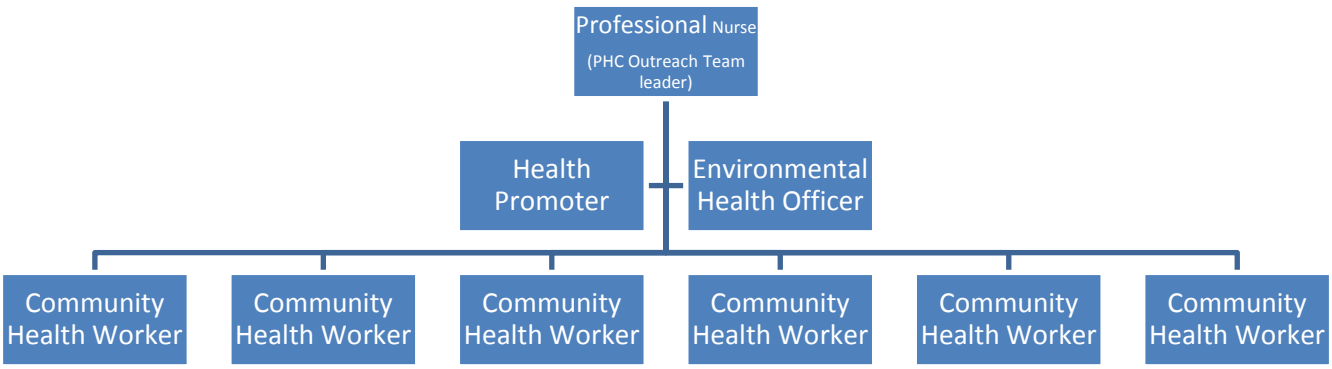
JOB DESCRIPTION

Name	Persal Number

A. JOB INFORMATION SUMMARY

Job Title	Community Health Worker (Training Post)
Occupational Specific Dispensation	N/A
Job Level	Level 1
Post class	Health and Support
Date	
Location	Various Communities
Component	
Post report to	Professional Nurse
Job Classification Code 05	

B. HIERARCHICAL POSITION OF POST



C. JOB PURPOSE (Linked to Strategic Plan)

A community health worker creates a bridge between the providers of formal health services, community services, social agencies and vulnerable populations within the community. Community health workers are trained to carry out basic assessments of communities, households groups and individuals, provide basic health education and referrals for a wide range of services, and support and assist in navigating the health and social services system. In addition community health workers can build community capacity through support groups and education campaigns and programs.

D. MAIN OBJECTIVES (Key Performance Areas (KPA's)

	MAIN OBJECTIVES (Key Performance Areas (KPA's))	INDICATORS (indicating how well standards were achieved)	%
1	1. **Provide information, education & support for healthy behaviours and appropriate home care** 1.1 Promote key family practices: 1.2.1 Infant and young child feeding, 1.2.2 New born care, 1.2.3 ORT, hand washing, 1.2.4 Nutrition 1.2.5 Antenatal and postnatal care for women 1.3 Promote HIV prevention including HIV testing, condom use, partner reduction, circumcision, STI treatment 1.3.1 Promote voluntary counseling and testing for HIV 1.3.2 Distribute condoms 1.3.3 Advise on TB infection control in the home 1.4 Provide information on risk factors for chronic diseases 1.5 Provide information and motivational interviewing on substance abuse 1.6 Provide information on prevention of injuries in homes	a) Health education at an individual, group and community level conducted according to protocol b) Relevant and appropriate health information provided to individuals, household, groups and local community c) Records of health education provided is kept and updated d) Identifies health education interventions and develops a plan for delivery of health education to households, communities and local community	20%
2	**2 Carry out a Community Assessment** 2.1 Identify community structures and resources 2.2 Identify community health needs 2.3 Plan community based activities according to identified needs of communities 2.2.1 Support immunisation, vitamin A and de-worming campaigns 2.2.2 Distribute condoms in non-traditional outlets 2.2.3 Support HIV educational and treatment literacy campaigns 2.2.4 Support exercise, diet and smoking cessation campaigns 2.2.5 Support pedestrian safety initiatives 2.2.6 Support campaigns to reduce the availability of drugs and alcohol	a) Compiles a profile of community worked in according to a template b) Information gathered using various sources of information c) Community based interventions are based on findings of assessment d) Contributes to the assessment of community need e) Community members are mobilized to address community problems f) Community based interventions implemented and reported	5%

	MAIN OBJECTIVES (Key Performance Areas (KPA's))	INDICATORS (indicating how well standards were achieved)	%
3	**3 Conduct household assessments & identify those at risk and high risk** 3.1 Conduct structured household visits 3.2 Biographical profile 3.3 Information on health status 3.4 Level of health and social risk facing households and individuals 3.5 Need for services ease of access to health and social services 3.6 Identify vulnerable households	a) 100% of Households in catchment area mapped b) Household visits conducted according to a schedule c) Purpose and tasks to be conducted to be conducted are planned prior to the visit d) Appointments for household visits are made e) All forms, screening tools and household records are available and completed accurately f) The household visit register is completed and updated g) Household visit is conducted within the allocated time h) Household profile compiled according protocol i) High and at risk households and individuals identified using screening tool j) Health and social services required by households identified	30%
4	**4 Provide psychosocial support** 4.1 Support women with post natal depression 4.2 Support HIV affected & youth and child headed households 4.3 Provide an integrated approach to adherence support for TB, HAART and other chronic disease medication in close collaboration with facility based counsellors 4.4 Provide post-trauma psycho social su*p*port	a) Pregnant and post natal women, child headed households, persons HIV positive, TB and chronic diseases and victims of trauma and violence are supported b) Comprehensive treatment adherence support provided to individuals and groups on ART and TB, chronic illnesses treatment	10%
5	**5 Identify and manage minor health problems** 5.1 Identify and treat diarrhea (ORT and continuous feeding) 5.2 Identify and refer pneumonia 5.3 Identify persons with opportunistic infections and refer 5.4 Identify and refer persons with sexually transmitted diseases 5.5 Promote and support good nutrition and nutritional supplements 5.6 Provide basic stroke support and rehabilitation 5.7 Support foot care in diabetics and elderly 5.8 Provide basic first aid in the home and community as required	a) Minor health problems during individual and household screening identified b) Individual and household record interventions for minor health problems provided and maintained *c)* Minor health problems managed according to protocols	10%
6	**6 Support screening and other programmes**	a) Available for PHC outreach team	5%

	MAIN OBJECTIVES (Key Performance Areas (KPA's))	INDICATORS (indicating how well standards were achieved)	%
	in schools and ECD centres	site visits to Schools and ECD b) Screening assessments carried out according to protocols c) All problems identified reported to team leader	
7	**7 All community, household and individual assessments, plans and interventions recorded** 7.1 Contribute to and update community profile record 7.2 Compile a map and a register of households 7.3 Compile individual records of all household and individual assessments, plans interventions and referrals	a) All required documentation and reports are completed accurately and submitted according to deadlines b) Strict confidentiality is maintained for all information and documents pertaining to area of work c) All information and documents are kept safely and secure from unauthorized access	10%
8	**8 Support continuum of care** 8.1 Promote and work with other sectors & undertake collaborative community based interventions **8.2** Address intersectoral issues: water sanitation & food security		10%

E: COMPETENCIES

KNOWLEDGE	CORE SKILLS	PERSONAL ATTRIBUTES	EXPERIENTIAL COMPETENCY
1. Community based care 2. Child Health 3. Basic First Aid 4. Community assessment 5. Household assessment 6. Health Promotion and Education 7. Health system (PHC, district and regional level health services) 8. Referral systems for health and social services 9. Supportive counseling 10. Treatment Adherence Counseling 11. Communicable diseases (HIV, TB, Malaria) 12. Non-communicable diseases (mental health, Hypertension, diabetes)	1. Numeracy 2. Literacy 3. Basic Communication 4. Report writing 5. Problem solving 6. Health promotion and education 7. Service co-ordination 8. Self-management 9. Teamwork 10. Assertive 11. Computer Literacy (desirable)	1. Responsive 2. Pro-active 3. Trustworthy 4. Respectful 5. Patient 6. Kind 7. Reliable 8. Professional 9. Accuracy 10. Flexible 11. Has Initiative 12. Cooperative 13. Team player 14. Supportive 15. Non-judgemental	1. Educational Qualification: 1.1 Certificate of completion for: 59 or 69 Day Training Programme 1.2 Qualifications: General Education and Training Certificate: Ancillary Health Care (NQF Level 1) or National Certificate: Community Health Work (NQF Level 2); or National Certificate: Community Health Work (NQF Level 3); or Further Education and Training Certificate: Community Health Work (NQF Level 4) 2. Experience: 1 year experience working in community health services

F. DELEGATIONS

LABOUR RELATIONS DELEGATIONS	HUMAN RESOURCES DELEGATIONS	FINANCIAL DELEGATION	SIGNING AUTHORITY	PROCUREMENT DELEGATIONS
None	None	None	None	None

G. AMENDMENTS TO THE JOB DESCRIPTION

The Head of Department or his/her nominee reserves the right to make changes and alterations to this job description, as he/she deems reasonable in terms of changes in the job content in line with the strategic objectives of the Department, after due consideration with the post holder.

H. PERFORMANCE INSTRUMENTS

The performance instrument of the post holder should be read as an extension to the job description.

I. JOB DESCRIPTION AGREEMENT

We, the undersigned, agree that the content of the completed job description provides an accurate outline and picture of the job as expected from the incumbent in the job:

Supervisor:	Job Incumbent:
Rank:	Rank:
Date:	Date:
Accepted	Signature:
Additional comments/proposed time of revision of the job description, only if there are changes in the job content. Date of revision:	

ANNEXURE V

Annexure V Road Map

1 Timeline for Implementing the Facility-Based Outreach Team: First Steps for Provinces, Districts and Facilities

Province	Time Frame	District/sub-district	Time Frame	Facility	Time Frame
1. Establish provincial implementation teams	Sep 2011				
2. Set up employment systems	Sep 2011				
3. Set up supervision, reporting and monitoring systems for outreach teams	Sep 2011				
4. Develop /refine protocols for referrals	Nov 2011				
5. Develop mechanisms for identifying outreach team supervisors	Sep 2011				
6. Develop recruitment and selection tools for CHWs	Sep 2011				
7. Establish training infrastructure	30 Sept 2011				
8. Plan phased implementation with districts and sub-districts	Sep 2011	1. Plan phased implementation in the district and sub-districts	Sep 2011		
9. Meet with civil society organisations providing health services	Sep 2011	2. Meet with civil society organisations providing health services in the district/sub-district	Sep 2011	1. Meet with civil society organisations providing health services	Sep 2011
		3. Assess needs in each area - and determine the composition of each team	Sep 2011	2. Determine local needs – and the composition of the outreach team	Sep 2011
10. Authorise the choice of facilities and composition of each team	Sep 2011				
		4. Distribute guidelines for systems (supervision, data collection)	October – November 2011	3. Set up systems following provided guidelines	Oct 2011
		5. Set up selection committees	Sep 2011	4. Set up selection committee	Sep 2011
		6. Recruit and select staff for outreach team	Sep – Oct 2011	5. Recruit and select staff for outreach team	Sep – Oct 2011
11. Keep records of all staff and ensure they are paid	On-going activity	7. Contract newly appointed staff	Oct – Dec 2011	6. Contract newly appointed staff	Oct – Dec 2011

		8. Induct and orientate staff – and facilitate initial top-up training (600 CHWS and 100 PN)	Oct -Dec 2011	7. Induct and orientate new staff - and facilitate initial top-up training	Oct –Dec 2011
12. Co-ordinate training	Oct –Dec 2011	9. Facilitate top-up training	14 Oct -Dec 2011	8. Ensure staff attend top-up training	Oct–Dec 2011
13. Monitor progress	15 Decembe r 2011	10. Monitor progress	15 December 2011	9. Monitor progress	15 December 2011

2 High Level Roadmap for Provinces Implementing PHC Outreach Teams

1. Establish provincial implementation teams
2. Set up employment systems
3. Set up supervision, reporting and monitoring systems for outreach teams
4. Develop /refine protocols for referrals
5. Develop mechanisms for identifying outreach team supervisors
6. Adapt national recruitment and selection tools for CHWs and HCs
7. Establish training infrastructure
8. Plan phased implementation with districts and sub-districts
9. Meet with civil society organisations providing health services
10. Authorise the choice of facilities and composition of each team
11. Keep records of all staff and ensure they are paid
12. Co-ordinate training
13. Monitor progress

These are elaborated on below.

3. Detailed Road Map -Provinces

3.1 Establish provincial implementation teams

- Set up provincial implementation teams whose role will be to both drive the implementation process and support districts and sub-districts as they do so.

3.2 Set up employment systems

- Create the posts on the HR systems e.g. payroll (PERSAL)
- Ensure there is a supply of national contract forms adapted to the province, if necessary
- Ensure that HR staff are informed of the new posts and of recruitment and selection timelines – so that newly recruited staff are informed of what paperwork to submit so they are paid

3.3 Set up supervision, reporting and monitoring systems for outreach teams

- Clarify lines of accountability of the outreach teams as a whole.
- Set up supervision, reporting and monitoring systems for outreach teams through consultations with heads of facilities (through sub-district/ district-level meetings?) – e.g.
  - develop guidelines for how line management will work – in the field and in the facilities

  - identify mechanisms through which CHWs and HCs report to their supervisors
  - identify mechanisms for how referrals to and from the facility will work
- Develop an approach to monitoring that helps to rectify problem as they arise and harvests local systemic lessons

3.4 Develop /refine protocols for referrals

- Customise guidelines for referrals – both to and from facilities by CHWs and HCs.

3.5 Develop mechanisms for identifying outreach team supervisors

- Identify mechanisms for each facility to assess current staff vis-a-vis new PHC structure – particularly with respect to who will supervise the outreach team.

3.6 Develop recruitment and selection tools for CHWs and HCs

- Draft advertisements for outreach team members, professional nurses and CHWs (based on national guidelines)
  - Establish and orientate local-level selection teams
  - Review the national criteria for selection of CHWs and HCs - and determine if any factors need to be customised for local conditions – being aware of needing to lower the bar in some instances, but not in ways that will undermine service delivery
  - Identify HR staff members to train selection committees in fair and representative selection processes

3.7 Establish training infrastructure

- Review national guidelines for induction / orientation of newly-appointed CHWs – to make them relevant to your province. Identify areas where the sub-district / facility will need to customise them further.
- Identify a unit in the provincial department that will co-ordinate and oversee the orientation and training to be offered until approximately mid-2012 when the new qualifications will become available.
- Review 'top-up' training modules made available by the National Department – and prioritise those that most affect the province generally.
- Identify training providers who could be contracted to offer this 'top-up' training as well as full course for entirely inexperienced employees.

3.8 Plan phased implementation with districts and sub-districts

- Assess the budget available and costs incurred in selecting, employing and training CHWs and HCs
- Identify sub-districts which may be most able and resourced to implement the outreach teams within the larger PHC system – to enable 'quick wins as well as lessons to be learned
- Consult districts and sub-districts regarding their (ideal) timing for implementation, briefing them regarding what this will entail
- Discuss doing local community audits

3.9 Meet with civil society organisations providing health services

- Meet with civil society organisations providing health services – particularly those whose staff you are hoping to recruit – on a district/sub-district basis.

3.10 Authorise the choice of facilities and composition of each team

- Receive recommendations from districts regarding
  - which facilities to be prioritised for implementation; and
  - the composition of each outreach team (based on the local burden of disease, the nature of the area, distances etc)
  - the number of households (CHWs) and clients(HCs) that can feasibly be seen each month.
- Confirm there is budget available for this implementation.

3.11 Keep records of all staff and ensure they are paid

- Receive contracts of newly appointed staff from the district office and process them as for all state employees.
- Where newly appointed staff's starting dates are near monthly pay day, ensure they are actually paid.

3.12 Co-ordinate training

- Once selection of some staff for outreach teams has been completed, ask Districts for a list of training needs – and arrange and co-ordinate locally accessible training.
- Ensure that districts / sub-districts submit records of who was trained in what – and keep a database of training in this period.

3.13 Monitor progress

- Monitor the progress of the implementation of outreach teams - within the larger context of delivering PHC
- Engage in consultations with districts/sub-districts regarding concerns and challenges – and record these with a view to refining the systems

4. Detailed Roadmap: Districts / Sub-Districts

4.1 Plan phased implementation in the district and sub-districts

- Meet with Province to identify sub-districts which may be most able and resourced to implement the outreach teams within the larger PHC system – to enable 'quick wins as well as lessons to be learned
- Consult sub-districts regarding their (ideal) timing for implementation, briefing them regarding what this will entail
- Discuss doing local community audits

4.2 Meet with civil society organisations providing health services

- Participate /call a meeting with civil society organisations providing health services - particularly those whose staff you are hoping to recruit – on a district/sub-district basis. Discuss the overall plan for revitalizing primary health care and the role of outreach teams in particular, and how this will affect them and their staff.

4.3 Assess needs in each area - and determine the composition of each team

- Determine how many CHWs and HCs are needed in each facility, based on various local factors – especially
  - the burden of disease
  - the nature of the area (urban, peri-urban, rural) and the density of housing and distances this implies
  - the number of households (CHWs) and clients(HCs) that can feasibly be seen each month

  This can be done in a variety of ways - one of which is to involve the sub-district, facilities and NPOs working the area in doing a community audit.
- Convene and participate in community audit.
- Make recommendations to the province regarding the composition of the outreach team for each facility in your area – as well as which facilities should be prioritised for early implementation

4.4 Distribute guidelines for systems

- Customise the provincial guidelines regarding
  - supervision
  - data collection
  - monitoring
  - referrals – both to the facilities by CHWs and HCs, and to HCs from the facilities and hospitals.

  to suit the local conditions and existing systems in the district/sub-district
- Distribute to facilities

4.5 Set up selection committees

- Identify sub-district staff to participate in selection of outreach team staff
- Convene facility-level selection committees

- With HR staff from the province, facilitate the training of selection committee procedures, including reviewing selection criteria and the testing procedures

4.6 Recruit and select staff for the outreach team

- Participate in identifying / recruiting and selecting outreach team supervisor (a professional nurse)
- Ensure that application forms and tests provided by the province are available at the facility-level selection processes
- Secure the availability for the selection process of people in the district/sub-district who can act as assessors and moderators for the assessment process for CHWs and HCs
- Distribute notices (using standard wording provided by the province) to all local civil society organisations who employ some form of community-based care worker in each facility's 'catchment' area – with a view to recruit CHWs and HCs from their staff.
- Participate in selection committee (incl. testing) – and in deciding who to employ as CHWs and HCs.
- Check shortlisted applicants' security records - as required by the contract.

4.7 Contract newly appointed staff

- Ensure signed contract received and send to province for payroll and record purposes

4.8 Induct and orientate staff – and facilitate initial top-up training

- Check that provincially-customised guidelines for induction/orientation are distributed to facilities who are about to select staff for their outreach teams – and have them customise it for their local area.
- Convene and facilitate induction of outreach team supervisors and CHWs and HCs. (This to include basic 'top-up' training that enables each cadre to start work – e.g. household surveys for CHWs and protocols etc. for HCs.)

4.9 Facilitate top-up training

- Send names of newly appointed outreach teams supervisors to the provincial training co-ordinator – to facilitate their attendance at supervisory training.
- Compile a list of training needs identified during selection at various facilities and submit to provincial training co-ordinator – noting the priority areas wrt burden of disease in each area.
- Keep and submit to province records of who was trained in what – and keep a database of training in this period.

4.10 Monitor progress

- Monitor the progress of the implementation of outreach teams - within the larger context of delivering PHC
- Engage in consultations with the facilities and the province regarding concerns and challenges – and record these with a view to refining the systems

5 Detailed Roadmap: Facilities

5.1 Meet with civil society organisations providing health services

- Participate in a meeting – called by the district/sub-district - with civil society organisations providing health services - particularly those whose staff you are hoping to recruit.

5.2 Determine local needs – and the composition of the outreach team

- Participate in community audit – to assess the burden of disease, numbers of households, distances etc.
- Respond to any consultation with the district regarding whether or not your facility should be prioritised for early implementation
- Participate in compiling the district's recommendations to the province regarding the composition of the outreach team for your facility.

5.3 Set up systems following provided guidelines

- Receive guidelines from the district office on
  - supervision
  - data collection
  - monitoring
  - referrals
  - treatment and management guidelines
- Customise these to suit your facility – without losing the intention and outputs

5.4 Set up selection committee

- Approach community leaders and NPOs to participate in the selection committees of outreach team staff
- Identify staff member to participate in facility-level selection committees of outreach team staff.
- Attend training of selection committees

5.5 Recruit and select staff for outreach team

- Participate in identifying / recruiting and selecting outreach team supervisor (a professional nurse)
- Distribute notices to all local civil society organisations who employ some form of community-based care worker in each facility's catchment' area – with a view to recruit CHWs from their staff.
- Participate in selection committee – and in deciding who to employ as CHWs
- Send list of shortlisted applicants to district office for their security checks.

5.6 Contract newly appointed staff

Liaise with provincial office to contract people who are being appointed.

5.7 Induct and orientate new staff - and facilitate initial top-up training

- Customise guidelines for induction/orientation – received from the district/sub-district - for your local area.

- Liaise with district/sub-district office re convening and facilitating induction of outreach team supervisors and CHWs and HCs. (This to include basic 'top-up' training that enables each cadre to start work – e.g. household surveys for CHWs and protocols etc.)
- Participate in induction of outreach team supervisors and CHWs .

5.8 Ensure staff attend top-up training

- Send names of newly appointed outreach teams supervisors to the District – for them to attend supervisory training.
- Hear from the provincial training co-ordinator re the course schedule for training needs identified during selection to be met.

5.9 Monitor progress

- Monitor the progress of the implementation of outreach teams - within the larger context of delivering PHC
- Engage in consultations with the sub-district regarding concerns and challenges – and record these with a view to refining the systems