

Progress in the establishment of Ward-based Outreach Teams: experiences in the North West Province

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This chapter briefly describes the implementation of the Ward-based Outreach Teams (WBOTs) in the North West Province. The authors then highlight some of the findings of a rapid assessment of provincial and district implementation of Ward-based Outreach Teams conducted in the province during December 2012 and January 2013. The purpose of the chapter is to describe features of implementation that enabled the early uptake of the WBOTs in the province and to identify factors impacting on sustainable implementation that have relevance across the country.

There has been a steady growth in roll-out and implementation of the PHC re-engineering strategy since 2011. By March 2014, 227 WBOTs (involving 1 643 community health workers and 201 team leaders) were functioning across the province. Implementation strategies included the establishment of a provincial task team, planning which was informed by a number of data-gathering exercises, a piloting process, implementation of a monitoring and evaluation system, development of supportive partnerships, and training of teams and team leaders.

The rapid assessment found high levels of knowledge and ownership of the strategy across the province, but also concerns around its future. Based on the North West experience, the authors draw out a set of factors which will influence the sustainability of the WBOT strategy across the country. These strategies include making provision for: adequate financing, evidence-informed planning and implementation, provincial and district governance, communication and dialogue, appropriate partnerships and operational research on WBOTs.

Although it is too early to comment on sustainability or impact, pilot Ward-based Outreach Teams have been established in all 19 sub-districts of the province, household profiling and registration completed, and the process of household follow-up visits initiated.

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Introduction

Following the Alma Ata Conference in 1978,¹ a number of countries formulated policies to entrench the principles of “health care for all” and align their plans with that of the primary health care (PHC) framework, albeit with considerable diversity in country experiences and approaches.²

Common features of these policies included coherent and consistent efforts towards the development of integrated health systems, the participation of communities through structures at different levels, deployment of community health workers (CHWs), and a focus on intersectoral actions to address the determinants of targeted major health problems.

In 2010, the Minister of Health proposed the Re-engineering of PHC³ in South Africa through a strategy constructed around a three-pronged approach to achieving a population-based family health programme. In this model, the focus of healthcare delivery would be on communities and families with a specific emphasis on health promotion and prevention. Three streams form the backbone of the PHC Re-engineering Strategy, namely: Ward-based PHC Outreach Teams (WBOTs), School Health Teams and District Clinical Specialist Teams, with District Management Teams, Sub-District Management Teams and the Chief Executive Officers (CEOs) of district hospitals being the drivers of health service delivery to communities.

The guideline for Ward-based Outreach Teams recommends that a team comprise six community health workers (CHWs), a Professional Nurse (as team leader) and one environmental health and health promotion practitioner, all of whom are linked to a PHC clinic. The intention is for these teams to work together to promote health and prevent disease through a variety of interventions based on the concept of a healthy individual, a healthy family, a healthy community, and a healthy environment.³

The successful implementation of a policy with such system-wide effects entails developing new goals, forms of engagement with households, service delivery roles, and relationships between players within the primary health care system.⁴ Achieving such changes requires the buy-in of a considerable number of actors, the mobilisation of additional resources, development of new systems, and significant changes in the orientation and everyday practices of frontline providers.

This chapter briefly describes the implementation of the WBOTs in the North West Province (NW) and then highlights some of the findings of a rapid assessment of provincial and district implementation of WBOT conducted in the province in December 2012 and January 2013. As an early adopter of the WBOT model of the National Department of Health, the North West Province offered an opportunity to explore key successes and challenges of the model. The chapter concludes with a reflection of critical issues related to the sustainability of WBOTs.

Profile of the North West Province

The North West Province has a population of approximately 3.5 million people and is largely a rural province. The province is divided into four districts (Dr Ruth Segomotsi Mompati, Dr Kenneth Kaunda, Ngaka Modiri Molema and Bojanala) and has a well-established district health system, more than 300 clinics and community health

centres, and 22 hospitals. Expenditure on PHC is above the national average (R831 vs R780 per capita in 2012/13), even though total health expenditure per capita (and equitable share allocation) in the province is one of the lowest in the country.⁵

The North West's health indicators tend to be average by national standards: its inpatient early neonatal mortality rate in facility is 10.475 per 1 000 live births, slightly higher than the national average of 10.2 per 1 000 live births, while its TB treatment completion rate in 2010 was slightly lower than the national average: 74.8% vs 78.9%, prompting a number of interventions in the province in 2011.⁵

Implementation process

The PHC Re-engineering Strategy was officially introduced in the North West Province in May 2011 at a high-level meeting attended by senior staff at district, provincial and national levels. Strategic partnerships were also developed with non-governmental and donor organisations working in the province. A provincial PHC re-engineering task team with set terms of reference was established. The provincial task team consists of the Chief Director (CD): District Health Services (DHS) from each district, and provincial managers from the Directorates for Strategic Programmes, District Health System (DHS), Hospitals, Finance, Communication and Human Resources (HR). The team was initially responsible for spearheading a number of initiatives in preparation for the implementation of the strategy and continuing to plan and recommend for all three streams. These initiatives included developing selection criteria for nurses and CHWs to lead and participate in the outreach teams respectively, identification of implementing wards as pilot sites and developing a provincial communication strategy. It was decided to establish at least one WBOT in all sub-districts and a total of 24 pilot sites, were identified in October 2011.

Related working groups and subcommittees were also established to advance the application of the task team's decisions. While the task team was empowered to take relevant provincial-level decisions, a channel for reporting and escalating problems through the management chain was also developed.

The structure and organisation of the task team, particularly the inclusion of district managers, and the identification of dedicated champions at provincial level and in each district, provided focal points for project management at all levels of the system and facilitated the effective communication of a uniform message across health structures.

A costed provincial PHC re-engineering plan was drawn up with districts taking responsibility for developing their plans and activities. All four districts integrated the PHC re-engineering project into their District Health Plans (DHPs) and identified a focal person to co-ordinate the activities of the three streams and contribute to the monthly reporting system.

Using evidence for planning

An evidence-informed approach to planning and roll-out was made possible by a number of specific data-gathering exercises at the start of implementation. One of these was a baseline audit of all categories of health caregivers linked to the North West Department

of Health through non-governmental organisations (NGOs). The audit established that there were 5 167 health care givers providing mainly home-based care and TB DOTS (Directly Observed Treatment Strategy), 80% of whom had no accredited qualification, and 25% of whom had received no stipends.^a Using the audit findings, an electronic database of CHWs was created for the provincial DoH Human Resources (HR) directorate to enable selection of CHWs for pilot sites. The database information also facilitated the development of costed operational and training plans, to ensure smooth disbursement of stipends.

GIS maps indicating geographic location of wards, available local services and health resources of all wards being serviced by WBOTs were created by a health systems strengthening NGO, Health Systems Trust. These were used to inform the household profiling and registration process, using nationally developed M&E tools. The registration process allowed for the profiling of basic household demographic and socio-economic status, and included simple household screening to identify “vulnerable” households for referral and/or follow-up. The tools also include reporting forms that are used to document follow-up visits, referrals, daily counts and monthly summaries. Eighteen community dialogues were also conducted as part of the social mobilisation to introduce WBOTs and market the services in all areas where pilot sites were established.

When the province started implementing the PHC Re-engineering Strategy in 2011, 24 functional teams were established as a pilot. One thousand five hundred CHWs were trained in Phase 1 Orientation Basic Foundation Training: Maternal, Neonatal and Child Health (MNCH), HIV and Aids and TB, and Basic Skills. Seventy-eight Professional Nurses were trained to be Team Leaders on Phase 1 Basic Foundation and supervision, performance management, mentoring and coaching. Nine Master Trainers and 25 Trainers for CHWs were trained and a two-day workshop on leadership and supervision was conducted with support from development partners. As at March 2014, 227 Ward-based Outreach Teams (1 617 CHWs and 206 PNs/TL) had been established.^b

Most of the 24 team leaders selected for the initial pilot phase were released from clinical work to lead their teams on a full-time basis and CHWs were appointed on a 12-month fixed-term contract as of April 2013. Challenges around communication between CHWs and team leaders and travel for team leaders into communities were resolved by an allocation of R100 per month for telephone calls and reimbursement for transport.

Monitoring and evaluation

With the Department of Health’s National Health Information System (NHISSA) as the focal point and overall steward of the process, a consortium of organisations (University of the Western Cape, Health Information Systems Programme, Health Systems Trust, Medical Research Council of South Africa) developed and piloted a nationally standardised M&E system for Ward-based Outreach Teams, integrated into the District Health Information System (DHIS).

The principle on which the monitoring and evaluation system was based was the need to integrate it with existing data and data flows, minimise data collection, focus on essential data, and avoid

duplication of information already collected at facility level.

A standardised set of tools was developed, consisting of:

- A routine monthly reporting system, based on a one-page, simple tick sheet, aggregated on a monthly basis and submitted with the facility-level data into the DHIS. This system provides activity reporting along 15 indicators (Table 1) (of which seven have been included in the National Indicator Data Set – NIDS). This includes coverage of households (registration and follow-up) by outreach teams, head counts (<5 and 5+ years), supervisory rates, nature of activity (e.g. antenatal, child health, chronic diseases), and referral rates.

Table 1: Indicators from monthly reporting system

	Indicator Name
1	Outreach household visit registration coverage (annualised)
2	Outreach household registration visit rate
3	Outreach household follow up visit rate
4	Outreach household supervised visit rate
5	Outreach household antenatal care rate
6	Outreach household postnatal care rate
7	Outreach household child under 5 years health care rate
8	Outreach household adherence support rate
9	Outreach household clients home based care rate
10	Outreach household clients referred to health facility rate
11	Outreach household clients referred to social services rate
12	Outreach household clients referred to home-based care rate
13	Outreach household client 5 years and older coverage
14	Outreach household client under 5 years coverage
15	Outreach household – health facility back referral rate

- A two-sided household registration and screening tool, which provides the entry point into households, enables a profile of the household to be conducted and determines the nature and frequency of follow-up. This tool is part of service delivery but also provides valuable household information for planning and evaluation of the PHC Outreach Team Strategy. A DHIS database has been created for this purpose, although to date there has been limited entry of data into the DHIS.
- Tools that aid service delivery and follow-up of households (individual health records, referral forms), that are not intended for entry into the DHIS, but can serve as programme audit tools if so desired.

Both a paper-based and an mHealth version of the M&E system were piloted in the North West Province, with initial training conducted in 2011 and 2012.

In December 2013, an evaluation of the validity and quality of the M&E system in the province was conducted, assessing ease of use, and completeness and accuracy of data collected.⁶ The evaluation found that by the end of November 2013, more than 300 000 individual household visits had been recorded in the routine DHIS for 2013.⁷ The conclusions of this evaluation were that the forms were well understood by CHWs and for the most part well completed.

a Personal Communication: Ms R. Senokwane: Provincial Co-ordinator of Ward-based Outreach Teams in the North West Province. September 2014.

b Personal Communication: Ms R. Senokwane: Provincial Co-ordinator of Ward-based Outreach Teams in the North West Province. September 2014.

The most frequent sources of error were arithmetic: additions of totals (especially related to head counts) in tick sheets and accurate transfer of data from weekly to monthly tick sheets. This problem was largely overcome in the mHealth version of the system, where data transfer and additions are done automatically.⁸ Quality and timely data flow were also dependent on the involvement and oversight by team leaders, and greatly improved with feedback and additional support.

Key remaining issues are the design of regular reports and use of data at a local level, and processes of entry of household registration data into the DHIS.

Findings from the rapid assessment

This section provides information on some of the key findings from the rapid assessment of provincial and district implementation of PHC Outreach Teams conducted in the province in December 2012 and January 2013.

The rapid assessment involved in-depth interviews with 27 provincial, district and frontline managers, a group discussion with the task team, and group discussions with CHWs. These interviews assessed, amongst others, knowledge of, attitudes to, and experiences of the strategy in the province.

Issues arising from the rapid assessment related to resources (financial and human) as key constraints to implementation, on the one hand, and a high level of knowledge and ownership facilitating implementation on the other.

Financial resources

The PHC Outreach Team Strategy in the North West Province was introduced as a re-organisation of existing service delivery. The implications of this are that no new or ring-fenced resources were allocated for implementation, and all expenses had to be absorbed into existing district and sub-district budgets. Interviewees described the absence of dedicated financial resources from national or provincial government as a key weakness of the PHC outreach team implementation. Additional resources needed included vehicles for supervisory staff, supplies for the CHW kit bags, transport and cell-phone allowances for CHWs, stationery, filing cabinets for storing records, and most significantly, the deployment of Professional Nurses as team leaders, most of whom were reassigned to outreach teams from existing clinic staff establishments. The low level of remuneration and frequently interrupted stipends of CHWs was raised by many respondents as a significant threat to sustaining the work of teams.

Senior managers indicated that under the prevailing fiscal climate it was unlikely that additional resources would be made available, and that districts were being encouraged to “work differently” within the PHC re-engineering framework and obtain necessary budgets accordingly.

At the time of interviews, access to these resources was constrained across teams, with at best some sub-districts offering reimbursement of travel costs. A number of teams did not have access to dedicated space in health facilities, and were unsure about what to do with large volumes of accumulating paperwork. In some instances CHWs kept patient records with them.

There were subsequent efforts through the task team to address uneven resourcing and standardise access to transport, cell-phone and uniform allowances in the province.

Human resources

Respondents suggested that expecting Professional Nurses to be in charge of outreach teams was unrealistic and that in the long run, enrolled nurses should be trained for this purpose. As one District Director commented:

The number of nurses that are exiting the public service is more than those that are entering. There is also natural attrition where people are dying or fall sick. [We should] train and use another cadre of health workers such as the enrolled nurses. If we train them to be team leaders, or at least if we group wards so that one professional nurse supervises a number of wards, because we are running out of professional nurses.

Knowledge and ownership of the strategy

One of the findings of the review process was the high level of knowledge and ownership of the outreach team strategy among stakeholders in the province, and their willingness to integrate and adapt their work accordingly. Interviewees spoke of the tangible benefits of the community dialogues and proactive household approaches as expanding access, improving relationships with communities, and increasing knowledge and uptake of services. Both the CHWs and the outreach team leaders articulated their roles in ways that were consistent with the PHC Re-engineering Strategy.

The CHWs interviewed were also in support of the new approach to improve access to care, and believed that the status of their work had been considerably enhanced. As one stakeholder commented, CHWs are now able to:

come up with a very comprehensive picture of health care... so you don't have the CHWs saying I only deal with DOTS, or mental illness etc., but they are taking ownership of their areas/communities and get to know what exactly is happening in that area. They have become the ears of the department and have the information about the community on their fingers. They would tell you, they have so many people suffering from certain illnesses, so many people who need child grants etc. It is a wonderful thing to get all this information that we are able to use across all departments. That has also made the CHWs very important in the community.

Through the briefings they received from provincial and (in some instances) national players, CHWs were aware of plans for future training phases, and expressed a willingness to expand their scope of work to include HIV counselling and testing, general counselling, and taking blood pressure measurements.

PHC facility managers expressed varying levels of support for PHC re-engineering and the WBOTs. Possible reasons for this include the fact that the orientation of facility managers was only starting at the time of the interviews, occurring long after that of other players (team leaders, local area managers and CHWs). An area of concern for the facility managers was that they felt they had been inadequately

briefed on how to manage the allocation of professional nursing staff from their staff establishment to the outreach teams.

Facility managers also suggested that the policy had increased their burdens – not only did they have to release a Professional Nurse from the clinic, and provide space and supplies for CHW kits, but the household profiling process had uncovered pockets of unmet needs as well as under-utilisation of their clinics – both of which were not planned for.

This led to a situation where team leaders were sometimes held responsible for seeing referrals from outreach teams whereas in other instances patients were seen by the remaining clinic staff. Team leaders reported facing pressure to return to clinics. In several instances, support to team leaders and teams was primarily from the local area manager rather than through the facility managers.

The biggest challenge for implementation, both for sustaining what has been achieved to date and for further scale-up, is ensuring the adequate resourcing of WBOTs. Without stable and adequate CHW stipends, maintaining the motivation and momentum of teams will be very difficult.

Recommendations

Drawing on the experiences of the North West Province, for a sustainable PHC Outreach Team Strategy, the following key areas for system strengthening are proposed:

Adequate financing

- Ward-based Outreach Teams are a fundamental requirement for successful implementation of the envisioned PHC Re-engineering Strategy and lack of adequate financial resources will continue to pose a major risk to the successful implementation of the strategy. Plans for allocating ring-fenced districts budgets accompanied by clear accountability and reporting mechanisms are required.
- The establishment of outreach teams as a key component in the implementation of the PHC Re-engineering Strategy is being done within a context of general under-resourcing and poor functioning of community-based services. Existing challenges to the stable and adequate provision of stipends for CHWs will threaten sustainability and quality of services and should be addressed with urgency.

Evidence-informed planning and implementation

- An evidence-informed approach to planning and implementation, building on the standardised information systems, supplemented by regular audits and evaluative research, needs to be implemented at both provincial and national levels.
- While the core DHIS indicators for WBOTs provide an assessment of coverage and a broad profile of their household activity, the monitoring of WBOT impacts is only possible when combined with an assessment of facility-based indicators that are sensitive to community-based action. Such indicators would include early antenatal booking, retention in care and immunisation coverage. Routine reports and regular review of these indicators in sub-district and district-based reports are

key to further implementation and for holding stakeholders accountable.

Provincial and district governance

- Effective provincial governance is key to implementation of outreach teams. This includes the setting up of special implementation support and co-ordinating structures such as the PHC re-engineering task team, and the integration of planning and monitoring of outreach into existing district and sub-districts planning and review processes.
- A clear strategy for roll-out/scale-up involving effective planning, regular engagements and critical reflection is also key.

Communication and dialogue

- Comprehensive communication and consultation strategies have been vital to the success in the NW in terms of expanding access, improving relationships with communities, and increasing knowledge and uptake of services. Forums for constructive engagement between community members, local managers and facility staff – brainstorming main health problems, discussing root causes and identifying recommendations to address these – are important.
- Active and ongoing involvement of key players in the frontline of the PHC system, especially PHC facility managers and area managers and supervisors is key.

Ongoing partnerships

- The experience in the NW suggests that openness to and engagement in partnerships that provide relevant technical and implementation support to the district and province were essential for facilitating a responsive and effective process for implementing the PHC re-engineering strategy. However, the sustainability of such partnerships may need to be evaluated further.

Further research

While the key question for policy-makers relates to the effectiveness and sustainability of community health workers and the adopted Ward-Based Outreach Team approach, there is also a need for operational research that investigates factors that influence and support community health workers. These factors include community support structures, health systems support, service delivery platforms, referral mechanisms and the use of technology, such as mHealth. Further research is needed on realistic norms for household coverage by CHWs. For example, the mHealth pilot in the North West, involving a team of 10 CHWs in a rural setting, found that the average size of the CHWs' catchment population was 146, ranging from 86–237 households per CHW. These numbers are lower than the national norms (250 households per CHW).

Conclusion

The findings of the rapid assessment of the WBOT implementation in the North West may provide valuable lessons for PHC Outreach Team implementation in other provinces. The deliberate and process-rich nature of the implementation strategy, bolstered by strong leadership and vision, and the commitment to community and frontline provider participation, provide a good case study of what is required in the early stages of implementation of a policy “with system-wide effects”. The next challenge is sustaining the initial momentum and ensuring further scale-up. Addressing these will require new strategies and cycles of learning – the capacity to renew and adapt – and most significantly, addressing the challenge of resource mobilisation and finding ways to achieve further gains through existing resources.

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