COMMENTS ON THE POLICY FRAMEWORK AND STRATEGY FOR WARD BASED PRIMARY HEALTHCARE OUTREACH TEAMS AND THE WBPHCOTS STRATEGY FRAMEWORK IMPLEMENTATION PLAN

Submitted by: SECTION27 on 1 September 2017

Introduction

1. SECTION27 is a public interest law centre that seeks to influence and use the law to protect, promote and advance human rights. One of our priority areas is the right of access to health care services as guaranteed by section 27 of the Constitution.

2. From as early as 2008, SECTION27 (then known as the AIDS Law Project) has been advocating for the formalization of the community health worker ("CHW") workforce and has actively participated in related discussions.

3. On 22 August 2017, the National Department of Health (NDoH or Department) hosted a Round Table Discussion to allow input from role players and stakeholders into the Draft WBPHCOT Policy Framework Implementation Plan. To facilitate the discussion, the Department circulated two documents:

    i. Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams July 2017 ("Policy"); and
    ii. WBPHCOTs Strategy Framework Implementation Plan ("Implementation Plan").

4. We welcome the development of these working documents and thank the NDoH for the opportunity to provide comment on them. Given the very short time period provided to give comments (we were told that the submission would need to reach

NDoH by 1 September 2017), we are unable to comment fully on the Policy and Implementation Plan but highlight only a few matters.

5. For further analysis of issues such as the CHW to household ratio, CHWs scope of work and how CHWs should be incorporated into and employed within the health system, please refer to research conducted by SECTION27 on the ways to make a CHW programme work, which research can be found here: https://www.spotlightnsp.co.za/2016/11/30/community-health-workers-spotlight-depth-feature/.

Comments

Public consultation

6. Movement towards a national policy for CHWs began in around 2008. In 2011, South Africa established ward-based CHW outreach teams, as part of a series of strategies to strengthen primary health care (PHC). In April 2015, the Department produced a draft policy with the stated aim of improving access and health outcomes and taking health services to the community. The draft policy outlined that communities (in the form of wards) should have at least one PHC outreach team comprising, amongst others, a professional nurse, an environmental health officer, and six CHWs.

7. Subsequent to the April 2015 policy draft, the Department has gone on to produce two further versions (Versions 10 and 11 in November 2016 and June 2017 respectively) of the policy draft, each being used at the two round tables that have been hosted in 2017.

8. While we appreciate the continued work on the policy, we note that the Department has not given an opportunity for public comment on either version 10 or 11. This is concerning because both versions are considerably different from the April 2015 version, which not only contained more detail and envisaged a CHW programme that was consistent across the country, but was also made available to the public for comment. Further, we are of the view that comments on the Implementation Plan

cannot be made in a vacuum and reference must be made to the Policy. It is for these reasons that our comments are not restricted to, although they are focused on, the Implementation Plan.

Lack of detail and lack of consistency across Provinces

9. We note the intention, in versions 10 and 11 of the Policy, to give a great deal of scope to Provinces in determining how to run CHW programmes. The Policy and Implementation Plan read more like an early stage elucidation of options than a national policy on a matter of human resources for health. While we appreciate the need for the NDoH to give due regard to the powers and functions of Provinces, we remain concerned that with such a broad framework, consistency in service provision and employment practices across the country is unlikely.

Fair labour practices

10. In Section 4.2 of the Policy, challenges that have been faced in implementing ward based community outreach teams are highlighted. A significant proportion of these challenges relate to the working conditions of CHWs. The Policy however contains scant detail on how it intends to address these challenges. Instead, a significant proportion of the document is dedicated to justifying the need for CHWs. It does not consider the interests of CHWs in fair labour practices and the importance of ensuring such practices for a sustainable programme, and while the values and principles that the Policy promotes are outlined, the value of "fair labour practices", is absent. The working conditions of CHWs must be addressed if the programme is to be successful.

Policy outcomes and implementation impact

11. Section 5.4 of the Policy relates to the desired policy outcome. It states "[t]he long-term impact of the WBPHCOT policy framework and strategy should be a long and healthy life for all within a supportive and cohesive community". Whilst we do not dispute the important contributions made by CHWs and home based carers ("HBCs")

to health care services, we submit that there is a difference between a policy outcome and the impact which can be causally linked to that outcome. The intended outcomes of this Policy are to formalize the CHW and HBC cadres and to standardize their recruitment, management, remuneration and ultimately improve their working conditions. This much can be gleaned from the policy objectives and Implementation Plan. On the other hand, the desired impact of implementing the Policy is "a long and healthy life for all within a supportive and cohesive community".

12. It is therefore our view that the policy outcome places an inordinate emphasis on the impact of implementation rather than on the issues that the policy intends to address. We draw attention to this not as an issue of semantics but because equating a policy outcome and the impact of implementation makes it difficult for policy outcomes to be monitored. It is important that such monitoring and evaluation takes place to enable necessary and timeous alterations or amendments needed for implementation and the achievement of the ultimate desired impact on the lives of South Africans.

Timeframe inconsistencies

13. The draft Implementation Plan stipulates the dates by which activities must have been completed. This is a welcome aspect as it indicates that finality is envisaged, as opposed to open-ended intention. The issue, however, is that there is no indication of when the different role players are expected to begin their activities or whether these activities are already ongoing, and if so at what stage they are. It is therefore difficult to give input on whether the timeframes are reasonable for the activities.

14. Apart from the lack of start dates, there are four specific timeframe inconsistencies that we have identified.

15. Section 5.3.3 of the Policy refers to the development and maintenance, by Provincial Departments of Health, of a database of the current CHWs and HBCs. The information will then be consolidated into one national repository by the NDoH. On the other hand, activity 1.4.1.1 in the Implementation Plan states that by November 2017, the

NDoH must have created access to the national repository. In our opinion, activity 1.4.1.1 incorrectly assumes the existence of an accurate database (or Provincial databases) of existing CHWs. This view is supported by the worrying fact that throughout the Policy, there is no mention of how many CHWs are currently in the system.

16. Activity 1.1.3.2 is supposed to end in March 2018. It is not clear what the Provinces will be able to report on by that date because, as per 1.1.2, managers will only be fully trained by 2020. Is it the intention to roll out the WBPHCOT teams prior to the managers being trained? Further, the time frames between NDoH designing the quarterly reporting tools (November 2017) and Provinces submitting those reports (March 2018) is very short. This means that only one report will be submitted, this may not be sufficient for monitoring and evaluation of the policy implementation.

17. Further, activities 2.1.1.1 through to 2.2.1.1 are heavily reliant on each other. In our opinion, they have to be staggered. For example, in order to allocate WBPHCOTs (activity 2.1.1.2) in line with the Policy (section 4.3), the research referred to in 2.1.1.2 must have been completed. For that reason, we are concerned about the time frames within which those activities must be completed.

18. The Implementation Plan states that by April 2019, the scope of work for CHWs and OTLs must have been adopted. We suggest that the scope of work for CHWs, HBCs and OTLs should be finalized and adopted prior to the finalization of objective 2.3.2 relating to remuneration, which should be finalized by March 2018. The remuneration guidelines have to be informed by the scope of work.

<u>Membership and leadership of WBPHCOTs</u>

19. We have identified a number of issues relating to the membership and leadership of the WBPHCOTs.

20. The Policy does not discuss the current status of CHWs in the country. For instance, it does not indicate how many CHWs are currently being utilized by the provinces. As a result, it does not address what will happen to any "excess" CHWs who are already working within those wards, but cannot be accommodated within the outreach teams.

21. The two cadres, Environmental Health Officer and Facility based Health Promoter, mentioned in tasks 1.2.1.2 and 1.2.1.3 of the Implementation Plan, are not mentioned in the Policy as forming part of a WBPHCOT. Clarity must be given on how they are going to be working with or within the WBPHCOT and how they are accounted for in management/reporting structures.

22. The Policy refers to an Outreach Team Leader (OTL), who is going to be an enrolled nurse. Task 1.2.1.4 of the Implementation Plan refers to a CHW Team Leader. This role is not defined in the Policy. Is there a difference between the OTL as defined by the policy and the CHW Team Leader? It is also not clear from the Policy whether a team leader will be a person employed specifically and only to discharge those duties or whether these will be duties over and above other duties that they must discharge at the PHC facility.

23. The Policy states that enrolled nurses will be appointed as OTLs. We suggest that in addition to creating a database for CHWs/HBCs as stated in 1.4.1.1, a database for enrolled nurses should also be created and maintained. In addition to the supervisory role played by OTLs they link CHWs and HBCs to facilities. Maintaining a database of enrolled nurses will also contribute to ensuring that WBPHCOT are appropriately staffed. In terms of the policy, the team size in fixed and each team **must** have an OTL. However, task 2.4.1.2 states that OTLs will be assigned to team(s) depending on the size of the team. There needs to be clarity on whether WBPHCOT team size variable.

24. One of the challenges identified in the Policy is the lack of uniformity across Provinces. All the tasks related to objective 1.2.1 in the Implementation Plan have been allocated to role players at the district and sub-district level. We suggest that to ensure

uniformity, the roles and responsibilities/job description for the different team members must be defined at national level.

25. Sub-objective 2.3 addresses the need to ensure appropriate implementation and management of recruitment, selection, appointment, placement, remuneration, skills development, dispute resolution and occupational health and safety processes for all members of WBPHCOTs. It is, however, not clear how these management structures will apply to CHWs and HBCs employed by NGOs. Further, the activities only refer to CHWs. Is this to the exclusion of HBCs?

Distribution of WBPHCOTs

26. In order to have the desired impact, WBPHCOT will have to be appropriately distributed. Although the Policy states several factors that must be considered in distributing the teams, the Implementation Plan mentions consideration of only one, the Stats SA ward based poverty level ≥ 0.4. We suggest that other factors such as the burden of disease should be considered.

Conclusion

27. We once again thank the Department for the opportunity to make this submission. We trust that this submission will be of assistance to the Department.

28. For further information, please contact:

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