Province of KwaZulu-Natal

Operation Sukuma Sakhe

Integrated Community Caregiver Foundation Course

uThungulu District Training Report

OPERATION

Sukuma Sakhe

STAND UP AND BUILD

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Acronyms and Abbreviations

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

Acronyms and Abbreviations

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

1. Introduction

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

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

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

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

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

2. About uThungulu

uThungulu District Municipality is situated in north-eastern KZN and is made up of six local municipalities: Mfolozi, Mthonjaneni, Nkandla, Ntambanana, uMlalazi and uMhlathuze. According to Census 2011, uThungulu District Municipality has a population of just under one million living in 203 000 households. The population is largely isiZulu speaking and over 80 percent of whom live in rural areas. The significant economic centre is Richards Bay whose harbour facilities have attracted large-scale industrialisation to the district. Most people (65 % of the population are economically active) work in the community, social and personal service sector, followed by agriculture and the wholesale and retail trade sector.

There are major service delivery backlogs, especially in the rural areas with 30.5% of households having piped water inside the dwelling, 27% having flush toilet connected to sewerage and 76% having electricity for lighting. The major challenges for uThungulu are poverty, crime and HIV and AIDS.

3. About the Community Caregiver (CCG)

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

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

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

- Profiling of households using a household profiling form
- Health promotion to effect behaviour change and screen for high risk behaviour
- Basic environmental health assessment to identify health and manage health risk
- Assessment of all family health cards to identify existing illnesses for support
- Identification of early warning signs for outbreak of diseases and refer accordingly
- Manage emergencies and refer accordingly
- Provide HIV, AIDS, STI, TB, PMTCT and any other health and wellness information dissemination after screening using standardised screening tools
- Ensuring referral for early booking and registration for ANC (antenatal care)
- Adherence support for long term and chronic medication including DOTS support, adherence to ARVs and nutrition supplements
- Dispelling myths around HIV and encouraging more people to test and increase uptake on HAART
- Growth and development monitoring, including the Road to Health Chart which will increase vaccination rates, growth monitoring, nutrition and developmental assessments
- Conduct childhood nutritional assessment through the use of the tape measure for mid-upper arm circumference ensuring appropriate referrals
- Encourage one home one garden enhancement and support
- Mobilise communities on health, social and development issues
- Promote basic home-based care including palliative care
- Establish support groups (facilitate support groups and refer clients to them)
- Provide early identification of Orphans and Vulnerable Children for referral
- Provision of material assistance in the form of food parcels, feeding schemes, assistance with laundry and school uniforms and after school recreation activities (NIP site)
- Referral of children under 5 to Early Childhood Development (ECD) (including partial care arrangements for children)
- Screen and refer family members to access social services DSD Service offices - Foster Care, Places of Safety, Substance Abuse, Child Abuse, Family Counselling, Care for the aged, victim empowerment, etc

About the Community Caregiver (CCG)

- Screen and refer family member to access social grants and ID documents
- Monitor school attendance and assist with homework where necessary
- Development of care plans for children, addressing their emotional, social and health needs
- Refer clients to existing Child Care Forums, income generation projects
- Create linkages between households and government departments
- Prepare and submit reports using prescribed reporting tools

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

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

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

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

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

About the Integrated Community Caregivers Foundation Course

4. About the Integrated Community Caregivers Foundation Course

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

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

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

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

Learner materials for the Integrated CCG Foundation Course include:

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

The aim and objectives of the Integrated CCG Foundation Course Training

5. The aim and objectives of the Integrated CCG Foundation Course Training

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

Specifically, the objectives of the training are to provide:

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

6. Approach and method for the training roll-out

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

A partnership framework consisting of stakeholders from BRHC, OTP, DoH and DSD has been developed. The roles and responsibilities of each partner is defined and agreed upon. The role of BRHC is to perform project management tasks, develop and print all training materials, develop the advocacy and communication plan (see Appendix 1), offer technical assistance to the training task teams and to implement the training roll-out.

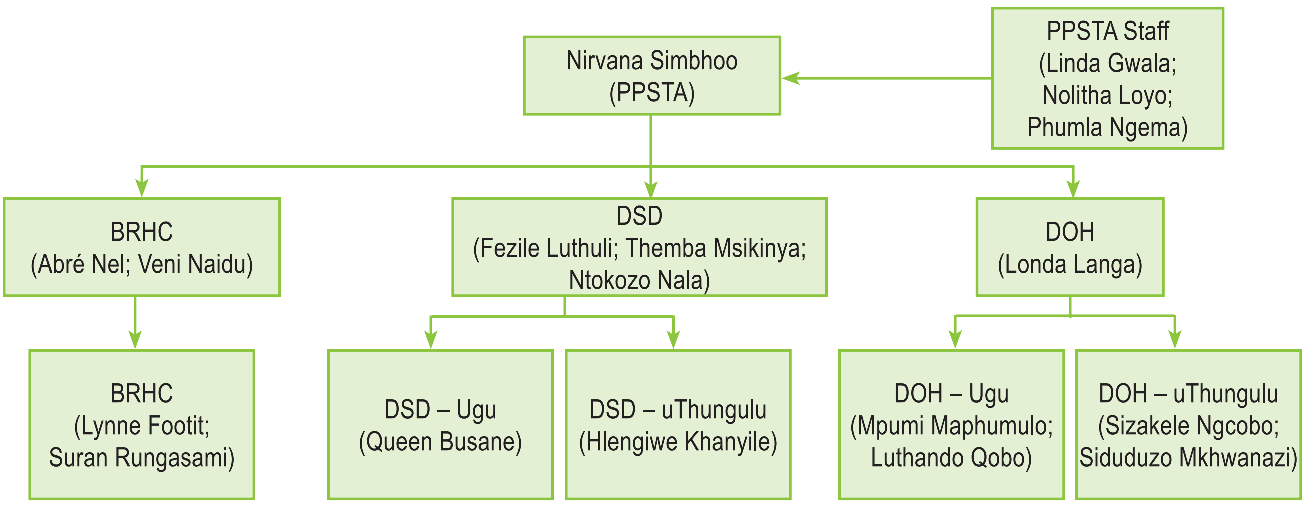
As part of the partnership framework, two task teams have been established - the Provincial Training Task Team and the District Training Task Team.

6.1 Provincial Training Task Team

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

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

Figure 1: Provincial Training Task Team Membership

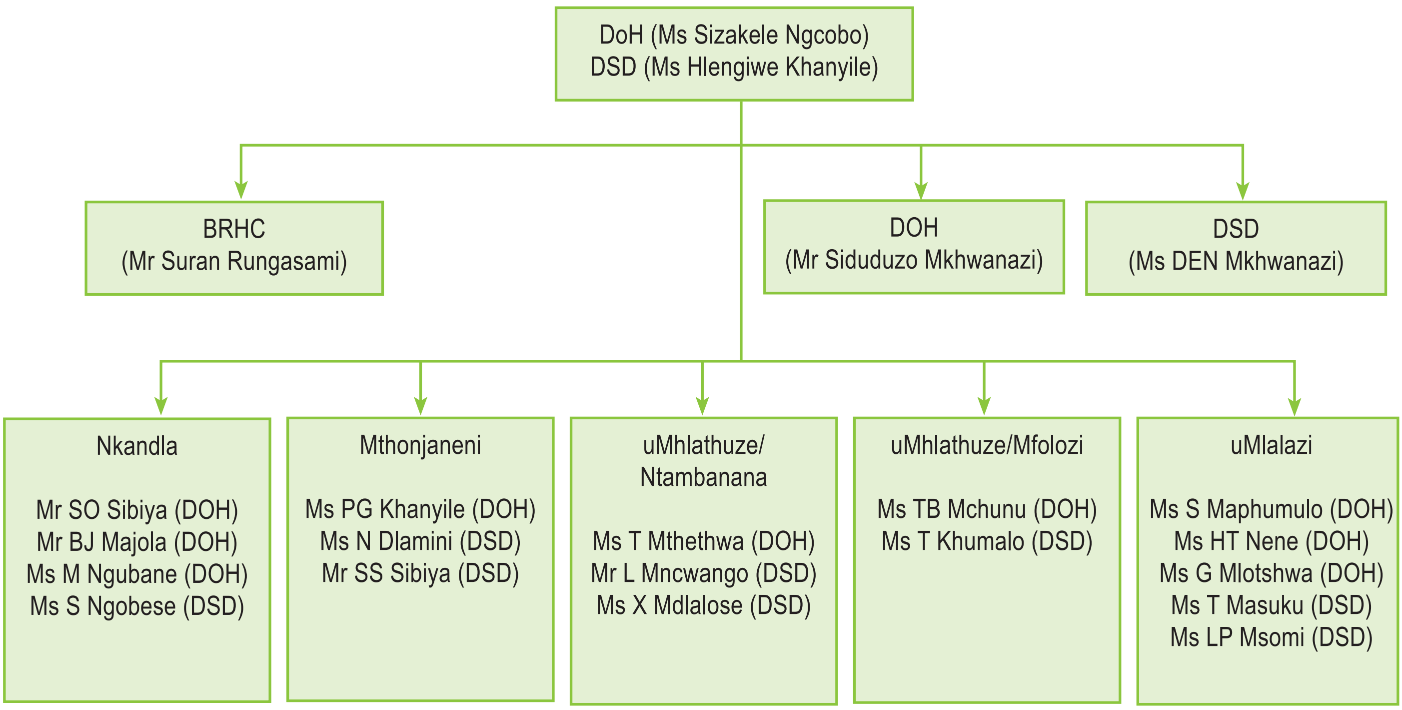


6.2 District Training Task Team

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

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

Figure 2: District Training Task Team Membership



Approach and method for the training roll-out

6.3 Training approach

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

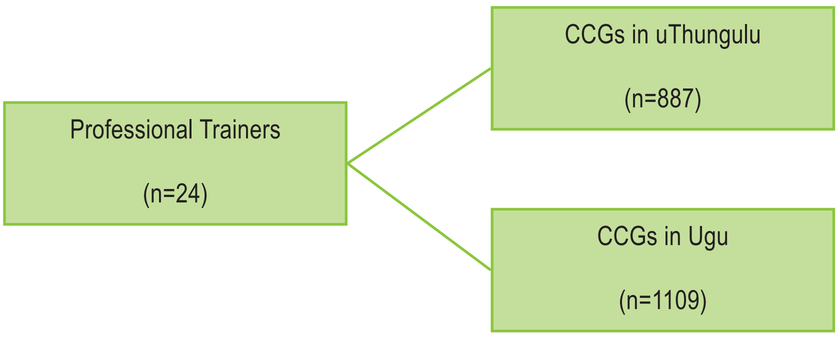
The training approach was participatory, interactive and based on adult learning principles. In this context, participants are given opportunities to interact within discussion groups, study groups, focus groups, work groups, and simulation groups. The following techniques and tools formed part of the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

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

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

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

Figure 3: Two-tier training approach



6.4 Training Materials and Equipment

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

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

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

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

6.5 Quality Assurance

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

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

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

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

Table 1 is a list of tools generated to provide quality assurance for the planning phase. An administrative file has been compiled with copies of these checklists.

Table 1: Quality assurance documents to support the planning phase

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

Approach and method for the training roll-out

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

Table 2 is a list of tools generated to provide guidance on quality during the training phase of both Professional Trainer and CCGs during their respective training sessions. An administrative file has been compiled with copies of these tools. All tools administered by the CCG were translated into isiZulu.

Table 2: Quality assurance tools to support the project during training

Name	Purpose	Administered by
Professional Trainer Assessment	To assess the performance of Professional Trainers in a simulated environment	Quality Assurance Officers
Written Summative Assessment	To assess the PTs knowledge and application of AET methodologies	Training Manager
Attendance Register	To monitor CCGs attendance	Facilitator
Pre-Assessment	To assess the level of all the CCGs prior knowledge to assist the trainer to address gaps and pitch the programme at the correct level	Facilitator
Post-Assessment	To assess transfer and retention of knowledge and to assist the learner to address gaps in knowledge	Facilitator
Role-play Checklist	To assess the CCGs practical application of their knowledge	Facilitator
CCG Learner Feedback Form	To obtain feedback with regard to the training	CCG
Facilitator Checklist	To guide Facilitator on processes and procedures required during the training	Facilitator
QA Officer Checklist	To supply the Quality Assurance Team with the relevant criteria to evaluate the training intervention per site	QA Officer

Approach and method for the training roll-out

To measure success of the project, a Monitoring and Evaluation (M&E) Framework was developed covering three phases of the project - the training of Professional Trainers, training of CCGs and post-training assessment of CCGs in field 3 to 6 months after training.

Pre- and post-testing was conducted to determine the level of learning and the improvement in knowledge and skills as a result of the training. Participants were asked a series of questions at both the beginning of a module (pre-test) and then again at the module's completion (post-test). Ten multiple choice questions were developed for each module except for the more extensive module 4 which had 15 questions. The questions were designed to provide maximum coverage of the module. Facilitators were instructed to read out the multiple-choice options to the class to accommodate varying levels of literacy and facilitate common understanding amongst learners.

Professional Trainers are assessed in three ways:

- Pre- and post-test
- A practical test in a simulated training environment
- A written summative test covering aspects of adult education training principles

It was expected that Professional Trainers knowledge would increase as a result of their training. Existing literature do not support percentage improvement. Professional Trainers were expected to have a high level of prior knowledge based on their selection criteria. For them to achieve post-test, facilitation skills test and written summative test scores in excess of 66 percent is a reasonable expectation and is supported by the relevant literature.

CCGs are assessed in two ways:

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

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

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

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

Approach and method for the training roll-out

Table 3: Monitoring and Evaluation Framework

Objective	Indicator	Numerator	Denominator	Source Document	Frequency
Training of Professional Trainers					
Train Professional Trainers to competently facilitate the Integrated CCG Foundation Course	Proportion of Professional Trainers with post-test score > 65%	Number of PTs with a post-test score > 65%	Number of Professional Trainers trained	Pre- and post-test questions	Once-off at the end of PT training
	Proportion of Professional Trainers who passed the facilitator test in a simulated environment (practical test) Target score = 66%	Number of Professional Trainers who passed the facilitator test > 65%	Number of Professional Trainers trained	Observation Checklist	Once-off at the end of week 2
	Proportion of Professional Trainers who passed the written summative assessment (delivery) Target score = 66%	Number of Professional Trainers who passed the written summative assessment (66% of criteria met)	Number of Professional Trainers trained	Written Summative Assessment	Once-off at the end of week 1
Training of CCGs					
Train all CCGs in the District to competently transfer knowledge using skills gained during the Integrated CCG Foundation Course	Proportion of CCGs on PERSAL trained (Target = 80%)	Number of CCGs trained	Number of CCGs on PERSAL database	CCG Attendance Register	Every day during training
	Proportion of CCGs with post-test score > 60%	Number of CCGs with an increase in knowledge from pre- to post-test (Post-test score of 60%)	Total number of CCGs trained	Pre- and post-test questions	Before and after each module
	Proportion of CCGs who pass the role-plays with scores of 66% and above	Number of CCGs who attained scores of 66% and above	Total number of CCGs trained	Role-play Checklist	During days 8 and 9 of the training programme

Approach and method for the training roll-out

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

7. Results

7.1 Professional Trainers

PTs were recruited predominately from networking with trainers in the field and from other training organisations. After interviewing 50 candidates, 16 PTs were initially recruited and received ten days training from 2 to 13 July 2012 in Durban. During Group 1, a further six were recruited and inducted during the CCG training. From Group 2, two Facilitators were allocated per training session to avoid burnout. A further two PTs were inducted and trained during Group 2 training and used as reserves.

Co-facilitation teams were carefully matched to balance facilitation strengths and weaknesses as well as to ensure that there was proper induction of new trainers by more experienced trainers. Teams were provided with a “crash course” on co-facilitation and mentored and coached for the duration of the training.

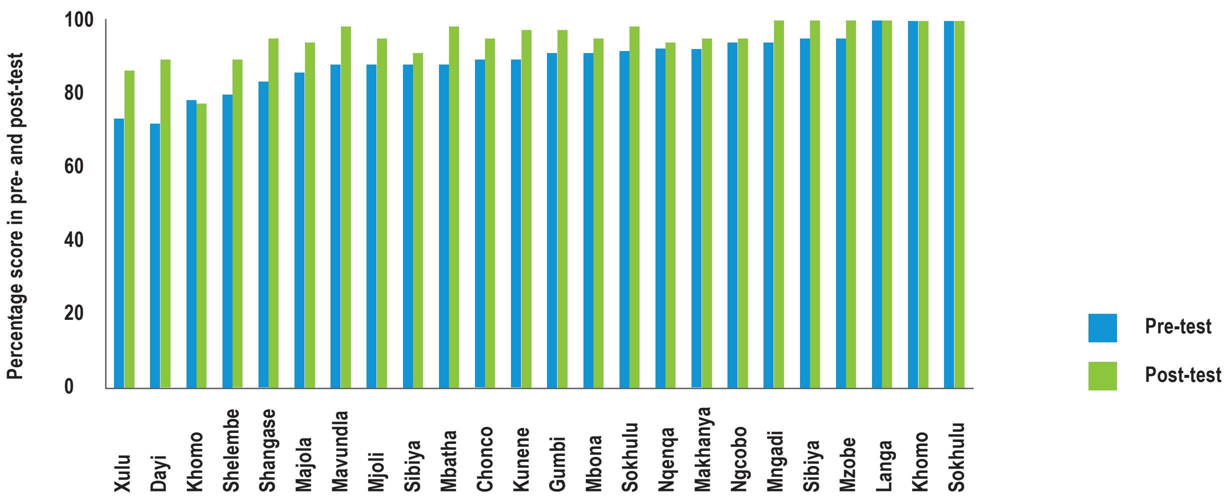
7.1.1 PT Performance

Pre- and Post-Test

The indicator for the first assessment (pre-and post-test) is an increased percentage signifying an increase in knowledge. The limitation of this indicator is shown by the fact that some PTs scored 100 percent in both the pre- and post-test, resulting in no measured increase in acquired knowledge.

Of the 24 PTs who participated in the assessments, only one had a decrease in scores between the pre- and post-test (78 percent in the pre-test and 77 percent in the post-test). The average pre-test score was 89% (range 72 to 100) and the average post-test was 95% (range 77 to 100). The pre- and post-test scores for the 24 PTs are shown in Figure 4.

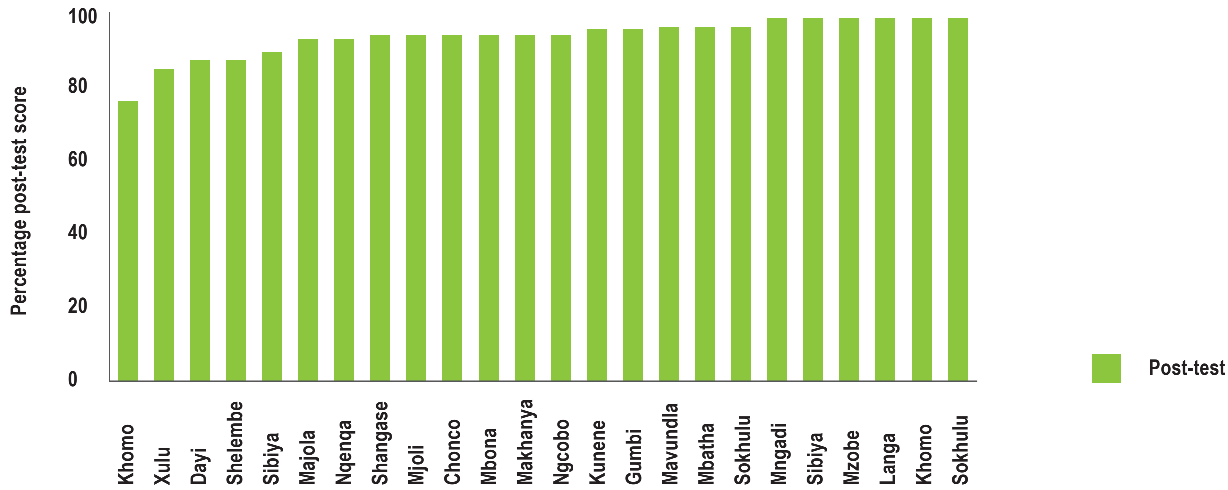
Figure 4: PTs pre-and post-test assessment



Results

The post-assessment training scores show that all PTs passed the post-test (see Figure 5). The distribution of the results shows that all PTs had an excellent level of content knowledge to facilitate the Integrated CCG Foundation Course. Only one PT had a score of less than 80 percent and twenty scored over 90 percent.

Figure 5: Distribution of post-test results



PT Observation (role-play) Results

This assessment involved PTs being observed training in a simulated environment and acted as a gauge how effectively they would deal with any probable scenarios that might occur in the training environment. Simulation is a way to assess PTs' abilities to think on their feet and apply adult education learning principles so as to ensure that CCGs achieve the requisite learning outcomes.

The expected outcome for this indicator of facilitator preparedness to conduct training on the Integrated CCG Foundation Course was a score of 66 percent. Figure 6 shows that the majority of scores (n=18) were high, that is, above 70 percent; the group average was 80 percent. Three PTs scored below the expected level.

PTs have varying levels of facilitation skills and this information was used when pairing PTs for co-facilitation. PTs were supported throughout the training roll-out in an effort to provide them with mentoring and coaching.

This indicator has limitations in that some PTs performed better in isiZulu and some were nervous to perform in a simulated environment in front of their peers. However, this assessment provided a measure of facilitation skills and suggestions for improvement were offered and monitored during the training sessions.

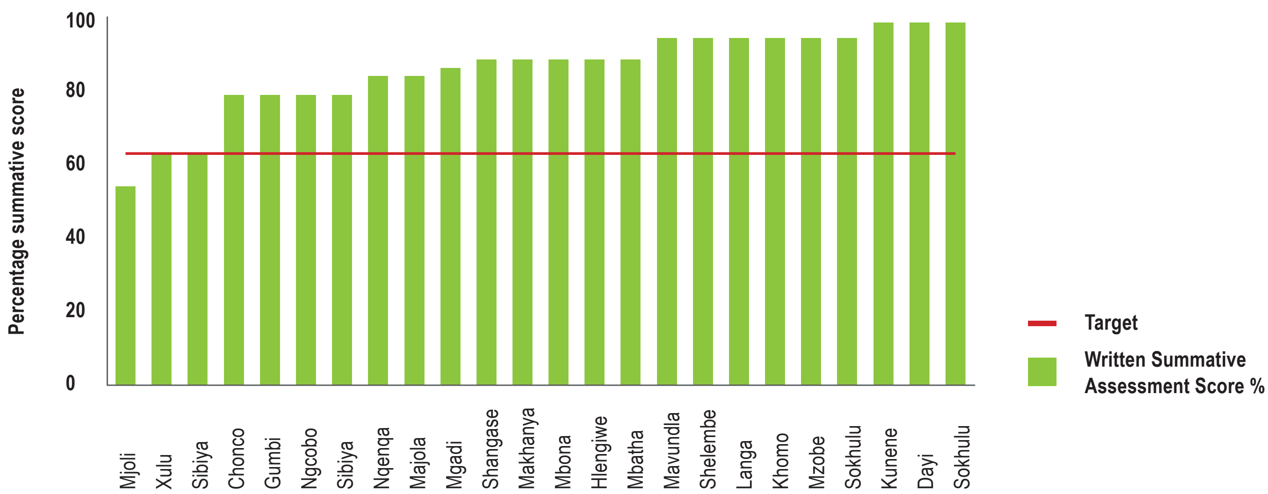
Results

Figure 6: Distribution of observation (role-play) results

Written Summative Test Results

The written summative assessment tested PTs understanding of adult learning principles. Once again, the target for this assessment for individual PTs was a percentage score of 66 percent. The group average was 87 percent with the majority of PTs (n=21) scoring over 80%. Three PTs scored below the target. It is interesting to note that only one of the PTs scored low in both the observation assessment and the written summative test.

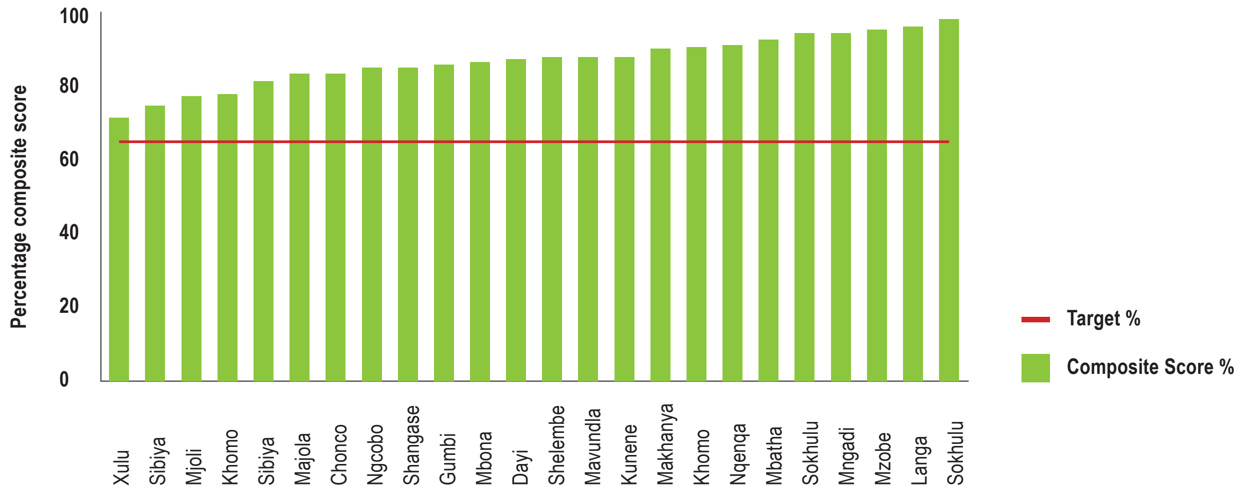
Figure 7: Distribution of summative test results



Results

Combining the scores of all the assessments, one can derive a composite score as shown in Figure 8. This may suggest how well individuals are likely to perform better in the classroom by combining their knowledge and facilitation skills. All PTs exceeded the minimum expectation. The PT with the lowest score was ill during training but performed better during site visits.

Figure 8: Composite score percent



7.2 CCGs

The CCG results will be discussed in five sections: Recruitment of CCGs and allocation to classrooms, communication with CCGs, CCG disbursements, CCG attendance and CCG performance.

7.2.1 Recruitment of CCGs and allocation to classrooms

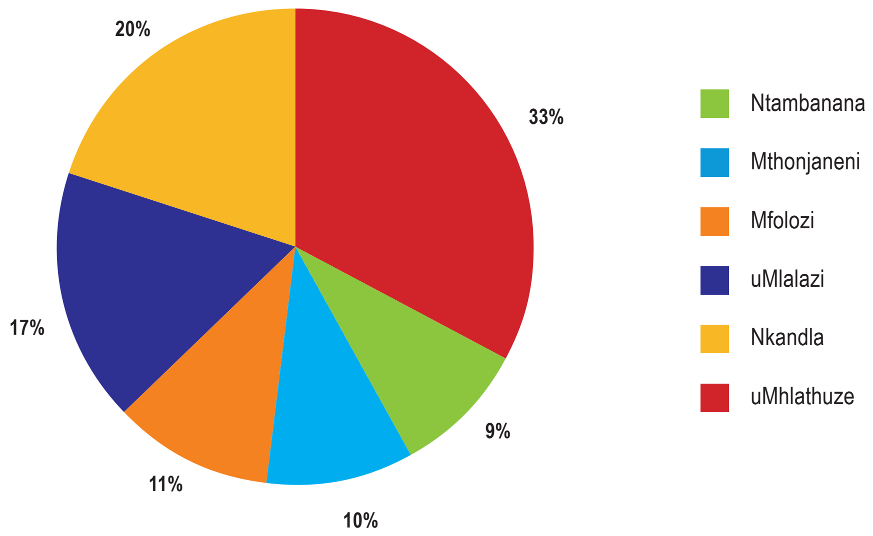
Database

The Departments of Health and Social Development provided a PERSAL database with 941 names and contact details of the CCGs expected to undergo training in uThungulu. During pre-registration six CCGs were added, three were recorded as deceased, 23 left the programme before training commenced, one was on maternity leave, one was sick and 25 were promoted to become Nutritional Advisors and were sent for specialised training. Of the original list of 941, only eight CCGs who did not pre-register or attend The pre-registration database, categorised according to wards, was signed by 886 CCGs confirming their contact details or providing contact details of a relative or neighbour.

Of the 886 CCGs, a third were from uMhlathuze. Approximately 70 percent of CCGs were from three municipalities - uMhlathuze, Nkandla and uMlalazi (see Figure 9).

Results

Figure 9: Origin of CCGs by municipality



Allocation to training sessions

The 886 CCGs were divided into four training groups and 45 training sessions (see Table 4), based on their geographical location across the municipalities and the optimum number of 20 learners per training session. Other considerations were the number of suitable venues available and the number of trained PTs. The target number of training sessions per group was set at a maximum of 12 (see Table 4). The number of groups per municipality was as follows:

Table 4: Number of training sessions per municipality

Municipality	Group 1	Group 2	Group 3	Group 4	Total
Ntambanana	1	1	1	1	4
Mthonjaneni	1	1	1	1	4
Mfolozi	2	1	1	1	5
uMlalazi	2	2	2	2	8
Nkandla	2	2	3	2	9
uMhlathuze	4	4	3	4	15
uThungulu District Total	12	11	11	11	45

A process was followed in allocating CCGs to training sessions. First, the database was divided among wards. Second, an assessment was made on location of wards and number of CCGs in a ward to warrant a training session. In situations where there were more than 40 CCGs and more than one venue available, the ward was split into two training sessions. In situations where there were insufficient CCGs in a particular ward, they were allocated to attend the training session nearest to their ward.

7.2.2 Communication with CCGs

A communication plan was developed for the training roll-out consisting of the letter from the DDG to the CCG, the invite itself, pre-registration and four SMSs providing information and reminding the CCG to attend the training session. Primary communication with the CCG was in the form of direct communication from the CHFs and HIV and AIDS Coordinators. CCGs were invited to training through a formal invitation and letter from the Office of the Premier. CCGs thereafter received several SMS messages in isiZulu to remind them to attend training, and to bring with them vital information such as a copy of their identity document and a copy of their bank statement as proof of banking details.

The SMS messages allowed important information such as training dates, venues, time and other information to be communicated to CCGs instantly and simultaneously. SMS messages were sent two weeks prior to training, one week prior to training, and one day prior to training. Each SMS provided a call back number facility for CCGs who require more information. Where no cell number was provided for a CCG, an administrator communicated in isiZulu directly with the CCG via other communication methods such as a Telkom landline or via the CHFs and HIV and AIDS Coordinators. In addition, CCG supervisors, CHFs (DoH), as well as HIV and AIDS Coordinators (DSD) visited sessions as a further incentive for CCGs to attend.

SMS follow-up survey

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

1. **Did you receive the SMS?**
2. **Can you read the SMS?**
3. **Do you understand the content of the SMS?**
4. **Will you be attending the training session?**

Of the 90 CCGs that were surveyed, 75 percent confirmed receipt of the SMS and of their attendance. The remaining CCGs in the survey either had a wrong number or did not receive the SMS. A list of these CCGs was compiled for the District Training Task Team who assisted in communicating with the relevant CCGs, and CCG information was updated where necessary. In addition, the Professional Trainer reported when a learner did not attend class on the first day of training, and communicated this to the QA Officer. CCGs who failed to attend training from the first day were contacted directly and encouraged to attend.

7.2.3 Number of CCGs Trained

A total number of 886 CCGs were trained in uThungulu from 23 July to 21 September 2012 in 45 training sessions (see Table 5). The overwhelming majority of the CCGs were African female (see Table 5).

Results

Table 5: CCG demographics by training group

Date of training session, 2012	Number of classes	Number of CCGs trained	CCG demographics	
			African males	African females
23 July – 3 Aug.	12	236	7	229
13 – 23 Aug.	11	217	9	208
27 Aug. – 7 Sept.	11	208	5	203
10 – 21 Sept.	11	225	8	217
Total	45	886	29	857

The learner demographics by municipality are shown in Table 6.

Table 6: CCG demographics by municipality

Municipality	Number of Males	Number of Females	Total
Mfolozi	1	93	94
Mthonjaneni	3	86	89
Nkandla	5	177	182
Ntambanana	4	72	76
uMlalazi	12	137	149
uMhlathuze	4	292	296
Total	29	857	886

The average size per training session planned for was 20 CCGs, as this is regarded as the optimum training level. However, due to demographics and geographical location of wards, some class sizes were greater or smaller than this. The smallest class size was 13 in uMlalazi and the largest was 26 in Mthonjaneni (see Table 7).

Table 7: Attendance at training sessions

District	Group 1	Actual CCGs	Group 2	Actual CCGs	Group 3	Actual CCGs	Group 4	Actual CCGs	Total Actual CCGs
Mfolozi	1.1	23	2.1	18	3.1	21	4.1	14	76
	1.2	18				19			18
Mthonjaneni	1.3	20	2.2	24	3.2	19	4.2	26	90
Nkandla	1.4	17	2.3	17	3.3	21	4.3	21	76
	1.5	18	2.4	21	3.4	20	4.4	25	84
					3.5	22			22
Ntambanana	1.6	20	2.5	20	3.6	18	4.5	18	76
uMhlathuze	1.7	19	2.6	26	3.7	13	4.6	19	77
	1.8	24	2.9	20	3.8	13	4.7	18	75
	1.9	25	2.10	22	3.9	20	4.8	21	88
	1.10	15		21			4.9	20	56
uMlalazi	1.11	17	2.11	15	3.10	20	4.10	21	73
	1.12	20	2.12	13	3.11	21	4.11	22	77
Total		236		217		208		225	886

7.2.4 Certification of CCGs

CCGs will each received a certificate of attendance provided they have attended ten days. CCGs who missed half days or less were given the opportunity to make up their lost time by attending other training sessions and still qualified for the certificate. Of the 886 CCGs who attended the training sessions, 881 will receive the certificate of attendance. Five CCGs did not qualify due to illness.

The high attendance rate of learners during the training roll-out is attributed to the level of consistency and effort that went into advocacy in all Municipalities. When learners were absent, it was for reasons that were not within their control.

7.2.5 CCG Disbursements

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

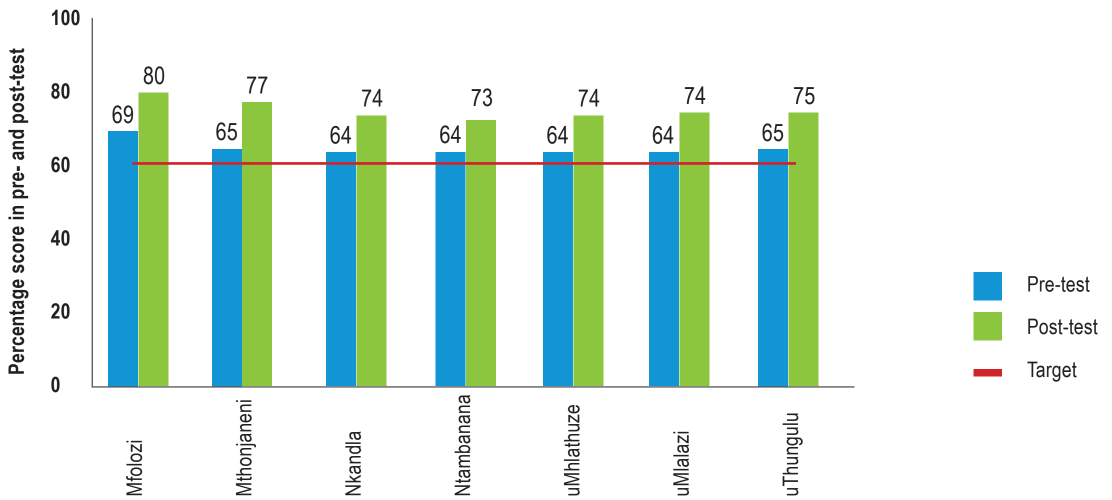
CCGs were requested to provide their banking details for an electronic transfer of the disbursement. Banking details were collected and captured on a disbursement register. The majority of payments (85 percent) were made electronically. In the event of discrepancies arising out of incorrect banking details or bank account not corresponding with the name of the CCG, CCGs received cheque payments via the District Training Task Team or EFTs once banking details were verified via PERSAL.

7.2.6 CCG Performance

Pre- and Post-Test Results

CCG performance was measured by the improvement between pre-and post-test scores.The average improvement between pre-and post-test for uThungulu was 10 percentage points and the results are consistent across municipalities. On average, the CCGs in each municipality easily exceeded the post-test target of 60 percent (see Figure 10).

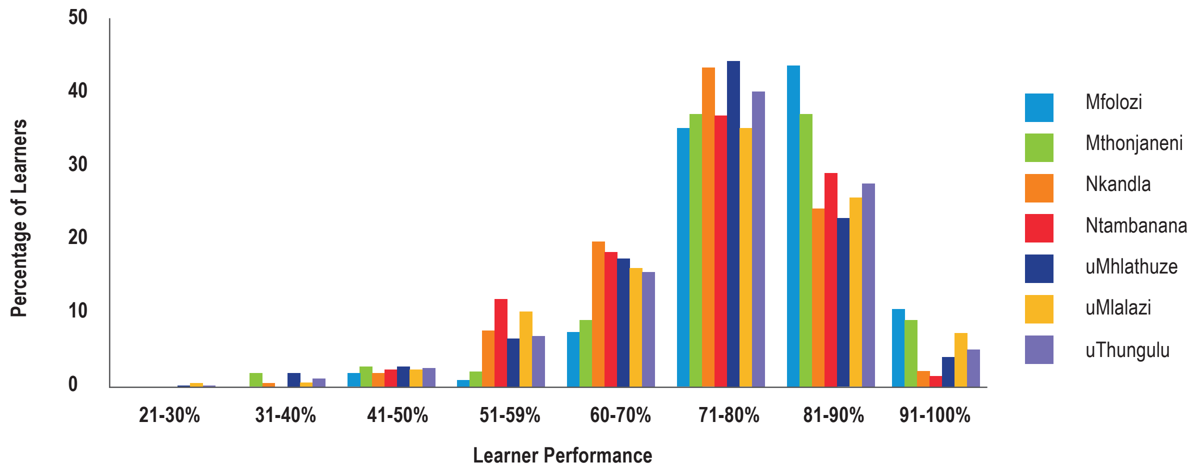
Figure 10: CCG pre-and post-test results per municipality



A closer examination of the results shows that 64 CCGs (7 percent) had post-test scores below their pre-test scores. Of these, some were sick or unable to complete their tests. Of greater importance, there were 99 CCGs (11 percent) with scores of less than 60 percent (see Figure 11). A database of CCGs scoring less than 60 percent was generated and submitted to the municipalities for coaching and mentoring support. It is recommended that the post-test be administered to these CCGs again by the respective municipalities in three months' time.

Results

Figure 11: Distribution of post-test scores per municipality



CCG role-play assessment

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

- Appropriate introduction to client
- Encourages client to feel comfortable
- Ask questions to profile the household
- Assesses clients' needs appropriately
- Ability to select and uses the appropriate screening tool
- Demonstrates competence in using the Care Pathways
- Provides the clients with relevant and factual information
- Ability to seek clarity where necessary
- Ability to use the demonstration tools accurately
- Records information for follow-up

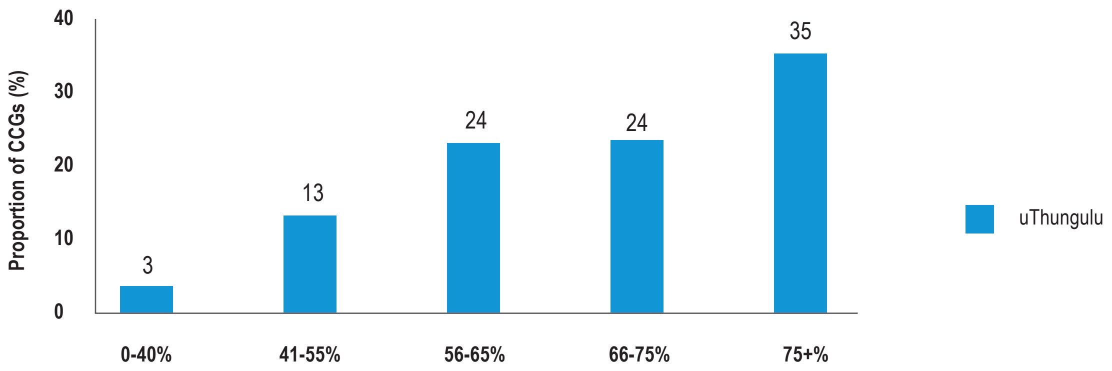
The results show that the average score achieved by CCGs in the District was 69 percent, with all municipalities except Nkandla reaching or exceeding the target score of 66 percent (see Table 8).

Table 8: Overview of role-play scores

Municipality	Mfolozi	Mthonjaneni	Nkandla	Ntambanana	uMhlathuze	uMlalazi	uThungulu average
Average score per Municipality	74%	70%	65%	66%	67%	73%	69%

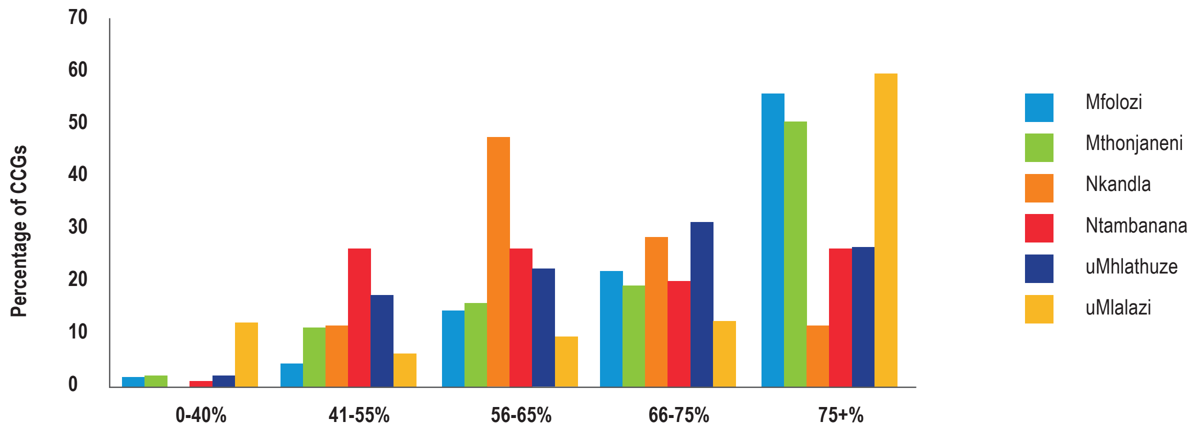
The distribution of role-play scores (see Figure 12) reveals that 59 percent of CCGs reached or exceeded the target score of 66 percent. A further 24 percent achieved scores between 56 and 65 percent and need a little coaching to meet the minimum criteria of being able to transfer knowledge to household members. There are 16 percent or 146 CCGs with scores of less than 56 percent who need more training to bring their knowledge and skills to the level that will allow them to perform their scope of practice.

Figure 12: Distribution of role-play scores for uThungulu



Of concern is that 53 percent of CCGs in Ntambanana and 41 percent of CCGs in uMhlathuze had scores less than 66 percent (see Figure 13). While Nkandla showed the lowest average in score in the District, the majority of CCGs have scores of 56 percent and more.

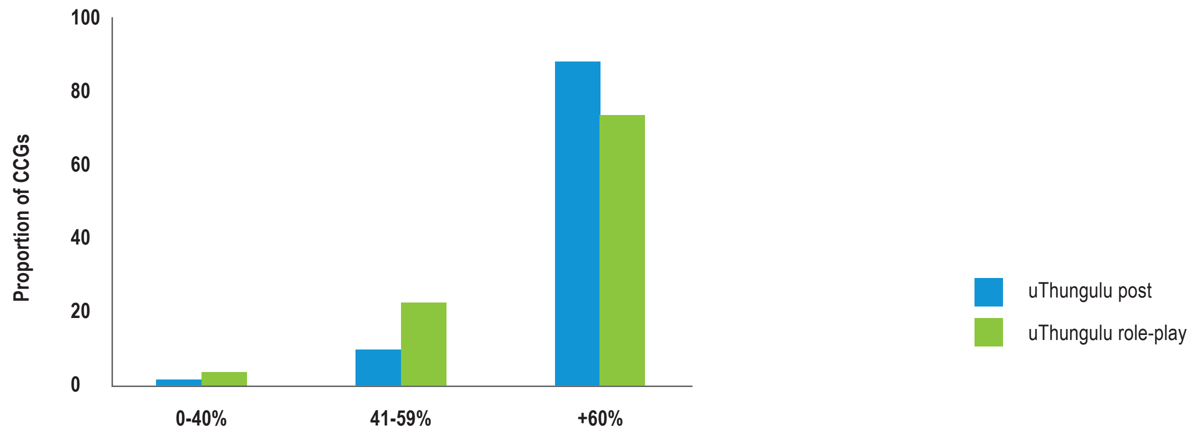
Figure 13: Distribution of role-play scores within municipalities



Summary of CCG Performance Results

In summary, a higher proportion of CCGs obtained 60 percent or more in their post-test results than in their role-plays (see Figure 14) indicating a higher level of knowledge. One in five CCGs obtained unsatisfactory role-play scores of between 41 and 59 percent, indicating that they require additional coaching in applying their skills. Approximately 10 percent of CCGs failed their post-test and role-plays.

Figure 14: Distribution of post-test and role-play scores – uThungulu



In Mfolozi (see Figure 15) and uMlalazi, the majority of CCGs performed well in their post-tests as well as in their role-plays. In Nkandla (see Figure 16), just over a third of all CCGs performed satisfactorily in their role-play assessments while the majority performed well in their post-tests. A similar result was found for Mthonjaneni, Ntambanana and uMhlathuze. In Nkandla, some CCGs explained that they required more time than the allocated ten days.

Figure 15: Distribution of post-test and role-play scores – Mfolozi

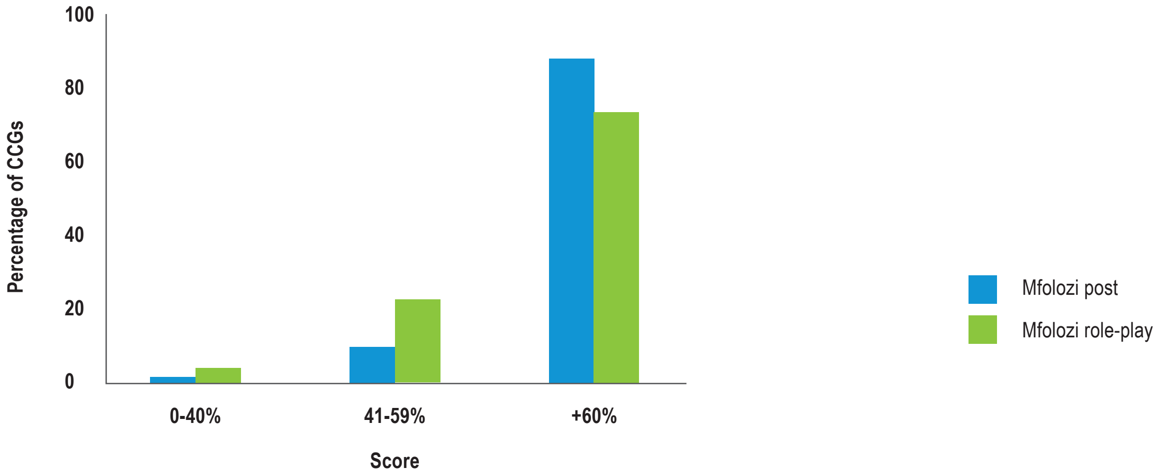
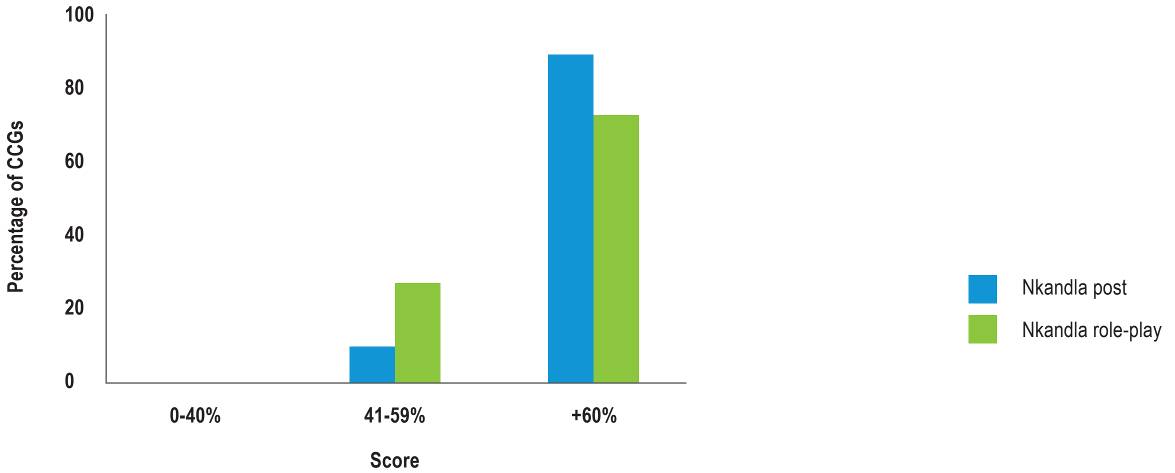


Figure 16: Distribution of post-test and role-play scores – Nkandla



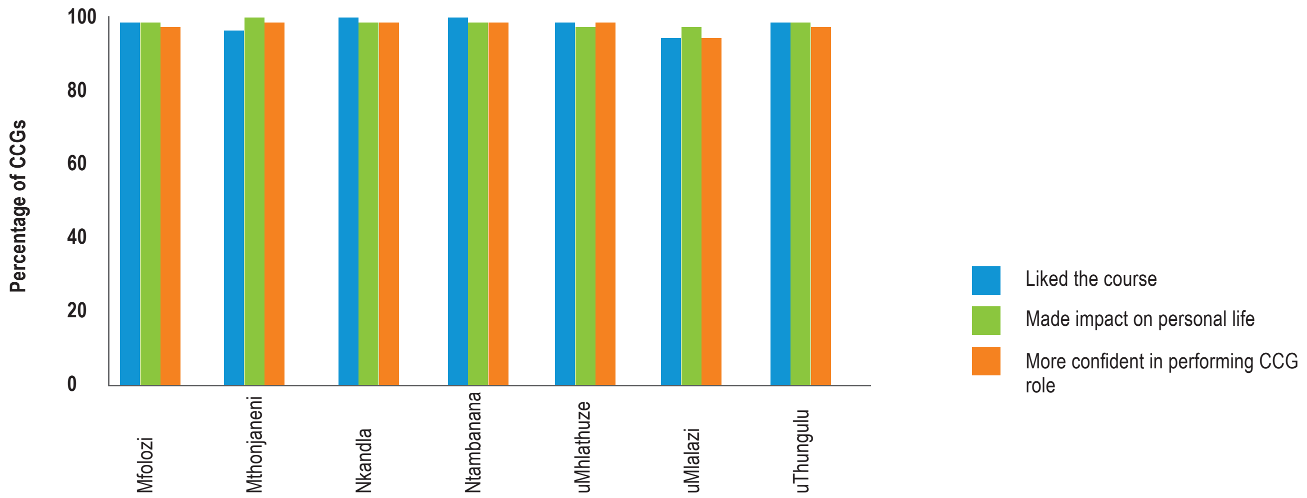
8. CCG learner feedback

Learner feedback was obtained through a self-completion questionnaire(the learner feedback form). Questions and answer choices were read out to assist slower learners. The feedback addressed learner confidence, facilitator presentation, training materials and logistics.

The overwhelming majority of CCGs across all municipalities liked the course. They felt it made an impact on their personal life and helped them feel more confident in performing their role as CCGs (see Figure 17).

For some CCGs the Integrated CCG Foundation Course was the first formal training course they had attended. The training material was comprehensive and informative, covering topics from prevention, treatment to care and support. CCGs were encouraged to act as role models by using and practicing the knowledge themselves.

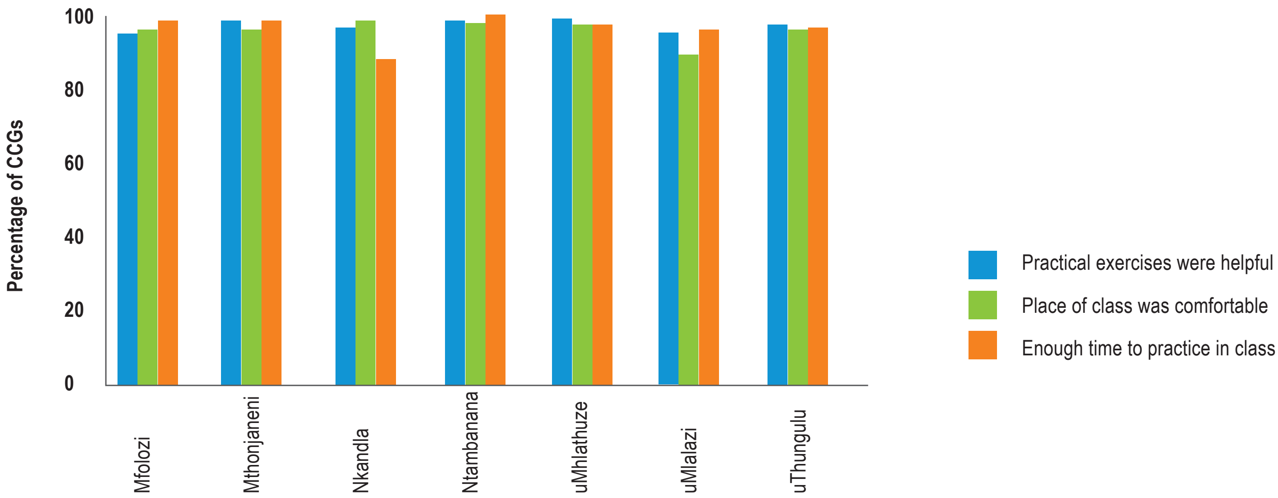
Figure 17: CCG learner confidence



CCGs enjoyed the practical nature of the Integrated CCG Foundation Course, given that it covered the use of screening tools to screen individuals within the household, checklists to identify issues at individual and household level, case studies and individual and group work. Approximately 30 percent of the teaching has been didactic while 70 percent practical. The majority of the CCGs across all municipalities found the practical exercises helpful, the pace of the class comfortable and that there was enough time to practice in class (see Figure 18).

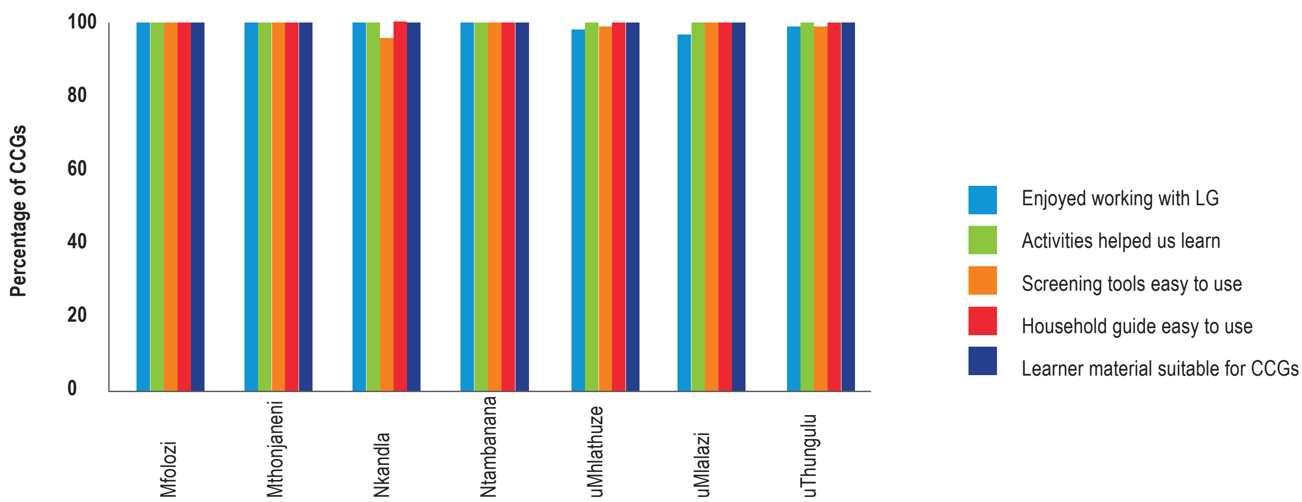
CCG learner feedback

Figure 18: Course presentation



Almost all CCGs enjoyed working with the learner materials (see Figure 19). They found the activities, which included many case studies, interesting and helpful in their learning. CCGs were appreciative of the screening tools which guide them to ask the right questions at household level so as to enable them to refer their clients to access appropriate services. CCGs also found the Household Guide a useful tool to carry with them and to refer to. They will be referring to the Household Guide during home visits. Most importantly, CCGs found the materials suitable for their purpose. These results suggest that the CCGs are encouraged and feel empowered by having tools to assist them to carry out their daily functions.

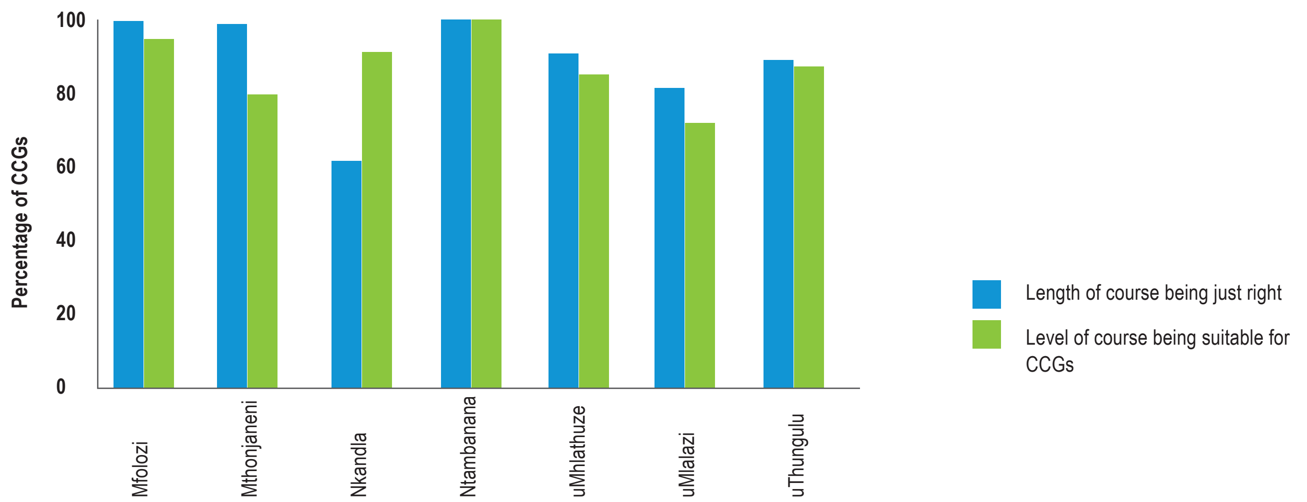
Figure 19: Training materials



CCG learner feedback

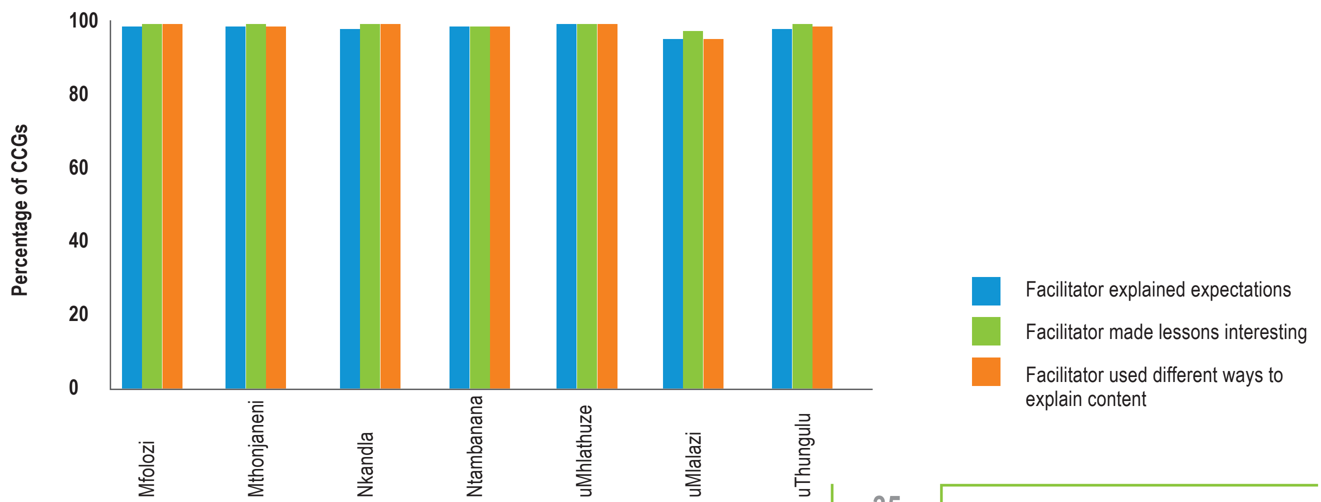
CCGs were asked about whether they felt the course duration was too long, too short or just right (see Figure 20). The majority of CCGs across all municipalities felt that the length of the course, that is, ten days, was just right. In Nkandla, the CCGs felt that more time was required. In uMlalazi, 15 percent of CCGs felt that the course was too long and too easy for CCGs. It is recommended for Nkandla CCGs that time be allocated during CCG meetings to practice the tools. The PTs found some CCG groups needed more time to understand concepts than others.

Figure 20: Course duration



The vast majority of CCGs across all municipalities felt that the facilitator explained what was expected of them (Figure 21). CCGs felt the lessons were interesting and that the facilitator used different ways to explain concepts. At the end of each training day, CCGs showed appreciation to the facilitator and at the end of the training session, some CCGs offered presents such as home grown vegetables to the facilitator. (This was despite communication that went out to CCGs not to offer gifts). Facilitators played a vital role in facilitating the training sessions. Facilitators understood the vision of OSS and their passion transferred to the classroom.

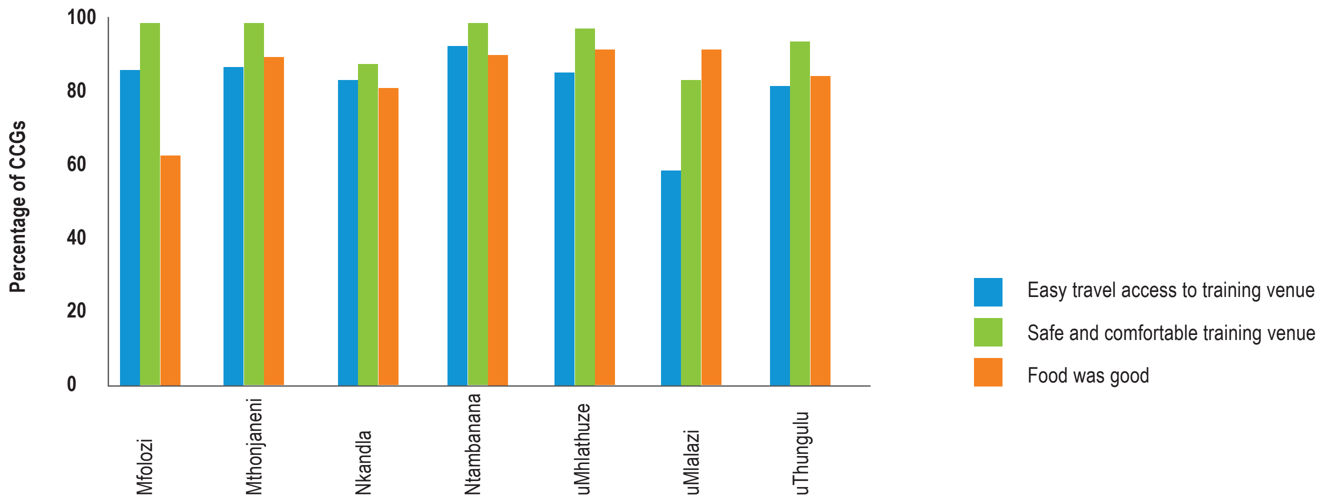
Figure 21: Facilitator evaluation



CCG learner feedback

The training venues were easily accessed by the vast majority of CCGs, the exception being uMlalazi. In some wards where there were fewer CCGs they were combined with those from other wards in one training session. The majority of CCGs found the venues comfortable and safe. In cases where venues were found dirty, CCGs stepped in and cleaned the classroom. The majority of CCGs found the food acceptable.

Figure 22: Logistics



8.1 Appreciation from CCGs, PTs and LOs

In all groups throughout the uThungulu roll-out, CCGs consistently informed their PTs about what the training meant to them. For many, the Integrated CCG Foundation Course was the first training they had attended. For others, the way the training was conducted, the content and the intent behind the training boosted their morale and acknowledged the important role they were playing in the community.

“We are very happy and satisfied about the course. It was an eye opener with regard to serving the community and it helped us with tools to identify community needs.” (CCGs, Group 2.3)

“The best thing about the course was that facilitators were patient with us and explained clearly. Even the ones left behind were brought up to speed. The facilitators encouraged us to be optimistic and patient with our clients.” (CCG, Group 2)

“The learners pointed out that this course is their best course they have ever attended. They made a speech at the end.” (Logistics Officer)

“Participants had a positive attitude toward learning. They were eager to learn and participated actively.” (Professional Trainer)

CCG learner feedback

"I enjoyed the course, felt warm and accepted and able to express my views. I hope to have more courses of this nature that would benefit the CCGs and our households/communities." (CCG Group 2.1)

Across all groups there were comments about how the training empowered CCGs with professional and personal skills. Many CCGs indicated that they felt more confident to communicate and do their work as a result of the training. CCGs noted that not only did it impact on them professionally; it also built knowledge on how they should take care of themselves and live healthily.

"This training has helped me in my daily life as I learnt about healthy living in order to prevent diseases. I learnt to understand myself as a champion in the Operation Sukuma Sakhe and as change agents in the community." (CCG, Group 4)

"The CCGs are excited about the bringing together of mandates of DoH and DSD. Previously they had viewed each other with suspicion – but now saw some integration and working together. They have commended OSS for this vision." (Nonhlanhla Shangase, PT)

PTs acknowledged in their feedback the important role that was played by the HIV and AIDS Coordinators and CHFs. They indicated that it served the function of ensuring high attendance rate in the training and it reinforced the message that CCGs play a valuable and critical role in the community.

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

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

9. Critical Success Factors for training roll-out

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

10. Conclusion and recommendations

Provincial, District and Local Level Buy-in and Support:

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

Professional Trainers

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

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

Attendance

Approximately 99 percent (n=886) of all CCGs on PERSAL have been trained on the Integrated CCG Foundation Course in 45 training sessions across uThungulu. The provision of a travel disbursement proved useful in providing CCGs with the means to travel to the training venue. The survey conducted with ten percent of the samples CCGs to ascertain whether they received the SMS and confirmed attendance was a useful gauge to guide attendance and further action.

Database

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

Training Materials

It is necessary to have all training materials standardised and translated by the same or similar translator based in KZN to ensure consistency. Learner materials were received very well by CCGs, especially the Care Pathways and

Conclusion and recommendations

the Screening Tools which will help them screen, educate and refer clients more effectively.

Number of CCGS Trained

Of the 886 CCGs trained in uThungulu, 97 percent were African female. Attempts need to be made to recruit male CCGs and CCGs from wards where there are insufficient number of CCGs.

CCG Performance

The vast majority of CCGs scored over 60 percent in the post-test assessment. The average post-test score for the District was 75 percent. For the 99 CCGs who scored less than 60 percent in their post-test assessments, it is recommended that coaching support be provided via their peers and the post-test be re-administered to them in three months' time by the District. There are also 146 CCGs who require refresher training to bring their knowledge and skills to the level that will allow them to perform their scope of practice.

Learner Feedback

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

CCG Supervision

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

Policy Implications

The experience of the uThungulu Integrated CCG Foundation Course has clearly demonstrated that the Integrated CCG Programme can be extended to the whole province.

The Integrated CCG Foundation Course provides a strong platform for training all CCGs in the province who are on the PERSAL system.

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

Conclusion and recommendations

Overall

The CCG Integrated Foundation Course was a success due to the commitment of all Partners, the Professional Trainers, Provincial, District and Municipal Officials and staff from BRHC. Shortcomings were identified and corrected as they arose due to high level of presence and activity by all Partners. The short time allocated for pre-planning was made up by extra hours invested by the project team during the roll-out. The overall success of the roll-out in uThungulu District is due to the high level of commitment and passion of the officials in the District and Municipalities without which no training can occur.

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

Appendix 1:
Stakeholder Advocacy and Communication Plan

Advocacy and Communication Objective	Champion (Allies) – Likely supporters, these will be our agents for change	Role of the Champion	Communication Intervention/what information do they need	Key message	Target audience (Who is the message aimed at?)	Medium	Frequency	Means of Verification	Accountable Agency for this ACC activity
Advocate to all stakeholders to support the training roll-out of the CCG integrated Foundation Course	DDG, COHOD, HOD Health, HOD DSD MANCO, OSS Structures, DM CCG structures, Local Municipalities PPSTA	Advocate and communicate the CCG Integrated Foundation Course	a) Training curriculum b) who should attend c) length of course; d) training time line	All CCGs and their supervisors + CHFs and HIV and AIDS Coord to attend the CCG Foundation Course	PAC, MANCO, HODs, OSS District Managers and their staff, OSS Task Teams and their members	Publish a letter signed by DDG; PPP presentation for senior managers	Beginning of project once off	Take copies of letter and PPP to District level staff to ensure their receipt	PPSTA/BRHC
Publish and disseminate the training roll-out plan and training schedule	HOD Health and HOD DSD	Disseminate the training roll-out plan and schedule	a) Training dates and venues	CCGs and their Supervisors to attend the CCG Foundation Course	OSS senior managers and OSS structures, District Managers and their staff including CCGs and Supervisors	Letter on OTP Letterhead	Once off	District level staff down to CCGs within war rooms	District structures/ BRHC
Advocate for CCG attendance and use of CCG Training material (to achieve minimum 90% attendance)	District Managers Health and DSD	Send Invitation and instruction to all CCGs and supervisors to attend, participate and use the tools of the CCG Integrated Foundation Course	a) Training dates and venues b) supervisors checklist to assess CCGs in field	CCGs and their Supervisors to attend the CCG Foundation Course and confirm attendance and check CCGs use of material post training	CCG Supervisors	Invites to CCGs & Supervisors in District letterhead, CCS supervisor checklist Develop supervisor checklist to be used	Once off	CCGs aware of invitation and CCS aware of the checklist Supervisor checklist distributed	Provincial/District structures/BRHC

Advocacy and Communication Objective	Champion (Allies) – Likely supporters, these will be our agents for change	Role of the Champion	Communication Intervention/what information do they need	Key message	Target audience (Who is the message aimed at?)	Medium	Frequency	Means of Verification	Accountable Agency for this ACC activity
Publish the progress report of the CCG integrated Foundation Course	PPSTA, DDG OSS	Disseminate the progress report	a) Numbers trained and scores achieved b) challenges and lessons learned, recommendations	Progress of training & mitigate challenges	PAC, MANCO, HODs, OSS District Managers and their staff, OSS Task Teams	Progress Report full report and PPP	On-going	Copies of agenda, discussions with key stakeholders	PPSTA/BRHC
Publish and disseminate the project training report	PPSTA, DDG OSS	Disseminate the project training report	a) M&E report b) training approach c) training results d) copies of training program and training slides and facilitators guide e) next steps – include photos in report	Successes and next steps	PAC, MANCO, HODs, OSS District Managers and their staff, OSS Task Teams	Report in Word and PPP	Once off	Copies of agenda, discussions with key stakeholders	PPSTA/BRHC

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