JOHANNESBURG HEALTH DISTRICT
Department of Family Medicine, Wits

Practice Booklet
January 2021
Report on Chiawelo Community Practice

The South African government plans to implement **National Health Insurance** (NHI). The 2011 Green Paper on NHI spoke of the priority of strengthening the District Health Services. Government has issued "Provincial Guidelines for the implementation of the three streams of **PHC Re-Engineering**" in which it describes three streams to 're-engineer' the current district health system: **District Clinical Specialist Teams** (DCSTs), **School Health Teams** (SHTs) and **PHC Outreach Teams** or **Ward-Based Outreach Teams (WBOTs)**. We are implementing the WBOT programme (using the National Department of Healths Toolkit, that guides this), and trying to improve on it.

History of COPC

Although the South African government based the WBOT programme on Cuban and Brazilian experiences it is actually a South African innovation. Cubans and Brazilians were inspired by the community-oriented primary care (COPC) approach, modeled by Sidney and Emily Kark in the 1940s in Pholela, Kwa-Zulu Natal. The Karks, young Wits doctors, went to Pholela in 1940. Edward Jali (a clinical associate) and Amelia Jali (a nurse) were also key to developments at Pholela. Pholela was one of a few pilots supported by the Ministry of Health in their attempt at setting up a National Health Service (NHS) in tandem with the NHS in the United Kingdom. Key players were Eustace Cluver (Secretary of Health), Harry Gear (Deputy Chief Medical Officer), George Gale (Chief Medical Officer) and Henry Gluckman (first National Minister of Health 1946-1948).

The Kark's first innovation was to develop a Community Health Centre (CHC) with team-based comprehensive task-shifted personal care serving ±30 000 people in the rural community of Pholela, where the norm in South Africa was personal care by private GPs. Their second innovation was to develop Community-Oriented Primary Care (COPC) for a small defined unit of ±1000 people, combining personal care with public health. They examined the impact annually, comparing a new adjoining area of 1000 people with the previous area/s.

By 1948 there were more than 40 such CHCs in South Africa. Their work spread throughout the world, with a young intern Dr. Jack Geiger taking the concept back to the United States of America (USA). Currently 10% of the USA population, mostly poor and marginalized, are serviced by a CHC. However, the Karks were persecuted by the apartheid government installed in 1948 and left for Jerusalem in 1958. COPC has taken root in many parts of the world: Israel, Spain, USA, Canada, Cuba, Brazil etc.

Ward-Based Outreach Team Programme

The Ward-Based Outreach Team (WBOT) is based on municipal or local government wards. According to the policy each ward is expected to have one or more PHC Outreach Teams comprised of one professional nurse (as team leader), one environmental health office and one health promotion practitioner as well as six community health workers (CHW). They are expected (with one other professional nurse and enrolled nurse at the clinic) to serve a population of **1500 families** (± 6000 people) in the accountable delivery of health services. Each WBOT is expected to offer an integrated health service to households and individuals within its catchment population.

The roles of the WBOT overall are:

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

treatment
- Treatment of **minor ailments**
- Basic **first aid** and emergency interventions

The roles of each CHW (allocated 250 households as part of a WBOT) includes:

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

However there appear to be challenges with implementation of the WBOT Programme: poor human resource planning, the lack of skills and the lack of integration. A study of WBOTs in Johannesburg found two challenges: leadership-management and human resource. The leadership-management challenge was poor leadership and planning with an under-resourced centralized approach, poor communication, uncertain impact on current services, resistance to change and poor integration. The human resource challenge was mostly about the employment plight of CHWs and inappropriate team structure (Moosa, Derese, & Peersman, 2017). Brief investigations show piles of household registration forms in clinics with no review of the data collected. CHWs simply report on the number of visits undertaken with no link between this public health information and personal care at clinics. It is more of a once-off public health screening programme than COPC, as the Karks had practiced in Pholela. PHC in Johannesburg appears more focused on pushing the queue (Moosa & Gibbs, 2014).

COPC as a model for NHI practice - a simple framework

The concept of Community-Oriented Primary Care (COPC) is not completely understood nor being acknowledged, let alone celebrated as a South African innovation. It is unfortunate that COPC seems to be poorly implemented worldwide, with high-minded theory and impractical approaches. Professor Shabir Moosa, linked to the Wits Department of Family Medicine, has attempted to implement COPC, as the Karks did but naming it community practice to differentiate it from family practice or general practice. The Chiawelo Community Practice in Soweto is a real-life model of general practitioner-led teams suitable for National Health Insurance.

Chiawelo

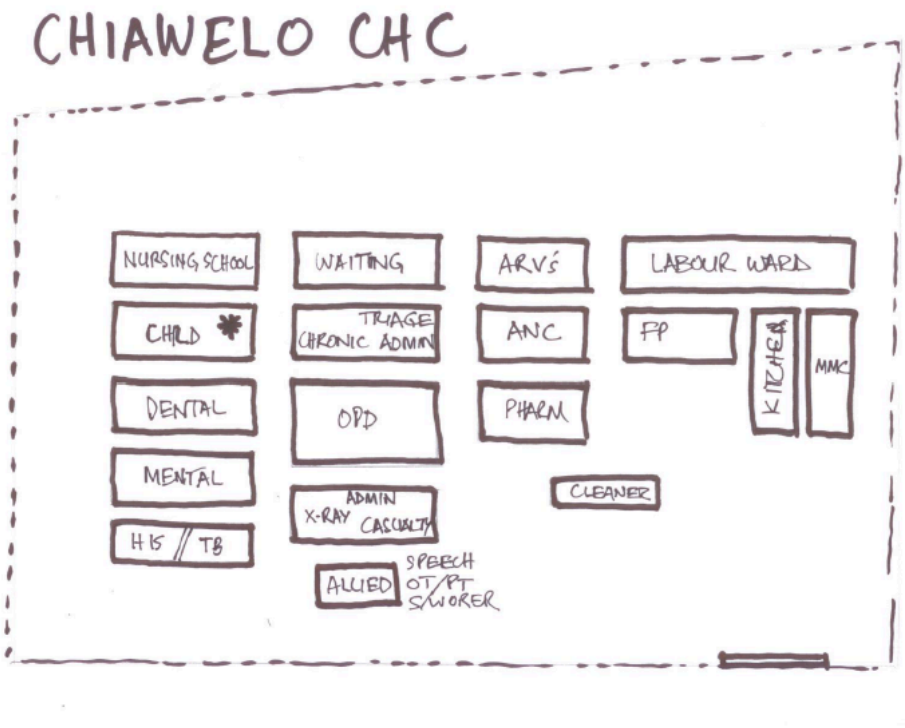
Chiawelo was established as an ethnic extension to Soweto in 1956 for Tsonga- and Venda-speaking residents. This was part of the state's strategy to sift black Africans into groupings that would later form the building blocks of the so-called "independent homelands". More details are available at http://en.wikipedia.org/wiki/Soweto

Chiawelo Community Health Centre

Chiawelo Community Health Centre (CHC) is one of the five major CHCS in Soweto and dates back to the 1980s, when the apartheid government tried reforms to appease the restless black population following the 1976 youth-led riots. It is a sprawling set of ±17 prefabricated buildings (more like a small hospital without beds) providing a range of services to almost a quarter of Soweto's ±1.5m population: an outpatient department sees patients for acute problems, whilst a chronic section deals with chronic diseases.

Whilst HIV is now somewhat integrated into chronic are there is a separate section dealing with TB. There is a pharmacy, X-ray and 24hr emergency service available. There are separate mother and child services, with well-baby, antenatal, family planning and maternity sections. There are also allied health care services like dentistry, community psychiatry, physiotherapy, speech and audiology and occupational therapy.

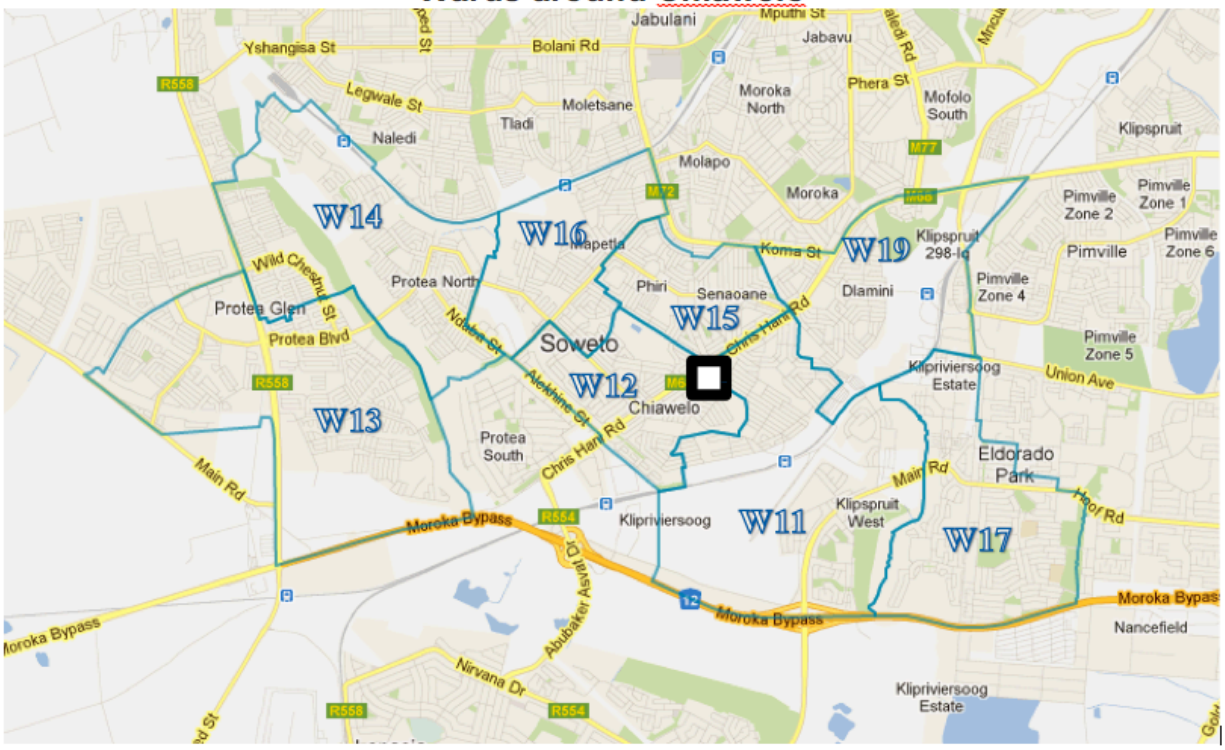
Whilst Chiawelo CHC provides this wide range of services, actual care is very fragmented with poor patient-, person- and people-centeredness. Chiawelo Community Practice, as Chiawelo CHC's Ward-Based Outreach Team (WBOT), operates from one of the seventeeen buildings (*asterisked below) in Chiawelo CHC, as an attempt to implement the WBOT programme more robustly as COPC.



Chiawelo CHC (black square below), is located in Ward 11, but its catchment area consists of many wards: 10, 11, 12,13,14, 15, 16, 19 & 33. Most patients come from Wards 11,12, 15 and 19. There are 6 local government clinics in the same area but they only have nurses providing care, with weekly doctor visits, so many patients come to the CHC for medical care. There was also an attempt to re-orient the CHC into community practices by these wards from October 2015. A survey of all patients coming into the CHC in 2015 showed the following profile: 49% of patients came from Wards 11 (23%), 12 (15%) & 19 (11%), 26% from Wards 15 & 16 and the rest of 25% coming from Wards 10, 13, 14, 33 and beyond.

This failed despite several attempts, with nurses rebelling against changing their old ways and managers seeming powerless.

Wards around Chiawelo



The following are the populations in these wards using StatsSA data.

Ward area	Population	Population
Ward 11		33473
• Chiawelo area (±Ward 11)	13104	
• Klipspruit area (±Ward 11)	10464	
Ward 12		27300
Ward 15		26784
Ward 19		28668

StatsSA http://www.census2011.co.za/

Our history in Chiawelo

Professor Shabir Moosa started engaging with the community health committee as well as community leaders like councillors, principals, traditional healhers etc. from September 2013 to implement COPC in Chiawelo. There was unanimous support for this project from key stakeholders, including the CHC Committee.

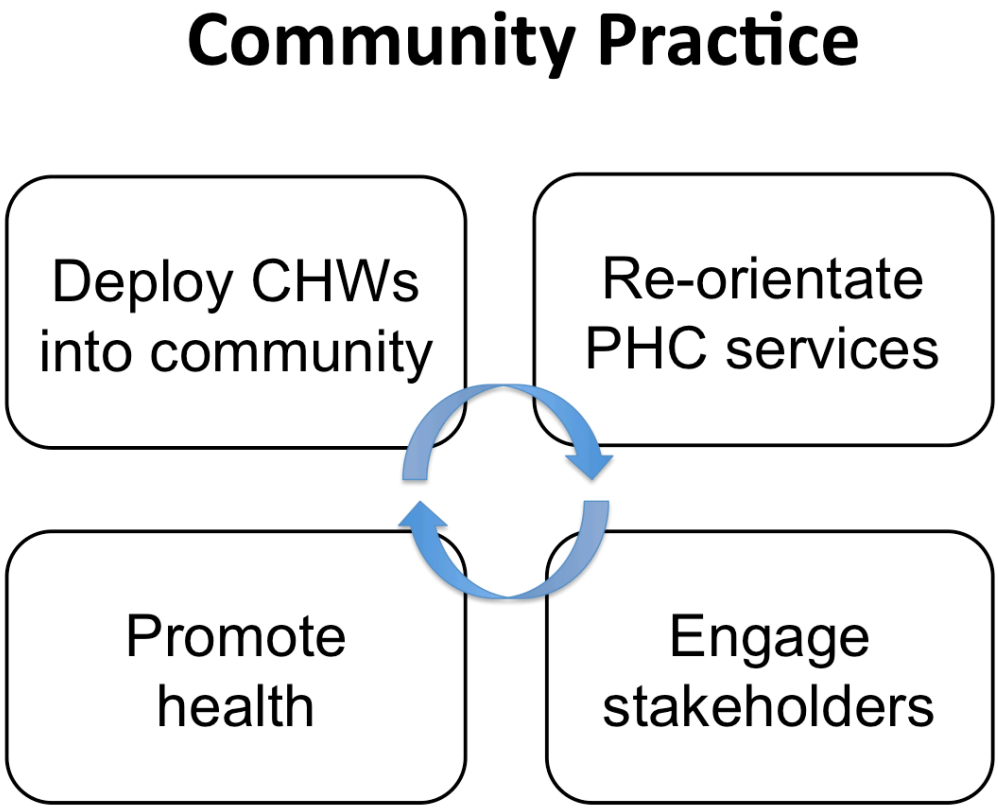
Prof. Moosa began Chiawelo Community Practice in Ward 11, employing 18 CHWs via Wits since Feb/July 2014. Spaces in Chiawelo were renovated and furnished to serve as offices, seminar room as well as consulting rooms, costing ±R350 000 in Wits funds. Whilst the renovated space, called Chiawelo Community Practice (CCP), is a part of Chiawelo CHC services it is also being used for service development, teaching, advocacy and research.

This space functioned under the complete direction of Prof. Moosa and was accountable to the facility manager with monthly reports.

We were fortunate in that despite management opposition to CCP these CHWs were absorbed into the public service in June 2014 after the MEC visited and insisted that CCP continue despite the exhaustion of Wits funds. Managers have been tepid in their support as it challenges the approach of current PHC services. CCP functioned very well from 2014 to 2017, when it was small, with CHWs appointed and trained by Prof. Moosa dealing with the administration of CCP and covering only Ward 11. CCP was expanded to the full building in 2018 to cover parts of Ward 12 and Ward 19 by absorbing 40 other CHWs appointed via NGOs and with different attitudes / processes. The initial structure of the practice was disrupted, and it was forced to function more like the CHC. The work of CCP has been hamstrung by these over the years and now functions sub-optimally. Nevertheless, it still has the essentials of the original COPC approach that was implemented in 2014.

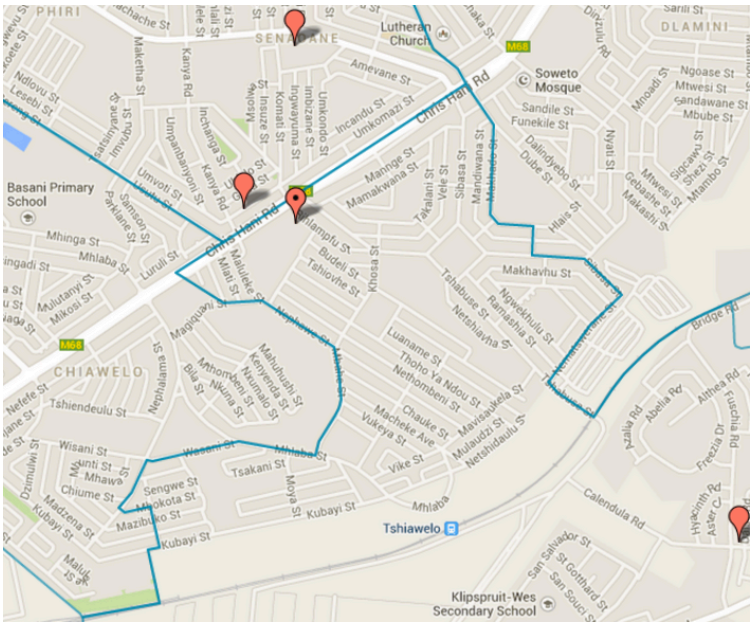
Chiawelo Community Practice

Chiawelo Community Practice (CCP) attempts to move away from COPC being a project with a planning approach towards making prevention an integral part of daily work. CCP is based on the following four key drivers in a systems-based approach (all four juggled as we proceed). COPC is not about clinicians walking around in the community doing home visits. It is an approach that manages the enrolled population, not just the patients that walk into the clinic. The lead clinician should typically delegate a senior nurse to support the enrolled nurse CHW Team Leaders and CHWs with education and developing health promotion plans on a morning weekly, have CHW Team Leaders join a weekly one-hour clinical meeting and will typically spend 1 morning a month meeting with Community Stakeholders in discussion on community problems and health promotion plans. See CCP details below.



Population management

A key component of CCP is to engage with the population. This can happen in a variety of ways, by person, calling or social media. Disempowered communities like in a township benefit easier with CHWs. The original ward engaged, Ward 11, is described below.



Ward 11 consists of the upper half of the Soweto suburb of Chiawelo. CHWs work across the Soweto part of Ward 11. The Klipspruit part of Ward 11 is across the railway line and is not covered by CCP.

A Google map of Ward 11, Chiawelo (just around the Chiawelo Community Health Centre) was printed out. The area was crisscrossed by CHWs developing a social assets map. An A0 municipal map was also obtained. CHWs did a dipstick of density of lots/addresses by visiting a few addresses per street to check the number of people per lot. The eighteen CHWs then allocated themselves to areas based on lots, in an equitable manner, usually covering 1000 people. This allocation of CHWs to different areas is laid out on a municipal map and is available on our walls.

Once they had their area clearly demarcated, they were tasked to go to every address and develop a "**census" or street summary or family list** of ALL families with family names and the number of people per family listed, with a unique family identifier e.g., W11 (Ward 11) A (for CHW from A to Z, depending on the number of CHWs) and a three-digit number.

Each CHW then visited each family to do a household registration by filling in the form the National Department of Health uses. This included household details (including housing issues); a list of family members; and household illness and health risk issues (HIV, TB, pregnancy etc.). This served to register the family into the Chiawelo Community Practice. There could be referrals by CHWs but each family was also given a letter stating that the family may access ALL their public health care services freely at CCP, if they felt sick and needed health care. The letter had a telephone number (a simple R400 Neotel handset with R50 airtime per 6mths in 2015-2017 and then a set of 12 mobile phones from 2018) and residents were encouraged to make appointments to reduce short waiting times.

The CHWs captured problems identified in this household registration onto a **problem list** and progressively developed a community profile or diagnosis of residents of Ward 11. The census-like information of total families and population as well as key registration data e.g., no. of families and people registered were captured onto a laminated chart and were supposed to be updated regularly by CHWs. This sits next to the map as a summary of monthly progress but CHWs have not been updating this after the disruption in 2018.

The family lists or 'census' of Ward 11 as at December 2017 showed a population of 21602 people / 5910 families. CHWs registered 18076 people / 4253 families i.e., 4.3 persons per family. CHWs also built up the list of key stakeholders in the community and mapped many

social resources in the community e.g., schools, churches etc. that were put up in clinicians' consultation rooms. Prof Moosa facilitated the learning of CHWs over afternoons and then on Fridays over a few months in 2014 in a learner-centred approach. CHWs in Ward 11 also attended a CHW course by an NGO paid for by Wits. Clinicians and team leader were supposed to continue, facilitating the CHWs learning weekly on Friday mornings (using the National Department of Health CHW Training Manual and key Gauteng Health documents). This has been challenged. Each CHW has a priority list of patients per condition. The clinicians are aware of the dynamics of the community and regularly discuss issues with CHWs. Interns are expected to do pre-arranged necessary home visits with CHWs on an afternoon, weekly as a learning exercise.

The community profile (or community diagnosis) for Wards 11 (vs. Soweto overall) using 2011 Gauteng City Region Observatory data (as at Oct 2013):

Table 1: Ward 11 Community Profile vs. Soweto

Community Profile	**Ward 11**	**Soweto**
Demographics		
• Household density	1214	2450
Socio-economics		
• Economically active adults	39,6%	38%
• Unemployment	**39,2%**	**44.5%**
• Adults receiving social grants	22,9%	21.4%
• Average household income	R4900	R4805
• Informal housing	0%	1,7%
• Without access to housing (RDP)	**16,3%**	20.1%
• Without access to drinking water (RDP)	1,1%	5.7%
• Without access to sanitation (RDP)	1,2%	7.7%
• Without access to lighting electricity (RDP)	1,7%	11,5%
• Without access to cooking electricity (RDP)	1,9%	12.9%
• Clinics and schools are within 5km/3km	Yes	Yes
• Female-headed households	37,4%	42%
• Child-headed households	0,7%	0.9%
• 7-14yr olds not attending school	**4,9%**	**4,9%**

Analysis of the registered ±18000 people confirmed a largely elder population (35%) in the community. In discussion with CHWs many of the elder homeowners are setting up and renting shacks, as their children left to get their own homes. There are sometimes up to five shacks and many children living in them. Families may live in the shacks between two weeks and two years. They represent a growing migrant community living in Chiawelo.

Analysis of the ±18000 people revealed

- 100% access to electricity, toilet, piped water and working fridge.
- 29% receiving grants & 1% eligible needing grants
- a low employment rate (although there were many gaps)

The CHWs data in registering ±18000 people since February 2015 was analysed and showed 3139 problems, with 89% resolved as at end 2017. Analysis of the 3139 problems shows the data below.

Report on CHW follow ups - Nov 2017																			
	Basic Health						Maternal							Chronic					
Ward 11 Profile	TB suspect	HIV test	FP	HBC	Grant	OVC	**Preg**	**Delivery**	**<2,5kg**	Immun#	Vit A	Wt	PCR	TB	HIV	HT	DM	Other
Problem found	84	457	207	13	12	0	155	148	3	9	7	1	7	67	306	1027	301	335
Resolved	67	200	157	10	10	0	143	148	3	9	7	1	6	67	305	1027	298	332
% Problem	0,5%	2,5%	1,1%	0,1%	0,1%	0,0%	0,9%	0,8%	0,0%	0,0%	0,0%	0,0%	0,0%	0,4%	1,7%	5,7%	1,7%	1,9%

We had 1027 patients with hypertension, 301 with diabetes and 306 patients with HIV. Many of these patients were adherent to treatment but CHWs were not doing as well in following up patients who have requested an HIV test or want access to family planning. The data around pregnancy is inconsistent considering that this data was collected over two years and was not updated regularly. It is important to note that CHWs spoke to one family member, who answered all the questions about the entire household. It highlights some of the limitations of the one-off household-based registration form as a CHW might not know all the ongoing sensitive and personal health related information about each member of the family who lives in the house e.g., wanting an HIV test or family planning.

There was an attempt in mid-2018 to get Ward 11 CHWs to collect data from every individual in each family using tablets. The online tool was developed to include many more preventive measures like Pap smears, smoking, mental health as well as screening tools that are recommended by the United States Preventive Services Task Force. Unfortunately, this was limited by the CHWs abusing the tablets for phone calls and bringing the effort to a halt within a few months. Subsequently there was an effort to get volunteers to collect this information at the clinic in CCP using a Preventive Care Record based on the online tool, but this process delayed the queues and patients became very unhappy with the waiting times. The Preventive Care Record has been retained in the files but is often not addressed by clinicians in routine patient care.

CHWs and Team Leaders in Wards 11,12, 15,16, & 19 were linked to CCP in June 2015 and 120 more CHWs were added to the 20 CHWs to make a total of 140 CHWs by August 2015. There was a training, orientation, mapping and registration process started for these CHWs with just 7 Team Leaders altogether. Progress has been slow with only Ward 12 started in November 2016. As of December 2017 (more than 2 years after starting) Ward 12 CHWs, covering only half the ward, had only registered 17% of the estimated ward population of 18637 residents. Ward 19 CHWs covering most of the ward, had only registered 25% of the estimated ward population of 19110 residents as of December 2017 (more than 2 years after starting). Ward 15 & 16 CHWs are based in Senoane Clinic with their patients being seen there in part.

PHC services re-engineered

Patients come straight to the Chiawelo Community Practice in Chiawelo CHC, as per the letter handed out by CHWs. It invited them to use CCP for ALL services needed, from immunization to chronic care (including insulins and ARVs). Services are limited to acute and chronic care as nursing managers refused to provide CCP with nurses, consumables and support for immunization, family planning and antenatal care. CCP was managed by CHWs 2014-2017: coordinated by a senior CHW, with two CHWs acting as receptionists and one CHW (qualified as an auxiliary nurse) doing vitals. This was disrupted in 2018-2019 with all 40 CHWs expected to rotate in groups of four through CCP on a daily basis to assist

with filing and vitals and continues to date. Our filing and administration system has been compromised. In 2019/2020 we were allocated a professional nurse to coordinate CCP and an enrolled nurse in 2020 to do vitals, with help from CHWs. The nurse rotations have settled over 2020. The original date and time appointment system was disrupted as well in 2019 when all the mobiles were progressively 'lost' by the rotating CHWs. We still encourage appointments, but it is date based and only done in person at the front desk by those (mostly chronics) leaving the clinic.

When a patient arrives and is validated as being registered with the CHW forms in the CHWs file a family folder is made up (with a file for the individual patients and an CHW folder for the family, containing the filled household registration form). The clinician fetches the family folder from the shelves in the waiting room and call in the patient. Clinicians are expected to briefly review the CHW file to understand the patient within the family-community context. We urge interns to write notes in the CHW folder with instructions for CHWs to follow up after consultations with patients, but this does not always happen as interns rotate weekly. Clinicians put the CHW folder aside for follow up. A CHW can bring anything to the clinicians' attention at any time via the Team Leader but we try to also have a weekly discussion as a team on problem patients or generally.

Chiawelo Community Practice is a fairly comprehensive service integrated around patients, including a fair range of medical services (and medication) available at the CHC. All CHC processes and systems are respected. There is a paper trail for all work done in this space. Medication is ordered and accounted for with the CHC Pharmacy. We strive to store medication in accordance with pharmacy regulations. All statistics are collected daily and supplied to clerks, section data capturers and DHIS data capturers. Reports, according to the Toolkit for PHC Outreach Teams are provided monthly to the facility manager and district managers.

The clinical associate, Ms. Shivani Pillay, is seeing all patients with 2-3 interns (rotating two-weekly in COPC and supported by Dr Kabir (Family Physician) and the occasional first-year Family Medicine registrar (rotating for three months in COPC). Patient numbers per day remain ±80 per day for ±30 000 people from Ward 11, 12 and 19. Utilization of the Chiawelo Community Practice is hovering at 0,67 visits per person per year, much less than public service averages, as a function of CCP's easy access and CHW support. A study of a random sample of 424 households in Ward 11 by a registrar in 2018 showed use of CCP by 98,3% of the population, access by visits strongly correlated to expressed need. It showed 90,3% having easy access to CCP (vs. 1,9% for the CHC) and 92,2% satisfied with CCP (vs. 28% with the CHC). When asked whether the CHW changed the frequency of their visits to CCP 44.2% said CHWs decreased their visits to CCP. An audit of CCPs chronic care showed substantially better records and adherence to guidelines than the CHC. A study by medical students showed that CCP costs a quarter of the public service expenditure per capita in Johannesburg. CCP was used to model a proposal for feasibility testing of NHI Capitation contracting to GPs.

Stakeholder engagement

There have been regular one-to-one discussions with a variety of stakeholders. They are on three levels:

a. Health sector (facility manager, doctors, nurses, programmes, allied health care workers, etc.)
b. Other government sectors (social workers, schools etc.)

c. Community (Councillor, Ward Committee, CHC Committee, traditional healers, churches etc.)

The Sub-District D (Soweto) and CHC manager has been fairly supportive of the development of the Chiawelo Community Practice and mediating issues with other staff in the CHC. We have engaged with nurses and doctors in the routine outpatient and chronic sections as well as various programmes – mental health, child health, family planning and HIV clinic. We also engaged extensively with allied health care workers in Chiawelo CHC – occupational therapist, physiotherapist and audiologist. A social worker, Mr Nduvuho, visits CCP every two weeks to deal with social problems picked up. This has been supported occasionally by social worker students from Unisa working to support CHWs. We have reached out to schools with various health promotion programmes in addition to providing schools with access to clinic support for sick children, supporting the school nurse programme and contributing to Life Orientation lessons.

Considerable engagement has occurred with the councillor of Ward 11, Ms. Meisie Maluleke, councillors of Wards 12, 15,16 and 19 and the local Parliamentary Office. There has been strong engagement with members of the ward committees and their portfolios. There has also been strong respectful engagement with church leaders, school principals and traditional healers. Chiawelo has an active community of traditional healers. A group of more than 20 healers, belonging to the Traditional Healers Organisation (THO), meet weekly in the community to discuss problem and support each other. The THO, an international organisation representing the rights of healers across Southern Africa, advocate for a strict code of conduct in order to “assure the values, quality of treatment, efficacy, safety and ethical standards of member practitioners”. Chiawelo Community Practice (CCP) has met a number of times with this group of healers to introduce them to the practice and to develop a working relationship. The healers explained that in the past, they have had a difficult relationship with the existing public service as many of their clients have been discouraged by clinic staff from using their services. As a starting point, CCP has stressed an open-door policy where healers are encouraged to send problem patients to the practice. A collaborative research project is ongoing with this group of healers to model an effective means of linking the two healing systems.

An annual meeting occurs with key stakeholders, including community representatives, facility manager and councillor, to work on priority programmes. We have a regular CCP Stakeholder Workshop to engage the variety of community and other stakeholders more broadly and regularly as a formal platform for the development of community priorities and empowerment. Community stakeholders raised the following issues as priorities in the Annual Workshops in November 2015 and April 2017: poverty and unemployment, substance (nyaope) abuse and teenage pregnancy. Our last meeting in February 2019 showed the same with teenage pregnancy changed to environmental health.

We have tried to bring together leaders on a monthly basis, but this can be challenging with their competing priorities. We have developed leadership amongst our patients in health clubs as part of our health promotion efforts. They have become a staple for our monthly community stakeholder meetings from February 2018 until the COVID-19 disruption in March 2020.

Health promotion

We apply prevention at many levels.

- Primordial Prevention (factors impacting health beyond the control of individuals – usually social determinants of health)
- Primary Prevention (factors impacting health that are within the control of individuals but where there is no disease)
- Secondary Prevention (screening for disease that is unknown)
- Tertiary Prevention (checking for complications of known disease)
- Quaternary Prevention (checking for problems created by caregivers)

CHWs address social determinants of health (in some measure by linkages), by educating of risky behaviours e.g., smoking, sexual behaviour etc. and they do some screening for disease as part of their process of visits. CHWs have a joint daily health club (with stretching and strengthening, some aerobics and group discussion in support / health literacy group meeting in their area. We have five daily health clubs for the ward. This focuses on elders, develops fitness as well as acts as a social support system. CHWs also visit schools sometimes in collaboration with the school nurse.

Our key advocacy tool is stakeholder engagement especially local community leaders. This includes relating to various government departments through Ntirhisano, a project for inter-sectoral collaboration by the Gauteng Premiers Office.

Tertiary prevention (managing complications) and quaternary prevention (ensuring we don't harm patients') is a part of our service quality improvement at CCP. We have a chronic care form that allows monitoring of chronic diseases using a flow chart and planning care for the future. We also arrange for CHWs to do strong health education, drug deliveries and follow up on chronic patients two monthly.

Health promotion is a complex task and is evolving slowly based on regular interaction with data from the CHWs, practice and community consultation. It may require more individual-based data and stronger evidence for targeted interventions to change behaviour rather than 'campaigning' with T-shirts and food.

There were a host of health promotion achievements in 2017 (albeit limited to Ward 11):

- There were a host of students visiting Chiawelo and participating in home visits and health promotion activities.
- There were six Health Clubs with more than 200 people participating in daily exercise
- There were plans for food gardens and cooking classes in walking clubs.
- There were engagement swith all primary schools on the back of a joint venture with an NGO, Dreamfields, to set up a soccer/netball league involving ±4000 pupils in twice weekly games. CHWs also engaged in life orientation lessons. This has been challenged by poor CHw cooperation across wards.
- There was engagement with high schools, in a drug abuse campaign.
- Unisa Social Worker did internships in CCP, worked on social issues per ward.
- There was engagement with Oral Health practitioners in Wits as well as in the district.

Details of their work for the year are available on the website www.afrocp.org.za > Chiawelo Community Practice> Team, as minutes of these monthly meetings and an annual report from each of them.

Access

We are trying to enable a more accessible and stronger relationship with patients and so are working with different models of communication e.g. Whatsapp. This will address other obstacles to access: cost and ease. The practice times are 8.00am – 3.30pm daily but call to check the appointment times for your clinician. We encourage appointments. We had a robust time-based appointment system with 50% of our practice using this with only 10% no shows. Unfortunately, we don't have phones any longer. Visit the practice front desk between 8-4pm daily to make an appointment. Patients are encouraged to see the same clinician for any episode of care. Patients are not limited and are able to access general services at the CHC at any time in an emergency. Patients should obtain their records from the emergency area and provide it CCP when they visit. If patients are housebound or too ill to get to the practice their CHWs may request a home visit. A clinician will decide whether or not the visit is necessary. It may be that the clinician advises the patient over the phone. Emergency Services are available at the Chiawelo CHC from 4pm to 12am. Patients are asked to inform the doctors / nurses there that they are part of the Chiawelo Community Practice. We urge patients to let us know of their new address or telephone number so that we can keep our records up to date. If patients move outside our practice area we urge them to check with the practice whether we can still continue to care for them in the same manner.

Access to Information

All members of the practice team have access to patient information to varying degrees. All staff have received training in confidentiality and have signed a confidentiality agreement. All patients are entitled to have access to their medical records. Copies of medical records may be made available although there will be a charge. Please ask the practice receptionists for further information. Anonymised patient data may be used for audit and research. If you do not want your records used for this please indicate so in the consent form at registration.

Suggestions and Complaints

Suggestions and complaints are always welcome and can be directed to any member of staff or sent to the practice secretary via the suggestion boxes.

The Practice Charter is Batho Pele

Batho Pele is a Sesotho phrase meaning 'People First', committing the public service to serve all the people of South Africa. The Batho Pele values and principles underpin the country's coat of arms. On 1 October 1997, the public service embarked on a Batho Pele campaign aimed at improving service delivery, to the public. For this new approach to succeed some changes need to take place. Public service systems, procedures, attitudes and behaviour need to better serve its customers – the public.

Batho Pele is a commitment to values and principles:

- Ensuring **higher levels of courtesy** by specifying and adhering to set standards for the treatment of customers
- Setting service standards specifying the **quality of services** that customers can expect
- Providing more and **better information** about services so that customers have full, accurate, relevant and up-to-date information about the services they are entitled to receive
- **Regular consultation** with customers about the quality of services provided

- **Increasing access** to services especially to those disadvantaged by racial, gender, geographical, social, cultural, physical, communication, and attitude related barriers
- **Increasing openness and transparency** about how services are delivered, the resources they use and who is in charge
- **Remedying failures** and mistakes so that when problems occur, there is a positive response and resolution to the problem
- Giving the best possible **value for money** so that customers feel their contribution to the state through taxation, is used effectively and efficiently and savings are ploughed back to further improve service delivery.

Wits Teaching & Research

Chiawelo Community Practice, in Chiawelo CHC, is trying to create comprehensive team-based care that can model the future National Health Insurance (NHI). It is also being used to train registrars (specialists in training), community service doctors and interns in Family Medicine as well as various undergraduate students of the University of Witwatersrand. Sometimes doctors sit in with students or vice versa. Occasionally you may be asked for consent to have your consultations videoed or photographs taken for the purpose of training. In all cases, you have the right to request privacy with your doctor.

CCP is providing a unique platform for research in PHC Re-engineering and National Health Insurance (NHI). Whilst members of the Department of Family Medicine plan to do research in this environment, ALL research projects planned will first have to get ethical approval from Wits and then formal permission from the provincial / district authorities before proceeding. Chiawelo Community Practice (including the PHC Outreach Programme) is being modeled on COPC innovated in South Africa as well as on practices in the UK National Health Service. Funding has been previously provided by the EU-FP7 and Discovery Foundation, under the Wits Department of Family Medicine.

The CCP Family

1. Prof. Shabir Moosa, Family Physician
2. Dr. Humayun Kabir, Family Physician
3. Ms. Shivani Pillay, Clinical Associate
4. Family Medicine Intern
5. Family Medicine Intern
6. Sr. Kgomotso (PN)
7. Sr. Patience (EN)
8. Sr. Nelly (EN Team Leader)
9. Sr. Happiness (EN Team Leader)
10. Sr. Rivalani (EN Team Leader)

Linked Government Facilities

1. Senoane Local Government Clinic
2. Lillian Ngoyi CHC
3. Zola CHC
4. Jabulani Hospital
5. Chris Hani Baragwanath Hospital

Local Health NGOs / Facilities

1. Old Age Home
2. Childrens Home
3. Home-based care
4. SANCA
5. Church
6. Community Centre
7. Childrens Shelter Mofolo
8. Hospice
9. Local GPs

Useful Contacts

1. Chiawelo CHC: 011 9862159 / 011 9841599
2. Hillbrow District Office: 011 6943710
3. Chris Hani Bara Hosp: 011 9338000
4. South Rand Hosp: 011 6512000
5. Services
    a. EMRS/Fire/Ambulance: 10177 / 112 (Cell)
    b. Police/SAPS: 10111
    c. Sanitation / Water: 011 9866072
    d. Electricity: 011 3755555
    e. Home Affairs: 011 9384257 / 3296 / 0729199586
    f. Grants: 011 3101248
    g. Social Services: 011 9825810
    h. Telkom Repairs: 011 3379088
6. Schools
    a. Hitekani Primary 011 9848968 / hetekani.primary@webmail.co.za
    b. Tshilidzi Primary
    c. Gazankulu Higher Primary
    d. Ngungunyane High