

BRIEF | Enhancing CHW roles: Embedding participatory learning to strengthen Primary Health Care

VAPAR policy brief 1 July 2026

Purpose

This brief summarizes what the VAPAR community mobilization training adds to existing Community Health Worker (CHW) and Outreach Team Leader (OTL) training in Mpumalanga, what the recent evidence shows, and what is needed to move from project-based training toward routine system embedding. **Audience** Provincial, district and sub-district PHC, Health Promotion, Human Resource Development, Regional Training Centre and programme managers, and partners supporting CHW-led community mobilization.

Relevance for Mpumalanga PHC

CHWs are central to ward-based outreach and to the ambition of bringing PHC closer to households and communities. Policy and training frameworks already recognise competencies such as communication, teamwork, health promotion, service coordination and community engagement.

In practice, however, CHWs and OTLs often work under high service pressure, variable supervision, limited resources and uneven access to continuing professional development. The gap is therefore not only whether CHWs have been trained, but whether training helps them analyse local problems, convene the right actors, communicate across clinic-community boundaries, and translate community knowledge into practical action. This is the implementation gap that the VAPAR training was designed to address.



What decision-makers need to know

- VAPAR is an implementation support for rural PHC that includes a practical co-learning approach that can be embedded in routine in-service training and supervision, not a separate vertical programme.
- In 2024, we rolled-out training to 57 CHWs and OTLs across Ehlanzeni, Nkangala and Gert Sibande, using participatory tools to address real service and community challenges.
- Trainees reported greater confidence, clearer mobilisation roles, improved problem-solving and stronger collaboration with OTLs, facility staff and community actors.
- A peer-to-peer "multiplier effect": 21 of 22 interviewed trainees reported sharing learning with others, with a minimum self-reported reach of about 280 additional people.
- Diffusion is promising but should be quality-assured. Counts are self-reported, training fidelity was not formally assessed, and uptake may be uneven where supervision, time, resources and foundational skills vary.
- Maternal and Child Health (MCH) is a strong next-use case for adapting the same co-learning model to CHC readiness, ANC mobilisation, referral pathways and low-risk delivery planning.

What was implemented

VAPAR began as a learning platform linking verbal autopsy evidence, community experience and health-system actors in shared cycles of evidence, action and learning in rural Mpumalanga. During COVID-19, the programme was adapted to support CHWs in community mobilisation. The 2024 phase scaled structured community mobilisation training across all three Mpumalanga health districts.

What the evidence shows

The evaluation synthesized training and project documentation, dissemination materials and 22 interviews with CHWs and OTLs across 21 clinics. Six linked findings were derived for policy and implementation.

Component	What this involved	Finding	Policy meaning
Reach in 2024	Training across Ehlanzeni, Nkangala and Gert Sibande. Reported direct training: 57 participants - 40 CHWs and 17 OTLs.	1. Confidence and role clarity	Participants reported greater confidence to speak, facilitate, raise concerns and understand community mobilization as part of PHC work.
Training model	Training-of-trainers and facilitated learning cycles combining discussion, practical exercises, field application and reflection.	2. Practical use of tools	Problem trees, action pathways helped CHWs move from naming problems to analysing causes, identifying stakeholders and planning actions.
Tools	Problem-tree analysis, stakeholder mapping/Venn diagrams, ranking/scoring and action pathways for planning, responsibilities, resources and follow-up.	3. Better teamwork and clinic-community feedback	In some settings, CHWs, OTLs and facility staff reported improved coordination around tracing, follow-up, health talks and referral issues. Benefits were stronger where teams and supervision were stable.
Service priorities used in training	Treatment adherence, stigma, tracing/loss to follow-up, health-seeking behaviour, referral coordination, household registration and community trust.	4. Peer diffusion or "multiplier effect"	21/22 interviewed trainees reported sharing training with others through in-service sessions, informal mentoring or day-to-day support. Minimum reported reach was ~280 additional people, excluding participants who shared learning but did not give a number.
Implementation route	Use existing PHC and in-service spaces where possible, rather than creating a parallel training platform.	5. Constraints shaping sustainability	Transport, uniforms, equipment, workload, protected time and literacy variation affected who could apply and share learning. These are implementation conditions, not reasons to abandon the approach.
		6. Early institutional uptake	Provincial actors positioned the training within revitalised Health Promotion, Regional Training Centre alignment, in-service registration discussions and wider roll-out planning.

Participant voices

"We no longer call them defaulters; we say missed appointments. We apply the tools we learned during the training to understand the main reasons for defaulting." **CHW, Nkangala**

"I can see a great change from my OTL, now when we request him to go with us to the field he does not refuse; he understands the importance of going to the field with us." **CHW, Gert Sibande**

"Every Friday, I do in-service training for CHWs, OTLs, and OPM. The OPM was the first to sign the register." **CHW interview respondent**

Recommendations for consolidation and scale-up

The main opportunity is incremental institutionalization: align the VAPAR tools and facilitation approach with existing CHW curricula, Regional Training Centre processes, district and sub-district in-service training, OTL coaching and Health Promotion priorities. This avoids presenting VAPAR as a new vertical programme and preserves what makes it valuable: practical, participatory, problem-solving learning connected to local service realities. In 2025, provincial workshops and subsequent Departmental endorsements indicate that VAPAR is already being considered as a strategic vehicle for revitalizing Health Promotion, strengthening CHW roles and developing a more practical learning system for PHC teams. The next steps are convert this policy support into a manageable implementation package.

Recommendation	Implementation detail
1. Embed participatory learning in routine systems	Map VAPAR tools against existing CHW and OTL training/WIL content. Assign ownership across PHC, Health Promotion, HRD and the Regional Training Centre. Register or accredit as appropriate for in-service learning.
2. Strengthen supportive supervision and mentoring	Formalize OTL and facility-manager coaching roles. Protect time for in-service reflection and field follow-up. Use existing Friday/in-service platforms where they are functioning.
3. Quality-assure the multiplier effect	Treat peer diffusion as a route to scale, but document it with simple registers: who was trained, by whom, on which tools, when, and with what follow-up. Add short competency checks and refresher/calibration sessions.
4. Make scale-up equitable	Use tiered delivery and extra mentoring for CHWs with different literacy and educational backgrounds. Do not rely only on high-confidence or high-literacy CHWs to carry diffusion unsupported.
5. Link mobilization to routine monitoring	Track feasible indicators such as number of CHWs/OTLs trained, peer diffusion, action plans completed, tracing completeness, referral completion, missed-appointment follow-up and community-identified issues addressed.
6. Resource a minimum enabling package	Secure basic materials, printing/manuals, transport support, protected learning time and essential working tools. Build sustainability into PHC and Health Promotion budgets and partnerships.
7. Consolidate before wider roll-out	Use Mpumalanga as the demonstration and learning site, with documented implementation lessons, quality assurance and costed options before national benchmarking or cross-provincial adaptation.

Maternal and Child Health adaptation: a practical next use case

MCH is an appropriate next application of the VAPAR co-learning model because it depends on coordination between households, CHWs, CHC teams, referral facilities and district managers. The proposed VAPAR-LINC adaptation should be framed as translation of an established cooperative-learning model into integrated maternity care, not as evidence that VAPAR has already improved MCH outcomes.

MCH problem area	How VAPAR tools could support action
ANC mobilization, early engagement	Problem trees to identify why pregnant women miss or delay ANC and action pathways to plan CHW follow-up, family engagement, reminders and escalation.
Low-risk delivery readiness at CHCs	Stakeholder mapping to clarify roles across CHW, CHC, midwife, ambulance/referral and district management actors. Identify readiness gaps and responsibilities.
Referral, triage and escalation	Use action pathways to define steps, decision points and feedback loops between community screening, CHC readiness, referral hospitals and emergency pathways.
Community trust and service acceptability	Use facilitated dialogue to surface concerns about place of delivery, respectful care, transport, safety and perceptions of risk.

MCH problem area How VAPAR tools could support action

Learning and monitoring

Use routine feedback loops to track ANC engagement, referral completion, low-risk delivery planning, CHW/CHC communication and unresolved system barriers.

Consolidation pathway

- Month 1-2: confirm provincial ownership and technical working group across PHC, Health Promotion, HRD, RTC, district managers and VAPAR partners.
- Month 2-4: complete curriculum mapping, facilitator package and simple quality-assurance tools for peer diffusion.
- Month 4-6: select demonstration sites and run refresher/calibration sessions for master trainers, OTLs and peer facilitators.
- Month 6-12: test the MCH/CHC adaptation in selected sites, review implementation data quarterly and refine before wider roll-out.

Conclusion

The VAPAR experience in Mpumalanga shows that structured participatory learning can strengthen CHW-led community mobilisation in ways that are practical, acceptable and aligned with rural PHC realities. The most important finding for policy is not simply that CHWs valued the training, but that they used and shared it: the tools travelled into routine in-service spaces, facility teams and community-facing work. This creates a credible pathway for scale, provided peer diffusion is supported, documented and quality assured. The next phase should therefore focus on consolidation: embedding the approach in in-service training, supervision and Health Promotion systems; resourcing a minimum enabling package; protecting equitable access to learning; and using MCH as a carefully documented adaptation to test how cooperative learning can support integrated community-based maternity care.

Evidence for this brief

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6. Mpumalanga Department of Health and VAPAR. VAPAR Workshop Summary: Enhancing CHW Roles in PHC. Government Boulevard, Riverside, Mpumalanga. 25 March 2025.
7. Mpumalanga Department of Health. Letters of support for VAPAR follow-on collaborations, including ISPF Research Collaboration Grant and VAPAR-LINC Learning for Integrated Care. 2025.

Evidence status

The evidence supports claims of feasibility, acceptability, reported capability-building, peer diffusion and early institutional uptake. VAPAR provides a credible route to strengthen routine CHW learning, supervision and community mobilization if embedded with modest resources and quality assurance.

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