BRIEF | Enhancing CHW roles: A practical co-learning tool for CHW-led community mobilization in Primary Health Care

VAPAR Policy Brief 2; July 2026

The VAPAR tools helped CHWs and OTLs analyze service and community challenges, identify stakeholders, plan practical action and share learning through routine in-service spaces. The next step is to embed this co-learning cycle as an implementation support mechanism for rural PHC. This requires clear supervision, quality assurance and modest resources. This brief presents the VAPAR approach as a practical tool that CHWs, OTLs, facility teams and Health Promotion managers can use to move from local problems to shared action, learning and follow-up. **Audience**: Provincial and district PHC, Health Promotion, Human Resource Development, RTC, health programme managers and partners supporting CHW-led mobilization.

Purpose

VAPAR generated a practical co-learning tool for CHW-led community mobilization. The tool has been implemented across all three Mpumalanga districts, was taken up by CHWs and OTLs in real service problems and showed substantial self-reported peer diffusion. The next phase should consolidate the tool within PHC, Health Promotion and RTC/HRD systems, with quality assurance and follow-on testing in MCH.

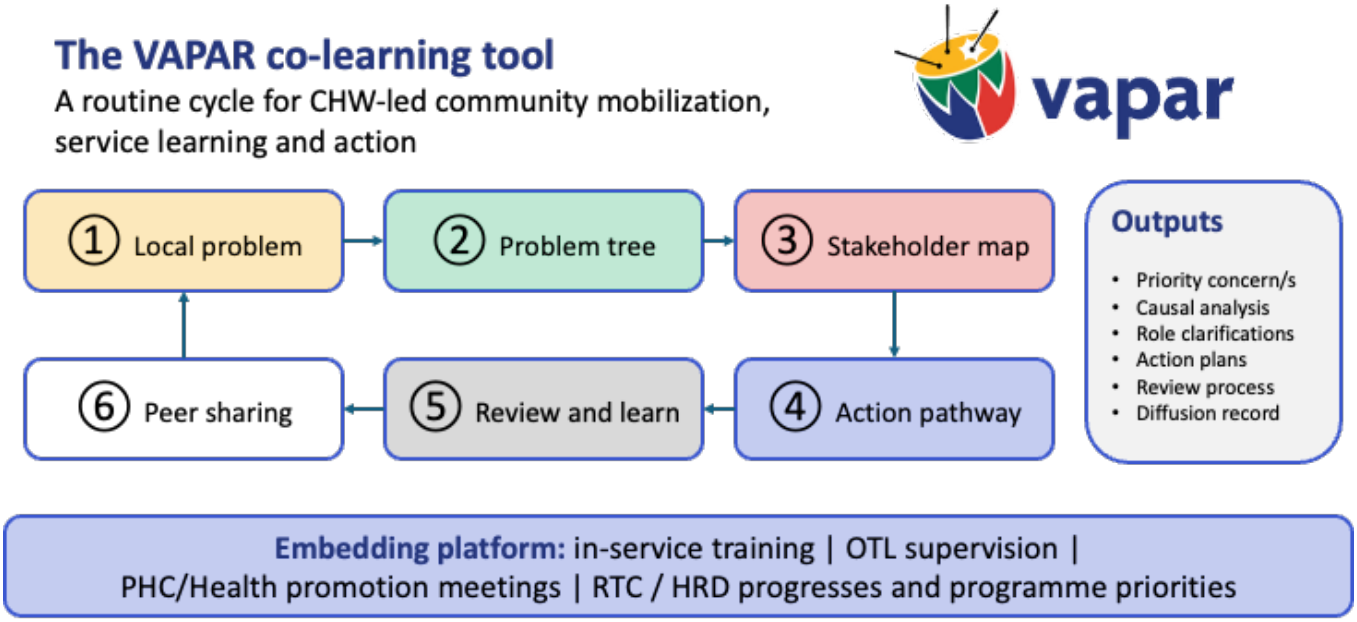

Figure 1. A six-step cycle for using VAPAR tools in routine PHC, Health Promotion and in-service learning.

Tool	Process	Output
Problem tree	Breaks down a recurring problem into visible effects, immediate causes and deeper household, community, facility or system drivers.	Shared causal analysis; clearer understanding of stigma, transport, clinic processes, poverty, communication and service barriers.
Stakeholder / Venn mapping	Maps actors, influence, relationships and possible support around the issue.	Clearer roles for CHWs, OTLs, operational managers, traditional leaders, families, programme staff and other sectors.
Action pathway	Turns the analysis into sequenced steps with named responsibilities, resources and deadlines.	Action plan for tracing, adherence support, referral coordination, health talks, community meetings or facility-level changes.
Reflection and peer sharing	Reviews what changed, what blocked progress and learnings to be shared.	In-service learning, mentoring, refresher sessions and diffusion records.

Adding value to CHW training and roles

The distinctive value lies in the sequence of tools. A problem tree builds a shared analysis of visible problems and underlying causes. Stakeholder/Venn mapping clarifies who has influence, who needs to be involved, and where relationships need strengthening. The action pathway converts analysis into feasible steps, responsibilities, resources, timelines and review points. The 2024 VAPAR training in Mpumalanga used district engagement, training-of-trainers and practical learning cycles. The training equipped CHWs and OTLs to convene community groups, understand local health issues from multiple perspectives, generate evidence, and facilitate action in clinics, communities and public services.

Embedding in practice

The immediate policy opportunity is to routinize the VAPAR cycle: a structured way for outreach teams to identify problems, analyze causes, plan action, review progress and share learning. Embedding can use PHC/Health Promotion infrastructure as feasible, with clear ownership at provincial, district and facility levels

Evidence point	What was reported
Reach	Training took place across Ehlanzeni, Nkangala and Gert Sibande. Direct training recorded 57 participants: 40 CHWs and 17 OTLs.
Capability gains reported	CHWs and OTLs described greater confidence, clearer mobilization roles, improved facilitation, stronger problem-solving and more confidence engaging community and facility stakeholders.
Use in service problems	Tools were applied to adherence, stigma, tracing/loss to follow-up, referral coordination, household registration, patient communication and community trust.
Peer diffusion	21 of 22 interviewees reported sharing learning. Numeric reports totaled at least 280 additional people reached, with several reports lacking a number. One OTL reported training 49 CHWs at Embalenhle CHC.
Implementation conditions	Transport, uniforms, equipment, workload, protected learning time, literacy variation and uneven supervision shaped who could apply and share learning.
Institutional signals	MDoH materials position the approach within Health Promotion, Regional Training Centre alignment, in-service registration discussions and further roll-out planning.

System location	How the tool could be used
PHC/Health Promotion	Use the cycle in health promotion planning, CHW platform meetings and district/sub-district review spaces to connect community priorities with service response.
OTL supervision	Use problem trees and action pathways during field support and in-service reflection. OTLs can coach CHWs through analysis, action planning and follow-up.
Regional Training Centre / HRD	Map VAPAR tools against existing CHW and OTL curricula, work-integrated learning and in-service requirements. Develop a short facilitator package and quality-assurance checklist.
Facility management	Bring operational managers into selected sessions so facility-side barriers, staff attitudes, administrative processes and referral routines can be discussed constructively.
Programme priorities	Use the cycle for HIV/TB adherence, NCD follow-up, maternal and child health, teenage pregnancy, malnutrition, health-seeking behaviour and other locally identified priorities.
Peer diffusion	Support cascade learning with registers, agreed tool scripts, refresher sessions and feedback to maintain quality as the approach spreads.

Minimum scale-up package

Requirement	Practical detail
People	Master trainers, OTLs, CHW peer facilitators, facility managers, district PHC/HP/HRD leads and programme focal persons.
Time	Protected in-service slots for facilitation, field application and review; realistic expectations for CHWs and OTLs under service pressure.
Materials	Short manual, laminated tool sheets, registers for diffusion, action-plan templates, stationery and simple monitoring forms.
Support	OTL mentoring, facility-manager engagement, district feedback sessions and refresher/calibration meetings.
Quality assurance	Trainee registers, which tools were used, examples of action pathways, brief competency checks and follow-up on selected action plans.
Equity	Tiered delivery/additional mentoring for CHWs with different literacy, educational and confidence levels.
Monitoring	Track direct training, peer diffusion, action plans, follow-up meetings, referral/tracing processes and unresolved system barriers. Health outcome indicators require a separate evaluation design.

MCH adaptation Learning for Integrated Care (LINC)

Maternal and Child Health is a strong next use case because community-based maternity care depends on coordination between pregnant women, households, CHWs, CHC teams, referral hospitals and district managers. Mpumalanga Department of Health supports VAPAR-LINC with the MCH adaptation around increasing low-risk deliveries conducted in CHCs, strengthening referral of obstetric complications, and coordinating CHWs who screen pregnant women in the community.

A follow-on application has been prepared. The team plans to apply to the MRF Extended Policy and Practice call and other suitable schemes from September, when the call opens. The proposed MCH work would translate the VAPAR co-learning cycle into practical tools for CHC readiness, ANC mobilization, triage, referral, community trust and learning across community and facility levels.

Decision points

- Confirm tool location/s, teams and timeframes: PHC, Health Promotion, HRD/RTC and district in-service platforms.
- Develop OTL and facility-manager roles in coaching, follow-up and QA.
- Use self-reported peer diffusion as scale pathway, simple records and competency checks.
- Adapt tool for MCH/CHC readiness through planned follow-on applications.

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Recommended next steps

MCH focus area	Adaptions
ANC mobilization	Use problem trees to understand late booking, missed ANC, transport, household dynamics, service concerns and communication gaps.
CHC readiness for low-risk delivery	Use stakeholder mapping to clarify roles across CHWs, CHC staff, midwives, operational managers, ambulance/referral services and district teams.
Referral and escalation	Use action pathways to agree steps, decision points, responsibilities and feedback loops for obstetric complications.
Community trust and respectful care	Use facilitated dialogue to surface concerns about place of delivery, safety, respectful care and perceived risk.
Learning across levels	Use quarterly review cycles to connect CHW/community intelligence with CHC and district service-readiness decisions.

Timeframe	Action
0-3 months	Confirm provincial ownership group across PHC, Health Promotion, HRD/RTC, district management and VAPAR partners. Agree the tool package and minimum monitoring dataset and framework.
3-6 months	Complete curriculum mapping, facilitator guide, quality assurance checklist and peer diffusion register. Hold refresher/calibration sessions with master trainers and OTLs.
6-12 months	Use follow-on funding to test the MCH/CHC adaptation in selected sites, review implementation data quarterly and refine package before planning broader roll-out.
12+ months	Prepare costed options for provincial scale-up and national benchmarking, based on implementation learning and documented quality assurance.

Evidence status

The strongest claims are feasibility, acceptability, reported capability-building, peer diffusion and early institutional uptake. Service effects and health outcomes need further prospective evaluation. The multiplier figure should be reported as self-reported peer diffusion with a minimum numeric reach, with transparent limits around coverage and fidelity.

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