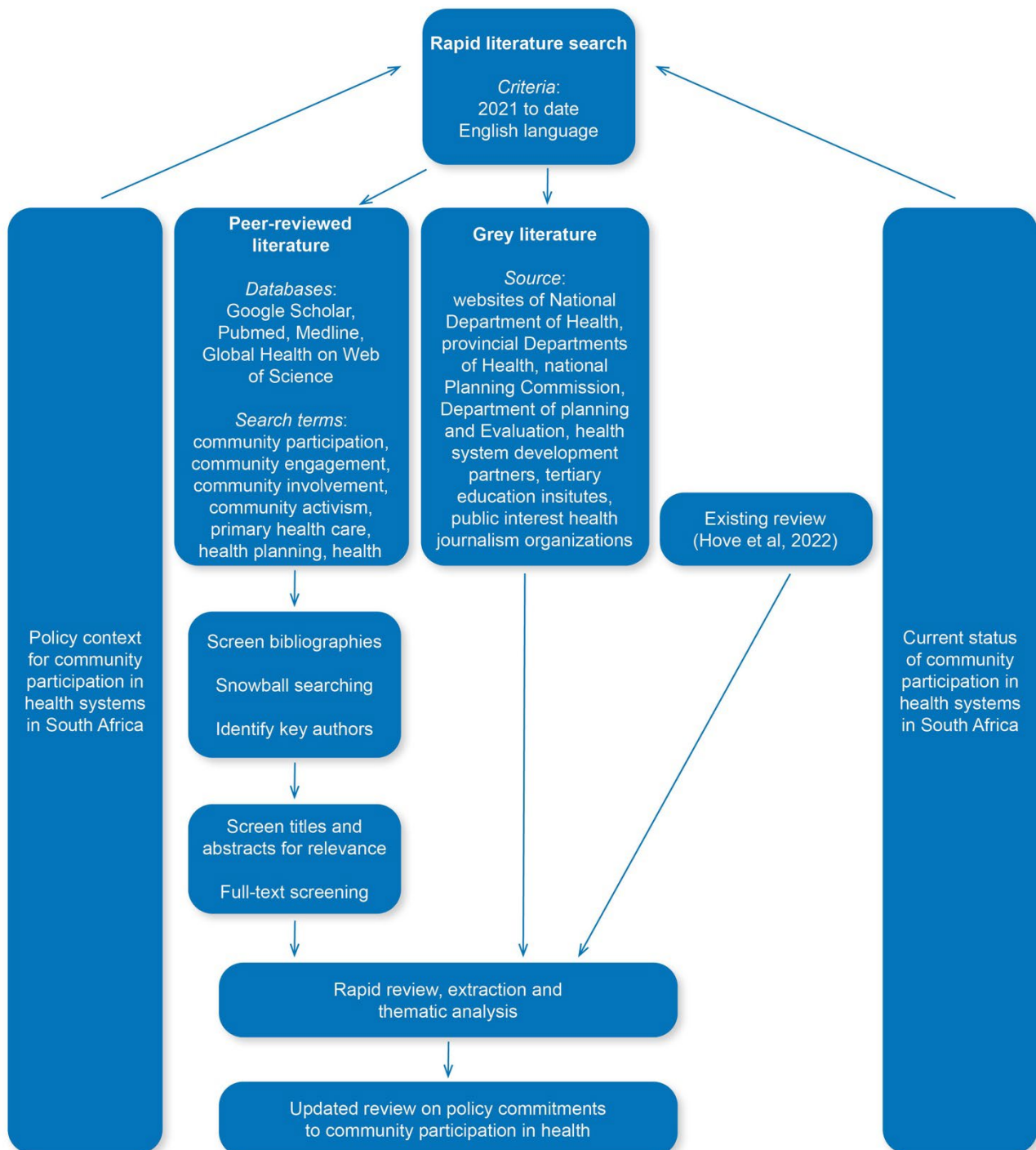


Appendices

Appendix 1: Desk review framework



Appendix 2: Thematic framework

Overarching theme	Sub-themes	Examples	Illustrative quote
(1) Strengthened confidence, facilitation and role clarity	Increased confidence to speak/facilitate; clearer legitimacy of mobilization as “core work”; more system-oriented problem-solving	Reports of improved facilitation, communication and role clarity; increased willingness to engage clinic colleagues and community actors	<i>I have gained confidence through this training, now I am able to stand in front of people and speak with confidence (CHW, Ehlanzeni)</i> <i>VAPAR provided role clarification for me as a CHW, I got to learn a lot of things which I never had knowledge about (CHW, Ehlanzeni)</i>
(2) Participatory tools applied to local service challenges	Tools used to analyze causes and translate into practical action steps	Problem trees and action pathways used for adherence, stigma, tracing/LTFU; actions included reminders, registration/tracing routines, health education, referral coordination	<i>Now they can [trace] them all, because of the strategies we developed after the training (OTL, Gert Sibande)</i> <i>There is a huge difference, especially to my knowledge here at the facility (CHW Nkangala)</i> <i>I always carry my CHW training manual whenever I encounter problems; I always refer to it (CHW, Ehlanzeni)</i>
(3) Extending mobilisation knowledge and practice in communities and across sectors	One-to-one encounters with patients and households; convening groups in the community; tools supporting existing engagement groups and processes; multi-sectoral engagement; understanding engagement processes.	Problem trees used with community groups, traditional leaders, and in places where men gather to drink. Referrals and collaboration with Education and Social Development departments. Community-facing activity constrained by resources, timing and workload.	<i>“The first group was 15 people, second group was 7 people. These were not CHWs but people from the community, mostly women...” (CHW, Ehlanzeni)</i> <i>“I even went to a certain place where people gather to drink alcohol and got few men there, I shared with them the problem tree, we discussed about the reasons why people become lost to follow up.” (CHW, Ehlanzeni)</i> <i>“I did not know the procedure for mobilizing the community... As an OTL, I am now equipped to organise events, like community events with much confidence. I now know how to identify and invite them.” (OTL, Ehlanzeni)</i> <i>“We involve different stakeholders in our work, Indunas, home affairs and many others” (OTL, Ehlanzeni)</i>
(4) Teamwork and clinic-community interactions	Improved collaboration in some settings (CHW-OTL-facility); better coordination via in-service spaces; persistent community relational challenges	Better follow-up coordination and communication; uneven leadership continuity; stigma/mistrust/refusals remained challenges	<i>--- empowering CHWs allows them to address minor issues and regain community trust in the health system (CHW, Ehlanzeni)</i>
(5) Multiplier effect (peer diffusion)	Rapid peer sharing via formal in-service and informal mentoring; diffusion began quickly	21/22 trainees reported sharing learning; estimated reach ~280; most diffused: problem trees/action pathways	<i>Every Friday, I do in-service training for CHWs, OTLs, and OPM. The OPM was the first to sign the register.</i> <i>I will continue to use the tools in the field and continue to share with my colleagues whatever I learnt from VAPAR (CHW, Ehlanzeni)</i>
(6) Structural constraints shaping sustainability and equity	Resource, workload and skills constraints limited routine application and equitable benefit	Transport/equipment/uniform gaps; limited protected time; literacy variation; mandate/recognition gaps	<i>DoH lacks staff and resources for this training. Partner [VAPAR team] with DoH to ensure sustainability (CHW, Ehlanzeni)</i> <i>Training requires funding and well-organized logistics. If they can provide all these resources, I believe they should adopt it.” (CHW, Gert Sibande)</i>
(7) Early signals of institutional uptake (including alignment with PHC priorities and regional training systems)	Positioning within Health Promotion; steps toward RTC alignment/in-service registration; discussions of wider roll-out	Endorsement in dissemination outputs; “ways forward” roadmap: curriculum mapping, tiered model, competency baselines, leadership convening	<i>---this approach can be sustained if is incorporated in our in-service training (CHW, Gert Sibande)</i>

Appendix 3: Reported diffusion (“multiplier effect”) of participatory learning beyond primary trainees (key informant interviews, n=22)

Px ID	Cadre	Reported training others	Estimated number reached	Cadres reached	Mode*	Setting (typical)
P01	CHW	Yes	NR	Unspecified	Informal	Day-to-day sharing
P02	CHW	Yes	8	CHWs	Unspecified	Unspecified
P03	CHW	Yes	NR	CHWs	Informal	Informal sharing (no formal session yet)
P04	CHW	Yes	8	CHWs	Unspecified	Unspecified
P05	CHW	Yes	22	Community members	Informal	Community engagement
P06	CHW	Yes	15	OTLs; CHWs	Unspecified	Unspecified (“3 days”)
P07	CHW	Yes	NR	CHWs (untrained)	Both	Twice-weekly sessions + informal
P08	CHW	Yes	30	CHWs	Formal	Office meetings
P09	CHW	Yes	21	CHWs	Formal	Friday in-service
P10	CHW	Yes	40	CHWs; OTLs	Formal	Friday in-service
P11	CHW	Yes	18	CHWs; OTLs; OPM	Formal	During working hours
P12	CHW	Yes	30	CHWs	Formal	Three sessions (45 mins)
P13	CHW	Yes	9	CHWs	Formal	Friday in-service
P14	CHW	Yes	18	CHWs	Informal	Unspecified (planned sessions)
P15	CHW	Yes	NR	OTLs; CHWs	Informal	Day-to-day sharing
P16	CHW	Yes	NR	CHWs; OTL; OPM	Formal	Friday session
P17	CHW	Yes	11	CHWs; OTL	Formal	Facility boardroom
P18	OTL	Yes	1	OPM	Informal	1:1 / informal
P19	OTL	No	0	—	—	—
P20	OTL	Yes	NR	OTLs; CHWs	Informal	Unspecified
P21	OTL	Yes	NR	CHWs	Formal	Health education days
P22	OTL	Yes	49	CHWs	Formal	Structured facility training

Summary: 21/22 respondents reported peer diffusion; minimum estimated reach ≥280 (sum of numeric reports; excludes NR).

NR = diffusion reported but no numeric estimate provided. * Mode coded from descriptions (formal=in-service/organized sessions; informal=mentoring/day-to-day sharing; both = both explicitly stated). Abbreviations: CHW, Community Health Worker; OTL, Outreach Team Leader; OPM, Operational/Clinic manager; NR = not reported (no numeric estimate provided); Px, participant.

Appendix 4: Fieldnotes J Hove, 30 January 2025

Reported impacts

Participants reported increased confidence as a result of the facilitation skills developed during the community mobilization training. They highlighted that these skills have significantly enhanced their ability to engage effectively in their roles. Furthermore, they recommended evaluating the actions implemented post-training to both motivate CHWs and ensure the training's long-term impact.

The group work component of the training was particularly well-received. Participants appreciated the opportunity to collaborate, share experiences, and learn from one another. This collaborative approach also revealed that some challenges stem from the clinic or facility level, often involving healthcare workers or CHWs themselves. Recognizing these internal issues was a significant step forward, as it encouraged participants to reflect on their roles and identify areas for improvement within the healthcare system.

The training demonstrated a strong 'multiplier effect' as CHWs actively shared the tools they learned during the sessions with their colleagues in their respective facilities. After every tool was introduced, CHWs reported disseminating the knowledge and skills acquired, further extending the reach of the training. Additionally, they requested some of the material used during the sessions to facilitate broader knowledge-sharing and ensure continued application of the training principles within their teams.

In Ehlanzeni, within the BBR district, a Community Health Worker (CHW) platform was established following the initial phase of training and before its expansion. This platform has been operational since June 2023 and continues to date. The CHWs meet quarterly to discuss health issues, share opportunities, and address challenges faced in their clinics across the BBR district.

Appendix 5a. Closing remarks, key messages and acknowledgement VAPAR Workshop: C Nelson, Chief Director PHC, Mpumalanga province, 25th March 2025

We are pleased to confirm that the roles of community health workers (CHWs) in primary health care have indeed been significantly enhanced through this initiative. This is an important milestone in ensuring that CHWs are better equipped to address the health needs of the populations they serve. We are also committed to ensuring the roll-out of integrated training for CHWs, equipping them with the skills, knowledge, and practical tools they need to excel in their roles. This integrated approach will enhance the quality and consistency of care provided, ensuring that CHWs are able to work seamlessly with other health service providers.

Appendix 5b. Implementation roadmap: proposed next steps

1. Map VAPAR training against existing CHW curricula;
2. Establish baseline CHW competencies to inform career pathways;
3. Conduct stakeholder analysis across human resource development, regional training centre, finance and health programme actors;
4. Develop an inclusive, tiered training model for CHWs with different educational backgrounds;
5. Convene senior provincial management to align the training with PHC priorities;
6. Design an integrated rollout plan;
7. Seek national engagement for benchmarking and scale-up.

Source: Provincial dissemination workshop report