Experiences of Community Health Workers (CHWs) and their wellbeing: A study of CHWs in Johannesburg Townships.

M.A Sociology Research Report

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Declaration:

I declare that this research project is my own, unaided work. It has not been submitted before for any other degree or examination at this or any other university. I am submitting it for the degree of Master of Arts in Health Sociology at the Faculty of Humanities of the University of the Witwatersrand, Johannesburg.

Lethiwe Mashinini.
Signature ……..
31/03/2022.

Dedication:

For this piece of work my greatest gratitude I account it to my Lord and Saviours Jesus Christ of Nazareth. Without him, I would have not completed this research. In months of being stuck, lost for direction and motivation only he was cable of pulling me through. I would have never imagined that this research would take me the amount of time it took to complete. Nonetheless, I have learned a great deal through the process and I see God's grace for being able to finally complete and submit this research. Udumo lonke ngilinika uJehova Sebaoti (All glory I account it to LORD Almighty).

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Abstract:

Community Health Workers (CHWs) have become important role players in the provision of health and social services in many underprivileged communities around South Africa. Despite the role and impact of these cadres in many communities, few studies have focused on the impact of their work on their wellbeing. Hence, the study's interest in expanding its inquiry on the experiences of CHWs and their impact on the cadre's wellbeing. This research further inquired about the national CHWs policy and CHWs scope of practice facilitated through the WBPHCOTs strategy that resulted from the re-engineering of the PHC model. As an observer qualitative data was collected through non- participative observation. Drawing from in-depth interviews this study further examined and describes the self-reported experiences of CHWs and NGO managers. To frame the experiences of CHWs and the impact of these experiences on their wellbeing the research findings were theorized from the perspective of social constructionism. The fundamental concern was to understand how cadres define, describe, and think about different social aspects of their life as CHWs and how these experiences influence their reality. Specifically focusing on two NGOs situated in Johannesburg townships the study participants were composed of eight CHWs (six female and two male cadres) as well as two male managers who were consulted as key informants. Concerning the national CHWs policy and the guiding scope of practice in the functioning of CHWs, the research yielded interesting findings. The managers of the NGOs were unaware of the existence of the national policy framework dubbed the *Ward-based primary healthcare outreach team's strategy* (WBPHCOTs) policy framework. Hence, the organizations had not adopted or aligned the work of CHWs with the WBPHCOTs strategy policy framework. Instead, the NGOs maintained their arrangement of CHWs programmes as multi-stakeholder projects. This raises concerns about the implementation of the WBPHCOTs policy framework as a national CHWs policy, particularly in the NGO sector. The research also revealed multifaceted findings about CHW's experiences, which were largely positive and influenced by altruistic sentiments. Cadres also felt a sense of self-development and the possibility of improvement in their lives, which had a positive impact on their social wellbeing. CHWs also encountered some negative experiences such as challenging working conditions and poor remuneration and this had adverse impacts on their physical, psychological, and economic wellbeing. Therefore experiences of CHWs impacted their wellbeing both positively and negatively.

Keywords:

CHW(s), Cadres, Experiences, NDOH, NGOs, PHC system, Wellbeing.

Definitions:

Cadres: refers to a collection of individuals forming a small team that is specially selected or organized and trained for a specific purpose or occupation (ReservoDictionary, 2021). For example, a cadre of CHWs or medical doctors.

Carer/ Caregiver: refers to individuals who provide formal or informal assistance and support within facilities or communities. The aid may be directed to people experiencing health conditions and disabilities as well as elderly people. This may include psychological care (like counselling) and financial support (assisting with the application for social grants) plus hands-on physical assistance (such as bathing and cleaning). (World Health Organization (WHO), 2004).

Facility/Health Facilities: refers to institutions providing health care services. For example, clinics, primary health care centres/community health centre, and hospitals (KwaZulu Natal Department of Health, 2011; WHO, 2021).

Task-shifting: refers to the practice of delegating tasks or services from senior to junior cadres or from professionally trained cadres to less highly trained health workers. This may involve transferring services and responsibilities from various groups of professional cadres to lay cadres (Philips, Zachariah & Venis, 2008; Zachariah et al, 2009; Odendaal & Lewin, 2014; Adams et al, 2015). These transferred tasks are those which are simple but time-consuming (Malan, 2014). For example, assigning CHWs the role of Antiretroviral therapy (ART) readiness training for patients initiated on ARVs and defaulter tracing of ART patient drop-out, which was previously conducted by nurses (Schneider et al, 2008).

CHAPTER ONE: INTRODUCTION.

1.1. Introduction.

As this study was focused on CHWs, the introductory chapter provides a background on these cadres. It traces the history of CHWs globally and within the South African context. Followed by a problem statement that formulates the basis of the research as well as the research questions that guided this study. Concluding with the aims and objectives of the study which highlight the purpose of the study.

1.2. Background.

Community Health Work programmes date to approximately 50 years ago. Focused on the provision of basic healthcare services within their communities (Lehmann & Sanders, 2007). A historical understanding of CHWs dates even much earlier as the notion and formalization of Community Health Work was predated by Russia's Feldhsers and China's barefoot doctors (Spencer, Gunter & Palmis, 2010; Perry, 2013). Wherein in the 1800's Russia trained Feldhsers as paramedics, who assisted physicians in providing medical services, as well as treating emergency conditions while also helping with ambulance practice. Furthermore, in the 1920s China implemented a prominent CHWs project as a unique way of promoting the development of health programmes in resource-limited areas. This was known as the John Grant, Jimmy Yen, and C.C Chen Primary Health Care Project and it involved the training of lay health workers. Providing services related to documentation of important events of vaccination against smallpox. Including the administration of uncomplicated tasks like conducting health talks within the community and identifying community needs through surveys. By the 1950s to 1970s, the number of such cadres had reached an estimation of over one million (Perry, 2013; 2018; Saxena, Maheshwari & Saxena, 2017).

In other parts of the world, CHWs programmes were preceded by informal helpers labeled by different terms. For instance, *Health Extension Workers* in Ethiopia and *Lady Health Workers* found in Pakistan (SoulCity, 2016). *Village Health* W*orkers* located in several African countries as well as in Bhutan, Indonesia, Afghanistan, Mexico, Thailand, and Europe. *Brigadistas* and *Health Promoters* found in Latin America, *Community Leaders* functioning as health workers in

Karelia and Finland plus *Shastho shebikas* of Bangladesh (Perry, 2013; Saxena et al, 2017). A notable endorsement of Community Health Work programmes especially in developing countries was at the 1978 Alma Ata international health conference. This also included the embracement of Primary Health Care (PHC) and the potential role that CHWs could play in improving the healthcare system within poor communities (Perry, 2018). Hence, post-conference saw rapid growth in CHWs initiatives around the world but soon decreased around the 1990s. Then peaking again in the early 2000s as there was an increasing need for healthcare services due to the scourge of HIV/AIDS and healthcare professional deficiency (Lehmann & Sanders, 2007). Thus, there was an increase in the initiation of CHWs programmes as voluntary health projects, but these stayed at the fringe of the healthcare system (Fernando, 1995). While CHWs were also placed to assist in several programmes within the PHC systems (Fernando, 1995; Lehmann & Sanders, 2007). For example, Brazil's 1980 government-based and CHW-driven "Programa Agente Comunitário de Saúde" (Community Health Agents Program), which by 1994 was amalgamated with the National Family Health Programme (Lehmann & Sanders, 2007). Hence the strengthening of CHW programmes and the incorporation of CHWs as part of national health systems have been emphasized by global key figures at the 2013 Third Global Forum on Human Resources for Health hosted in Brazil (Schneider, Schaay, Dudley, Goliath & Qukula, 2015).

In South Africa, the provision of community-based PHC services by CHWs can be traced from the 1930s to the early 1940s (Tollman, 2002; Gofin, 2006). Similar to many global states, in South Africa the most prominent development of Community Health Work was also influenced by the Alma Ata Conference. Which grew the country's interest in CHWs programme around the late 1970s and 1980s as means of providing primary healthcare services during the apartheid era (Lehmann & Sanders, 2007; Clarke, Dick & Lewin, 2008; Languza, Lushaba, Magingxa, Masuku & Ngubo, 2011). These programmes were directed toward Black/African communities that received poor healthcare services due to discriminatory healthcare policies, inherited from the early twentieth century and further exacerbated with the institutionalization of the apartheid regime (Nxumalo, Goudge & Manderson, 2016).

Even beyond 1994 post-apartheid, the use of CHWs continued and people within African communities were encouraged to join these initiatives as volunteers. As the newly elected party,

the African National Congress (ANC) framed this as an opportunity for volunteers to be involved in national building and realize a life that is better for everyone. As the programmes continued, the year 2002 was termed 'the year of the volunteer'. The president of that time Thabo Mbeki made reference to "Letsema" a principle of (volunteerism) all in the name of Ubuntu (humanity) and launched the amavolontiya (volunteers) programme (De Wet, 2012). Then evolving into a stipend remunerated service assigned with job descriptions as well as titles and broadly referred to as CHWs (Languza et al, 2011; De Wet, 2012; Schneider & Nxumalo, 2017).

In recent years South Africa's healthcare system has been reformed to intensify the development of the CHWs programme and expand on the inclusion of community-based work (Schneider et al, 2015). Which was inspired by the Brazilian PHC model observed by the then health minister Dr. Aaron Motsoaledi and MECs during their 2010 study tour in Brazil (Spotlight, 2015; SoulCity, 2016). The continuation of Community Health Work programmes and the development of community-based healthcare services from 1994 post-apartheid and beyond resembles South Africa's political, philosophical, and socio-economic landscape. Moreover, it presents opportunities for employment creation and alleviation of poverty and assists in addressing the shortage of workforce within the healthcare sector (Languza et al, 2011; De Wet, 2012).

By 2011 the National Department of Health (NDOH) was linked to about 65 000 and 72 000 facility and community-based CHWs around South Africa (NDOH, 2011; Lehmann & Gilson, 2013; Malan, 2014; Schneider et al, 2015; Spotlight, 2015; SoulCity, 2016). These cadres comprised of health promoters posted in the clinics and around the community as well as facility-based HIV counselling and testing (HCT) counsellors and home-based caregivers (Spotlight, 2015). These CHW programmes are not only set up by the government but NGOs also facilitate projects undertaken by CHWs. Some of these organizations are funded by the government and CHWs are paid a stipend by the state via these non-profit organizations (NPOs) (Schneider et al, 2015). NPOs or NGOs remain active agents in addressing community health issues through Community Health Work initiatives. Relying on the aid of CHWs these organizations constitute important role players in the provision of healthcare (Van Pletzen, Zulliger, Moshabela & Schneider, 2014).

CHWs have helped increase coverage and access to basic health services globally and they have been recognized as positively impacting health outcomes in underprivileged communities (Lehmann & Sanders, 2007; SoulCity, 2016; World Health Organization (WHO), 2018). In South Africa, the role of CHWs in public healthcare has been significant, more so in HIV/AIDS interventions and the success of these programmes would have not been possible without the presence of CHWs. These cadres do not substitute professional health workers but are valuable in addressing new needs such as, conducting treatment adherence training and forming treatment buddies for TB and HIV patients. (Schneider, Hlophe & Van Rensburg, 2008). Hence, in recent years a move towards the development of the CHWs programme and increased community-based initiatives as part of South Africa's health system have been observed (Schneider et al, 2015).

The global emergence of Covid-19 has affected humanity and health systems around the world and just like during the advent of pandemics like HIV/AIDS, CHWs became important role players in responding to Covid-19 and providing healthcare services to different populations. Showcasing the significance of integrating CHWs into the health system and meeting society's health needs. As Covid-19 vaccinations become available for different countries, CHWs continue to be critical players in achieving vaccine approval and uptake. CHWs facilitate the introduction of vaccines to communities, identify target populations, engage and mobilize communities for inoculation uptakes as well as conduct tracking and follow-up care (WHO, 2021).

During the outbreak of the coronavirus CHWs in South Africa assisted to educate communities about Covid-19 and precautionary measures, they handed out educational pamphlets, screened people in the community for Covid-19, referred to clinics those suspected of infection, and track Covid-19 positive contacts (van Dyk, 2020; Right To Care, 2021). Similar aid was provided by CHWs in countries such as Nigeria and Zimbabwe where CHWs conducted Covid-19 contacts monitoring, health education, and awareness campaigns in communities (Africa-CDC, 2021). CHWs also helped health sectors to ensure that other health services were provided during the global health crises caused by Covid-19, which required that health workers and resources be focused on combating Covid-19. For example, during South Africa's first lockdown CHWs in the Western Cape were tasked with delivering chronic medication to patients at their homes. This helped the elderly and sick people receive their medication and prevent them from being exposed

to Covid-19 by being kept away from health facilities (van Dyk, 2020). During the emergence of Covid-19 Haiti strengthened its existing ART distribution programme in the GHESKIO center. They provided ARV treatment for up to 3 months for HIV patients and delivered the medication to those who were unable to collect it from the facility. Currently CHWs in GHESKIO help to encourage people to attend their medical check-ups as well as support awareness campaigns around the importance of Covid-19 prevention and vaccinations (UNAIDS, 2021). Thus, health experts such as Uta Lehmann posit that the Covid-19 epidemic has rekindled respect for CHWs from other health workers and communities served by CHWs (van Dyk, 2020).

Data for this study was collected pre-coronavirus hence the content of this study does not reflect the experiences of CHWs in the context of Covid-19. However, it can be argued that findings from this study may be useful to propel future studies on the experiences of CHWs in times of Covid-19 since CHWs have been important role players in the fight against this pandemic. It would be important that future studies investigate the impact of CHWs' experiences on their wellbeing during their time of service in the era of Covid-19.

1.3. Problem Statement.

CHWs improve people's health and quality of life in many communities by facilitating access to PHC services amongst poor communities experiencing perpetually inadequate services. As frontline support structure CHWs link the community to both health and social services. Acting as social change agents they empower communities through biomedical and psychosocial programmes which enhance people's wellbeing (Schneider et al, 2008; Languza et al, 2011; NDOH, 2011; 2018). Considering the impact made by CHWs in many marginalized communities it is of interest to also reflect on how these cadres are affected in the process. There are numerous studies on Community Health Work were scholars such as Fernando (1995); Lehmann and Sanders (2007); Uebel, Nash and Avalos (2007); Schneider et al (2008); De Wet (2012); Odendaal and Lewin (2014); Adams et al (2015); Dageid, Akintola and Sæberg (2016) have reported extensively about the work of CHWs. Even though studies have documented the work of CHWs, there is limited focus on how cadres experience their work. Studies have not looked at how CHWs' experiences have an impact on the cadre's wellbeing. Existing studies tend to focus on how CHWs contribute to the health sector and the benefits of the work of CHWs in different communities. There are insufficient studies on how the experiences of CHWs relate to their wellbeing thus the

state of CHWs' wellbeing is not well known or documented in the literature. Opening a research gap for this study to inquire about the experiences of CHWs and the impact on their wellbeing.

As African states look to use the service of CHWs to supplement the deficit of healthcare workers within the sector, it is important to address issues of policy related to Community Health Work (Lehmann & Gilson, 2013). It has been noted that as countries implement Community Health Work programmes they grapple with issues of replicating good practices and the uniform adoption of effective policy options. Across and within countries the endorsement of CHWs and their assimilation into the health system is still irregular. Pointing to the necessity of CHWs being guided by evidence-based health policy and support systems to maximize the work and impact of Community Health Work cadres (WHO, 2018). In South Africa measures have been taken to assimilate CHWs as part of the healthcare system and develop reforms to guide the work of CHWs. Although the country's PHC system was re-engineered and CHWs incorporated into the health system through the WBPHCOTs strategy, the adaptation and implementation of a national CHWs policy were delayed for many years. Whereby from 2011 to 2017 CHWs continued working without an official policy (Languza et al, 2011; Malan, 2014; SoulCity, 2016; Schneider, 2017; Schneider & Nxumalo, 2017). Even with the finalization of the WBPHCOTs strategy policy framework and it being adapted as a national CHWs policy in April 2018, this framework provided inadequate guidance on the standardization of CHWs distribution and assignment of their responsibilities (Section27, 2019). Raising the question of "how the work of CHWs has been guided in their years of functioning in the absence of a national CHWs policy?"

1.4. Research Question.

The following research questions guided this paper so that the inquiry achieved the aims and objectives of the study:

1. How do CHWs experience their work?

2. How have the experiences of CHWs as health caregivers impacted their wellbeing?

3. In the years of functioning in the absence of a CHWs national policy, how has the CHWs scope of practices been guided?

1.5. Aims and Objectives of the study.

There has been a recognition of CHWs in Low-middle income countries (LMIC) as important role players in championing the Millennium Development Goals (MDGs) (Lehmann & Sanders, 2007; Singh & Sachs, 2013; Saxena et al, 2017). Such as MDG 3 (Ensuring healthy lives and promotion of well-being for people of all age groups), MDG 4 (Reduce child mortality), MDG 5 (Improve maternal health), and MDGs 6 (Combat HIV/AIDS, Malaria and other Diseases) (Barron, 2012; Mensah, 2014; WHO, 2018). Understanding the role of CHWs and their impact on society this study focused on the work of CHWs in South Africa. The aim of this inquiry sought to gain an understanding of the experiences of CHWs as health caregivers and whether and if so, how these experiences impact their wellbeing. Therefore the study explored the experiences of CHWs as cadres providing healthcare services at the PHC level within two NGOs situated in Johannesburg townships. The 2030 National Development Plan (NDP) called for households to have access to an adequately trained Community Health Worker (CHW) based in their community (NDOH, 2018). Even though such reforms identify the need for CHWs in South African communities, up until 2018 these cadres functioned in the absence of a national CHWs policy. Hence, the study sought to further understand the adaptation and scope of practice of cadres working as CHWs in the absence of a national CHWs policy. To expand the study's understanding of the function of CHWs within such a scanty policy environment the research expanded its inquiry amongst the managers of the two NGOs. The managers provided information about the work of CHWs and their knowledge of the WBPHCOTs strategy policy framework that was adapted in 2018 as a national CHWs policy.

CHAPTER 2: LITERATURE REVIEW.

2.1. Introduction.

An estimation by WHO indicates a global healthcare worker shortage of about 7.2 million. Amongst the 57 affected countries, 36 of these states are situated in Sub-Saharan Africa (Adams et al, 2015). South Africa is one of the latter countries experiencing a stark deficit of healthcare workers (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009) strained by the historical burden of HIV/AIDS that required an expansion of HIV/AIDS programs (Lehmann & Sanders, 2007; Coovadia et al, 2009). This burden has left South Africa's healthcare system challenged with a narrowing resource gap which has affected access to healthcare and healthcare goals (Fernando, 1995). South Africa has joined the global trend of adopting CHWs to supplement the healthcare worker deficit and to also counter the scourging effects of HIV/AIDS, especially in Sub-Saharan Africa (Fernando, 1995; Lehmann & Sanders, 2007; Topp et al, 2015).

In different parts of the world, the implementation of the CHWs programmes has taken place as a multi-sectoral venture which amalgamates healthcare services with literacy and the creation of a source of income within communities (Fernando, 1992 as cited in Fernando, 1995). In South Africa, such is observable with government programmes like the Ward-based outreach teams (WBOTs) implemented by the NDOH. Also, through community-based service programmes that combine health and social services provided by NPOs. Most Community Health Work initiatives are implemented by NPOs, presenting as organizations such as Community Health Based Centre's (CHBCs) or Community Based Organizations (CBOs) and NGOs. Through the help of CHWs working as home-based carers, counsellors performing HIV Testing Services (HTS), auxiliaries, and midwives, these organizations run programmes related to the treatment of HIV/AIDS, TB treatment surveillance, treatment of malaria, child and maternal projects such as immunization, breastfeeding promotion, undernutrition reduction as well as prevention and treatment of childhood illnesses (Schneider & Lehmann, 2010; De Wet, 2012; Adams et al, 2015; Topp et al, 2015; Akintola & Chikoko, 2016; Caprara, Mati, Obadare & Perold, 2013).

Therefore, CHWs have been significant role players in the provision of healthcare services, especially in poor and under-resourced communities grappling with a myriad of health issues.

Considering the nature of Community Health Work, this review offers a discussion on the implications of being a CHW and the gendered nature of Community Health Work. The literature contextualizes the role of CHWs in South Africa, as well as the country's CHWs policy framework since South Africa has its unique presentation and implementation of Community Health Work programmes. This literature review includes an elaboration on the NGO sector to understand their role in the implementation of health programs as assisted by CHWs. This section will also delve into the notion of wellbeing to formulate an understanding of the impact of care work on CHWs. Concluding with a theoretical framework that guided the framing of the findings within the study. This review begins by discussing the broad understanding of CHWs and their roles.

2.2. A general understanding of CHWs and their roles.

Scholars' understanding of CHWs and their roles vary. CHWs are labelled differently and perform several tasks specific to the various countries and communities. This is determined by the needs and available resources within their settings (WHO 2004). In simple terms, CHWs can be defined as lay community members that either work part-time or full-time, acting as the community's first contact in the provision of healthcare and connectors to the healthcare system (WHO, 2004; Languza et al, 2011; Saxena et al, 2017). CHWs can work as remunerated or non-remunerated volunteers within local healthcare systems. In countries such as South Africa and Ethiopia some CHWs are compensated in stipends or kindness by their communities or by the government (WHO, 2004; Akintola, 2011; Dewing, Mathews, Schaay, Cloete, Simbayi & Louw, 2015; Maes, Closser, Tesfaye & Abesha, 2019).

These cadres may be employed by CBOs and/or healthcare facilities working in both rural and urban communities. They typically share features with the communities they serve in terms of socioeconomic background, ethnicity, and life experiences (WHO, 2004; Dewing et al, 2015). CHWs are mostly community members themselves and in some communities, these cadres are chosen by members of the community (Lewin et al, 2005; Malan, 2014; Saxena et al, 2017).

Most of these cadres do not have formal professional or tertiary education and normally receive some form of in-service training when they become CHWs. Hence they are also regarded as Lay healthcare workers (LHWs), or as Lay healthcare advocate promoters, Community health advisors, Outreach educators or Peer-health educators, and Primary healthcare workers (PHCWs) (Lewin et

al, 2005; Dewing et al, 2015). Including Home-based caregivers or Community caregivers all falling under the umbrella term of 'CHWs' and serving in an array of posts (Lehmann & Sanders, 2007; Schneider & Lehmann, 2010; Akintola, 2011; Languza et al, 2011). CHWs function as non-professional cadres but play a crucial role in responding to community health needs and advancing health outcomes (Lewin et al, 2005; Lehmann & Sanders, 2007; Ingram et al, 2012; Oliver, Geniets, Winters, Rega, & Mbae, 2015; Saxena et al, 2017). While easing the strained healthcare system from an increased disease burden as a result of the scourge of HIV/AIDS (Akintola & Chikoko, 2016).

Efforts of assimilating CHWs into formal healthcare facilities have assisted several developing states like South Africa, Kenya, and Zambia to increase the delivery of healthcare services (Dewing et al, 2015). Hence, in 2012 WHO recommended the application of Task-shifting to CHWs as means of maximizing the potential of CHWs to address the deficit of healthcare professionals and also improve service delivery and manage human resources. While also accelerating the attainment of MDGs amongst LMICs (Were et al, 2008; Odendaal & Lewin, 2014; Akintola & Chikoko, 2016).

2.3. The implications of being a CHW.

Findings from a study conducted by Odendaal and Lewin (2014) amongst 14 LHWs in peri-urban Cape Metropole indicated positive implications related to being a CHW. Cadres reported feeling empowered by being involved in community interventions as means of helping their communities. Their work as non-professional health workers gave them a sense of personal and communal benefit. In addition to that CHWs also reported improvement in knowledge in areas of disability and rehabilitation, handling emergencies as well as being able to properly identify and treat minor illnesses like fever and diarrhea. Which improved their ability to assist communities and their family members with basic healthcare services. They also learned skills and knowledge from patients on how to grow vegetables.

According to Dageid et al (2016) the learning acquired by CHWs in their work as presented in the study conducted amongst twelve AIDS care female volunteers in two peri-urban townships of KwaZulu Natal (KZN), served as motivational factors for many CHWs in their work as activists and caregivers. Allowing CHWs to learn and share their knowledge, and skills and affect change

in the community. Albeit their work had the potential of being exposed to risks such as infections, emotional strain, or reprisal from the community (Greif, Adamczyk & Felson 2011). Another motivational factor that is a positive aspect of CHWs' experience is the opportunity of securing some form of employment or income by receiving monetary remuneration (Schneider et al, 2008; Friedman et al, 2007; Dageid et al, 2016).

However, the latter benefit is opposed as being quite minimal because it is mostly in the form of a stipend, ranging from R1000 (US$100) to R1200 (US$120) a month and varying according to provinces (Schneider et al, 2008; De Wet, 2012; Malan, 2014; Odendaal & Lewin, 2014). At times CHWs use this very stipend to pay for transport fares when visiting their patients as some CHWs are not provided with transport money (Odendaal & Lewin, 2014). Helen Schneider points out that CHWs earn even less than domestic workers (Malan, 2014).

Cobbing, Chetty, Hanass-Hancock, and Myezwa (2017) further reported that CHWs providing palliative care in the rural part of KZN found navigating the physical environment challenging. Walking long distances to attend to patients located in different homesteads and this being more exhausting under extremely hot weather conditions. Like other health cadres, CHWs were at high risk of occupational tuberculosis infection due to the increasing incidences of drug-sensitive and resistant TB infection (Adams et al, 2015), and these cadres are sometimes viewed as not being part of the formal health system (Odendaal & Lewin, 2014).

Aitken (2013); Tsui, Salisbury-Afshar, Zulliger, and Perry (2013); Spotlight (2015) argued that with the progression of community health worker programmes CHWs are overburdened by the allocation of numerous tasks. Especially tasks in which they have not been trained, making it challenging to work under such conditions. Hence, they posit that the role of CHWs needs to be considered carefully and defined more clearly. So that CHWs can effectively perform their duties as required by their employers while also remaining accountable to the served communities. According to WHO (2008) at the community level cadres should be properly recruited, well trained, and supervised while simplifying their tasks. That means following a competence-based approach where cadres are tasked according to the training they have received and their capability to perform their duties.

Scholars from other African states have found similar experiences related to successes and defies encountered by CHWs. For instance, in Uganda CHWs serving in a health programme targeting women recounted benefiting from their work. Firstly, they experienced personal growth and a sense of self-satisfaction, acquired new skills, increased their knowledge of women's health issues, healthcare rights, and services, and also acted out healthy behaviours. Secondly, they experienced sociocultural advantages such as social support and solidarity prompted by social interaction. Lastly, they also reported socio-political gains which translated to better their social status and respect from community members (Jack, Kirton, Birakurataki & Merriman, 2012). In a Tanzanian study, CHWs volunteering in a programme related to HIV/AIDS and skill development reported positive experiences, such as skills development and earning recognition from the community. But they also experienced negative effects like burnout, domestic violence, and stigma (Corbin, Mittelmark & Lie, 2016).

2.4. Gendered nature of Community Healthcare Work.

Another consequence of community health work presented in literature was its gendered nature. Research studies conducted amongst community health cadres like caregivers and LHWs were saturated by women. The noted gendering among CHWs has been attributed to the general existence of traditional gender roles and social expectations regarding household and care work. Whereby women are usually socialized into behaviours and competencies to undertake roles and responsibilities of caregiving activities (Akintola, 2006; Rotolo & Wilson, 2007; Manning, 2010). These activities deemed as women's work enforce gender inequality (Greif et al, 2011).

In comparison to their male counterparts, it is more probable that women are involved in caregiving organizations as an extension of women's role which is mostly domestic-oriented while men tend to engage more with political organizations (Greif et al, 2011). Moreover, many women undertake healthcare work as means of securing an income and a livelihood (Topp et al, 2015; Dageid et al, 2016). Thus, the health sector presents with the opportunity to create economic means through the creation of eligible job opportunities, particularly for women (WHO, 2018).

On the other hand, such work may be exploitive labour for women who already find themselves in poverty because they sometimes work as volunteers not receiving any remuneration (Akintola, 2011; Maes et al, 2019). Female cadres endure psychosocial distress and experience caregiving as

stigmatizing and burdensome (Akintola, 2006; 2011; Maes et al, 2019). They often work under unfavorable psychological and physical conditions while being offered limited support (Thabethe, 2011). This result in the reduction of opportunities for women to progress socially and economically since caregiving or volunteerism is less esteemed and undervalued (Greif et al, 2011). Such working conditions are more prevalent where the work of cadres is not regulated by policies that protect their rights (Caprara et al, 2013). Hence the need for empowerment of CHWs as means of contributing to realizing gender justice at a community level (WHO, 2018).

2.5. Roles of CHWs within the South African Context.

Beyond the primary role of caregiving and most of these cadres being women the scope of CHWs has expanded and varies according to the needs of different countries wherein Community Health Work programmes are organized by both the NGO and Government sectors. Prompted by an HIV burden CBOs and healthcare facilities in South Africa adopted CHWs programmes to provide community health interventions such as HCT services, the roll-out of HIV and TB treatment, treatment-adherence support, or surveillance through Direct Observation Therapy (DOT) support. In addition, CHWs have been involved in Home-Based Care (HBC) for People living with HIV/AIDS (PLWHAs), care and support for children orphaned by HIV/AIDS as well as extending healthcare services to facilitate mother and child health programmes and care for those affected by other chronic illnesses (Lehmann & Sanders, 2007; Schneider & Lehmann, 2010; De Wet, 2012; Odendaal & Lewin, 2014; Malan, 2014; Topp et al, 2015).

Furthermore, CHWs serve as health promoters carrying out activities like door-to-door campaigns, and where necessary they refer people to the clinics. They educate people about diseases like TB and cancer through information dissemination. They also deliver medication to chronically ill patients that are unable to fetch their medication from the clinic due to ill health. They assist patients to manage side effects and help them with pill count as well as their treatment dosage. In addition to that CHWs assist to trace people who have defaulted on treatment related to TB and HIV. They provide psychosocial support and HBC to individuals who are terminally ill (Odendaal & Lewin, 2014; Nxumalo et al, 2016; SoulCity, 2016; Naidoo et al, 2018). CHWs have also effectively assisted in the delivery of health interventions related to immunization of children,

treating respiratory infections, and communicable illnesses like malaria (Dewing et al, 2015; SoulCity, 2016; Khuzwayo & Moshabela, 2017).

CHWs have not only been confined to healthcare services but also assist as part of development work teams and extend their services beyond their scope of practice (WHO, 2004; Nxumalo et al, 2016). Assisting to address social conditions related to education, poverty, housing, and food provision and disseminating information to the community regarding access to services of welfare, like social grants, birth certificates, and identity document applications. This ambit includes matters related to water and sanitation hence it can be said that CHWs have an intimate and holistic interaction with the served communities (Nxumalo et al, 2016). Considering their continuous role, CHWs are included and used in PHC programmes (Fernando, 1995) and as volunteer activists continuously advancing not only healthcare services but also human-rights work. This highlights the need for change in the health sector and the development of policy that would guide the work of CHWs and acknowledge the rights of these cadres who are mostly women. Reforms help to form a supportive milieu for cadres and create a space to acknowledge and respect their work (Greif et al, 2011). Thus around 2008 groups such as the AIDS Law Project (ALP) had been calling for the formalization of CHWs as part of the health system (Mafuma & Stevenson, 2017).

2.6. South Africa's CHWs Policy Environment.

Heeding the call to formalize CHWs into the health system the South African government re-engineered the country's PHC system in 2011. This was done as means of establishing a policy environment committed to the reconstruction of the country's health system (Jinabhai, Marcus & Chaponda, 2015). Leading to significant changes in the country's healthcare system post-apartheid regime in 1994. Wherein the 1997 White Paper for the Transformation of the Health System in South Africa envisaged the decentralization and restructuring of the health system into a district health system (DOH, 1997). Which was meant to improve the deliverance of healthcare services in South Africa (DOH, 1997; Lehmann & Gilson, 2013). Further changes in South Africa's health system were inspired by the 2010 Brazilian study tour undertaken by the minister of health Dr. Aaron Motsoaledi and a MECs lead team. The purpose of the expedition was to learn about Brazil's PHC model to help upgrade our health system. Hence, upon their return ensued the re-engineering of South Africa's PHC system (Malan, 2014; Nxumalo et al, 2016; SoulCity, 2016). Considering the country's health landscape together with lessons informed by the Brazilian study tour the

development of the PHC re-engineering strategy was envisaged as an effort to reinforce the provision of PHC services within the framework of the National Health Insurance (NHI) (Jinabhai et al, 2015; Schneider et al, 2015; 2017; SoulCity, 2016; NDOH, 2018).

By 2011 the National Health Council organized the NDOH to reconstruct the Public Health-Care system into three streams. The *district clinical specialist teams*, devised as the main providers of support; *school health teams*, to provide school-related health services; and the *ward-based primary healthcare outreach teams (WBPHCOTs)* strategy composed of a professional nurse, environmental health officer as well as CHWs referred to as WBOTs (Malan, 2014; Jinabhai et al, 2015; Spotlight, 2015; Nxumalo et al, 2016; SoulCity, 2016; Mafuma & Stevenson, 2017; NDOH, 2018). The latter stream is the cornerstone of PHC service at the community level. Through the re-engineering of the PHC model and the WBPHCOTs strategy, CHWs were to be officially incorporated into the health system for the first time (NDOH, 2011) reverting the isolation from the health sector that community-based or lay workers had experienced before (Schneider et al, 2008). So then re-engineering the PHC system was significant because WBOTs was the first countrywide effort of assimilating CHWs into the PHC system since the late 1940s (Jinabhai et al, 2015). Even in 1997, the White Paper that articulated the transformation of the health sector did not make any recommendations for including CHWs as public servants but they remained excluded from other formal health cadres (Nxumalo et al, 2016; Section27, 2019).

The Brazilian-inspired PHC re-engineering project was the most significant initiative to develop Community Health Work programmes and formalize CHWs as part of the health system. The then minister of Health Dr. Aaron Motsoaledi announced the development of a CHWs programme alike to that of Brazil (Malan, 2014; Schneider, 2017). The formulation of the national CHWs policy in the context of the re-engineering project sought to effect uniformity across Community Health Work projects that already existed. And further launched a formal process of assimilating CHWs within the public health system (Lehmann & Gilson, 2013; Malan, 2014) in pursuit of strengthening the country's PHC system (Mafuma & Stevenson, 2017).

However, the fashioning of the CHWs programme in the context of the re-engineered health system has developed within a scanty policy environment. The NDOH began with the publication of a discussion paper in 2010 dubbed; Re-Engineering Primary Health Care in South Africa. It

detailed plans, structure, and implementation of the re-engineering model (Malan, 2014; Akintola & Chikoko, 2016; Schneider, 2017; 2019; Assegaai & Schneider, 2019). NDOH followed with the publication of the 2011 provincial guidelines for the implementation of the three streams of the re-engineered PHC system. Wherein the WBPHCOT strategy as the third stream outlined the process of integrating CHWs into the PHC system (Van Pletzen, et al, 2014; SoulCity, 2016; Schneider, 2017; NDOH, 2018). The WBPHCOT strategy intended to formally integrate CHWs into the country's health system as part of the health labour force mobilized to serve as assorted lay health cadres broadly trained in different health issues (Schneider et al, 2008; Lehmann & Gilson, 2013; Malan, 2014; Swartz & Colvin, 2015; SoulCity, 2016; Schneider, 2017; Schneider & Nxumalo, 2017). They were also expected to facilitate health prevention and promotion, providing caregiving services and collaborating across sectors to address social aspects of health and being deployed in areas like informal-urban settlements, townships, and rural communities (Schneider et al., 2008; Schneider & Nxumalo, 2017).

According to the 'Contract of appointment: Community Health Worker Training Post' released with the 2011 provincial guidelines for the implementation of the three streams of PHC re-engineering, the first set of CHWs were to be recruited and hired as contract workers for a year and remunerated R2500 per month (NDOH, 2011). These guidelines proposed the appointment and reimbursement of CHWs be facilitated through the Provincial Department of Health (PDOH) rather than NGOs (Malan, 2014). Recruitment of CHWs was intended to start with the existing database of CHWs found in NGOs associated with NDOH (NDOH; 2011; MedicalBrief, 2016; SoulCity, 2016; Marcus, Hugo & Jinabhai, 2017; NDOH, 2018). CHWs programme would prioritize those with a minimum of grade 12 and included the possibility of recognizing prior learning for CHWs that had received relevant training and were already part of the system (NDOH, 2018; Pillay, 2018). Those not meeting the requirements would not be terminated but negotiated with to consider the possibility of being alternatively located or phased out during the period of transition (NDOH, 2018).

In 2015 NDOH released a draft of the Policy Framework and Strategy for Ward-Based Primary Healthcare Outreach teams that expanded on the establishment of Community Health Work programmes and plans of improving the existing work of NGOs in community-based care

developed to support the response to HIV/AIDS. This 2015 WBPHCOTs strategy framework was to be adopted formally as a policy for guiding Community Health Work programmes (Schneider, 2017; Schneider & Nxumalo, 2017). But it was only finalized by NDOH around April 2018 and titled; Policy Framework and Strategy for Ward Based Primary Healthcare Outreach Teams 2018/19-2023/24 (Section27, 2019; Pillay, 2018; NDOH, 2018; Assegaai & Schneider, 2019).

The drafting of these different reforms culminated in a policy environment that has led to efforts to re-engineer the PHC system and implement Community Health Work programmes (Malan, 2014; SoulCity, 2016). These amendments proposed by the government and their efforts to re-design an integrated PHC system increased the state's involvement in guiding Community Health Work programmes, especially with the development of the WBPHCOTs model (Schneider & Nxumalo, 2017). However, advancing from envisioning the WBPHCOTs strategy to its full implementation has moved at a slow pace (SoulCity, 2016). Leading to CHWs functioning within a feeble policy environment because even though the WBPHCOTs strategy had been worked on since 2011 (Jinabhai et al, 2015), the processes of finalizing and implementing a policy for CHWs remained incomplete for many years and was only finalized around 2018 (Section27, 2019, NDOH, 2018; Pillay, 2018).

Although NDOH had established the WBPHCOTs strategy, the 2011 provincial guidelines for the implementation of the three streams of PHC were left to each PDOH to adapt as they saw fit and the local government was allocated the responsibility of appointment and payment of cadres. Resulting in differing provincial approaches to implementing the WBPHCOTs strategy and inconsistencies across provinces (Malan, 2014; Schneider & Nxumalo, 2017; Mafuma & Stevenson, 2017). Moreover, provincial health ministries utilized CHWs as it suits them and not being considerate of the NPO sector (Van Pletzen et al, 2014). Hence CHW programmes amongst provinces only have some similarities but differ in how the provinces adopt the WBPHCOTs strategy policy framework in the implementation of Community Health Work programmes (Lehmann & Gilson, 2013; SoulCity, 2016). The implementation of the WBPHCOTs strategy by different PDOHs appears to be in contrast with the recommended reforms of the WBPHCOTs strategy policy framework. Compared to district clinical specialists and school health teams, the WBPHCOTs programme does not have a standardized system of operation (SoulCity, 2016).

These dynamics challenge the reforms intended to standardize the work of CHWs in South Africa (Malan, 2014).

Delays in finalizing and implementing the WBPHCOT strategy policy framework as a national CHWs policy led to instability in the work of CHWs and resulted in several shortcomings as Community Health Work continued to be precarious and cadres still functioned as volunteers (Malan, 2014; SoulCity, 2016; Awethu.amandla, 2017; Mafuma & Stevenson, 2017). CHWs have also felt unhappy about their labour rights and how they have been treated even as they were being integrated as part of the workforce within the re-engineered PHC system which has led to several protests organized by CHWs in different provinces (MedicalBrief, 2016; SoulCity, 2016; Awethu.amandla, 2017).

In 2014 the Free State DOH did not follow the recommendations made in the 2011's provincial guidelines for the implementation of the three streams of the re-engineered PHC. Which proposed that the recruitment of CHWs as part of WBPHCOTs programmes should start with cadres from the existing pool of CHWs working in NGOs associated with DOH. In the absence of an official CHWs policy, about 2200 CHWs in the Free State became unemployed after they were not recruited to be part of the WBOTs programme. The available pool of CHWs and the organizations which still retained CHWs were cut off from being funded by the DOH. CHWs in the Free State hosted a night-long vigil protest at the provincial headquarters in Bloemfontein and 130 of these cadres were charged for hosting an illegal protest (SoulCity, 2016).

In 2016 CHWs in the Gauteng province hosted a demonstration at the offices of Gauteng's DOH (GDoH). These cadres complained of being treated as volunteers and hired on a contractual basis rather than being permanent employees of the government. They also experienced delays in receiving their stipend, as CHWs would go for months without being remunerated (MedicalBrief, 2016; Awethu.amandla, 2017). In the same year, a case was launched with the Public Health & Social Development Sectoral Bargaining Council (PHSDSBC) whereby CHWs under the Gauteng Community Health Care Forum (the Forum) wanted GDoH to recognize them as permanent workers. GDoH denied that CHWs were the departments' employees. To further dodge the responsibility of being the employer of CHWs, in Gauteng the department contracted SmartPurse Solution as payroll administrators for CHWs in the province. The department advanced claims that

CHWs were employed by SmartPurse Solution since they have been paid by SmartPurse since April 2016. Since 2016 the department continuously employed delaying tactics and did not pay the stipend of CHWs who refused to sign contracts with SmartPurse as their employer. By 2017 some of the CHWs had been exhausted by all the threats, tactics, lies, and illegal acts of the department. However, the success of workers in July 2018 at the Constitutional Court case of NUMSA vs Assign labour brokers was promising for CHWs. The Con-Court judgement meant that even when employees are employed by an organization like SmartPurse if CHWs have worked for more than three months for the department they are to be deemed the employees of GDoH whom they actual serve (Lehulere, 2018).

While there has been continued work on the WBPHCOTs strategy policy framework the practical and policy glitches surrounding the WBPHCOT strategy must be addressed to reach its maximum potential (Jinabhai et al, 2015). CHWs policy framework and its implementation seem more like an optional exposition detailing the initial stage of the WBPHCOTs programmes and appear less like a national policy that is meant to guide human resource issues within the health sector. Moreover, the role of NGOs continues to be ambiguous and the WBPHCOTs strategy framework does not clearly address the issue of surplus CHWs that were not recruited from NGOs as part of the WBOTs (Mafuma & Stevenson, 2017). Dynamics surrounding the position of NGOs within the re-engineered PHC system and the implementation of the WBPHCOTs policy prompt the following section to unpack the existence of NGOs in South Africa. By so doing the discussion also elaborates on the general understanding of the NGO sector.

2.7. NGO Sector.

NGOs can be understood as assorted groups of establishments as the rationale around the advent of NGOs differs in various parts of the world. NGOs are motivated by different political, religious, and cultural influences hence they are synonymous with multiple acronyms like; *CBOs, FBOs* (Faith-Based Organizations), *NPOs*, *CSOs* (Civil Society Organizations), *VNPOs* (Volunteer Non-profit Organizations), VOs (Volunteer Organizations) and POs (Peoples Organizations). This list enumerates about 48 different acronyms and terms and their presence have become widespread (United Nations Environment Programme (UNEP), 2007; Lewis & Kanji, 2009).

In South Africa NGOs established a community presence in the 1940s around the era of the apartheid regime. Providing community-based care in marginalized communities independent of the government and continuing with their services post-apartheid in 1994. Several unregulated NPOs led Community Health Work programmes and more of these programmes were developed with the emergences of the HIV pandemic to respond to the scourge of HIV (Fernando, 1995; Friedman et al, 2007; Van Pletzen et al, 2014; Schneider & Nxumalo, 2017). Hence, the argument that the development of the NGO sector was fostered by the need to aid people who found themselves in poverty. Particularly in communities that were bypassed by functioning public services challenged by the shortage of resources or controlled by privileged leaders. Whereby leaders reached biased decisions that did not favour adequate public service provision in relegated communities. In this respect, NGOs have assisted to make up for some of the state's shortcomings. Performing duties that are tasked to the state they deliver public services to marginalized communities and tackle issues that would naturally be addressed by the government (Lewis & Kanji, 2009). Therefore NGOs function as service delivery and civil society entities (Banks, Hulme & Edwards, 2015).

As denoted by their label NGOs should be looked at in context to their relationship with the government as non-state actors since the legitimacy of NGOs is affected by their relationship with the government (Lewis & Kanji, 2009). For instance, even with the dawn of a democratic South Africa, the formalization of CHWs into the health system was not prioritized by the government but Community Health Work programmes were undertaken by NGOs (Friedman et al, 2007). It was only around the year 2000 that the government identified the role of NPOs and their contribution to the labour force and it organized to contract NPOs as providers of community-based care services (Schneider, 2017).

This initiative ushered in some form of partnership between South Africa’s government and community-based care NGOs as the government called for the coordination of single and multipurpose CHWs in communities and committed to providing some sort of funding to CBOs. Albeit the NDOH avoided taking responsibility for direct employment and training of CHWs as it cautioned that CHWs who worked as volunteers should not assume that they would be allocated to paid work. The government relegated to NGOs the responsibility of employing CHWs and

recommended that organizations provide CHWs with accredited training. The government also failed to provide grants to CBOs or NGOs leaving the remuneration of CHWs the responsibility of NGOs, with organizations only affording CHWs a minimal stipend (Schneider et al, 2008). Showing that even though NGOs differ from government bodies, they often develop relationships and get into partnerships with the state and corporate entities. For NGOs, part of this partnership involves soliciting financial sponsorship because NGOs tend to be non-profit making organizations. While the government partners with NGOs as they are viewed as a cost-effective and helpful option for service delivery within the public sector. As they usually operate at a low cost because they relied on voluntary participation from members of the community (UNEP, 2007; Lewis & Kanji, 2009; Mannell, 2014).

Interaction between South Africa's government and CBOs increased through the WBPHCOTs strategy which forms the third stream of the re-engineered PHC system. The strategy was developed in consultation with local health facilities, the Department of Social and Development (DSD), and the NPO sector (NDOH, 2011). Thus, there is an acknowledgment of the NGO sector within the WBPHCOTs strategy policy framework, and the government further displayed the intention of working in partnership with NGOs. Regardless of such engagements and good intentions, the re-engineering PHC strategy does not clearly state the role of CBOs (Van Pletzen et al, 2014; Akintola, Gwelo, Labonte & Appadu, 2016; Schneider & Nxumalo, 2017). It only sketchily mentions the significance of communication with the NPO sector regarding transformation in community-based care and facilitating these changes (Van Pletzen et al, 2014).

Influenced by the 2011's provincial guidelines for the implementation of the three streams of PHC re-engineering that were left to each PDOH to adapt as they saw fit, provinces differ in their approaches to implementing the WBPHCOTs strategy leading to inconsistencies across provinces (Schneider & Nxumalo, 2017; Mafuma & Stevenson, 2017). Therefore, even in the context of a re-engineered PHC system NGOs in each province interact differently with the government. In the implementation of the WBPHCOTs strategy, some NGOs remained recruiters and employers of CHWs. While in some cases local government recruited CHWs from CBOs and contracted them as WBOTs (Akintola et al, 2016). Thus, the donor relationship that NGOs have with the government has been criticized. Given its potential to limit the crucial role played by NPOs as a

countervailing power against the bureaucracy of the latter institutions (Banks, Hulme & Edwards, 2015).

Greater inconsistency in implementing the WBPHCOTs strategy is notable concerning the reimbursement of CHWs. For example, in some provinces, the government allocated funds to NGOs to employ cadres and mandated these organizations to also act as paymasters of CHWs on behalf of the PDOH (SoulCity, 2016; Lehmann & Gilson, 2013; Van Pletzen et al, 2014). In other provinces, CHWs are directly contracted and paid by PDOH cancelling the mediation of NGOs. For example, in the Eastern Cape, KZN, Northwest, and Gauteng CHWs are remunerated directly by the PDOH, whereas in Western Cape, Free State, Limpopo, and Northern Cape CHWs are employed and remunerated by NPOs as contractors of local government (Malan, 2014; Schneider & Nxumalo, 2017). Bornstein and Sharma (2016) also lambasted the partnership between NGOs and government as yielding negative consequences where NGOs find themselves entangled with government institutions in a complex way, resulting in organizations being less critical of the state and becoming complaisant to areas of incompetency by the latter.

Furthermore, some have pointed to a dilemma about the existence of NGOs and wonder; if services delivered by NGOs serve as means of addressing people's current needs or if NGOs are just filling in the gap for the state up until government can improve and fulfill their social service provision mandate. Or they function as independent establishments contracted by the state to deliver public services and NGOs form part of a long-term plan (Lewis & Kanji, 2009). For Example, in South Africa CBOs implementation of community-based care through the aid of CHWs predates the re-engineering of the PHC system, and NGOs continued to have a significant stake in the implementation of Community Health Work programmes in the milieu of a re-engineered PHC system (Friedman et al, 2007; Van Pletzen et al, 2014).

NGOs continue to be significant role players in addressing the needs of many underprivileged communities. Community Health Work programmes are some of the most prominent initiatives that have been used by NGOs to address community health issues. These programmes have been facilitated with the help of CHWs whose role determines the extent to which organizations can fulfill their mandate (Van Pletzen et al, 2014). Therefore, the dynamics, successes, and failures experienced by NGOs also affect the experiences of CHWs which also affects their wellbeing.

Begging the question, 'how do the experiences of CHWs as health caregivers impact their wellbeing?'

2.8. Wellbeing.

Since this study also raised a question about the wellbeing of CHWs conceptualizing an appropriate understanding of wellbeing enables the research to intently locate the primary inquiry of the study; to reflect on the wellbeing of CHWs in context to their experiences in the field of community health work. Griffin (1988) emphasizes the importance of identifying the context in which wellbeing appears and its purpose in that milieu before this concept is explained. Literature indicates that wellbeing is understood synonymously with *Subjective Wellbeing (SWB)* (Diener & Suh, 1997; Diener, Suh, Lucas & Smith 1999; Schwarz & Strack, 1999; Helliwell & Putnam, 2004; Kim-Prieto, Diener, Tamir, Scollon, & Diener, 2005). Therefore, it should be noted that the term wellbeing will be used interchangeably with SWB.

The notion of wellbeing is quite broad and could be understood differently in varying contexts. Part of conceptualizing wellbeing ensues by accepting that it does not have a particular definition that is unanimously agreed upon. Scholars have proposed multiple perspectives on understanding wellbeing. In this study, a review of wellbeing will ensue from two perspectives, the *hedonistic* and *eudemonic* approaches.

According to the hedonistic approach, wellbeing is associated with happiness as a form of hedonic gratification or pleasure indulgence (Waterman, 1993; Ryan & Deci, 2001; Jen, 2017). SWB is an outcome of positive attributes such as pleasant emotions like joy or happiness and the absence of negative attributes such as sadness and hopelessness (Waterman, 1993; Lyubomirsky & Lepper, 1999; Ryan & Deci, 2001; Baron, 2006; Selamu et al, 2017; Centers for Disease Control and Prevention (CDC), 2018). Wellbeing is accompanied by a state of health, happiness, success, and wellness. It is fundamentally about living a life that is satisfying and ultimately good. Simply put wellbeing pertain to existing as both happy and virtuous (Kwon, 2008).

Hedonic gratification arises with the satisfaction of either physical, intellectual, or social needs (Waterman, 1993). Also, SBW is more of three aspects encompassing phenomenon that is inclusive of life satisfaction together with the existence of positive experiences and the avoidance of negative experiences (Diener & Suh, 1997; Ryan & Deci, 2001; Jen, 2017). For example, in the

study by Selamu et al (2017) Health Care Workers (HCWs) provided their subjective account of wellbeing as having a positive experience in their workspace. This involved having a good rapport with the communities they serve, being healthy, and being able to sustain their financial needs and an absence of negative factors in their lives. That meant being safe from infections in the workplace and feeling protected from any violence either from patients or their caregivers. Therefore, wellbeing as a positive outcome is important for many people and sectors of society (CDC, 2018).

Conversely, the eudemonics perspective offers an alternating stance on wellbeing and the distinction presented by this perspective is a move from focusing on people's state of happiness. Proponents of eudemonic wellbeing contend that subjective happiness does not always equate to wellbeing because not all pleasurable experiences are good for a person nor promote their health and wellness. Subjective happiness does not necessarily result in a state of wellbeing (Ryan & Deci, 2001). Even when people are happy, healthy physically, financially stable, and accomplished in other facets of life, they may not feel satisfied (Hall, 2008). People may be challenged in different areas of their life or have negative experiences and still be well. Wellbeing also involves finding a balance between encountered challenges and collective resources that are available to people (Dodge, Daly, Huyton & Sanders, 2012).

The eudemonic approach focuses on people's psychological wellbeing, their experience of life, the meaning of prosperity, personal achievements, actualization of the self, and the significance of their life (Waterman, 1993; Kramer, 1997; Ryan & Deci, 2001; Baron, 2006; Abera, Yitayal & Gebreslassie, 2014). Hence, eudemonic wellbeing involves much more than a state of happiness or being satisfied but entails personal development, feeling a sense of fulfilment, and having an impact on society (Shah& Marks, 2004). In a study conducted among 18 female farm entrepreneurs in Sweden Sörensson and Dalborg (2017) found that wellbeing is related to conditions that enable personal growth, or development, and the ability to contribute to society. Whereby entrepreneurs who experienced increased levels of wellbeing expressed eudemonic-related sentiments. Such as feeling like they were making a difference within the community, feeling valuable as job creators in the village, and experiencing personal development by being self-employed.

A combination of self and collective efficacy positively affects people's wellbeing (Roos, 2009). Enabling individuals to function positively in life and become whole individuals that contribute to society (Keyes et al, 2008). For example, Simmons et al (2019) study about educators' wellbeing was embedded in the idea that people construct multiple realities through interpersonal interaction and experience of the world. Thus high levels of wellbeing positively affect both individuals and society (Shah & Marks, 2004; Huppert & So, 2013). Eudemonism entails the person living life to its maximum potential as an avenue to wellbeing (Jen, 2017) as people's state of wellbeing is informed by their experience of life (Griffin, 1988; Hall, 2008). Whereby individuals live their lives according to their true selves, resulting in them feeling alive and authentic. This means that people fully engage in meaningful activities, are congruent with their values, and experience self-actualization by realizing their potential through personal or skills development and fulfillment of their life purpose (Waterman, 1993).

Albeit there is a distinction between hedonistic and eudemonic wellbeing these perspectives are not mutually exclusive but to some respect, they reach a point of intersection (Ryan & Deci, 2001). Wellbeing is a combination of both hedonic and eudemonic elements, an experience of feeling good and leading a well-functioning life (Huppert & So, 2013). For this reason, understanding wellbeing calls for the exploration of happiness (hedonic) and the meaning of life (eudemonic). Eudemonic encounters influence hedonic pleasures and vice versa indicating that wellbeing is informed by an interaction of hedonic and eudemonic experiences (Jen, 2017). Therefore, wellbeing is more than a specific outcome or an ending state of being but a continuous process. It is inclusive of eudemonic experiences, such as the ability to realize one's potential and live a life that is meaningful and hedonic experiences like happiness and life satisfaction. Therefore, better pursuance of wellbeing integrates both hedonistic and eudemonic encounters. However, the intersectionality of these approaches does not invalidate the possibility of experiencing wellbeing as distinctly hedonic or eudemonic (Jen, 2017).

Wellbeing does not present in a particular facile manner, but it is in pursuit of quality of life that people's wellbeing involves physical wellness, psychological stability, and material gains (Linton, Dieppe & Medina-Lara, 2016). Meaning that wellbeing presents as a multidimensional phenomenon which points to its broadness but more importantly to the opportunity of observing the further personification of wellbeing. Dimensions of wellbeing may include, *physical*,

psychological, and social (Kwon, 2008; van Schalkwyk & Wissing**,** 2010; Linton et al, 2016; Szántó, Susánszky, Berényi, Sipos & Murányi, 2016; Myers et al, 2017) and *economic* wellbeing. And these aspects are not limited to the abovementioned but extend to over a hundred dimensions of wellbeing (Helliwell & Putnam, 2004; Linton et al, 2016; Myers et al, 2017).

More than *physical* wellbeing relating to the state of a person's physique and their ability to function it also involves people's ability to lead a healthy life, how they make sense of their environment, and their capacity to handle encounters of distress (Linton et al, 2016). For example, findings from Atanes et al (2015) indicated that compared to other primary health care professionals (Such as Family Physicians, Registered Nurses, and Nursing Assistants), CHWs were susceptible to burnout due to the demands of their job that involve dealing with intricate community matters. This involves addressing the spread and prevention of infectious disease and tackling issues related to violence and poverty while also residing in the very same community that they served. Wellness relates to 'personal' health manifesting physically or psychologically (Kwon, 2008).

Psychological aspects of wellbeing are related to the quality of a person's mental and emotional health. An important question to have in mind about the psychological domain is how people think and feel about their state of life and their experience of happiness. (Linton et al, 2016). For instance, people are satisfied with their lives which leads to them experiencing positive emotions and fewer negative emotions (Ryan & Deci, 2001). Psychological wellness trickles down to the behavioural level as it concerns the impetus at which people are encouraged to perform daily activities and their interest in what is happening in the world (Wissing & Van Eeden, 1997). According to eudemonia the realization of people’s potential is associated with psychological wellness (Ryff, 1989). Wellness is associated with emotional intelligence, thinking constructively, and being hopeful and optimistic since people's psychological wellbeing is influenced by a positive self-concept (Wissing & Van Eeden, 2002). Including personal development, living a purpose-driven life together with acceptance of oneself, being autonomous, having control of one's environment, and engaging in positive relationships (Ryan & Deci, 2001).

The social aspect of wellbeing can be understood by everyday behavior and activities people undertake and the impact it has on their lives. Extending to the quality of relationships people have

with each other and the social support they gain from social interaction. Therefore, the social domain of wellbeing ranges from the self to connections with other people within one's intimate milieu and broader society (Linton et al, 2016). For example, family members, friends, colleagues, and employers. Resonating with Keyes et al (2008, 182) framing of SWB as individuals plural framing of their life as 'We and Us' beyond micro social conditions that affect individuals, SWB is the inclusion of macro conditions such as the economics of wellbeing.

Economic or material aspects of wellbeing include people's ability to earn an income, possessed assets, and state of wealth. For the majority of society one way of meeting these aspects of economic wellbeing is through employment (Helliwell & Putnam, 2004). Marks and Shah (2004), coincide that joblessness can lead to unhappiness, and having a good quality job can be the basis for wellbeing. The interplay of these aspects presents themselves interestingly in the findings of a study by Sörensson and Dalborg (2017) relating to work set-up, wellbeing, and everyday life conditions of female entrepreneurs. Whereby, one of the entrepreneurs felt that working and owning a business negatively affected her wellbeing as she felt overwhelmed with the work from her business. Her counterparts who were mostly focused only on their business reported positive wellbeing outcomes instead. Even though they felt like they worked hard and for long hours, they still felt good, and motivated, found meaning in running their business, and generated income for themselves. Therefore, from the vantage point of social and economic aspects of wellbeing Selamu et al (2017) posit that, since wellbeing relates to an individual's interaction with their milieu it is useful to be aware of socioeconomic factors that are threatening to one's wellbeing.

Wellbeing is influenced by an interaction of biological, social, environmental, lifestyle, and systemic factors {i.e. type of care offered by organizations of healthcare} (WHO, 2004). For example, Reza, Subramaniam, and Islam (2019) reported that the poor condition which Asian migrant workers in Asia lived and worked under gave rise to undesirable social wellbeing. Subsequently leading to poor physical, psychological and economic wellness. Hence, migrant workers working in the field of construction presented with depression which was also interrelated with physical illness, hefty workload, and a low income that further led them into debt. Therefore, people's overall experience of SBW is influenced by different areas of life, like employment conditions and relationships with family and their partners. People can find joy and satisfaction from various moments of happiness in different areas of life (Migdal, 2007).

Overall, the discussion confirmed the anticipated extensiveness of wellbeing as well as the ambiguity and complexity of wellbeing. Wellbeing cannot be reduced to a singular perspective leaving the notion exposed to varying interpretations. Especially with the availability of different philosophies, scholars, and research deliberating the framing of wellbeing (Migdal, 2007; Hall, 2008; Chelmow, 2010; Dodge et al, 2012). In this study, it is more appropriate to view wellbeing as occurring on a continuum of hedonistic and eudemonic experiences. Rather than SWB being a unidimensional concept the focus on wellbeing should also be multifaceted (Linton et al, 2016). Means that wellbeing is understood as a dynamic state of being that is characterized by physical, psychological, social, and economic wellness (Paim, 1995; Diener et al, 1999; Roothman, Kirsten & Wissing, 2003; WHO, 2004; Kwon, 2008; Linton et al, 2016; Szántó et al, 2016; CDC, 2018). The multidimensionality of wellbeing offers an opportunity to avoid the omission of critical facets of wellness in an attempt to understand people's state of wellbeing. But enable an understanding of wellbeing at a personal level in context to one's environment.

2.9. Theoretical framework

Reality does not exist waiting to be discovered but is constructed through social processes (Conrad & Barker, 2010). The meaning of a constructed artifact may be inferred differently within different communities (Morrall, 2009). For example, Waterman, (1993); Ryan and Deci (2001); Jen (2017) posit that some people may associate their state of wellbeing with hedonic experiences, while others lean towards eudemonic experiences of wellbeing. Hence social constructionism unpacks how phenomena are branded and responded to (Brown, 1995). Mooting the review of the literature to offer a discussion on social constructionism as the conceptual framework used in this study.

2.9.1. Social Constructionism.

This approach is relevant for this study because social constructionism does not aim at yielding fixed and entirely valid knowledge given that human science cannot be regarded as truly objective. It rather creates an opportunity to appreciate that which is possible by consulting with the individuals themselves. Social constructionists opt to critically engage in assumptions about the social realm that are overlooked (Galbin, 2014). One such assumption being overlooked in the field of Community Health Work is the CHWs' scope of practice in the absence of a national CHWs policy. This study adopted an open posture without expecting to reach a fixed understanding of the functioning of CHWs in the context of the WBPHCOTs strategy policy

framework. Moreover, social constructionism is primarily concerned with illuminating how folks come to define, describe and reason about the existence of their world as they live it (Gergen, 1985). Just as the study's exploration of CHWs experiences seeks to define and describe cadre's experiences with the existence of their wellbeing.

Social constructionists focus on cultural and historical facets of the studied phenomenon (Conrad & Barker, 2010; Lupton, 2012). This is an attempt to elucidate people's ways of understanding in context to their present existence as well as in historical times and possibly in the future as they advance (Gergen, 1985). The intended purpose is to understand different aspects of human society such as health and wellbeing as a social construct informed by the belief that large and small features of human life are constructed continuously (Olafsdottir, 2013). Social constructionism relates to the reality of an experienced phenomenon by questioning the objective realness of social experience or their purpose creation through social action (Brown, 1995). Phenomenon's present as reality through the merging of particular social and historical processes (Morrall, 2009). For example, the structuring of South Africa's national CHWs policy is embedded in the history of CHWs, dating from the 1940s were cadres functioned as volunteers serving in the NGO sector. Then being assimilated into the PHC system around 2011 as influenced by the social interaction of government and the NGO sector.

Social constructionism offers an approach to inquiring about the presence of essential truth about a phenomenon and the assumed truth is regarded as the outcome of power relations. Meaning that the truth is hardly neutral but mostly operates to benefit one party over another (Lupton, 2012). Such as the NDOH's sluggish pace of constructing and implementing the WBPHCOTs strategy policy framework as South Africa's national CHWs policy. A process that the government has been lambasted for because it has been disadvantageous to CHWs. As it absolved the government from taking financial responsibility as employers of CHWs and allowing the government to hire these cadres on contractual basis rather than being permanent government employees (Malan, 2014; SoulCity, 2016; Awethu.amandla, 2017; Mafuma & Stevenson, 2017).

Social constructionism focuses on the meaning of a phenomenon developed through interaction within a social context. Asserting that the meaningfulness of a phenomenon does not necessarily exist in the phenomenon but is constructed socially (Conrad & Barker, 2010). Through discourses and social engagement embedded in complex histories and sustained through culture, people

generate their social experiences or reality (Lupton, 2012; Galbin, 2014). Hence, constructionism considers how people or individuals as a group engender their perceived social reality and knowledge (Berger & Luckman, 1991). Since over time different facets in people's lives have been formed, retained, and ruined by interacting with others (Galbin, 2014).

During the process of social construction, a phenomenon evolves into being significant and then identified as influencing people's lives. Of importance being ways in which people relate to the conditions they find themselves in (Torres, 2015). Some phenomena are not seen as real or regarded as existing. Suggesting that people's state of wellness is non-existent unless they identify them as existing and assign them descriptions. These differing interpretations are influenced by cultural values within a community (Morrall, 2009). What is known about a phenomenon is the artifact of social relations, and this knowledge is not permanent but is subject to change. As a result, the reality is not taken as independent of human participation nor is knowledge regarded as being universal (Lupton, 2012; Galbin, 2014). Just as an understanding of CHWs wellbeing was anticipated as a product of their experiences as health caregivers. Bearing in mind that cadres present varying realities of wellbeing which are embedded in their participation with the served communities and those in authority.

Even though social constructionists recognize biophysical realities of human experiences related to wellbeing they do not focus on the bodily or biophysical state of health. Constructionists focus on sociocultural aspects as they believe that a better understanding of people's reality should take into consideration their social experiences. The eventual meaning of people's experience of wellbeing gain significance through social and cultural practices. This is an alternative process of thinking and understanding human experiences (Lupton, 2012; Galbin, 2014). The biophysical is considered per the culture and social analysis which is virtually constructed within a socio-historical context and is continuously renegotiated (Lupton, 2012). That which is taken as being experiences of the world does not necessarily determine an understanding of the world (Gergen, 1985). It is rather in context to the social environment that the world is better understood thus social milieu matters when considering people's wellbeing (Olafsdottir, 2013).

Unpacking sociocultural aspects of the human experience offers medical sociology an understanding of physical wellbeing. This is an outcome that is constructed and reconstructed over

time through human interaction. Issues of wellbeing present the prospects of exploring the interplay between biological and social factors in influencing people's lives (Olafsdottir, 2013). Shifting wellbeing out of the social context to a purely biomedical context renders those affected powerless and isolated (Vaughan, 1991). Thus, an adaptation of social constructionism within this thesis offers an opportunity to investigate CHWs' experience of wellbeing and lenses of unpacking CHW's social experiences as well as the policy environment related to the CHWs programme.

Overall social constructionism provides lenses to understand socially constructed aspects that are taken for granted and creates an opportunity for reaching a range of perspicuitys. Especially because the practice of constructionism is not aimed at yielding findings that prove or convince one about the correct understanding of a social phenomenon. Instead, it expands our prospects for reaching a better understanding of our inquiry of social phenomena and the social world (Camargo-Borges & Rasera, 2013). This is important because present-day researchers cannot claim that findings entirely express or represent the opinions and experiences of research participants (Charmaz & Belgrave, 2013).

2.10. Conclusion.

The above review of literature covered different aspects related to CHWs. In so doing the discussion portrayed a reflection of Community Health Work globally and within South Africa. The review also provided a better understanding of CHWs and their role as social and health cadres as well as the implications of being a CHW, while highlighting the gendered nature of Community Health Work. Details about the CHWs' policy environment within the South African context were also provided. Furthermore, the literature unpacked the notion and set-ups of NGOs in South Africa. A discussion about the conceptualization of wellbeing and its applicability within this study was also provided. Ending with the framing of social constructionism as a framework that guided the framing of the research findings, with the hope of reaching a better understanding of CHWs' experiences and the impact on their wellbeing. While also critically engaging with the overlooked CHWs scope of practice in the years of the absence of a CHWs national policy. Culminating from the varying topics covered within the literature review is the setting and reinforcement of the study's context which is set amongst CHWs and the field of Community Health Work. The methods chapter follows below, detailing the processes and procedures applied in the study.

CHAPTER THREE: METHODS.

3.1. Introduction.

This chapter defines and justifies the methods used in this study. The chapter ensues with details about the study site, followed by an outline of the study's research design, sampling technique & selection criteria, as well as sampling, techniques of data collection, ethical considerations, and procedures that were taken into account when conducting the study. Concluding with the researchers' reflexive account and discussion about the study's limitations.

3.2. Study Site.

Community Health Work programmes have been growing in numbers within South Africa, especially in rural and township communities. This drives an interest to study their role in townships and we have discussed that NGOs are relevant in overseeing the work of CHWs. Hence, this research study was conducted in neighboring townships South of Johannesburg amongst NGOs involved with CHWs. These organizations were established in the early 2000s in response to the damning effects of HIV/AIDS and they launched health programmes such as HCT, HIV/AIDS treatment, and adherence support as well as Home Based Care. They further adopted TB screening initiatives and the DOT programme due to the increase in TB as one of the leading HIV co-infections. Seeing that many children become orphaned due to HIV/AIDS, the organizations extended to include psycho-social programmes related to orphaned and vulnerable children (OVC) and functioned as Drop-In Centres.

NGOs are evolving entities and seldom perform a single role but engage in wide-ranging roles and activities (Lewis & Kanji, 2009). To date, these organizations have expanded to include peer-education and health promotion programmes as well as mid-childhood skill development programmes, youth, and teenage projects, and elderly care. All these programmes and projects are facilitated by CHWs functioning as HIV-Testing Service (HTS) Counselors, Social Auxiliary Workers, Peer-educators, Home-Based Carers, and Health Linkage Officers. The outlined services provided by the NGOs within this study position them as being hybrid by evolving from being health-related organizations to incorporating social services. While the described work of these organizations as well as the scope of the CHWs programme that they run are typical of many NGOs which resembles the make-up of NGOs as discussed in the literature review.

3.3. Research Design.

Firstly, the study undertook a qualitative route rendering it suitable for the researchers' pursuit of meaning-making regarding human action (Schwandt, 2001). Qualitative accounts allow the researcher to discover how research participants experience different aspects of their lives (Totman, Hundt, Wearn, Paul, & Johnson, 2011). For example, how CHWs within the NGO sector experience Community Health Work and the impact it has on their wellbeing. Such an inquiry is enabled by the suitability of qualitative research to be centered in the milieu of social institutions and organizations, especially because the context in which people function influences their experience of life. By adopting a qualitative design information was gathered, consolidated, and presented from multiple sources (Yin, 2011).

What was even more advantageous with this design was the generation of data by allowing participants to describe their experiences of working as CHWs in an open-ended manner and not be restricted by quantitative questions. Thus, a qualitative research design was chosen for this study because it allowed for the generation of in-depth information about the experiences of CHWs (Braun & Clark, 2006; Bless, Higson-Smith & Sithole, 2013). Proving to be useful in exploring the views and real-life context of CHWs in the setting of health and social care (Hancock, Ockleford & Windridge, 2009).

Secondly, this research took on a multiple cross-sectional design because it permitted the research to collect data from the interest population as well as from two or more samples of respondents (which were CHWs and NGO managers) and this information could be obtained from the participants at different times (Levin, 2006; Ford, 2010; Bajaj, 2013; Singh et al, 2015). A multiple cross-sectional design also presented the advantage of being easy to implement and it is time and cost-effective (Levin, 2006; Pandis, 2014).

Lastly, this study was also phenomenological and this design seeks to describe the meaning that people derive from their lived experiences through the transformation of these experiences into descriptive accounts. This was done by exploring people's viewpoints or perceptions and understanding of specific situations or phenomena (McMillan & Schumacher, 2010; Pathak, 2017). The study employed an interpretive (hermeneutic) phenomenological approach which enabled the study to capture CHWs' descriptive accounts of their subject experiences as it is lived

and what these experiences mean to them (Nieswiadomy, 2012; Miles, 2015, Pathak, 2017). Phenomenological studies are also suitable when dealing with small sample sizes (Miles, 2015). However, Holroyd (2007) does cautions that any research involving human beings is unable to uncover everything and so even with an interpretive hermeneutic phenomenology some experiences of CHWs shall stay undiscovered.

3.4. Sampling Technique & Selection Criteria.

Sampling was done by applying non-probability sampling, which included a combination of purposeful sampling (using convenient and snowball sampling). Through non-probability sampling, the researcher non-randomly selected suitable participants that were available and willing to participate in the study (Laher & Botha, 2012). Since the adopted sampling technique was purposive an inclusion criterion was determined wherein eligible participants were individuals who had been working in health-related programmes. The participants had to be part of the NGOs for more than a year so that they had adequate information and experience to reflect on and inform their responses during the interview. Being purposive, CHWs who meet the participation criteria were conveniently sampled by accessing those that were available and willing to be interviewed (Bless et al, 2013; Etikan, Musa & Alkassim, 2016). Building from the referral of the interviewed participants more CHWs were sampled through snowballing (Patton, 1990; Punch, 2006; Black, 2009; Laher & Botha, 2012). Based on their experience, NGO managers were purposefully sampled to reflectively provide in-depth information related to policy matters (Patton, 1990; Etikan et al, 2016).

3.5. Sampling.

This study aimed to understand the experiences of CHWs, hence the study's population was composed of CHWs and NGO managers who would further expand on details related to the policy framework. Both different types of participants worked in health-related and psycho-social programmes. The sample was drawn from the available population within the two selected NGOs and 10 participants were sampled to be interviewed.

Participants were identified by pseudonyms, in **NGO-1;** four participants were interviewed, three of them were Black/African female CHWs, and one Colored[1] male manager. All these participants were fluent in English but to better articulate herself in some of her responses Lerato spoke in Setswana.

Mulalo: Manager, male and in his mid-40s, all-round programme manager, started working as a CHW and has been with the organization for 18 years.

Johanna: CHW, female and in her early 60's. She is an HTS counsellor and one of the coordinators of the HTS programme and has been working as a CHW for 18 years.

Thandeka: CHW, female and in her early 30's, serves as an HTS counsellor and has been a CHW for 8 years.

Lerato, CHW, female and in her late 20s, started as a volunteer, then worked as an OVC caregiver and work as a Linkage Officer. She has been a CHW for 5 years.

In **NGO-2;** six participants were interviewed, five of them were CHWs composed of one Colored and two Black/African females and two Black/African males, and one Black/African male manager. Again, all the participants were fluent in English but to better express themselves in some of their responses they also spoke in IsiZulu and IsiXhosa.

Patrick: Manager, as well as supervisor and mentor to CHWs, male in his mid-30s and, has been working at the organization for over 10 years.

Sipho: CHW, male and in his mid-20s, works as an HTS counsellor and has been a CHW for 2 years.

Portia: CHW, female and in her late 20's, works as an HTS counsellor and has been a CHW for 6 years.

[1] **Colored:** One of the four racial groups (such as Black, Asian, White) in South Africa. This term was derived during apartheid to racially classify mixed raced individuals by differentiating them from Black or White people.

Nyiko: CHW, male and in his late 20's, peer-educator and a coordinator for Jozi Homile peer-educators and has been working as CHW for 4 years.

Dineo: CHW, female and in her late 40's. Works as a Home-Based caregiver and has been a CHW for 1 year.

Khensani: CHW, female and in her late 30's. She started as a peer educator, then worked as an HTS counsellor, and works as a Linkage Officer. She has been a CHW for the past 7 years.

CHWs formed the most participants and the majority of these cadres were females representing the characteristics of this population which resembles the gendered nature of community care work in South Africa as revealed in the literature review. Moreover, the majority of the participants were Black/African and two were colored individuals because these NGOs were situated in communities occupied by African and colored people. These are the communities where Community Health Work programmes have been historically based because African communities have been subjected to poor healthcare services due to discriminatory healthcare policies, inherited from the early twentieth century and further exacerbated with the institutionalization of the apartheid regime (Nxumalo, Goudge & Manderson, 2016). (*See table 1 below, labelled as sampling table, which provides segmentation of the research sample*).

ORGANIZATIONS	**SAMPLE**	**SIZE**	**GENDER**	**LANGUAGE**
NGO-1	- *CHW's*	3	3 Females	English & Setswana
	- *Manager*	1	1 Male	English
NGO-2	- *CHW's*	5	3 Female	English, IsiXhosa & IsiZulu
			2 Males	English, IsiXhosa & IsiZulu
	- *Manager*	1	1 Male	English & IsiZulu

Total	*8 CHWs* *2 Managers*	10	6 Female 4 Males	English, Setswana, IsiXhosa & IsiZulu.

Table 1: Sampling table

Qualitative studies tend to comprise of a small sample size as they are not guided by statistical justifications (Punch, 2006) and ten participants may be the minimum for studies that are hermeneutic phenomenology designed (Gentles, Charles, Ploeg & McKibbon, 2015). They rely more on purposeful strategies and a small sample can be valuable in studies seeking in-depth information from people's wide-ranging experiences. Thus the sample size of the study was appropriate for what could be achieved with the limited time and resources afforded to the researcher (Patton, 1990).

3.6. Techniques.

Firstly, observations were conducted by the researcher within the organizations as well as when CHWs conducted their fieldwork. This helped the researcher to familiarize herself with the organizations, and their staff and gain information about the Community Health Work programmes run by each organization. It also allowed the researcher to explore possible opportunities for accessing participants to engage in interviews. This kind of observation can be described as simple or non-participative which allows the researcher to witness by seeing or hearing the occurrence of natural events at the study site. It involves the researcher being an outsider that observes and records the occurrences of events without participating or offering suggestions in the interaction of the study participants (McMillan & Schumacher, 2010; Bless et al, 2013).

Secondly, a one-page Participant-Information Form was used to collect demographic information before conducting interviews. Thirdly, to tap into the vast storehouse of information in-depth interviews were conducted (Ackroyd & Hughes, 1981). In-depth interviews are extensive and utilize open-ended questions as well as probing to enable the researcher to collect data about how participants come to make sense, understand and derive the meaning of significant life events (McMillan & Schumacher, 2010).

Two interview schedules were developed as a guide, one for CHWs and another for NGO managers. Both these schedules were informed by literature on CHWs, Community Healthcare

Work, the NGO sector, CHWs policy framework, and the 2011 PHC policy guidelines. The CHWs' interview schedule was composed of 25 questions including possible probing questions. This schedule aimed to explore CHWs' experiences, and it was divided into three sections covering *Contextual questions; Experiences of being CHWs; Impact of Community Health Work on CHWs' wellbeing*. The NGO manager's schedule comprised 31 questions including possible probing questions. This interview guide aimed to gain information related to CHWs programmes, guidelines informing CHW programmes, facilitation of support and supervision of CHWs and it was dived into three sections covering *Contextual questions, Policy environment, and questions related to the functioning of the NGOs.*

3.7. Ethical Consideration.

Ethical clearance to conduct the study was obtained from the Human Research Ethics Committee at the University of Witwatersrand (under protocol number SOCL/18/05/03). When collecting data from the research participants ethical standards were observed as follows.

The NGO managers granted the researcher permission to engage in field research or modified participant observation. In both organizations, CHWs were informed that the researcher would conduct modified participant observation and the researcher participated in fieldwork with CHWs after being granted permission by both the managers and CHWs. During fieldwork, the researcher did not interact with any of the participant's clients when they conducted the HIV/AIDs campaign nor with the clients visited by care workers. During these visitations, the researcher did not enter the homes of the patients but waited for the cadres a few houses away from the patient's homes.

All participants were informed that their participation was voluntary and that they could withdraw from the study at any time they wished to do so. It was also communicated to them that no harm or benefits were expected from their participation. Participants were also informed of their right not to answer questions that they felt were uncomfortable, or they did not want to answer. Before each interview participants were taken through the Participant-Information Sheet detailing the study's background and interview process. The Participant-Information Sheet was also given to them should they need to go through it again. Informed consent for their participation and recording of the interview was ensured by signing the consent form. This was done after the details

of the consent forms were explained to them and had been given a chance to read through the consent form.

The approximate time for the interviews was an hour. It was informed to the participants that anonymity was not guaranteed as they had interacted with the researcher face to face, but they were ensured that their participation would be kept confidential as none of their personal information would be disclosed, and identifying information was removed from the interview transcripts. The participant's identity was protected by using pseudonyms and the collected data was only accessible to the researcher and supervisor. The interview recordings and transcripts were stored in a password-protected computer and would be destroyed after five years.

3.8. Procedures.

Upon receiving clearance of the reviewed application for ethical clearance from the School of Social Sciences Ethics Committee at the University of the Witwatersrand the researcher was able to ensue with fieldwork. Suitable NGOs which undertook health-related work were identified and approached by visiting them to negotiate the possibility of conducting the research study at these respective organizations. During the visitation, a request was put forward to be granted permission to conduct the study at these NGOs and the request was also detailed in a formal letter that was left behind with the contact person in each NGO. Between 06 -27 August 2018 negotiations were made and an agreement was reached with the NGOs and documented in the signed agreement letters. After receiving permission from the NGOs to conduct the study in their respective organization's arrangements were made to visit the organization to begin the research. At NGO-1 observations were conducted on 02 and 09 October 2018 followed by the interviews on 13, 22, and 27 November 2018. At NGO-2 the observations took place on 1 and 15 November 2018 followed by the interviews on16, 21, and 27 November 2018. Details of these procedures are provided below.

3.8.1. Data Collection.

The researcher began the collection of data through field research by conducting non-participant observation and this was done by visiting each NGO at least twice before conducting interviews. At NGO-1 the first visitation involved attending staff members' morning devotion session, touring around the organization, and being orientated about the different programmes and projects

undertaken by the organization as well as being introduced to CHWs. During the second visitation, the researcher accompanied CHWs in the field as they were conducting an HCT campaign.

At NGO-2 the first visitation involved spending the day in the organization whereby the researcher attended the staff members' morning devotion, toured around the organization, and being orientated about the different programmes and projects run by the organization as well as being introduced to CHWs and attending an in-house social-skills workshop. This mini-workshop was conducted because most of the CHWs could not conduct fieldwork due to the rainy weather. During the second visitation, the researcher accompanied CHWs who functioned as caregivers as they were conducting fieldwork which involved home visitations around the community to check on the elderly who were on chronic medication.

It was during the process of these visitations that the researcher was also able to assess possible days when participants would be available for interviews. During the field research, field notes were jotted down in a notebook and where possible the researcher was able to ask questions to gain clarification of what was observed. Furthermore, the field research helped to better understand the functioning of each NGO, and observe a typical day experienced by CHWs and their working conditions hence observations made during field research also helped to improve probing questions during the interview process. Babbie (2013) purports that collecting data through field research or observation was advantageous because it allowed the researcher to make direct observations by being present in the field without participating in the activities since non-participative observation limits the researchers' participation in major events (Bless et al, 2013). For example, during the HCT campaign held by CHWs from NGO-1, the research was only there as an observer but not part of the campaign.

Following the observation, the CHWs' interview guide was piloted with one CHW in each organization. After that, a few adjustments were made to some questions that were reported as unclear or ambiguous. The manager’s guide was piloted externally through an assessment moderator facilitating the Community Health Care programme (NQF level 3) at an HWSETA registered college. Their feedback helped to restructure questions related to the policy framework and make adjustments to unclear or ambiguous questions as well as reconsideration of certain probing questions. Then the researcher proceeded with the further collection of data through in-depth interviews.

During observation, it was revealed to the researcher that in both organizations CHWs do not conduct any fieldwork on Fridays, but they work within the organization. Therefore, interviews were planned to be undertaken on Fridays, and on two different Fridays per organization, a visitation was scheduled where the researcher was able to access participants for interviews. Participants who were available at the organization and willing to be interviewed were selected for in-depth interviews which were conducted at a vacant HTS counselling room. After each interview participants were asked to recommend a colleague who could be approached for an interview.

During the interviews, notes were taken whilst the session was also tape-recorded to be able to transcribe the interview. Interviews were conducted in English but for clarification, some questions were further elaborated in vernacular spoken by the participants which were Setswana, IsiXhosa, and IsiZulu. Mostly, participants responded in English but from time to time they would also provide their responses in vernacular such as Setswana, IsiXhosa, and IsiZulu. Time taken with each interview differed ranging from 40 minutes to an hour. The research found the in-depth interviews to be useful in gathering data as they enabled the researcher to probe in depth about different phenomenons and also ask for clarification needed on the presented issues (Legard, Keegan & Ward, 2003).

3.8.2. Data processing and Analysis.

To prepare the data for analysis, all the recorded interviews were transcribed and data that was presented in vernacular was translated into English. Thereafter data was analyzed using the principles of Braun and Clarke (2006) thematic analysis. Following the recommended steps, the analysis was aimed at answering the research questions by exploring the emerging themes, and examining similarities and differences within the data set (Totman et al, 2011). Thus, the researcher was able to engage with information about CHW's experiences, sense, and reality of the policy framework related to CHW programmes. As Braun and Clarke (2006) posit that life experiences and the meaning of experiences, realities, and human interaction are reflected in occurring discourses within society.

Step 1 of the analysis enabled the familiarization of the data set, and this occurred during transcription and by reading and re-reading the transcribed data (Bryman, 2004; Braun & Clarke, 2006; Dageid et al, 2016). Step 2 entailed the identification of interesting features of the data set and generating initial codes (Braun & Clarke, 2006; Totman et al, 2011). Followed by Step 3 which

involved an active search for themes from recurring patterns or frequently used expressions that stood out from the generated codes. Then in Step 4 themes identified in the previous step were reviewed, refined, and finalized to develop a thematic map (Braun & Clarke, 2006; Dageid et al, 2016). Moving to Step 5 which was the definition and naming of themes and sub-themes which chronicles the meaning of patterns developed during analysis. Lastly, Step 6 involved compiling a report informed by meaning generated from the patterns and this was also related to literature whilst responding to the research question (Braun & Clarke, 2006). The presented findings generated by analyzing the interviews were also supported by data collected during field research.

3.9. Reflexivity.

Reflexivity can be understood as the researcher's assessment of how their background, opinions, and interests influenced the process of qualitative research (Krefting, 1991). Meaning that the researcher rigorously scrutinizes and reflects on themselves throughout the research process by considering issues such as their positionality and how they relate with participants as well as how they generate data (McMillan & Schumacher, 2010). To begin with, as a researcher I was introduced to the participants as a student from the University of Witwatersrand and a member of the community where one of the organizations was based. To avoid participants viewing my position as threatening or being concerned about their privacy because I was also a member of the community, it was explained to the participants that the research was conducted specifically for academic purposes. During data collection, it was also emphasized to the participants that all the gathered information would be kept confidential. Addressing the issue of confidentiality also helped the participants to freely share criticism related to their respective NGOs, managers, or other stakeholders. To be aware of and improve on my subjective biases as a researcher I made field notes and reflected on them after every visitation, observation, and interview. The field notes documented the date of visitations, time spent at each study site, and my interaction with the participants.

The use of observations rendered some weakness as the participants modified their behaviour due to the presence of a researcher. But as I visited the organizations for the second time and even accompanied the cadres when conducting their fieldwork over time participants became more relaxed and less aware of my presence as a researcher thus being more natural in their interactions. This even helped to form a rapport with the participants which made the interviews to be less intimidating for both the researcher and the participants.

3.10. Limitations of the study.

It is acknowledged that this study presented some limitations. The study aimed to attain some representativeness as much as it possibly can, however the size of the sample was small considering that the study was conducted in two NGOs. Hence, the findings of the study may not be an overall representation of CHW's experiences working within the NGO sector in Gauteng. Therefore, the researcher cautions against the generalization of findings to the general population of CHWs working in NGOs. The use of convenient sampling further limited the representativeness of CHW's experiences from each study site because it excluded the possibility of including participants who were not on-site but would have been willing to participate in the study. Snowball sampling also presented the possibility of biases of an over-representation of cadres from the same network who may share similar views and experiences.

Due to time constraints and the availability of participants the sample comprised of CHWs from different programmes that are funded and guided by stakeholders such as DOH, DSD, and the City of Johannesburg (COJ) reducing the homogeneity of the sample as well as the possibility of generalization of findings regarding the WBPHCOTs policy framework as it was envisaged by DOH. The cross-sectional design of the study only offered the research a snapshot of the cadre's experiences at one point in time. The use of observation presented with limitations such as it being time-consuming and not being able to be carried out when participants interacted with their clients. Plus, aspects such as participants' beliefs or attitudes could not be understood through observations. The use of in-depth interviews counteracted the limitations encountered during observations. The researcher was able to probe and ask questions or get clarification about some of the events and interactions witnessed during observations. In-depth interviews are interactive, and this enabled the research to have a one-on-one interaction with the different participants which allowed them to talk freely.

On the other hand, the use of interviews also had its limitations. Some participants provided responses that were either too short or too long and other participants diverted from the asked questions but through probing and reframing of questions these limitations were circumvented. The research was able to use probes to encourage the participants to further elaborate and explain any surface-level responses and get a better understanding of their responses. At the beginning of the interviews, some participants were distracted by the presence of a recorder but as the interviews progressed, they became less aware of the device. The use of a recorder allowed the researcher to

capture all the contents of the interviews and not rely on their memory as this content would be lost over time. Data stored via the recorder allowed the researcher to access information that they had missed during the interviews. These interviews were played and replayed over time for clarification and transcription. By using the recorder the researcher was able to be present in each interview without worrying about capturing interview notes based on all the words of the participant's responses. The process of transcribing the interviews was daunting and significant information was covered in paragraphs and pages of verbosity. Nonetheless, the benefits of collecting data through tape-recorded interviews outweighed the limitations. The simplicity of thematic analysis limited the study to only focus mostly on the noticeable emerging themes from the data set. Regardless of all the study limitations, research needed to be conducted about the experiences of CHWs.

3.11. Conclusion.

Outlining the study-site sketches a better understanding of the context of the study, while the study's design elaborated on the qualitative nature of the research as a multiple cross-sectional design based on interpretive (hermeneutic) phenomenology. Techniques employed being non-participative observation proceeded through field research and interview guides to facilitate in-depth interviews as means of data collection. The study sampled its participants through convenient and snowballing techniques due to time and resource constraints. All of this was guided by ethical considerations that are recommended for qualitative research studies and the collected data was analyzed through Braun and Clarke (2006) thematic analysis. The researcher's reflexive account and the limitations of the study reflect biases that were presented and how they were counteracted when undertaking the research study. The next chapter presents research results derived from data analysis and a discussion of these findings.

CHAPTER FOUR: RESULTS AND DISCUSSION OF FINDINGS.

4.1. Introduction.

This chapter presents results generated from data collected from a sample of CHWs and NGO managers and analyzed through thematic analysis yielding the development of themes and subthemes that seek to provide a discussion on the researched topic. The discussion is contextualized in the literature that corroborates or refutes the deliberated subject matters and social constructionism was used to further explain the findings being discussed. The presented themes and subthemes begin by addressing the institutional side of the CHWs programme within the studied NGOs. The second part of this chapter details the experiences of CHWs and how these experiences impact the cadre's wellbeing. Direct quotation of participants was used to strengthen and support the discussed themes and subthemes.

4.2. Knowledge of the WBPHCOTs Strategy Policy Framework.

Like other NGOs in different parts of South Africa, organizations featured in this study have assisted to provide health, social and developmental services through Community Health Work programmes thus contributing to the deliverance of health and social services by supporting initiatives of the re-engineered PHC system. In this way, CHWs embody community participation by providing services related to HIV/AIDS testing, support, and care; treatment and management of chronic illness; information dissemination; OVC and HBC. Considering the work done by CHWs within the NGO sector and the introduction of the WBPHCOTs Strategy Framework which was meant to guide the work of CHWs calls into question the NGOs' knowledge of the policy framework. Especially because the WBPHCOTs Strategy policy guidelines did not clearly spell out the role of NGOs in the implementation of the WBPHCOTs Strategy (Pletzen et al, 2014).

It appeared that the organizations were not aware of the existence of the WBPHCOTs strategy framework. When asked if they knew any CHWs policy, managers Patrick and Mulalo indicated that they were not aware of any policy. Instead, Mulalo spoke about the requirement of being a CHW and even called for the development of the CHWs policy. Patrick discussed how the CHWs programme in their NGO functioned under the auspice of labour laws, HR policy, and the NPO ACT. When further asked specifically about the WBPHCOTs policy framework, Mulalo stated that he was unaware of this framework. While Patrick seemed to have some idea about the notion of the WBPHCOTs strategy and explained that he knew about the WBOTs that work at the clinics.

Below are the manager's response to a question about the national CHWs policy or the WBPHCOTs strategy framework.

> **Interviewer:** Is there any policy that you know about concerning CHWs?
> **Mulalo:** Umm---, when you say policy?
>
> **Interviewer:** Any policy by the government that you know about that is available
>
> **Mulalo:** Err--- ok, I am not sure if I am now answering you about policy or...What we do know is that CHWs, err --- should at least have the necessary experience or training to be able to do this particular job. So if a policy can be developed to say that at least all CHWs should have a certain training or qualification. Then I think then Community Health Work will become more enticing, will be more recognized…
>
> **Interviewer:** do you know maybe about the Ward-Based Primary Health Care Outreached Team Strategy by… [Participant Interjects]
>
> **Patrick:** WBOT? …Yes we know about them. Fortunately enough they have recruited some of the volunteers, they are part of WBOT, and some come here from [Name of the organization] now they are working there as WBOTs in the clinic.

Scholars warned that in the process of adopting CHWs programmes in the PHC system through the re-engineering project, the WBPHCOTs policy framework failed to clearly state the role of CBOs. The poor knowledge of the WBPHCOTs strategy policy framework noted amongst organizations within this study may be linked to the shortcomings of the framework as pointed out by scholars. It appears that there had been little effort to create awareness about the finality of the policy and insufficient encouragement for NGOs to adopt the WBPHCOTs policy. Mottiar and Lodge (2018) noted that in the process of re-engineering the PHC system and structuring the WBPHCOTs programme, DOH doles out or side-lines local NGOs which provided community-based care services amongst AIDs patients.

The presenting dynamics around the knowledge of the WBPHCOTs strategy policy framework within the NGO sector showcases the view by social constructionists that the existence of essential truth in the occurrence of events is an outcome of power relations that may be less beneficial to one party over another (Lupton, 2012). This is observable in the inadequate consideration of the role of NGOs within the WBPHCOTs strategy policy framework. This can be linked to poor knowledge of this strategy amongst NGOs. Signifying the importance of impartial interrogation of the reality about social experiences as being created through social action (Brown, 1995).

4.3. Implications of working with multiple stakeholders.

Considering the above findings it is apparent that the CHWs programme in these organizations had not been aligned with the WBPHCOTs policy framework, which was understandable as the policy framework had been finalized in 2018. But it can be argued that this may also be due to the NGOs' lack of knowledge about the WBPHCOTs policy because the organizations were not up to date with the developments of a national CHWs policy.

In their functioning, the studied NGOs facilitated different health and social programmes, and CHWs scope of practice varied across the different programmes because it was established and negotiated in context to the requirements of the stakeholders partnered with. Amongst the many programmes run by the two organizations four major programmes stood out, which are HTS, Jozi Hlomile peer-education, OVC, and HBC. Due to the diversity of each programme, these projects have been facilitated in partnership with DOH, DSD, and COJ. The scope of practice for CHWs within the different programmes was organized under the auspice of stakeholders partnered with and each stakeholder also provided financial sponsorship. DOH was linked with HTS programmes {inclusive of TB screening and Linkage Officer Services}. OVC and HBC programmes were related to DSD and COJ-sponsored Jozi Hlomile peer-education programme. In the below excerpts Patrick as one of the managers and Nyiko the Peer-education coordinator provide details about stakeholders partnered with in the different CHWs programme.

> **Interviewer:** So who are the other stakeholders that form part of the organization?
> **Patrick:** DSD, DOH, Local Development, Jozi Ihlomile…
>
> **Nyiko:** Ok us who are doing door-to-door we are called peer-educators…
>
> **Interviewer:** Oh ok, for Jozi Hlomile.
> **Nyiko:** Yes that's the name of the programme.
>
> **Interviewer:** Oh, so the programme is sponsored by the COJ?
> **Nyiko:** COJ, yes (Explaining that Jozi Hlomile peer-education programme is sponsored by COJ).

The presented setup by NGOs which involved organizing CHWs programme as projects partnered with governmental departments has been prominent in South Africa. This can be linked to the history of partnerships between NGOs and the government. Whereby literature indicated that around the year 2000 government identified the role of NPOs in providing community-based service through CHWs. NGOs were also seen as contributing to the labour force and the

government organized to contract NPOs as providers of community-based care services (Schneider, 2017). Around 2011 DOH had been funding 1260 NGOs (Van Pletzen & Macgregor, 2013, cited in Mottiar & Lodge, 2018). Contingent to the type of services provided by NPOs, organizations continue to be funded by DOH or DSD to provide services related to OVC, substance abuse, palliative care, HBC, health promotion, and TB DOT services (Ogunmefun et al, 2011). Years later the same trend still prevails amongst NGOs wherein CHWs programmes run by NGOs in Limpopo and Gauteng were linked to DOH and DSD (Mottiar & Lodge, 2018).

Literature indicated that NGOs do not only develop relationships or partnerships with the state, where possible they also work and are funded by other organizations and corporates (UNEP, 2007; Lewis & Kanji, 2009; Banks et al, 2015). This was the case with the organizations within the study. They also had other stakeholders that provided them with supplementary assistance like financial aid, training of CHWs, and material or equipment to further capacitate CHWs, and their staff members. For instance, in the below quotations Mulalo and Patrick explained that HIVSA and ANOVA supported their organizations with HIV training and presentations to CHWs. Stakeholders also provided them with materials like syringes, testing kits, and strips. Private entities like South African Lotto provided them with financial sponsorship.

> **Mulalo:** Yes, yes, we have ANOVA, one of our major stakeholders. In health, ANOVA and HIVSA are our main stakeholders...
> …So they see to it (ensure) that the organization is well, get the capacitation with the staff and equipment so that they are able to report their funders.

> **Patrick:** …we have Lotto that is funding us, also forms as a stakeholder, we have HIVSA that is funding us. …It varies from funder to funder, the lotto is just giving us money and money for capacitation of staff… …HIVSA they give us the money, they make sure that they train us and also they mentor us. …so what is common amongst them is mentoring and some of them they give us finances.

4.4. Recruitment, Contracting and Duties performed by CHWs.

The discussion about the process of recruitment, contracting, and duties performed by CHWs provided insights into matters concerning the guidance of CHWs' scope of practice in the period of functioning without a national CHWs policy as well as in recent years considering that findings have shown that the NGO managers were not aware of the existences of the WBPHOTs strategy framework.

In terms of recruitment of CHWs, the organizations required individuals to have completed their grade 12 as this also aligned with the requirement from their governmental stakeholders like DOH and DSD. Working with cadres who had matriculated enabled the organization to enroll CHWs in leanership programmes that may become available to the organizations. Previously these organizations had recruited cadres who had not reached or completed grade 12. However, as time went by some of these cadres have been enrolled in ABET[2] or considered as part of the Recognition of Prior Learning (RPL). What follows are the manager's explanations of the recruitment criteria.

> **Mulalo:** Now it's the government's expectations from the organization that they want people with matric. …sometimes some people who have done learnerships around health, some people did training around health… …But remember it's also up to the organization to see that these people are properly equipped to go out and do health services around the community that we serve. …There is no actual level of qualification to determine that this person is a community health worker… …there was a programme of recognition of prior learning … remember it was mostly nurses and old ladies who did HBC training for six months maybe and then they were sent into the community to do HBC and they were considered CHWs.
>
> **Interviewer:** …so do you ever take (recruit) those who do not have matric?
> **Patrick:** We did in previous years but now we are no longer err... encouraged to take such.
>
> **Interviewer:** Those you've sent to ABET are those that you recruited before?
>
> **Patrick:** [Nods] … we need to ensure that our objectives are met, so we have certain standards that we can't compromise. First matric is a priority for us and the department side so that when there are learnerships, we are able to send someone who is able to read and write.

The stance by NGOs to recruit cadres who were literate or those with grade 12 has been observed and emphasized not only in South Africa but also in other African countries working with NGO and state-based CHWs. For example, as South Africa introduced the WBOTs in 2011, 75% of CHWs in Northwest government-based facilities, were functionally proficient in literacy and numeracy and 43% of CHWs had completed grades 8-11. An estimate of 32% of CHWs had grade 12 and most of these cadres were selected from NGOs to form part of the WBOTs (Ogunmefun et al, 2011; Nyalunga, Ndimande, Ogunbanjo, Masango-Makgobela & Bogongo, 2019). In Ethiopia

[2] **ABET (Adult Basic Education and Training):** a uniquely South African concept referring to education provided to adults by providing them with skills in literacy and numeracy. It allows adult individuals to access educational certificates that are recognized nationally.

CHWs or HEWs had graduated from secondary school (Teklehaimanot & Teklehaimanot, 2013). In Malawi government recruited CHWs as health surveillance assistants (HSAs) and required that the cadre's must be individuals who had a secondary school educational level (Nsona et al, 2012; Nyirenda, Namakhoma, Chikaphupha, Kok & Theobald, 2014).

Regarding the employment and contracting of CHWs, the organizations applied varying approaches. Mulalo mentioned that in their NGO cadres were considered employees of the organization and were only contracted to the NGO. They also recruited CHWs according to the kind of cadres needed by the organization and in alignment with the sponsor's funding proposal. Patrick stated that in their NGO, CHWs were also recruited and employed by the organization however these cadres signed contracts with both the organization and funders such as DOH and DSD. In the quotations below the managers discussed these issues.

> **Interviewer:** So are the CHWs employed by the NGO or by DOH?
> **Mulalo:** It is under the auspices of the organization to recruit people as its staff as the organization… …We check on the type of people we need for the type of work that we need through our funding proposals that we get. …Remember now the funding is given to the organization and the organization is now able to manage funding. …people are actually recruited under the organization they work for the organization, not for the department [of health].
> **Interviewer:** So the contract they sign with the organization?
> **Mulalo:** with the organization yes…
>
> **Interviewer:** …so you said the CHWs are employed directly by the NGO or are they employed by stakeholders such as the DOH, and DSD, or when they sign a contract is it with both the organization and the other stakeholders?
> **Patrick:** They sign both, they sign a contract from the funder. Maybe those from health, sign the contract from the health side. Those from DSD sign contracts from the Social Development side but we also have our own contact, so when you are a worker or employee right you sign two contracts, one from the funder, and one from us the organization.

The issue of contracting and employment of CHWs has been a complex matter for cadres deployed in NGOs. Even as South Africa was working on the adoption of a national CHWs policy the majority of CHWs were not contracted or employed by the government (Schneider et al, 2008). For example, in 2016 five CHWs had taken the GDOH to the labour court seeking the department to recognize them as employees rather than volunteers per the terms of Section 198B of the Labour Relations Act (LRA) (Lehulere, 2018). Several CHWs working in NGOs around Limpopo and Gauteng continue to be managed and paid by NGOs. Gauteng has tried to increase the deployment

of CHWs as part of the WBOT teams and being directly remunerated by DOH but many continue to be managed by NGOs. In KZN the situation has also improved whereby most cadres were directly employed and paid by DOH (Mottiar & Lodge, 2018).

CHWs performed different duties as per programme that they are assigned. *HTS counsellors* conduct onsite TB screening, HIV testing services, and condom distribution. They also extend these services by conducting field-based HTS campaigns whereby they use gazebos to set up testing stations at different parts of the community like the shopping centres, parks, and busy street corners. *Linkage officers* conduct tracing of treatment defaulters and dealt with clients referred to them by counsellors for follow-up services and also link clients with the clinic for TB or HIV treatment initiation. *Home-based caregivers* conduct home visits to assist sick patients with medication intake, cleaning for or accompanying those who are ill and the elderly to health facilities. *Peer educators* conduct door-to-door campaigns around the community, they educate people about different illnesses and provide them with condoms. During these campaigns, cadres were also able to identify people who are ill and link them to home-based caregivers or healthcare services. *OVC caregivers* focus on children who are orphaned by monitoring their wellbeing and school progress. They also assist at the drop-in[3] centre with vulnerable children from the community through the feeding scheme, assisting them with homework and engaging them in sporting activities. In the quotations below Dineo and Nyiko explain their duties as follows.

> **Interviewer:** So how would you describe your daily experience as a CHW or what is your routine every day?
> **Dineo:** Routine every day is to go out to the patients and see what the need is. Individually with each patient what can you assist with, either by assisting to the clinic or SASSA office or doing shopping if it's not in the means of the patient...

> **Interviewer:** When you doing door-to-door what exactly do you guys do?
> **Nyiko:** We are educating them about different diseases and also making them aware of those diseases and also supply condoms for their own protection. …Because you see this programme really my sister, …this programme is the one which really unveils things/issues, it exposes people, people who are not taking treatment like we have such a number of people who are positive, we have such a number of people who are negative. It really exposes that these are the people who have such diseases…

[3] **Drop-in Centre:** Organizations or community-based initiatives existing to provide services such as food, overnight shelter, or mental health support to vulnerable or local people such as orphaned children, teenagers, or homeless people.

Tasks performed by participants were typical of many other CHWs even though they were performed under different conditions. Mottiar and Lodge (2018) reported the various tasks and functions of CHWs in different parts of South Africa. Cadres in Gauteng, Limpopo, and KZN provided different home-based activities to people like assisting with bathing, feeding, and changing soiled linen for sick people. Growing vegetable gardens for soup kitchens through donations made by retail stores plus CHWs also supplied those in need with food parcels through the assistance of DSD. They also ran TB DOT support programmes, traced treatment defaulters, escorted patients who were sick to the clinic, and conducted door-to-door activities and condom distribution. All these activities were also reported by other scholars in the literature discussing the role of CHWs in South Africa.

When the need arose CHWs were asked to assist in the other programmes. For example, as co-ordinator for Jozi Hlomile, Nyiko explained that he sometimes assists with HTS services even though he was not part of this programme. Although participants were allocated to different programmes almost all these cadres reported assisting in the OVC programme which hosted different activities such as the feeding scheme, sports, and assisting children with homework. It appeared that the OVC programme was the most demanding programme because of the kind of activities and the number of children served under this programme. On the contrary Ogunmefun et al (2011) found that in previous years amongst other services such as OVC programmes and health promotion, HBC and TB DOT services were the largest programmes run by CHWs in the Northwest province. In the quotations below Nyiko and Sipho speak about other programmes they have assisted in.

> **Nyiko:** Yeah ---, it depends, sometimes I assist because we have an OVC programme here at the organization. Sometimes I do assist those other coordinators of the OVC when they need help here and there. I am not only focused on Jozi Hlomile… I also assist if those for HTS need a helping hand, I also assist them. Each and every programme here at the organization…

> **Sipho:** …I use to help out with the children, things like that. Because like I was that side and this side. You see, I was also working this side of HTS, and also helping out with the children. If maybe there do not have enough people because like they will not be able to serve the children being like three people. Because like there have to be those who will be washing dishes and those who will be dishing out.

CHWs' scope of practice was malleable and contoured according to the demands of each programme and the requirements of the stakeholders funding these programmes. This configuration of the CHWs programme resembles the tenet of social constructionism that reality was an outcome that is proactively crafted. Meaning that people construct their existence through social processes rather than their reality existing and waiting to be discovered (Conrad & Barker, 2010). This is observable in how the NGOs under research have come to exist and function by running diverse CHWs programmes while being mindful of striking a balance with the requirements and expectations of their different funders. The NGOs adopted recruitment, contracting, and allocation of tasks resolutions and strategies to construct and facilitate diverse Community Health Work activities. CHWs performed duties such as HTS and TB screening services; door-to-door initiatives; HBC service; OVC activities. The NGOs structuring of CHWs programmes through multi-stakeholder partnership was typical of several organizations considering that literature showed that NGOs usually form relationships and partnerships with corporates and state institutions. This partnership includes financial sponsorship since organizations are non-profiting generating (UNEP, 2007; Lewis & Kanji, 2009). It can be argued that the partnerships that NGOs form with communities, and private or public bodies have developed to form a historical and cultural context that influences the existence and functioning of NGOs. Asserting Morrall's (2009) argument that through social construction the occurrence of events presents as reality through the merging of particular social and historical processes.

4.5. Dynamics of facilitating multi-stakeholder CHWs programme.

Facilitating multi-stakeholder CHWs programmes has helped the NGOs to structure and direct the functioning of each programme but the participants indicated that this setup also presents with some complexities. Firstly, cadres did not receive the same amount of stipend remuneration because the organizations negotiated different funding conditions with each stakeholder. Both the managers and CHWs mentioned that CHWs were paid according to the funds that each NGO was able to secure from the donors of each programme. Cadres working as OVC caregivers received a stipend of about R1900 which was paid from the DSD coffers. Cadres providing HTS service facilitated in partnership with DOH received a stipend of R3500 per month. Clarity was not given on the remuneration of cadres working as peer educators under the sponsorship of COJ. Kok et al (2015) reported similar findings that apart from community-level challenges associated with multiple vertical CHWs programmes, at a personal level CHWs were negatively affected by the

occurrence of differences in procedures regarding the incentivization and career developments, and these challenges affected cadre's performance. Ogunmefun et al (2011); Mottiar and Lodge (2018) purported that incongruities related to stipends were linked to NPOs being funded by diverse sponsors such as DOH, DSD, European Union, and Hope Call with each funder having different standard rates. The quotations below captured Nyiko and Patrick's narration of these dynamics.

> **Interviewer:** …so is the stipend the same for those who are paid by the NGO or those paid by DOH or do you have a separate contract, you've negotiated?
> **Nyiko:** Yeah separate contract. …depends on your contract. If COJ says; you as a peer-educator or Jozi Hlomile I give you such an amount, also those of OVC the contract says I will give you such an amount. It depends on your contract, and how you negotiated.
>
> **Patrick:** They are not getting sufficient money, they are getting something like R1900, which is not enough. …They differ per programme, here I am talking about those who are with DSD, working on OVC. HTS they receive R3500 that is (HIV) testing and counselling
>
> **Interviewer:** so those responsible for the payment of OVC caregivers is DSD?
>
> **Patrick:** Yes and HTS is from DOH.

This multi-stakeholder setup also results in financial instability for the NGOs. As quoted below Mulalo mentioned that financial instability arose due to some funders discontinuing their sponsorship. Patrick stated that at times organizations experienced delays in receiving funds during periods such as dry season which took two to three months. During this time the remuneration of CHWs was also affected because their payment was delayed while cadres were expected to work. Although cadres were back paid their stipend when the NGOs finally received their funds, working under such conditions was demotivating for some of the cadres. It was also difficult for the manager to delegate CHWs to their work because some of the CHWs did not have food themselves.

> **Mulalo:** Basically, as an organization, the most important thing for the organization is sustainability. ...It is up to the organization to see that they constantly seeking funders, donors, and sponsors, to sustain the programmes that we have. …it is up to us also as an organization to continuously seek other donors and sponsors that go in line with perhaps community health and if we are able to perhaps get that sponsor or funder we are able now to add something on to the stipend of the CHW. In most instances that also depends on how long that funder is going to fund you.
>
> **Interviewer:** …so do you ever experience any challenges as you said that CHWs are paid by different funders?

Patrick: Yes, the delays of funding from the department side when they are auditing the books, we call it dry season here. The dry season is nothing else but proper editing of the books especially at the end of the financial year checking that all the money that has been used according to SLA (Service Level Agreement) so then they need to pause and investigate did we use the money according to the agreement that we had with the funders.

Interviewer: How long does the dry season usually take?
Patrick: +/- 2 months or 3.

Interviewer: During that time how do you think that affects the CHWs?
Patrick: Yeah it affects them, it affects them a lot to a point that sometimes it's hard to delegate them because some of them don't have food…

Similar findings have been reported in previous studies. Ogunmefun et al (2011) mentioned that in Northwest province only 25% of the CHWs received stipends. NPO managers from this province also mentioned that the amount received by cadres was not standardized across NGOs, it ranged between R1100 to R1500 and sometimes the payment of these stipends was irregular. Resulting in cadres feeling disregarded and not taken seriously and leading to feelings of resentment between cadres and managers. Kok et al (2017) reported the occurrence of tension amongst cadres who volunteered and those employed as CHWs. Compared to individuals employed as CHWs, those who volunteered were irregularly paid and this resulted in jealousy between the two groups of cadres. Mottiar and Lodge (2018) found that several cadres in Gauteng, KZN, and Limpopo were not receiving their stipend even though they were meant to be remunerated. While cadres in Nyalunga et al (2019) complained of being overworked but paid poorly resulting in cadre commitment deficiency and poor performance, especially amongst cadres who had to use their stipend for travelling to attend to some of their patients. Issues related to stipends also affected the relationship between NPO managers and CHWs.

Findings indicated that another negative outcome that resulted from the instability of a multi-stakeholder CHWs programme was the reinforcement of the precarious nature of Community Health Work. Whereby, CHWs were not afforded employment benefits such as personal leave, UIF compensation, and medical aid. In the below excerpts, Lerato mentioned that they worked throughout the year and only took a break when the organization closed in December. They were only allowed to take family responsibility leave when the need arose but they were not granted personal leave. Khensani expressed that when conducting fieldwork, they were exposed to risks

like being bitten by a dog, knocked by a car, or attacked by some. Yet they did not have a workplace compensatory bureau that could cover them should they encounter harmful incidents.

> **Interviewer:** Oh you do not have leaves during the year?
>
> **Lerato:** Yeah, it's only in December… …but if you have a problem at home then you are able to get that leave but, you see that it's not a personal, its responsibility, family responsibility you see. The personal leave you get it in December only.
>
> **Khensani:** Working conditions, yah conditions outside in the field are quite different only because like dealing with people. Firstly, it's a challenge because we are dealing with lots of characters but then what is most challenging for us is that as an NGO we are funded for limited things and there is no Medical Aids, there are no like, what if maybe I am bitten by a dog at some house, I won't have any place where I can go and claim. …You see, when bitten by a dog or I was knocked by a car. I got there and there was someone mentally unstable and armed with a gun and just, you see. You have to expect anything when meeting/going into the community and there's nothing that can compensate you for that.

Similar challenges were also reported by Nyalunga et al (2019) of CHWs working under difficult conditions such as cadres lacking working material and equipment, like medication, transportation, uniforms, and name tags. They also walked long distances and were concerned about their safety when they travelled to their client's homes or when they encountered mentally ill patients. As a result, cadres felt that they were overloaded with work while their stipend remuneration was inadequate. Hence, Kok et al (2015) emphasize the importance of having general CHWs' policies that cover matters related to human resources like working conditions, training, career path as well as remuneration and incentives. Calling for the implementation of human resources policies that guide the practice of CHWs since cadre's basic rights remained unofficially covered.

Lastly, the managers lamented that from time to time different funders came up with new mandates or implemented changes in the programmes which they sponsored. This meant that both the NGOs and CHWs had to try and juggle different demands or changes from the various sponsors. Sometimes it was difficult to keep up with these demands because now and then funders would introduce new instructions which the organization and cadres had to adapt or fulfil. For example, in the below excerpts, Mulalo mentioned that DOH reduced HTS counsellors working hours to six but still maintained the required target for the number of people tested for HIV, it became difficult for cadres to reach the target as they were working fewer hours. Patrick expressed that sometimes funders also changed the focus of the programmes without providing CHWs with enough training in the new area of focus. This meant that the organization had to find ways of equipping cadres

with information related to the new area of interest and making sure that CHWs were also able to adapt to the changes. Like DOH's request to extend HIV testing service to children from the age of 12. This was a challenge for cadres since some families felt that cadres were being intrusion because they did not understand why their children needed to be tested.

> **Mulalo:** …The demands or the objectives of the funder will determine the effect it has on our CHWs. For instance, we just recently got a mandate that all counsellors are to work six-hour shifts. …From DOH, that all counsellors are supposed to work six hours shifts. But then the demand on the number of people that are required to be tested and the number of people for instance HIV positive people that need to be identified cannot be reached now because they are working less hours…
>
> … It depends on the objectives of your funder in most instances. They can change at any given time… … I'm sorry to say sometimes we lose good workers because they can't handle the diversity of some funder's request.
>
> **Patrick:** So yeah, it's critical and even though we have challenges because the department wants us to test the children at an early age, starting from 12 so there is a challenge because off family members, they don't understand why their children need to be tested. It's like you are intruding into their personal lives.

Mulalo and Patrick further mentioned that these demands and changes were frustrating for cadres and caused tension between CHWs and the organizations. The NGOs tried to adapt to the demands of their funders so that they retained the sponsorship and secured cadres' employment. However, cadres felt forced upon and saw their organizations as failing to consider their needs when engaging with funders. As a result, NGOs end up losing good workers because some cadres were not always able to handle the diversity and demands of some funders. The exodus of CHWs disadvantaged both the organization and their clients considering that these cadres had privy to clients' private information. It was even more challenging when clients had formed a bond with the ex-CHW then they had to form relations with the new cadre being assigned to them. When dealing with issues concerning HIV/AIDS it took time for clients and the newly assigned cadre to establish a trusting relationship. Therefore, running a multiple-stakeholder CHWs programme did not only result in unfavourable financial implications. It also led to challenges that compromised the independence of NGOs while negatively affecting the experiences of cadres.

Lewis and Kanji (2009) argue that working with multiple vertical programmes allowed organizations to be innovative. But it also resulted in undue pressure and rendered NGOs as being ineffective or unable to cope hence NGOs have been seen as inconsistent or failing to undertake

long-term work. Bornstein and Sharma (2016) cautioned the partnership between NGOs and government as possibly resulting in undesirable outcomes. Such as NGOs being negatively mixed up with state institutions and failing to be critical of their government partners or even being complaisant to some of their state-based partner's incompetence. Mannell (2014) also criticized NGOs for losing their genuineness and pursuing projects that were regarded as important to the funders. Nonetheless, NGOs were still useful for providing the public sector with cost-effective service delivery since they function at a low cost because they mostly relied on volunteer work provided by members of the community hence, they attract state-based partnerships (Lewis and Kanji (2009).

Previously scholars have reported other Shortcomings of running multi-stakeholder CHW programmes. For example, Ogunmefun et al (2011) posits that sometimes NPOs found it strenuous to compile and submit different monthly reports to various funders. Resonating with the criticism provided in literature that, sometimes NGOs have been found to compile questionable reports (Lewis & Kanji, 2009). Moreover, working with multiple vertical CHWs programmes may lead to confusion in the roles and responsibilities of CHWs since cadres are expected to execute various tasks in the same community. Leading to community members being confused and having unrealistic expectations from cadres. It also results in pressurizing and stressful conditions that are dissatisfactory for CHWs because they may not be able to meet the community's expectations and this may even negatively affect their performance (Kok et al, 2015; Kok et al, 2017). Hence, the need to resolve the different challenges faced by CHWs because over time it leads to cadres feeling demotivated and eventually dropping out to seek employment elsewhere (Nyalunga et al, 2019). Such an outcome was unfortunate given the great dependence on CHWs to provide healthcare services to community members within their homes, especially in underprivileged communities. As representatives of the health system and bearing the status of being more than community members CHWs need to be supported with resources as they promote and teach about health amongst community members. There is a need for communities, NGOs, and the government to come up with creative ways of maintaining the work of CHWs to full term (Mlotshwa, Harris, Schneider & Moshabela, 2015).

4.6. Becoming a CHW.

Discussing the institutional aspects of the CHWs programme within the studied NGOs enabled the study to unpack CHWs' scope of practice in the absence of a national CHWs policy. At this point what follows seeks to answer questions about the experiences of CHWs and how these experiences impact the cadre's wellbeing. Before delving into the discussion about CHW's experiences we must begin by understanding how and why cadres became CHWs.

Participants shared differing experiences on how they started working as CHWs. Most of the participants were driven into being CHWs by socioeconomic circumstances. For example, Lerato said that she did not know much about Community Health Work when she approached her respective NGOs in a quest for an occupation. She went into the organizations looking to volunteer with the hope that she could be employed by the organization. Portia mentioned that she became a CHW because she needed some form of employment after completing high school. Khesani became a CHW after losing her job. Johanna became a CHW after she stopped working from her job of 10 years. She started working as a CHW in the early years of the HIV pandemic and joined the organization because she wanted to engage in Community Health Work to help the community deal with HIV/AIDS. In the below quotations cadres shared their reasons for becoming CHWs;

> **Portia:** Because I had come out of school, I did not have money to go to university but when I got here I was able, at least getting that stipend made a difference in my life, I can say that.
>
> **Khensani:** I came here looking for a job not knowing what to expect, I knew that there was something around health, maybe Community Healthcare Work but I didn't care. The only thing as long as I was going to find something that will help me feed my kids.

Literature also indicated that socioeconomic factors have influenced several cadres to become CHWs. Schneider et al, (2008); Friedman et al (2007); Dageid et al (2016) also cited the need for securing some form of employment or earning an income as having influenced the cadre's choice of Community Health Work. In Mlotshwa et al (2015) comparable results were also reported of cadres embracing their role as CHWs since it rendered as some form of employment especially because they lacked education and struggled to find jobs. Some of these cadres appeared desperate and felt that it was better to be an LHW rather than doing nothing and hoped that volunteering in HBC may lead them to other job opportunities.

4.7. Factors motivating the work of CHWs.

Reviewed literature alluded to philanthropic factors as influencing the work of CHWs. Citing motives like selflessness, moral responsibility, and proactivity as well as an opportunity for cadres to not only learn but also share information and their skills with the community while making a change in the served communities (Dageid et al, 2016). Even though cadres within this study were driven into Community Health Work by financial and other personal reasons, their sustainability as CHWs was motivated by intentions of humanitarianism. Such as developing an interest in their job, making a change in the community, or their initial intentions of engaging in philanthropic and ardent work. Lerato asserts that even though she came into the organization looking for a job and started as a volunteer, as time went by she fell in love with her work. Similar utterances were made by Khensani stating that she started working as a CHW due to her needing a job but she has been working as a CHW for the past seven years because she develop an interest in her job. Being able to make a difference in people's lives made her change how she viewed her job and herself hence she has fallen in love with her job. Portia mentioned that apart from needing a job she was a CHW because she liked helping people and working with the community. Mulalo posits that considering that cadres were remunerated with a stipend that was barely enough for them to lead a decent life, cadres were sustained as CHWs because of their passion and commitment. Below are quotations of these sentiments shared by participants.

> **Lerato:** For me to be a CHW, I came here looking for a job, and then from there I heard that people volunteer. I volunteered and I volunteered and then I fell in love with volunteering right and then from there I started as a caregiver.

> **Mulalo:** …the stipend that you will receive is hardly manageable for you to be able to make a decent proper life out of it. It's more your passion and your commitment to CHW that allows you to stay in this profession.

Literature captured similar findings reported amongst CHWs such as Palliative Care Volunteers. These cadres explained that through their work they wanted to help the community in which they lived and improve the communities' health conditions. The impetus for cadres to serve in palliative care was influenced by personal experience of previously nursing or caring for friends or family members who had been ill. Some of the cadre's motives increased after losing loved ones who were under their care hence they wanted to help other people who needed analgesic care (Jack et al, 2012; Mlotshwa et al, 2015; Kasteng et al, 2016).

In correspondence with literature experiences of CHWs within this study indicated the continuous reverberation of socioeconomic factors as influencing the cadre's choice of being CHWs. However, cadres were motivated to continue working as CHWs by philanthropic factors. It can be argued that the different motivational factors that influenced participants' choice of engaging in Community Health Work resembled the social constructionism of CHWs' social reality. CHWs constructed their reality through participation, meaning that cadres constructed, retained, or impaired their social reality over time through social engagement (Berger & Luckman, 1991; Lupton, 2012; Galbin, 2014).

4.7.1. Positive reinforcement of motivational factors.

Even when LHWs were propelled into Community Health Work by noble intentions however such intentions may not be sustained under conditions lacking positive reinforcement, support, and motivation from the community including those stakeholders running health programmes (Daniels et al, 2005). Therefore, reinforcing the above reported motivational factors amongst participants was the response they received from their clients and community members who valued the work and services provided by CHWs. Community members responded with gratitude and recognized the important role played by CHWs within their communities.

At different stages, most of the participants shared how they were addressed and appreciated by different community members. In the below excerpts Lerato explained that community members assigned her the title of a 'nurse'. When she walks around the community people always ask, when will she check on them? Nyiko explained that as they passed by different community members, they would hear people informing others of how they were helped by CHWs. Sipho mentioned that the councillor also praised the cadres for the work they do in the community. Mulalo mentioned that the highlight of his job was when a client thanked cadres after they had helped them.

> **Lerato:** Err, the community already gave me the role, they call me a nurse. So every time I walk around, they will say ‘nurse, nurse so when are you going to check us’.
>
> **Sipho:** Like not long ago we were called by the councilor, you get me. Like he (The community councilor) had invited us, he did something, like there was the community. It is whereby he thanked us saying; 'thank you for always being there for this community, if it was not for us CHWs like some people would not know their status'…

Other scholars have also reported corresponding findings to those recounted in this study. In Daniels et al (2005) LHWs mentioned being supported by community members. Community members were also cooperative to the services delivered by CHWs and acknowledged cadres for their work. Cadres also received recognition from other health providers such as ambulance staff members. Kok et al (2017) reported that CHWs from Mozambique mentioned that civilians felt that the work done by CHWs was to the advantage of the community resulting in cadres forming a trusting relationship with community members. These cadres also mentioned that they hardly got any complaints from the served communities, but community members asked for the provision of more services. Hence cadres were left to assume that this signaled that they provided quality care services. In Jack et al (2012) Community Volunteer Workers in Kampala reported that their position as CHWs helped them gain respect and elevated their status. Leading to one cadre being approached for the positions of sub-county councilor while another cadre was elected by community members as vice-chairperson in the village all because they had formed trusting relationships within the communities they served.

The occurrence of these positive reinforcements has been described in the literature as being advantageous for CHWs. By helping cadres to gain social capital and enabling them to develop skills that could improve their lives (Jack et al, 2012; Corbin et al, 2016). Portraying the social constructionism of the meaningfulness of Community Health Work that is derived from the cadre's interaction with the community and the positive response received from community members. This meaningfulness of Community Health Work does not just exist for cadres but is socially constructed through social interaction with community members (Conrad & Barker, 2010).

4.8. CHWs negative experiences.

The discussion about CHW's trajectory into Community Health Work as well as motivational and reinforcing factors that influence cadres rendered the experiences of CHWs as being positive. Regardless of all the positive experiences that came with being a CHW, participants asserted that Community Health Work also presented with negative experiences.

Lerato mentioned that she felt disregarded by some people within the community. While Portia felt disregarded by the government. Due to their working conditions, she also felt that some people within the community looked down on them. These negative encounters left her feeling belittled, embarrassed, and wishing that she had been exposed to better opportunities in life. Nyiko felt that

as cadres working within the NGO sector, they did not receive enough acknowledgement from the government, but much recognition was directed to cadres working in governmental facilities like clinics. He lamented that this adversely impacted their performances whereby they sometimes appeared as lacking interest in their job. Interestingly Mlotshwa et al (2015) reported that even though being a CHW elevated the status of cadres and filled them with pride, community health work also presented with unforeseen consequences. Such as creating a gap between cadres and other community members since they were now seen as transformed from being ordinary members of the community and this made cadres feel excluded as in-group community members. Below are quotations of some of the participant's negative experiences.

> **Lerato:** It's something I am experiencing, ok not all of them but others or us here. The way, the way we work sometimes other people, we, what can I say? I don't know how to put it. But there are times you feel that I don't know how to say it [whispering]. Yeah like err, some other time people make you feel like, they disregard or make you as if what you are doing no it's nothing, it's not enough, right. But as long as you know that you change people's lives…
>
> **Portia:** Yeah, because they look down on us greatly while we doing a lot with our work. …The governments, I can say it's the government, even sometimes the community as well, some you see, you have set the tent/gazebo and some think that you are crazy or something, while you are trying to help them, you understand.
>
> **Interviewer:** So how does that make you feel?
>
> **Portia:** you feel small as if you do not know what you doing, as if, you do not have a life, you can just imagine. …you feel bad, sometimes you say; 'you know maybe if I have got more information, I would be far if I have got more education I would not be here in my life'. You sometimes end up seeming as if you do not have love for your work due to things like that…

Just as presented in the literature gender tends to feature negatively amongst CHWs wherein Community Health Work was largely populated by women who endured the burden of caregiving. This is influenced by traditional gender roles and social expectations that imposed caring and domestic duties on females and women being socialized to fulfil these expectations (Akintola, 2006; Rotolo & Wilson, 2007; Manning, 2010). This study also revealed that the majority of CHWs were women and in some way gender also outplays itself unfavourably. In the excerpts below Dineo narrated a story of being deployed to provide caregiving services to a patient suffering from a stroke without being trained on how to treat stroke or bedridden patients nor was she supported with debriefing. She had to rely on personal experiences and her knowledge as a female

cadre. Similarly, female cadres in Kok et al (2015) also saw their caregiving role as an innate duty while their male counterparts were seen as lacking traits like gentle care and patience needed to care for sick people.

> **Dineo:** …to know how to, like I had to use my own initiative, how to do this thing, you know. How to clean that pipe and how to do the syringe and, you just use your own knowledge. You being a woman you know what is hygiene and all that, what it's all about. So you take it from there as a woman, not as a caregiver, you take it from a woman's point of view.

Resonating with literature these findings indicate the continuation of the tradition of assigning caring duties to women (Daniels et al, 2005). Indicating that the gendered nature of Community Health Work tends to entrench and reinforce gender inequality by placing women in low-paying voluntary work (Akintola 2006). From the perspective of constructionism, the gendered nature of Community Health Work may be understood as an extension of the configuration of gender in society at large. Whereby through discourse and social interaction sustained through culture, the experiences of CHWs were influenced by their gender (Lupton, 2012; Galbin, 2014). Social constructionists could argue that an understanding of the gendered nature of CHWs' present experiences relates to the history of gender which may also be telling of how the field of CHWs continues to advance in the future (Gergen, 1985). Thus, Daniels et al (2005; 100) pose the question. "If women are the majority of people doing various forms of informal community care, how are we to sustain their efforts without further entrenching the gender inequalities of their social settings?"

Conversely to some level, Community Health Work may be to the benefit of women. By exposing them to opportunities where they can pursue dreams they may have not been able to attain otherwise while being esteemed and recognized in the community for their noble work (Kaler & Watkins, 2001; Daniels et al, 2005). However, these opportunities are not exclusive to women. It can be argued that these benefits seem to be exaggerated as being only in the interest of women while data continue to indicate that female cadres encounter other challenges like safety issues when working in certain demarcations. In the below excerpts Nyiko explained that as a peer-education coordinator he feared that some of their female peer-educators could be robbed should they carry out, door-to-door campaigns at certain informal settlements. Such incidence was

reported amongst female CHWs in Papua New Guinea working in a rural setting. Cadres felt afraid and unsafe because of the occurrence of substance abuse among young men and female cadres encountered incidents of violent assaults and verbal abuse. These occurrences demotivated CHWs while also affecting their performance and led to the resignation of some cadres (Razee, Whittaker, Jayasuriya, Yap & Brentnall, 2012). While female LHWs working at a village clinic in Malawi did not only fear the possibility of contracting infections but they worried about incidents of drug theft from members of the community (Callaghan-Koru, Hyder, George, Gilroy, Nsona, Mtimuni et al, 2012).

> **Nyiko:** …And also we sometimes work in the informal settlement, where there are shacks. Yeah, you can see that where there are shacks, it is mixed up but we do not go in if we see that in that particular informal settlement, that no, here we cannot go in, it's dangerous… Our people may end up being robbed, there, no, we do not like going there… …Especially because we have females, isn't they are peer-educators. So females can be a target because they cannot fight for themselves as males do.

Amid the negative experiences, participants were still positive about the work and future of CHWs. For example, in the quotes below Thandeka was of the view that the work of CHWs could be professionalized in the future. While Nyiko believed that the work of CHWs should continue because they were able to help people in the community by making them alert to health issues and connecting them to facilities like clinics.

> **Thandeka:** The future is very bright, I do believe that one day we will have professional and qualified CHWs.
>
> **Nyiko:** Exactly, yeah because it will continue you see because that's why I am saying it makes the community alert...

When asked if cadres would recommend that other people become CHWs, Khensani is quoted below as the only participant who stated that she would not recommend that other people become CHWs. Raising concerns such as CHWs not being adequately remunerated and suggested that other people could undertake occupations like nursing and social work because these professions had better work conditions and better compensation packages. Resonation with Kasteng et al (2016) that even though CHWs valued the afforded opportunity of making a social contribution to

the community cadres also hoped that being part of the volunteer programme would yield to other rewards in the future such as the prospect of career development and monetary compensation.

> **Interviewer:** So would you recommend that other people become CHWs?
> **Khensani:** [Silent] *err no. …As much as it helps the community, the job is not paying, I would recommend to someone to go for something that will pay and at the same time be doing what they want, to change the community …because the conditions of the job are not ok*

The other seven CHWs said that they would recommend that other people become CHWs. However, they also acknowledge that Community Health Work may not be suitable for everyone because one needed to withstand several challenges such as being remunerated with a stipend and taking care of sickly people. They emphasized that individuals were sustained as CHWs by their patience, perseverance, and passion. Portia and Johanna stated that being a CHW exposed one to training and allowed them to learn a lot about health issues while being able to make a difference in people's lives within the community. Portia directed her encouragement to the youth and those who were unemployed but Dineo cautioned that some of the caregiving responsibilities may be difficult to bear for young people. The latter findings concurred with those in Daniels et al (2005) whereby LHWs working at a farm in the Western Cape alluded to the work of CHWs not being suitable for everyone. These cadres mentioned that as a CHW one had to possess certain qualities and skills like advocative and interpersonal skills, be reliable, accessible, and cooperative. Below are quotations of participants' recommendations.

> **Johanna:** I can recommend but it depends on the person's patience and perseverance because they will tell you stipend Hah! Hayi (*No*) I won't work for a stipend, you see things like that. But working conditions are very good, you learn a lot here, you develop yourself, you attend a lot of training and you gain more experience.
>
> **Interviewer:** So would you recommend to someone to become a Home-based caregiver?
> **Dineo:** I would but it must be from within because it's not for everybody. Caregiving because you come across various situations and you must be able to handle the situation. You know sometimes you get patients that mess themselves and you know the young ones are not into this so it must really be from within you. To have the passion to do this, it mustn't be just work, it must be passion.

According to social constructionism people's understanding of reality is not universal and it is also subject to change (Lupton, 2012; Galbin, 2014). Such was apparent in how participants deliberated the question of recommending to other people to become CHWs. Although all the participants acknowledged challenges such as poor remuneration and difficult working conditions only one

participant stated that she would not recommend that other people become CHWs while the other participants were of the contrary. Even though they differed in their reasoning these cadres said they would recommend to other people to become CHWs. Hence, Torres (2015) emphasized that people's experienced reality related to conditions in which they found themselves because through social construction people's experiences evolve to become significant and individuals identify these changes as having an impact on their lives.

4.9. Altruistic experiences associated with the work of CHWs.

Overall, the work of CHWs was associated with experiences of altruism since cadres felt positive about contributing to the community by impacting the lives of people through the services they provided within the community. In the quotes below, Thandeka and Mulalo associated CHWs with titles of heroism such as 'Steering' (*Slang word for a hero*) and 'foot soldiers' of the health system because cadres were in the forefront of the health system helping to identify health problems amongst people and referring them to health facilities such as a clinic. Lerato believed that CHWs were able to change people's lives and felt that they were doing a good job. Such positive findings and CHWs experiences of altruism resonate with lay cadres in Daniels et al (2005); Akintola (2011); Maes and Kalofonos (2013); Mlotshwa et al (2015), whereby in Daniels et al (2005) LHWs narrated stories about their work involving advocacy and acting as a mediator between patients and health service providers by accompanying patients to health centres, handled referral letters and also collected diagnosis of the clients on their behalf. Whilst in Mlotshwa et al (2015) some cadres shared that their reason for serving the community was their way of paying it forward since they were the former recipient of healthcare services from other CHWs in their time of ailment. The latter findings are a different motivational factor compared to cadres within this study.

> **Thandeka:** Wow. Yoh! Mina (I), CHWs are steering I can say because we are the first people to identify or to diagnose before we refer people to the clinic so we do or I play an important role in the community. …They are the steering, there are the ones that diagnosed before and link the people to care so we are doing a great, job for the community or let me say South Africa as a whole.

> **Mulalo:** I believe that CHWs are the foot soldiers of the health system in this country and they are the ones who are doing the actual work. Going into people's houses, who are touching children's lives, who are at the forefront in the clinic and at organizations, to be the first to be able to assist and help people through their medical conditions and to be able to walk with them…

From the social constructionism perspective CHWs, altruistic experiences were embedded in their social interaction with the served communities. It can be argued that expressions by participants that; 'they were able to change people's lives, or they were doing a good job' suggest that their interaction with the community fostered in them the meaningfulness of doing Community Health Work. Cadres saw their role as CHWs as being important because they were at the forefront of the health system and helped to improve people's lives as a result participants associated CHWs with heroic titles like 'Steering's or 'Foot Soldiers of the health system' (Brown, 1995; Conrad & Barker, 2010; Torres, 2015). CHWs' experiences and reality were constructed through social relations within the served communities (Lupton, 2012; Galbin, 2014).

4.10. Negative and Positive Experiences of Wellbeing.

The impact on CHWs' wellbeing of the above-discussed experiences was both negative and positive. Their wellness was negatively impacted by cadres encountering adverse experiences like unfavourable working conditions and poor remuneration. CHWs wellness was also impacted positively wherein the upside for cadres was finding meaning in their work and making an impact in society. The impact experienced by CHWs is related to their physical, psychological, economic, and social wellbeing. Even though wellbeing was understood as a continuum between hedonic and eudemonic experiences the positive impact on cadres' wellbeing related to eudemonia.

4.10.1. Physical and Psychological wellbeing.

Literature postulate that physical wellness is related to people's physical form and how they function including how individuals come to understand their surrounding and their ability to deal with stressors (Linton et al, 2016). In this study, CHWs reported that their experiences as health caregivers negatively affected their physical wellbeing. Cadres mentioned that their work entailed moving around the community and facilitating programmes like HTS services, door-to-door campaigns, and HBC services. Conducting such duties had some negative impacts such as somatic fatigue, dehydration, and back aches. Lerato mentioned that she felt the toll of working through the year without having a day off or workers' leave. Dineo stated that as a Home-based caregiver and being almost 50 years of age, she experienced exhaustion as a result of walking in the sun and lifting heavy patients. Nyiko also concurred that duties such as conducting door-to-door campaigns and HBC services involved walking long distances to reach different people around the community and cadres had to do so even in hot weather conditions. In comparison to findings from this study, CHWs in Kok et al (2015) were also concerned that environmental challenges like walking long

distances encumbered their performance. Stating that compared to households within l km, those between 2 and 3 km were unable to access the services of cadres because they were unable to travel such a copious distance. At different stages in the interview, CHWs shared the following impact on their physical wellbeing.

> **Lerato:** Wooo err [Giggles] you not going to say anything right [Whispering]. For me right, sometimes you know, it's draining right whereby I feel eyi [sigh] I need a day off, not, weekends is not enough, remember weekend you busy with other things. Yah sometimes you feel like, hoo aha ahe [moan], yah a bit of a day off or leave of some sort and not that we have to wait for December… … its tiring yoh, [In a whispery voice] I am tired even now.

> **Dineo:** …the walking is effecting, you must understand it's about age here, but because you get tired you really get tired. …you know and sometimes picking up, lifting heavy patients like big patients... It sometimes does affect you, it does affect my health now personally. …sometimes your back, like now walking or standing long, it affects your knees and legs. That's what it's doing to me, cause (*because*) I can feel now it's catching up with me you know. …Like now is terrible because we must walk out to our patients and the sun really dehydrates you…

In their study, Noonan and Tennstedt (1997) found that even as cadres experienced the CHWs' role as burdensome, some cadres found meaning in their role while other cadres did not find any meaning. Cadres who found meaning in their work developed a positive self-esteem which also enhanced their psychological wellbeing. The latter findings are alike to Johanna's experiences although other participants experienced negative effects on their physical wellbeing in the below excerpt, she mentioned that as an HTS counsellor and being in her early 60's her physical wellness was positively impacted. She had seen an improvement in her physical health due to the knowledge she gained as a CHW. Asserting that in comparison to other people her age, she did not have hypertension or sugar diabetes. Her physical wellness was improved because as a CHW she had learnt how to take good care of herself. In comparison to Dineo, Ryff (1989) would associate Johannas' experienced impact on her physical wellbeing with the notion of life span development. A process that involved the ability to manoeuvre and gain control of a complex milieu. Allowing an individual the opportunity to develop and improve their world or alter it through physical and mental action enabling other people to age successful by taking advantage of presenting environmental opportunities.

> **Johanna:** It (*Her health)* has improved because people of my age are now sick. I don't have high blood, I don't have sugar (sugar diabetes), and I don't have HIV. So I think my health has improved because of the knowledge that I now have. I make sure that I take good care of myself and do the right things all the time.

CHWs' psychological wellness was negatively affected. Cadres mentioned that they encountered emotional stressors that led to psychological distress. Lerato mentioned that at times she had to deal with difficult clients who did not want to adhere to their treatment. It was not easy to engage them about the importance of treatment adherence and show them the importance of their lives. Dineo mentioned that when she started working as a Home-based caregiver three of her patients passed away in three consecutive weeks. This experience was emotionally distressful because she had just started working and had formed a relationship with her patients. Khensani stated that in some of the challenges that their clients present with, as cadres they ended up sympathizing rather than empathizing with their clients. Below are quotations of participants' accounts related to their psychological wellbeing.

> **Lerato:** ...at times you find that like it's draining you see, when dealing with may be difficult clients, clients that don't want to take treatment. It's not easy to pursue somebody to explain to them how important it is like, show them how important is their life. So it's draining, so support from family is important so that when I get home they understand that no today yah it was a hectic day.
>
> **Dineo:** …at the beginning of my employment, I just lost three patients a week after each other. That was a bit, cause (because) when you think to yourself what happened now. This patient died, a week after that patient died and a week after that patient die so it was a bit and I had to go to all three (funeral services) to represent the job I'm doing. …It wasn't nice. September I started here, October, and November then the patients died. …so it was a bit emotional because I got to know these patients.

Psychological stressors experienced by participants had the potential to influence the cadre's level of motivation and the performance of their duties (Wissing & Van Eeden, 1997). For example, Lerato mentioned that sometimes her work felt draining hence the support of her family was very important. According to Noonan and Tennstedt (1997); Lamberston (2020) having social support improved the psychological wellbeing of cadres such as caregivers and clergy. Suggesting that people's SBW was influenced by experiences related to their occupational conditions and social relationships (Migdal, 2007).

4.10.2. Economic Wellbeing.

Literature indicated that the issue of compensation for CHWs has been a point of contestation given that for many years CHWs in different parts of the world and in South Africa have been remunerated with a stipend. In South Africa the stipend payment even varied across provinces (Schneider et al, 2008; De Wet, 2012; Malan, 2014; Odendaal & Lewin, 2014). Data from this study also showed that compensation of CHWs persists as an issue and cadres' economic wellbeing was related to them being remunerated with a stipend. Bringing into mind Khensani's previous comments that part of the reason why she would deter others from being CHWs was because of the poor compensation received by cadres. Therefore being able to acquire a good quality job forms the basis of people's wellbeing (Marks & Shah, 2004), since people can meet their economic wellness through employment (Helliwell & Putnam, 2004). Implying that people's wellbeing should be understood in context to socioeconomic conditions that affect their wellbeing (Selamu et al, 2017).

Below are excerpts from different parts of the interviews where other participants expressed their frustrations with the stipend remuneration. Contesting their stipend as being inadequate hence they desired augmentation of their remuneration. Portia mentioned that due to needing more money to take care of her family at some point she stopped working as a CHW and sought employment at a retail store. Johanna and Khensani shared their desire for augmentation of their stipend as it was currently inadequate and even called for CHWs to be paid a salary rather than a stipend. Singh, Chaudoir, Escobar and Kalichman (2011); van de Ruit (2019) also found that CHWs continue to complain of remuneration that varied from no payment to a small stipend payment. Kok et al (2015) offered a different dynamic to this debate by arguing that the income generation of CHWs enforced a gendered response to cadres becoming and remaining CHWs. In patriarchal communities where males are expected to be breadwinners, men may be less inclined to become CHWs. They are even more likely to stop working as CHWs and seek other forms of income generation due to poor remuneration or the voluntary nature of Community Health Work which limited the ability of male cadres to realize their financial responsibility. This argument may account as one of the factors that have resulted in a smaller number of male CHWs and future research need to thoroughly explore this dynamic.

> **Portia:** …I worked here in the organization from 2007 until 2010. In 2010 I went to work at [Name of a retail store], then I came back here in 2016. ... because as you know that

when we are in the NGO we only get a stipend, so as people we've got families to provide for, you understand…

Johanna: …you know, we get stipends, so if we could get funders so that we can augment our stipends….

Khensani: To stop the stipends and we live on salaries like any other (*other professions*).

Uttering the comments below, managers Mulalo and Patrick conceded that the stipend received by CHWs was not enough. They observed that some cadres felt demotivated, and this affected how they performed their work and applied themselves in the community since CHWs felt that they were not able to grow themselves with the amount of stipend they received. They also mentioned that at times NGOs lost competent CHWs since some cadres chose to seek other lucrative employment opportunities because they were not paid enough. Thus, Shah and Marks (2004); Sörensson and Dalborg (2017) posit that people's state of wellbeing influenced their ability to contribute to society as well as conditions that fostered their personal growth and development.

Mulalo: …the amount of money that they receive will determine their attitudes towards their job. …If I get a stipend of R1500 a month that is what you will get out of me. …why should I go the extra mile, why should I do more, why should I try and develop myself? I am not able to develop myself with a stipend or with the money that I am getting, …so that's just the attitude that you will get and that is in turn what we give back to the community.

Patrick: …losing competent caregivers because we are not paying them enough. … Losing caregivers while they are looking for greener pastures because they are not well paid. That is one of the challenges that we come across.

Similarly, different studies have reported varying personal, occupational and relational effects related to CHWs' economic stature. Such as CHWs' livelihood and commitment to their work being influenced by receiving inadequate remuneration (Kok et al, 2015). Managers of cadres in Mozambique also mentioned that financial issues like the backlog of funding payments affected the remuneration of cadres and resulted in cadres being demotivated, performing poorly and some of them even dropping out. Financial challenges also strained the relationship between cadres and supervisors which made it difficult for supervisors to question cadres about their performance (Kok et al, 2017). Therefore, Community Health Work programmes should be set up to afford CHWs the cost-benefit of the services they provided, and to positively influence and sustain cadres

because opportunity costs and expectation of future benefits also influenced CHW's choice of Community Health Work (Kasteng et al, 2016). Van de Ruit (2019) found that poor payment of CHWs even encouraged moonlighting amongst cadres as means of augmenting their stipend, especially cadres working in urban NGOs. Bearing consequences such as CHWs competing with each other and compromising the quality of their work because cadres were handling competing work demands and even ended up duplicating services provided to their communities.

Portia concurred that the stipend they receive was little, but she acknowledged that it made some difference in her life. The below excerpt indicated that Nyiko held an ambivalent view about the remuneration of CHWs. He acknowledged that the stipend was not enough but also argued that the stipend should not be viewed as a salary. It should be considered as compensatory means to thank CHWs for the work that they did. Asserting that cadres can use the stipend to cover basic needs like food and toiletries or they could also use it for making copies of CVs to apply for better job opportunities. As objective as this assertion may be however studies revealed that CHW's participation was influenced by subjective experiences that necessitated cadres to receive some form of remuneration. For example, Mlotshwa et al (2015) found that cadres did not only use the stipend for their own needs, but they also used it to buy food for some of their patients who did not have money. While Kasteng et al (2016); Nyalunga et al (2019) reported that some cadres used their stipend to cover their travelling cost as they attended to different patients in the community. Moreover, although cadres were aware of the financial dynamics related to Community Health Work and had become volunteers knowing that they should not expect any payment some still chose to work as CHWs and hoped that they would receive some monetary compensation. Initially, 70% of cadres had anticipated receiving a stipend and 43% of them hoped that they would receive an allowance in the future (Kasteng et al, 2016).

> **Nyiko:** the stipend my sister is a stipend……I think yah somewhere somehow it's not enough but I am thankful for the stipend. The stipend my sister is something that is temporal… eish how can I put it, the stipend is just money to thank you for the work that you do, it does not mean that you have to grow old in that programme because a stipend will always be a stipend**.** …It will never change and be a salary, the stipend is given to you to thank you, so that you may be able to buy what …toiletries, be able to have food from that stipend. I can say that it's not enough. But at the same time, I can also say it is enough …at the same time it helps you out to have money to make copies of CVs, do your CV and travel to go submit those CVs here and there.

4.10.3. Social Wellbeing.

In the literature review an understanding of people's social wellbeing related to activities they engage in as well as their general behaviour and the impact that these factors have on their lives. But beyond the self, social wellbeing extends to the connections that individuals establish with one another within their local milieu and broader society (Linton et al, 2016). The study findings showed that the impact of CHWs' experiences on their social wellness ranged from occupational advancement, and personal development as well as social and behavioural changes.

Firstly, the results suggested that there was some sort of progression within the field of Community Health Work. Cadres were exposed to different experiences and opportunities to advance between different roles and positions. For example, Lerato started working as a volunteer, then became an OVC caregiver and moved to be a health screening campion and then became a linkage officer. Nyiko started working as a peer educator and then became a peer-education co-ordinator. Sipho was part of the peer-education programme and then moved to be an HTS counsellor. Khensani started working as a peer educator, she then advanced to be an HTS counsellor and then moved to be a linkage officer. In the below quotations CHWs spoke of moving between different positions.

> **Nyiko:** …actually I am a co-ordinator but I've been a peer-educator right. … So I got promoted, so that's why I am a coordinator now…
>
> **Khensani:** Right now from being a peer educator because I started as a peer educator, then I went to testing. …I became a counsellor, then after becoming a counsellor now I'm a linkage officer.

Moreover, experiences of being a CHWs incited new interest and desire for cadres to venture into other lucrative professions. Leading to some of the CHWs taking action to try and improve their level of education so that they could pursue careers in other professions. For example, in the below quotations Lerato and Nyiko mentioned that working with people and health-related matters made them realize that they wanted to pursue a career in professions such as nursing. These participants were either upgrading or rewriting their matric so that they could improve their marks and apply to study nursing or other health-related fields. Portia mentioned that she had previously applied to study at the University of South Africa (UNISA) as this institution offered part-time studies but her application was unsuccessful. Similar findings were also reported amongst LHWs in Daniels et al, (2005) as cadres expressed that they had desires of working as nurses and hoped that being an LHW would afford them opportunities to fulfil their desires. Other cadres also stated that being

an LHW made them realize that they possessed abilities they never thought they had. LHWs were even inspired to try and further develop their skills since they worked in an environment that exposed them to opportunities. Cadres felt like they could advance their careers or even search for other jobs, and as such cadres felt that to some degree being an LHW profited them personal. Mlotshwa et al (2015) found similar results but with some divergence, wherein cadres settled for being carers because they were unable to pursue their desired professions. For instance, a 22-year-old cadre stated that rather than being at home and not doing anything they chose to settle for HBC work since they had always wanted to be a Social Worker and care for those in need. Whereas another carer mentioned that they did not have a job because they were uneducated, but realized that they could work in the field of HBC.

> **Lerato:** …I became a health screening campion and then as I was busy working with people I realized that I want to be a nurse and then that's where I started, I continued because I realized that I love helping the community… …I am currently rewriting my matric so that I get good marks and then I will apply for nursing.
>
> **Nyiko:** Since this job is related to health, I wanted like to continue with my studies, I am getting a stipend. This stipend can help me to pay for those subjects and upgrade myself… Maybe I can find myself being a doctor or a nurse and be working at the clinic… …until I reach the level that I want to be at. …There is a place where I am upgrading as we are speaking, I am upgrading my matric results

Lastly, participants mentioned that working as a CHW in their respective NGOs afforded them opportunities for learning and development by exposing them to training. Cadres saw their work as some sort of stepping stone and viewed Community Health Work as having helped them to improve their lives and change their behaviour. For instance, in the below excerpt, Dineo and Portia were grateful to their NGOs for the opportunities afforded to them. The former participant stated that as a CHW she had the advantage of being enrolled for ABET. The latter participant mentioned that they were sometimes enrolled for learnerships and that she had improved a lot because of her organization considering that when she started, she did not even have a bank account. Nyiko mentioned that since working as a CHW he was able to differentiate what was right or wrong for his body. He felt confident and changed his health behaviour by reducing his intake of alcohol and improving his attitude towards people and the community. Similar results were reported by LHWs in Daniels et al (2005) stating that they found any type of training offered to them a novel experience. Some of the training made cadres feel anxious and doubtful but with

time they became grateful for these opportunities. Cadres improved their levels of literacy because most of them hardly had formal education and very few of them had completed high school. Kruithof, Visser-Meily and Post (2012) also argue that positive effects on caregiver's wellbeing include increased self-esteem.

> **Portia:** here we also get training, they give us training so that we can study and improve our knowledge. Sometimes you get learnerships, you study… …then with time you might find yourself getting a better job, to craft your future… …I have improved because of this NGO, you see I am very grateful for this NGO because it improved me in a lot of things. When I got here, I did not even have an account (*bank account).*

> **Nyiko:** …improved and also changed because when I look way back then now, I can see myself now that; no, now it is me than before because most of the time things that I did were not good for my health, you see. But now since I joined this programme, I can see what is wrong and what is right. What is right for my body and what is wrong for my body. There are changes, there are changes, and a lot of changes … and also my attitude, my attitude. Towards myself … before I worked, I did whatever at any time that was not right. Like I have noticed an example that I can give, I used to always drink alcohol, like not being considerate of myself. But now I can see that I am able to respect people within the community… … because previously I was not working, I was just hanging around in the community, I just use to speak anyhow with people that; hhe, blah, blah especially people who are elders, …but now I am able to be respectful, I know that the community comes first.

Overall the discussion about the felt impact on CHWs' wellbeing as healthcare givers showcased the wellness of cadre's as occurring on a continuum which affected their physical, psychological, economic and social wellbeing. According to cadres' descriptions of their experiences, CHWs' wellbeing existed both negatively and positively (Morrall, 2009). It can be argued that from a social constructionist perspective CHWs wellbeing was influenced by an interaction of physical and social factors (Olafsdottir, 2013). Physical conditions such as walking in the sun, taking care of ill patients and not being afforded days off or work leaves as well as social conditions like dealing with difficult clients, losing patients and encounters with difficult clients had an adverse impact on CHWs' physical and psychological wellbeing. Cadre's economic wellbeing was also negatively affected and both the CHWs and managers attributed this negative impact to being remunerated with a stipend. This stipend was inadequate and led to some of the cadres seeking

other employment opportunities. Highlighting the importance for cadres to earn an income and the meaning of socioeconomic events that impact their wellbeing (Charmaz & Belgrave, 2013).

The positive impact on physical wellbeing reported only by Johanna shows the difference in how cadres define, describe and reason about the existence of their world as they live it (Gergen, 1985). While the positive outlook held by Nyiko about the stipend whereby he advised that the stipend could be used to make copies of CVs and travel to seek other work opportunities rather than it being viewed as a salary indicates that even in similar contexts people relate differently to their conditions. Meaning that the cadre's wellbeing evolved into being significant by how it influenced their lives (Torres, 2015). Hence social constructionism focuses on how phenomenon's are branded and responded to (Brown, 1995).

It is in context to the social environment that the world is better understood thus social milieu matters when considering people's wellbeing (Olafsdottir, 2013). CHWs' social wellbeing was positively impacted. Through their work, CHWs experienced occupational advancement by undertaking different positions and being part of different Community Health Work programmes. Training offered to cadres also resulted in personal development and their interaction with the community led to social and behavioural changes. From a social constructionist perspective, this understanding of CHWs' social wellbeing is embedded in their social experiences (Lupton, 2012; Galbin, 2014). And so the reality of CHWs' social wellbeing did not exist waiting to be discovered but it was constructed through social processes (Conrad & Barker, 2010) and the construction of CHWs wellbeing was inferred differently by the different cadres (Morrall, 2009).

Considering the positive and negative experiences, the cadre's wellness was mostly related to eudemonic wellbeing. Even though CHWs encountered negative physically, psychologically and financially experiences they still found meaning in their work, experienced personal growth and were incited to pursue other careers in the health profession. Suggesting that cadres found some balance in the challenges that they encountered and the resources available to them (Dodge, Daly, Huyton & Sanders, 2012). Cadres did not explicitly mention experiencing hedonic wellness like happiness and life satisfaction however this does not take away from the positive impact related to eudemonic wellbeing because subjective happiness does not always equate to wellbeing and not all pleasurable experiences are good for a person nor promote their health and wellness (Ryan & Deci, 2001).

4.11. Conclusion.

The analysis of data yielded interesting results that offered this research a different and broader view of CHW's scope of practice in the years of functioning without a national CHWs policy. Results presented more information about the NGO's knowledge of the WBPHCOTs strategy policy framework as well as the functioning of the CHWs programme within the NGO sector. The managers of the NGOs did not know about the WBPHCOTs strategy policy framework. CHW's scope of practice within the NGOs has been stakeholder or funder driven. Keeping in mind the expectations of their funders the organizations applied varying recruitment and contracting strategies. Duties performed by CHWs were undertaken according to the demands of each programme and the expectations of the funders. The OVC programme was the biggest project and almost all cadres helped in the OVC and other programmes should a need arise. Hosting multi-stakeholder Community Health Work programmes presented with shortcomings such as unequal stipend remuneration, financial instability and work conditions that led to Community Health Work being precarious.

This study held no fixed ideas about the topics being researched but as informed by the literature review certain patterns of themes were anticipated related to the experiences of CHWs and the impact that Community Health Work has on cadres' wellbeing. Cadres were driven into Community Health Work by economic factors or the need for employment, but they were motivated and sustained as CHWs by humanitarian intentions like, developing an interest in the job and making a difference in the community. Cadre's philanthropic intentions were reinforced by the positive response from the community. Even with the positive experiences of engaging in Community Health Work, cadres also encountered negative experiences. Such as being disregarded by the community and government plus some of the community members looked down on CHWs due to their work conditions. However, cadres still associated Community Health Work with altruistic experiences and referred to CHWs as steering or foot soldiers because they contributed to improving the community and positively impacted people's lives.

From the different experiences of being a CHW, the cadre's wellbeing was impacted both positively and negatively. Resulting in the research locating CHW's wellness in context to their physical and psychological as well as economic and social wellbeing. At the physical level cadre's wellbeing was negatively impacted by experiences of carrying out duties such as door-to-door

campaigns and HBC services which involved walking long distances in the sun and assisting ill patients. Hence cadres complained of dehydration, back pains and fatigue. However, one of the older participants reported an improvement in her physical wellbeing because of the knowledge she had gained as an HTS counsellor. At the psychological level, CHWs experience psychological distress due to cadres encountering emotional stressors such as dealing with difficult clients, the death of their patients and witnessing some of the challenges experienced by their clients. At the economic level, CHW's wellbeing was also negatively affected as cadres were dissatisfied with being remunerated with a stipend. Participants felt their stipend was inadequate and desired for it to be augmented. The managers concurred with the sentiments of cadres and purported that they ended up losing competent CHWs because cadres were not paid enough. Interestingly one of the participants had a mixed view regarding the stipend. Acknowledging that the stipend was inadequate, he cautioned that a stipend should be viewed as means of thanking CHWs for their work rather than it being considered a salary. He argued that cadres could use the stipend to cover their basic needs like toiletries and for making copies of CV's and travelling to seek other job opportunities. At the social level, CHWs' wellbeing was positively impacted as the cadre's experienced occupational advancement, personal development as well as social and behavioural changes. For example, cadres had the opportunity of advancing between different positions. Moreover, being a CHW developed an interest in cadres for working with health-related and community issues and incited a desire for working in health-related fields such as nursing. Lastly, cadres felt that working as CHWs within their respective NGOs exposed them to opportunities that have helped them to learn, improve their lives and change their behaviour.

The adopted theory provided the study with lenses of framing and contextualizing findings. Social constructionism was able to relate the reality of CHW's experiences as being crafted through social action. Social constructionism provided viewpoints from multiple perspicuity's and this was advantageous because it enabled the presentation of different views to better understand issues related to guiding scope of practices for CHWs in the years of operating without a national CHWs policy to present times. Social constructionism shared a similar caution that this study was also conscious of, which was to yield findings that were not meant to prove or convince others about a correct understanding of CHWs experiences or the impact of their experiences on their wellbeing as health caregivers and matters related to CHWs policy environment but hoping to shed light on

how CHWs have come to define, describe and explain their existence in society as they live it. The next chapter follows with a concluding discussion and recommendations.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS.

This chapter presents a conclusion to the study by furnishing a summary of the discussions of each chapter. This discussion will show whether the objectives of the research study were achieved. The objectives of the study were to explore the experiences of CHWs as cadres providing healthcare services at the level of PHC in Gauteng province within two NGOs situated in Johannesburg townships. The aim was to understand if and how CHWs' experiences as health caregivers impact their wellbeing and in the absence of a national CHWs policy the research sought to understand CHWs' adaptation and scope of practice in their years of practice.

Background on the global and local emergence of CHWs and Community Health Work programmes was provided. This discussion located the history of CHWs in countries such as China and Russia. It also pointed to the adaption of CHWs in other parts of the world such as Ethiopia, Pakistan, Afghanistan, Mexico, Thailand, and Latin America, and detailed the advent, adaption, and expansion of CHWs in South Africa. Although the study was conducted before the dawn of the Covid19 pandemic a brief account was provided of the role and work of CHWs during the emergence of Covid19.

It was discovered that previous research studies tend to focus on the work of CHWs and the impact of their work within the health sector as well as the contribution made by these cadres in different communities, especially among marginalized populations. Few studies have looked at the experiences of CHWs in context to their wellbeing. Leaving a gap for studies to explore the experiences of CHWs and the impact of their experiences on their wellbeing. Moreover, in the process of officially assimilating CHWs into South Africa's PHC system through the re-engineering of the PHC system, the WBPHCOTs strategy was launched in 2011. This was informed by the 2010 Brazilian excursion undertaken by the then Minster of Health Dr. Aaron Motsoaledi and a MECs lead team. By 2015 NDOH released a draft of the Policy Framework and Strategy for WBPHCOTs which was to be later adopted into a national CHWs policy. However, the finalization of the WBPHCOTs strategy framework into a national CHWs policy was delayed for serval years and only finalized in 2018. Even in its finalization, the policy provided insufficient guidance on the standardization of CHWs distribution and their scope of practice, raising the question of "how the work of CHWs has been guided without the presence of a national CHWs

policy?" The study sought to fill the identified gaps by utilizing a qualitative research study. The qualitative nature of the study enabled it to seek resonance with the study participant by understanding the cadre's experiences from their accounts. Data was collected through non-participative observation and in-depth interviews which were analyzed through thematic analysis. Although these techniques presented some limitations they were chosen because of their effectiveness and relevance to this research study. This study also took into consideration all relevant ethical issues.

To achieve the study's objectives relevant literature covering the work of CHWs was consulted. The review of the literature revealed that an understanding of CHWs and their roles varied across the world. CHWs functioned as paid or unpaid volunteers as well as lay or non-professional workers. Different studies covering the work of CHWs unpacked positive implications of being a CHW such as improvement of cadre's knowledge in different areas of health. CHWs also expressed personal growth, a sense of self-satisfaction, and sociopolitical gains such as advancement in their social status. Being a CHW was also an avenue for earning some form of income even though it was a minimal stipend. Negative implications of being a CHW included the potential of being exposed to risks such as TB infections, emotional strain, and burnout, walking long distances under hot weather conditions, and being overburdened with numerous tasks while being poorly trained. The gendered nature of Community Health Work was also presented as the majority of CHWs were female and women became CHWs as means of earning an income. Sometimes such work was exploitive labour to women because some of these cadres worked as non-paid volunteers.

Literature also showed the extent of the role of CHWs in South Africa where they functioned as assorted groups of health and social cadres. They undertook activities such as health promotion, door-to-door campaigns, health interventions related to mother and child programmes, and treating respiratory infections and communicable illnesses like malaria. Cadres further provide HCT services, HIV and TB treatment roll-out, DOT support, and HBC for terminally ill persons and PLWHAs. CHWs provide care and support to OVC and those affected by other chronic illnesses. CHWs also assist to deal with social issues related to poverty, education, housing, and food

provision, as well as information dissemination related to welfare services like social grants and identity document applications.

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Literature further detailed South Africa's process of assimilating CHWs into the PHC system. This discussion traced the process of re-engineering the country's PHC system into three streams. The third stream is the cornerstone of the PHC system and is referred to as the WBPHCOTs strategy. Followed by a discussion about the NGO sector and the notion of wellbeing.

In South Africa NGOs had been working independently of government and established a community presence since the 1940s as providers of community-based care in marginalized communities and maintained their existence even post-apartheid. The emergence of the HIV pandemic saw an increase in NPOs that led to Community Health Work programmes aimed at responding to the scourge of HIV. Therefore, in South Africa NPOs were the pioneers of CHWs programmes. It was in the early 2000s that the government showed an interest in NGOs as providers of community-based care services through the work of CHWs. The PHC re-engineering project came with the inclusion of CHWs into the PHC system through the WBPHCOTs strategy and increased the interaction between the government and CBOs. The NGO sector was acknowledged within the WBPHCOTs strategy policy framework and the government showed interest in working in partnership with NGOs. Regardless of this interest, the WBPHCOTs strategy policy framework failed to clearly state the role of NPOs in the process of implementing the WBPHCOTs strategy.

The discussion on wellbeing showed the broadness of this notion since it cannot be reduced to a singular perspective. In this study, wellbeing was understood as being a state that occurs on a continuum of hedonistic and eudemonic experiences. SWB presents as a dynamic state of being that is characterized by physical, psychological, social, and economic wellness. Lastly, social constructionism was covered as the theoretical framework applied in this study. It was evident from the literature that this approach does not offer a specific set of guidelines. But it offered lenses of viewing CHWs experiences as a process of social construction and wellbeing as an outcome

This study was conducted the same year that the Policy Framework and Strategy for Ward-Based Primary Healthcare Outreach Teams (2018/19 - 2023/24) was finalized. However, findings indicated that the studied organizations had not adapted or aligned themselves with this policy

framework. This was made evident by the manager's lack of knowledge about the existence of the WBPHCOTs strategy policy framework. The managers maintained that the functioning of their organizations and CHW programmes were guided by regulations like labour laws and the NPO ACT as well as organizational HR policies. Moreover, the organization of CHWs programmes was configured as multi-stakeholder projects whereby, the scope of practice guiding CHWs was established and negotiated in context to the requirements of the major stakeholders partnered with in each programme. This suggests that NGOs may have not been following nor have they been up to date with developments related to CHWs policy or the WBPHCOTs strategy framework.

The study was able to explore how the cadre's scope of practice was guided in the years of functioning without a national CHWs policy and the years when the WBPHCOTs policy was finalized by inquiring about matters related to recruitment, contracting, and duties performed by CHWs. The organizations had evolved to prefer the recruitment of CHWs to be individuals with grade 12 and enrolling on ABET cadres who had been previously recruited without completing their matric. Some of these cadres were retained on conditions of RPL. NGOs differed in how they contracted CHWs, in one organization cadres were considered employees of the organization and only signed a contract with the organization. In the other organization, CHWs signed a contract with both the NGO and their major funding stakeholders like DOH and DSD. In terms of duties performed by CHWs, cadres were assigned duties as per the requirement of the CHWs programme that they were allocated. However, from time-to-time cadres were asked to assist in other programmes should there be a shortage or need for more help in a different programme. One such programme is the OVC project since it hosted various activities and served several children. In both organizations, all the CHWs assisted in the OVC programmes regardless of them being allocated to other programmes like HTS, HBC, and peer education.

The manner and means in which the organizations structured and facilitated Community Health Work through multi-stakeholder CHWs programmes led to the rising of various challenges. Such as disparities in the remuneration of cadres because the NGO's funding settlement differed with each stakeholder. NGOs also found themselves vulnerable to financial instability when some of their sponsorships came to an end or during the dry season. Running multi-stakeholder CHWs programmes meant that organizations had to juggle and meet different demands and changes from various funders. Some cadres were unable to withstand these changes or demands and this led to

some of them stepping down from being CHWs. Which was a disadvantage for both the NGOs and their clients as organizations lost valuable workers and clients had to form new relations and establish trust in their relationships with the new CHWs assigned to them.

Findings from the study offered an assorted insight into the experiences of CHWs especially those within the NGO sector which helped to better understand the everyday practices of CHWs. To a large extent, the experiences of CHWs were positive as cadres saw the virtuous impact of their work in the served communities and this was of great motivation to them which further induced their interest as CHWs. The response from community members was also positive as participants indicated that different members of the community appreciated and commended the work done by CHWs. Resulting in participants feeling appreciated and recognized thus reinforcing cadres' positive experiences as well as intentions of altruism. Cadres associated CHWs with titles of heroism such as 'Steering' and 'foot soldiers' and lauded themselves for doing a good job by being able to change people's lives. However, participants also reported encountering some adverse experiences in their practice as CHWs. Cadres felt disregarded by the government and some people within the community. Some of them also felt that some community members looked down on them due to the conditions they work under. They also complained that in comparison to cadres working in clinics, as CHWs working in the NGO sector they received limited acknowledgment and recognition from the government. Moreover, women remain the majority cadres in Community Health Work and somehow gender continued to reverberate negatively since there were safety concerns for female cadres to work in areas such as informal settlements. Plus one of the female cadres shared their experience of being expected to provide caregiving services to a stroke patient while being provided with inadequate training and skills to perform such a task. Amid the negative experiences cadres were still positive about the work and future of CHWs hence the majority of the cadres said that they would recommend other people to become CHWs. Only one participant reserved her recommendation of encouraging other people into Community Health Work. Instead, she recommended that people who wanted to be in the helping profession should rather pursue other professions that offered better working conditions and compensation packages.

An intricate understanding of wellbeing allowed the study for a more in-depth investigation of CHWs' wellbeing. Findings about the impact on CHWs SWB as healthcare givers ranged from physical and psychological to economic and social wellbeing. The optimism reported in CHW's

experiences was to some degree replicated in their wellbeing especially their social wellness. However, the positive impact on CHWs' wellbeing was undermined by the predominance of negative effects on the cadre's physical, psychological, economic, and social wellness. Only one participant reported some positive impact on their physical wellness as a result of working as a CHW while other participants alluded to their physical and psychological health being negatively impacted by some of the working conditions and social interactions encountered with patients. The negative trend of CHWs being impacted as health caregivers continued to be felt by cadres at the economic level. Even though one participant offered ways in which CHWs could maximize their stipend to better themselves, however, being remunerated with a stipend was undesirable for most participants since it unfavourably affected their life experience along with their sense of prosperity and personal achievement. Cadres felt dissatisfied with being remunerated with a stipend because the amount was little, and these sentiments were also echoed by their managers. Who lamented that cadres were poorly compensated and CHWs were left feeling demotivated by the stipend payment which affected how they served in the community and resulted in some CHWs quitting their job. There were some changes regarding CHWs' social wellness as cadres predominately expressed positive outcomes. For example, cadres experienced some form of personal achievements or positive changes in their lives which influenced their general experience of life and fostered in them the significance of being health caregivers. Cadres viewed being a CHW as having provided them with a start in life while some felt that it provided them with an opportunity to discover and pursue other passions and careers in the field of health as well as help them to adopt positive health and behaviour changes.

Considering the findings of the study as well as its limitations, the study offers the following recommendations. Firstly, the selection of a bigger sample size from more NGOs is recommended for future studies as this may yield better results and offer better representation including the possibility of generalization. Considering that organizations facilitate different Community Health Work projects, future research could do better by looking at the experiences of CHWs as per programme within NGOs. Findings also showed that each CHWs programme differed and involved separate funders or stakeholders who presented with their requirements and contracting conditions. Therefore, studies are required in the NGO sector that would focus on the role and impact of the stakeholders and funders involved in the functioning of these programmes. While

further inquiring about the stance and responsibilities of these stakeholders or funders regarding the establishment and implementation of CHWs policy. Finally, the issue of WBPHCOTs policy concerning CHWs programmes funded by DOH within NGOs remains inadequately captured in literature. Future studies could do better by elaborately exploring this subject matter, especially amongst NGOs that are solely focused on Community Health Work programmes mandated by NDOH.

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