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# Exploring the relationship between nurses and community health workers and the perceived impact on service delivery in Lesedi Sub-District

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# Exploring the relationship between nurses and community health workers and the perceived impact on service delivery in Lesedi Sub-District

**By**

**ALETTA MOLOBANE NTLATLENG**

**A mini dissertation**

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Secondary Supervisor: Professor Frances Griffiths

**CANDIDATE'S DECLARATION**

I, Aletta Molobane Ntlatleng (student number: 2079729), understand and declare that I'm aware of the Witwatersrand University plagiarism policy.

I declare that the mini dissertation "EXPLORING THE RELATIONSHIP BETWEEN NURSES AND COMMUNITY HEALTH WORKERS AND THE PERCEIVED IMPACT ON SERVICE DELIVERY IN LESEDI SUB-DISTRICT" is submitted to the University of Witwatersrand for master's in public health, and this work has never been submitted by me or anyone before.

I have fully acknowledged and referenced all the work that I took from other authors (articles, internet, books, audios etc.). I will not permit anyone to use my work with an intention to present it as their own. Ethics was approved by Witwatersrand Research Health Ethic Committee.

Aletta Molobane Ntlatleng



**Signature:**

Date: 25/09/25

DEDICATION

This work is dedicated to my grandfather, grandmother and my aunt (Moshidi) whose compassion has laid a foundation for all the success I carry today, I will forever be grateful.

To my grandfather, Moremi Wilson Nkoane, may your soul continue to rest in peace (1935-2005), You were a fountain of love, your daily morning routines has taught me to be a better parent, you laid a foundation that koko continued, thank you Matlala-Nkoane! Robala ka Khotso

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I would like to thank God and for His protection, shielding and wisdom to complete this work.

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To the School of Public Health lecturers at University of Witwatersrand University, thank you for your motivation and choosing me as one of your students.

**ABSTRACT**

BACKGROUND:

In the low- and middle-income countries, community health workers (CHWs) play a key role in providing primary health care services, particularly in resources constrained settings. The CHWs bridge a gap between the community and the health care facilities, by bringing healthcare directly into the homes of individuals. They are vital in contributing to the management of non-communicable and communicable diseases through disease prevention and health promotion campaigns, following up and collecting medication for patients. Despite this, there are challenges experienced by the CHWs programmes. These challenges include lack of working tools, poor supervision and relationship with the healthcare systems and community structures. The aim of the research was to examine the relationship dynamics experienced by CHWs with the other health care facility staff, particularly the primary care nurses, and the possible perceived impact on patients care which forms part of difficulties in integrating CHWs within the health care system. The study was underpinned by the theoretical framework of Interprofessional Health Collaboration (IPHC), which emphasizes effective communication, teamwork, and shared responsibilities across professional boundaries.

**METHODS:**

This study is a secondary analysis of qualitative data collected as part of Batlhokomedi Project. The project studied the implementation of the national CHWs program in six primary healthcare (PHC) facilities in Sedibeng district of Gauteng Province. The Batlhokomedi project sample was made of CHWs, supervisors, clients, facility staff members and community representatives. The current analysis is from focus group discussions (FGD) and individual interviews from two clinic's participants (Clinic A and Clinic B). The clinics were selected purposely because of their geographical location. Using thematic analysis method, 6 FGDs from CHWs (Clinic A and B), 1 interview from the facility manager (professional nurse, Clinic A), 2 interview transcripts from team leaders (assistant nurses, Clinic A and B) and 1 interview from the health promoter (Clinic A) were analyzed.

**RESULTS:**

The study found that inter-professional communication within WBOTs, including reporting and referral systems, was functional but inconsistent. CHWs submitted regular reports and referrals, yet delays in feedback limited timely decision-making and coordination of patient care, which in turn affected patients' access to appropriate and continuous care. Appreciation and recognition from clinic staff and higher-level stakeholders were infrequent, leaving CHWs feeling undervalued, which negatively influenced their motivation and engagement, ultimately impacting the quality of care delivered to patients. Team functioning varied: one team demonstrated effective planning, coordination, and knowledge sharing, which supported smoother task execution, strengthened collaboration, and improved patient follow-up. In contrast, the other team experienced poor planning, role confusion, and low morale, creating gaps in service delivery and potentially undermining patient trust in the healthcare system. Collaborative leadership differed across hierarchical levels: co-worker support was generally strong, supervisor support varied between teams, and clinic staff support was limited. Conflicts arose over resources, uniforms, and perceived power dynamics, reflecting systemic tensions that affected team cohesion and the ability to deliver coordinated care. Overall, these findings highlight variability in team performance, communication, and support mechanisms within the WBOT program, with direct implications for patient care and the quality of relationships within the healthcare team.

**CONCLUSIONS**

The CHWs within the Ward based outreach teams (WBOT) experience several challenges which affect their relational encounter with clinic staff. The negative relational dynamics forms a larger systemic challenge within the WBOT. The systemic challenges which affect service delivery. Hence, affecting the integration of CHWs within the CHWs program, translating into challenges with service delivery model.

**RECOMMENDATIONS**

To strengthen CHW integration and improve health outcomes, a collaborative effort among stakeholders is needed. This includes revising policy frameworks to enhance interprofessional collaboration, ensuring adequate resources and infrastructure support, providing continuous

training, and leveraging digital technologies within CHW programmes. Embracing the principles of Interprofessional Health Collaboration is key to enabling CHWs to function effectively within the broader health system.

KEY WORDS: Community Health Workers, Ward-Based Outreach Teams,

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**ABBREVIATIONS**

CHWs: Community Health Workers

DOH: Department of Health

GDP: Gross Domestic Product

HCS: Health Care Staff

HIV: Human Immune deficiency Virus

NDP: National Development Plan

NCDs: Non-Communicable Diseases

PHC: Primary Health Care

SA: South Africa

UHC: Universal Health Care

WBOT: Ward-Based Outreach Teams

WHO: World Health Organization

## DEFINITIONS

CHWs: Community Health Workers - Community Health Workers (CHWs) are frontline public health workers who are trusted members of the communities they serve. They act as a bridge between the community and the formal healthcare system by providing culturally appropriate health education, basic preventive and promotive care, and by facilitating access to health and social services.

WBOT: Ward-Based Outreach Teams- Ward-Based Outreach Teams (WBOTs) are a key component of South Africa's Primary Health Care (PHC) re-engineering strategy, introduced to strengthen community-level healthcare delivery. Each WBOT is typically composed of a team, usually a professional or enrolled nurse, and a group of Community Health Workers (CHWs), supported by other healthcare professionals as needed.

Inter-professional Health Collaboration (IPHC)-Inter-professional Health Collaboration (IPHC) refers to the process by which multiple health workers from different professional backgrounds work together with patients, families, communities, and each other to deliver the highest quality of care. This collaboration involves shared decision-making, open communication, mutual respect, and clearly defined roles and responsibilities.

Cadres: A group of specialized individuals trained to work in a specific field or profession.

# CHAPTER 1: INTRODUCTION, RESEARCH AIMS AND LITERATURE REVIEW

## 1.1 Introduction to the chapter

This chapter provides a comprehensive overview of the study that explores the perceived relationships between Community Health Workers (CHWs) and clinic staff, and how these relationships influence the effectiveness of services delivered through the Ward-Based Outreach Team (WBOT) program in the Lesedi sub-district of the Sedibeng district, South Africa. The chapter begins with a general introduction and background to the WBOT initiative and the roles of CHWs. The chapter further outlines the study's aims and objectives, followed by a detailed rationale that justifies the importance of exploring inter-professional collaboration at the community level. A review of existing literature is presented to highlight current knowledge, gaps, and theoretical perspectives relevant to Inter-professional Health Collaboration (IPHC) in community health settings. The chapter concludes by summarizing the key insights and setting the foundation for the research methodology described in the next chapter.

## 1.2 Introduction

According to WHO (2018), healthcare delivery models around the globe should be community-based, incorporating the contributions of primary, specialized, and social care organizations. CHWs programs are symbolic of community-based interventions because they are predominantly structured to function within the impoverished communities to lessen the burden of disease and supplement health care workforce (Christopher et al., 2011; Assegaai and Schneider, 2019a). Gaziano, et al (2015) argue that CHWs are essential in task shifting in the context of PHC facilities, this is deemed as a vital strategy since there is inadequate workforce. CHWs are selected forefront ancillary workers in the health care system, and they are trained to provide PHC, particularly working within communities from which they are drawn (Languza et al., 2011; Nxumalo et al., 2016). However, while in the past CHWs only had a limited scope of practice, in the current times their responsibilities are broadening in relation to comprehensive health care provision (Christopher et al., 2011). The responsibilities of CHWs have and continue to progress over the years (Thomas et al., 2021). These responsibilities require CHWs to perform their duties within Primary health Care (PHC) alongside a variety of health care professionals. Hence the objective

of this study is to determine some of the relational dynamics that occur within CHWs and clinic staff. This research can add to broader understanding of how the CHWs are integrated and treated within PHC.

### 1.3 Background

On a global scale, most countries utilize the CHWs workforce since it is a cost-effective strategy that governments use to reduce disease burdens and address the shortage of health workers (Johnson et al., 2022; Huang et al., 2018). The World Health Organization (WHO) indicated that 41 million individuals lose their lives prematurely due to non-communicable diseases (NCDs) each year (WHO, 2021). This number will continue to grow if these diseases are not prevented and treated, particularly in developing countries (Boutayeb, 2010). According to WHO (2021), 77% of these diseases occur in low-middle-income countries. Additionally, Boutayeb (2010) indicated that communicable diseases such as HIV/AIDS, Tuberculosis (TB), Malaria, and acute respiratory infection are killing an estimate of 12 million individuals per year in developing countries. These countries also lack resources such as a workforce to deal with their healthcare needs (Johnson et al., 2022). Moreover, Gross Domestic Product (GDP) per capita on health expenditure is lower in low-middle-income countries (LMIC) than in developed countries (Ke et al., 2011). Most of the population living in these countries suffer from poverty and are unable to afford health care needs as required (WHO, 2017).

Hence, Saksena, et al., (2014) maintain that LMIC need to implement strategies that focus on improving quality, efficiency, and equity of health care, treating patients with an aim to minimize medical costs. These strategies are more directed towards limiting financial hardship to poor communities (Saksena et al., 2014). Universal Health Coverage (UHC) is a program that encourages such strategies, particularly for LMIC. A program that insists on provision of quality health care according to the population needs, at the lowest cost possible (Saksena et al., 2014). Despite that, WHO highlighted that there is no single program to fit all countries, as programs should be tailored according to the context and population needs (WHO, 2007). Conversely, in the year 2018 the WHO encouraged countries to prioritize preventative and promotive health care in combating disease burden, strategies widely noted to have minimal costs implications for LMIC (WHO et al., 2018). In this plight, scaling up CHWs programs in sub-Saharan countries is vital to

decrease the burden of diseases and minimize the cost of health care (Singh and Sachs, 2013). Subsequently, the CHW frameworks are within the targeted strategies to achieve universal health care at the lowest cost.

As a result, the South-Africa (SA) government between the years 2010- 2011 introduced the Ward-Based Outreach Teams (WBOT) as a strategy to re-engineer primary health care (PHC) (Thomas et al., 2021). The WBOT teams are responsible to screen, counsel, educate, follow-up and prevent diseases in the communities (Thomas et al., 2021). Yet, research indicates that these programs are tainted by various challenges (Tseng et al., 2019). These challenges may have an impact on how WBOT performs on their daily task's competencies. Also, challenges may impact on the relationships the team members have with each other within the context of work, resulting in possible poor patient outcomes (Reeves et al., 2017). Hence, this study explored collaborative relationships between CHWs and clinic staff within the challenged context of the WBOT whereby poor service delivery and teams led by junior supervisors exist. The knowledge and understanding of these teams can add to the value of how can CHWs work with other cadres and what support is needed to deliver effective WBOT for better patient outcomes within these challenges.

### 1.4 Research question

How do CHWs and clinic staff collaborate within the WBOT and what is the perceived impact on service delivery?

### 1.5 Overall aim

To explore how the enrolled nurses and CHWs perceive their relationships and the perceived impact on the services provided by CHWs in the WBOT programs at the Sedibeng district: Lesedi sub-district.

## 1.6 Objectives

1. To describe from the enrolled nurses' and CHWs' perspectives the relationships within the WBOT teams, what influences them, and their impact on services using the IPHC framework.
2. To compare enrolled nurses' and CHWs' perspectives for commonality and differences in how they perceive the relationship.
3. To explore why these commonalities and differences exist.

## 1.7 Study Rationale

The Ward-Based Outreach Team (WBOT) program is a critical component of South Africa's primary healthcare re-engineering strategy, designed to extend health services to communities through a team-based approach. Within this framework, Community Health Workers (CHWs) and enrolled nurses collaborate to deliver a broad range of preventive, promotive, and basic curative services. However, the success of this collaborative model depends heavily on the quality of the working relationships between CHWs and enrolled nurses.

In practice, the dynamics between these two cadres may be shaped by a variety of factors including role clarity, communication, mutual respect, and institutional support. Limited evidence exists on how these professionals perceive their working relationships and how these perceptions influence the effectiveness and quality of services delivered under the WBOT program.

In the Sedibeng district, and particularly the Lesedi sub-district, understanding these interpersonal and professional dynamics is essential to improving health outcomes at the community level. This study aims to fill the knowledge gap by exploring how enrolled nurses and CHWs perceive their working relationships and the perceived impact of these relationships on service delivery. The findings can inform policy and operational improvements, support better team cohesion, and ultimately enhance the delivery of community-based health services.

By providing insight into relational dynamics in the WBOT context, the study will contribute to strengthening South Africa's broader primary healthcare strategy and ensuring that CHWs are effectively supported in their roles.

## 1.8 Literature review

There has been extensive research regarding the CHW frameworks and their function within the mechanism of health care delivery. Although there is a wide range of literature this review will closely focus on burden of disease in SA, framework of CHWs, relationships within the workplace CHW within challenges healthcare system, relationship with health care workers, CHWs post COVID-19

### 1.8.1 Burden of disease in South Africa

South Africa, paralleling other countries in the sub-Saharan region, faces a significant burden of disease. This challenge is underscored by the Parliamentary Monitoring Group, which notes the prevalence of a wide range of diseases impacting the population (Parliamentary Monitoring Group, 2016). This prevalence is graphically represented in Figure 1 which Roser, et al. (2021) utilized to demonstrate the distribution of disease burdens across different global regions, highlighting the disproportionate impact on areas like South Africa. Particularly, Figure 2, also derived from Roser, et al. (2021), reveals that non-communicable diseases (NCDss) and communicable diseases (CDs) constitute over 80% of the total disease case load within the South African healthcare system. This burden includes a complex mix of health challenges, such as HIV/AIDS, Tuberculosis, various NCDss, injury-related health issues, and diseases stemming from nutritional deficiencies (Parliamentary Monitoring Group, 2016). These health challenges are not evenly distributed across the population; for instance, HIV and AIDS, combined with Sexually Transmitted Infections (STIs), affect an estimated 7.9 million people, a significant portion of the country's populace (Roser et al., 2021).

Vos, et al. (2020) provide a critical insight into this global health crisis by noting that many of these diseases are largely preventable. However, the capacity for effective disease management is

hindered by the constrained resources within the public health system in South Africa, as highlighted by Maphumulo and Bhengu (2019). This constraint necessitates innovative and cost-effective healthcare strategies (Vos et al., 2020). In response to these challenges, the South African government has implemented primary health care (PHC) strategies aimed at broadening disease awareness and prevention. These strategies, as Tseng, et al. (2019) point out, are particularly geared towards serving low socio-economic communities, where the burden of disease is often the heaviest, and it was highlighted in this study the significance using CHWs as one of the progressive strategies within South Africa. Also, central to these strategies is the document of National Development Plan (NDP) 2030, which Jager, et al. (2012) describe as a governmental initiative to promote equitable and efficient healthcare distribution and to foster community-based care.

An example of these efforts is the WBOT program, developed within the framework of the NDP. This program, as it integrates CHWs into the broader health system and other societal sectors, represents a concerted effort to address the multiplicity of health challenges faced by South Africans, particularly those stemming from the quadruple burden of disease. The WBOT program, therefore, stands as a testament to the government's commitment to enhancing healthcare delivery through innovative and community-centric approaches (Jager et al., 2012).

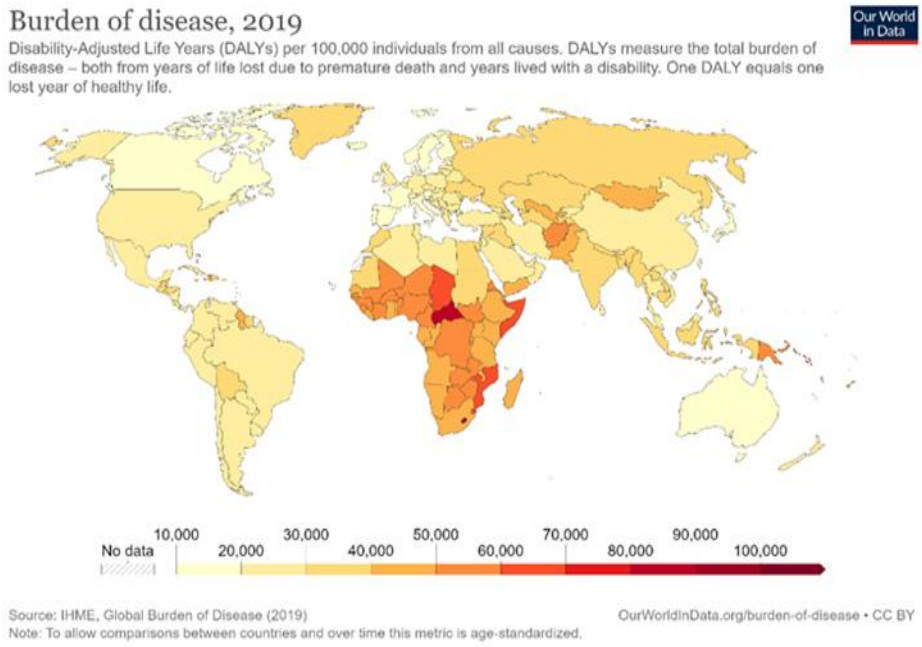


*Figure 1 Distribution of disease burden according to the world regions* (Roser et al., 2021).

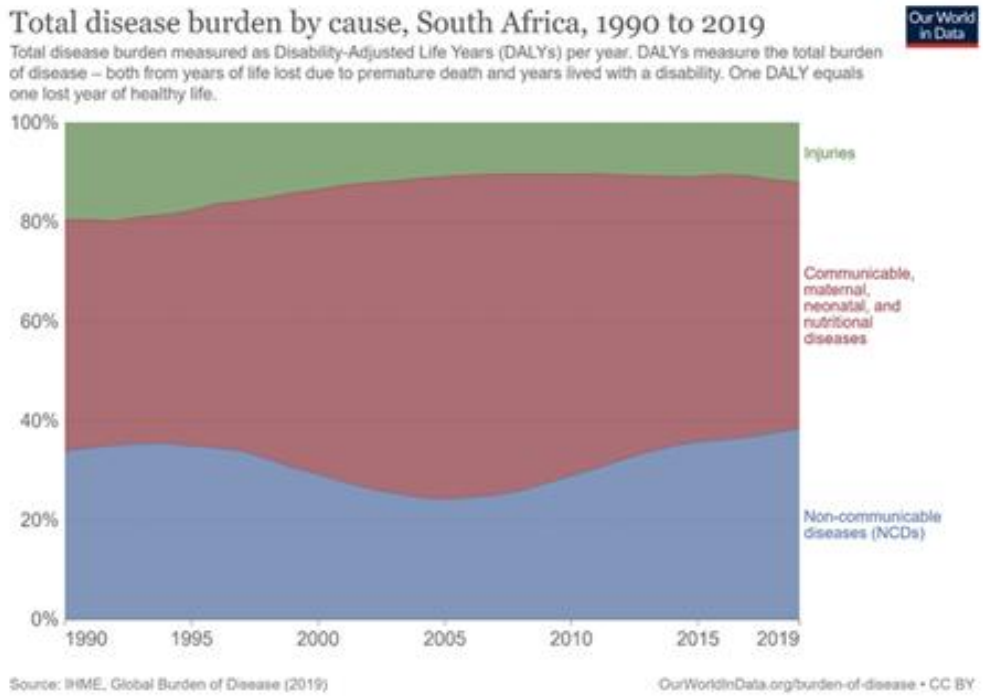



*Figure 2 South African Burden of disease* (Roser et al., 2021)

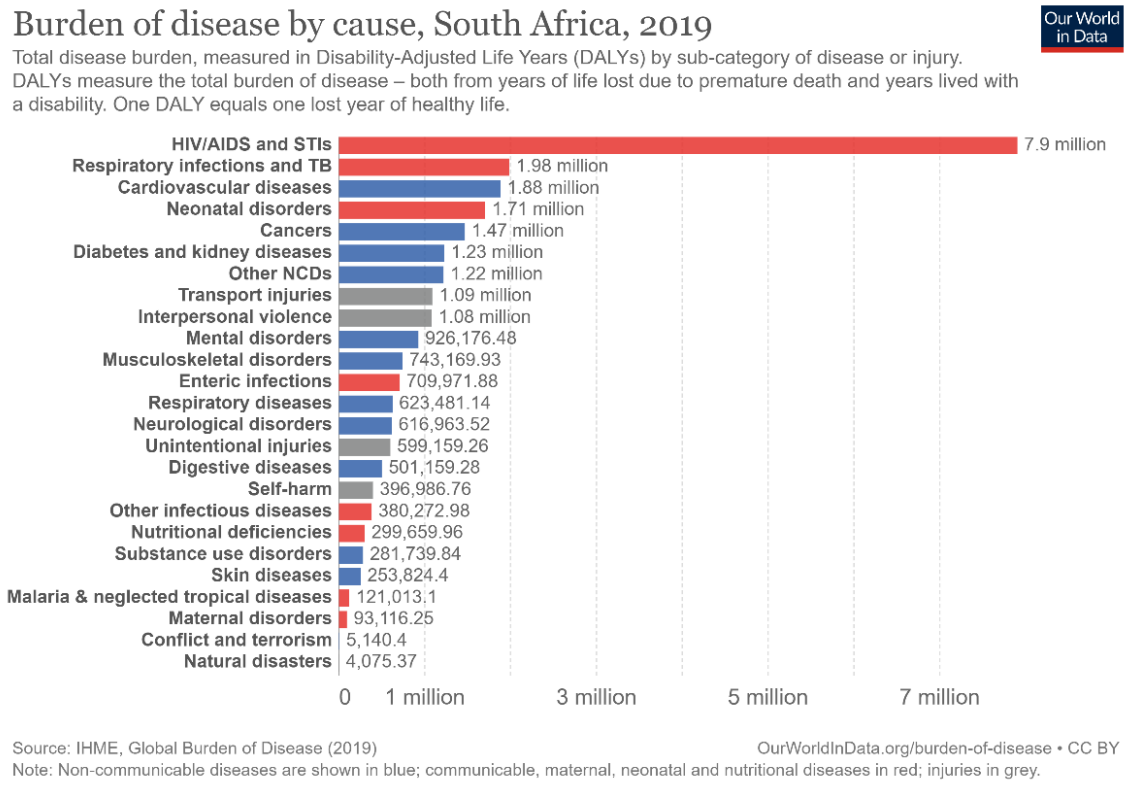



*Figure 3 Burden of disease by cause in South Africa (Vos et al., 2020)*

### 1.8.2 Global comparisons and implications for South Africa

In the realm of global health, the burden of disease and the role of community health workers (CHWs) present a diverse picture, particularly when comparing countries with similar socio-economic profiles to South Africa. This comparison is not only a tool for understanding the nuances of healthcare challenges but also serves as a gateway to exploring effective strategies and models that have been successful in different parts of the world.

The burden of disease in developing countries, as elucidated by Boutayeb (2010) in a global study zooms into developing countries, is characterized by a double burden of communicable and non-communicable diseases. South Africa, like many other developing countries, faces this dual challenge. The country grapples with infectious diseases such as HIV/AIDS and tuberculosis, as well as a rising tide of non-communicable diseases like hypertension and diabetes. This situation is mirrored in other nations with similar socio-economic conditions, where limited resources, socio-economic disparities, and varying health infrastructure compound the health crisis.

The role of CHWs in mitigating this burden is pivotal. In sub-Saharan Africa study, as detailed by Christopher et al. (2011), CHWs have been instrumental in delivering curative interventions against diseases such as malaria, pneumonia, and diarrhea, significantly impacting child mortality and morbidity. South Africa's approach to integrating CHWs into its healthcare system can glean valuable insights from these successes. The systematic use of CHWs in disease-specific interventions in other sub-Saharan countries demonstrates the potential for similar models to be adapted and applied within the South African context.

Furthermore, the comparative analysis reveals the significance of interprofessional collaboration in enhancing the effectiveness of CHWs. The Canadian Interprofessional Health Collaborative (CIHC) framework, as described by McGill University (2021), provides a comprehensive structure for such collaboration. This framework, with its emphasis on collaborative practice and patient-centered care, could serve as a model for enhancing the role of CHWs in South Africa. It highlights the need for integrating CHWs into the broader health team, ensuring that their contributions are valued and their potential fully realized.

Strengthening CHWS programmes is essential to improving primary healthcare delivery, particularly in underserved areas. Key areas for improvement include comprehensive training, consistent supervisory support, and the effective integration of CHWs into formal health systems to ensure continuity and quality of care (Perry et al., 2013; WHO, 2018). Drawing from global examples, it becomes evident that successful CHW programs are those that are well-supported and adequately integrated into the health system. South Africa can benefit from adopting similar strategies, focusing on enhancing the capacity, reach, and impact of its CHWs.

Franklin et al. (2015) underscores the importance of interprofessional teamwork and collaboration between CHWs and healthcare teams. This integrative review suggests that effective teamwork can improve service delivery and patient care outcomes. By comparing South Africa’s healthcare structure with countries where CHWs are effectively integrated into health teams, it becomes clear that fostering a collaborative environment is crucial for maximizing the impact of CHWs.

### 1.8.3 Community health workers

CHWs programs utilize a mixture of service delivery methods such as outreach programs, screening, educating, home visits, and delivering medication to sustain PHC services (Thomas et al. 2021; Nxumalo et al. 2016; Languza et al. 2011). CHWs are also responsible for following up on patients who have been identified by healthcare staff at the their respective clinics, which facilitates the process of preventing patients from losing their follow-ups (Kok et al., 2015). In spite of the many responsibilities CHWs have within their communities, in Figure 3 Austin-Evelyn et al (2017) highlighted not only CHWs responsibilities but other sectors collaborating with CHWs.

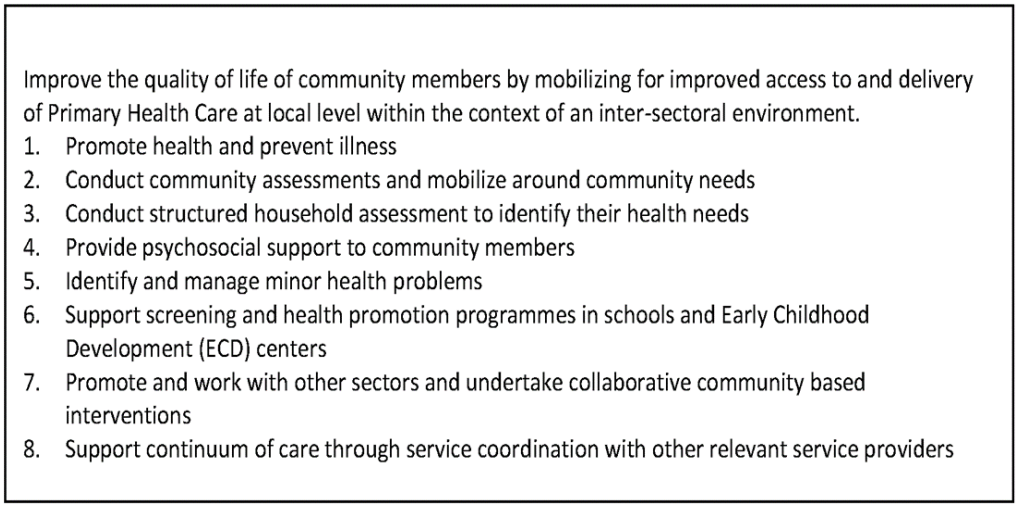



*Figure 3 Scope of CHW* (Austin-Evelyn et al., 2017)

Globally, CHWs act as vital conduits between communities along with its supporting sectors and the health care system (Cometto et al., 2018). As expected, CHWs are anticipated to perform this broad scope within a functioning health system with existing professionally trained workforce. However, integrating CHWs programs within these conditions has been difficult because of the challenges such as poor supervision, poor remuneration, poor working conditions, poor resources, and lack of regular working space to name but a few (Malatji et al., 2019).

### 1.8.4 Challenges of integrating CHWs programs into the health care system.

CHWs in South Africa need to be integrated into health systems because their services close an existing gap within the health care system (Nxumalo et al., 2016). Moreover, Mofolo, et al. (2019) suggest that there are good efforts to incorporate CHWs into the health system and other community structures. Despite this, integrating CHWs into SA communities has been challenging (Jobson et al., 2020). Kok, et al. (2015) noted that, for CHWs programs to function commendably, health systems need a clearly defined hierarchical structure that links the CHWs with their respective communities and PHC multidisciplinary teams, this study was done in multiple low- and middle-income countries across Africa and Asia. Also, Schneider and Lehmann (2016) recommends that CHWs programs need to be integrated into community systems that include stakeholders such as political structures and social development organizations. This will ensure that implementation of CHWs programs are recognized by the community at social and political levels. The process to integrate CHWs should be considered relative to health care staff (HCS) roles and the general structure of the health system within South Africa (Schneider and Lehmann, 2016). For the program to function efficiently, the responsibilities of HCS and CHWs need to be clearly defined within the program (Franklin et al., 2015). Moreover, Foronda, et al. (2016) maintain that CHWs ought to work under supervision for optimal performance. On the other hand, in the SA setting, the supervisory relationship has been noted to have its challenges (Tseng et al., 2019). These challenges may be caused by different contextual circumstances and can vary according to different sources. However, in their research Kok, et al (2015) argues that the top-down approach to supervising CHWs greatly impacts on working relations between nurses and CHWs. Based on this, Ludwick, et al. (2018) did a study in Uganda and recommended that formal open communication channels be encouraged within CHWs programs. Therefore, supervisors should support CHWs in supervision and training to enhance program objectives in a consultative and collaborative manner for optimal team performance (Franklin et al., 2015). Ludwick, et al. (2018) note the importance of CHWs collaborating with health clinics staff as a vital strategy and that excluding CHWs from major activities of the clinic may result in CHWs job dissatisfaction. Furthermore, Kok, et al (2015) opine that integration can improve service delivery systems. The integration of CHWs into the health care system has been described to result in tense and maladaptive relationship dynamics with the nursing staff (Assegaai and Schneider, 2019a; Tulenko

et al., 2013). Challenges such as these, however, may reflect the need to support CHWs programs rather unsolvable phenomenon (Christopher et al., 2011); (Schneider and Lehmann, 2016). Assegaai and Schneider, (2019b) highlight the seriousness of addressing these challenges from a systemic perspective. A systemic perspective will ensure a comprehensive approach to the planning and design of programs. Additionally, evidence-based practices should guide the CHWs integration into the health system, therefore researched solutions should be utilized to tackle existing challenges (Escajeda, 2016).

It is important to examine whether nurses receive adequate support and training on how to supervise and collaborate with CHWs, and whether this responsibility is embedded within their professional identity or treated as an additional, informal task. In many low- and middle-income countries (LMICs), including South Africa, the supervision of CHWs under programmes like the WBOT is often assigned without formalized training or systemic support, resulting in inconsistent implementation and strained interprofessional relationships (Schneider and Lehmann, 2016; Kok et al., 2015).

In contrast, several other countries have taken deliberate steps to institutionalize nurse-CHW collaboration through structured training and integration. For instance, Ethiopia's Health Extension Program includes a defined role for nurses in mentoring and supervising health extension workers, supported by government-led training frameworks (Perry et al., 2014). Similarly, in Brazil's Family Health Strategy, nurses are trained as team coordinators, working alongside CHWs in multidisciplinary teams with clearly defined supervisory and collaborative roles (Perry et al., 2014). India's ASHA program also incorporates structured supervisory mechanisms where Auxiliary Nurse Midwives (ANMs) receive orientation on managing CHW interactions, though implementation varies across states (Scott, George and Ved, 2019).

These examples show that when supervision and collaboration with CHWs are integrated into nursing education, job descriptions, and institutional policy, the relationship becomes more effective, sustainable, and professionally recognized. This highlights the need for clearer training pathways, policy support, and role definition in contexts like South Africa, where the success of CHW programmes depends heavily on strong facility-level leadership and interprofessional collaboration (Schneider and Lehmann, 2016; Kok et al., 2015).

### 1.8.5 Collaboration Relationship within health care

#### *1.8.5.1 Nurses and CHWs roles in collaboration relationships*

The primary role of a nurse in a health care collaboration team is vital but with ever evolving patients' needs, there are challenges continuously emerging within the context of nurses collaborating with other professionals as highlighted in a study in United States (Clarke and Hassmiller, 2013). Generally, nurses are aware of their scope of practice, but they are meet with identity crisis when faced with interprofessional collaboration (Clarke and Hassmiller, 2013). Nurses directly work with various health care workers, facilitating several roles depending on the setting. Hence, the interprofessional role of nurses in the evolution of healthcare education and practice environments is challenged by being expected to portray many differing roles as stipulated in the study done in Canada (Sommerfeldt, 2013). In retrospect, nurses are an integral part of the health workforce, they are critical in working with other professionals in these collaboration relationships (Clarke and Hassmiller, 2013). In addition, Wong, et al. (2013) in their systematic review in Canada suggested that nursing staff are the leaders in health care and can foster an environment that encourages collaboration, ultimately resulting in better outcomes for patients. Considering this, nurses should be given opportunities to play a leading role in fostering a culture of collaboration for the planning, organizing and encouraging decision making in health care systems. Also, these opportunities are necessitated as the health-care system needs a window to grow its collaboration opportunities among health care providers (Hassmiller and Combes, 2012). Emphasizing earlier statements, nurses need to collaborate with CHWs within the CHWs programs to improve service delivery in the PHC settings. Moreover, they need to assume a leadership role as they are professionally trained compared to the CHWs. In that case, nurses should provide a collaborative relationship to CHWs that generate culture of mentoring, advocating, skills transferring, consultations, communication, and other principles of inter-professional interdependency (Christopher et al, 2011;Foronda et al, 2016); Assegaai and Schneider, 2019a). Nonetheless, this should not be seen as superficial task from the nurse's perspective, as it requires formal understanding of their field in relation to those of CHWs (Fawcett, 2012).

*1.8.5.2 Relationships between CHWs and nurses within the WBOT*

As expected, the South African WBOT programmes are designed to function under the supervision and guidance of trained nurses (Assegaai and Schneider, 2019a). Hence, a working collaborative and consultative relationship between the two cadres is anticipated. Also, because nurses are formally trained, supervision is seen as a key priority for CHWs program (Assegaai and Schneider, 2019b; Malatji et al., 2019). The relationship between the two cadres is crucial for training, developing, and motivating CHWs particularly in countries with low-middle income socio-economic status (Tseng et al., 2019; Kok et al., 2015); Assegaai and Schneider, 2019a). Positive supervision is seen as a key priority for the WBOT programs to function effectively (Tseng et al., 2019). However, the interactions between CHWs and nurses are not the most harmonious in the WBOT programmes, particularly with enrolled nurses (due to limited training) compared to professional nurses (Ngcobo & Rossouw, 2020; Tseng et al., 2019; Assegaai and Schneider, 2019a). The interaction challenges could be explained by studies and reports that highlighted how CHWs have been seen as ancillary individuals, rather than a full independent health system workforce over the years (Gilson et al., 1989; Lehmann and Sanders, 2007). Also, the ill-treatment of CHWs transpires across other cadres of the healthcare system, both in developed and undeveloped countries (Perry et al., 2013; Macdonald De Jong, 2015); Assegaai and Schneider, 2019a; Marcus et al., 2017). As a result of the collaboration relationship gaps, the programs tend to have relationship challenges that result in poor patient care across different countries (Perry et al., 2013; Thomas et al., 2021; Huang et al., 2018).

*1.8.5.3 In what ways do collaborations affect the outcomes of health care services?*

Globally, interventions that target better collaboration among health care workers have the potential to improve health outcomes (Reeves et al., 2017). In an earlier study done by Strasser, et al. (2008) a collaboration intervention group had better improvement in stroke patient's functional outcomes than the control group. Additionally, Schraeder, et al. (2001) in a quantitative study, indicated that collaborative model of care can reduce illnesses that causes mortality in the elderly population. Also, Martin, et al. (2010) outlined several studies that yielded positive health outcomes towards patients care in the primary health care settings. Conversely, recent studies suggest that collaboration has little, mixed or no results on health outcomes (Alderwick et al.,

2021). Nonetheless, health care in recent times has evolved and is provided within complex health care systems, with multiple factors affecting patient outcomes. Supper, et al. (2015) have shown that there are several barriers and facilitators to collaboration relationships which can impact on service delivery. Hence, one should take cognizance that these studies of service delivery in collaboration take place within different settings thus outcomes may differ. Even so, Alderwick, et al. (2021) highlights that there may be challenges to delivering, assessing, and valuing collaboration programs. Despite this, the consensus across literature suggests that collaboration relationships may result in better outcomes for health care services (Reeves et al., 2017).

*1.8.5.4 The influence of collaboration between health workers on the delivery of services*

According to WHO (2010) there are three significant mechanisms that contribute towards optimal health care service delivery. In Figure 5 an organization must receive institutional support from all levels of the institution, including micro and macro levels, in order to achieve its collaborative goals for better health care services (D'Amour and Oandasan, 2005). Inadequate intuitional support may lead to fragmentation of health care services (WHO, 2010). Lack of organizational support in health care collaboration was reported to have been one of the factors that contributed to poor mental health services (Steihaug et al., 2016). Equally important, the promoting of working culture mechanisms has been shown to contribute to evidence-based care, given the communication and decision-making processes that occur during interactions between health care providers (Reeves, 2011). Lastly, it has been shown that space design, facilities, and the built environment can play a significant role in enhancing or detracting from collaborative practice in an interprofessional clinic (WHO, 2010). Specifically, physical space should not reflect a hierarchy of positions. It may also be beneficial to create a shared space to facilitate communication such as organize rooms and spaces in a way that eliminates any barriers to successful collaboration (WHO, 2010)

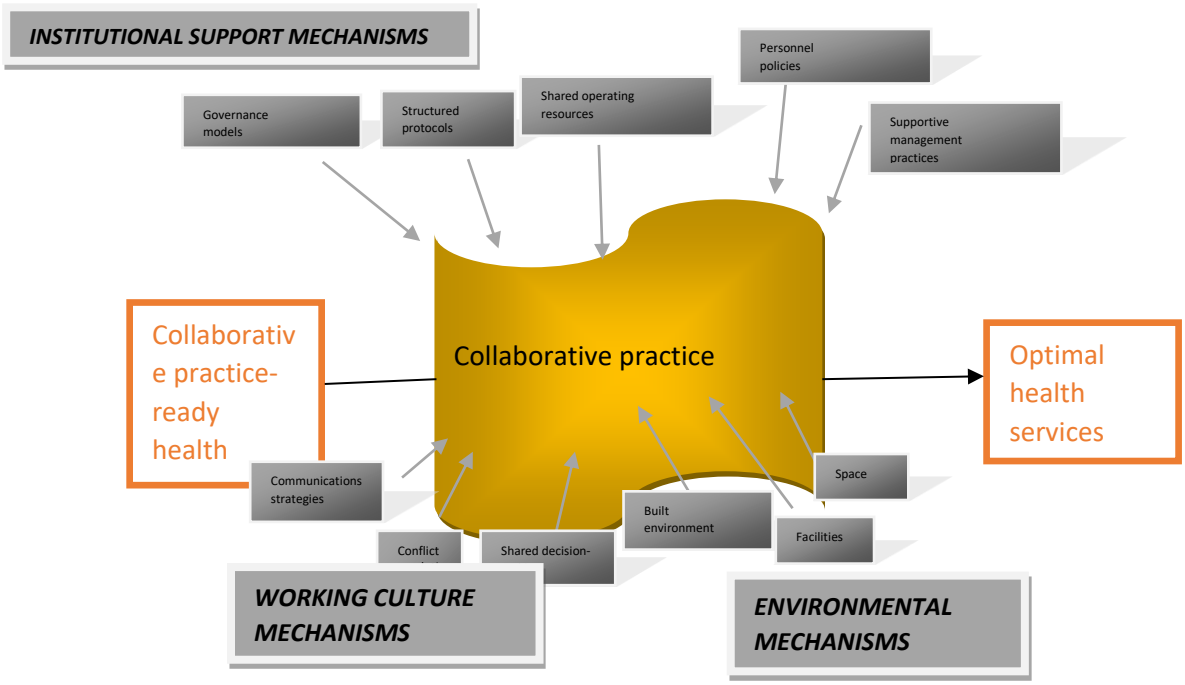



*Figure 4 Examples of mechanisms that shape collaboration at the practice level (WHO, 2010)*

### 1.9 Theoretical framework

This study is guided by Inter-professional Health Collaboration (IPHC)-developed in Canada- as a theoretical framework. The framework was selected by the researcher because it has relevant information regarding the research topic. Most relationship collaboration frameworks are used to assist health providers to work together for a common purpose (Green and Johnson, 2015). Collaborative practices are important in the provision of quality care to patients (Hepp et al., 2015). Furthermore, the framework was developed using existing evidence-based literature on how inter-professional relationships function in Canada (CIHC, 2010). This framework has been employed in the clinical, educational, and policy contexts (Macdonald De Jong, 2015). The framework profiles six competency domains: interpersonal communication, role clarification, team functioning, collaborative leadership, inter-professional conflict, and patient/community-centered care (CIHC, 2010). While this research focused on key elements of interprofessional collaboration

namely interpersonal communication, team functioning, collaborative leadership, and interprofessional conflict it is important to note that the data did not yield sufficient insights related to 'role clarification,' which is a core component of the Interprofessional Collaborative Practice Framework. This limitation may be due to the nature of the data pool, which did not explicitly explore participants' understanding or negotiation of roles within the CHW-clinic staff dynamic.

### 1.9.1 Communication

The first domain is the shared communication process between the individuals who provide the service to the patient (CIHC, 2010). Foronda et al. (2016) provide an integrative review of interprofessional communication in healthcare, shedding light on the various dimensions and challenges of this critical aspect of healthcare delivery. Their review indicates that while there is a consensus on the importance of effective communication, the implementation of strategies to enhance this remains a challenge. This gap is particularly evident in high-pressure environments, where the need for quick, clear, and accurate communication is often combined with the stressful and dynamic nature of the setting. Franklin et al. (2015) extend this conversation by focusing on the role of community health workers (CHWs) in healthcare teams. Their integrative review underscores the need for effective teamwork and collaboration between CHWs and other healthcare professionals. In the context of delivery suite teams, the integration of CHWs can provide valuable insights into patient backgrounds and community-based health dynamics, which are essential for holistic patient care. However, the effectiveness of this integration hinges on the ability of the team to communicate effectively, respecting and incorporating the diverse perspectives that each member brings to the table.

#### *1.9.1.2 The role of communication within teams*

Communication should encompass teamwork, responsiveness, and a responsible approach. Shared communication should encourage information sharing, respect, mutual understanding, and listening skills (CIHC, 2010). In a study done by Hepp, et al. (2015) in acute care health settings, the authors indicated that communication can be improved by regular meetings, formal written documentation, and open verbal communication among HCS. On the contrary, a study by

Berridge, et al. (2010) show that success in communication depends on contextual factors such as working environment, thus can differ from setting to setting. Furthermore, the dynamics of communication within healthcare teams, particularly in health care teams, is a complex interplay of multidisciplinary interactions that require a nuanced understanding and strategic implementation. Also in the study they provide a comprehensive insight into this phenomenon by exploring communication in delivery teams through contrasting research observation approaches. Their study underscores the criticality of effective communication in high-stakes environments, where the efficiency of information exchange can significantly impact patient outcomes. The intricacy of communication in such settings is further complicated by the diverse backgrounds and expertise of the team members, each bringing a unique perspective and knowledge base to the collaborative process. In the realm of interprofessional collaboration in health care, Bosch and Mansell (2015) emphasize the importance of fostering an environment where open and efficient communication is paramount. Their work highlights the necessity of breaking down the silos that traditionally exist in healthcare settings, advocating for a more integrated and collaborative approach. This perspective aligns with the views of Clarke and Hassmiller (2013), who articulate the role of nursing leadership in promoting interprofessional education and practice. They argue that leadership in nursing goes beyond managing nursing staff; it involves creating a culture where collaborative practice is encouraged and facilitated. This notion is crucial in the context of PHC settings, where the seamless integration of various professional inputs is vital for effective patient care. Cornick, et al. (2018) contribute to this discussion by introducing the Practical Approach to Care Kit (PACK) guide, a tool designed to support clinical decision-making in primary healthcare. This tool exemplifies the practical application of structured communication strategies in healthcare settings. By standardizing and simplifying the communication process, the PACK guide aids healthcare professionals in navigating the complexities of patient care, ensuring that critical information is accurately conveyed and understood across the team. Such examples can be developed for CHWs programs to modify and simplify their communication with other clinicians.

### 1.9.2 Role clarification

The second domain, role clarification is where a person is conscious of their role and the role of others in the workplace (McGill University, 2021). CHWs need to understand their scope of practice and that of HCS to make proper referrals and provide services required to communities (Ludwick et al., 2018). In addition, HCS should know the roles of CHWs so that it is easier to continue service delivery (McGill University, 2021). The disparity in role clarification can result in conflict and poor patient care (Ludwick et al., 2018). Thus, collective team knowledge of multidisciplinary skills facilitates better patient care among healthcare professionals (Bosch and Mansell, 2015). Sherwen, et al (2007) suggest that HCS should be trained at higher institutions levels (as students) in terms of the roles of CHWs.

Nonetheless, a study done in Canada indicated that healthcare workers' understanding of their roles and others within the changing health care systems is critical in developing and maintaining functional collaborations (Hudson et al., 2017). Also a study done in America, indicated that it is important to note that roles change over time due to the evolutionary nature of diseases (Aiken, 2003). The changing of disease composition requires different health care staff from varied portfolio roles for multiple service packages (Sibbald et al., 2004; Cornick et al., 2018). Thus, as health care evolves and patient care requirements grow globally, parallel professional development and education must emphasize patient-centered teamwork approaches (Babiker et al., 2014). Earlier research studies also suggested that health care services were moving away from physician centered approach to tackling diseases (Aiken, 2003). Hence, observations from a universal review indicate that health care teams should move toward support and interdisciplinary care (Babiker et al., 2014). Interdisciplinarity encourages roles and responsibilities to be shared and teams to work together to promote health, prevent, and manage diseases (Aiken, 2003). Therefore, it is important that an individual understands the roles of others and can clearly articulate and perform theirs. Moreover, for the team to achieve its health service outcomes all the disciplines carry the responsibility of not only understanding their roles but those of others as highlighted in systematic review research done in England (Sibbald et al., 2004). Hence, the collaboration principle encourages team members to share skills and roles when needed (Bosch and Mansell, 2015). This form of role sharing is important to facilitate better working relationships, tackling diverse diseases

and alleviate burden to health workers who are overburdened by responsibilities such as nurses and doctors (Aiken, 2003; Babiker et al., 2014). However, exchanging roles should be done within teams where shared respect and respective roles are clearly defined (Christopher et al., 2011).

### 1.9.3 Team functioning

The third domain, team function domain highlights that collaboration is vital in planning, solving problems, and shared decision-making for the best outcomes of communities (CIHC, 2010). Due to the complexity of current community health needs, HCS must collaborate with all those involved in patient care. In a universal empirical study by Manser (2009), it was discovered that the perceptions and behaviors of HCS towards the team play a role in overall team effectiveness. Furthermore, teamwork has a direct impact on the patient's outcome (Manser, 2009). The HCS and CHWs consequently need to function as a team to deliver the best health outcomes to the communities.

### 1.9.4 Collaborative leadership

The fourth domain collaborative leadership highlights the importance of having leadership shared among all. This domain indicates that leadership is an interdependent phenomenon. HCS and CHWs should find ways to build collaborative leadership with CHWs (CIHC, 2010). Collaborative leadership is shared leadership. In a study by Ludwick et al (2018) the researchers demonstrated that shared leadership generates a sense of importance across all team members. However, Moseley (2018) argues that collaborative leadership extends far above just sharing leadership within an organization. In the article the author stipulates that collaborative leadership encompasses sharing of information freely, cross-functionality and interdisciplinary work, and decision-making transcend across all levels of the organization. “By collaborative leadership, we mean the process of engaging collective intelligence to deliver results across organizational boundaries when ordinary mechanisms of control are absent. It’s grounded in a belief that all of us together can be smarter, more creative, and more competent than any of us alone, especially when it comes to addressing the kinds of novel, complex, and multi-faceted problems that organizations face today” (Yukawa, 2022). This information aligns with earlier literature that

demonstrates that roles and responsibilities ought to be shared, hence even leadership roles are not to be excluded from that philosophy.

### 1.9.5 Conflict resolution

The Fifth domain, interpersonal conflict resolution is the essence of how well the team can handle conflict (McGill University, 2021). Conflicts are divergences that the team might experience upon working together. The team must be able to address these divergences constructively. The consonance of team members will determine how conflict is identified, mitigated, and resolved (CIHC, 2010).

### 1.9.6 Patient/Community-Centered

Lastly, the patient/community-centered care domain which identifies and acknowledges a patient as a full member of the team (CIHC, 2010). The framework highlights that patients are an integral part of the services that are provided. The HCS and the CHWs need to create opportunities to implement systems that engage and involve patients as shared decision-makers for optimal service delivery (Vestergaard and Nørgaard, 2018). The framework has been widely used to promote service delivery, build collaborative partnerships, and in higher institutions to prepare students to function better in multidisciplinary teams (McGill University, 2021; Bates et al., 2019; CIHC, 2010).

## 1.10 Other considerations

### 1.10.1 Cultural competency in CHW programs

Cultural competency within the CHW programs, particularly in a nation as culturally diverse as South Africa, holds paramount importance. Cultural diversity is described by Werner and DeSimone (2012, p.525) as “the existence of two or more persons from different cultural groups in any single group or organization”. While interpersonal cultural competency is defined as having an ability within the organization’s working relationships to achieve common goals, irrespective of individual cultural differences (Mobula et al., 2015). This aspect of healthcare delivery is often

underscored in the literature as a critical factor in the success of health interventions (Alderwick et al., 2021). In South Africa, the complexity of healthcare challenges is amplified not only by the burden of disease as outlined by Boutayeb (2010) but also by the intricate tapestry of cultural beliefs and practices that shape the population's approaches in the working environments (Swanepoel, 2015). CHWs must navigate these cultural nuances to effectively deliver health services. More importantly, health care staff with knowledge on cultural competency have a more positive outlook on the services provided by CHWs (Mobula et al., 2015). The importance of understanding and respecting these differences cannot be overstated, as they significantly influence the relationship of CHWs with other cadres. Thus, cultural differences within the CHWs stakeholders should be evaluated and addressed if there are challenges that hinder health care services.

Furthermore, the supervisory relationships and networks within which CHWs operate, as explored by Assegaai and Schneider (2019a), also need to be culturally competent. This extends beyond the CHWs themselves to include those who train, supervise, and work alongside them. The Inter-professional Health Collaboration framework developed in Canada CIHC (2010) emphasizes the importance of role clarification and team functioning within healthcare teams. Applying this framework in the South African context requires an appreciation of the cultural dynamics that influence these roles and functions. As CHWs interact with various healthcare professionals and community members, their ability to navigate cultural differences plays a critical role in team cohesion and the overall effectiveness of healthcare delivery.

Cornick et al. (2018) discuss the development of clinical decision support tools in primary healthcare, which underscores the need for these tools to be adaptable to different cultural contexts. This adaptability is crucial for CHWs who often serve as the first point of contact in the healthcare system. They must be equipped with knowledge and tools that are sensitive to the cultural specifics of the communities they serve. This is not a straightforward task, as noted by Clarke and Hassmiller (2013), who point out the evolving nature of healthcare roles and the necessity for interprofessional education and practice. For CHWs, this means continuous learning and adaptation to ensure that their practices remain relevant and respectful of the cultural diversity of their patients and colleagues.

### 1.10.2 Challenges and opportunities post-COVID-19 pandemic

The COVID-19 pandemic has radically transformed the global health landscape, introduced unprecedented challenges and created new opportunities, particularly in the realm of low-socio economic communities (Salve et al., 2023). This transformation necessitates a thorough examination of the shifting burden of disease and the evolving role of CHWs in response to the pandemic. The pandemic has necessitated a reevaluation of healthcare delivery models, with CHWs at the forefront of this transition (Goudge et al., 2020). The burden of disease in South Africa, already strained by communicable and non-communicable diseases, has been further complicated by the emergence of COVID-19, necessitating an agile and adaptive response from the healthcare sector.

CHWs in South Africa, who have traditionally played a vital role in bridging the gap between communities and the healthcare system, have found themselves navigating a new landscape of health challenges brought about by the pandemic (Lalla-Edward et al., 2022). The role of CHWs has expanded beyond traditional boundaries, encompassing not only the management of existing health conditions but also the response to COVID-19, including community education, contact tracing, and supporting vaccination efforts. This expanded role has presented both challenges and opportunities, reshaping the landscape of community health in significant ways. One of the primary challenges faced by CHWs in the wake of the pandemic has been the increased risk of exposure to the virus, coupled with the need for additional training and resources to safely carry out their duties (Salve et al., 2023). This challenge is compounded by the already existing resource constraints within the South African healthcare system, as outlined by Maphumulo and Bhengu (2019). CHWs have had to adapt rapidly to the evolving situation, often with limited resources and support, underscoring the need for robust systems of training and support for these critical healthcare workers.

Despite these challenges, the pandemic has also presented opportunities for innovation and growth in the CHW sector. As observed by Marcus, et al. (2017), the pandemic has highlighted the importance of CHWs in the healthcare system and has brought to the fore the need for integrated, community-based healthcare models. This recognition has the potential to drive increased investment in CHW programs, leading to better training, support, and integration of CHWs into

the broader healthcare system. The importance of interprofessional collaboration, as emphasized by Green and Johnson (2015), has never been more evident than post the COVID-19 pandemic. The need for coordinated, collaborative approaches to healthcare delivery, involving various healthcare professionals including CHWs, is critical in addressing the complex health challenges posed during pandemics. This collaborative approach is not only essential in managing the immediate crisis but also in building resilient healthcare systems capable of responding to future health emergencies.

The pandemic has also underscored the importance of effective teamwork in healthcare, as discussed by Manser (2009). The dynamic and rapidly evolving nature of the COVID-19 crisis requires healthcare teams, including CHWs, to work together efficiently and cohesively. This necessitates a focus on team training and development, as highlighted in the study by Strasser et al. (2008), which demonstrated the positive impact of team training on healthcare outcomes. Furthermore, the pandemic has highlighted the need for adaptable and flexible healthcare delivery models that can respond to changing health needs. As outlined by Supper et al. (2015), the barriers and facilitators to effective collaboration in healthcare need to be understood and addressed to ensure efficient and responsive healthcare delivery. The PACK guide developed by Cornick et al. (2018) provides an example of a tool that can support healthcare professionals, including CHWs, in adapting their practice to meet the evolving needs of their communities. It is important to note that this study draws pre-COVID-19 data, reflecting the dynamics of teamwork and communication in healthcare delivery prior to the global pandemic. While the context has evolved considerably since then, the findings remain highly relevant for informing post-COVID policy and practice.

### 1.11 Problem statement

In South Africa, the impact of CHW in the WBOT have shown to enhance overall patient care, especially those in remote areas and vulnerable groups (Murphy et al., 2021). However, WBOT still experiences challenges in operation and functioning, due to CHWs being poorly integrated within the PHC (Thomas et al., 2021; Tseng et al., 2019; Ngcobo & Rossouw, 2020). This further impacts on the CHWs' relationship with nurses, whom they are supposed to directly work with

(Tseng et al., 2019). The inter-dependence relationship between CHWs and nurses directly impacts service delivery (Malatji et al., 2019). Therefore, this relationship must always remain harmonious and beneficial, to enhance the efficiency of WBOT programs. Based on this, this proposed study seeks to explore the relationship between CHWs and enrolled nurses, and how this impacts WBOT programs. Lesedi- sub-district teams are among the teams that experience significant challenges due to supervision structure and the location of clinics (Malatji et al., 2019; Tseng et al., 2019). Hence, the Lesedi sub-district will be the focus of the proposed study. An understanding of relational dynamics can help to improve the outcomes of WBOT teams. As a result of understanding these dynamics, policies may be better geared toward resolving the problems associated with relationships in the WBOT programs.

## 1.12 Conclusion

In summary, this chapter has laid the foundation for understanding the critical role of inter-professional collaboration between enrolled nurses and Community Health Workers (CHWs) within the Ward-Based Outreach Team (WBOT) program, particularly in the Lesedi sub-district. By outlining the study's background, aims, objectives, and rationale, and by reviewing existing literature, the chapter has highlighted the significance of professional relationships in enhancing the quality and reach of primary health care services. The reviewed evidence emphasizes that effective teamwork, mutual respect, and role clarity are central to the success of community-based health interventions. These insights not only underscore the importance of the current research but also shape the questions and approach adopted in the subsequent chapter. The next chapter will present the research methodology, detailing how the study was designed and conducted to explore the perceptions and experiences of CHWs and enrolled nurses in the selected district.

# CHAPTER 2: RESEARCH METHODOLOGY

## 2.1 Introduction to the chapter

This chapter focuses on describing the methodology, methods and steps taken to ensure trustworthiness during the processes of the study. This includes study design, description of the primary study, ethics, sampling and participants, data management, data analysis and detailed information on the steps taken to ensure trustworthiness, including reflexivity.

## 2.2 Methodology

Methodology is the systematic strategy a researcher undertakes to complete a research project (Terre Blanche et al., 2006). This section will highlight study design and the detailed description of the primary data.

### 2.1.1 Study design

The study design envisioned for this research is a meticulously planned procedure aimed at addressing the central research question, as outlined by Terre Blanche, et al. (2006). This proposed study, conceptualized as a component of a larger investigative project (see 2.1.2), adopts a methodological framework centered on the secondary analysis of qualitative data. Such an approach is in line with the recommendations and methodological considerations put forth by Riegel and Dickson (2016). This secondary analysis methodology involves comprehensive re-examination and interpretation of existing qualitative data, which were initially collected for different research purposes. This approach enables the researcher to delve deeper into the data, extracting new insights and understanding that were not the primary focus of the original study. The secondary analysis of qualitative data is a valuable and efficient method for exploring new research questions or examining existing data from a different perspective, thus maximizing the utility of previously gathered information (Tate and Happ, 2018). This approach is particularly advantageous in the context of this study, as it allows for a thorough investigation of the research question without the need for extensive primary data collection, thereby optimizing resource utilization and offering a unique lens through which to examine the research problem.

### 2.1.2 Description of the primary study

The primary study under consideration was an extensive research project conducted in the Sedibeng District of Gauteng Province, South Africa, spanning from September 2016 to February 2019. The study was investigating the implementation of CHW programmes in Sedibeng district, as detailed in the work of Goudge, et al. (2020). This research endeavor was comprehensive in its scope, involving a diverse range of participants integral to the healthcare system. Data collection encompassed insights from CHWs and their respective supervisors, encompassing both professional and enrolled nurses in six PHC facilities, all teams were purposely selected as per their profession. Additionally, the perspectives of clinic managers, patients, and community representatives were also meticulously gathered, ensuring a holistic understanding of the healthcare dynamics within the district.

The project was methodically structured into three distinct phases, each designed to explore different facets of the healthcare system and the interplay between various stakeholders within it. This tripartite division of the study allowed for a nuanced exploration of the healthcare landscape in the Sedibeng District, capturing the complexities and intricacies of healthcare delivery and management from multiple viewpoints. The data collected from these diverse groups provided a rich and multifaceted understanding of the healthcare challenges, successes, and opportunities within the district, laying a solid foundation for this current study to build upon.

#### *2.1.2.1 Phase 1: situational analysis (baseline data)*

In this phase Tseng, et al (2019) and Goudge, et al. 2020) reported that six WBOT teams were selected based on their supervision, configuration and location for investigation. This study is based on the data collected from these teams. The data set was collected from three sub-districts of Sedibeng district i.e. Mid-Vaal, Emfuleni, and Lesedi, in each sub-district two similar teams were drawn to be studied. In mid-Vaal teams were characterized by CHWs who are supervised by

professional and enrolled nurses at the local clinics and operating in townships with relatively better income, in Emfuleni the CHW teams were supervised by professional and enrolled nurses in the health posts and serviced townships and large informal settlement with a lot of migrants, whereas Lesedi sub-district teams were supervised by only enrolled nurses in clinics, which services rural areas, informal settlements, and farming communities. Data collection tools covered e.g. supervision practices, services providers, and a tripartite relationship that constitutes the healthcare system, clients, and the community. The results from this study highlighted that CHWs supervised predominantly by junior nurses received insufficient supervision. Furthermore, a shortage of resources and poor integration within the healthcare system limited the CHWs program's effectiveness.

#### *2.1.2.2 Phase 2: piloting a roving nurse mentor intervention*

The second phase by Malatji et al. (2022) a nurse mentor (senior nurses/professional) intervention was introduced in the two teams led by junior enrolled nurses with 2-year nursing qualifications and no experience in supervising/working in CHWs teams prior. The purpose of the study was to strengthen CHWs' supervision support, and relationship with the health care system and community. The intervention for mentorship occurred in the same resource-scarce environment as the initial project. The project envisioned training and support from the senior nurse who had an undergraduate 4-year degree, with 15 years of experience, including 6 years of working as a supervisor in the CHWs program. As part of the intervention, she provided guidance and support on household registration, medication adherence monitoring, and following up on patients who defaulted on their medication. The nurse mentor led initiatives to foster collaboration of CHWs with other vital stakeholders, an important agenda to integrate CHWs into the health system. The outcomes from this study indicated that utilizing a roving nurse to mentor junior nurses and their teams can have positive outcomes; nevertheless, consideration should be made of how well the CHWs are integrated into the health system.

*2.1.2.3 Phase 3: evaluating the sustainability of the intervention*

The third phase by Malatji al. (2022) assessed how the effects of the intervention were generated and sustained. The researchers conducted a longitudinal process evaluation using in-depth interviews, focus groups, and observations. These qualitative methods were administered before, during, and 6 months of post-intervention. The participants in the study were CHWs supervisors, CHWs, facility staff members, and individuals who represented the community. The evaluation indicated that the department of health must formally employ the CHWs to sustain the roving nursing mentorship program. Also, the program could not fully integrate the CHWs into the local structures due to the unpredictable nature of the local structures.

## 2.3 Methods

Methods are necessary tools undertaken to achieve the current research; it consists of all the techniques the researcher undertook to investigate the research (Bhosale, 2021). This includes acquiring ethics, samplings of the participants, data management, and data analysis.

### 2.2.1 Ethics

The ethical considerations for this research were meticulously addressed, ensuring adherence to the highest standards of research integrity and participant safety. The researcher signed a declaration to declare that the work produced was written sorely by her (see Appendix I) and that she follows plagiarism principles (see Appendix II). Ethical approval for the study was rigorously sought and obtained from the Witwatersrand Human Research Ethics Committee, reflecting a commitment to ethical research practices and participant well-being. This approval, signified by clearance number MED23-01-024, serves as a testament to the study's compliance with ethical guidelines and standards (see Appendix III). Since the primary data were collected prior to the

enactment of the Protection of Personal Information Act (POPIA), authorization to use the data for this study was obtained from the original data holders as the researcher for this study was not part of the team in 2016 (see Appendix IV).Informed consent had been obtained from all participants in the primary study, including agreement that the anonymized data could be used for future research purposes (see Appendix V). In addition, ethical protocols related to confidentiality, voluntary participation, and secure data storage were strictly adhered to throughout this secondary analysis, with access to data limited to authorized researchers only.

Additionally, the researcher has undertaken specialized training in research ethics, evidenced by the acquisition of a certificate in the introduction to ethics from the Training and Resources in Research Ethics Evaluation (TRREE). This training further underscores the researcher's dedication to conducting research that is not only methodologically sound but also ethically responsible.

Moreover, the primary study, from which the data set for this research was derived, also received ethical clearance, indicated by clearance number M160354. This clearance indicates that the original study was conducted in accordance with ethical standards and principles, thereby ensuring that the data used in this secondary analysis is derived from a study that prioritized ethical considerations, particularly in terms of participant rights, safety, and data confidentiality. This comprehensive approach to ethical research practices underlines the commitment to maintaining the highest standards of research ethics throughout all stages of the study.

### 2.2.2 Sampling and participants

This study focused on the collaborative relationship between nurses and CHWs from two facilities in the Lesedi sub-district. These facilities were purposely selected because, in addition to being located far away from the other two main districts, they are only led by junior nurses. Hence, the facilities were faced with more operational challenges than the other two districts (Tseng et al., 2019). To answer the research question all the CHWs and nurses' the following transcripts from the baseline data were analyzed:

| *Data collection method* | *Participant category* | *Number* |
|---|---|---|
| *Interview* | Professional Nurse (Facility Manager) | 1 (Clinic A) |
| *Interviews* | Enrolled nurses | 2 (Clinic A and Clinic B) |

| | | |
|---|---|---|
| *Focus group discussion* | CHWs (FGD) | 5 (42 participants)<br>18 (Clinic A)<br>24 (Clinic B) |
| *Interview* | Health Promoter | 1(Clinic A) |
| *Total* | *9* | |

*Table 1 Number of transcripts that were analyzed*

Recruitment of participants: All CHWs and nurses working in the selected facilities were invited to participate in the primary study. The researcher approached the staff directly, explained the study objectives, and obtained informed consent prior to including their baseline data transcripts in the analysis. By including all eligible staff from these facilities, the study ensured that the data reflected the full range of experiences within these teams. In this secondary study, baseline data transcripts from all recruited CHWs and nurses within the selected clinics were then analysed to explore collaborative relationships between nurses and CHWs within these facilities.

### 2.2.3 Data management

The management and storage of data in this research were handled with utmost care, adhering to rigorous standards of data security and confidentiality. To ensure the integrity and safety of the data, it was securely stored on a computer that was protected by a robust security code, all personal identifiers had been removed from the primary data prior to this study, and the files were labeled using project-specific identifiers rather than participant names to ensure confidentiality. . This measure was taken to prevent unauthorized access and safeguard the data against potential breaches or loss, also this forms part of the local storage, a rigorous backup system plan (Kanza and Knight, 2022). The data was regularly backed up to a cloud account managed by the university, offering an additional layer of security and ensuring the preservation of data in case of any local system failures. This cloud-based backup solution provided a reliable and secure method for storing sensitive research data, further ensuring its integrity and accessibility.

Access to this data was strictly controlled and limited to authorized personnel only, namely the researcher and her designated supervisors. This restricted access was crucial for maintaining the confidentiality of the data and ensuring that it was used solely for the intended research purposes. Furthermore, the research protocol included provisions for sharing the data with third parties, strictly for research-related purposes. Any such sharing was to be conducted in adherence to established ethical guidelines and data sharing agreements, ensuring that the data's integrity and confidentiality were maintained even when accessed by other researchers. This approach to data management and sharing underlines the commitment to ethical research practices, data security, and the advancement of knowledge in the field (Kanza and Knight, 2022).

### 2.2.4 Data analysis

#### *2.2.4.1 Analysis design*

By utilizing the comparative method of analysis, the researcher explored, discussed, analyzed, and critiqued the collaborative relationship patterns that emerged based on the IPCH framework. The framework sub-headings were compared with the ideas from the data set to develop themes for the study (Terre Blanche et al., 2006). Also, data from nurses and CHWs were compared to identify emerging themes. Furthermore, discrepancies and similarities among the emerging themes were explored, to determine possible structural influences.

#### *2.2.4.2 Steps in comparative thematic analysis*

The researcher followed the steps below for analysis of data. Analysis was undertaken using manual data analysis methods through the thematic content analysis:

The analysis was conducted using Braun and Clarke's (2006) six-phase framework for thematic analysis. The process began with an in-depth familiarization with the data, enabling a deep understanding of participants' accounts. Initial codes were then generated to capture meaningful

patterns, which were subsequently organised into potential themes. These themes were reviewed and refined in relation to both the coded extracts and the dataset. This iterative movement between data and interpretation allowed themes to emerge that were firmly grounded in participants' experiences while addressing the research questions in a coherent and meaningful way.

The approach was further informed by insights from Silverman's (2013) particularly in relation to comparative analysis and the assurance of trustworthiness. Reflexive practices were employed to recognise how researcher perspectives might influence interpretation, while strategies such as triangulation and the inclusion of rich, thick description were used to enhance credibility. Together, these methodological considerations supported a transparent, rigorous, and nuanced representation of the complexity and diversity within participants' perspectives.

The researcher then coded the data using the IPHC framework. The researcher identified codes that were emerging from the transcripts in addition to the IPHC framework. Similar codes were grouped into themes. The researcher re-visited the data to align it with the themes and subthemes (Terre Blanche et al., 2009). For accuracy, the researcher revisited the raw transcripts and compared them with information within the identified themes. The researcher made necessary corrections. Supervisors regularly checked the emerging themes and categories to make certain they are aligned with the transcripts and gave continuous feedback.

Finally, the researcher compared data from across the data set within each theme. During this step, the researcher interpreted and discussed the results in relation to the IPHC framework and wider published literature; this is the final step in the process. The discussion formed part of the analysis of what the study has found regarding the collaboration between nurses and how it impacts services (Terre Blanche et al., 2009).

### 2.4 Ensuring trustworthiness

Qualitative studies require trustworthiness to ensure rigor and quality (Terre Blanche et al., 2009). The following concepts were adopted for this purpose in this study:

### 2.3.1 Trustworthiness was addressed

Credibility refers to the notion that the information in the data represents the actual ideas, knowledge, and experiences of the participants (Terre Blanche et al., 2009). To ensure credibility, the researcher can utilize triangulation, member check, prolonged engagement and persistent observation as outlined by (Korstjens and Moser, 2018). In study, credibility was supported through triangulation of data sources, including baseline interviews and field notes, and verification of findings against the original transcripts. Member checking was not feasible as participants were not re-contacted The interview In line with Silverman's (2013) recommendations, trustworthiness in this study was addressed using rigorous and transparent research practices. Silverman emphasizes that credible qualitative research requires clear documentation of the analytic process, allowing others to understand and evaluate how interpretations were reached. To achieve this, detailed records were maintained throughout the study, including verbatim interview transcripts, coding frameworks, analytical memos, and reflective notes. This audit trail provided a transparent account of decision-making during the analysis and ensured that interpretations could be traced back to the original data.

Silverman (2013) also highlights the value of presenting "low inference" data, favouring the inclusion of participants' own words over heavily paraphrased accounts. This study therefore integrated rich, illustrative quotations to support analytical claims, enabling readers to see the connection between the data and the interpretations presented. Furthermore, reflexivity was maintained to acknowledge and critically reflect upon the researcher's influence on the research process, while triangulation across data sources was employed to enhance the credibility of the findings. These strategies, consistent with Silverman's framework, strengthened the dependability, confirmability, and overall trustworthiness of the study. The transferability of the study findings is supported by the detailed description of the research context. Therefore, by providing this rich contextual information, other researchers and practitioners can assess the applicability of these findings to similar settings.

### 2.3.2 Reflexivity

A qualitative researcher should examine how their position relates to that of the participants in the study to minimize bias (Swaminathan and Mulvihill, 2018). In the process of meaning making, the researcher will be guided by self-introspection. Qualitative data analysis requires the researcher to understand how her own beliefs, ideologies, background, values, and perceptions impact the analysis (Swaminathan and Mulvihill, 2018). As a result, the researcher continually reflected on her belief system perceptions and how they may potentially influence the analysis of the results. During the study, the researcher kept a diary of all her introspections that might otherwise have influenced her findings and reviewed the diary as analysis proceeded.

#### *2.3.3.1 Self-reflection by the researcher*

My experience as a speech therapist provided me with the necessary insight into the health care system. Due to my experience in primary and district health care, I had a preconceived understanding of the challenges faced by health care workers at that level of care. In addition, I had an understanding of the negative and positive effects of health care staff behavior on patients. This had to be recognized by me as well as the fact that my experiences cannot be generalized across all fields of health care. On the first day that I started reading the transcripts, I simply read through them without any expectations or understanding of the framework, avoiding imposing that knowledge on the data analysis process. As the data analysis progressed, I began to look into the framework. However, there were emerging themes that were not included in the framework. Throughout the process, I let the data set guide me. The latter stages of data analysis have revealed that CHWs face difficulties that I have never encountered before. Despite working in a health care center, I am not familiar with all the challenges and experiences faced by CHWs. In addition, since I have never worked with CHWs, I cannot dictate how their supervisors and clinic staff should conduct themselves. There were challenges along the way during this process, and I found it difficult to return to analyzing the data; however, whenever I was analyzing the data, I did not want to be rushed for the purpose of completing the project. I always understood the

importance of producing quality work that is true to the representation of data, therefore I had to revisit the themes a number of times.

### 2.3.4 Confirmability

Confirmability means the extent to which the research findings can be confirmed by other researchers (Korstjens and Moser, 2018). Confirmability was achieved through assistance from the supervisors who assisted with coding the data and corrected where necessary during the coding stages.

### 2.3.5 Transferability

A research study's transferability refers to its capability of being applied in other situations (Moule and Goodman, 2014). In this study, transferability was achieved through critical appraisal of other research studies that apply to this study. Furthermore, this research made a detailed description of the setting, to guide the reader to the type of context this study occurred (Moule and Goodman, 2014).

## 2.5 Reflection on using secondary data analysis method

A key challenge in conducting this study was working with secondary qualitative data that was not originally collected with the current research question in mind. As a result, certain elements central to the Interprofessional Collaborative Practice Framework such as role clarification were underexplored or absent in the data pool. This limited the depth of analysis in some areas and required careful interpretation to remain aligned with the study's objectives. Additionally, the inability to probe further or clarify responses with participants posed constraints in achieving richer contextual insights. However, despite these limitations, the data provided valuable perspectives on team dynamics, communication, and collaboration within the CHW program, which were still highly relevant to the study’s aims.

## CHAPTER 3: PRESENTATION OF FINDINGS

### 3.1 Introduction to the chapter

This chapter presents the study findings. Firstly, the participant demographic data will be presented, followed by the presentation of the findings using the study objectives. Participants' direct quotations are also provided as part of the themes.

### 3.2 Demographic data

Presented in this chapter are results from CHWs and nurses from two clinics who participated in Sedibeng's research primary study. All the participants were females, and they were black. Data collection was in English language, to clarify where the participants did not understand Isi-Zulu and Sesotho languages were used. The following number of participants participated in the study:

#### 3.2.1 Participants demographic information

| **Category of Staff** | **Team A** | **Team B** |
|---|---|---|
| **SUPERVISORS (ENROLLED NURSES)** | | |
| Number of years in the program | 0.3 | 0.4 |
| Gender | Female | Female |
| Number of years a s an enrolled nurse | 6 years | 2 years |
| Number of nurses enrolled in each team | 1 in the whole team | 1 per group within the team |
| **CHWs** | | |
| Gender | All females (18 participants) | All females (24 participants) |
| Training and certification within DOH | None | None |
| **PROGRAM COORDINATORS (Health promoter & Professional nurse)** | | |
| Average years of experience within WBOT | 3.5 years | - |
| Gender | All females (2 participants) | None |

*Table 2: Nursing Categories and CHWs*

This secondary study included three categories of staff across two teams (Team A and Team B): supervisors (enrolled nurses), community health workers (CHWs), and programme coordinators (health promoter and professional nurse). All participants were African and female, reflecting the gendered composition of the WBOT workforce in this context. Team A included one enrolled nurse supervisor with 0.3 years in the WBOT programme and six years of nursing experience. Team B also had one supervisor with 0.4 years in the programme and two years of nursing experience. All CHWs were female, with Team A comprising 18 participants and Team B comprising 24 participants. None of the CHWs had received formal training or certification through the Department of Health (DOH). Only Team A had programme coordinators, consisting of two female participants (a health promoter and a professional nurse) with an average of 3.5 years of experience in the WBOT programme. Team B had no participants in this category. Furthermore, Table 2 provides further detail on the composition and characteristics of the staff teams, complementing the information in Table 1 on data collection methods and participant numbers. By specifying the roles, gender, experience, and training of supervisors, CHWs, and program coordinators, Table 2 clarifies which transcripts correspond to which participant categories. For example, the baseline interview transcript of the professional nurse (Facility Manager) in Table 1 aligns with the program coordinator category in Table 2, while the focus group discussion transcripts for CHWs in Table 1 correspond to the CHW entries in Table 2. Similarly, the interviews with enrolled nurses in Table 1 are linked to the supervisor category in Table 2. This linkage allows readers to understand how the data were distributed across participant roles and supports the interpretation of findings in relation to team composition and experience

### 3.3 Findings

The central themes that emerged from the data are the participants' perceptions on working relationships and other contributing factors to the relationship. From these 2 themes 6 subthemes emerged namely, Inter-professional communication, Team functioning, collaborative leadership, inter-professional conflict resolution, resource shortage and professional training. Within these categories CHWs and nurses expressed how they function and relate within the WBOT, including discussions about what are the contributory factors that determine their actions, feelings, and

behavior. In addition, the results demonstrate how relationships and their predetermination affect the care of patients. Table 6 summarizes the themes and subthemes.

Theme and Subthemes:

| **Themes** | **Subthemes and Sub-sub themes** |
|---|---|
| 3.3.1 Perspectives about the factors contributing towards the relationships within the WBOT teams (Theme 1) | **3.3.1.1 Inter-professional communication (Shared communication)**<br>a. Reporting system<br>b. Referral system<br>c. Appreciation and recognition<br>**3.3.1.2 Team functioning**<br>a. Care coordination.<br>**3.3.1.3 Collaborative leadership**<br>a. Sharing functions and supporting each other.<br>b. Team leader support<br>c. Inter-support and partnership with the clinic<br>**3.3.1.4 Inter-professional conflict resolution**<br>a. Conflict within the WBOT |
| 3.3.2 Other contributing factors to the relationship (Theme 2) | **3.3.2.1 Resource Shortage**<br>**3.3.2.2 Lack of professional training** |

*Table 3 Themes and Subthemes*

### 3.3.1 Perspectives about the factors contributing towards the relationships within the WBOT teams (Theme 1)

#### *3.3.1.1 Inter-professional communication (Shared communication)*

Communication is the process of transferring information from one party to another. Fatimayin (2018) states that it is a means of sharing thought processes of individuals relating to feelings, ideas and knowledge base. Communication has five elements namely, sender, message, medium of transmission, medium of reception and receiver (Fatimayin, 2018). In this study, communication refers to sharing information between CHWs, nurses and facility staff. This includes the types of communication channels, perception of the information and how the information is received by the other party. The result of this study highlights the reporting and referral systems as a form of communication among the participants.

### a. Reporting systems

a. Reporting systems

Reporting systems are an integral part of the health care system to prevent clinical errors, transfer information, and manage patient health information (Sujan, 2015). This sub-theme relates to the sharing of information among individuals working in the WBOT. CHWs communicate with the clinic manager and their nursing assistant team leader to transfer information regarding patients and daily activities.

All informants indicated that CHWs are required to submit weekly patient reports to the team leader, who then submits them to the facility manager. The report serves as a communication channel regarding patients, including caseloads and daily activities, and allows CHWs to express concerns so they can receive support.

*"We write report, like today is Thursday I will record that down and on Friday I submit my weekly report. We submit Monday in the morning, because the sister wants 30 households per CHW, daily we do 6 households, if I do less than that I have to explain why I could not reach my target on this day" (Participant Clinic A – CHW)."*

The report is based on the daily patient forms that CHWs use to record individuals cared for within the community. However, participants from Clinic A noted that the forms do not capture all the necessary information to document patients' health needs, so CHWs maintain additional notebooks to record extra details. All information is summarized in the weekly reports, which the team leader consolidates and submits to the facility manager.

CHWs and the team leader meet every morning to discuss patient-related issues. In Clinic A, reports are submitted weekly (every Monday), whereas in Clinic B, they are completed daily to assist with arising patient care issues. Daily reports in Clinic B also allow the enrolled nurse to accompany CHWs to patients who require additional support.

*"Yes, we don't do the same work, when we come in the morning we first discuss whatever the team leader wants to say, and then she will give us the list of defaulters. Then we in our group decide what we are going to do today; we don't plan the same way. If one team or group is going with the team leader, other groups will do different things. We do the planning in our respective groups" (Participant Clinic B – CHW)"*

Overall, reporting systems are necessary to ensure that patients receive the required care in a timely manner and that gaps in service delivery are identified and addressed.

### b. Referral systems

A referral system is a structured process through which health care professionals or individuals within different levels of care in health institutions communicate and coordinate information to ensure effective service delivery (National Department of Health, 2020). These results highlight the referral systems in place, the challenges CHWs experience, and the role of CHWs within this system.

CHWs reported that referrals generally work but are sometimes inconsistent, highlighting gaps in the system.

*"Ja, referral is working, but the challenge of referral is, sometimes you refer the client if he's sick, or maybe once you referred the client to the social services. Like last, I referred three person, but only one returned to the clinic. But we did referral. Sometimes it's working, sometimes it's not working." (Participant from Clinic A – CHW)"*

CHWs also described instances where referred patients are not received properly at the clinic, indicating breakdowns in communication and coordination.

*"Another thing, when you find someone who needs a referral, when the patient comes to the clinic the nurses do not want to see the referred patient, they send him up and down." (Participant from Clinic B – CHW)"*

According to participants, the referral communication chain involves mutual referrals between CHWs and clinics, as well as coordination with other multidisciplinary teams. CHWs refer patients using referral forms, while the clinic provides lists of patients needing follow-up. New patients identified by CHWs are also referred to the clinic, with referral letters serving as the primary mode of communication.

Despite these systems, referrals are not always efficient. Participants from Clinic A indicated that patients referred to the clinic are sometimes not assisted by clinic staff, and there are no special systems in place to support referred patients. Within Clinic B, participants reported additional challenges, including patients being redirected multiple times and occasional breakdowns in communication, such as cases where patients referred to social workers did not receive assistance.

### c. Appreciation and recognition from clinic staff

Recognition forms part of external validation from clinic staff to CHWs. In a working environment, such validation serves as a motivating factor (Winn et al., 2018) and is a component of extrinsic motivation. This sub-theme pertains to expressions of appreciation or recognition that CHWs receive from clinic staff during discussions.

Participants from Clinic A indicated that some appreciation was expressed by the health promoter and facility manager.

*"The health promoter sometimes does appreciate us, when she goes to the meetings, she always tells them that level of sickness in Vischkuil has reduced, TB has reduced, thank you guys. You can even go to the sister's office now to see, there a chart that shows TB has reduced." (Participant from Clinic A – CHW)"*

However, there were mixed reactions among participants regarding the overall level of appreciation. Some CHWs felt there was no recognition, while others acknowledged appreciation from the facility manager and health promoter.

In Clinic B, CHWs reported that appreciation was limited to one nurse, with other clinic staff not acknowledging their efforts.

*"In this clinic, only two people once appreciated us, especially when it comes to successful tracing of defaulters, sister Thoko she does appreciate our hard work, because we do find those defaulters and they come to the clinic, but the rest nothing." (Participant from Clinic B – CHW)"*

Participants also reported experiencing negative criticism regarding their employment prospects. Despite this, the team leader indicated that she and the CHWs maintained good working relationships with the clinic staff.

Overall, the CHWs expressed feeling underappreciated for their work within the clinics, with recognition being limited to a few supportive staff members.

#### *3.3.1.2 Team functioning*

Team functioning refers to the processes in how a team performs in relation to behavior, feelings, and cognitive execution (McGuier et al., 2021). The behavioral process is comprised of how individuals act within the team, this includes coordination of tasks, information transmission, resolving disagreements and coming up with a decision together (McGuier et al., 2021). Feelings are an affective aspect of team functioning, whereby it includes cohesiveness of the team, trust and respectfulness of the members, and productivity of the team. Finally cognitive processes refer to the amount of knowledge, shared understanding of goals and the mixture expertise within the team (McGuier et al., 2021). In the study, the concepts relate to the planning, coordination, existing support systems within the team, excursion and efficiency of how the tasks within the WBOT are performed.

**a. <u>Care Coordination</u>**

Health care systems are designed to be coordinated systematically to produce the desired results (WHO, 2010). This principle applies equally to PHC services, particularly CHW programs. While there is extensive literature from different contexts on health service coordination, research specifically on PHC coordination requires further exploration (Khatri et al., 2023). Studies on care

coordination at the PHC level are essential to address challenges associated with fragmentation in health care (Wang et al., 2016).

In this study, care coordination refers to the planning and discussions that WBOTs incorporate into their schedules to achieve common goals. Systematic planning of care is critical for teams to function optimally and to avoid poor organizational and patient outcomes (Wang et al., 2016).

Clinic A participants reported that activities and house visits are often done without formal planning, depending on factors such as patient load, type of disease, and challenges faced during the day.

*"No, we do not plan. For example, I know what I was doing the previous day, so on the following day I am going to continue what I did not finish on the previous day. On Fridays we trace patients, the other four days (Monday to Thursday) I cover my 30 households." (Participant from Clinic A – CHW)"*

The team leader in Clinic A highlighted that her planning focuses mainly on administrative responsibilities, such as taking attendance, occasionally accompanying CHWs to the field, and collecting reports. The facility manager noted that, although ideally the team leader should assist CHWs with fieldwork twice a week, the planning responsibility is largely left to the team leader. CHWs expressed dissatisfaction with unplanned fieldwork, noting that it leads to poor supervision during patient visits.

In contrast, Clinic B CHWs reported structured daily planning, holding morning meetings to discuss and coordinate their activities.

*"When we arrive in the morning we clock in, we check if there's a tracing list from the clinic, we then divide the list according to our number and part of allocation, then we go to trace those patients. When we're done with them, we then visit our patients to check on them. If time is not on our side, we pause and continue the next day. If we had few traces, we also do household registration, we can go to look for that patient. After that, we do households registration." (Participant from Clinic B – CHW)"*

Clinic B participants indicated that while schedules are generally followed, they can sometimes be disrupted by tasks such as collecting medication or by time pressures from the clocking-in system. Both teams, however, agreed that TB patients require daily follow-up to prevent absconding.

Overall, Clinic B participants expressed satisfaction with planning and supervision, whereas Clinic A participants highlighted challenges stemming from lack of structured coordination. These differing approaches to planning and coordination appear to influence team relations with supervisors and overall team functioning.

*3.3.1.3 Collaborative leadership*

Collaborative leadership is about team interdependence, information sharing and overall flow of transparency in execution of activities within the organization, where everyone is involved in decision making. Hence, the effectiveness of WBOTs hinges on robust support systems and clear internal and external collaboration mechanisms, aspects that, as research and anecdotal evidence suggest, are currently fraught with challenges (Tseng et al., 2019). Some of the challenges within the WBOT are irregular support, collaboration, and consultation mechanisms, to name just few. This research investigated how these challenges extend towards their collaborative leadership within the teams.

**b. <u>Sharing functions and supporting each other</u>**

A well-functioning team should be able to share information, and members should support each other to function optimally (McGill University, 2021). Information sharing is particularly important in teams composed of individuals with different knowledge and experience backgrounds. To ensure the team thrives, all members should be able to assume leadership responsibilities at certain times, requiring collaboration and mutual support (McGill University,

2021). In this section, the researcher explored how functions are shared, how CHWs support each other, and opportunities for CHWs to take leadership roles.

Participants highlighted varying experiences in work sharing and support:

*"Yes, when I am not available, my partner can work alone, she will also visit my patients." (Participant from Clinic A – CHW)*

*"Nobody does my work if I'm not here." (Participant from Clinic B – Supervisor (Enrolled Nurse)"*

CHWs reported that work is generally evenly distributed according to assigned groups. Patients are assigned based on catchment areas, and CHWs are expected to serve households near their designated areas. Within each group, members share responsibility for patients requiring daily follow-ups, including weekends, so that if one CHW is absent, others ensure continued care.

However, in Clinic A, one participant noted an incident where her patient did not receive care because both she and her group partner were absent, and neither other groups nor the team leader intervened. She expressed feelings of hurt, interpreting this as a lack of collaboration between groups. Despite this, CHWs in both clinics generally support each other and share responsibilities effectively, with only isolated incidents of non-collaboration.

Opportunities to assume leadership roles appear limited. In Clinic A, one CHW reported being responsible for the team leader's duties when she was absent, whereas in Clinic B, CHWs did not have opportunities to take on the team leader's responsibilities.

Overall, CHWs generally share responsibilities effectively and support one another within their groups, ensuring continuity of patient care. However, isolated incidents of non-collaboration were reported, and opportunities for CHWs to take on leadership roles remain limited, particularly in Clinic B

### c. Support from the team leader.

Supportive supervision plays a critical role in CHW programs; however, research highlights challenges within WBOT regarding supervision (Tseng et al., 2019). In this section, the researcher explores opportunities for supportive supervision and CHWs' perceptions of their working relationship with their team leader.

CHWs in Clinic A reported mixed experiences regarding the level of support received from the team leader. Some participants noted that the team leader rarely accompanied them on field trips despite prior discussions.

*"We once asked to travel with her the following day, till today she has not travelled with us." (Participant from Clinic A – CHW)"*

Some participants reported that the team leader provided information they already knew during fieldwork. Others defended her, noting her multiple responsibilities, including clinic duties and training. One participant, whose patient did not receive care during her absence, expressed that the team leader should have taken responsibility.

In contrast, Clinic B CHWs described their team leader as supportive, motivating, and helpful, noting that she demonstrates effective skills and teaches them during fieldwork.

*"She supports us even when we go to the field, when we have patients that are older, the manner in which we communicate with the clients she motivates us and she shows us how to treat them. And we get respect always when she is with us." (Participant from Clinic B – CHW)"*

The clinics differ in team leader structures and experience. Team A's leader has worked within the WBOT for 3 months and rotates among all CHW groups, while Clinic B's leader has 4 months of experience and supervises a single CHW group. The facility manager in Clinic A expects regular and consistent monitoring of CHWs, but the strategies used by team leaders vary. Clinic A's team leader conducts fieldwork at random and sometimes does not accompany CHWs despite prior

planning. Conversely, Clinic B's team leader holds daily morning meetings and goes to the field to assist with difficult patients the following day.

Overall, CHWs in Clinic A expressed partial satisfaction with supervisory support, while Clinic B participants reported high satisfaction. The differing approaches to supervision appear to influence both the effectiveness of fieldwork and CHWs' perceptions of support.

### d. Inter-support and partnership with the clinic

In healthcare settings, professionals from diverse backgrounds often experience conflict, which arises when differences in interests, ideas, or expectations cannot be resolved amicably (Xu & Davidhizar, 2004). Within this study, CHWs highlighted several sources of conflict in their interactions with clinic staff.

One issue related to uniforms. Clinic A participants reported being pressured to wear uniforms, but they lacked the funds to purchase them. This demand remained unresolved and created tension between the CHWs and clinic staff.

Another source of conflict concerned the bags provided to CHWs, which contained work equipment such as patient forms and raincoats. Clinic staff insisted that these bags should remain at the clinic after fieldwork. CHWs, however, strongly disagreed, raising concerns about accountability and safety:

*"We take them with us, however, their rules say, when we come back from the field we supposed to drop here in the clinic, but we did not agree on that. They said, if you lose one item from the bag, it will be deducted from your salary. So, we said, it's better if I miss something myself, I know that I won't be worried, but it gets lost here at the clinic who will know, because everyone will deny it, and our stipend is too little." (Clinic A – CHW)*

For CHWs, leaving the bags at the clinic exposed them to potential financial loss and denied them access to essential items like raincoats when travelling. They argued that because the bags were issued in their names, they should remain their responsibility:

*"They won't get them back because these bags were released on our names, when my contract ends it will be in my house, it will never come back here." (Clinic B – CHW)*

Clinic staff, on the other hand, emphasized that the bags were Department of Health property, not personal belongings of the CHWs. This difference in interpretation added to the mistrust, with CHWs perceiving the staff as deliberately making their work conditions more difficult.

Across both clinics, CHWs expressed that while they support the clinic—particularly through tracing and follow-up—the same level of support is not reciprocated. The lack of recognition and respect from clinic staff has resulted in unhealthy working relationships, ongoing conflicts, and poor collaboration.

#### *3.3.1.4 Interprofessional Work conflict*

In healthcare settings, professionals with diverse backgrounds are bound to face conflict, which can arise from differences in interests, expectations, and ideas that are not amicably resolved (Xu & Davidhizar, 2004). Within this study, CHWs highlighted several such conflicts in their interactions with clinic staff.

One issue raised in Clinic A related to uniforms. Participants reported that they were expected to wear uniforms, yet they did not have the financial means to purchase them. The insistence from clinic staff on this requirement created unresolved tension between the two groups.

A second and more widely reported source of conflict concerned the bags provided to CHWs, which contained work equipment such as patient forms and raincoats. Clinic staff instructed CHWs

to leave these bags at the clinic after fieldwork, but the CHWs resisted, citing concerns over accountability and access:

*"We take them with us, however, their rules say, when we come back from the field we supposed to drop here in the clinic, but we did not agree on that. They said, if you lose one item from the bag, it will be deducted from your salary. So, we said, it's better if I miss something myself, I know that I won't be worried, but if it gets lost here at the clinic who will know, because everyone will deny it, and our stipend is too little." (Clinic A – CHW)*

Some CHWs went further, stating that because the bags were issued in their names, they considered them their own responsibility, even beyond the contract period:

*"They won't get them back because these bags were released on our names. When my contract ends, it will be in my house; it will never come back here." (Clinic B – CHW)*

The CHWs also raised practical concerns, noting that if the raincoats in the bags were left at the clinic, they would be unprotected when travelling to or from the field in bad weather. Furthermore, they feared that items stored at the clinic could be lost or misused without accountability.

In contrast, clinic staff emphasized that the bags and equipment belonged to the Department of Health, not to the CHWs personally. This difference in perception fuelled mistrust, with CHWs believing that staff were deliberately making their work conditions more difficult.

### 3.3.2 Other contributing factors to the relationship

During this section the researcher identifies other factors that contribute to the relationship dynamics which are not within the Inter-professional Health Collaboration model.

*3.3.2.1 Lack of Resources*

Resources are essential for teams to function effectively in a collaborative setting (WHO, 2010). This section explores how the shortage of resources affected team relationships and patient care within Clinics A and B.

Both clinics reported a persistent lack of equipment, transport, and office space. CHWs in Clinic A explained that they did not have storage space for patient records, forcing them to take forms home. Similarly, Clinic B participants either stored records in a nurse's office or at home. The Clinic A team leader confirmed that there was no dedicated office for administration or rest, with meetings often held outside. In Clinic B, CHWs shared space with clinic staff but described the environment as hostile:

*"Another thing here, some of us have got accounts and they require work contact numbers, the facility manager told us that we should never ever use the clinic landline to open our accounts, because we are pairs, we do not belong in this clinic. This really hurt us, last week we wanted to start chaos." (Clinic B – CHW)*

*"This place is far, if they can get means of transport to go to their places it can be better, and then if they can get equipment as I have said…blood pressure machine…blood glucose machine… At least they did give the tape measure, but it's only those things." (Clinic A – Health Promoter)*

The lack of necessities such as stationery and medical devices created additional frustrations. Although some kits were delivered during the study period, Clinic A reported expired consumables, while Clinic B noted that supplies were insufficient and mainly targeted geriatric patients.

Resource shortages placed strain on relationships between CHWs and clinic staff. In Clinic A, participants reported losing trust when a scale originally assigned to CHWs was taken by the clinic. Others expressed doubts about whether consumables would be shared, given that clinic staff themselves struggled with shortages. In Clinic B, CHWs felt disrespected when told not to use the

clinic landline or when subjected to verbal insults from staff. These experiences reinforced feelings of exclusion, with CHWs repeatedly told they did not "belong" to the clinic.

Participants emphasized that patients were directly affected by these shortages. In Clinic A, the loss of the CHWs' scale and limited access to blood pressure machines meant that patients experienced longer waiting times and unnecessary travel. Remote patients were particularly disadvantaged, as they had to pay for transport to clinics that CHWs could have screened in the field. Without reliable transport, CHWs reported that some patients defaulted on care. A participant from Clinic B described how a health promoter refused to accompany them to a sick patient because they were not permitted to use the state car, further limiting service delivery.

Additionally, the lack of confidential space for consultations compromised patient privacy, raising ethical concerns about the quality of care provided.

Overall, the absence of adequate resources undermined collaboration between CHWs and clinic staff, eroded trust, and negatively impacted patient care. Resource shortages not only strained team relationships but also contributed to patients' unnecessary financial costs, confidentiality breaches, and treatment defaults.

#### *3.3.2.2 Lack of professional training*

The CHWs within the WBOT were not trained by the Department of Health (DOH). They lacked formal training and certified documentation to validate their skills, which created ongoing challenges in their working environment.

*"They always tell us that at any time we can be jobless, so now we do not have the chance [to] buy uniforms and look nice because anytime you can be told that the contract won't be renewed, you do not have the qualification and you do not meet the requirements. So, we are told sad things every day." (Clinic B – CHW)*

Participants from Clinic A reported that CHWs had not received any formal training for approximately two years during the study period. During a strike, the absence of training was raised as one of their major concerns, but this issue remained unresolved by the DOH.

The lack of qualifications made some CHWs feel insecure in their roles and fearful of dismissal. Participants from Clinic B described feeling intimidated when clinic staff questioned their competency or reminded them that they did not have the necessary qualifications.

This absence of training and recognition not only heightened CHWs' sense of job insecurity but also fueled disrespect from some clinic staff. The unequal treatment reinforced the perception that CHWs were undervalued members of the health system, further straining professional relationships within the clinics.

# CHAPTER 4: DISCUSSION OF FINDINGS

## 4.1 Introduction to the chapter

The purpose of this chapter is to provide more effective implications about the study and to obtain a more meaningful interpretation of the findings (Taherdoost, 2022). The findings reveal significant insights into the dynamics of relationships, shedding light on both the strengths and areas of concern, and potential areas for improvement within WBOT as directed by literature. The discussion mirrors the results to keep the interpretation grounded in flow of the findings and aligned with the study's theoretical framework.

## 4.2 Theme Discussions

### 4.2.1 Theme 1: Perceptions about WBOT working relationships

The fundamental foundation of a health system is the innate nature of people having a working relationship for a common purpose; hence difficulties arise from these relationships (Gilson, 2003). This discussion will draw upon specific findings from the research to elucidate the importance of perceptions of participants on how they function during work routines, communication strategies utilized, support systems available and discussion surrounding CHWs being appreciated.

*4.2.1.1 Inter-professional communication*

**a. <u>Reporting systems</u>**

Within the WBOT context, the reporting system emerged as more than an administrative process; it functions as a central communication channel linking CHWs, clinic staff, and the broader health system. This study found that both clinics maintained consistent weekly reporting, adhered to a clear hierarchical structure for submitting reports, and demonstrated that CHWs possessed sound knowledge of the required data sheets. These practices reflect the literature's recognition that well-structured reporting supports effective communication among healthcare professionals and enhances the quality of data for decision-making (Health Excellence Canada, 2023; Agarwal et al., 2019; Kok et al., 2015). Because CHWs serve as a vital link between communities and health facilities, their reports not only convey patient-level information but also facilitate a broader

analysis of community health needs, aligning with the aims of integrated primary healthcare (CIHC, 2010).

Despite these strengths, the findings also indicate that the communicative potential of the reporting system is not fully realised. Although literature such as Kiarie et al. (2021) emphasises that reporting improves patient monitoring and outcomes in diverse settings, participants reported delays in the review of submitted reports. This lag disrupts timely feedback and limits the two-way flow of information necessary for coordinated patient care, reflecting Foronda et al.'s (2016) observation that formal structures alone do not guarantee effective interprofessional communication. Participants suggested that daily or more frequent reporting, the use of more comprehensive data sheets, and the adoption of sustainable, digital-based systems could address these gaps. Such improvements would help transform reporting from a static, record-keeping task into a dynamic communicative process that informs clinical decision-making in real time. Cornick et al. (2018) similarly advocate for standardised communication systems combined with prompt feedback loops to ensure that reporting supports both information sharing and collaborative action. In this way, the WBOT reporting system can be seen as a strong foundation that, with operational and technological enhancements, could more fully realise its role in sustaining effective interprofessional communication and improving patient outcomes.

### b. Referral Systems

Referral systems form another part of communication systems within WBOT. Referral systems are designed as highlighted in a study done in Mozambique to ensure that CHWs patients receive timely and appropriate care by facilitating the smooth transition of patients from community-based care to clinical settings when necessary (Give et al., 2019). These systems allow CHWs to communicate patient information and care needs to clinic staff, thereby ensuring that patient care is continuous and coordinated. This form of communication encourages information sharing among health professionals (CIHC, 2010). This study identified the strengths such as availability of referral forms, referral channels and feedback channels when the patient has been seen by either the CHWs or clinic staff in both clinics. Hence, this coordination between the two parties enhances access to health services for patients from both the nearest hospitals and the clinic. Furthermore,

by giving feedback on whether the patients were found in the community by CHWs, trust is built between the two parties for future referrals. This then enhances patient's chances of accessing health care (Give et al., 2019). Furthermore, positive referral systems as a communication measure enhance motivation for the CHWs (Ludwick et al., 2018). Nonetheless, the CHWs are more responsive in attending the referrals from the nursing staff and treat patients referred by nurses as priority, but this gesture is not reciprocated. Give et al. (2019) also mentioned that referrals from CHWs tend not to be prioritized by the nursing staff. This does not only affect patients' health outcomes but also undermines the trust and relationship between the community and the healthcare system. More interestingly, a positive referral response by nurses would build a better communication facilitating feelings of being respected and validated from the CHWs side (Ludwick et al., 2018). Hence, in the WBOT the CHWs generally feel undermined and disrespected by the clinic staff. Referring patients as a form of communication adds to the systematic challenges experienced by the CHWs. Hence literature states the importance of implementing more robust feedback mechanism between clinic staff and CHWs to foster better communication and collaboration and consultation (Give et al., 2019; Ludwick et al., 2018: Mkhize, 2020). However, training on referrals should be awarded to all stakeholders who are embedded in the WBOT system, including patients and clinic staff, this will reduce inconsistencies and lack of accountability. Clinic staff should also be trained on the integration of the CHWs, and overall impact of CHWs negligence by the supporting clinic.

### c. Appreciation and recognition

The majority of CHWs in this study highlighted that the staff rarely communicated appreciation nor recognition but did not clearly state the implications and factors contributing to such. This oversight can lead to feelings of undervaluation and isolation, undermining their commitment and enthusiasm for their work. Research highlights that according to the Social Identity Approach (SIA), one identifies within a team that she or he is accepted. Hence, one is positively encouraged to identify with a social union when positive reinforcements are clearly communicated and understood. Thus, CHWs will be motivated to carry out tasks if they find themselves within a team that communicates well appreciation and recognition (Van Knippenberg and Van Schie, 2000). Thus, communicating appreciation and recognition can form a base for reinforcing activities that

are required by those within the organization. For example, Strachan et al (2015) agrees that SIA models are appropriate in the CHWs settings. Appreciation and recognition are pivotal elements that significantly influence the morale, motivation, satisfaction, and retention of CHWs within the healthcare sector (Winn et al., 2018). The importance of these factors cannot be overstated, as they directly impact CHWs' motivation, their sense of value and belonging within the healthcare team, and, ultimately, influencing the quality of patient care delivery and the kind of association they have with their core-workers. Nonetheless, CHWs function within a complex health care system, the nature of appreciation and recognition should be expected from variety of stakeholders, patients, clinic staff, community leaders, local and national governments. Also, Morris (2015) states that appreciation occurs in various forms, from formal recognition during meetings guided by policies to informal expressions of gratitude, all are necessary within organizations. For instance, in this study one CHW from clinic A noted that the health promoter recognizes their efforts in different settings and CHWs from clinic B also mention being appreciated by two nurses regarding tracing patients in the clinic. However, the study also reveals inconsistencies in the manner and frequency of appreciation extended to CHWs by clinic staff. The inconsistencies and poor appreciation may induce feelings of being overlooked, with their efforts seldom recognized in any meaningful way. This discrepancy not only affects individual CHWs' job satisfaction but can also contribute to a broader sense of disconnection from the healthcare team. Also, the poor recognition from the higher-level stakeholder(government) who's openly the employer to the clinic staff, might be the influential factor in how the CHWs are treated by the clinic staff. The impact of these dynamics extends beyond individual feelings of appreciation; it has tangible implications for patient care and the effectiveness of the healthcare system. Research states that CHWs who feel valued and acknowledged are more likely to be engaged, motivated, and better patient care, which in turn enhances the quality of services they provide to the community (Give et al., 2009; Winn et al., 2018; Strachan et al., 2015). Conversely, a lack of recognition can lead to demotivation, decreased job satisfaction, and potentially higher turnover rates among CHWs. One participant in this study indicated that she felt used by clinic, as they are readily available to assist the clinic, but little is reciprocated, hence such emotions these can be bridged by actions of appreciation.

The importance of enforcing consistent and meaningful recognition is therefore crucial for fostering a positive and collaborative working environment within WBOT. Hence, addressing the

need for better opportunities to appreciate and acknowledge the CHWs within WBOT cannot be overstated. Strategies to enhance appreciation might include formal recognition programs, regular feedback and acknowledgment sessions, and opportunities for CHWs to share their experiences and successes with the broader healthcare team. Such measures can help reinforce the integral role of CHWs in the healthcare delivery system, encouraging a culture of respect and mutual support. Addressing this gap requires a deliberate effort to foster a culture of appreciation within the healthcare system through formal and informal appreciation protocols, recognizing CHWs as integral members of the healthcare team.

#### *4.2.1.2 Team functioning*

The findings in this study highlight two teams that executed planning differently, one well-coordinated (Team B) and the other having challenges (Team A). The framework highlights that team functioning is related to working together to plan, solve problems and deciding on matters of service delivery (CIHC, 2010). The findings for this study justify research findings that teams who work together as a team are more likely to perform better in their outcomes, as seen within team B (Manser,2009). When there is no planning in health care services disconnection often occurs and patient value is reduced per provider effort (Wang & Hall, 2019). For example, the participants from clinic A indicated that there is no planning in their daily schedules, subsequently there is no commitment to the tasks they do daily. Also, this is seen with their team leader who is reported to not fulfilling her obligations towards assisting them during fieldwork. This causes frustration and confusion among CHWs in clinic A towards the team leader. In a study by Manser (2009) it highlighted that such behaviors within a team tend to decrease overall effectiveness. Hence, literature indicates that care coordination encourages partnerships with the working environment and continuity of care to patients (Khatri et al., 2023). Also, the interprofessional framework encourages that teamwork should be taught to undergraduate students so that knowledge is transferred from undergraduate to the working environment (McGill University, 2021).

*4.2.1.3 Collaborative leadership*

The results in this study were inspected at three different hierarchical structures were interdependence and leadership took place among CHWs (Co-worker support), between the team leader and CHWs (supervisor support) and between the clinic and CHWs (organizational support).

**a. Co-worker support**

The CHWs teams reported that they depend on and assist each other to carry out their daily tasks, even if one is absent. This type of support does not only influence the team outcomes, but it can also affect role perceptions, work attitude, and individual effectiveness (Chiaburu and Harrison, 2008). Also, the participants reported learning through each other in the fields, Lee et al. (2015) named this concept knowledge sharing, which has positive impact on job satisfaction. The general sense within the CHWs regarding assisting each other is largely positive in both clinics. Lee et al. (2015) further stated that knowledge sharing has impact on the solidarity of the team. Overall, these practices have positive correlation with work performance and job satisfaction (Occhipinti et al., 2018). However, there were noted gaps, inter-relatedness and trust within the core-worker relationship that can be strengthened in clinic A, this could be the result of poor planning and coordination among the team as previously discussed. The team has to identify tasks, coordination and planning there to avoid grey areas (Youn et al., 2022).

**b. Supervisor support**

The analysis of collaboration and support relating to the supervisors (assistant nurses) and CHWs within the WBOT is not uniformly negative between the two clinics. The research findings illuminate a dichotomy within the WBOT at Sedibeng, where support relationship from a team leader can close some of the gaps experienced due to poor support from the mother clinic. These successes are highlighted by Clinic B which has regular consistent communication, clear responsibilities, structured collaboration and support from their team leader. These characteristics have been researched to have positive impact on the relationship characteristics such as compassion, trust, respect, influence on each other and relationship development (Adeniyi and Brown, 2024; Yadav and Sushil, 2024; Iresearchnet, 2020). In contrast team A highlighted the

inconsistent support and lack of accountability by their team leader, hence they narrated that they need improvement in these areas as part of supervisor support system. The relationship between the two teams regarding their team leaders are distinctive, team B uses more polite, affectionate and accommodating language to describe their leader, while team A is opposite and some of the utterances undermine the efforts of their leader. These occurrences can be a highlight on how poor support from a supervisor can influence the direct relationship of an employee-supervisor.

**c. Clinic staff**

While both teams of CHWs feel under-supported by the clinic staff, clinic A is supported to a certain extent by the health promoter and the facility manager. Nonetheless, a supportive team leader can close some of the persisting collaborative challenges faced by the CHWs regarding clinic staff as seen in clinic B. For instance, CHWs recounts scenarios whereby the team leaders assist them with tasks such as collection of files. Collaboration for patients and support is better when the supervisor is more engaged and is able to attend to the prescriptive needs of the CHWs as needed, thus it is based on building a relationship (Ludwick et al., 2018). This can also be seen in literature whereby Malatji et al. (2022) utilized a roving nurse to facilitate supervision within CHWs framework, which lead to better outcomes in the team functioning. Furthermore, sustaining a positive ethical supervisory relationship assists the organization employees to collaborate and to have higher job satisfaction (Alam et al., 2021).

The contrast between these experiences' points to an underlying need for enhanced collaboration and support mechanisms for collaborative leadership purposes, within the WBOT by all stakeholders. Such enhancements could take multiple forms, from implementing regular team meetings to establishing clear channels for communication and feedback between the clinic and CHWs. Also, addressing these challenges necessitates a concerted effort to strengthen the bonds of teamwork within the WBOT. This includes recognizing and addressing the barriers to effective collaboration leadership building; such poor consultation and collaboration opportunities, improving human resource limitations, improving skills transfer and policy gaps. Importantly, enhancing collaborative leadership between CHWs and clinic staff is not merely about improving operational efficiency; it's about building a more cohesive and empowered team that is better equipped to meet the complex health needs of the community.

*4.2.1.4 Conflict and disputes*

At the core of these conflicts are disproportionate preconceived power dynamics, which often revolve around essential items like bags and uniforms that are necessary for CHWs to perform their duties efficiently and professionally. While each party sentiments regarding the issues of bags and uniform are on a surface level significant, such disputes are not trivial; they symbolize the struggle for CHWs recognition and respect within the healthcare delivery system. These disputes over seemingly simple issues that can be effectively and actively resolved, emphasize the broader issues of inadequate support and the undervaluation of CHWs' challenges within the healthcare hierarchy. The disputes are not mutually constructively resolved within both teams. Hence there is no consonance within the WBOT as outlined by the inter-professional framework (CIHC, 2010). These disputes and conflicts are symptomatic of a larger need for clear communication channels and protocols that delineate responsibilities and expectations (Foronda et al., 2016). Effective communication is the cornerstone of any successful team, and this is particularly true in the context of healthcare delivery, where coordination and cooperation can significantly impact patient care outcomes. Establishing regular meetings, feedback mechanisms, and joint training sessions could foster better understanding and collaboration between CHWs and clinic staff, mitigating conflicts arising from misunderstandings and misaligned expectations.

Cultivating mutual respect is perhaps the most fundamental element in resolving conflicts and disputes between CHWs and clinic staff. Respect for each other's roles, expertise, challenges and contributions to healthcare delivery can transform the working environment, fostering a culture of open communication, particularly on resolving conflict (Ludwick et al., 2018). Recognizing the unique value that CHWs bring to the healthcare team and treating them as equal partners in the mission to improve community health, is essential for building a cohesive and effective team (Assegaai and Schneider, 2019a). Also recognize that CHWs have been working for many years for other institutions, they have abilities to recognize their vocational needs.

In addressing these conflicts and disputes, it is crucial to adopt a systemic approach that goes beyond surface-level solutions (Cometto et al., 2018). This involves not only resolving immediate conflicts but also tackling the underlying attitudes, policies, and structures that perpetuate these

conflicts. Engaging in open dialogue, revisiting organizational policies, and advocating for systemic changes are all part of the complex process of building a more harmonious and effective working relationship between CHWs and clinic staff.

### 4.2.2 Theme 2: Other contributory factors that are not on the theoretical Framework.

#### *4.2.2.1 Lack of Resources*

Resource constraints present a multifaceted dilemma within the WBOT, directly impacting the effectiveness of CHWs, relationship with clinic staff and the quality of patient care they deliver. The essence of this challenge lies in the scarcity of critical resources—ranging from insufficient medical supplies, lack of transport to the absence of a dedicated workspace. These constraints not only hinder the operational efficiency of the WBOT program but also exacerbate relational tensions between CHWs and clinic staff, thereby affecting the overall dynamics of community healthcare delivery (Christensen et al. 2021; Jaskiewicz and Tulenko, 2012; Cometto et al. 2018; Perry et al. 2013; Christopher et al. 2011; Nxumalo et al. 2013; Schneider and Lehmann, 2016).

Moreover, many CHWs during this study report having to operate without a fixed base, leading to challenges in organizing their work, storing supplies securely, and maintaining patient privacy. The absence of a dedicated space for CHWs not only impacts the efficiency and confidentiality of their work but also affects their professional identity and legitimacy in the eyes of the community and healthcare professionals. The community bare witness to this dilemma as it unfolds, particularly when they visit the clinic. CHWs highlighted how this limitation undermines their operational capacity and professional standing. The clinic staff does not seem to fully accommodate the CHWs programs in utilizing the facility, hence there are times when the work of the CHWs is not given preference when they need to use the facility room, rather they are sometimes excused in an unprofessional manner. The reported lack of a dedicated workspace for CHWs not only affects their efficiency but also their identity within the healthcare system, echoing the literature's discussion on the importance of embedding CHWs within healthcare settings to reduce job dissatisfaction (Ludwick et al., 2018). Addressing these resource gaps is crucial for

empowering CHWs, aligning with the literature's advocacy for comprehensive program planning and evidence-based approaches to CHW integration into the health system (Assegaai and Schneider, 2019b).

The scarcity of resources often leads to increased pressures and demands on clinic staff, who may perceive CHWs as additional burdens rather than valuable partners in healthcare delivery. This perception can foster an environment of misunderstanding and resentment, undermining the potential for effective collaboration and mutual support. Addressing these tensions requires efforts to bridge the resource gap and foster a culture of respect and cooperation between CHWs and clinic staff. Also, Empowering CHWs through targeted interventions aimed at bridging resource gaps. Also, encouraging interventions that encourage multi-disciplinary teams to accommodate CHWs within resource budget plans. This also involves but not limited to increasing investment in professional development programs for both cadres but also ensuring a reliable supply of medical essentials and establishing dedicated temporary or permanent workspaces for CHWs. Such interventions would not only bolster the operational capacity of the WBOT program but also enhance the overall quality of community health services.

#### *4.2.2.2 Lack of professional training*

Moreover, at the heart of the issue is the inadequacy of professional training for CHWs. Comprehensive training is crucial for ensuring that CHWs are well-equipped with the necessary skills and knowledge to address the diverse health needs of the community effectively (Nyalunga et al., 2019). However, they receive basic training, which may fall short of preparing them for the complexities of their roles (Christopher et al., 2011). This gap in professional development not only can limit their capacity to provide high-quality care but also undermines their confidence and authority in the eyes of patients and clinic staff. Contrary, a study presented by Nyalunga et al. (2019) investigated that the CHWs have a positive perception regarding their training. Nonetheless, the CHWs who participated in this study, voiced their lack of training as a concern to their professional development. Training is not only about technical skills but also about the skills to resolve conflict and work with other professionals. Lastly, training of CHWs necessitates a holistic approach that considers the broader systemic issues within the healthcare system. This includes advocating for policy changes that recognize the vital role of CHWs within the healthcare

continuum and allocating sufficient resources to support their work. Strengthening partnerships between governmental and non-governmental organizations, healthcare institutions, and communities is also crucial for creating a more resilient and resourceful healthcare infrastructure.

## 4.3 Conclusion to the chapter

The study intricately unveils the multifaceted dynamics defining the interactions between CHWs and clinic staff, spotlighting prevalent hurdles such as communication breakdowns, teamwork deficiencies, and resource constraints issues. To navigate these challenges, a multifaceted approach is imperative, encompassing the establishment of robust communication networks, consistent acknowledgment and multiple stakeholder contributions, bolstered teamwork and support mechanisms, and a comprehensive strategy to mitigate resource shortages. By prioritizing these areas for improvement, there is a substantial opportunity to not only refine the symbiosis between CHWs and clinic staff but also to elevate the operational efficacy and impact of the WBOT program on decreasing disease burdens. Such enhancements are pivotal for fostering a more collaborative, efficient, and supportive healthcare delivery environment, which is instrumental in achieving superior health outcomes for the communities. This concerted effort towards addressing the intricate issues at hand is not just a step towards refining professional relationships but a leap towards realizing the overarching goal of a healthier, more supported community.

# CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

## 5.1 Introduction to the chapter

The conclusion chapter serves as the capstone of this study, synthesizing the findings and insights gleaned from an in-depth exploration of the challenges and dynamics within the WBOT, with a particular focus on the experiences of CHWs and some participants from the clinic staff. This investigation has traversed the complex landscape of community healthcare delivery, unveiling the multifaceted roles of CHWs and their interactions with clinic staff, against a backdrop of systemic constraints and operational challenges. Through a meticulous analysis of the data, grounded in the literature review, this study has uncovered critical insights into the operational difficulties, resource constraints, relational tensions, and disputes that shape the everyday realities of CHWs and impact the efficacy of community health services.

As we draw this research to a close, it is essential to reflect on the implications of these findings, not only for the WBOT program and its stakeholders but also for the broader field of community healthcare delivery. The conclusion chapter aims to distill the key lessons learned, articulate the practical and theoretical contributions of the study, and outline recommendations for policy, practice, and future research. Furthermore, this chapter will contemplate the limitations of the current study, acknowledging the areas that warrant further exploration to enhance our understanding and support of CHWs within the healthcare ecosystem.

In synthesizing the study's outcomes, we will revisit the central themes that have emerged, including the critical need for enhanced training and support for CHWs, the importance of clear communication and collaboration within healthcare teams, and the imperative of addressing resource constraints and systemic inequities. By highlighting these themes, the conclusion will underscore the essential role of CHWs in community healthcare delivery and advocate for strategic interventions that bolster their capacity to serve as vital links between communities and the healthcare system.

## 5.2 Limitations

The following limitations were identified by the researcher:

a. **Narrow focus on operational and relational dynamics:** By concentrating on the specific interactions and challenges faced by CHWs within the WBOT, this study may not fully capture the broader systemic issues that impact community healthcare delivery. Such a focus potentially overlooks the influence of wider socio-economic, political, and environmental factors that shape healthcare outcomes. While the study was designed with careful attention to the principles of qualitative trustworthiness, namely credibility, transferability, dependability, and confirmability, certain limitations remain. In line with Silverman's (2013) guidance, strategies such as triangulation, member checking, and maintaining an audit trail were implemented to strengthen the credibility and dependability of the findings. However, research subjectivity and the potential for participant self-presentation cannot be entirely eliminated.

b. **Geographic and contextual limitations:**

The findings of this study are drawn from observations and data collected within a specific geographical area in Sedibeng, shaped by the unique demographic, socio-economic, and organizational characteristics of this setting. While the results may not be statistically generalizable in a quantitative sense, they hold value in terms of their transferability to similar contexts. By providing rich, contextual detail, the study enables readers and practitioners to assess the extent to which these insights might be applicable to other regions with comparable health system structures, resource profiles, and community health needs. This approach acknowledges that variations in local policy, infrastructure, and workforce dynamics may influence outcomes, while still recognizing the broader relevance of the operational lessons drawn from the Sedibeng WBOT experience.

c. **Secondary data analysis methods:** The research employs a secondary data analysis method, with no opportunity for collecting further data should the need arise. This research was completely based on the data that was collected in the primary study. The data for role clarification and patient/community centered were limited for analysis. Despite these

limitations, the study provided the opportunity to explore the relationship between clinic staff and the CHWs within WBOT. Furthermore, this research highlighted how patients are affected by the challenges faced by CHWs. This research will contribute to the policy, educational, and practice development of WBOT programs within South Africa and other countries with similar settings.

### 5.3 Key findings

The core findings of this research underscore the critical challenges encountered by CHWs, notably the inadequacy of professional training, insufficient medical supplies, lack of dedicated workspaces, and the ensuing relational disputes with clinic staff. These challenges are not isolated but interlinked, collectively impacting the quality-of-care CHWs can provide and their job satisfaction and efficacy. The study highlights how these issues exacerbate the existing pressures on certain patient goals, ultimately affecting the health outcomes of the communities served.

A significant revelation of this study is the profound impact of resource constraints and operational challenges on the operational efficiency of the WBOT program. The scarcity of essential resources, such as medications and protective equipment, alongside inadequate training, severely restricts CHWs' ability to perform their duties effectively. This not only compromises patient care but also diminishes the morale and professional identity of CHWs, further straining their relationships with clinic staff.

### 5.4 Theoretical and practical contributions

Theoretically, this research contributes to the broader discourse on community healthcare delivery, offering deeper insights into the systemic barriers that undermine the work of CHWs in relation to their relationship with clinic staff. It enriches the existing literature by providing a granular understanding of the operational realities faced by CHWs, thereby laying the groundwork for more nuanced policy and practice interventions. Furthermore, focusing on the National Health Insurance (NHI) which aims to deliver universal health coverage by bridging the gap between South Africa’s public and private health sectors, the CHW programmes are positioned as one of the cornerstones of this transition with its challenges ; uneven preparation, funding constraints,

and fragmented policy implementation raise concerns that without stronger support and integration, the NHI's promise may remain only a dream.

Practically, the study offers actionable recommendations aimed at enhancing the support structure for CHWs. These include advocating for comprehensive training programs, ensuring a steady supply of medical resources, and establishing clear communication channels and protocols to delineate responsibilities. By addressing these core areas, the study underscores the potential to significantly improve the efficacy of the WBOT program and, by extension, community health outcomes.

## 5.6 Recommendations for policy and practice

**a. Enhanced Training and Professional Development**

- The need for continuous, comprehensive training programs for CHWs cannot be overstated. Such programs should not only cover basic healthcare provision but also extend to areas like patient communication, digital health tools, and emergency response. Investing in the professional development of CHWs through certifications and advanced training opportunities can significantly improve their confidence and competence. This approach requires a collaborative effort from governmental health departments, non-governmental organizations (NGOs), and international health agencies to develop standardized, yet adaptable, curricula that reflect the evolving nature of WBOT needs.

**b. Resource Allocation**

- Adequate resource allocation is critical for the functionality and effectiveness of CHWs. This encompasses not only medical supplies and protective equipment but also access to transportation and communication tools. Policymakers should prioritize budget allocations that ensure CHWs are well-equipped to perform their duties, thereby enhancing the quality of care delivered to communities. Strategies might include partnerships with private sector entities for the provision of resources, as well as innovative supply chain solutions to ensure timely and efficient distribution of medical supplies.

**c. Infrastructure Support**

- Developing dedicated workspaces for CHWs is essential for several reasons. Firstly, it provides a professional environment conducive to the administrative and planning aspects of their work. Secondly, it ensures the confidentiality and dignity of patient interactions are maintained. Infrastructure support also extends to the provision of secure data management systems that enable CHWs to record, access, and share patient information trefficiently and responsibly. Investment in infrastructure must be seen as an investment in the overall quality of community healthcare services.

**d. Strengthened Communication and Collaboration**

- The establishment of clear, consistent channels of communication between CHWs and clinic staff is fundamental to resolving many of the operational challenges identified. Regular meetings and feedback mechanisms can help to align expectations, share insights, and collectively address emerging issues. Joint training sessions, possibly leveraging digital platforms, can facilitate mutual understanding and respect across professional boundaries, fostering a team-based approach to healthcare delivery. This recommendation calls for the integration of communication and collaboration strategies into the standard operating procedures of health institutions, ensuring that CHWs are fully integrated into the healthcare team.

Implementing these recommendations requires a multi-faceted approach that engages all stakeholders in the healthcare system. It involves policy reforms that recognize the critical role of CHWs, financial investments in training and resources, and a commitment to fostering a culture of respect and collaboration between CHWs and other healthcare professionals. Success in these areas will not only enhance the working conditions and effectiveness of CHWs but also contribute significantly to the health and well-being of the communities they serve.

As these recommendations are adopted and implemented, it is crucial to monitor and evaluate their impact continuously. This will involve setting clear benchmarks for success and mechanisms for feedback from CHWs and the communities they serve. Through this process, policies and practices

can be iteratively refined, ensuring that the support for CHWs remains responsive to their needs and the needs of the communities they serve.

## 5.7 Possible areas for future research

### a. Expanding the Scope of Systemic Issues

Future studies could widen the lens to explore how broader operational systemic issues, including healthcare policy, financing, and the social determinants of health, affect the implementation and effectiveness of the WBOT program. Understanding these broader dynamics is crucial for developing more resilient and adaptive community healthcare systems.

### b. Technology's Role in Enhancing CHW Efficacy

The potential for digital health solutions to support CHWs offers a promising area for future research. Studies could investigate how mobile health (mHealth) applications, telemedicine, and other technological innovations can enhance the efficacy, efficiency, and reach of CHWs. Research might focus on identifying barriers to technology adoption among CHWs and developing strategies to overcome these challenges, for the purpose of this study; strategies such as CHWs clocking their critical patients on the system for the team leader to be aware ahead of time so that leaders can plan ahead their supervision. Also, clinic staff and CHWs can communicate via mobile health systems to enhance misunderstands, these programs can be monitored by an independent individual such as a district manager.

### c. Impact of Policy Changes on the WBOT Program

Policy changes can significantly affect the operation and success of community healthcare initiatives. Future research could examine the impact of specific policy reforms on the WBOT program, assessing how changes in funding, governance, and regulatory frameworks influence the

program's effectiveness and the holistic well-being of CHWs. Furthermore, as previously indicated that CHWs programs are strategies used within the resource constrained countries, as South African health care system prepares for NHI such context specific research is vital in this preparation.

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APPENDIX

APPENDIX I: Declaration Letter

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG | FACULTY OF HEALTH SCIENCES

PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I _____Aletta Molobane Ntlatleng_____ (Student number: __2079729_____) am a student

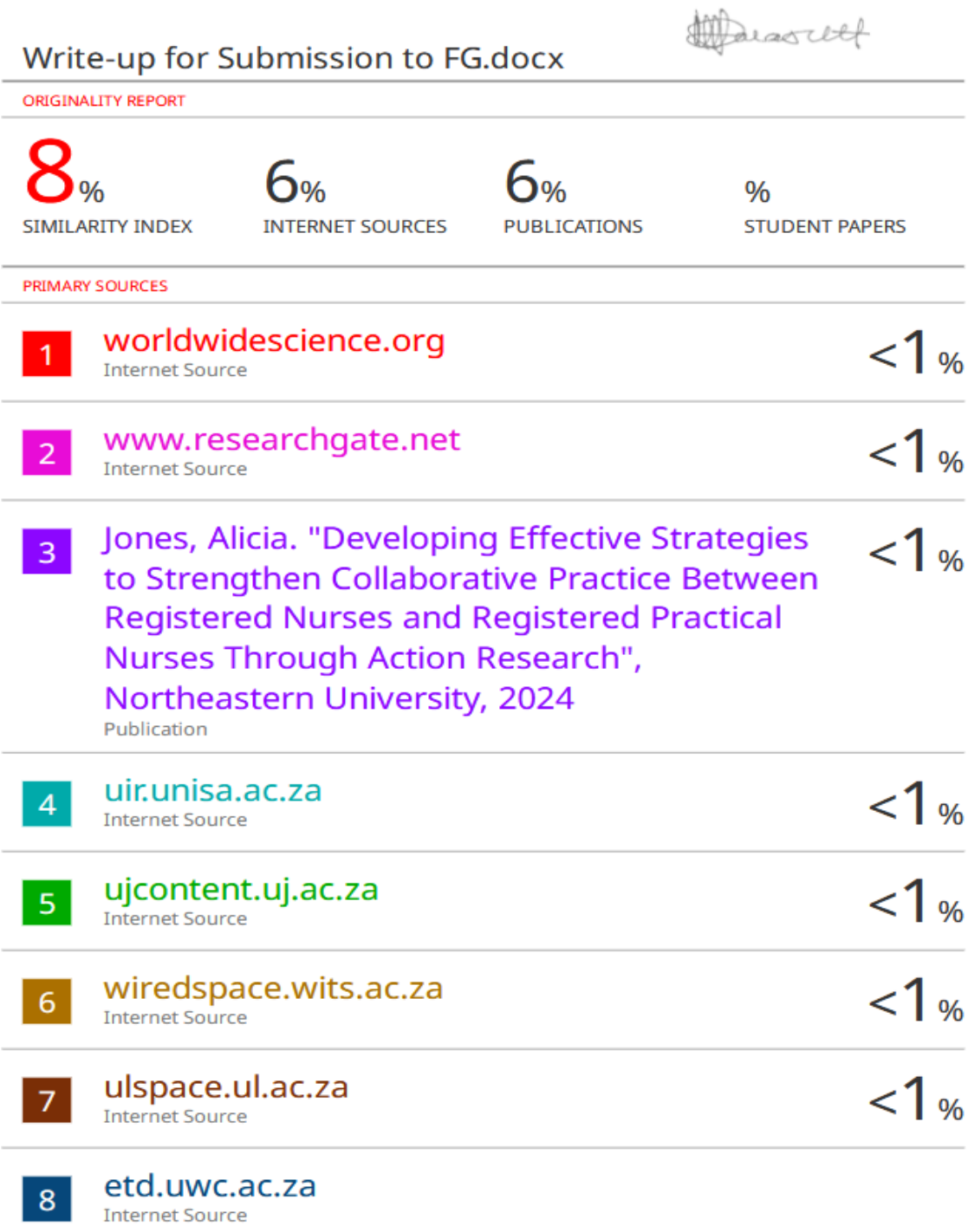
registered for the degree of _____MA in Public Health (Health Systems and Policy)_____ in the academic year ____2025___.

I hereby declare the following:

- I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.
- I confirm that the work submitted for assessment for the above degree is my own unaided work except where I have explicitly indicated otherwise.
- I have followed the required conventions in referencing the thoughts and ideas of others.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work or that I have failed to acknowledge the source of the ideas or words in my writing.
- I have included as an appendix a report from "Turnitin" (or other approved plagiarism detection) software indicating the level of plagiarism in my research document.

Signature: ___ _____ Date: 21/01/2025_____

APPENDIX II: Plagiarism Report



Write-up for Submission to FG.docx

ORIGINALITY REPORT

| 8% | 6% | 6% | % |
|---|---|---|---|
| SIMILARITY INDEX | INTERNET SOURCES | PUBLICATIONS | STUDENT PAPERS |

PRIMARY SOURCES

| | | |
|---|---|---|
| 1 | worldwidescience.org<br>Internet Source | <1% |
| 2 | www.researchgate.net<br>Internet Source | <1% |
| 3 | Jones, Alicia. "Developing Effective Strategies to Strengthen Collaborative Practice Between Registered Nurses and Registered Practical Nurses Through Action Research", Northeastern University, 2024<br>Publication | <1% |
| 4 | uir.unisa.ac.za<br>Internet Source | <1% |
| 5 | ujcontent.uj.ac.za<br>Internet Source | <1% |
| 6 | wiredspace.wits.ac.za<br>Internet Source | <1% |
| 7 | ulspace.ul.ac.za<br>Internet Source | <1% |
| 8 | etd.uwc.ac.za<br>Internet Source | |

APPENDIX III: Ethical clearance certificate

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Miss Aletta Molobane Ntlatleng

## HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

## CLEARANCE CERTIFICATE NO. M230221 MED23-01-024

| | |
|---|---|
| **NAME: (Principal Investigator)** | Miss Aletta Molobane Ntlatleng |
| **DEPARTMENT:** | Wits: Public Health<br>Sedibeng Clinics |
| **PROJECT TITLE:** | *Exploring the relationship between nurses and community health workers and the perceived impact on service delivery in Lesedi sub-district* |
| **DATE CONSIDERED:** | 24/02/2023 |
| **DECISION:** | Approved unconditionally |
| **CONDITIONS:** | Second supervisor added 06/05/2024 |
| **SUPERVISOR:** | Mr H. Malatji and Prof F. Griffiths |
| **APPROVED BY:** | Prof. Yasmin Adam, Co-Chairperson, HREC (Medical) |

**DATE OF APPROVAL:** 03/04/2024 **EXPIRY DATE:** 03/04/2028

**This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.**

**DECLARATION OF INVESTIGATOR(S)**

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report** in the month date of convened meeting each year until study is closed. Failure to submit annual report will result in ethics clearance certificate suspension. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. Unreported changes to the application may invalidate the clearance given by the HREC (Medical). Login to upload signed copy of this ethics clearance certificate prior to commencing with the study https://www.witsethics.co.za/login.aspx. Email a signed copy of ethics clearance certificate to HREC-Medical.ResearchOffice@wits.ac.za.

Principal Investigator Signature _____ Date _____

**PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES**

APPENDIX IV: Permission to use the primary data

The Centre for Health Policy

28th April 2022

**To the Wits Human Research Ethics Committee (Medical)**

**RE. Granting permission to do secondary analysis on data collected pre-POPIA Act**

This letter serves to inform you that Aletta Molobane Ntlatleng (Student ID: 2079729) is a student at the Wits School of Public Health who is planning to conduct a research project titled: Exploring the relationship between nurses and community health workers and its impact on ward-based outreach teams (WBOT): An inter-professional collaboration analysis, in Sedibeng district, Gauteng province.

This letter is to grant permission for the student to access that transcript data from this study.

The student will be conducting a secondary analysis using data collected as part of a study on which I was a primary investigator: Implementing Comprehensive, Integrated, Community-based Health Care for Under-Served, Vulnerable Communities in South Africa: A Practical, Evidence-Informed Model.

The ethics approval for this study was awarded in 2016 ie before the Popia Act (2021) (attached). As a result, there was no statement in the information sheet about the possibility of the data being used by other researchers to answer additional, but related questions.

Given pre-POPIA ethics approval of the original study, we have been advised that Eleni Flack-Davison Head of Office of Research Integrity, at the central University Research Office says it is acceptable for the students to do the analysis, as long as the data is fully de-identified to ensure there is no chance of anybody re-identifying a respondent.

I hope all is in order. If not, please do not hesitate to contact me
Sincerely,

**Jane Goudge**
Professor
Centre for Health Policy, School of Public Health; Email: Jane.goudge@gmail.com

*Health Policy and Systems Research*

3rd Floor, New School of Public Health Building, Wits Education Campus, 27 St Andrews Rd Parktown
Private Bag X3 Wits 2050 · Tel: 27 (0) 11 717 3420 · Fax: +27 (0) 86 568 9144 · www.wits.ac.za/chp

APPENDIX V: Data collection tools

**Tool E: Group interview with Community Health Worker team**

**Introduction**

**Thank you again for agreeing to be interviewed. To start the session I am going to ask each of you in turn to tell me how you came to join the team?**

*Go around every participant in turn*

**Thank you. I am now going to ask you about your work with WBOT. Please all help to answer the questions.**

**I would like you to tell me about what you do day to day.**
- Please tell me about how a typical day at work starts, what do you do?
- What happens during a typical day?
- What happens at the end of the day?

**Do you plan your work? How?**
- How do you plan your work or decide which households you'll visit on a particular day? (do you do this with your colleague(s) who pairs up with you?)
- How do you keep track of the households where you need to follow up on a patient?
- Do you do different tasks on different days of the week? What are these?

**Can you please tell us a bit more about household registration?**
- When do you do household registration?
- How often do you do household registration? How long does it take?
- Is there any form you use when doing household registration?
- What questions do you ask? What do you focus on?
- Is there more than one kind of household registration?
- What happens to these forms afterwards? Do you use them later on?
- What happens to the information you collect during household registration? (probe, are there new patients identified and assigned after household registration? How are they assigned?)

**Can you please tell us a bit more about home based care work?**
- Do you do any home based care? When does it happen?
- How much of your time do you spend doing home based care work?

**Please can you describe for us the data reporting system here?**
- What information do you record when you are out in the community?
- What do you do with this information, and when?
- How do you prepare your statistics?
- What challenges do you experience with preparing your statistics?

**Thank you. Now please tell me about your pack.**
- What is in it?
- When do you use the contents? What for?
- How are the consumables (name them e.g. forms, dressings) replenished?
- How is the equipment (name it e.g. glucometer, bp machine,) maintained in working order?

**What other support do you get to make your work easier?**
- Material resources, e.g. airtime, a meeting place, a place to store your files? Are these sufficient? If not, please explain?
- Support from colleagues, your team leader, the clinic staff, from the community?





**What do you do when you need help?**
- What type of situations do you find when you need help?
- What help is available?
- How do you access the help?
- Is the help you receive sufficient? Please explain.

**What happens when a team member is struggling or can't visit all of their households, for example because of sickness?**
- How does the team work when one member can't do their job?

**What achievements in your work are you proud of?**
- What do you think has enabled you to achieve this?
- What would enable you to achieve more?

**What are the challenges that you face?**
- What dilemmas do you face in your day to day work?
- Please tell me about times when you have faced conflicting demands?
- Possible probes:
  - Workload
  - Completing paper work
  - Preparing statistics
  - Payment, Clocking system
  - Transport
  - Appreciation, recognition
  - Conflict with community
  - Conflict with OTL or facility/health post staff
  - Working after hours & over weekend (types of tasks; how often, how long)

**Job security**
- Do you feel that your job is secure? Have you encountered or heard problems about contract renewal with SmartPurse?
- What do you feel about your prospects for career development and promotions?
- Are you worried that you might face job loss or layoff?
- If you were laid off, are you worried that you would have difficulty finding a suitable job?
- How do you feel about SmartPurse?

**Please could you tell us a bit about the strike?**
- What happened?
- Have the issues been resolved?

**How do you relate to the community?**
- What does the community think of you as a team?
- How does the community share complaints, concerns or compliments about the WBOT team with you?
- Are there other organisations providing health care in the community and what do they do?
- How do you relate to them?

**For CHWs who were previously working for an NGO:**
**Has your work changed since you moved from the NGO to the WBOT team? If so, how?**
- Which people in the community were you looking after when you worked for the NGO?
- What kind of tasks did you do when you worked for the NGO?
- Who was supervising you when you worked for the NGO?
- What resources did you have when you worked for the NGO?
- What challenges did you experience when you worked for the NGO?



ed States) Text Predictions: On Accessibility: Investigate Focus

How is your work different now that you work in the WBOT team?

**Ending the focus group**
Thank you. I think we've covered all of the questions that I wanted to ask you today. Do you have anything else you wanted to add?

**Topics we would like to hear about from the interviewees:**
guidelines, policies and protocols;
registration of households, case finding;
home visit records, numbers, planning;
recent health campaigns and role of Community Health Workers;
access to supplies, transport, advice, equipment, space to meet and store;
referral management and feedback;
language barriers;
safety and security of CHW in the community;
previous training and experience of CHW;
current/recent in role training
payment ;
supervision from team leader;
households refusing entry;
liaising with clinic staff;
communication with other organisations providing care in the community.

**Suggested generic prompts to use to encourage participants to continue:**

*To get going on a topic if they are unsure of where to start or what to say:*
Start wherever you want
Start with what you think is most important
Why not start by telling me what happens in a day, starting at the beginning

*To go into more depth or to encourage continuation of their account*
Please tell me more about that
Please explain that for me
Why was that?
What did you feel about that?
What happened then?
Please can you tell me more about (person, role, place, organisation, activity etc.)





**CHW Focus Group Discussion Questionnaire** **FGD ID:** _____

| | | |
|---|---|---|
| 1 | Date of interview | |
| 2 | Name of Health post / clinic | |
| 3 | Age (Years) | |
| 4 | Gender (please circle) | Male Female |
| 5 | How many years have you worked as a CHW? | |
| 6 | How many years have you worked as a CHW in this area? | |
| 7 | How many years have you been a part of this team? | |
| 8 | How many households are you responsible for.? | |
| **Travelling from home to the clinic or health post** | | |
| 9 | How long does it take you to get from your house to the clinic or health post where you are based? | _____ hours _____ minutes |
| 10 | How do you mainly travel from your home to the clinic or health post where you are based? Please circle, and describe if other | Walk<br>Taxi<br>Other: _____ |
| 11 | If you travel from your home to the households you visit by taxi, please provide the fare, in Rands. | |
| **Travel from your home to the households you care for** | | |
| 12 | If you travelled directly from your home to a household you care for, on average how long would this take you? | _____ hours _____ minutes |
| 13 | If you needed to travel directly from your home to a household you car for, what mode of transport would you mainly use? | Walk<br>Taxi<br>Other: _____ |
| 14 | If you would travel from your home to a household you care for by taxi, please provide the fare, in Rands. | |
| **Education, training and other employment** | | |
| 15 | What is your highest level of education (please circle) | Some primary school<br>Completed primary school<br>Some secondary school<br>Completed secondary school (passed matric)<br>Some tertiary education |
| 16 | If you have completed some tertiary | |





| | | |
|---|---|---|
| | education, please describe | |
| 17 | Please describe any CHW training you have done | |
| 18 | Do you have any other job apart from this one? (Please circle) | Yes No |
| 19 | If you do have another job, please describe this | |

APPENDIX VI Consent forms

V0.95; 12 September 2016

**CONSENT FORM FOR INTERVIEW TO BE AUDIO-TAPED**

I have had the study explained to me. I have understood all that has been read and had my questions answered satisfactorily

☐ **Yes** *please tick* **I agree for the interview to be audio-recorded**

**Signature:** _____ **Date:** _____

**Participant Name:** _____ **Time:** _____
***(please print name)***

I certify that s/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

**Signature:** _____ **Date:** _____

**Designee/investigator's name** _____ **Time:** _____
*(please print name)*

**CONSENT FORM FOR INTERVIEW**

I have had the study explained to me. I have understood all that has been read and had my questions answered satisfactorily

☐ **Yes** *please tick* **I agree to be interviewed**

I understand that I can change my mind at any stage and it will not affect me in any way.

**Signature:** _____ **Date:** _____

**Participant Name:** _____ **Time:** _____
***(please print name)***

I certify that s/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

**Signature:** _____ **Date:** _____

**Designee/investigator's name** _____ **Time:** _____
*(please print name)*

**CONSENT FORM FOR GROUP INTERVIEW**

I have had the study explained to me. I have understood all that has been read and had my questions answered satisfactorily

☐ **Yes** *please tick* **I agree to participate in the group discussion**

I understand that I can change my mind at any stage and it will not affect me in any way.

**Signature:** _____ **Date:** _____

**Participant Name:** _____ **Time:** _____
***(please print name)***

I certify that S/he apparently understood the nature and the purpose of the study and consents to the participation in the study. S/he has been given opportunity to ask questions which have been answered satisfactorily.

**Signature:** _____ **Date:** _____

**Designee/investigator's name** _____ **Time:** _____
*(please print name)*