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**Community health worker's perceptions of their role in primary  
healthcare in Ga-Segonyana rural district**

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**A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in  
partial fulfilment of the requirement for the degree Master of Public Health in Rural Health**

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## **Declaration**

I, Ann Mkhondwane, declare that this research report is my own work. It is submitted in partial fulfilment of the requirements for the degree Master of Public Health in the field of Rural Health, at the University of the Witwatersrand, Johannesburg. It has not previously been submitted and will not be presented at any other university for a similar or any other degree award.

**Signature:**

**Date:**

## **Dedication**

I dedicate this research to my mother, Matilda Mthabela, who taught me to persevere and be prepared to face the challenges of life with faith and humility. She is a constant source of inspiration to my life.

This work is also dedicated to my son, Kamogelo Sedibe. My son, thank you for understanding and being supportive even when being “without mommy” was hard.

## Abstract

**Background:** Primary Health Care (PHC) is globally recognized as one of the effective strategies for the implementation of Sustainable Developmental Goals (SDGs). The global shortage of health care workers weakens the health care system, which impacts negatively in the achievement of universal health coverage and the SDGs. Community Health Workers (CHWs) are recognized as an integral resource in addressing the shortage of health workers in health care. In the rural villages of Ga-Segonyana, access to healthcare services remains a challenge and the use of CHWs to address the problem is strongly advocated.

**Aim:** The study sought to explore the perceptions of community health workers (CHWs) of their role regarding the services they render to the community and their contribution towards strengthening PHC services in Ga-Segonyana local municipality.

**Methods:** This study utilised an exploratory research design to conduct semi-structured interviews with nine purposefully selected CHWs in the Ga-Segonyana. All the interviews were translated from Setswana to English language and transcribed verbatim. Directed content analysis was used to analyse data from the transcribed interviews. Atlas ti computer software, version 7.0, was used for data analysis. .

**Results:** Despite their lack of a written scope of work, the CHWs were able to outline their roles and responsibilities as expected by the employers. In terms of their work as CHWs, the results indicated that they have had both good and bad experiences. CHWs perceived the training received to be related to the nature of their work. However, there were no support systems to assist them with issues like psychological trauma and other pertinent situations in which they find themselves. The perceived barriers and challenges to CHWs pertain to ill-treatment to which they have been subjected by patients, lack of support systems, lack of recognition for their contribution, lack of training, lack of co-operation and collaboration from the relevant departments and organisations and other stakeholders, lack of resources and late payment of stipends.

**Conclusion:** The study successfully explored the CHWs' perceptions of their role on the services they render to the community and their contribution towards strengthening PHC services in the rural district of Ga-Segonyana. Understanding CHW roles will assist in examining how their roles might determine how they perform their daily tasks. So the study managed to highlight the importance of investing in CHWs for the empowerment of impoverished areas in South Africa.

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## **List of acronyms**

AIDS	Acquired Immune Deficiency Syndrome
APHA	American Public Health Association
CHWs	Community Health Workers
CMC	Christian Medical Commission
HIV	Human Immunodeficiency Virus
HREC	Human Research Ethics Committee
NCDs	Non-Communicable Diseases
NHI	National Health Insurance
OECD	Organisation for Economic Co-operation and Development
PHC	Primary Health Care
SDGs	Sustainable Developmental Goals
TB	Tuberculosis
US	United States of America
WHO	World Health Organisation

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# Chapter 1

## Introduction and background

### 1.1. Introduction

Access to basic health services remains a challenge worldwide. A number of studies globally demonstrate the significance of using community health workers (CHWs) in health promotion and improving the healthcare system. In South Africa, the Department of Health has been advocating for the use of CHWs. This study looks at the perceptions of CHWs with regard to their role in strengthening primary health care in Ga-Segonyana rural district. This chapter presents the background of the study, a literature review which draws on a number of studies done globally, the problem statement, the significance of the study and its underpinning purpose.

### 1.2. Background

According to the World Health Organisation (2013) report, the global shortage of health professionals stood at 7.2 million. It is further estimated that by 2030, there will be a shortage of about 18 million health professionals –a shortfall of roughly seven million on the 2013 forecast (WHO, 2016). It has also been estimated that by 2030, worldwide demand for health workers will increase to 80 million from 40 million in 2013, but only 65 million health workers will be provided, leading to a shortage of 15 million workers (Liu, Goryakin, Maeda *et al*, 2017). According to Liu *et al* (2017), the largest net shortages are predicted to occur in the East Asia and Pacific regions (8.3 million), followed by South Asia (3.2 million), Latin America and the Caribbean (2.6 million), and Europe and Central Asia (1.2 million).

Reliable statistics about human resource shortages in the health profession in Africa remain scant and where they are available, they are difficult to standardise and make international comparisons (Department of Labour, 2008, Nkomazana, Mash, Shaibu *et al*, 2015, Nkomazana, Phaladze and Mash, 2015). While other studies point to the oversupply of health professionals in Africa, recent evidence suggests that high levels of unemployment on the African continent has resulted in an oversupply of health professionals by 0.8 million in 2013 (Liu *et al*, 2017). It is estimated that 7.6 million health workers will be needed in Africa in 2030 (WHO, 2017). So sub-Saharan Africa bears the greatest burden of the shortage of health professionals (Miseda *et al*, 2017, Nkomazana, 2017). In line with this argument, the WHO report highlights that Africa

remains overburdened with the challenges of diseases, with an HIV incidence rate of 1.24 per 1 000 of uninfected population in 2016 (WHO, 2018). So Liu *et al* (2017) state that the demand for health professionals will be high in Africa by 2030. This is true especially in developing countries where the supply of health workers is hugely concentrated in urban areas, compared with rural areas (Miseda *et al*, 2017).

This shortage is also exacerbated by the brain drain, with most health professionals migrating to developing countries like the United States of America and Britain. In this line of argument, Labonté, Sanders, Mathole *et al* (2015) state that South Africa's healthcare sector could be in deep crisis, partly due to the emigration abroad of many South African nurses in search of better employment conditions. Although South Africa is seen as offering high salaries compared with its African counterparts (for example, Zimbabwe, Malawi, and Nigeria) it has contributed substantially to the attrition of health care professionals from an African perspective, mainly due to its unique political history (Nkomazana, 2017). South Africa has been failing to grapple with a health care system crisis which encompasses shortage of health personnel since democracy in 1994 (Barron and Padarath, 2017). This is a clear testimony of the existence of problems in the current administration in South Africa and there is an urgent need to address them.

The global shortage of health professionals weakens the health care system which has a negative effect on the achievement of universal health coverage and Sustainable Development Goal 3 (SDG 3) (WHO, 2016). Even more, the need is dire within sub-Saharan Africa, characterised mainly by high maternal mortality and morbidity rates, and the prevalence of HIV/ Aids (Kendall, Danel, Cooper *et al*, 2014, Tlou, 2018). According to Gerein, Green and Pearson (2006), the continued shortage of health staff will affect the quality of health services, which has an adverse effect on the morale of health professionals. It has been reported in the United Kingdom that the shortage of midwives has led to personal injury and frequent delays in carrying out emergency caesarean sections (Borneo, Helm and Russell, 2017, Sandall, Homer, Sadler *et al*, 2011).

Several studies have shown that addressing the health workforce shortage is central to achieving better health outcomes (Ashcroft, Elstein and Boreham, 2003; Jimba, Cometto, Yamamoto *et al*, 2010; Miseda *et al*, 2017; O'Brien and Gostin, 2009; WHO, 2005). However, a number of studies indicate that the shortage of healthcare professionals is extremely difficult to resolve in Zimbabwe, Ethiopia, Nigeria, and Uganda (Narasimhan, Brown and Pablos-Mendez, 2004,

O'Brien and Gostin, 2009). In the face of shortages of healthcare professionals, community health workers (CHWs) were identified as essential role players in the improvement of access to primary healthcare (PHC) services and bridging the gap of healthcare costs. So it is well documented in the literature that CHWs play an indispensable role in the communities they serve (McCord, Liub and Singh, 2013; Perry and Crigler, 2013; Perry and Zulliger, 2012). According to Perry and Zulliger (2012), CHWs are conduits providing a critical and essential link within health systems, especially in situations where resources are constrained.

Various studies have been conducted in rural communities and urban communities. These show effective CHW programme integration into the healthcare system. For example, a study conducted in Gauteng, Limpopo and KwaZulu-Natal found that CHWs have contributed substantially towards the success one of the world's largest HIV/Aids treatment programmes (Mottiar and Lodge, 2018). In South Africa, a study conducted in the rural Eastern Cape Province noted improvement in maternal and child health services provision (Le Roux, Le Roux, Mbewu *et al*, 2015). In Ethiopia, positive spinoffs of CHW integration included a reduction in child mortality by two thirds and malaria by 55%, and improved uptake of contraceptives by women (Banteyerga, 2011).

In the light of the shortage of health professionals, to achieve universal health coverage, the South African government has re-structured (calling it "re-engineering") its primary health care (PHC) programme, which seeks to address health inequity with three main objectives. These include strengthening the district health system and putting emphasis on population-based health outcomes through proactive measures in the community (Gray and Vawda, 2016). The major strategy is ward-based PHC outreach teams, which aim to offer preventive care, and health promotion using multidisciplinary teams comprising a professional nurse, a health promoter, an environmental health officer and six CHWs. The South African government has also proposed the National Health Insurance (NHI) scheme which will involve implementing the re-structuring of PHC and taking social determinants of health into account (Pillay and Baron, 2011). The use of CHWs at household level for health promotion and prevention was found to be of great significance (McCollum, Gomez, Theobald *et al*, 2016, Tsolekile, Puoane, Schneider *et al*, 2014).

The use of CHWs to address the problem of health personnel shortage is strongly advocated. The South African government intends to roll out universal health coverage through NHI so as to ensure that everyone has access to comprehensive health care services (Ataguba and Akazili,

2010). The use of CHWs is strongly emphasised in the NHI as they serve as a link between vulnerable communities and the healthcare facility (Pillay and Baron, 2011). This study was conducted in Ga-Segonyana, a rural district in South Africa's Northern Cape Province where HIV/Aids and TB continue to be a challenge for residents, with an increased rate of non-communicable diseases (NCDs). The value of CHWs can never be underestimated in this setting with such problems.

### **1.3. Problem statement**

CHWs have direct contact with communities and patients, giving them a unique opportunity to gain insights and understanding of the social determinants of health in the communities they serve. So they serve as a bridge between the local community and the health services (Findley and Matos, 2015; WHO, 2006). Their input is vital in shaping PHC policies that will ensure delivery of relevant services to their communities. Despite the extensive use of CHWs in the Ga-Segonyana rural district, and their contribution into PHC services, it is unclear how they perceive their role as CHWs. CHWs' perceptions of their role are of significance as unclear roles may influence the quality of patient care, leading to poor health outcomes and misused resources. Also, decisions that are taken without understanding the roles of CHWs have implications for the costs of CHW programmes.

Studies have shown that CHWs' accounts of their role affect service delivery and the integration of some of their services into PHC (Oliver, Geniets, Winters *et al*, 2015). A lack of understanding of the roles of such people often results in inconsistent performance, leading to poor service delivery. PHC is about providing services that are appropriate and relevant to the communities, which requires insight into the community's problems. CHWs are well placed to provide that service. So it is important for CHWs to understand their roles so that they can contribute effectively to the goals of PHC. Some studies have noted that CHWs are also involved in informal activities, like cooking for some community members, yet this role is neither documented nor recognised by the health system (Sudhinaraset, Ingram, Lofthouse *et al*, 2013). The work of CHWs can be challenging, requiring them to adapt to various situations in any given community.

In addition, their roles have implications for the acceptability, feasibility and effectiveness of the programmes offered at community level. Studies have shown that successful and effective programmes – for instance, providing preventive health care services – are determined by the

quality of training received, supervision, support and the presence of strong leadership. Another study conducted in the US revealed that the training and supervision of CHWs is essential for successful programme implementation (O'Brien, Allison, Squires, Bixby and Larson, 2009). These factors need to be explored from the perspective of CHWs so as to standardise guidelines for selection and training.

This study intends to explore the perceptions of the CHWs in the Ga-Segonyana district regarding their own practices, experiences and feelings in relation to the training they have received to perform their roles and the types of skills they require to complete their tasks daily. Acknowledging how and why these roles are practised is of great importance in designing and implementing successful programmes.

#### **1.4. Justification of the study**

The study is motivated by the considerable shortage of health workers worldwide, which is worsening exponentially (Darzi and Evans, 2016). This shortage has been described as one of the most pressing global health issues of today (Aluttis, Bishaw and Frank, 2014). The under-supply of health workers poses a great threat to the quality of health services worldwide (Aluttis *et al*, 2014).

The use of CHWs in underserved communities to strengthen the health care system and to address human resources shortages has been well documented in various studies (Ashcroft *et al*, 2003; Jimba *et al*, 2010; Miseda *et al*, 2017; O'Brien and Gostin, 2009; WHO, 2005). In the rural villages of Ga-Segonyana, the shortage of human resources and access to healthcare services remain a challenge. Despite incentives to attract health professionals to work in the rural areas, high turnover of staff is still a problem due to challenging working conditions and the perceived lack of opportunities for their families. The available clinics are not adequately able to address the needs of the communities.

With the re-structuring of PHC in South Africa, there is a need to understand the work of CHWs, as they have been afforded a vital role in promoting PHC and extending their services to households and communities (Pillay and Baron, 2011). This study intends to explore whether the roles of CHWs and the various tasks they provide are accepted and regarded as appropriate by the CHWs themselves. Understanding CHW roles will assist in examining how their roles might determine how they perform their daily tasks. The study adds to the literature by incorporating

the perception of CHWs regarding their roles in the society. An understanding of these factors will provide insight into the importance of investing in CHWs and provide a framework for the strategies needed to enhance their roles.

### **1.5. Research question**

How do the community healthcare workers (CHWs) of the Ga-Segonyana rural district perceive their role in the services they render to the community and their contribution towards strengthening primary healthcare (PHC)?

### **1.6. Aim of the study**

The aim of the study was to explore CHWs' perceptions of their role regarding the services they provide to their communities and their contribution towards strengthening PHC services in the Ga-Segonyana rural district. The specific objectives of the research study conducted were:

1. To explore CHWs' experiences and their satisfaction in their roles in the PHC facilities of the Ga-Segonyana district.
2. To explore CHWs' views on their roles as performed, as opposed to the documented scope of CHWs.
3. To understand CHWs' perceptions of the training they received.
4. To investigate CHWs' perceptions on the support system, enablers, barriers and problems that influences their ability to render quality services in PHC, and to provide recommendations.
5. To explore CHWs' perceptions of mechanisms to improve the delivery of their services.

### **1.7. Literature review**

This section provides a review of related literature with an attempt to get more in-depth knowledge about the phenomenon under study.

### **1.7.1. Definition of community health workers (CHWs)**

The WHO (2007) defines CHWs as: *members of the communities where they work, who are selected by their respective communities, answerable to the communities for their activities, supported by health care system but not necessarily a part of the organization and have been trained to some extent but do not possess a formal professional certificate* (p3). Similarly, according to Zahn, Matos, Martinez *et al* (2010), the American Public Health Association (APHA) defines a CHW as a *frontline public health worker who is a trusted member of and/ or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery* (p8).

The core elements of these definitions is the term community, which enables CHWs to perform their work on the basis of shared culture, experiences and language as they serve the community they come from. They commonly work in communities outside the regular health facilities with limited training, as they lack professional certificates or a tertiary degree.

In the South African context, Van Ginneken, Lewin and Berridge (2010) define CHWs as *people chosen within a community to perform functions related to healthcare delivery, who have no formal professional training or degree* (p1 110). So they provide services to communities, families and individuals at community-based institutions and also at household level in each municipal ward (Ngcwabe and Govender, 2013).

Generally CHWs offer valuable support to communities because they relate to and better understand the community through shared life interconnection. They play a vital role in improving access and uptake to health care services for rural communities (WHO, 2007) and are regarded as fundamental role-players of the WHO health system building blocks (WHO, 2010).

### **1.7.2. Who are community health workers and their origin**

Community health workers are known by many different names in different countries (WHO, 2007). They have been referred to by different names or titles influenced by or related to the work that they do in their communities. Despite this, the common goal for CHWs is to render healthcare services to their communities. For example in Mozambique they are called *agentes polivalentes elementares* (APEs) whereas in Ethiopia they are known as health extension

workers (HEWs) (Donnelly 2011). However, in Zambia and Tanzania they are referred to as community health assistants (CHAs) and in Kenya and South Africa they are commonly known as lay health workers (Unicef, 2014).

In China, the barefoot doctors developed the concept of empowering community members to identify their own needs and implement their own solutions (Sidel, 1972). They started as farmer scholars in the 1930s and by the 1970s there were more than one million CHWs (Perry, 2013). A number of countries – like Brazil and Nepal – were inspired by this concept, which led to a number of programmes for CHWs. Today countries like Brazil boast about 222 000 CHWs based within their communities as part of a multidisciplinary team for health service provision (Perry, 2013). The successful implementation and effectiveness of CHW programmes has also led to the emergence of CHWs in low-income countries. For example, Nepal started in 1988 with its Female Community Health Volunteer Programme and today boasts about 49 000 CHWs today providing services in rural communities, with a major focus on maternal and child health (Laven, Beilby, Wilkinson *et al*, 2003).

In many countries, CHWs come from humble backgrounds, have low socio-economic status, reside in the communities they serve and are often women (Mireku, Kiruki, McCollum *et al*, 2014).

In South Africa, CHWs were previously known as lay health workers. The service has existed since the 1920s but were not incorporated into the public health service (Kautzky and Tollman, 2008). The 2010 visit to Brazil by Health Minister Dr Aaron Motsoaledi and other health officials led to a re-organisation of PHC. It is reported that CHWs contributed to social justice as they were seen as agents of change (Kautzky and Tollman, 2008). Their ability to interact with the community enables that community to adapt its circumstances and take ownership of its health. Health promotion and prevention has become a major focus in healthcare, with a greater need of CHWs. CHWs play a significant role in their communities as they provide opportunities for enhancing the effectiveness of curative and preventive services (WHO, 2007). The Joint Learning Initiative on Human Resources for Health framework identified four levels of health workers, namely: the family, informal and traditional workers, community health workers and professionals (Initiative, 2004). So they are the anchor of the health system.

### 1.7.3. CHWs' roles and scope of work

The scope of practice for CHWs continues to be an area of interest, as well as the extent to which they deliver in their roles (WHO, 2007). Their scope may be comprehensive or limited to specified interventions, depending on the setting. The WHO (2007) defined the role of CHWs as mainly including home visits, ensuring sanitation, the provision of health education on chronic diseases (like TB and HIV/Aids), and family planning education, among others.

According to a report by Cochrane, the involvement of CHWs within a limited scope of practice has benefits in promoting child services like immunisation, growth monitoring and maternal services, like encouraging breastfeeding (Lewin, Munabi-Babigumira, Glenton *et al*, 2010). In addition, some studies have encouraged comprehensive roles within primary care services, such as preventive and promotive care (O'Brien *et al*, 2009). In sub-Saharan Africa, they have been used in HIV/Aids, tuberculosis and malaria programmes, environmental health and non-communicable diseases (Perry and Crigler, 2013). A number of studies have emphasised their role in health education, prevention of illnesses, community outreach and providing support to patients (Perry and Crigler, 2013).

However, in other countries, like Ghana, the scope of practice extends to curative care, including treatment of malaria (Baatiema, Sumah, Tang *et al*, 2016). Studies have shown that poor scope of practice leads to inefficiency in rendering quality services (Baatiema *et al*, 2016). In Rwanda, CHWs were involved in mobilising the community to use bed nets for malaria prevention and took an active part in encouraging communities to start vegetable gardens to address food shortages (Glenton and Javadi, 2014). They assisted communities in developing and maintaining healthy lifestyles through proper screening and referrals. A study done in Lesotho revealed a significant role played by CHWs in rendering first aid services and giving health education on diseases like HIV/Aids, high blood pressure and TB (Seutloali, Napoles and Bam, 2018). In Malawi, CHWs provide health promotion by giving education on social issues like violence against women, the importance of child immunisation and testing for HIV (Glenton and Javadi, 2014).

In Brazil, CHWs played a significant role in mobilising communities to enrol in immunisation, maternal and child care intervention programmes (Giugliani, Harzheim, Duncan *et al*, 2011). So in Brazil there is a better understanding of communities and the social systems found within those communities. CHWs share the language, ethnicity and socio-economic status of their communities, so are able to offer culturally appropriate services. They give informal counselling

and advocate for their communities. A study done in Nepal showed how female community health workers played a vital role in family planning and their involvement in the treatment of simple childhood illnesses (Nepal Ministry of Health and Population, 2011).

A study conducted to explore the roles of CHWs in management of non-communicable diseases in an urban township in Cape Town, showed how the CHWs aided the screening of very ill patients and educated the community to improve adherence to medication regimens (Tsolekile *et al*, 2014). According to Department of Health (2011), all CHWs in South Africa should be trained with the PHC training package, which identifies 12 roles to be performed by CHWs working in PHC. These include home-based care, counselling, support and stress relief; health promotion and education at household level, referral to relevant departments; initiatives and support for home-based projects; liaison between the Health Department and the community; mobilisation against diseases and poor health through campaigns, word of mouth and so on; directly supervised treatment support (DOTS); the screening of health-related clinic cards for compliance or default; health status assessments for all family members and giving advice, weighing babies and recording the weights on the “Road to Health” card; and providing prevention of mother-to-child transmission of HIV/Aids (Department of Health, 2011).

The discussion document on PHC Re-Engineering summarises the roles and scope of work for CHWs as shown in Figure 1.1.

	Maternal Neonatal Child Health	HIV & TB	Chronic Non-communicable Diseases	Violence & Injury
<b>HOUSEHOLDS</b>				
Screening, assessment & referral	Pregnant women, newborn & infants	HIV Testing, regular CD4, early HAART, TB symptoms	Screen for hypertension, diabetes	Substance abuse, domestic violence
Information & education	Feeding, hand washing, Oral Rehydration Therapy (ORT)		Diet, exercise, lifestyle	
Psychosocial support		Integrated approach to adherence support		Victim support
Basic home treatment	ORT, worms, refer pneumonia, Vitamin A		Foot care	First aid
<b>COMMUNITY, SCHOOLS &amp; EARLY LEARNING CENTRES</b>				
Assessments, campaigns, & screening	Immunisation, water and sanitation, nutrition, food security	Condom distribution, youth programmes	Diet, exercise	Pedestrian safety

Figure 1.1: Roles of CHWs\_Source: national Department of Health (2010)

PHC, which uses limited resources to improve health outcomes, relies on health workers like physicians, nurses and community health workers, as well as on community participation, to achieve and address unequal health care services (International Conference on Primary Health Care, 1978). In the area of PHC, CHWs are the key role players, and undertake various roles including community mobiliser, health promoter and preventive services provider (Glenton and Javadi, 2014).

#### **1.7.4. Community participation in PHC**

##### *1.7.4.1. Definition of community participation*

The successful implementation of CHWs' work requires community participation. The literature shows that community participation has a multitude of definitions and so has been understood differently. The lack of a standard definition for community participation has also led to the lack of a common approach to programme implementation (Mubyazi and Hutton, 2012). For example, McCoy, Hall and Ridge (2012), expressed frustration with the inability to give standard definitions of community participation. In this line of argument, Rifkin (2014) reported that the concept of community participation has been understood in the context of an intervention for improving health outcomes, rather than a process to implement and support health programmes to sustain these outcomes. Nxumalo (2013) states that community participation should include a process of community capacity-building.

Despite the many definitions of community participation, this study adopts the definition provided in the Alma-Ata PHC report, that it is the process by which individuals and families assume responsibility for their own health and welfare and those of the community, and develop a capacity for contributing to their and the community's development (WHO, 1978).

Community participation was endorsed by the Christian Medical Commission (CMC) as an effective strategy for enabling CHWs to render their services (Perry, 2013). CHWs are recruited from the communities they serve, taking into account the social and cultural context of those communities (Perry and Crigler, 2013). Community members play a significant role in the selection of CHWs. Communities take part in various ways, like planning and supporting CHW programmes (Perry and Crigler, 2013). The WHO, in support of the Alma-Ata Declaration of 1978, also put emphasis on community participation as an effective strategy for achieving health for all.

1.7.4.2. *The link between community participation and health outcomes*

Cueto (2004) defines the value of community participation for CHWs as that which enables people to be more supportive of health services, having a voice in the decision-making process in terms of resource provision and the associated risks in a manner that empowers them. In this line of argument, LeBan, Perry, Crigler *et al* (2014) illustrate the role of CHWs in community participation as shown in the table below:

Table 1.1 : Community participation by different CHW roles

<b>CHW role</b>	<b>Importance of community participation</b>	<b>Ways community can participate</b>
Health promotion, including communication, counselling, and support to improve health and prevent disease.	Behaviour change requires repeated, intensive contacts over an extended period, and is influenced by peer support and community	Participatory community or peer groups who witness visible change provide support and continuity for behaviour change.
Health provider, including treating common illnesses, referral to health facilities, and care and support to the chronically ill.	Cultural perceptions of illness and treatment may undermine prevention, treatment, and care options unless addressed openly.  Social relations of care, if not understood and managed well, can worsen health status.	Participation in community planning approaches or formative research to uncover specific terminology and belief patterns that lead to behaviour change.  Participation in quality improvement processes for provider interaction and use of facility-based services.  Selection of specialised volunteer cadres who are patient advocates or who support referral to CHW.
Agent of change, including support for community mobilisation, empowerment, and human rights.	Structural risks to good health (power dynamics, poverty, discrimination) will not change without community action.	Engagement in the problem-posing and problem-solving process at community meetings can lead to collective action to change circumstances.
Health management, including vital event and other reporting.	Communities may not want to provide vital events information to government agents.	Election of a volunteer cadre that supports the CHW with household visits to neighbours (i e, Care Group approach).

Source: LeBan *et al* (2014)

Table 1.1 above provides clarity on the parameters demarcating the roles and obligations of the CHW, the community and the health centre. Community participation enhances the role of CHWs through supporting their initiatives. It is reported that in some countries, like Honduras, village health committees enhance the role of CHWs through supervision and the provision of incentives, which has a positive effect on CHW programmes (Alamo, Wabwire-Mangen, Kenneth *et al*, 2012). For example, studies done in Ethiopia revealed community participation through religious groups, women's groups and traditional healers, which in turn creates trust (Perry and Crigler, 2013). The successful implementation of the Philani Mentor Mother programme in the rural Eastern Cape was done through the support of local chiefs and community participation (Le Roux *et al*, 2015).

Within the discourse of community participation there is a belief that it enhances self-reliance, health promotion, empowerment and collective action (Nxumalo, 2013), the provision of more resources and greater control for the community (Rifkin, 2009), and political acceptance and cost-effective means of addressing health problems in communities (Lehmann and Sanders, 2007b), enhances empowerment in the community (Hickey and Mohan, 2005; Vega-Romero and Torres-Tovar, 2007) among others. In Tanzania, village health workers who were involved in the running of a maternity project had the emergency vehicle financed by the community (George, Mehra, Scott *et al*, 2015). Communities were in turn helped to take responsibility for their own health as they engaged with CHWs. Similarly, a study by Abad-Franch, Vega, Rolón *et al* (2011) found evidence of a causal link between community participation and improved health status. The study concluded that participation enhanced the control of disease but indicated that further evidence was needed.

However, Rifkin (2014) argues that these are mere assumptions, as they have not been empirically proved true. Rifkin (2009) analysed these assumptions and found that a number of studies had reported on advocacy, without concrete evidence. Lack of empirical evidence of direct benefits suggested that the concept of community participation became more nuanced (Rifkin, 2014). The existence of different contextual variables has made it difficult to facilitate community participation (Nxumalo, 2013). In this line of argument, Preston, Waugh, Larkins *et al* (2010) found no evidence to suggest that there is a link between community participation and improvements in rural health outcomes. However, the authors state that this lack of evidence does not mean lack of effect, as a number of considerations have to be taken into account, like the contextual environment of a programme. To this end, the complexity of the factors

influencing community participation has resulted in a distorted direct link between community participation and improved health outcomes.

The success of community participation could also be dependent on the contextual variables surrounding a programme. These contextual variables emanate from the fact that communities are heterogeneous and diverse, for example, in terms of needs, beliefs and culture. According to WHO (1978), community participation is determined by factors like culture, history, government policy and social, political and economic structures.

#### *1.7.4.3. Policies to enhance community participation*

It is also vital that community participation is enhanced through policies. It is reported that countries with clearly outlined policies for community participation achieve cohesion and accountability. The development of such policies involves government, community leaders and religious leaders and has a positive effect on community participation. However, Nxumalo (2013) argues that despite the acceptance that policies play an important role in enhancing community participation, the extent to which communities are involved in shaping those policies remains unknown.

#### *1.7.4.4. Key enablers for and barriers to community participation*

There are also enablers to the success of community participation in health programmes, as documented in the literature. These enablers include the small-scale nature of the programmes (Lehmann and Sanders, 2007c) and proper alignment of programme activities to community activities (LeBan *et al*, 2014; Nxumalo, 2013). LeBan *et al* (2014) state further that enablers and barriers can be viewed in the context of power, skills and knowledge practices of engagement, transaction costs, cultural, active or passive resistance. The enablers are illustrated in the table below.

Table 1.2: Enablers of community engagement with CHWs

Category	Enablers
Power	<ul style="list-style-type: none"> <li>• Broad community participation with an appropriate cross-section of community members</li> <li>• Specific CHW selection criteria favouring disadvantaged groups</li> <li>• Involvement of community governance group</li> </ul>
Skills and knowledge	<ul style="list-style-type: none"> <li>• Clear and realistic goals for CHW and community with appropriate skills-based training and continuing education</li> <li>• Networking among peer CHWs and shared learning</li> </ul>
Practices of engagement	<ul style="list-style-type: none"> <li>• Environment of mutual respect, understanding, trust</li> <li>• Open and frequent interaction, information and discussion</li> </ul>
Transaction costs	<ul style="list-style-type: none"> <li>• Members see engagement to be in their self-interest. There are benefits to engagement as offsetting costs, including small visible activities</li> <li>• CHW travel stipend and perceived valuable incentives</li> </ul>
Cultural	<ul style="list-style-type: none"> <li>• History of collaboration and co-operation in the community</li> <li>• Partnership-defined quality (PDQ) approaches</li> </ul>
Active or passive resistance	<ul style="list-style-type: none"> <li>• Positive past experience</li> <li>• Members feel ownership and share a stake in both process and outcome</li> </ul>

Source: LeBan *et al* (2014)

Pertaining to barriers, LeBan *et al* (2014) highlight that there are external factors that constrain the promotion of community participation. According to LeBan *et al* (2014), these factors include political involvement and selection criteria that favour influential and sometimes wealthy people. LeBan *et al* (2014) summarise these barriers as shown in the table below:

Table 1.3: Barriers to community engagement with CHWs

Category	Barriers
Power	<p>Misuse of power by professionals, leaders and developmental actors</p> <ul style="list-style-type: none"> <li>• Discursive – defining who can be engaged</li> <li>• Positional – controlling the terms of engagement</li> <li>• Financial – shaping level and type of support provided for communities</li> </ul>
Skills and knowledge	<p>Lack of relevant skills and knowledge impeding communication</p>

Category	Barriers
Practices of engagement	Style of meetings, failure to accommodate cultural diversity, accessibility
Transaction costs	Time lost and financial resources required, especially in rural areas
Cultural	Stereotypical attitudes among officials toward gender roles and the disabled; dominance of deficit images of communities as having high needs and few assets
Active or passive resistance	Apathy and disinterest in communities that have been co-opted in the past

Source: LeBan *et al* (2014)

### 1.7.5. The effect of CHWs on service delivery

Globally, many studies have been conducted to review the influence of CHWs in improving health outcomes in rural communities. A number of governments worldwide have responded to the Alma-Ata Declaration on primary healthcare in 1978 by implementing national programmes for community health workers (CHWs).

A systematic review by Lewin *et al* (2010) highlights the influence of CHWs, including increased immunisation uptake, breastfeeding promotion and improved health outcomes for infectious diseases (Lewin *et al*, 2010). Similarly in Ghana, the eradication of Guinea worms was attributed to the role played by CHWs (Baatiema *et al*, 2016). In Ethiopia, the uptake of contraceptives came as a result of well-trained CHWs (Banteyerga, 2011). Similar results were found in a study conducted by Christopher, Le May, Lewin *et al* (2011) in sub-Saharan Africa from 1987 to 2007. The study focused on seven interventions in curative treatments, with or without preventive components, for malaria, diarrhoea or pneumonia in children. The study found that CHWs in national programmes achieved large mortality reductions of 63% and 36% respectively, when insecticide-treated nets and anti-malarial chemoprophylaxis were delivered, in addition to curative interventions.

A systematic review on effectiveness and factors influencing performance of CHWs by Vaughan, Kok, Witter *et al* (2016) found strong evidence that using CHWs in health programmes can be a cost-effective intervention in lower-middle-income countries (LMICs), particularly for tuberculosis. However, this study also found that CHWs were not allowed to deal with issues related to reproductive, maternal, newborn and child health (RMNCH) and malaria. In Afghanistan, Huber, Saedi and Samadi (2010) found that CHWs were able to increase the

contraceptive prevalence rate (CPR) by 24% 27% within eight months in 13 provinces.

In the US, Swider reports a positive effect of CHWs in increasing access to health care in underserved communities (Swider, 2002). Overall, the use of CHWs has shown success in improving chronic disease management (Islam, Riley, Wyatt *et al*, 2014, Spencer, Rosland, Kieffer *et al*, 2011), promoting positive lifestyle behaviour changes (Elder, Ayala, Campbell *et al*, 2005) and reducing unnecessary use of the health service (Enard and Ganelin, 2013). A systematic review by Jack, Arabadjis, Sun *et al* (2017) found that some CHW interventions have reduced costs and preventable use. So CHWs are increasingly being acknowledged as valuable members of the healthcare workforce in the US due to their unique potential for generating positive health outcomes (American Medical Association, 2015).

In South Africa, with the implementation of PHC re-structuring in 2010, positive spinoffs included CHWs as catalysts in the implementation of policies due to their contribution in preventive and promotive services (Prasad and Muraleedharan, 2007). A study conducted in the restructuring of PHC in the rural Eastern Cape documented success in the selection process for CHWs of the Philani Mentor Mother programme in building relationships with families (Le Roux *et al*, 2015). This led to the integration of CHWs as one level of a multi-level health service system by which homes will be linked with clinics and a hospital. Ncama (2007) found that in South Africa, home-based care for persons living with HIV/Aids by CHWs facilitated the acceptance and disclosure of HIV-positive status. Recently, a study conducted by Nxumalo, Goudge and Manderson (2016) found that limited resources available to CHWs hindered their ability to meet householders' needs and for householders to benefit from existing services. On the other hand, CHWs in the Eastern Cape were better able to address the needs of poor householders because of the organisational support available to them.

#### **1.7.6. Problems for CHWs in community service provision**

A number of studies have revealed lack of training, poor selection and lack of incentives as barriers in the performance of CHWs (Oliver *et al*, 2015, Rowe, de Savigny, Lanata *et al*, 2005). Studies demonstrate that poor training results in poor services which affect health outcomes (Lehmann and Sanders, 2007a). A study conducted in Uganda reflected that CHWs recognise their lack of training as hindrance to rendering effective services, resulting in low morale and lack of confidence (Martinez, Vivancos, Visschers *et al*, 2008). In India, Sharma, Webster and Bhattacharyya (2014) found that the professional challenges faced by CHWs were recruitment

based on favouritism rather than competence; lack of clear affiliation of CHWs to any department or authority; absence of mechanisms to ensure job accountability; and non-cordial relationships among CHWs and co-workers. These sentiments were also echoed by studies conducted in the South African context (Christopher *et al*, 2011; Perry, 2013, Perry and Zulliger, 2012). A study conducted in Kenya demonstrated that CHWs can be poorly perceived as not being useful by the community due to lack of resources (Rachlis, Naanyu, Wachira *et al*, 2016).

A study conducted in South Africa's Eastern Cape Province with 91 CHWs found that the implementation of outreach team oversight, desired field-based training and a lack of supervision in the community were perceived as weaknesses (Austin-Evelyn , Rabkin, Macheke *et al* (2017). Moosa, Derese and Peersman (2017) found that difficulties with the formalisation and training of CHWs and appropriate task shifting to nurses posed a challenge to implementing PHC outreach programmes in South Africa. In another study, White, Govender and Lister (2017) found that the CHWs were predominately women and their experiences varied. White *et al* (2017) found several factors lacking in the current PHC programme, like a formal growth pathway or formal training to align the CHWs with the National Qualifications Framework (NQF). These suggest that most of the problems encountered by CHWs pertain to selection, clarity of role, training, skills, supervision, incentives, and job security.

### **1.8. Chapter summary**

This chapter provided an introduction to and background of the study. .This chapter outlined the project statement of the study, its justification, the research question and its aim. The chapter also presented the related literature. The reviewed literature pertains to the CHWs' roles and scope of work, their participation in PHC, the effect of CHWs on service delivery and the problems they face in carrying out their duties.

## **Chapter 2**

### **Methodology**

#### **2.1 Introduction**

The aim of this study is to explore the perceptions of CHWs regarding their role in the services they render to their communities and their contribution to the strengthening of PHC services in the rural district of Ga-Segonyana. This chapter describes the research design adopted for the study. Study sample site and population, sample selection approach, data collection, data management and analysis are also discussed.

#### **2.2 Research design**

A research design offers an overall plan for the study in terms of how the participants were selected and how the data was collected (Welman, Kruger and Mitchell, 2009). Opie (2004) states that a research design is determined by the methodological approach to be adopted by the researcher, the type of data to be collected, the manner in which data is collected, data analysis methods and reporting of findings. While Tobin (2006) highlights that there are many design alternatives, the most common ones are experimental research design, a survey research design, a case study, exploratory and ethnographic research designs.

This study adopted an exploratory research design. An exploratory approach was chosen as it is essential when the researcher is breaking new ground, and it almost always yield new insight of a phenomenon (Babbie, 2013). Furthermore, this design allowed the researcher to apply rigor so as to produce conclusive results (Manerikar and Manerikar, 2014).

Through this approach, it was possible for the researcher to engage deeply and interact with CHWs through semi-structured interviews. The researcher was able to generate and understand in detail the perceptions of CHWs about their role on the services they render to the community and their contribution in the strengthening of PHC services, which is a relatively new phenomenon.

### **2.3 Research Methodology**

According to Polit and Beck (2017), a research method is a technique used to construct a study and to collect and analyse data in a systematic manner. There are two widely recognized research methods, which are; the quantitative (positivist) and the qualitative (phenomenological) method.

The quantitative research method makes use of statistical ways to measure results determinately. This method can also be used for testing the robustness of results obtained from a series of qualitative experiments, as to reach to a conclusion. Creswell (2009) states that quantitative methods use surveys and questionnaires to collect data, which in turn allows inferences to be made as long as the sample is representative of the target population. Wyse (2011) states that measurable data is usually used to explicate facts and reveal patterns in research and also data collection methods are better structured as compared to qualitative research methods. Therefore, quantitative research ensures that attitudes, opinions, behaviours, and other defined variables are quantifiable.

On the other hand, qualitative research attempts to understand the world from the subject's point of view and unravel the meaning of people's experiences (Creswell, 2010). Therefore, the qualitative research method collects qualitative data, which is non-numerical, and analyse verbal discourse through interviews, written documents or participatory field observations. Researchers use the qualitative approach to explore the behavior, perspectives, experiences and feelings of people. Additionally, qualitative research methods are referred to as naturalistic since they enable researchers to often engage with individuals whose views and thoughts they wish to explore (Malagon-Maldonado, 2014).

This study used the qualitative approach as it was the most appropriate given the nature of the investigation. Moreover, the researcher becomes the key tool for data collection in qualitative research through examining textual, observing behaviour or interviewing informants (Creswell, 2014). In this instance, the researcher became the key research tool by interviewing the research participants at the research site.

In this particular study, the research method is described in terms of the; research setting, study population, study sample, data collection process and data analysis process. This is detailed in the subsequent sections below.

## 2.4 Study site

The current study was conducted in Ga-Segonyana Local Municipality in the Northern Cape Province, over a period of one month (March 2018). Ga-Segonyana has the largest population (104 408 people) compared with other local municipalities in the John Taolo Gaetsewe district (Ga-Segonyana Local Municipality, 2018). Ga-Segonyana Local Municipality comprises 36 residential areas, of which 20% is urban and the remaining 80% rural. The municipality is divided into 13 wards. The rural areas in this district are administered by tribal authorities. The rural communities are characterised by low population density as the villages are scattered. This affects service delivery and infrastructure development. Most of the population is unemployed (58%), with 4.8% of the population relying on old age pensions, 4% on disability grants and 11.6% on child support grants (Zahn *et al*, 2010).

The study was conducted in Mothibistad town and in Seoding, a village in Kuruman town. Mothibistad is a town with a population of 9 616 and Seoding a village with a total population of 1 900 (StatsSA, 2011). These sites were chosen because they are in a deep rural environment, with a larger number of people in need of the services of CHWs. There are two hospitals nearby, one in Kuruman, the area's central business district, and the other in Batlharos village. There are also five primary healthcare clinics in the catchment areas, in Mothibistad, Seoding, Manyeding, Gamopedi and Tsineng villages. The other villages rely on mobile clinics with limited a scope of health services. The available clinics are not able to address the needs of the community adequately due to their lack of access to basic services, poor staffing, lack of medical supplies and equipment (Ga-Segonyana Local Municipality, 2015). A map of the study site appears in Figure 2.1 below.

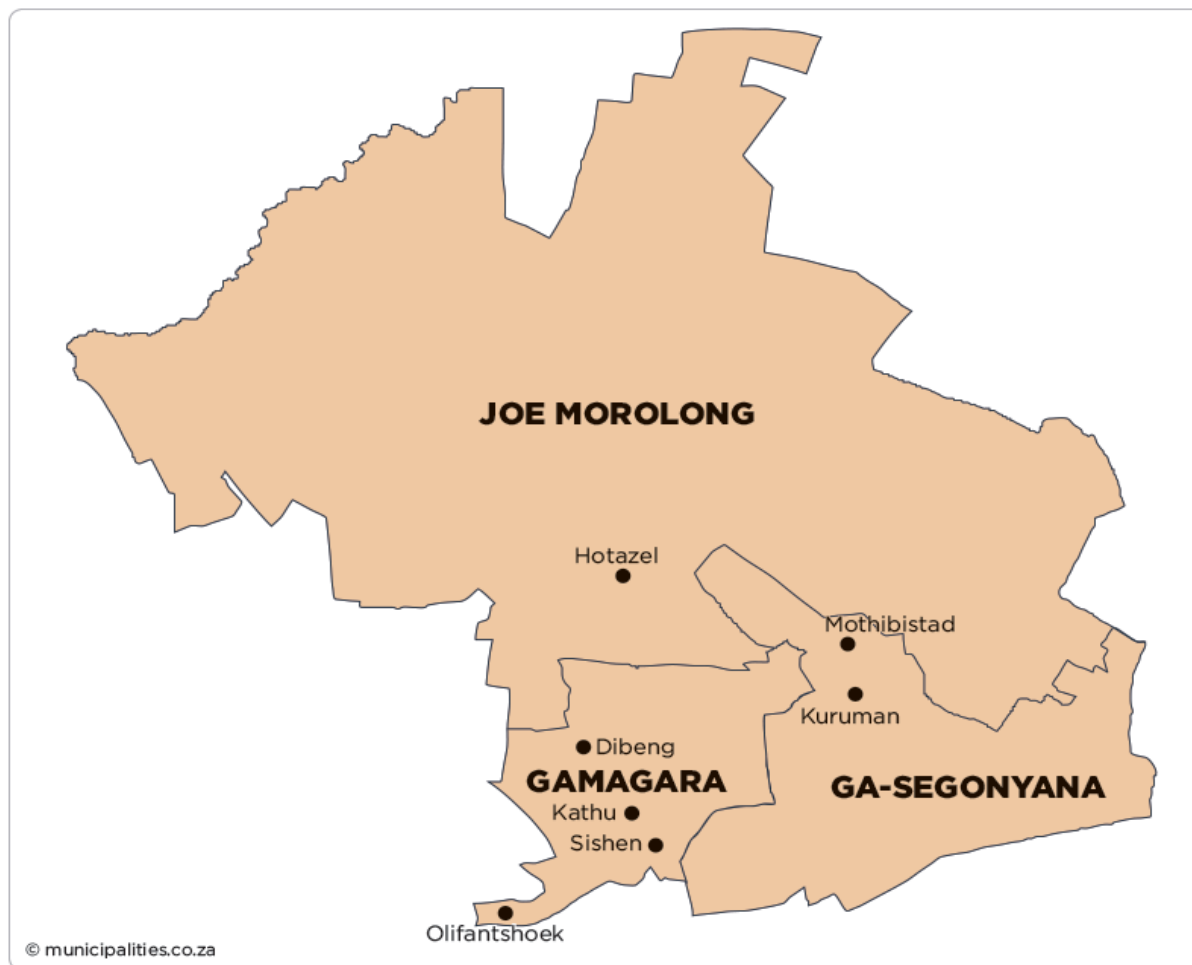


Figure 1.1: The map of John Taolo Gaetsewe District municipality Source: Municipalities of South Africa (2018)

## 2.5 Study population

The participants for this study were individuals identified as CHWs by the NGO Maruping Health Care Group and the district municipality. The CHWs in the area of study are employed by the Maruping Health Care Group and are contracted to the Northern Cape Department of Health. The total number of CHWs in John Taolo Gaetsewe District Municipality is 843 (Parliamentary Monitoring Group (MPG), 2016).

## 2.6 Study sample

Nine CHWs were drawn from the two PHCs of Mothibistad and Seoding villages. Purposive sampling was used to select participants at the sites identified. Purposive sampling is a technique of sampling in which the participants to be observed are selected on the basis of the researcher's judgment about which ones will be the most useful (Babbie, 2013). Cresswell and Plano Clark (2011) state further that purposive sampling involves the identification and selection of

individuals who are especially knowledgeable about or experienced with a phenomenon of interest. With purposive sampling, the researcher was able to recruit those CHWs who were able to provide valuable data about their roles in relation to the services they provide to the community. As a result, the researcher was able to save time and money as the interviews were conducted with the right individuals who were able to communicate their experiences and opinions in an articulate, expressive, and reflective manner.

The participants were informed about the study by the facility managers of the PHC clinics and those who were available and able to participate in the study showed up on the set date. The researcher did not have a pre-determined sample size, therefore the participants were interviewed until the point of saturation was reached. A saturation point is when you are no longer getting new information or the information will be negligible and you stop collecting additional information (Kumar, 2011). The point of saturation for this study was reached after interviewing nine CHWs from Mothibistad and Seoding villages. This was done as to ensure a broad range of representation.

### **2.6.1 Inclusion criteria**

CHWs employed for more than three months by the Maruping Health Care Group, an NGO contracted to the Northern Cape Department of Health, were selected to take part in the study, as they would have finished their three-month probation period. This would enable them to provide valuable data about their roles in relation to the services they provide to the community. Despite this inclusion point, all the available participants had more than ten years of experience. In addition, CHWs were selected due to their being residents in the villages where they provided the service. It is also worth noting that all the available participants were female and older than 40 years although age and gender were not considered as inclusion criteria.

### **2.6.2 Exclusion criteria**

Exclusion criteria included:

- CHWs who took part in the pilot study for the current study.
- CHWs who have worked for less than three months.
- CHWs not resident in the village where they provide services.

## **2.7 Pilot study**

The interview guide (*Appendix 1 – Interview guide*) was pre-tested in a pilot study conducted with the two CHWs in Bathloros village, 20km from Mothibistad and Seoding village. The community was chosen for pilot testing to limit the participation of the CHWs who work in Bathloros from being part of the final sample as their later behaviour could have been influenced by previous exposure to the study. Data from pilot interviews was not included in the final data analysis of the study. While no questions were amended following the pilot study, the researcher found this exercise beneficial as the exposure helped her in terms of how to put questions to the participants to enable them to answer freely. The pilot study also helped the researcher to practise asking probing questions of participants as a way of gaining detailed perceptions. These techniques were found helpful during the actual interviews.

## **2.8 Data collection**

To gain insight into the role of CHWs and the services they provide, the researcher conducted semi-structured interviews with nine CHWs in the two PHC facilities. Prior to data collection, the participants were informed about the study by the facility managers of the PHC clinics following their routine monthly meeting. Each facility provided a private room for conducting interviews. The rooms were welcoming, clean, and conformable and provided the participants with privacy. Semi-structured interviews comprised a pre-determined set of open questions in the interview guide, which provided the researcher with a better understanding of the research phenomenon. Apart from demographic information about the participants, the interview guide mainly covered the perceptions of CHWs on issues around their responsibilities and experiences in the community where they work. The researcher was guided by an interview guide throughout the interview process (*Appendix 1 – Interview guide*).

The interviews took roughly 30 to 45 minutes for each participant. Participants were interviewed in Setswana, the native language in the area. Prior to participation, they were given an information sheet explaining the nature of the study (*Appendix 2 – Information sheet for the study participants*). Participants were also invited to give informed consent prior to participation in the study (*Appendix 3 – Consent form for in-depth interview*). An audio recorder was also used to capture the interview discussion with the permission of the participants (*Appendix 4 – Consent form for audio recording interview*).

## **2.9 Data management and analysis**

In preparation for data analysis, audio-recorded interviews were translated from Setswana into English and transcribed verbatim by the researcher. Directed content analysis was used to analyse data from the transcribed interviews. Directed content analysis starts with a theory or relevant research findings as guidance for initial codes (Hsieh and Shannon, 2005). The branch codes were identified with reference to the reviewed literature, study objectives and research questions. The branch codes were further broken down into fine codes. For instance, CHWs' views of their performed roles, as opposed to the documented scope of CHWs, were identified as a branch code derived directly from a research objective.

During this process, Atlas ti computer software, version 7.0, was used for data analysis. The software aided in classifying and arranging the information and examining the relationships in the data. To ensure truthfulness in the study, a detailed research process as postulated by Fereday and Muir-Cochrane (2006) is provided:

### **2.9.1 Generating codes**

A fundamental aspect to qualitative data analysis is coding. According to Charmaz (1983), coding serves to summarise, synthesise and sort observations made of the collected data, which contributes immensely to improving qualitative data analysis (Theron, 2015). This process involves a researcher looking into the perceptions of CHWs pertaining to a number of aspects that affect their service delivery. The two commonly used approaches are open coding and closed coding; this study adopted the closed coding approach. Closed coding involves pre-determined themes based on the predetermined coding scheme. Predefined codes help with the integration of concepts that are already familiar from the existing literature (Bradley, Curry and Devers, 2007). Despite the downside of closed coding where a researcher may potentially force the data to fit into a list of codes, Bradley *et al* (2007) argue that building from previous insights can also trigger a researcher to bring new dimensions to the research field.

### **2.9.2 Identifying themes**

From initial coding, the second phase involved sorting different codes into potential themes. Different codes were sorted and collated under the same thematic umbrella with broad codes and fine codes. These broad codes are refined and become themes on the thematic framework and the fine codes become the sub-themes as presented on table 3.1.

### **2.9.3 Reviewing themes**

This stage involved the refinement of the identified themes to check whether each of the themes has enough data to support it. Through this exercise, it was found that some of the data supporting certain themes was too diverse and effort was made to ensure that data supporting each theme cohered meaningfully. All extracts under a coded theme were reviewed to check whether it forms a coherent pattern (Braun and Clarke, 2006). In those instances where a coherent pattern was not established, a new theme was created to accommodate those extracts. The final review process involved assessing the representation of the themes in relation to the research questions or the existing literature.

### **2.10 Ethical considerations**

Ethical clearance to carry out the study was obtained from the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (M170972) and the Northern Cape Department of Health. Maruping Health Care Group agreed to provide CHWs after approval from the district. Following a brief overview of the study, participants were given information about the nature and purpose of the study (*Appendix 2 – Information sheet for the participants*).

#### **2.10.1 Informed consent**

Written informed consent was obtained from CHWs to enable them to take part in the study (*Appendix 3: Consent form for in-depth interview*). Participants were informed of their rights to withdraw from the study if necessary and to have their data removed without being penalised. Written consent for audio recording was also obtained (*Appendix 4 - Consent form for audio recording interview*). Consent and transcripts will be stored by the researcher safely in a locked cupboard for five years. Audio files will be password-protected in the researcher's personal laptop for five years to allow publication of the study. The laptop will be kept by the researcher in a safe cupboard.

#### **2.10.2 Confidentiality**

The researcher acted with integrity and maintained confidentiality through the course of the study. To ensure participants' confidentiality, pseudonyms were used during the interviews and on the analysed data. The interview data will be encrypted and saved on a memory stick (USB). The researcher will keep the USB safe in a locked cupboard. The data will only be used for academic purposes by the researcher and the respective supervisors.

### **2.10.3 Reflexivity**

Reflexivity is a process whereby researchers reflect about how their biases, values, and personal background, such as gender, history, culture, and socioeconomic status, shape their interpretations formed during a study (Creswell, 2014). From an insider perspective, the researcher grew up in a similar environment to those of the participants and can relate with the lifestyles experienced by the communities. This facilitated understanding and the interpretation of non-verbal cues, as well as reducing the chances of making inappropriate assumptions. As someone in the field of nursing, I played an outsider role, which might have influenced how the participants responded during the interview. For instance, I could probe further when I picked up that the participant had left out critical information on a certain aspect. I went in with an open mind so that my knowledge of the field did not influence me before conducting the research. It was important to explain to the participants prior to the interview that the research was for educational purposes and that no one would be penalised in the process.

### **2.10.4 Trustworthiness**

Given that this was a qualitative study, issues pertaining to trustworthiness, principles of credibility, transferability, dependability and confirmability were considered important and these are discussed below.

*Credibility* refers to the researcher's linking the study's findings with the reality so as to demonstrate that the results of the research are believable (WHO, 2007). This was achieved by validating the codes with the supervisors through a series of drafts and meetings. The existing literature was also re-visited and linked to the study objectives and research questions.

*Transferability* refers to the ability of the research study findings to be replicated in another context. This was achieved by following a systematic approach that involved detailing the research methodology, including research design, study site, study population, sampling, data collecting and analysis. A detailed account of how the study unfolded was provided by the researcher.

*Dependability* refers to the extent that the research can be repeated by others with the results remaining consistent (WHO, 2007). This was achieved through a detailed description of data collection and data analysis steps to ensure that it can be duplicated. Inter-coder reliability is concerned with the extent to which two or more independent coders agree on the coding of the

content of interest with the application of the same coding scheme (Lavrakas, 2008). For this study, there were not many instances of diverging views between the coders about the categorisation of codes, mainly because prior literature and research questions were used as a guideline.

*Confirmability* refers to the fact that the findings are truly participants' responses and not due to any bias from the researcher (Bedelu, Ford, Hilderbrand *et al*, 2007). This was achieved by data auditing, emphasising all the crucial steps taken in data analysis. Also, to illustrate the points raised by the participants, direct quotations were provided. The researcher interpreted the meaning in the data within the confines of the participant's responses.

## Chapter 3

### Results

#### 3.1. Introduction

This chapter presents the results emanating from the interviews conducted. The chapter provides a detailed account of how CHWs of Ga-Segonyana rural district perceived their role with regard to the services they render to the community and their contribution to the strengthening of primary healthcare (PHC). The results will be presented according to the study objectives.

#### 3.2. Demographic profile of the participants

This section presents the demographic information of the participants. According to Table 3.1, the average age of the participants was 51 - 60 years (66.7%). Regarding the highest level of education, 88.9% of the participants disclosed that they had Grade 11 or less. The level of work experience for 77.8% of the participants ranged between 16 and 20 years. 88.9% of the participants were either married or divorced, with only 11.1% still being single. The demographics also show that 100% of the participants were all female.

Table 3.1: Demographic profile of participants

Demographics	Number (N)	Percentage (%)
<b>Gender:</b>		
Male	0	0
Female	9	100
<b>Marital Status:</b>		
Single	1	11.1
Married	6	66.7
Divorced	2	22.2
<b>Age (Years):</b>		
41 - 50	3	33.3
51 – 60	6	66.7
61 and above	0	0
<b>Level of Education (Grade):</b>		
Undisclosed	1	11.1
6 and below	0	0
7 – 11	8	88.9
12 and above	0	0
<b>Years of Experience (Years):</b>		
11 - 15	1	11.1
16 – 20	7	77.8
21 and above	1	11.1

### 3.3. Presentation of results

As indicated above, the results are presented according to the research objectives that framed the study. Figure 3.1 below captures the thematic framework outlining five key study themes and subsequent subthemes that will be presented in different sections of the report.

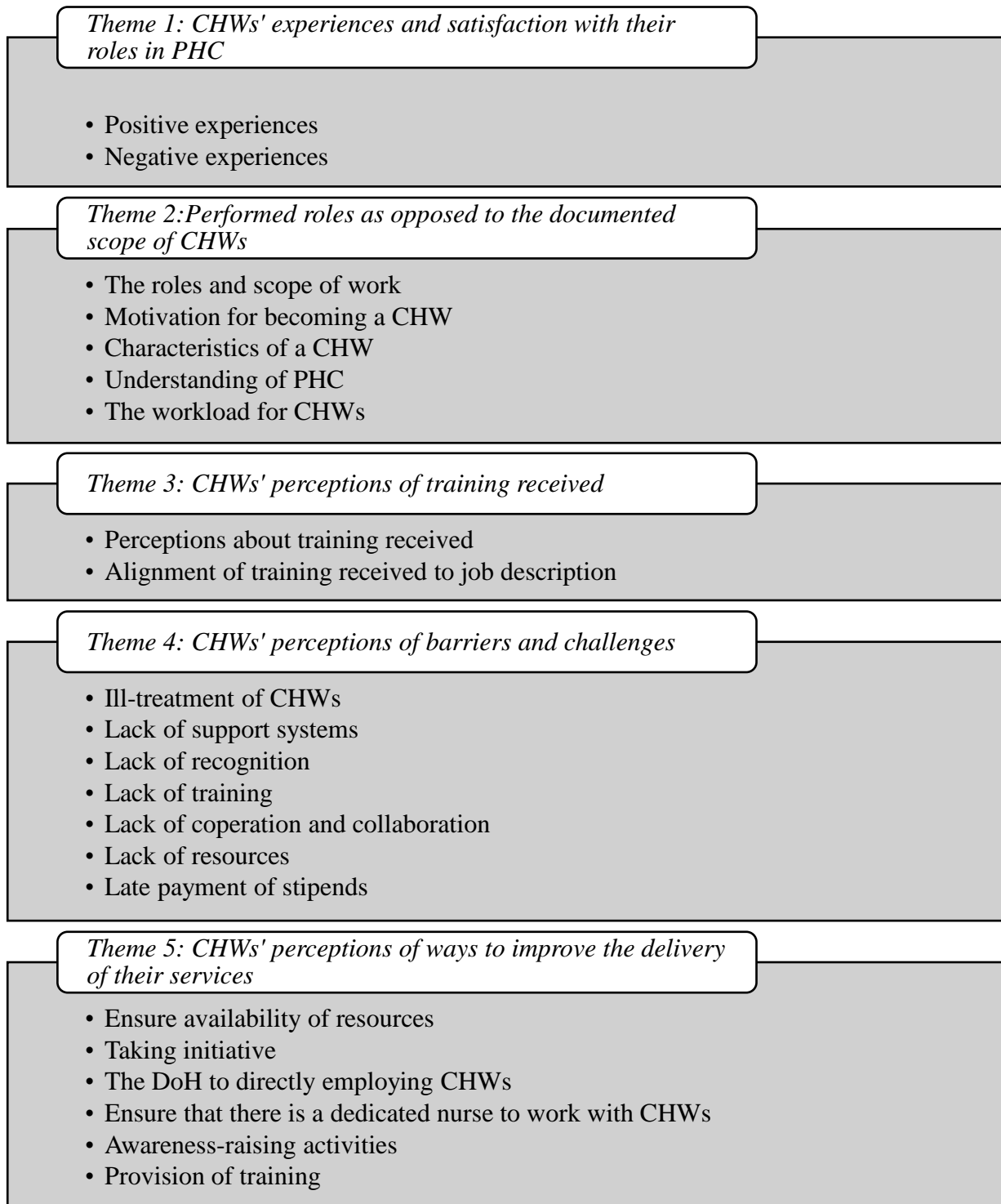


Figure 2.1: Thematic framework

### 3.3.1. Theme 1: CHWs' experiences and satisfaction with their roles in PHC

The first theme presented on this section focuses on objective one of the study, which sought to explore the CHWs' experiences of and satisfaction with their roles in PHC. To explore this, the participants were probed to provide a detailed account of their experiences as CHWs. From the narratives, the CHWs' experiences can be categorised into two: good and bad experiences.

#### 3.3.1.1 Positive experiences

Participants stated that they enjoy their work as CHWs because they are learning a lot. The training received has also given them fresh insight into healthcare service delivery. Participants' responses included:

*I gained a lot of things because the first time when we worked in [X village] we went for training in Kimberley for two weeks. The training was about how to deal with a client. (Participant 8, 47, Grade 11)*

*I have learnt quite a lot as a community health worker, especially when it comes to dealing with the elderly. I remember in 2014 I was sick and my patients were worried, but when I got better and returned to work, they were very happy. (Participant 7, 53, Grade 9)*

Another participant highlighted that the positive outcomes that result from her involvement in the community has given her joy. She had this to say:

*As I have just said, some patients do not want to take their treatment, reason being some of them do not have an income. So far, this reason is the cause for their not taking their treatment because doing so requires that they eat first. For a few of the patients we have been to SASSA to request grants on their behalf and SASSA responds positively by giving them three- to six-month grants. (Participant 8, 47, Grade 11)*

#### 3.3.1.2 Negative experiences

According to the participants, in the early days there was no fairness in their terms of remuneration. While some groups of CHWs were remunerated, others were not. They were however not deterred from carrying out their duties, as they believed that their experiences could one day be applicable in their own family context, as illustrated below:

*For a long time we worked for no pay at all. While this was happening there was a group that received something, but at this time our group received nothing. We only started to get*

*something in 2008, but because we were doing this for the people we were able to continue without being paid. We also learnt that even if you are to lose your job tomorrow, the skills I learnt through this journey can also be used in my home. (Participant 1, 52, Grade 9)*

*It is as if our work is not appreciated by the nurses, but we keep on doing the right thing. (Participant 5, 55, Grade 7)*

Participants related their bad experiences to the encounters they had while on duty. This related to the misery experienced by their patients at their hands. The constant experience of death has been traumatising to the CHWs and has had dire psychological effects on them. This is illustrated by participants who said:

*That is a very painful thing to see, someone dying in your hands . . . For me it is as if I had not done anything. I ask myself questions and you do not have someone to talk to who can say: "Sorry, you lost a patient because of this and that" . . . You are thinking about losing a patient, maybe I may have been wrong here. That is what does damage to your heart. (Participant 1, 52, Grade 9)*

*Another thing: there is a patient who died just the day before yesterday . . . sometimes we do not allow certain patients to travel to social workers due to their ill-health. We would rather take it on ourselves to travel for them and also to collect their pills [treatment]. (Participant 7, 53, Grade 9)*

Another challenge is the negligence and stubbornness on the part of patients about their health status, and some elderly patients default on their medication because they cannot travel to the clinic, which in most cases is far:

*Some of the patients are ignorant and refuse to take their medication. I do not know how to put this but some are just plain stubborn . . . and some elderly people default on their medicine because of transport challenges. (Participant 3, 51, Grade 9)*

As indicated by one of the CHWs, what is frustrating is that no action is taken by the government even though it has been recognised that education is fundamental to the problems faced by the communities they operate in:

*A lot of the time when they are at the clinic, can we not be trained so that we can educate them on such illnesses, how to take their medication and when to take it until they complete*

*their treatment.* (Participant 3, 51, Grade 9)

Lack of resources for the CHWs has also contributed substantially to negative experiences, as in most cases they have to use their own money for travelling. Participants had this to say:

*What can we do, as we also do not have the resources to get to where we need to be when we need to because a person may be in dire need of medication. We end up taking money out of our own pockets.* (Participant 3, 51, Grade 9)

*The experiences are that others hide their medication while some even end up defaulting on the treatment, it is as though it is my responsibility to spend my money on taking them to the clinic.* (Participant 6, 47, Grade 9)

Lack of documentation, particularly identity documents (IDs), on the part of patients was a problem as explained by participants. This had impeded the ability of patients to access benefits like social grants:

*What I came across in my work is children who do not have IDs. You would find girls aged 16 or 18, but they lack IDs and are pregnant. I encourage girls who are 15 and still going to school that they can get prevention at the clinic just until they turn 18. Tis not to say they should fall pregnant at 18, but because at that age you would have an ID and would not necessarily struggle when applying for the child grant. At 15 the child's mother will be the one responsible for the application on behalf of the pregnant teenager – this is avoidable, but the lack of knowledge about methods of prevention offered at the clinic makes it impossible.* (Participant 4, 55, Grade 10)

### **3.3.2. Theme 2: CHWs' views on their performed roles as opposed to the documented scope of CHWs**

This main theme addresses objective 2 of the study. A number of sub-themes emerged pertaining to CHWs' views of their performed roles as opposed to their documented scope of work. These included the roles and scope of work, motivation to become a CHW, characteristics of a CHW, understanding of PHC, and the workload for CHWs. The results for each sub-theme are presented below with supporting participants' quotations.

### 3.3.2.1 *The roles and scope of work*

The participants were asked to highlight the documented scope of their work or their job description as community healthcare workers. Some participants indicated that their roles and responsibilities were not documented, while others affirmed that they are indeed documented.

As highlighted below, one of the participants said they do laundry for patients and bath them as part of their duties:

*And sometimes you get elderly patients who live alone. When you visit such a patient you first need to clean the house, wash their laundry and maybe cook for them. (Participant 9, 59, Grade 10)*

Another participant highlighted that they teach families about what to do when they live with a patient and said:

*What we have been taught is that you help your patient the moment you enter their house. You have a sit-down with the family and teach them about what to do when you are living with a patient. Some people's expectations are that as a community healthcare worker I must do everything for them, like take the patient to the clinic and bring them back and we use our own money in doing this. (Participant 1, 52, Grade 9)*

Another aspect of work involved taking care of sick patients with chronic conditions like, TB, diabetes, high blood pressure and HIV, as well as pregnant women. The participant had this to say about it:

*Yes, as community health workers we take care of sick patients with chronic conditions like; TB, diabetes, high blood pressure and HIV. We also encourage people to always take care of themselves and refrain from having sex without protection. (Participant 4, 55, Grade 10)*

One participant indicated that she takes patients' blood pressure, measures their weight and height, does health screening and collects sputum, among other things (Participant 5, 55, Grade 7).

Participants also indicated that they offer counselling, encouraging patients with chronic conditions to continue taking their treatment, and to ensure that their environment is clean. The participant said:

*. . . we check and make sure that they take their medication on time and we also check that where they live is clean. (Participant 3, 51, Grade 9)*

Another participant indicated that as CHWs, they encourage young mothers to apply for a child support grant on time and to go for family planning. The participant said:

*A counsellor and encourage them to continue taking their treatment . . . Some of the young girls, when they fall pregnant, don't apply for a grant in time, while others go for family planning. So we encourage them to apply. (Participant 6, 47, Grade 9)*

Encouraging antenatal patients to attend clinic to ensure quality care through the pregnancy and birth; and for postnatal patients to make follow-up bookings earlier and to visit the clinic regularly to ensure physical and emotional recovery from pregnancy, is one of the responsibilities that emerged from the interviews. The participant said:

*We take care of postnatal as well as antenatal patients. The postnatal patients we get to come and make bookings earlier at this clinic and to visit the clinic regularly. When we are done, we teach those who are pregnant so that when they reach five months they are adequately prepared. (Participant 8, 47, Grade 11)*

### *3.3.2.2 Motivation to become a CHW*

The motivating factors among the participants were mainly ingrained into their family, societal and personal experiences and the need for an income (economic gain). From a family perspective, one participant said:

*It was because a very long time ago my mother's sister was very sick. I was the one taking care of her, organising the taxi to take her to hospital and doing everything for her. After that her late son, we were the ones taking care of that boy. Also my twin sister was very sick and I took care of her as well. (Participant 6, 47, Grade 11)*

Participants have witnessed people with chronic ailments like HIV and TB who were stigmatised and neglected, and then saw a need to become a CHW to be able to take care of them. In this regard, participants had this to say:

*For me to decide to become a community health worker I realised how people in our community were suffering from illnesses and in some instances you would find there was no-*

*one available to help them. Maybe the individual in question is an elderly person, sometimes a child whose parents have died. There are many orphans one encounters, and many of them do not even have IDs, as most are from rural areas. So you find that they have no family and live by themselves in unhygienic conditions. Often these orphans go to school without anything to eat because there is nothing at home. You have a household headed by children. (Participant 3, 51, Grade 9)*

Another participant said:

*It was seeing our people suffering, especially when they are very sick. They would sometimes not admit that they had TB, for instance, and such an individual could end up getting his/her entire family infected with TB. (Participant 4, 55, Grade 10)*

From the point of view of personal experience, one participant indicated that she was motivated to serve as a CHW because of how she was treated when she learnt that she was HIV-positive:

*It is the love I have for people. Mostly what motivated me is the time when I got sick. I got to the clinic, I found out that I was HIV-positive, then I had that in my heart that people must know how to handle it. They must know how to suppress their viral load and see that HIV does not kill, let alone other chronic illnesses. Take your medication and do not take it for granted. If you take your medication, nothing is going to stop you from living. (Participant 1, 52, Grade 9)*

However, another participant highlighted the need of an income as a motivation for becoming a CHW:

*Eish, what else could it be if not for suffering. A person had not been working and without a source of income. So I saw that if I joined in here I could get something, even though we started as volunteers and were paid nothing. Then in 2001 we started receiving a little something, a stipend. (Participant 5, 55, Grade 7)*

### *3.3.2.3 Characteristics of a CHW*

Participants described a number of traits they considered important for a good CHW. These traits included friendliness, patience and selflessness, positive loving attitude, respectful to others and oneself, among others. These traits were explained as follows:

*They need to be friendly and patient. (Participant 5, 55, Grade 7)*

*They need to be respectful to others and themselves. You also need to be happy, especially when going to see clients because they cannot see your unhappy face. You are supposed to be happy. Some clients do not take us seriously, but when you get there, you do something like a speech so that the client is attracted to you. You must be attractive to the client. (Participant 8, 47 years, Grade 11)*

*You need to be a loving person, one who is able to take care of themselves and others because we fail to do what we have to properly due to a lack of resources. (Participant 9, 59, Grade 10)*

#### 3.3.2.4 Understanding of primary healthcare

The results also reveal that the participants defined primary healthcare within the confines of helping people by referring them to the clinics or hospitals and prevention of diseases. Comments included:

*Yah, primary healthcare is to help people and care for them. It links with my work because by doing community health work I am the one who refers you to the primary healthcare worker because to get to a worker everything begins with me. I am the first one that is going to see and refer you to the clinic and the clinic will take it from then on.” (Participant 1, 52, Grade 9)*

*Primary healthcare, we end up doing referrals from the community to the clinic or from the clinic to the hospital and sometimes from the hospital to the regional . . . (Participant 3, 51, Grade 9)*

Another participant indicated that she encourages pregnant women to visit the clinic early for regular check-ups and screening, saying:

*Primary healthcare to me is when someone is two weeks pregnant or more, I encourage them to come to the clinic and check because when they do not and wait until they are maybe three months, it is only then that they are tested for maybe diabetes or HIV, to prevent them from being transmitted to the child. (Participant 4, 55, Grade 10)*

### 3.3.2.5 *The workload for CHWs*

Participants indicated that their workload was high due to the limited number of CHWs and that the households to be visited are far apart. One participant said:

*. . . each and every day you go to the five patients and they are far . . . only to find that we don't reach some points . . . the community doesn't know that there is only a handful of us.*  
(Participant 3, 51, Grade 9)

### **3.3.3. Theme 3: CHWs' perceptions of training received**

Objective 3 of the study sought to understand CHWs' perceptions on their training. To fulfil this objective, participants were asked to give their perspectives regarding the training received and alignment of the training received to job description. Participants' views are presented below.

#### *3.3.3.1 Perspectives of training received*

Most of the participants acknowledged that the training they had received was crucial for the nature of their work. They perceived that training have helped them to do their work better. The participants had this to say about it:

*The training was excellent and I do not have a problem.* (Participant 1, 52, Grade 9)

*It is important in that they have taught me how to deal with people as well as how to talk to them. What they really teach is how to approach people.* (Participant 3, 51, Grade 9)

However, despite the fact that they were receptive about the content of the training they received, the participants highlighted that the training was not enough and that they had not received certification after they had completed it. In this regard, one participant said this:

*It is not enough. We did get trained for MDR but we have not yet received certificates for the training and it has been a very long time now* (Participant 5, 55, Grade 7)

#### *3.3.3.2 Alignment of the training received to job description*

All the participants mentioned that they had received training related to the nature of their work as CHWs. The training provided included re-structuring ("re-engineering"), primary healthcare,

TB, HIV, breast cancer, MDR, and adherence support. According to the participants, these training sessions lasted between one week and two months, depending on the issues covered. The participants had this to say:

*Eh . . . re-engineering in 2000 and I think 2014 to '18. It is a long, long time. (Participant 2, 42)*

*We do receive training but it makes no difference because training for re-engineering we last received in 2012 if I am not mistaken. So far we have not received any certificate for it. We are constantly told that we will receive them. When you are as old as some of us, when you only train us and not re-train, you are basically teaching us to forget. We do receive training though. (Participant 1, 52, Grade 9)*

Although there is an alignment, participants indicated that the training was not enough:

*They do go hand-in-hand, but half the time you come to find that there are no resources. Even when they are available we are not permitted to leave with them. In the context where you find a patient blowing hot and cold and need to check whether their blood pressure is high so that you can administer their medication, but you cannot because resources are not available. (Participant 3, 51, Grade 9)*

Some of the participants were of the view that they should have received training in line with the ever-changing health environment over and above the training they were receiving. This is alluded to by one participant who said:

*I would not say I am exactly satisfied [with the training] because when you are being trained, the very same people who train us initially still need to come back and refresh us, because things in government and particularly in health constantly change (Participant 8, 47, Grade 11)*

#### **3.3.4. Theme 4: CHWs perceptions on barriers and challenges**

The fourth objective of the study was to investigate CHWs perceptions on the support system, enablers, barriers and challenges that influences their abilities to render quality services in PHC and provide recommendations. In this regard, there are myriad problems raised by the participants, which they experience while undertaking their duties. These problems included ill-treatment of CHWs, lack of recognition, lack of training, lack of co-operation and collaboration,

lack of resources, and late payment of stipends. Perceptions of CHWs on these issues are discussed in detail below.

#### 3.3.4.1 Lack of a support system

The participants indicated that the government does not provide any support system to assist them to deal with issues such as psychological trauma, and other pertinent situations they find themselves. As a result, they have dealt with the problems they face on their own and sometimes resort to family members for comfort.

Some of the participants had this to say in this regard:

*We receive no support at all. Unless when you get home and your child realises that there is something wrong with you and they ask about it . . . So there is nothing that the health department does to help us in terms of support, like people we can sit down with and talk to about the challenges we encounter on the job. We need it, seriously because I see it myself sometimes when I come from the hospital. When we do referrals and you see a very sick person when you are escorting them to the hospital you end up seeing that person admitted, only to be told the following day when you come to see him/her that he/she has died. It is as if you are a failure and have not done your work. You are trying but eish . . . Support system? Currently we do not have it. I am not going to lie because when you experience that there is no one to talk to you. You only tell your group and that is where it ends . . . Yah, you get to know these people. They are now your family, they are yours. When you lose one person it is painful . . . We cry on each other's shoulders. (Participant 1, 52, Grade 9)*

Due to circumstances like these, participants emphasised a need for grief counselling to help them cope, as they often feel powerless and useless when a patient dies under their watch.

*The only support you get is when you get to the clinic, but after the funeral no-one comes and offers us counselling . . . Yes, because grief counselling is important, but unfortunately we do not receive any counselling. (Participant 3, 51, Grade 9)*

Another participant said:

*We do not get support and it feels as if I have not done my job. All of this is hurtful because someone has lost their life on my watch. (Participant 4, 55, Grade 10)*

The participants also indicated that they do not receive the benefits normally made available in a normal working environment. These include workman's compensation in the event of injury. They had this to say:

*We work broken-hearted. When you sustain injuries on duty there is no compensation for it. You leave penniless and your children orphaned although you died working for the community.* (Participant 4, 55, Grade 10)

*There was no stipend when we volunteered.* (Participant 5, 55, Grade 7)

Participants stated that despite raising their problems with the relevant authorities, no-one seemed to listen to them, or even attempt to address them. The participants had this to say in this regard:

*Nothing, to a point where you feel like quitting because of bickering nurses who say I talk too much. This is as a result of feeling pain, all because you want to help people. All you think about is: "What if it was you in that situation?"* (Participant 7, 53, Grade 9)

*We do not have any support because every time we complain about clients who default on their treatment the sisters summon us to the clinic. When a patient defaults it is our duty to go look for that person and bring them to the nurse's attention once found. When that specific task needs doing, they know us but when you refer a client who needs immediate attention it is a problem.* (Participant 8, 47, Grade 11)

Participants also raised the issue of stress, which affects them at both work and home.

*You have a combination of stress from home and work. We receive no support at all, unless when you get home and your child realises that there is something wrong with you and they ask about it. We are affected inasmuch as our personal problems are concerned and what we encounter in our work.* (Participant 1, 52, Grade 9)

Lack of recognition of the work done by CHWs by other health professionals, like nurses, was one of the fundamental problems identified by the participants. Apart from not being appreciated for their efforts, CHWs are often ridiculed and ill-treated by nurses. One participant said:

*It is as if we are not good enough even to get food around here. I think it is because we are community healthcare workers that we are treated this way, that we are treated like*

*trash. We do not want to come to clinics. Let them increase our pay while we are still working in the field because that is what we volunteered for. When people are sitting here [in the clinic] they are not aware of what is really happening in the community and what hurts the most is that those affected who work in the field where there are those infected with MDR or TB who work mornings in the field. When they wake up this early they don't get anything . . . You are then confronted by stench as the windows would be closed and this would be because you are the one responsible for washing the patient. Even when you bring such patients to the nurses themselves they are reluctant to attend to them. Instead they would ask: "What exactly does a community healthcare worker do?" Those are not nice words, but we continue doing our work because we put our people first. (Participant 1, 52, Grade 9)*

The lack of recognition also emanates from the patients themselves, who often insist that they can only take instruction from a nurse, not a CHW. One participant said:

*To make things easier the registered nurses need to accompany us when we visit patients because some patients are so stubborn that they would tell you are not a nurse. (Participant 4, 55, Grade 10)*

#### 3.3.4.2 Ill-treatment of CHWs

The main challenge highlighted by the CHWs was the ill-treatment received at the hands of patients in the face of expectations that they should cater for patients' needs, and lack of cooperation from the respective clinics. One participant said the main problem they faced was patients refusing to take their medication as prescribed, giving hunger as the cause. Participants had this to say about it:

*. . . Some people even refuse to take their medication because they do not have food. They make remarks like "How am I supposed to take medication on an empty stomach?" We are burdened with such problems even in our many attempts to ask for porridge and milk at the clinic to take to them. Many times you find that there is none to be had. When you fail to get this for them you are also shouted at and told that you can't help them with anything and all you do is make them sign a lot of papers . . . Nurses are not the same as people. (Participant 1, 52, Grade 9)*

#### 3.3.4.3 Lack of training

Participants stressed that they are sometimes confronted with the situation where a patient suffers from a disease they have not been trained to deal with. This has led them to breach the confidentiality clauses that guide their conduct by snooping in patients' medical records in an effort to understand the situation better. One participant had this to say:

*The challenges are sometimes that you see a person having cancer and you have never experienced it or you have not seen a person with cancer. You will end up reading and it is wrong to read another person's confidential things, but sometimes it gets to that level where you want to see what is going on here. What is going on with this person?* (Participant 1, 52, Grade 9)

*The last form of training we received was the one on primary healthcare.* (Participant 4, 55, Grade 10)

#### 3.3.4.4 Lack of co-operation and collaboration

Lack of co-operation and collaboration from the relevant departments, organisations and other stakeholders, like chiefs and headmen, or even the patients themselves when they refuse to sign the forms, has been identified as a barrier. These sentiments were shared:

*When we do referral letters for patients and maybe they do not have an ID and it happens that they want to apply for a child grant, the social worker fills in the form, but when you bring it to the nurses they do not fill in the letter, they just return it to you as it is. It is the registered nurses' duty to fill in this form and account that nurse so and so was responsible for patient X and the form has to be both stamped and signed . . . And when they don't do this it means I also haven't done anything unless that document is completed, stamped and signed.* (Participant 4, 55, Grade 10)

One of the main issues raised by the participants was that nurses refuse to fill in patient forms as expected:

*When we refer a patient the forms must be signed at the back for us to see that they were attended to, but most nurses do not fill them and we really feel undermined. The forms come back blank to show that they were not attempted.* (Participant 5, 55, Grade 7)

Patients were also identified who did not co-operate with the CHWs when they do their work. In this regard, participants stated that patients refuse to sign forms. These signatures serve as confirmation of the CHW's visit:

*Some of the challenges are that there is a form, an individual form and what is written down serves as proof for work done. Every time when we go into the field we use this individual form when attending a patient on that day. The patient has to also sign it as proof that you did attend them. The challenge is some refuse to sign. (Participant 6, 47, Grade 9)*

In addition, patients sometimes make their homes inaccessible by unleashing their dogs on the CHWs:

*It could be that the patient's house we visiting either has dogs or the people in that house just do not want you there. So that in itself is a challenge. (Participant 8, 47, Grade 11)*

#### 3.3.4.5 Lack of resources

CHWs need regular replenishment of supplies, medicines, and equipment to carry out their tasks effectively. The CHWs indicated that the lack of transport funding has greatly inhibited their ability to bring defaulting patients to clinic as they cite transport problems as the reason for their defaulting. In this regard, the participants had this to say:

*You cannot work without equipment. What are you doing, you are just going to a patient not knowing if the BP is okay or what. You just go there and lecture. (Participant 1, 52, Grade 9)*

*When you come across a patient who is really sick, you are unable to assist them because you lack the ability to do so adequately. You are then forced to tell the patient to go to the clinic for further assistance and that you are unable to help them at the time. Here at the clinic we are given house numbers to go and check on the defaulters in particular. When you tell a defaulting patient they need to visit the clinic, some complain about the impossibility of doing so in their ailing state of health. (Participant 4, 55, Grade 10)*

The participants highlighted lack of resources as a major impediment to the delivery of their services. These resources include equipment (blood pressure machines), money for transport (for themselves and patients), gloves, masks and money for airtime. The participants had this to say:

*It is the lack of resources . . . gloves, masks and many more. At times you come to find a patient who is really sick and they are coughing and you have to attend that patient without safety gear. (Participant 5, 55, Grade 7)*

*Our work on its own is difficult because sometimes when you are at the clinic looking for materials only to find that they aren't available. (Participant 8, 47, Grade 11)*

#### 3.3.4.6 Late payment of stipends

Another issue raised as a challenge by the participants was late of payment of stipends, which has led them to falter on their policies. Consequently, participants had the following to say:

*. . . And you run the risk of forfeiting your funeral insurance because of all these late payments. (Participant 7, 53, Grade 9)*

*The money issue. We receive a stipend but it does not come in time. Often we remain unpaid and the reasons for this are not communicated to us. (Participant 8, 47, Grade 11)*

### **3.3.5. Theme 5: CHWs' perceptions of mechanisms to improve the delivery of their services**

The fifth objective of the study was to explore CHWs' perceptions of ways or mechanisms to improve the delivery of their services. To address the identified challenges, participants recommended several improvements: ensuring availability of resources; taking initiative; the Department of Health to employ CHWs directly; ensure that there is a dedicated nurse to work with CHWs; awareness raising activities' and provision of training.

#### 3.3.5.1 Ensure availability of resources

To remedy the lack of resources, the participants highlighted that it is important that critical resources like gloves, BP machines, thermometers, and blood glucose machines are made available:

*Yes, they should give us gloves and everything else we may need, then we won't have problems. NGOs – I do not want them. (Participant 1, 52, Grade 9)*

### 3.3.5.2 Taking initiative

In some cases, the participants advised that CHWs should take initiative themselves. This means instead of making referrals, they can sometimes take people without IDs to Home Affairs and ensure that they are issued IDs:

*For the IDs we go to Home Affairs or find a family around which has an understanding of the orphaned child's family history. (Participant 3, 51, Grade 9)*

### 3.3.5.3 The Department of Health to employ CHWs directly

Participants felt that it could make their lives better if they were employed directly by the Department of Health. One participant said:

*To be honest we want to be directly employed by the department of health. (Participant 8, 47, Grade 11)*

### 3.3.5.4 Ensure that there is a dedicated nurse to work with CHWs

Participants suggested it was important to have an arrangement where there is a dedicated nurse who will work with the CHWs constantly and be able to travel with them to patients who are bed-ridden or very old:

*The support we need is that we should have a nurse who we would work with daily, because as community health workers we are part of an NGO. You sometimes encounter a bed-ridden patient and we do not know what to do or how to help such a patient. In such cases you need a nurse beside you. We are not trained as nurses are. We need those nurses to work in collaboration with us. (Participant 8, 47, Grade 11)*

### 3.3.5.5 Awareness-raising activities

Participants alluded that some of the treatment they receive could be due to ignorance. Participants suggested that awareness-raising activities should be conducted to inform communities about the role of CHWs and how they uphold confidentiality. To this end, participants said:

*So the community needs to be called and informed about the work we do in their homes and who we are basically, because some people are just not comfortable with us entering their homes or maybe they are afraid that we might divulge the sicknesses they suffer*

*from to others. We have recently had a workshop on confidentiality, but the patients also need to be sat down and made aware of this, particularly who we are and the kind of work we do. (Participant 8, 47, Grade 11)*

#### *3.3.5.6 Provision of training*

To address the problem of lack of training, one participant suggested that workshops be held to capacitate CHWs on issues that confront them daily.

*They need to be lectured or given a workshop; if that thing will come back then we deal with it. (Participant 1, 52, Grade 9)*

### **3.4. Chapter summary**

This chapter provides a detailed account of how CHWs of the Ga-Segonyana rural district perceive their role with regard to the services they render to the community and their contribution in the strengthening of primary healthcare (PHC). The motivation to become a CHW was mainly due to personal, family and societal experiences. While there was no written scope of work for the CHWs, they were able to outline their roles and responsibilities as expected by the employers. This chapter also outlined the main traits that are critical for one to become a good CHW.

The training provided to the CHWs was related to the nature of their work, and was perceived to be aligned with the CHW job description. This chapter also shows major problems faced by CHWs related to ill-treatment by patients, lack of recognition for their contribution, lack of training, lack of co-operation and collaboration from the supporting departments, organisations and other stakeholders, lack of resources and late payment of salaries. This chapter also makes recommendations for the improvements with regard to the problems identified.

## Chapter 4

### Discussion of results

#### 4.1.Introduction

The aim of the study was to explore the perceptions of CHWs regarding their role with regard to the services they render to the community and their contribution in the strengthening of PHC services in the rural district of Ga-Segonyana. The pervious chapter presented the research results. This chapter presents a discussion of the results, linking them to the literature. The chapter provides insights pertaining to the CHWs' views regarding various aspects of their work. The discussions of the findings from this study are provided in the context of global findings arising from similar studies.

This chapter starts by discussing participant demographics as to provide a broader understanding of CHWs. The discussion of results is presented according to each study objective in this order: CHWs' experiences and satisfaction of their roles in PHC; perceptions and views pertaining to their performed roles as opposed to the documented scope of CHWs; the training received; barriers and problems, and mechanisms to improve the delivery of their services.

#### 4.2.Participant demographics

This study found that the participants had attained an educational level of Grade 11 or less. Similar results were found in the study by O'Brien, Squires, Bixby *et al* (2009) that highlighted that most CHWs lack high school diplomas. This suggests that high school diplomas are not mandatory and do not form part of the selection criteria for CHWs. The level of work experience for most (seven) of the participants ranged between 16 and 18 years; one had just 15 years' work experience and one 27 years. The high level of experience among the participants is an indication that they have been in the field for a long time and have information about how the delivery of PHC in South Africa has evolved over time. It might also mean that they have deeper insights regarding the issues they have experienced and the coping mechanisms they have adopted.

### **4.3. Discussion of results**

What follows is a detailed discussion on each of the five objectives or themes of this study.

#### **4.3.1. CHWs' experiences and satisfaction with their roles in PHC**

The first objective of the study was addressed by the theme CHWs' experiences and satisfaction with their roles in PHC. In this regard, the study found that CHWs had both negative and positive experiences in providing the service.

The positive experiences described by the participants included the feeling of self-worth as they became involved in educating the community and the personal empowerment they gained from training received. Another positive aspect was the joy the participants feel when the patients they assist have recovered. These results were echoed in a study by Ahmed (2011) who found that CHWs perceived their contribution to society as rewarding as they help in resolving the community's problems. Therefore, the delight and fulfilment shown by patients could be more rewarding to CHWs.

On the other hand, the results reveal that the CHWs had bad experiences, mainly due to unfair remuneration, witnessing patients' suffering, the death of patients, lack of recognition, negligence and stubbornness on the part of the patients, and lack of resources. Similarly, other studies found that CHWs are usually faced with difficult situations while rendering their services, sometimes with traumatic outcomes (Lowe, 2015; Odhiambo, Musuva, Odiere *et al*, 2016). These studies suggest that CHWs need psychological support to help them cope in these kinds of situations. The lack of appreciation and the disrespect of nurses suggests that CHWs are demotivated most of the time. Similarly, Brunie *et al* (2014) highlight that demotivation featured most among CHWs, an improvement in this area could enable them to keep delivering their best service to the community. In this regard, there is need for the raising of awareness on the part of professional nurses with regard to the important role played by CHWs in rendering health services to the community.

#### 4.3.2. CHWs' views on their performed roles as opposed to their documented scope

The second objective of the current study is linked to the theme CHWs' views on their roles as performed, as opposed to the documented scope of CHWs. This objective was fulfilled by assessing the CHWs' perceptions about their roles and scope of work, motivation to become a CHW, the characteristics of a CHW, their understanding of primary healthcare, and their workload.

With regard to the CHWs' perceptions about their roles and scope of work, the study found mixed results, with some participants claiming that there is no written scope, while others said they had a documented scope of work. Despite these deviating views, it was clear that the CHWs perceived their scope of work to involve taking care of sick patients at their homes (home visits), provision of treatment, providing counselling services, facilitating access to social grants, and provision of PHC (pregnancy screening, primary health education, awareness raising, child vaccinations, HIV testing). These findings are similar to those of Lowe (2015), who identifies the roles of CHWs as including the promotion of health and prevention of illness; the conducting of structured household assessments to identify health needs; the provision of psychosocial support to community members and the conducting of community assessments and mobilising community needs. This seems to suggest that the roles and responsibilities are uniform across a number of countries. CHWs play an important role in local communities, especially in rural areas, in terms of ensuring that sick patients do not have to travel long distances and join long queues.

An interesting finding from this study is that CHWs perceived themselves to be responsible for ensuring the correct administration of prescribed medication. Similar results were also noted in a study by Omedo, Matey, Awiti *et al* (2012), which found that it was imperative for CHWs to control how they administer the medication. These findings are also in line with those by Tsolekile *et al* (2018) where they found out that the chronic disease related roles performed by CHWs included the distribution of medication.

The study also found that many of the roles and responsibilities provided by CHWs are consistent with those stipulated in the document Re-Engineering Primary Health Care in South Africa (National Department of Health, 2010) (see *Section 1.7.3*). These roles and responsibilities are mainly focused on proactive community-based services. Similar results were reported in a number of studies where the roles include liaison between communities and

healthcare agencies; guidance and social assistance to residents; provision of culturally appropriate health or nutrition education; and advocating for individual and community health (Bovbjerg, Eyster, Ormond *et al*, 2013, Grant, Wilford, Haskins *et al*, 2017, Nxumalo *et al*, 2016). This suggests that the functions performed by CHWs are consistent with the objectives of the community-based organisations to which they are affiliated. These community-based organisations aim at ensuring proper provision of health care to marginalised communities in South Africa. Therefore, the involvement of CHWs in South Africa could be a major contributor to the effective delivery of community-based programmes.

The motivation for becoming a CHW was one of the sub-themes under this objective. This study revealed that most of the participants were motivated by intrinsic rewards to assist those who were in need in their communities. Although this is plausible, Omedo, Matey, Awiti *et al* (2012) found that voluntarism without some form of motivation is not sustainable. This seems to suggest that there is need for incentives for CHWs to be well motivated in executing their duties.

The current study also reveals that the CHWs show compassion while undertaking their duties. This is reflected by their emphasis on personal hygiene and cleaning of living spaces. This also extends to their role as mothers to young girls when they promote safe sex and encourage those who fall pregnant to make early bookings at the clinic. These results are similar to those of Taylor (2015) who found that the individual's characteristics for being a CHW are critical for effective delivery of community-based programmes. There, the positive attitude, personal characteristics, skills and experience of CHWs are essential ingredients for an effective delivery of services.

In this line of argument, the current study further revealed that the main traits motivating the participants to become CHWs included friendliness, patience and selflessness, a positive loving attitude, respect for others and for oneself. Similarly, a positive loving attitude was regarded as critical for CHWs as the nature of their work requires that they provide personal care to the community (Nxumalo *et al*, 2016). Respect on the part of a CHW could mean that patients' privacy and dignity is prioritised. Such respect thus promotes patients' trust towards their local CHW. The role of trust in the provision of community services has been given a greater emphasis in the literature (Gilson and Erasmus, 2007; Glenton, Scheel, Pradhan *et al*, 2010; Palazuelos, Ellis, Im *et al*, 2013). Selflessness suggests that CHWs must be sensitive to patients' needs and feelings.

Based on the various definitions given for PHC by the participants, the study also found that CHWs had a good understanding of PHC, which forms a major component of their duties. In this respect, Dookie and Singh (2012) highlight that poor understanding of PHC often leads to misconceptions and unrealistic expectations about service delivery and health outcomes. The fact that CHWs included in this study have shown a good understanding of PHC is an indication that they have a good appreciation of how the community health framework should be implemented.

The last sub-theme linked to this objective 2 is the workload of CHWs. This particular study found that the workload is too high. This is in line with the study by Lowe (2015) in which it was found that CHWs face the problem of a large workload due to the sparse population of the communities where they work. This may affect both service quality and accessibility in a negative way.

#### **4.3.3. CHWs' perceptions of training received**

The third objective of the study was to explore the CHWs' perceptions of the training they have received. This objective was achieved by exploring the participants' perspective on the nature of training received and the alignment of these training to their job description.

Pertaining the nature of training received, the study found that despite the CHWs' having received once-off training, they perceived it to be insufficient. This finding is also mirrored in a study by O'Donovan, O'Donovan, Kuhn *et al* (2018), which found that the training provided to CHWs had no effect on the desired outcomes. Similar conclusions were also found in a report by Languza, Lushaba, Magingxa *et al* (2011), in which the lack of relevant training was identified as a problem. This means that as CHWs perform their duties, they become more informed about further training needs, perceived to be in line with the service they are providing. They have also realised that training is central for them to be able to provide adequate quality services to the community.

On that same note, this study also reveals that the training received by CHWs was informal and non-certificated. This finding is similar to that of Tsolekile, Schneider and Puoane (2018), who found that out of the sample of 150 CHWs only 75 had received formal training related to diabetes and hypertension. Other studies identified the lack of formal training among CHWs as a risk (Abrahams-Gessel, Denman and Montano, 2015; and Lopes, Cabral and De Sousa, 2014).

The provision of formal training after which the trainees are formally certified could potentially enable CHWs to identify gaps (needs) that exist in their communities. The training provided should be recognised by the South African Qualification Authority (SAQA). Recognition of training by education authorities means that CHWs would be able to build a career path for themselves. Capacitating CHWs will also mean that they will be capable of acquiring and sharing up-to-date information regarding vaccines and microbicides with patients and communities.

Regarding the second sub-theme of alignment of the training to their job description, the research study revealed that the training received was related to PHC restructuring (“re-engineering”), TB, HIV, breast cancer, MDR, and adherence support. These trainings were related to the nature of their work as CHWs. The training forms a major aspect of their role in the community. Although Sosibo (2012) highlights the importance of research-related training as part of the capacitation of CHWs, participants in this current study did not mention it. Although the study found out that CHWs had received training in line with their daily duties, there is also a need to expand on their training as to cover a wide range of issues they encounter while rendering service to their communities. For example, training in counselling and research skills, which are beyond their ordinary duties, is recommended by the WHO (2012). According to the WHO (2012), the upskilling of CHWs is important to allow them to take on new roles and make a significant positive contribution to health outcomes.

#### **4.3.4. CHWs’ perceptions on the barriers and challenges that influence their abilities to render quality services in PHC**

Regarding CHWs’ perceptions of barriers and challenges, the main concerns raised pertained to the lack of support systems, ill-treatment by patients, lack of recognition for their contribution, lack of training, and lack of co-operation and collaboration from the supporting departments and organisations and other stakeholders, lack of resources and late payment of stipends. A clear resemblance to these barriers and challenges as experienced by CHWs in South Africa has been noted in studies conducted by Lehmann, Friedman and Sanders (2004), Nxumalo *et al* (2016) and Naidoo, Zuma, Khosa *et al* (2018). A study by Lowe (2015) also found that CHWs’ contribution to the community is not recognised. The current study reveals that the participants shared sentiments that nurses at clinics neither respect nor value their opinions. These sentiments were also reflected in a study conducted in the Free State by Schneider, Hlope and Van Rensburg (2008). These clearly suggest a need to address and enhance the effectiveness of the

provision of PHC services to the communities.

The study also found lack of support system in terms of counselling services and career progression. This is in line with a number of studies which identify the lack of support of CHWs as a disincentive for the career in rural areas (Chitha, 2007; Lowe, 2015). Consequently, there is a need for continuous support for CHWs in terms of counselling and training as suggested by Lehmann and Sanders (2007c) and Thomson (2014). Capacitation could be provided in a broader context of CHW training.

This study also shows that CHWs felt ill-treated by patients, even including verbal abuse and dog attacks. This kind of treatment of CHWs was also identified as a risk in a study by Lowe (2015). Operating in that environment suggests that CHWs are often demotivated and feel worthless. The feeling of not being appreciated or respected by clinic nurses was experienced by most of the CHWs interviewed in the study, which could indicate a lack of training on the part of nurses with regard to their roles in community health. According to the WHO (2012), it has become apparent that the health professionals like nurses need to be capacitated on issues beyond their current responsibilities so that they have a good mix of skills.

Lack of training has been mentioned by CHWs as a barrier to their ability to provide community health services. Similarly, a study by Lowe (2015) shows that CHWs perceive their training as too short and out-of-date. They contended that in order to cope with the ever-changing circumstances within communities, there was a need for continued education and refresher courses. The perception of a lack of training indicates that there has been less emphasis on training at provincial level. This observation is in line with a study by Austin-Evelyn *et al* (2017) which revealed that the training programme for CHWs in the Eastern Cape was under-resourced.

However, this finding comes alongside news of large financial commitment from the South African government and the international community for the training of CHWs. For example, the European Union committed R250 million over five years (2002-'07) for initiatives directed towards strengthening partnerships between the government and NGOs, with specific emphasis on HIV/Aids (Magingxa, Masuku, Ngubo *et al*, 2011). According to Magingxa *et al* (2011), the national Department of Health allocated R68 million for provincial funding of NGOs involved in HIV/Aids and TB care and support activities in the 2005-06 financial year. From the accounts of participants, it appears that a significant portion of this funding has not been directed for the

capacity building of CHWs. This problem of non-allocation of funds may need to be reviewed.

The capacitation of CHWs as the primary drivers of PHC has not been given proper consideration (Sosibo, 2012). This lack of training must be seen in the light of the fact that most of the CHWs had education up to Grade 11, as reflected in the demographic profiles of the participants in this study. That training for CHWs is very limited suggests that career progression also is limited. A number of studies have found that poor career prospects has been the main contributor to the rate of CHWs dropping out (Ballester, 2005, Scott and Wilson, 2006). High attrition rates among CHWs has also been observed in the literature (Alam and Oliveras, 2014; Gilson, Walt, Heggenhougen *et al*, 1989; Malcarney, Pittman, Quigley *et al*, 2017; Ngilangwa and Mgomella, 2018).

Lack of co-operation and collaboration from the supporting departments and organisations and other stakeholders was identified by CHWs as a major impediment. Similar sentiments were echoed in a study by McCallin and McCallin (2009) who found that political, organisational and professional leadership will be necessary if collaborative teamwork is to become an integral part of health service delivery. According to Nxumalo *et al* (2016), a lack of systems that provide promote integration suggests that CHWs lack the capacity to provide comprehensive services to the community. Another study, by Magingxa *et al* (2011), has also emphasised the importance of co-operation and collaboration. This suggests that with regard to the current study, teamwork is lacking and individuals are working in silos.

The CHWs also perceived lack of resources as a major barrier, especially money for transport. The WHO (2010) suggests that responsible stakeholders develop effective and appropriate protocols for referral and treatment options to ameliorate the problem of travel expenses. The sentiments expressed by the CHWs are an indication that the referral systems in South Africa are still not yet developed. In this context, Brunie *et al* (2014) state that the provision of adequate resources for the work of CHWs has significant positive outcomes with regard to community health imperatives attained. Similarly, a number of studies conducted in the South African context reflect the same views (Matwa, 2001; Nxumalo *et al*, 2016; Rutherford, Dockerty, Jasseh *et al*, 2009; Rutherford, Mulholland and Hill, 2010; Steyn and Levitt, 2006).

Working in an under-resourced environment could potentially affect the productivity, morale and quality of services of CHWs. Some critically ill patients failed to attend clinics to receive essential medication. Working in an exposed environment could also limit the performance of

some CHW duties for fear of exposing themselves to communicable diseases. Jaskiewicz and Tulenko (2012) state that working in an under-resourced environment without the required supplies and equipment reduces the effectiveness of community-based strategies.

The study also found that the issue of late payment of stipends is perceived by CHWs as a problem. Given that many CHWs are the breadwinners in their homes, late payments could add substantially to an inability to make ends meet. Similar findings were also reported by Lowe (2015), who found that the remuneration for CHWs is too little considering the hours they work and the risks they face.

If these problems are ignored, it is probable that they will eventually contribute to a high drop-out rate among CHWs as indicated in the literature (WHO, 2007). However, Lowe (2015) disputes this claim, noting that there had not been a drop-out of CHWs initially employed by the Department of Health. The main reasons for their clinging to their jobs were that they were passionate about their work and had been hoping that things would change (Schneider, Hlope and Van Rensburg, 2008).

The study found that despite the CHWs' dedicated efforts towards helping vulnerable elements in the society, there were indications that the workload was overwhelming, which affects service delivery and job satisfaction negatively. The matter of excessive workload for CHWs has been emphasised in the literature (Chin-Quee, Mugeni, Nkunda *et al*, 2016; Kasteng, Settumba, Källander *et al*, 2016; Puett, Coates, Alderman *et al*, 2012), hence the proposal by Jaskiewicz and Tulenko (2012) to allocate manageable tasks to CHWs as to ensure the effectiveness of PHC provision.

#### **4.3.5. CHWs' perceptions of ways to improve the delivery of their services**

The study identified several measures that could be implemented to address the problems faced by CHWs in delivering primary health services to the communities. These measures include: providing enough resources; taking the initiative; direct employment of CHWs by the Department of Health; ensuring that there is a dedicated nurse to work with CHWs; awareness-raising activities; the provision of training and effective integration of the CHW programme into the healthcare system. The last measure is consistent with a study conducted by Mottiar and Lodge (2018), which found that CHWs made a substantial contribution towards the success of the world's largest HIV/Aids treatment programme. This current study is also in line with

findings by Oliver *et al* (2015), Alam and Oliveras (2014) and Austin-Evelyn *et al* (2017), who found that training and development, proper supervision of CHWs and the provision of adequate resources and transport go a long way towards improving CHW service delivery. Therefore, better implementation of these measures is likely to result in effective and efficient delivery of health services to marginalised communities in South Africa.

#### **4.4. Chapter summary**

This chapter presented a discussion of the research results. The positive and negative experiences of CHWs in executing their roles, the requirements of a proper scope of work linked to certain incentives to motivate CHWs in their duties, the need for appropriate training and development, the absence of a proper support structure, inadequate resources and possible ways of improving the service delivery of CHWs were highlighted.

## Chapter 5

### Conclusions and recommendations

#### 5.1. Introduction

The aim of the study was to explore CHWs' perceptions of their role on the services they render to their community and their contribution towards strengthening PHC services in the rural district of Ga-Segonyana. The previous chapter presented a discussion of the research results. This chapter presents the conclusions of the study, recommendations, limitations and implications for future research.

#### 5.2. Conclusions

While the scope of work for CHWs is documented in some instances, the roles and functions are in line with those stipulated in the discussion document Re-Engineering Primary Health Care in South Africa. The role of CHWs to distribute chronic disease related medication is crucial as some patients are not able to travel on their own to health facilities. This helps these patients against the possibility of defaulting on their treatment. The CHW plays an important role in ensuring that communities can access PHC and are actively involved in matters that affect them. The involvement of CHWs in the provision of PHC also enhances the effectiveness of such programmes.

The CHWs derive satisfaction and fulfilment from their work through improvements in the general health of their communities. They perceive themselves as contributors towards better health outcomes in their communities. Consequently, professionalising and capacitating CHWs could be seen as a major step towards improving the quality of service delivery. On the other hand, many CHWs have had traumatic experiences while providing their services, therefore, the provision of counselling services will go a long way towards improving their working conditions.

The roles and responsibilities of CHWs are in line with the documented job descriptions, and the training provided to them is in line with their daily duties. What is important, however, is ensuring that the CHW receives a written job description detailing how she is supposed to discharge her duties. This will promote uniformity in terms of the services delivered in the

communities. Additionally, continuous training as a means towards the professionalisation of CHWs should be prioritised.

A number of barriers and problems faced by CHWs were identified in the study. These have a negative effect on the provision of health services to the communities. These factors might have a negative influence on the effectiveness of community health programme delivery in South Africa. In the light of these problems, measures should be taken to ensure that these negative effects are minimised.

Several measures that can be implemented to address the problems faced by CHWs in delivering primary health services to their communities were also identified. A better implementation of these measures would likely result in effective and efficient delivery of health services to marginalised communities in South Africa.

### **5.3.Recommendations**

The research has given an indication of the perceptions of CHWs regarding their role on the services they render to their communities and their contribution in the strengthening of PHC services in the rural district of Ga-Segonyana.

#### **5.3.1. Provide training on a regular basis**

- Training should be provided on a regular basis, with some follow-ups. From a national perspective, the training should be standardised and be recognised by SAQA. This will not only promote professionalism among CHWs but also ensure a career path for them.

#### **5.3.2. Improve communication**

- Within the context of training, there should be sessions held that promote communication and interaction between CHWs, nurses and community leaders in an effort to bring a common understanding of the role played by CHWs and how it could be enhanced. This will demystify the incorrect beliefs found among nurses that CHWs are inferior to them.

#### **5.3.3. Provide counselling support to CHWs**

- There is a need for the provision of counselling services to CHWs to help them cope with the traumatic experiences they are exposed to while carrying out their duties.

#### **5.3.4. Promote collaboration among government departments**

- There is a need for collaboration between the Department of Social Development and the Department of Health by having an auxiliary social worker work alongside the community health worker so that both health and social issues can be dealt with, as the workers meet the needs and answer the questions asked by residents. The learning and sharing of ideas applies equally to co-ordination among departments, and between CHWs and their communities.

#### **5.3.5. Awareness-raising initiatives**

- Acknowledgement of CHWs as people as well as in the work they do should be part of a way toward resolving the negative perceptions of nurses. This should start with round table discussions, where CHWs are given a platform to share their frustrations. This would give CHWs the fulfilment and satisfaction that their concerns are heard and resolved.

#### **5.4. Limitations and implications for future research**

The study had a number of limitations, as outlined:

- The study was limited to those CHWs who were employed by the district health department. The study did not include CHWs employed in the private sector. The exclusion of these CHWs meant that some valuable experiences and contributions were omitted.
- The researcher did not accompany CHWs in their daily work since the interviews were carried out at the clinics. Although this was not part of the research scope, accompanying the CHWs and observing them carry out their tasks might have added other dimensions to enrich the study.

#### **5.5. Implications for future research**

- Given that this study was conducted in just one province, the Northern Cape, future research should consider extending this study to the other eight provinces to assess whether the perceptions highlighted in this study apply to the rest of South Africa.
- Future studies should consider a larger representative sample and employ an all-encompassing research methodology, perhaps a mixed methodology.

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## **Appendix 1 – Interview guide**

Based on conceptual framework by WHO on CHW Roles and Tasks

### **Biographical Information**

1. Can you please tell me more about yourself?

**Probes:**

- a) Where were you born?
- b) Age
- c) Gender
- d) Marital status
- e) Education level
- f) How long have you been employed as a CHW?

2. Please tell me about your journey of becoming a CHW?

**Probes:**

- a) What motivated you to become a CHW?
- b) Please share your experiences of working as a CHW
- c) Please describe your role in the work that you do as a CHW.
- d) What is the documented scope of work for CHWs and how do you feel about it?
- e) Are your expectations in line with your scope of work as a CHW? Please explain?
- f) What do other healthcare professionals expect from you as a CHW?
- g) What is your understanding of PHC and how does it link to the work that you do?

3 Please tell me about the training that you have received as a CHW?

**Probes:**

- a) Type of training
- b) Who provided the training and how long was it?
- c) If you did not receive any training can you share with me why that is?
- d) How do you feel about the training you have received?
- e) Is the training in line with your scope of work? Please explain.
- f) How has the training helped you in doing your work?

4 Exploring attributes of CHWs

**Probes:**

- a) What attributes do you think are necessary for a person to be employed as a CHW?
- b) What is your most memorable experience (bad or good) since you started working as a CHW?

5 What are the facilitating and inhibiting factors towards rendering of quality services in your PHC?

**Probes:**

- a) What factors impact on the services that you render or the role that you lay as a CHW?
- b) What challenges are you experiencing in your work and how do you often deal with it?
- c) How do you feel about getting additional support? Please specify the type of support you need.
- d) Please indicate the kind of resources you have to do your work and how you feel about them.
- e) What improvements are needed for better efficiency of CHWs?

## **Appendix 2 – Information Sheet for the study participants**

**Study title: Community Healthcare Worker’s perceptions of their role in Primary Health Care of Ga- Segonyana rural district**

**Greetings,**

My name is Ann Mkhondwane. I am doing this study as part of my Master’s degree in Public Health at the University of the Witwatersrand in Johannesburg. I will briefly explain why I am doing this research, what will happen with the results from this research, any risks and benefits.

### **Aim of the study and invitation to participate**

I am conducting research on community healthcare workers perception of their role in Primary Health Care of Ga-Segonyana rural district. I would like to invite you to participate in a research project that seeks to explore the CHWs perception of their role in the service they render to the community and their contribution in the strengthening of PHC services in the district.

### **What is expected of the participant?**

Before volunteering to participate in this study, it is important that you read and understand the following explanation of the purpose of the study, the study procedures, benefits, risks, and your right to withdraw from the study at any time.

The information provided below will help you decide if you would like to volunteer. You should fully understand what is involved before you agree to take part in this study. If you have any questions, do not hesitate to ask me.

It is important that you understand the following:

Taking part in this study is completely voluntary. You may refuse to take part in this study or leave it at any time. There will be no negative consequences if one withdraws from the study and that the data collected will be destroyed. Your decision will not affect your ability to take part in other research.

### **1. Length of the Study**

The study will be conducted in the rural district of Ga-Segonyana in Northern Cape Province over a period of two months in 2018. It comprises of 33 residential areas of which 20% are urban and the remaining 80% are rural.

### **2. Study Procedures**

If you take part in this study, we will ask you to participate in an interview which should take one hour or less. You will be interviewed in English, but if there is anything you do not understand or if you would prefer to use your home language there will be someone on hand to assist with this. With your permission, the interview will be audio-recorded so that the interview does not miss anything that you say.

### **3. Risks**

There are no risks of being involved in this particular study, however the interviewer may ask questions or raise issues that are personal and of a sensitive nature that may make you feel uncomfortable or upset. It is not our wish for this to happen therefore you may skip any questions that you don't want to answer or discontinue the interview at any point. If you withdraw completely from the study, your name will be removed from the information gathered and the data already collected will be destroyed.

### **4. Benefits**

You will not benefit directly from taking part in this study. Information gathered from this study may help us learn more about the role of CHWs in your area and any information that we may add in questionnaire that we intend to use in the study.

### **5. Costs and Reimbursement**

There is no cost or payment to you for being part of the study.

### **6. Distress Protocol**

Should you in the course of the study show any sign(s) of distress, necessary information as to where to get help will be provided for you. You can get psychological services at no cost to you from the following contact: Social services: 053 773 1613

### **7. Confidentiality**

Anything that you share in the interview will be kept confidential in the following ways:

We will use a code instead of your name at all times. Any quotes, which will be transcribed directly from a translated transcription from the audio recording, will be anonymous.

All information obtained during the course of this study, including personal data and research data will be kept strictly confidential. Data that may be reported in scientific journals will not

include any information that identifies you as a participant in this study.

This information will be reviewed by authorized representatives of the study team

The information might also be inspected by the University of the Witwatersrand, Human Research Ethics Committee (Medical) (HREC).

## **8. Contacts**

Should you need further clarity about the study or want to obtain results of the study, please contact Ann Mkhondwane (Principal investigator) [amkhond@yahoo.com](mailto:amkhond@yahoo.com) Tel: 0822979176, Supervisors: Dr Tinswalo Hlungwani email:[tintswalo.hlungwani@wits.ac.za](mailto:tintswalo.hlungwani@wits.ac.za) Tel (011) 717 2734; Dr Motlatso Mlambo email:[motlatso.mlambo@wits.ac.za](mailto:motlatso.mlambo@wits.ac.za) [Tel \(011\) 717 2650](tel:0117172650).

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg. Should you wish to report any concern or complaints on any aspect of the study, the following contact details can be used: HREC (Medical) Chairperson: Prof. CB Penny email: [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za) Tel (011) 717 2301. (Administrators): Ms Z Ndlovu email: [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) Tel (011) 717 2700 and Mr R Mukansi email: [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za) Tel (011) 717 1234

Thank you for taking time to read this information Sheet.

### Appendix 3 – Consent Form for in-depth interview

#### Study title: Community Healthcare Worker’s perceptions of their role in Primary Health Care of Ga- Segonyana rural district

I hereby confirm that I have been invited to participate in the above study by the s staff .I have heard the aims and the objectives of the Research Project that are proposed. I was given the opportunity to ask questions and was also given enough time to think about this Research Project. I have not been forced or pushed in any way to take part. I am clear about the aims of the Research Project.

I have also received, read and understood the above written information regarding the study. I understand that **taking part in this Research Project is completely voluntary**. It is my own choice and I know that I may withdraw from it at any time without need to give any reasons. I am aware that the results of the study, including any personal details such as those regarding my age and residential area will be anonymously processed into a study report.

In view of the requirements of the research, I agree that the data collected during this study can be processed in a computerized system by the researcher or on her behalf.

PARTICIPANT:

_____	_____	_____
Printed Name	Signature/Mark or Thumbprint	Date and time

#### Statement by interviewer:

I have given written and oral information regarding this Research Project to the participant.

I agree to answer any future questions concerning the Project as best as I am able.

I will adhere to the protocol as it has been approved.

_____	_____	_____
Name of the interviewer	Signature	Date
Place		

**Appendix 4 – Consent Form for Audio Recording Interview**

**Study title: Community Healthcare Worker’s perceptions of their role in Primary Health Care of Ga- Segonyana rural district**

I, the undersigned agree to participate in this study research study “Community Healthcare Worker’s perceptions of their role in Primary Health Care of Ga- Segonyana rural district” and provide consent for the audio- recording of the interview.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix 5 –Letter of Research Approval, Northern Cape Department of Health



DEPARTMENT OF HEALTH  
LEFAPHA LA BOITEKANELO  
ISEBE LEZEMPILO  
DEPARTEMENT VAN GESONDHEID

Department of Health  
Private Bag X5049  
KIMBERLEY  
8301

Enquiries :  
Dipatlisiso :  
Imibuzo : Dr. Eshetu Worku  
Navrae :

Date :  
Letlha : 26 February 2018  
Umhla :  
Datum :

Reference :  
Tshupelo : 053 830 2134  
Isalathiso :  
Verwysings :

Dear Dr. Ms. Ann Mkhondwane

**PROJECT TITLE:** *Community Healthcare Worker's Perceptions of their Role in Primary Health Care of Ga-Segonyana Rural District.*

The application to conduct research study on the above-mention was received and has been reviewed by the Provincial Health Research and Ethics Committee (PHREC) and the District Health Research Committee Chairperson of JT Gaetsewe for gate – keeping permission.

***Approval is hereby granted to conduct this research study as indicated in the proposal, in Ga-Segonyana Rural District (Kagiso CHC and Seoding Clinic), Northern Cape Province.***

Your Provincial Ethics Reference Number is **NC\_2018RP\_01**, kindly use that reference number in correspondence with the PHREC administration.

**Please note the following:**

- 1) This approval is valid for a period of one (1) year**
- 2) The research is requested to make all necessary arrangement with each facility manger on when she/he will be visiting the facility to conduct this project.**



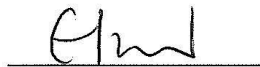
We are committed to achieving our vision through a decentralized, accountable, accessible and constantly improving health care system within available resources. Our caring, multi-skilled, effective personnel will use evidence-based, informative health care and maturing partnerships for the benefit of our clients and patients.

***Please note the following conditions:***

- 1) This project must be conducted at no cost to the Northern cape Department of Health
- 2) This approval is limited to the research proposal as submitted in the application
- 3) No variation or modification on the research project
- 4) PHREC may monitor the research progress at anytime
- 5) At the completion of your study, a copy of you final report must be submitted to the Research and Development Unit
- 6) The Northern Cape Department of Health Senior Management Committee shall be briefed on the outcome of the study prior publishing

***The committee wishes you success on your research study***

Yours Faithfully



Dr. Eshetu Worku  
Chairperson: PHREC  
E-mail: [eworku@ncpg.gov.za](mailto:eworku@ncpg.gov.za)  
Tel: 053 830 2134  
Cell: 072 703 8037

27/02/2018

Date

## Appendix 6 – Ethical Clearance



R14/49 Dr A Mkhondwane

### **HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL) CLEARANCE CERTIFICATE NO. M170972**

**NAME:** Dr A Mkhondwane  
**(Principal Investigator)**  
**DEPARTMENT:** School of Public Health  
Medical School  
University

**PROJECT TITLE:** Community Healthcare Workers' perceptions of their role in primary health care in Ga-Segonyana rural district

**DATE CONSIDERED:** 29/09/2017

**DECISION:** Approved unconditionally

**CONDITIONS:** Condition removed on 28 February 2018; Department of Health permission received on 26 February 2018

**SUPERVISOR:** Drs M Hlungwane and M Mlambo

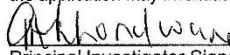
**APPROVED BY:**   
Professor CB Penny, Chairperson, HREC (Medical)

**DATE OF APPROVAL:** 22/12/2017

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

#### **DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on 3rd floor, Phillip V Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.  
I/We fully understand the conditions under which I am/we are authorised to carry out the above-mentioned 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 to the Committee. **I agree to submit a yearly progress report.** The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **September** and will therefore be due in the month of **September** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

  
Principal Investigator Signature

01 March 2018  
Date

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

## Appendix 7 – Plagiarism Declaration



PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I, Ann Mkhondwane\_ (Student number: 8906261/v) am a student

registered for the degree of \_Masters of Public Health in –Rural Health in the academic final year,3rd.

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.

Signature: Ann Mkhondwane Date: 28 February 2019

26/04/2015

1