



SCHOOL OF PUBLIC HEALTH

RESEARCH REPORT

Community understanding and patients' experiences with the ward-based outreach teams (WBOT) programme in Lesedi sub-district, Gauteng

A research report submitted to the School of Public Health

Faculty of Health Sciences, University of the Witwatersrand

In partial fulfilment of the requirements for the degree of Master of Public Health

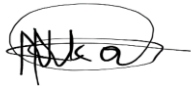
Submitted by Nkosephayo Thembie Nkambule

Student number: 2321227

Johannesburg, October 2024

DECLARATION

I, **Nkosephayo Thembie Nkambule**, declare that this research report is my own work. It is being submitted for the degree of Master of Public Health (MPH) at the University of the Witwatersrand, Johannesburg. It has never been submitted before for any degree or examination at this or any other university.

A handwritten signature in black ink, appearing to read 'Nkambule', enclosed within a hand-drawn oval.

(Signature of Candidate)

30 October 2024 in Johannesburg

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ABSTRACT

Introduction: Hospicentric primary health care (PHC) limited access to essential health services and resulted in perverse health disparities within and between countries. Community-based PHC was then needed to bring services to where people lived. South Africa implemented a community-based PHC programme called the ward-based outreach teams (WBOT) programme in 2011 as part of PHC re-engineering aimed at achieving equity and improving health outcomes. Since implementation, the programme has not been optimal in attaining its objectives due to the poor supervision of community health workers (CHWs), lack of resources and poor remuneration. Many studies have investigated programme implementation and functioning from the perspectives of managers and CHWs. There are limited studies on the insights and experiences of patients and community members who receive services provided by the CHWs.

Methods: This qualitative study used secondary data collected as part of the Bathlokomedi project in Gauteng Province. The Bathlokomedi project studied six WBOT/CHW teams with variations in supervision and location (e.g. clinic and health post-based teams) in 2016/17. Community health workers, supervisors, facility-based staff members, patients and community representatives were interviewed for the project. The primary study gathered data using a combination of qualitative and quantitative methods. The secondary study uses community representatives' and patients' interviews to analyse their understanding of the WBOT programme. Thematic analysis method was used to analyse data.

Findings: CHWs played a significant role in the WBOT programme by providing services such as delivering chronic medication to the elderly, ensuring medication adherence and support, supporting immunisation and growth monitoring. The employment of local people to serve as CHWs and active collaboration between the WBOT and the community helped to nurture a positive relationship. However, the lack of community engagement, lack of resources, non-comprehensive services, and CHWs' inability to maintain patient confidentiality and privacy impeded the success of the WBOT programme. Generally, the community representatives and patients reported dissatisfaction with the WBOT programme because the CHWs provided limited services to the community.

Conclusion: WBOTs can extend health services to people in need. Community-based PHC and CHWs are imperative for attaining universal health coverage (UHC) and health goals in

resource-constrained settings such as South Africa. For community-based PHC systems to be effective, services should be comprehensive and include a wide range of promotive, preventive, curative, rehabilitative and palliative services.

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LIST OF ABBREVIATIONS

ASHA	Accredited Social Health Activist
CHEW	Community health extension worker
CHW	Community Health Worker
DIC	Drop-in centre
DoH	Department of Health
FHS	Family Health Strategy
HBC	Home-based care
HEP	Health Extension Program
HEW	Health Extension Workers
LIC	Low-income Countries
LMIC	Low- and middle-income countries
NGO	Non-governmental Organisation
PHC	Primary Health Care
PII	Personal Identifiable Information
PPE	Personal Protective Equipment
TB	Tuberculosis
UHC	Universal Health Coverage
VVHW	Volunteer Village Health Workers
WBOT	Ward-based Outreach Teams
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Background

Leaders across the globe pledged their commitment to attaining ‘health for all’ by the year 2000 during the first International Conference on Health Promotion held in Alma Ata (1, 2). However, more than two decades later, many countries are nowhere near achieving the Alma Ata declaration (3). One factor that has contributed to this and derailed health systems’ progress towards attaining ‘health for all’ is the hospicentric set-up of the former primary health care (PHC) system (3) that neglected fostering ongoing well-being and healthy lifestyles for families in the communities(4). PHC is “essential health care made universally accessible to individuals and families in the community through their full participation, by means acceptable to them and at a cost that the community and country can afford” (4, 5).

In the subsequent international conference on PHC held in Kazakhstan in 2018, countries renewed their commitment to attaining ‘health for all’, especially in low-and-middle-income-countries (LMICs), in what is known as the Declaration of Astana (3). This conference put on the agenda prioritising underserved communities, improving service coverage, addressing the social determinants of health and improving health outcomes across and within countries (3). The era after the Kazakhstan conference was marked by a shift to focus on community-based PHC, i.e. its integration with facility-based care to have an integrated health system (1, 2, 3). The World Health Organization (WHO) recommends integrated health systems as they work best in improving service coverage and health outcomes (6, 7).

According to the WHO, health outcomes continue to deteriorate across the globe (7) and this is partially related to the fact that at least half of the world’s population does not have full access to essential services due to social and economic factors that put people on the margins of health systems (8). Therefore, bringing services closer to users using community-based PHC systems bridges the gap (8). Other authors vouch for community-based PHC over other PHC strategies as it promises equity and social justice in healthcare delivery (6, 8).

South Africa implemented a community-based PHC model called the ward-based outreach teams (WBOT) programme in 2011 as part of the PHC re-engineering model with the aim of

strengthening the delivery of PHC (9). Each WBOT comprises at least six community health workers (CHWS), a health promoter and an environmental health officer (10). The team is overseen by an outreach team leader (nurse) and it is expected to offer health promotion, preventative services and limited curative services to a defined community (10). The implementation and functioning of community-based PHC systems, including the WBOT programme, differs from place to place, even within countries. Therefore, this study aimed to explore patients' experiences with the South African WBOT programme in the Lesedi sub-district, Gauteng and how the community understood the role of the WBOT programme.

1.2 Statement of the problem

The WBOT programme aims to bridge the gap between health facilities and communities in South Africa (11). However, the programme has not been optimal in achieving its objective due to various reasons, including the limited scope of CHWs, limited support from local health facilities, poor supervision and the lack of equipment and training, amongst other challenges (12, 13, 14). Most studies conducted have focused on the experiences of the service providers, such as CHWs and their supervisors and clinic staff (10, 12, 13), and this has limited our understanding of the challenges confronting the programme. Hence, there was a need to explore the programme's functioning from the service users' perspectives to fully understand the challenges that were confronting the WBOT programme and its responsiveness to the health needs of the communities served. The accounts of community representatives and patients will help inform strategies and interventions that can be implemented to strengthen the programme's performance to meet communities' legitimate expectations and needs. Therefore, this study explored the community's understanding and patients' experiences with the WBOT programme in Lesedi sub-district, Gauteng.

1.3 Justification

Studies conducted in different provinces of South Africa have investigated and addressed systematic and operational barriers in the programme, focusing on experiences and perspectives of the CHWs, supervisors clinic staff and managers (10, 12, 13). However, there has been little focus on insights and experiences of patients and the community members who are the recipients of care and important stakeholders in the delivery of health services. Therefore, there is a need to

address the knowledge gaps and get the perspectives of CHWs' clients (patients) and community representatives on the functioning and challenges confronting the WBOT programme (11).

1.4 Research question

What is the community representatives' understanding of the WBOT programme and the experiences of patients receiving care from the WBOT programme in the Lesedi sub-district, Gauteng?

1.5 Aim and objectives

The overall aim of the study was to explore community representatives' understanding and patients' experiences of the WBOT programme in Lesedi sub-district, Gauteng. The specific objectives of the study were to:

1. Explore how community representatives understand the WBOT programme in Lesedi sub-district to operate/function.
2. Explore patients' experiences with the WBOT programme in Lesedi sub-district, Gauteng.
3. Explore the factors that facilitate or impede a positive relationship between community representatives and patients with the WBOT programme in the Lesedi sub-district, Gauteng.

1.6 Structure of the dissertation

This dissertation is divided into six chapters:

Chapter One provides the background and rational for the study.

Chapter Two presents a review of literature focusing on community-based PHC and its successes, the experiences of community members, facilitators and challenges of community-based PHC as well as the contextual history of community-based PHC in South Africa.

Chapter Three focuses on the research methods. The researcher provides an overview of the study design, study site, study population, study sample, data collection, data management and analysis, data trustworthiness and ethical considerations.

Chapter Four is a presentation of findings guided by the three study objectives.

Chapter Five is the discussion, which provides a synthesis of the key findings in relation to current literature.

Chapter Six provides overarching conclusions and recommendations for practice and future research.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

A literature review is a synthesis of past research done to gain knowledge and understanding of a research field as well as to evaluate prior research and identify knowledge gaps (15). The main aim of conducting a literature review is to “critically consolidate existing literature on a given topic” (15). This literature review covers the history of community-based primary health care (PHC) and its successes, the community’s experiences with PHC, facilitators and challenges of PHC systems, and finally, the historical context of PHC in South Africa.

2.2 History of community-based primary health care and its successes

According to the World Health Organization (WHO), comprehensive PHC constitutes a combination of preventive, promotive, curative and rehabilitative services and focuses on the family or community as the unit of care (7). Different terms have been used to highlight the phenomenon of bringing PHC closer to where people live or work, including community-based PHC (5, 15) and community-oriented PHC (10, 16, 17). This study was centred on community-based PHC. Community-based PHC is a process of improving health through community-based activities that may be linked to local healthcare facilities (16).

Community-based PHC systems are important and will continue to exist in the near future to compliment facility-based care (6). There are good examples of countries that embarked on the journey to strengthen the delivery of PHC through community-based health services, such as Brazil (20). In 1998, Brazil scaled up and strengthened community-based PHC through a programme that was termed the Family Health Strategy (FHS) (19). The FHS programme was a community-based PHC programme that used multi-disciplinary teams consisting of a physician, nurse, nurse assistant and CHWs to work in designated rural and underserved geographic locations (19). The FHS programme was able to improve access to care in Brazil: from 4% of the population served in 1998 to 64% in 2014 (19). Further, there was reported improvement in the quality of care, reduction in infant mortality, as well as mortality related to cardiovascular and cerebrovascular causes in adults (19).

Similarly, the Islamic Republic of Iran implemented the “The Family Physician and Rural Insurance Program”, which was a community-based PHC model that relied on trained CHWs to provide health care to villagers in rural and remote districts (20). The CHWs worked with physicians deployed in rural health centres who also functioned as supervisors in the programme. This programme was effective in expanding access to PHC and consequently increasing life expectancy and decreasing maternal and infant mortality in the country (21). In India, the community-based PHC model thrived through CHWs called Accredited Social Health Activists (ASHAs) who functioned as service providers imperative in decongesting and reducing pressure in the higher levels of the healthcare system (22). In this context, CHWs directly treated minor ailments in people’s homes and made referrals to nurses and midwives in health facilities within the community as appropriate (22).

Moreover, Ethiopia implemented a Community Health extension program (HEP) in 2003 to bridge the health disparities between rural and urban populations and to scale up PHC to reach marginalised villages (23). This programme also relied on CHWs called Health Extension Workers (HEWs) to provide PHC and an effective referral system to the local health posts and health centres as needed (23). The HEWs provided family planning, child immunisation, antenatal and postnatal services, malaria, HIV and TB care services within the first five years of implementation (23). In Southern Africa, Zimbabwe implemented a community-based PHC programme that utilised village health workers in 1981 to provide care in rural and peri-urban areas (24). In the Zimbabwean programme, supervision was provided by professional nurses within the ward, and the programme was able to increase access to health care and improve immunisation coverage, as well as decrease communicable diseases and maternal and child mortality (24).

2.3 The community’s experiences with community-based primary healthcare

Effective PHC is one that is comprehensive, of high quality, people-centred, affordable and accessible to all (6). Community members in Iran expressed contentment with their community-based PHC programme called the Family Physician Program and described it as their trusted service provider (20). The residents expressed that they did not see a need to consult private practitioners in the urban areas as the local PHC system was functioning well and served their health needs. Further, this was related to the fact that with this community-based PHC model, the community had more access to physicians, e.g. they could see a physician on the day of making

an appointment as opposed to the facility-based system where one would only see a doctor a month after making an appointment (20).

In Nigeria, the Community Health Extension Workers (CHEWs) programme and the Volunteer Village Health Workers (VVHW) programme were trusted and preferred sources of healthcare. Firstly, community members appreciated the proximity of care to their homes and the good relationship they had with the CHEWs and VVHWs (25). One participant in the study mentioned that all her pregnancy deliveries were at the local (rural) PHC facility, and the health team was professional and experienced (25). Similarly, in Ethiopia, the community expressed contentedness with their existing community-based PHC programme (23). According to community members, HEWs provided excellent services and maintained high interpersonal relationships with the community. Community satisfaction with the programme scored 72.8% (23).

In other settings, community members' experiences of community-based health care were different. In New Delhi, the community expressed that they preferred to be attended by private health practitioners over community-based health providers (26). As a result, only 55% of respondents attested to using services at the community level, though 82% were aware that they could receive health support in the comfort of their homes. The contributing factors were the shortage or lack of drugs and the CHWs' inability to run further health tests at a community level (26).

2.4 Facilitators and challenges of community-based primary health care programmes

In India, having trained health providers, such as nurses living in the community, was cited as an enabling factor in the community-based PHC system (22). For example, midwives were available to conduct deliveries locally as labour can come at any time as well as other emergencies, thus having skilled health providers and CHWs living proximal provided continuity of care (22). Further, training, continuing education, provision of equipment such as blood pressure monitors and medical kits including drugs, torch lights, mobile phones and financial incentives were listed as facilitators of community-based PHC programmes (22). However, the various challenges included gender, cultural and religious beliefs and health system factors such as unavailability of personnel upon referral, lack of work supplies and technologies needed for work (31).

Moreover, in China, facilitating factors were found to be support from the central government, integration of the programme into the already existing PHC system, good relationships between local people and CHWs, and financial incentives (27). On the contrary, one significant challenge was around the sociocultural norms in the country(27). In countries such as India, Pakistan and China where many women assumed the CHW role, their work was limited by cultural and religious beliefs. In these countries, women are excluded from leading in family and community matters (22, 27, 28). As a result, for example, CHWs in India were not effective agents in advocating for the use of family planning services because they did not have a voice in their community (22). Other challenges confronting the community-based PHC programme in China included poor road infrastructure, lack of transportation, lack of drugs, lack of knowledge and skills to meet the demand of being a CHW, lack of training for CHWs, and lack of financial support, amongst other challenges (27).

In another example, community agents in Brazil attested to the challenges of inadequate training and support in community-based PHC systems (29). They referred to themselves as ‘experienced experts’ with training from life experience and had no formal training (29). Another challenge in Brazil was that CHWs felt that they were not validated and trusted to give appropriate care and that community members still preferred hospital care and being attended to by a physician or nurse (29). Similarly, in Zimbabwe, the CHWs were constrained by low incentives, lack of working equipment and high workload (30).

2.5 Historical context of community-based primary health care in South Africa

In 2011, South Africa’s Department of Health (DoH) introduced measures to strengthen the delivery of PHC (9). A PHC re-engineering model, which comprised three streams, namely, school health teams, district health teams and ward-based outreach teams (WBOTs), was introduced (9). The WBOTs consisted of at least eight CHWs, health promoters and environment officers attached to a local health facility (9, 32). Each team was supported by an outreach team leader who was either a professional nurse or an enrolled nurse (32). The programme was adopted by the DoH to achieve equity in access to PHC and improve health outcomes (32). Furthermore, the WBOTs were introduced to foster interaction between health services and patients through outreach teams that extend the care continuum from health facilities to people in their homes and vice versa through referrals and follow-ups (9).

WBOTs extend care to people and families in the community who are on the social or physical margins of the healthcare system (11). The role of the outreach team includes community and household assessment to identify health needs and risks, providing first aid, treatment of minor ailments, psychosocial support, adherence follow-up and support, health education, and making referrals to hospitals, amongst other roles (32). Challenges that have been found since the rollout of the programme include inadequate training, random and poor coverage of communities and lack of a link between with the healthcare system (10). Further, it was found that some teams were functioning without working resources, including equipment, stationery, uniforms, and money for airtime and transport (33). Additionally, there were issues with poorly planned work schedules which left the CHWs with little control over their work (11), high workload and inadequate mentorship (34).

The sum total of the above challenges have been found to be contributing to the WBOT programme's underperformance in the different parts of South Africa (11, 12, 34). Noteworthy is that most of the studies that explored the challenges of the WBOT programme focused on CHWs as the source of information; the current study investigates the programme performance from the perspectives of community representatives and patients to better understand the programme.

2.3 Chapter summary

In this chapter, I reviewed the literature on the history of community-based PHC programmes and their successes and challenges. I highlighted various countries' experiences of the programmes, including gaps. I also provided the South African CHW programme's history, successes, and challenges. In the next chapter, Chapter Three, I provide the study's Methodology.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

In this chapter, I provide an overview of the study design, setting, and selection of case studies. Moreover, I describe the study population, sample, selection criteria, data collection methods, data management and analysis, and ethical considerations.

3.2 Study design

This research is a secondary analysis of data collected as part of an already-approved study known as the Batlhokomedi project (Table 3.1: Description of the Bathlokomedi project). Permission for the primary study is attached as APPENDIX 2: Ethical clearance for primary study.

Table 3.1: Description of the Bathlokomedi project

The mixed methods study explored the implementation of WBOT/CHW programmes in six PHC facilities in the Sedibeng health district (Gauteng, South Africa) in 2016/17. The project was divided into three phases. Phase 1 was a situational assessment of the functioning of the programmes with different supervision configurations (junior or senior nurse-led teams) and locations (clinic vs health post). Phase 2 was implementing a 14-month capacity-building intervention in two of the six facilities in the district. The intervention comprised a nurse mentor supporting teams led by junior supervisors/ enrolled nurses in one of the sub-districts of the district. Phase 3 was evaluating the intervention, and assessing whether the intervention gains were sustained over time.
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To gain information about community members' and patients' understanding of the CHW/WBOT programme, I analysed the qualitative data collected from two of the six PHC facilities that formed part of the Batlhokomedi study. The two PHC facilities were considered as unique case studies and compared with each other. A case study is a study where the phenomenon of interest is studied holistically in its natural setting using various data collection methods and sources to explore, describe or explain a complex phenomenon (36). The case study design was the most appropriate because community-based PHC programmes work differently in different settings; thus, this design enabled efficient study of the programmes in their contexts.

3.3 Study setting

The Batlhokomedi study was undertaken in Sedibeng health district, Gauteng. The Sedibeng health district comprises three sub-districts: Midvaal, Lesedi and Mfuleni. Sedibeng is a relatively affluent district with disadvantaged communities in the peripheries of the district. Statistics also show approximately 20% of the residents live below the poverty line (33). The secondary study was limited to only one sub-district: Lesedi. Lesedi sub-district experiences similar challenges found in the entire district of Sedibeng.

3.4 Study population

The primary study population included CHWs and their supervisors (i.e. professional or enrolled nurses), facility managers, clinic staff, key informants/community representatives and patients/clients of CHWs.

3.5 Study sample and sampling techniques

The sample in the primary study comprised CHWs and their supervisors, facility managers, clinic staff, key informants/community representatives and patients/clients of CHWs in the WBOT programme in Sedibeng Health District. The project used purposive and snowball sampling techniques to recruit participants. Purposive sampling is a non-probabilistic sampling approach that deliberately targets participants with specific desired qualities willing to participate in the study (37), in this study, patients who had been referred to the clinic during the visit by the CHWs were recruited. Snowball sampling is a non-probabilistic sampling technique that usually starts with a small number of participants who then make recommendations of other contacts who fit the inclusion criteria (38).

The secondary study was limited to patients of CHWs and community representatives in the Lesedi sub-district. Purposive sampling was used to recruit the patients and snowball sampling was used to recruit the community representatives. To recruit the patients, data collectors accompanied CHWs on household visits and asked those who got referred to health facilities for further care for a follow-up interview in a month's time. Regarding the community representatives, the data collectors identified a few prominent community members who then made recommendations of other community members who could also be interviewed. The community representatives included clinic committee members and ward councillors.

The study sample included 10 community representatives and 10 patients: 6 community representatives from site A, 4 from site B, and 5 patients from each site (Table 3.2: Study participants). All community representatives' interviews from the primary study were analysed in the secondary study and patient interviews with most information were chosen by the supervisors and used for the secondary analysis.

Table 3.2: Study participants

Category of participants	Data collection method	Total
Community representatives	Individual interviews	10
Patients	Individual interviews	10

3.6 Research tool and data collection method

Data were collected by trained data collectors in Sedibeng Health District from September 2016 to February 2017. Prior to fieldwork, the fieldworkers received training on community-based PHC, research methods, research ethics and data management. The data were collected using semi-structured interview guides (APPENDIX 6: Information Sheet for Interviewing Community representatives and Appendix 7: Information sheet for interviewing referred householder).

The patients and community representatives participated in one-on-one interviews. A one-on-one interview is an interaction between the researcher and the participant in which the latter is given the platform to narrate and provide in-depth insight about the area under investigation which they have experienced or witnessed (38, 39). One-on-one interviews offer the benefit of in-depth exploration of the new phenomenon under investigation while also allowing privacy, especially when dealing with a sensitive topic that cannot be discussed in group settings (41). The disadvantage of this method of data collection is that it is costly in terms of time and logistics, as it often requires travel and space to conduct the interview (41).

Patients were interviewed in the comfort of their homes during working hours, while community representatives were engaged in their homes, health facilities and community centres. The interviews were audio recorded, and field notes were written after each interview. Interviews were approximately 40 minutes long, and they were conducted in English and clarification was done in the participants' native language to ensure understanding and that respondent's narratives

were vivid and comprehensible. The secondary analysis used transcripts for the community representatives' data, while field notes from the data collectors were used for the patient's data as there were no transcripts from the interviews.

3.7 Data analysis and management

Thematic analysis was used to analyse data. Thematic analysis is a qualitative analysis method that classifies data to identify themes to describe and interpret the phenomenon of interest and report repeated patterns in the data (36, 37). Even though thematic analysis is iterative with no clear linear steps, the following are the steps that were taken during data analysis (42):

1. *Familiarisation with the data.* In this step, I read the transcripts repeatedly and insightfully to familiarise myself with the data.
2. *Generating initial codes.* In this step, I started connecting the data items and ideas coming from the data. I used inductive inference to make observations, discover patterns, and then make inferences/explanations.
3. *Searching for themes.* In this step, I examined the coded data extracts to identify potential themes. The themes were organised to demonstrate cross-connection with the study questions and objectives.
4. *Reviewing themes.* I reviewed the coded data and themes to assess if they aligned with the study objectives. This process entailed reviewing the themes as a group and merging duplicate themes.
5. *Defining and naming themes.* In this step, I named the themes and described how they fitted to the broader study question. The themes were also organised in a clear, logical and concise manner.
6. *Producing the report.* I presented the findings and interpretation of data in a narrative, clear, and conscious manner. I also quoted some data extracts in the report to give context and explain the findings.

To keep the data safe, transcripts and participant templates were securely kept on a password-protected laptop and Google Drive account that only I and the supervisors can access.

3.8 Trustworthiness of the research process

Various methods were employed to ensure the study's scientific rigour and data quality. Qualitative researchers must take steps to ensure the trustworthiness of the research process (44). Credibility, confirmability, dependability and transferability are some of the prerequisite concepts for ensuring the trustworthiness of qualitative research that researchers should pay attention to (40, 41). Firstly, credibility was ensured through data triangulation in the primary study as a combination of observations, random household surveys, focus group discussions (FDGs) and one-on-one interviews were employed to gather data about the WBOT programme (33). Secondly, I ensured the confirmability of the study findings by constantly referring back to the transcripts to ensure that participants' meaning was not lost during data interpreting, formulation of themes and writing processes. Further, I achieved the confirmability and dependability of the findings by supporting the themes with direct quotations from the interview transcripts as well this report details clearly all the steps I undertook from concept development to the reporting of the findings. Further, transferability was ensured by describing the context of the Lesedi sub-district and the context in which these two WBOT programmes operated vividly throughout the report to aid researchers note those contextual differences in their endeavour replicating this study in other settings.

3.9 Ethical consideration

The study was approved by the University of the Witwatersrand HREC Non-Medical Committee (Reference number: M220688, APPENDIX 3: Ethical clearance for secondary study) as a sub-study under an already approved study i.e. the Bathlokamedi study (APPENDIX 2: Ethical clearance for primary study). Furthermore, the Sedibeng Health District authorities also provided the research team with letters of permission to conduct the study in the selected PHC facilities. Moreover, I was granted permission to use data from the primary study by the lead researcher Professor Jane Goudge (Appendix 4: Letter granting access to primary study data).

In the primary study, the patients and community representatives provided written informed consent before they were interviewed (Appendix 8: CONSENT FORM FOR INTERVIEW). Also, with their permission, the interviews were also audio recorded (APPENDIX 9: Consent form for interview to be audio-taped).

To safeguard the participants' anonymity, the dataset referred to in the findings does not include participants' personally identifiable information (PII), such as names or identity numbers. Where

reference is made to a particular participant, a unique code which combines the site name and the participant's unique ID is used, for example VIS_HHI_AS_081216_1.

3.10 Chapter summary

This chapter outlined the methodology that guided the primary and secondary studies. The subtopics covered in the chapter include the research design, population and sampling methods, data collection methods and analysis, and steps taken to ensure to achieve research rigor. In the next chapter, which is Chapter Four, I present the study findings in line with the study objectives.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter entails a presentation of findings from the data collection process. It covers the demographic profiles of the participants, findings under each study objective and a summary of the chapter.

4.2 Participants' demographic profile

The study sample involved two sets of participants: community representatives and patients (Table 4.1: Demographic profile of community representatives and Table 4.2: Demographic profile of patients). The community representatives were described according to sex, position held in the community and the duration of stay in the community.

Table 4.1: Demographic profile of community representatives

Demographic Factor	Sub-category	Number of participants	Total
Sex	Male	6	10
	Female	4	
Position in the community	Ward coordinator	1	10
	Ward councilor	1	
	Clinic committee	2	
	Clinical	3	
	Programme manager	3	
Involvement with the community	Less than 1 year	1	10
	1-2 years	2	
	Above 5 years	7	

Table 4.1: Demographic profile of community representatives above describes the community representatives who participated in the study. Participants held clinical positions in the community such as clinic counsellor and health promotor. Findings were that most participants were males (60%) and had been residing in the community for more than 5 years (70%). They occupied positions in the community such as ward councillor and ward committee member.

Table 4.2: Demographic profile of patients

Demographic Factor	Sub-Category	Number of participants	Total
Sex	Male	1	10
	Female	9	
Age category:	20-29 years	2	10
	30-39 years	2	
	Above 50 years	4	
	Not stated	2	
Home language	IsiZulu	4	10
	Shona	1	
	Not stated	5	
Employment status	Employed	1	10
	Unemployed	9	
Social assistance access	Pension grant	2	10
	Child support grant	4	
	No grant	2	
	Not stated	2	

Table 4.2: Demographic profile of patients highlights the demographic profile of the patients. Patients were described according to sex, age, home language, employment status, and the type of social assistance they received from the government. The age range was 21 to 67, and the dominant language was IsiZulu (40%). Most of the patients were unemployed, and they were recipients of social grants.

4.3 Presentation of findings using study objectives

Table 4.3: Study objectives and the subsequent themes below is a summary of the findings using the three objectives of the study, and a detailed description of the themes follows thereafter.

Table 4.3: Study objectives and the subsequent themes

Objectives	Themes
1. To explore how the community understands the WBOT programme in Lesedi sub-district to operate/function.	Mixed understanding of the functions of the WBOT programme
	The PHC outreach programme
	CHWs as an integral part of WBOT
	WBOT as an ineffective and inadequate programme
2. To explore patients' experiences with the WBOT programme in Lesedi sub-district, Gauteng.	WBOTs as an extension of the clinic
	Satisfaction and dissatisfaction with CHWs' services
3. To explore factors that facilitate or impede community representatives' and patients' positive relationship with the WBOT programme in Lesedi sub-district, Gauteng.	Employment of local CHWs
	Active collaboration within the WBOT and with external stakeholders
	Lack of community engagement
	Non-comprehensive services
	Lack of resources • Lack of transport • Lack of working equipment
	Inconveniences of the clock-in/ clock-out system
	Inability to maintain confidentiality and privacy
	CHWs inability to access the community

4.3.1 Objective 1: The community's understanding of the WBOT programme

The first objective was to gain insights from the community representatives on how the community understood the role and/or function of the ward-based outreach teams (WBOT) programme. Four themes emerged from this objective, namely: mixed understanding of the functions of the WBOT programme, the PHC outreach programme, CHWs as an integral part of WBOT, and WBOT as an ineffective and inadequate programme.

Theme 1: Mixed understanding of the functions of the WBOT programme

The findings revealed that the community members had diverse understandings of the WBOT programme's roles and functions in the community. In site A, some community representatives thought that the WBOT programme was the same as the home-based care (HBC) programme, which was the main community service partner before the introduction of the WBOT programme in 2011. Some community representatives from the site reported that they were unsure about what the WBOT was or what it did and attempted to solicit clarity about the roles and functions of the WBOT from the research team during data collection. The community representatives shared the following:

We don't understand what a WBOT is. (USI_CRI_JD_280916)

The problem is that I cannot clearly define their role. I do not understand how they operate. (USI_CRI_NM_280916_1)

In site A, the community representatives reported not understanding the role of the WBOT and had inquired from the CHWs during home visits if they were still operating as they did in the HBC programme, to which some affirmed, while others affirmed the negative. This painted a picture that even the CHWs themselves were not confident about their role in the community. Notably, most community representatives from site A verbalised that they found the WBOT programme to be different from the HBC programme. The participants explained that the programme appeared to be more clinic-based than community-based.

So, we asked them if they were doing the same job although they were in the WBOTs, and they said yes. But some of them indicated they were no longer doing the same job. (USI_CRI_JD_280916)

Now they are doing the job that is based at the clinic. (USI_CRI_JD_280916)

Theme 2: The primary health care (PHC) outreach programme

The WBOTs provided some PHC services in the community, such as health education, treatment adherence support, etc., that community members would otherwise have to solicit at the clinic. Community representatives attested that they had seen CHWs provide health services in the community through home visits in both sites A and B, though site B reported that they would love to see the CHWs do more than just household visits.

They should also know that their role is to help the community with health issues, as I have mentioned that if they can have more programmes and more visibility, because they dwell too much on door-to-door, even though there are other programmes, they do door-to-door a lot, so if they can have other programmes that will involve the entire community.
(VIS_CRI_NM_171016)

What was common and outstanding in both sites was the significant role of CHWs in collecting and delivering chronic medication for patients who could not go to the clinic for various reasons. Sedibeng Health District PHC facilities had a chronic medication collection programme named Kgatalopelo. Kgatalopelo was a programme introduced by the Sedibeng Health District to deliver chronic medication to the elderly and people living with disability. CHWs were leading the implementation of this programme as their work already placed them in the community, and they were aware of the patients requiring this service. During the medication delivery, the CHWs also provide health education to the patients.

They give education, take the card and go to the clinic to fetch medication.
(USI_CRI_JD_280916)

Further, in site A, CHWs and the health promotor functioned as the clinic's eyes and ears, detecting and reporting emerging disease outbreaks.

Let's say for example, there is a diarrhoea break-out, then the only thing that we will do, we will have first to investigate how many children have diarrhoea. Let's say maybe we have three today and three tomorrow; we have to check if they come from the same section. Even then we will rely on the community health care workers and the health promotor to go and check on those sections. When they report, "Okay, we had a child with diarrhoea, here is the address", we have to go

check; maybe it's the very same section. If maybe it happens that it's the very same section, then yes, it's an outbreak. (USI_CRI_NM_280916_2)

The community representatives also explained that CHWs wrote patient referral letters to the clinic and social welfare offices, promoted healthy lifestyles, and sometimes assisted with feeding patients in site A. In site B, it was reported that other members of the WBOT, such as the health promoter, were often seen on the ground teaching and supporting the elderly on health-related issues, including nutrition.

They promote healthy lifestyles, teach the family about the importance of a clean environment, and always make sure that the windows are open and the patient is taking his treatment. (USI_CRI_NM_280916_2)

We have a health promoter from the clinic; they send her to come and teach the elderly about health issues. When they go to the clinic, the health promotor sees them (CHWs) as well, and we also consult with them when we have issues that we can't solve on our own. (VIS_CRI_NM_25101)

The WBOTs in both sites implemented health campaigns in the community. In site A, the WBOT was actively involved in HIV prevention, designing and implementing campaigns, including hosting the World AIDS Day campaign, distributing condoms, and sometimes screening for TB. Similarly, site B also implemented HIV prevention campaigns and distributed condoms.

But normally, I see them doing programmes around HIV or the HIV Day and a programme for distributing condoms. (USI_CRI_NM_280916_1)

Yes, what I know as a local resident is that there are campaigns, they used to do to teach about sex and distribute condoms and leaflets to teach people around the community; that's all I know for now. (VIS_CRI_NM_171016)

Noteworthy is that the WBOT programmes in both sites provided the PHC services mostly in the townships. Both sites had farms located distant from the clinic, and the CHWs struggled to visit the farms due to lack of transport and poor roads, especially site A.

We really need transport, it will help our old clients, and we can even make an arrangement with the clinic to transport the old patient to the clinic. It can also help us to reach the far places in the farms. (VIS_CRI_NM_251016)

The other challenge is that CHWs cannot reach farms, especially where they work in places like Rosedale and Langseekoeigat. Transport... every day there is a challenge of transport. (USI_CRI_NM_280916_20)

Theme 3: WBOT as an ineffective and inadequate programme

Narratives shared during the interviews revealed significant dissatisfaction with the WBOT programme. Participants constantly compared the WBOT programme with the HBC programme, which previously provided health services in the community. They were not pleased with the changes that came with the new programme. Firstly, the community representatives in site A were concerned that the CHWs spent most of their time at the clinic rather than being hands-on in the community. Even when the clinic did community outreach, CHWs in site A did not join the outreach team.

I cannot define what they are doing, so you only find them here in the clinic, but they are supposed to be more in the community and address issues of how people should live a clean lifestyle. (USI_CRI_NM_280916_1)

They also came and joined us when we have events or when we are have something. Now they are doing the job that is based at the clinic. (USI_CRI_JD_280916)

The community representatives in site A also mentioned that the WBOT CHWs were undertaking fewer activities in the community. It was unclear whether this could be attributed to a decrease in the scope of work in the WBOT programme or a lack of equipment. In the community representatives' view, this had resulted in insufficient care compared to the HBC programme. For example, CHWs could provide wound care in the HBC programme but not in the WBOT programme.

Further, I know that when the child has burns, they dress him or her. They've stopped doing that... so, we don't know whether they don't have the materials, but they are taking the child to the clinic, they refer... straight to the clinic. (USI_CRI_JD_280916)

Most of the CHWs in site A were accused of writing more referrals to the clinic for patients to be attended to than providing the care required by the community. As a result, the community viewed the programme as inadequate because even though it existed, the clinic remained the primary point of care, and there were not many services that the CHWs were providing at a community level.

When I visit a house and find that the child has a sore, I won't help that child; the only thing I can help her with is to refer. (USI_CRI_JD_280916)

Moreover, another observation from site A was that even though the community benefitted from community outreach, the clinic was left understaffed when an outreach was done, which negatively impacted the clinic's workflow. Striking the balance between having community outreach and sufficient staff at the clinic was difficult. On the other hand, site B was despondent with the WBOT programme as they felt the outreach teams were mostly focusing on HIV prevention and care services. The community representatives reported that even when they came across a patient with high blood pressure in the community, the outreach team would not provide any treatment for that client.

The challenge is that the clinic becomes understaffed when we go to the farms. (USI_CRI_NM_041016)

Even if a person is very sick with High blood pressure, we cannot help because we mainly look after people with HIV. (VIS_CRI_ST_251016)

In addition, the community representatives in site A complained that CHWs' home visits were less frequent. This was not observed in site B, where community representatives spoke well about the CHWs and mentioned that they worked hard and were thus happy with their work.

They need the WBOT in the farms; they need regular checkups. (USI_CRI_NM_041016)

So far, we are happy because they work very hard to do their job to take care of the old people. (VIS_CRI_NM_251016)

4.3.2 Objective 2: Patients' experiences with the WBOT programme

The second objective intended to explore patients' experiences receiving health support through the WBOT programme. All the participants interviewed had had at least one home visit by CHWs. Fieldworkers went to the households with CHWs during initial data collection and arranged for a follow-up visit for householders referred to the clinic. However, variation in the number of visits per family by CHWs was noted in the two sites. Some patients indicated that they had only seen the CHWs for the first time when they came with the research team during data collection. In contrast, others reported that CHWs had only visited their families on few occasions, and others attested to having received frequent visits, up to routinely two times a week. Therefore, the experiences of the patients were greatly varying. Two themes emerged from this objective: WBOTs as an extension of the clinic and satisfaction and dissatisfaction with CHWs services.

Theme 1: WBOTs as an extension of the clinic

Patients from both sites A and B revealed that they had been in contact with the WBOT through the CHWs. CHWs primarily conducted home visits to keep in touch with the individuals and families they supported. The patients in both sites (A and B) reported that CHWs visited them post-clinic attendance. Most of the patients revealed that they were clients at the clinic taking chronic medication, and CHWs visited them to deliver medication and to assess and assist with enhancing treatment adherence. The patients shared the following:

The CHWs often visit her to check if she is still taking her medication well. She is taking both HIV and TB treatment. She thinks if the CHW visits more often, it would be even more helpful because they started visiting three months ago. She said that they visit twice a week. (USI_HHI_SM_01116_1)

The CHW promised her that if she can't go to the clinic to fetch her medication, she must tell her so that she can collect them for her, but if she needs to see the doctor, the only thing that the CHW will do for her is to stay with the children in the daycare center while she went to the clinic. (VIS_HHI_AS_081216_1)

Further, patients in site B reported that CHWs assessed the immunisation status of children under 5 years during home visits, i.e. requested and checked road to health books to remind parents about scheduled immunisation dates and ensure adherence to the schedule.

The first day that the CHW visited her was early this year; the first day, she asked about the baby's clinic card. (VIS_HHI_AS_121216_2)

The yard also has a day-care centre in which the CHW also visits to see if children are fine and if they go to the clinic for check-ups. (VIS_HHI_AS_081216_1)

Moreover, in site B, CHWs followed up on referred patients to find out if they went to the clinic and the outcomes of that clinic visit to further assist and support the patients. CHWs in site B also visited patients who missed their scheduled clinic visit appointment and patients who were lost to follow up to find out their challenges and re-engage them in care.

If she misses her appointment at the clinic by only one day, they will come and ask why she did not go to the clinic. If she doesn't miss appointments at the clinic, CHWs don't come to her household. (VIS_HHI_AS_121216)

CHWs in site B also assisted sick and dependent patients with activities of daily living and provided health education to families. This was not reported in site A, where it appeared the CHWs had difficulties in providing services to patients, especially those residing in the farm areas. As a result, the patients located there felt neglected by the CHW programme as CHWs hardly visited.

The participant told me that the CHW was doing a good job when they were coming to the farm, but now that they no longer come to the farm. (USI_HHI_NM_031116_1)

She said she put her trust in the CHWs, but now they don't come and help her. (USI_HHI_AS_271016_2)

Overall, patients in site B had more contact with CHWs and, consequently, a better experience with the WBOT programme than patients in site A.

Theme 2: Satisfaction and dissatisfaction with the CHWs' services

Overall, satisfaction with the WBOT programme's services was dissimilar in both sites and even within the same site. Patients in both sites, A and B, reported varying degrees of happiness with the WBOT programme. Some patients in both sites reported being happy with the programme because the clinic services were good, the CHWs were understanding and polite, and the patients were provided with essential services.

The participant told me that the CHW was doing a good job when they were coming to the farm, but now that they no longer come to the farm. (USI_HHI_NM_031116_1)

She is happy with the service at the clinic, but the problem is that she took a lot of time waiting in queue, and the service is a little bit slow. (VIS_HHI_AS_121216_2)

Some patients in site A expressed dissatisfaction with the WBOT programme because CHWs did not render many services during home visits. The patients complained that CHWs were not hands-on in terms of providing care. The participants reported that CHWs did not bring equipment during home visits but visited to ask questions about treatment adherence and immunisation. Furthermore, the WBOT programme had stopped providing services in the farms, and patients complained about the neglect of the community in the farm areas.

This year, the CHWs came twice to check on them, and they did not bring medication, but they came to check and asked about health issues. (USI_HHI_NM_031116_1)

The patient mentioned that previously a mobile clinic visited the farm every month to deliver the medication and test for diseases, but now it's no longer coming. The CHWs are not going to the farm, so it's difficult for the patients. (USI_HHI_NM_031116_1)

Similarly, some patients in site B were not satisfied with the WBOT's services and thought care would be more effective if CHWs were hands-on, did follow-ups, and provided feedback. The patients reported that CHWs made empty promises and did not do follow-up visits or contact after the patient had been referred to the clinic.

The service that the CHWs are doing is not useful to her. The only thing that CHW did to help her was to take her clinic file to Vischkuil Clinic, which didn't even help her. She needs CHWs to improve their service by taking care of their patients, giving feedback and doing follow-ups. (VIS_HHI_AS_061216_2)

The CHW doesn't follow up on her to see how she is doing; the only thing that she is good at is making empty promises. (VIS_HHI_AS_061216_2)

Patients in site B explained they expected to receive health education and services when CHWs visit them. Unfortunately, some CHWs are unable to meet these expectations. Further, the patients wanted the CHWs to serve all the patients in the community as they saw that CHWs were not visiting other households with health needs.

She needs CHWs to guide her and also educate her, not only ask her if she is taking her medication well and count them. (VIS_HHI_AS_121216_2)

She wants CHW to do more than ask questions. She said that she knows a lot of children who live around, but they don't go to the clinic, so she suggests that the CHW work on that and try to make sure that they go to the clinic and stop asking questions and then leave, she need them also to help somehow. (VIS_HHI_AS_121216_2)

The patients in site B also explained that CHWs in the HBC programme supplied food parcels because they were taking chronic medication. Overall, satisfaction with the WBOT programme's services was dissimilar in both sites and even within the same site. Patients' experiences were varied.

The CHW doesn't help her with anything, as when she has asked her to help her with food, she does not do it as she also told the CHW that there is no food for them, and the CHW told her that she would speak to the social worker, till today she hasn't had anything from her about the social worker. (VIS_HHI_AS_061216_2)

The medication that she is taking also makes her hungry and she doesn't have food to eat. She told the CHW that she doesn't have food to eat but she did give her an answer. (VIS_HHI_AS_081216_1)

4.3.3 Objective 3: Factors that facilitate or impede community representatives' and patients' positive relationship with the WBOT programme

The third objective intended to explore the various factors that facilitated or impeded community representatives' and patients' positive relationship with the WBOT programme. Eight themes emerged: employment of local CHWs, active collaboration within the WBOT and with external stakeholders, lack of community engagement, non-comprehensive services, lack of resources, inconveniences of the clock-in/clock-out system, inability to maintain patient confidentiality and privacy and CHWs lack of community access.

Theme 1: Employment of local CHWs

Even though some members of the community and patients were unhappy with the services they received from the WBOT programme, some of the participants in site B reported a positive relationship between CHWs and the community. This was mainly because site B employed local women as CHWs. Community representatives verbalised that it was easier for the community to talk about their health issues with local CHWs as they could trust the CHWs, thus facilitating a positive and helpful relationship with the programme. The participants shared the following:

It's true that people relate better to people they know than to strangers. Another thing is trust because you cannot easily open your issues to a stranger, it becomes easy when you interact with the well-known. (VIS_CRI_NM_171016)

Further, as locals, the CHWs could walk to and from work in site B. This meant more hands-on time in the community, ease of access to the people and savings on transport costs for the CHWs.

We recruit people from Vischkuil because the person should be able to walk to work. They are receiving a stipend, not a salary, so they cannot travel all the way from Kwa-Thema, otherwise, transport will affect them badly. (VIS_CRI_ST_251016)

On the contrary, community representatives in site A verbalised that although CHWs from outside the area were employed, that did not pose a significant barrier as the community was receptive to them; however, transportation and reaching clients' homes remained challenging for the CHWs.

People in the farms do not have a problem with being seen by strangers.
(USI_CRI_NM_041016)

Theme 2: Active collaboration within the WBOT and with external stakeholders

Furthermore, participants in site B reported good collaboration within the WBOT programme and with various stakeholders external to the programme, which benefitted patients and families. Stakeholders outside the WBOT programme included non-governmental organisations (NGOs) and community-based programmes that were helping in the community.

Yes, we have a relationship with Rose for health programmes. (VIS_CRI_NM_251016)

Participants from Site B additionally reported good collaboration between the clinic and the drop-in centre (DIC). However, the communication was one-sided, mostly from the clinic to the DIC. The clinic referred patients on anti-retro treatment (ART) for food parcels at the DIC, but the DIC did not give feedback to the clinic regarding the referred patients.

We do door-to-door and also get some clients from the clinic. When they see that you are suffering, they refer you to us. (VIS_CRI_ST_251016)

In a year, the number of people we refer to all the stakeholders is more than 50, especially the ones living with HIV. This is their programme, we ensure they get food because they have to take their medication after meals. (VIS_CRI_ST_251016)

Overall, there was good collaboration between the WBOT and the various programmes providing social services in the community in site B. Auxiliary workers from the social welfare department and CHWs from the WBOT programme in site B were reported to work well together, and they actively collaborated; CHWs did home assessments during their routine home visits and informed auxiliary workers of families that needed support with social services such as obtaining civic documents. In turn, the auxiliary workers were reported to inform CHWs about families they found to be needing health support.

We work with them because CHWs also attend by CHWs, so when one of our clients has a problem, we know which CHW to talk to or if we see one client who is very ill, we quickly communicate with the CHW. (VIS_CRI_NM_251016)

Moreover, the NGOs in site B collaborated with the health promoter from the clinic, who became part and parcel of the adult centre and would visit to educate the elderly about health issues.

Our relationship with the clinic is very good because we cannot work without them, as we have the health promoter from the clinic; they send her to come and teach the elderly about health issues. (VIS_CRI_NM_251016)

Worth noting is that even though good collaboration was reported with the stakeholders (i.e. community-based organisations and NGOs), collaboration between CHWs and facility staff remained limited. It was reported that the CHWs in site B did not have space within the facility to meet their supervisors, conduct supervision sessions and store their patients' files. In site A, the CHWs stopped doing outreach with facility staff members because of transport challenges.

Theme 3: Lack of community engagement

Lack of community engagement was one factor that impeded a positive relationship between the WBOT programme and the community. It was reported that the community was not engaged during the transition from the HBC programme to the WBOT programme. As a result, the WBOT programme was not fully understood nor integrated into the community. In Site A, the community representatives mentioned that the community was not informed when the HBC programme was coming to an end. Some of the participants who were programme managers in the site were informed by the families they were working with that there were new CHWs from the WBOT programme, and not the old one from the HBC programme.

When I found the person who was very sick, I referred them to Siepiela, and they told me there's no more Siepiela, it's WBOTs now. (USI_CRI_JD_28091)

Community representatives in site B also reported that the WBOT programme was never introduced to the community. Instead, community members started receiving CHWs at their homes who explained that they were from the WBOT programme.

The first day she visited her was in June this year and she chased her away and told her that she is under the previous CHW is where they came back again with the previous CHW who told her that she must allow her to help her as she is in the same section with her.
(VIS_HHI_AS_081216_1)

Theme 4: Non-comprehensive Services

There were complaints that the CHWs provided few or limited services (e.g., only delivering chronic illness medication) and left without doing other activities. Community representatives and patients in the two sites concluded that the CHWs had specific health issues that they were interested in and neglected other needs. The CHWs were seen to mostly focus on immunisation, adherence to clinic appointments, and chronic illness medication refills.

When the CHWs arrived at this household her two children were at school so they did not ask about them, but they only checked on the last born who is under 5 and asked about the last she took her baby for check up in the clinic then she told the date. (VIS_HHI_AS_121216_1)

The thing that the CHWs do when they are in this house is that they ask her to go to the clinic and also ask her to always take her medication. They also ask her when she last went to the clinic and she tells them the date. (VIS_HHI_AS_121216_1)

One patient claimed that the home visits by CHWs in site B were not helpful at all as CHWs only delivered medication. Most patients verbalised that their wish was to be assisted with food parcels as they were taking medication, and the CHWs could not assist with that; thus, their services were perceived as not helpful.

The service that CHWs are giving her doesn't help her at all because they come to count medication only. (VIS_HHI_AS_121216_1)

The medication that she is taking also makes her hungry, and she doesn't have food to eat. She told the CHW that she doesn't have food to eat but she did not give her an answer.
(VIS_HHI_AS_081216_1)

Participants in site A had the same complaints and dissatisfaction. Some of the patients made an example that they had requested HIV counselling and testing services, and it had been three months since the CHW had returned to test them.

She also asked the CHW to return and test her husband for HIV, and the CHW agreed, but she didn't come, and it was around September. (VIS_HHI_AS_061216_2)

Dissatisfaction was also reported in site A, where complaints were made that services had been reduced. For example, wound dressing and patient bathing services, which CHWs in the HBC programme rendered to the community, were no longer available.

They were helpful in the community, especially to children when they were burnt with water; they knew everything about how to treat the sore and how to dress a wound.
(USI_CRI_JD_280916)

Moreover, it is worth noting that participants in site A had very little to say about the services of the WBOT / CHWs as this site mainly comprised farms and CHWs, and the clinic outreach team hardly made it to the farms for various reasons.

The CHWs last visited her when they came with fieldworkers after a very long time. They used to come very often at the beginning, but they stopped going to the farm (I think it's because of the clocking system that made them not go to the farm).
(USI_HHI_NM_271016_1)

Theme 5: Lack of resources

The WBOT programme lacked various resources necessary for its functioning and health service provision in the community. This included transport and working equipment such as gloves, medication, first aid kits, etc., which are vital for providing PHC services at the community level.

a. Lack of transport

Transport was one factor that impeded a positive relationship between the community and the WBOT programme. In site A, the patients in the farms and townships were reported to have a challenge with transport to reach the facility for health services. Further, community representatives outlined that transport was “awkward” to the extent that patients on chronic medication ended up defaulting on their medications. It was reported that the challenges with transport were worse when schools were closed, as patients used the local school bus to get to the clinic. Sadly, the bus service was unavailable during the school holidays.

Transport in the farms is very awkward, and for those who are sick with high blood and diabetes ... it is difficult for them to come to the clinic after conducting household visits; most of them are defaulters because there is no transport. Even today, there is no transport; they wait for the school bus to come to the clinic, and when schools are closed, it's a problem. (USI_CRI_NM_041016)

Furthermore, the participants from both sites A and B reported challenges with transport for outreach activities. In site B, it was reported that the clinic had one car assigned for all clinic activities, including community outreach. When that car was being used for other duties, such as attending meetings or when it broke down, community outreach was suspended.

We rely on a GG car and it is mostly used for meetings. Sometimes, it's not here, and you find that you are having a problem, and if we don't have the GG car, then we cannot get to our destinations. (VIS_CRI_NM_251016)

Even when the vehicle was available, it could not reach the far-off places in the farms due to poor roads. As a result, the outskirts of the farms did not receive consistent services from the clinic and CHWs.

When it comes to community healthcare workers, we usually have a transport problem, especially when we are doing outreach programmes. There is no outreach, especially in the far places. (USI_CRI_NM_280916_2)

When it is raining, no one can go to the farm; not even an ambulance can go there because of the poor road structure. (USI_CRI_NM_041016)

b. Lack of equipment

WBOT teams in the two sites were experiencing challenges related to a lack of equipment to varying degrees, which affected service provision. Some community representatives reported having witnessed a shortage of essential equipment in the programme, such as gloves, bandages, and diapers, that prevented CHWs from providing services during home visits.

The other thing they usually complain about is equipment. They no longer have the equipment that they were using before. So those are some of the challenges.

(USI_CRI_NM_280916_2)

In site B, the patients were unhappy with the WBOT programme as the CHWs never brought any equipment during home visits. They asked health-related questions and then sent the patients to the clinic through a referral letter. The patients articulated that the WBOT would be more useful if CHWs brought equipment such as scales to weigh under-5 children rather than just visiting to ask questions during home visits.

The service that she is receiving from the CHW is not that helpful because she doesn't come every month and doesn't bring anything with her. Maybe the CHW could bring the scale with her and check the children's weight. The CHW, when she visits her, only talks about her children's health and how they are doing; she doesn't touch or check her children.

(VIS_HHI_AS_121216_2)

Further, in site B there was a reported lack of stationery for CHWs to use on a day-to-day basis, only a notebook was provided at inception of the programme. Moreover, the lack of equipment especially personal protective equipment (PPE) was reported in site B and community representatives were worried about CHWs contracting communicable diseases such as Tuberculosis (TB) during home visits.

I do not want to lie; they carry nothing with them when they go to the field, and we are always worried about them because they deal with people who have TB.

(VIS_CRI_NM_251016)

Another concern reported in site B was that CHWs did not have raincoats and umbrellas and had to walk in the rain during household visits. This also often led to absenteeism when the weather conditions were extremely bad and thus services to the community deferred.

The main challenge is that they do not have equipment, when it's raining they do not have rain coats or umbrellas, they must travel as they are. Sometimes when it's raining in the morning, they do not come at all because they will be wet by the time they get to the office.
(VIS_CRI_NM_251016)

The clinic was also reported to sometimes be out of essential medicines, which deterred the community from visiting. Some patients in site B verbalised not honouring their referral to the clinic because they were deterred by the possibility of not finding the medication they required at the clinic.

The reason that made her not take her baby on time was that she thought that there would be no medication at the clinic. (VIS_HHI_AS_121216_2)

Theme 6: The clock-in / clock-out system

When the WBOT programme was implemented, a clock-in/ clock-out system to enhance accountability was introduced. CHWs had to clock in at the clinic in the morning before embarking on home visits in the community, and they would clock out at the end of the day. Findings in site A indicated that this was an inconvenience for the CHWs and significantly reduced their work hours for the CHWs. Starting at the clinic in the morning was time-consuming and limiting for the CHWs, particularly those who lived in the farms and were supporting patients in the farms. The CHWs had to start at the clinic in the morning, outside the farms, to clock in, then go back to the farms for home visits and return to clock out at the clinic in the afternoon.

Further, after clocking in, the CHWs were often left with no transport to return to the farms as the school bus they depended on for transport to and from the farms would have finished with the morning trips. Moreover, the CHWs had to leave early to clock out at the clinic in the afternoon, as early as lunchtime. This, in summary, meant less time on the ground providing services, and consequently, the community was dissatisfied with the programme.

It affects them a lot, especially those who are from the farms; they struggle because they have to make sure they catch a school bus in the morning, and in the afternoon, the bus

leaves at 1H30; that time, they are still waiting to clock out, and the bust has left already.
(USI_CRI_NM_041016)

In site A, the clock-in/ clock-out system also affected outreach activities. CHWs joined outreach activities late because they had to clock in first at the clinic in the morning. Some CHWs did not join outreach activities due to the delays caused by the clocking-in system.

Just like during the week of 20 and 21st of September, we had a campaign in one of the farms called Mandorel. We were supposed to be with community healthcare workers, but on the first day, we had two of them. Our challenge was that there were many people; we had to see about 100 people, but by two o'clock, the community healthcare workers had to go back and clock out.
(USI_CRI_NM_280916_2)

However, the clock-in/clock-out system was never a problem in site B. This was related to the clinic's proximity to the community and CHWs and the employment of local CHWs, who were local residents and lived closer to the clinic.

We recruit people from Vischkuil because the person should be able to walk to work. They are receiving a stipend, not a salary, so they cannot travel all the way from Kwa-Thema. Otherwise, transport costs will affect them badly. (VIS_CRI_ST_251016)

Regarding working hours, they do not have challenges; they work for 8 hours.
(VIS_CRI_NM_251016)

Theme 7: Inability to maintain patient confidentiality and privacy

Community members were complaining of the CHWs' gossip and their inability to keep patients' sensitive information confidential. As a result, community members were uncomfortable seeking health services, particularly HIV testing at the local clinics. At site A, it was reported that some patients would be very ill during home visits but refused referral to the clinic due to the unprofessional conduct of the CHWs. The clinic committee in site A was aware of these concerns and worked on resolving them together with the clinic manager.

People are afraid to come here and do their.... to test because they are afraid.
(USI_CRI_NM_280916_2)

The same issue was reported in site B, where community members had concerns about the CHWs discussing patients' sensitive information with external parties. Worth noting was that none of the patients interviewed articulated that their privacy had been breached in their prior engagement with the CHWs, but they were still fearful of this happening to them.

I think confidentiality is a challenge for now, but they know very well and they have to maintain it. They come to me to report and then we call that caregiver to solve it together, and this is very rare. (VIS_CRI_ST_251016)

She told the CHW that if she had any rumours about her status from the community, she would not allow her to come to her household again. CHW visit her every week to see how she is doing. (VIS_HHI_AS_081216_1)

Theme 8: CHWs' inability to access the community

It emerged that the WBOTs experienced difficulties accessing the community. Firstly, in site A, the CHWs experienced challenges reaching the farms when it was raining. To reach patients in the community, the CHWs had to cross rivers. Thus, CHWs from outside the farms (the majority) were vastly affected in conducting home visits when it was raining. Community members also could not go to the clinic when it was raining due to poor and slippery roads, and overflowing rivers.

It's very awkward when it rains. When it has rained, you won't be able to cross. Tell me how they are going to cross to come to the clinic if they do not get services where they stay.
(USI_CRI_NM_280916_1)

The CHWs also had difficulties accessing their patients working on the farms, as farm owners did not allow them to see the patients during work hours. In order to see their patients, the CHWs had to make appointments with the farm owners before they visited.

It's tough, because even with us when we go to the farms to visit the patient, the farms refuse to let us in or he will allow us to see those who are at home but not the ones who

are on duty at the moment. If the farm owner refuses to let us in, then there's nothing we can do. (USI_CRI_NM_280916_1)

So, you must arrange with him prior to the visit and request for the patients you would like to see on that day. (USI_CRI_NM_280916_1)

In addition, the clinic in site A hosted a lot of campaigns around the farms but had to wait until the workers had finished working for them to screen and do some check-ups. The WBOTs had to be strategic when referring farm workers to clinics. The farm owners preferred that the farm workers be referred to the clinic on different days so productivity is unaffected. In site A, the farm owners allowed patients to be seen in a staggered fashion such that workers went in groups to be seen by the CHWs. Sometimes the staggering was on different days, where the first few patients were seen on a particular day and the rest seen later.

The farms owner give permission to see the first few patients and see the other ones on the next appointment. (USI_CRI_NM_280916_1)

4.4 Chapter Summary

In this chapter, I presented the findings per the research objectives. The communities had a mixed relationship with the WBOT/CHWs. In one site (site B), the community was happy with the programme as it employed local people to serve as CHWs and they could trust and share with them their health issues openly. However, there were concerns about the conduct of the CHWs in both sites, particularly concerning maintaining clients' confidential information. As a result, patients were not keen to use the services of the WBOT programme. CHWs' lack of crucial resources complicated the relationship they had with the communities. The community felt the CHWs could not provide the support they required due to the lack of resources including transport and work equipment. In the next chapter, chapter five, I discuss the findings in relation to literature.

CHAPTER FIVE

DISCUSSION OF FINDINGS, STRENGTHS AND LIMITATIONS

5.1 Introduction

This study aimed to explore community representatives' understanding and patients' experiences with the ward-based outreach teams (WBOT) programme in Lesedi sub-district, Gauteng. In this chapter, I reflect on the study findings in relation to extant literature on community-based primary health care (PHC) programmes. The chapter also discusses the strengths and limitations of the study.

5.2 The community's understanding of the WBOT programme in Lesedi sub-district

The main findings were that the WBOT programme was viewed and understood as an extension of the clinic functioning mainly through community health workers (CHWs) to bring services to people in the community. Literature documents growing recognition of community-based PHC and CHWs as an imperative for attaining universal health coverage (UHC) and health goals in low-income countries (46). The Director-General of the World Health Organization (WHO) articulated that 'there will be no UHC without PHC and in low-income countries (LIC) there will be no PHC without CHWs' (47). As a result, many low- and middle-income countries (LMICs) with a shortage of health workers are investing resources in CHW programmes.

In the study, the CHWs functioned as vital health agents and an important link between the clinics and people in the community. Similarly, Schaaf et al described CHWs in a community-based PHC system as service extenders, cultural brokers and agents of change in that they are the bridge between community members and the formal health system (48). A critical synthesis outlined that in the African context, community-oriented PHC is indeed rooted on CHWs and there could not be a PHC system without CHWs (17). Several studies have shown that CHWs in low-and-middle-income-countries (LMICs) provide a combination of preventative, promotive and limited curative services (17, 23, 48, 49). However, the services of the WBOT programme were few and non-comprehensive yet effective PHC is said to be the one that is comprehensive and includes a wide range of promotive, preventive, curative, rehabilitative and palliative services (17).

Evidence from LMICs shows that CHWs effectively provide maternal and childcare services, support individuals with chronic conditions, and encourage treatment adherence surveillance,

health promotion and referral (17, 25, 30). However, in many settings, the CHWs struggle to be effective in providing these services due to poor supervision and lack of resources (17, 25, 30, 44). As a result, there is a growing perception that the CHWs are less effective and inadequate in meeting the health needs of the communities they serve.

5.3 Patients' experiences with the WBOT programme in Lesedi sub-district

Considering this objective, I explored patients' experiences with the WBOT programme in Lesedi sub-district, Gauteng. The main findings were that patients had access to CHWs in the WBOT programme in varying degrees thus the varying quality of relationship with members of the WBOT programme (especially CHWs). The common experience was that CHWs were not able to provide comprehensive services for various reasons and mostly referred patients to the clinic for care. The conduct of the CHWs was against the goal of CHW programmes, which is to provide basic healthcare services at the community level and reduce overcrowding at healthcare facilities (48, 49, 50).

In many countries, home visits are the main way CHWs keep in touch with patients and families in community-based PHC programmes (18). Mash *et al* introduced an important concept that in community-based PHC systems, home visits and household registration must take place at inception to identify the population to be served and assess the community's health needs (17). Moreover, the authors stated that home visits must be done in a systematic manner providing holistic care i.e. promotive, preventive, curative, rehabilitative and palliative care (17). This was not observed in the study, where no baseline assessment was done when the programme started, and home visits were haphazard during the implementation phase, thus perpetrating inequality in access to care. Some families/ patients interviewed were not being visited regularly as expected, while others had only been visited a handful of times since the WBOT programme was introduced in the district.

With patients and families verbalising being displeased with non-comprehensive services by the CHWs in the WBOT, literature also documents that community-based PHC programmes function in different ways in different countries, even within the same country, providing varying amounts and types of services. Countries such as Brazil that have modelled successful and effective community-based PHC systems (17) have been used as a benchmark for other health systems and were found to provide a comprehensive package of services including family planning,

immunisation, reproductive health, first aid, prevention of HIV/AIDS, TB and malaria, sanitation and waste management, rodent control, food safety and hygiene as well as health education etc. (23). With this reflection in mind, indeed the services of CHWs in the WBOT programme were limited and non-comprehensive. Moreover, Give *et al* emphasised the importance of using the referral system to link communities to healthcare facilities to ensure continuity of care, quality of care and to save lives (54). However, this was not the case in this study as the referral system seemed to be over-used, and that defeated the purpose of a community-based PHC, as patients were not attended to in the community but were referred to the clinic most of the time. This appears to be the case in other countries; in Ghana where it was found that a limited range of services resulted in the community-based PHC system being rated as too shallow to produce any significant benefit (55), while unmet expectations by the patients led to mistrust of the CHWs as use of referral was interpreted as low competence of the CHWs. (16, 43, 48).

Furthermore, De Maeseneer *et al* argue patients that who feel that their needs are not met by the healthcare system may not further seek services and may also discourage others from seeking care (56). These findings support the study's findings that patients did not honour referrals and stated that they were deterred from attending the clinic because, most of the time, the clinic was out of stock of medications.

5.4 Factors that facilitate or impede the community representatives' and patients' positive relationship with the WBOT programme

In reflecting on this objective, I explored the factors that facilitated or impeded the community's and patients' positive relationship with the WBOT programme in the Lesedi sub-district. The main findings were that the employment of local CHWs and active collaboration within the WBOT had a positive impact on the relationship, while the lack of community engagement and resources, amongst other things, impeded the relationship the patients and community had with the programme.

The employment of local people to serve as CHWs played a huge role in the acceptance and effectiveness of the WBOT programme in the sub-district. This practice is not unique to African countries. For example, the United States of America also prioritised the employment of locals as CHWs to facilitate patient and health service provider relationships (52). However, when the Brazilian government implemented the same, it was met with resistance as this was found to be

against the constitutional principle of equity and non-discrimination based on one's area of residence (57). However, The amendment of the constitution allowed this practice to continue (50, 51).

Moreover, as health systems transition to an integrated PHC system with a strong community health component, community engagement and participation have become an integral part of the health system (52, 53). Several scholars argue that communities are important stakeholders in the development and implementation of CHW programmes (6, 17, 52). The study found that the communities were not consulted in introducing and implementing the WBOT programme. This explains why some community members were unsure about the role of the programme. Scholars recommend that the planning, development and implementation of health programmes should be in collaboration with local communities to facilitate service uptake (17). Sadly, this was not done in the WBOT programme.

An integrative literature review documented the positive impact of active collaboration in the health system as well as having multidisciplinary teams that included CHWs, nurses, physicians and dieticians (61). The fact that active collaboration was perceived as contributing to the positive relationship in this study supports the need for collaboration within a dynamic team in community-based PHC systems. In other settings, collaboration was reported to be comprehensive and included collaboration within the team and interdependence of health providers in the programme, active participation of patients and regular team meetings (61).

The study found many of the CHWs operated with limited resources and this affected the relationship they had with patients. The lack of working equipment is a common challenge in CHW programmes, particularly in LMICs (24, 45, 55). The study showed that CHWs in some sub-Saharan African (SSA) countries worked without equipment such as medical supplies, transport, meeting space and office equipment, which resulted in limited effectiveness of the CHW programmes (17, 18). The unavailability of medicines and equipment amongst CHWs negatively impacts CHWs' reputation as they are seen as a cadre unable to provide the health services needed by the communities (45). This was evident in the study as the patients felt that the CHWs were not doing much to attend to their health needs; instead, they referred them to the health facility. A critical interpretive synthesis (CIS) found that the availability of working equipment enables

CHWs to provide the care required by patients and could also help boost patients' trust in the competence of CHWs (48).

5.5 Strengths and limitations of the study

The study had various strengths and limitations:

Firstly, the Batlhokomedi study was a large project that generated many interviews and observations. Although not all the interviews were included in the secondary analysis due to time and resource constraints, the project leaders helped identify strong interview transcripts and observation notes for this analysis.

Secondly, most of the participants had been in the community for over five years, so they were well-versed in the community dynamics. They could provide in-depth information during the interviews.

Thirdly, the research supervisors had been working with this community since the primary study was initiated in 2016 and were able to guide and provide extra information as needed to enhance my understanding and strengthen reporting.

However, since secondary data were used, clarity and further probing on some themes might have helped to get a richer description of the WBOT programme, but that was not possible as data collection was completed.

Lastly, some patients' interview transcripts were not available, so I had to depend on the field notes written by the data collectors. However, the supervisors' familiarity with the study sites helped overcome this challenge.

5.6 Chapter Summary

This chapter entailed a discussion of the main study findings in relation to the extant literature. The discussion was guided by the three study objectives and finally, the strengths and limitations of the study were discussed. In the next chapter, which is chapter six, I provide the overarching conclusion and recommendations for practice and future research.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

In the study, the ward-based outreach teams (WBOT) programme was used to extend care from the clinics to the people in need of health care in the community. However, because of the many challenges in the programme, it was perceived as less effective and inadequate in meeting the community's health needs, especially in site A. The World Health Organization (WHO) highlights that an integrated primary health care (PHC) system is the ideal system for bridging social and financial barriers to access (6). My study's findings accentuate that, above being comprehensive, PHC programmes must be well introduced, integrated, and managed to fit the local context and meet population health needs; otherwise, the benefits are forgone.

The study further supports that local community health workers (CHWs) are more effective in providing PHC services than hiring CHWs from outside the community as trust is enhanced and local barriers such as transport scarcity are bridged. Further, findings of varying levels of satisfaction with the WBOT programme attest to the fact that random and poor coverage of communities by CHWs results when the work of CHWs is not regulated. Also, as a result, inequalities in access continue to prevail and consequently the inequities in health outcomes within geographical areas and beyond.

In conclusion, community-based PHC programmes are most effective when services are comprehensive and can reach the most deprived areas and populations. CHWs when part of a comprehensive team can contribute to the coordination of health services, continuity of care, and improved quality of life.

6.2 Recommendations

Five categories of recommendations arising from this research, categorized according to the level of action that must take place: the South African National Department of Health, Gauteng Department of Health, local clinics, the community, and future research.

6.2.1 South African National Department of Health

I recommend that the South African National Government incorporate findings/ insights from this study into the strategic plan for the Department of Health to shape the framework that outlines the implementation, monitoring, and management of the WBOT programme. This will help guide and provide structure for the districts and local governments as they implement the WBOT programme so that it can align with the National Health goals at the grassroots.

6.2.2 Gauteng Department of Health

Firstly, I recommend that the local government in the Gauteng province should prioritize hiring local CHWs to work in the WBOT programme as this was one of the enabling factors in the Lesedi Sub-district that facilitated a positive relationship. Further, the programme needs increased supervision and better systems for accountability to avoid the inconveniences of the clock-in/ clock-out system. This could be in the form of timesheets that the CHWs will complete at the beginning and end of each day. Moreover, for the programme to attain its full potential, the Gauteng Department of Health must ensure that all the sub-districts have enough equipment and supplies to make the programme and CHWs more effective in the community. This includes ensuring the availability of transport, medication, working equipment, and personal protection equipment (PPE) that enable CHWs to provide services in the community and prevent the overuse of the referral system.

6.2.3 Local clinics

Managers at the clinics/ fixed PHC facilities from which WBOTs operate should afford the members of the WBOT, including CHWs' space for holding meetings to plan, manage and provide feedback on programme operations as needed. Further, collaboration is imperative, and CHWs, being a lower cadre in the health system, should function as part of a team of professionals with support.

6.2.4 The community

I recommend integrating the WBOT programme into the community for mutual benefit. The WBOT programme or its representatives should participate in community meetings to enhance communication and the relationship with local authorities and the community at large. This will

also help correct the misalignment of community members' expectations and the actual services CHWs can provide and ensure continuing health education in the community, which is a cornerstone of health promotion.

6.2.5 Further research

I recommend further research on the WBOT programme to better understand the dynamics and complexity of this PHC system to inform continuous quality improvement and effectiveness in bringing PHC to people and families in the community. This study dwelled on the perspective of the recipients of care, while previous studies, including the Bathlokomedi project, explored the perspectives of the providers in the system (10, 12, 13, 33). Little work has been done to explore the perspectives of both providers and receivers of care on the same scale, and looking at the system disjointly risks missing an understanding of its complexities and dynamics.

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APPENDIX 1: PLAGIARISM DECLARATION



PLAGIARISM DECLARATION TO BE SIGNED BY ALL HIGHER DEGREE STUDENTS

SENATE PLAGIARISM POLICY: APPENDIX ONE

I Nkosephayo Thembe Nkambule (Student number: 2321227) am a student registered for the degree of Master of Public Health in the academic year 2024.

I hereby declare the following:

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

Signature: 

Date: 30 October 2024

APPENDIX 2: ETHICAL CLEARANCE FOR PRIMARY STUDY

Human Research Ethics Committee (Medical)

Research Office Secretariat: Senate House Room SH 10005, 10th floor.
Medical School Secretariat: PV Tobias Building 2nd Floor.
Private Bag 3, Wits 2050, www.wits.ac.za
Email: HREC-Medical.ResearchOffice@wits.ac.za

Tel +27 (0)11-717-1252
Tel +27 (0)11-717-2700
Fax +27 (0)11-717-1265



18 April 2016

To Whom It May Concern

SUBJECT: CONFIRMATION OF STUDY APPROVAL

Protocol Ref No: M160354

Protocol Title: Implementing Comprehensive, Integrated, Community-based Health Care for Under-Served, Vulnerable Communities in South Africa: A Practical, Evidence-Informed Model

Principal Investigator: Prof Jane Goudge et al

Department: Centre for Health Policy

This letter serves to confirm that the Human Research Ethics Committee (Medical) has received an ethics application for the abovementioned study. In order for a clearance certificate to be issued, the researcher is required to submit written approval to conduct the study in your district/institution.

The researcher has been informed that this study cannot commence without your approval and receipt of the Clearance certificate from the HREC (Medical).

Should you have any queries, you may contact me at tel: 011 717 1234/2700/2656 or by email Rhulani.Mkansi@wits.ac.za

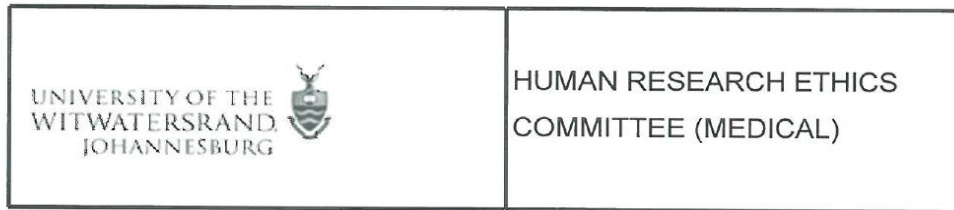
Yours Faithfully,

A handwritten signature in black ink, appearing to read 'Rhulani Mkansi', written over a dotted line.

Mr Rhulani Mkansi
Administrative Officer
Human Research Ethics Committee (Medical)



APPENDIX 3: ETHICAL CLEARANCE FOR SECONDARY STUDY



Office of the Deputy Vice-Chancellor (Research and Innovation)

TO: Ms NT Nkambule
School of Public Health
Centre for Health Policy
Medical School
University

E-mail: 2321277@students.wits.ac.za

CC: Supervisor: Professor J Goudge; Mr H Malatji
<Jane.Goudge@wits.ac.za>
and <HREC-Medical Research Office@wits.ac.za>

FROM: Mr Iain Burns
Human Research Ethics Committee (Medical)
Tel: 011 717 1252
E-mail: Iain.Burns@wits.ac.za

DATE: 2022/08/01

REF: R14/49

PROTOCOL NO: **M220688** (This is your ethics application reference number. Please quote it in all enquiries, oral or written, relating to this study.)

PROJECT TITLE: *Community understanding and patients' experiences of the Ward-based outreach programme in Lesedi sub-district, Gauteng*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to Government funding of the University.



MSWorks2000/Iain0007/Clearscan.wps



R49 Ms NT Nkambule

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
CLEARANCE CERTIFICATE NO. M220688**

NAME: Ms NT Nkambule
(Principal Investigator)

DEPARTMENT: School of Public Health
Centre for Health Policy
Medical School
University

PROJECT TITLE: *Community understanding and patients' experiences of the
Ward-based outreach programme in Lesedi sub-district,
Gauteng*

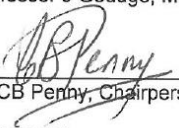
DATE CONSIDERED: Ad hoc

DECISION: Approved unconditionally

CONDITIONS: Sub-study under M16/03/54

NOTE: If contact information regarding student study participants is required,
please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>

SUPERVISOR: Professor J Goudge; Mr H Malatji

APPROVED BY: 
Dr CB Penny, Chairperson, HREC (Medical)

DATE OF APPROVAL: 2022/08/01

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

I/we fully understand the conditions under which I am/we are authorized 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 submit details to the Committee. I agree to submit a yearly progress report. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in 2022/06/01 and therefore reports and re-certification will be due in the month of 2022/06/01 each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

Date

APPENDIX 4: LETTER GRANTING ACCESS TO PRIMARY STUDY DATA



28th April 2022

To the Wits Human Research Ethics Committee (Medical)

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

This letter serves to inform you that Nkosephayo Nkambule (Student ID:2321227) is a student at the Wits School of Public Health who is planning to conduct a research project titled: Community Understanding and Patients' Experiences of the Ward-based Outreach Programme in Lesedi Sub-district, Gauteng.

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

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

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

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

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

Sincerely,

Jane Goudge

Professor

Centre for Health Policy, School of Public Health; Email: jane.goudge@gmail.com

Health Policy and Systems Research

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

APPENDIX 5: TURNITIN REPORT SIGNED

2321227_Nkosephayo Nkambule.pdf



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APPENDIX 6: INFORMATION SHEET FOR INTERVIEWING COMMUNITY REPRESENTATIVES

V0.95; 12 September 2016

Annex F: Information Sheet for interviewing community representatives

Formal Title: Implementing comprehensive, integrated, community-based health care for under-served, vulnerable communities in South Africa: A practical, evidence-informed model.

Hello, and thank you for your time today.

My name is _____. I work for the Centre for Health Policy at the University of the Witwatersrand. I am a researcher in the Batlhokomedi project, and I would like to interview you today as part of this project.

What is this research about?

We are conducting this research to understand how community health worker / WBOT programmes operate. We know that there are some innovative WBOT programmes in Sedibeng and we are keen to learn more about the programmes here. I understand that you hold an important position in the community. So we would like to hear about your experiences of having WBOTs in the community, both the successes and challenges.

The interview should take about 40 mins.

Voluntary Participation

It is up to you to decide whether you want participate in this study. If you agree to help with this research, and later change your mind, you are free to end the interview at any time, without any consequences.

Risks

There are no risks associated with talking to me today.

Confidentiality

No one other than my team members will be allowed to see the record of the interview. We will not use your name in any reports of this work. We will use a code instead of your name e.g. A or B.

My notes and audio recordings will be kept on a secure university computer server, and participant codes will be kept in a locked filing cabinet under the care of the project site manager, and will be destroyed once our research is complete.

Approval for and benefits of this work

The study has been approved by the ethics committee of University of the Witwatersrand, and Gauteng Province. We hope the study will contribute new ideas and insights regarding the provision of community health worker services.

If you agree to be interviewed, we would also like your permission to record the interview as it really helps later in the office.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact Julia De Kadt on Julia.DeKadt2@wits.ac.za, or 011-717-3434 or 074 336 9411.

If you are concerned about anything to do with the study in general, or wish to make a complaint, you can contact the chair of the ethics committee at the University of the Witwatersrand, who is Professor Peter Cleaton-Jones at telephone number: (011) 717-2301

SS

Tool F: Interviews with Community Representative

Introduction

Thank you again for agreeing to be interviewed. Are you happy to start?

First, could you please tell me a bit about yourself?

Probe:

What is your role in the local community?

Please tell me about the community.

Probes:

What problems are faced by the community (e.g. unemployment, lack of roads or water)?

What good things have happened recently / are happening in the community?

What is the role of the community in the recruitment of community health workers?

Perhaps we could now talk about the CHWs. What do the community health workers do to help the community?

Are you aware of community activities where community health workers have been involved?

Are there other activities that you think the CHW should do?

What does the community think of the Community Health Workers?

How does the community express their views?

Have you ever had complaints about CHW? What was the complaint and what happened next?

If a CHW or their team leader needs to communicate with the community, how do they go about this?

What things do they communicate about?

Are there other organisations providing similar health care in the community and what do they do?

What is the role of the clinic committee? Is it effective?

Ending the interview

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

Suggested generic prompts to use to encourage participants to continue:

To get going on a topic if they are unsure of where to start or what to say:

Start wherever you want

Start with what you think is most important

Why not start by telling me what happens in a day, starting at the beginning

To go into more depth or to encourage continuation of their account

Please tell me more about that

Please explain that for me

Why was that?

What did you feel about that?

What happened then?

Please can you tell me more about (person, role, place, organisation, activity etc.)

APPENDIX 7: INFORMATION SHEET FOR INTERVIEWING REFERRED HOUSEHOLDER

V0.98; 31 October 2016

Annex G: Information Sheet for interviewing referred householder

Formal Title: Implementing comprehensive, integrated, community-based health care for under-served, vulnerable communities in South Africa: A practical, evidence-informed model.

Hello, and thank you for your time today.

My name is _____. I work for the Centre for Health Policy at the University of the Witwatersrand. I am a researcher in the Batlhokomedi project, and visited your household about a month ago with a community health worker. I am here today just to follow up with you after that visit.

What is this research about?

We are conducting this research to understand how community health worker / WBOT programmes operate. We are here to learn more about the community health workers in Sedibeng, by talking to people like yourself about what the CHWs do.

The interview should take about 40 mins.

Voluntary Participation

It is up to you to decide whether you want to participate in this study. If you agree to help with this research, and later change your mind, you are free to end the interview at any time, without any consequences.

Risks

There are no risks associated with talking to me today.

Confidentiality

No one other than my team members will be allowed to see the record of the interview. No contents of the interview will be shared with the clinic or health post, or any Community Health Workers, including the Community Health Worker who brought me here. We will not use your name in any reports of this work. We will use a code instead of your name e.g. A or B. My notes and audio recordings will be kept on a secure university computer server. Participant codes will be kept in a locked filing cabinet under the care of the project site manager, and will be destroyed once our research is complete.

Approval for and benefits of this work

The study has been approved by the ethics committee of University of the Witwatersrand, and Gauteng Province. We hope the study will contribute new ideas and insights regarding the provision of community health worker services.

If you agree to be interviewed, we would also like your permission to record the interview as it really helps later in the office.

What if I have any questions?

You are free to ask me any question about this research. If you have any further questions about the study, you are free to contact Julia De Kadt on Julia.DeKadt2@wits.ac.za, or 011-717-3434 or 074 336 9411.

If you are concerned about anything to do with the study in general, or wish to make a complaint, you can contact the chair of the ethics committee at the University of the Witwatersrand, who is Professor Peter Cleaton-Jones at telephone number: (011) 717-2301

Tool G: Interviews with referred householder

Introduction

Thank you again for agreeing to be interviewed. Are you happy to start?

First, could you please tell me a little bit about yourself?

Probes:

Age

Gender

Language spoken

Number of people in household

Are you working?

If yes, what type of work do you do?

What other sources of income are there in the household (child support grants, pension, disability)?

Thank you. Now, let's talk a little bit about the Community Health Worker's visit. Please tell me about what happened when the Community Health Worker came to your house.

Probes:

What happened?

Can you describe how you felt about the visit that day?

Were any other household members around?

If so, what did other household members say or do?

What did the CHW suggest you do (in terms of your health/the issue you were experiencing)?

What did the CHW say she would do (in terms of your health/the issue you were experiencing)?

If the CHW suggested the patient should do something:

Were you able to do what the CHW suggested you do?

Probes:

What did you actually do?

Why?

What made it easy or difficult to do what the Community Health Worker suggested?

How helpful did you find the Community Health Worker's suggestion?

For householders who have not taken action based on the Community Health Worker recommendation:

Why didn't you do what the community health worker suggested?

If the CHW said she would do something:

Did the CHW do what she said she would do?

If the CHW didn't do what she said she would, do you know why? Do you think she will still do what she said?

Did the CHW do anything else?

Has the CHW made any other visits/follow-ups after the visit we've been discussing?

If so, when, and what did she do during those visits?

Could you please tell me about how you are doing now (with regards to your health/the issue you were experiencing)?

Probes (use only the appropriate ones):

What health care are you receiving now for your health?

Follow up visits, treatments, tests

What services are you receiving related to the issue you were experiencing?

Could we talk a bit about the CHW's service more generally?

Probes:

Is their service useful?

Can you give me any other examples of when they've assisted you?

Has it changed (over time)? How?

How could it be improved?

When did they start coming to see you?

How often do they usually come to see you?

Ending the interview

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

Suggested generic prompts to use to encourage participants to continue:

To get going on a topic if they are unsure of where to start or what to say:

Start wherever you want

Start with what you think is most important

Why not start by telling me what happens in a day, starting at the beginning

To go into more depth or to encourage continuation of their account

Please tell me more about that

Please explain that for me

Why was that?

What did you feel about that?

What happened then?

Please can you tell me more about (person, role, place, organisation, activity etc.)

APPENDIX 8: CONSENT FORM FOR INTERVIEW

V0.95; 12 September 2016

CONSENT FORM FOR INTERVIEW

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

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

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

Signature: _____ **Date:** _____

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

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

Signature: _____ **Date:** _____

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

APPENDIX 9: CONSENT FORM FOR INTERVIEW TO BE AUDIO-TAPED

V0.95; 12 September 2016

CONSENT FORM FOR INTERVIEW TO BE AUDIO-TAPED

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

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

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

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

Signature: _____ **Dat** _____
Designee/ _____ **Time:** _____
(please print name)