COMMUNITY HEALTH WORKERS' EXPERIENCES IN THE CARE OF CLIENTS WITH CHRONIC ILLNESSES IN JULESBURG, GREATER TZANEEN MUNICIPALITY, SOUTH AFRICA

By

MASHELE TJ

MINI–DISSERTATION

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DEDICATION

My dedication goes to all the community health workers, in Julesburg Local Area who are always there to support the patients and families in their communities, unconditionally.

DECLARATION

I, Tintswalo Johanna Mashele hereby declare that the mini-dissertation entitled ‘Community Health Workers’ Experiences in the Care of Clients with Chronic Illnesses in Julesburg, Greater Tzaneen Municipality, South Africa’ is submitted by me to the University of Limpopo for the Masters of Public Health. It has not been previously submitted for any other degree to this university or to another university. I declare that this is my own work, except where I have stated in design and in execution, and that all material contained herein is duly acknowledged. I have followed the required convention in referencing the thoughts and ideas of others.

2021/10/29

SIGNATURE --DATE: ---------------------------------------

Tintswalo Johanna Mashele

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DEFINITION OF CONCEPTS

Care

Care is defined as an act of caring, which means looking after, as well as displaying kindness and concern for, individuals who are unable to care for themselves (Oxford Dictionary, 2013, care entry). In this study, care refers to the act of caring for clients with chronic illnesses in the home environment by community health workers.

Client

The concept client is often used as a synonym for a patient who receives health care on an outpatient basis or outside the hospital or ward setting, especial when health maintenance, rather than illness, is the primary service provided (Segen's Medical Dictionary, 2012, client entry). In this study, client refers to individuals with chronic illnesses who need or receive care and treatment from community health workers in their home environment.

Chronic illness

Chronic illness refers to diseases that persist over an extended period of time, that last more than three months and are often associated with activity limitations (Segen's Medical Dictionary, 2012, chronic illness entry). In this study, a chronic illness refers to hypertension and diabetes mellitus that need long-term care and treatment support in the comfort of patients' homes.

Community Health Workers

Community health workers refer to trusted, knowledgeable frontline health personnel who typically come from the community they serve (WHO, 2018a). For the purpose of this study, community health workers will mean people from within a community appointed as members of a primary health care outreach team, trained to render health care services and who provide health promotion services to prevent illnesses within South Africa's primary health care (PHC) re-engineering model.

Experience

Experience is defined as the knowledge or mastery of an event or subject gained through involvement in, or exposure to, it (Oxford Dictionary, 2013, experience entry). In this study, experience is the reflection by community health workers themselves on what they go through while caring for patients with chronic illnesses.

LIST OF ABBREVIATIONS

AIDS: Acquired Immunodeficiency Syndrome
CHC: Community Health Centre
CHW: Community Health Worker
DOH: Department of Health
FGD: Focus Group Discussion
HIV: Human Immunodeficiency Virus
KII: Key Informant Interview
NCDs: Non-Communicable Diseases
OPM: Operational Manager
OTL: Outreach Team leader
PHC: Primary Health Care
TB: Tuberculosis
WBOT: Ward-Based Outreach Team
WHO: World Health Organization

ABSTRACT

Background: Chronic illnesses, including non-communicable diseases (NCDs), continue to be a public health concern, globally, and contribute to the high burden of diseases. These health challenges have led to the introduction of community health workers (CHWs) in both developed and developing countries as a way of dealing with these challenges. It is more than five years since ward-based outreach teams (WBOTs) were introduced into the Julesburg area in order to respond to the needs of the community, based on the government's focus on quadruple burden of diseases. The researcher is aware of the increasing workload, unclear roles and responsibilities, different approaches to CHWs' work taken, and the ever-changing focus of their work, based on the community needs and diseases that the community faces at a particular time. It is for this reason that the researcher is interested in understanding the CHWs' experiences and the manner in which they cope with challenges when working in their ever-changing environment, workload, work focus and roles and responsibilities.

Methods: A qualitative exploratory, descriptive and contextual study approach was used; data was collected using focus group discussions with CHWs and one-on-one interviews with key informants, using their supervisors to gather more information that could not have been shared by CHWs.

Result: The findings from the focus group discussions revealed that the CHWs have a high workload, while receiving stipend and are not permanently employed. CHWs have had experiences that make them feel unimportant and not needed, as well as enduring poor working conditions without sufficient personal protective equipment (PPE). Even though they experience dissatisfaction, they are passionate about continuing with their community-based work for many years, evidenced by those who have up to 22 years of service.

KEY CONCEPTS: Community Health Worker, Experiences, Healthcare, Chronic Illnesses, Non- Communicable Diseases, Ward-Based Outreach Team.

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CHAPTER ONE: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Chronic illnesses, including non-communicable diseases (NCD), have been a public health concern globally and have contributed to the high burden of diseases. According to the World Health Organization (WHO) burden of disease is the impact of health problems measured by the financial costs, as well as mortality, morbidity or other indicators (WHO, 2018). Burden of disease is often measured in terms of quality-adjusted life years or disability-adjusted life years, both of which quantify the number of years lost due to diseases. Chronic illnesses have affected millions of people in low-, middle-, and high-income countries; with middle- and low-income countries struggling to cope with this burden within their health systems (Maimela, Alberts & Van Geertruyden, 2018). Health systems in developing countries lack the capacity to deal with chronic illnesses, because they are already overburdened by communicable diseases (Ndou, Van Zyl, Hlahane & Goudge, 2013).

These health challenges led to the introduction of community health workers (CHWs) in both developed and developing countries as a way of dealing with them (Mhlongo & Lutge, 2019). CHWs are regarded as a solution for alleviating disease burdens in health systems by extending the care of the chronically ill in the community. The aim of introducing CHWs was to contribute towards improving access to the healthcare system, health education, health promotion, health information and treatment adherence (Rosenthal, Brownstein, Rush, Hisrsch, Willaert, Scott, Holderby & Durell, 2010). The thinking was that their introduction would improve the health status of individuals and groups, improve early detection of illnesses and improve health outcomes in the community through treatment support and monitoring (Rosenthal et al., 2010).

Evidence from different countries indicates that, through the deployment of CHWs, improved access to health care and quality of life for people in poor and underserved communities have been experienced in many communities (Rosenthal et al., 2010). Between 2000 and 2015, many countries used CHWs to address their health priorities and to reach their Millennium Development Goals (MDGs), as defined by the United Nations. The United States of America (USA) uses CHWs to deal with the leading causes of death in the country, which are hypertension and diabetes mellitus, as well as for dealing with the major risk factors for heart diseases, strokes and related deaths that affect almost one-third of USA adults older than 18 years (Hodgins, Crigler & LeBan, 2013).

1.2 BACKGROUND TO THE PROBLEM

In 2011, South Africa adopted the Primary Health Care (PHC) Re-engineering Model at district level to address the challenges faced in meeting the country's MDG targets related to maternal, child and infant mortality; tuberculosis (TB); and, the human immunodeficiency virus (HIV) (Statistics South Africa [StatsSA], 2015). PHC re-engineering was also meant to increase access to health services by communities, and to improve the quality of healthcare services, in general, through the formation of ward-based outreach teams (WBOTs) as part of the effort to reduce the huge burden of disease that South Africa was faced with (Khuzwayo & Moshabela, 2017).

The PHC Re-Engineering Model was designed to address the quadruple burden of diseases in the country that led to the development of South Africa's national CHW programme, which required the formation of WBOTs. These teams are constituted within health facilities to operate within municipal wards in order to provide health promotion and preventive services to individuals in their homes (Bac & Hugo, 2015). Each WBOT consists of a professional nurse (team leader), a health promotion officer, an environmental health officer and six CHWs. The CHWs each take responsibility for 250 households within their own communities (Assegaai & Schneider, 2019; Mhlongo & Lutge, 2019; WHO, 2018).

The work and practices of CHWs in the community are governed by the following: National Development Plan 2030, National Health Insurance White Paper, and the WHO guidelines on health policy and system support to optimise CHW programmes (Assegaai & Schneider, 2019; Mhlongo & Lutge, 2019). The roles and responsibilities of the CHWs within WBOT are to: promote healthy lifestyles and behaviours, assess community health needs and fulfil them, manage minor health problems, support linkages to health services and health facilities, create a voice for the people and serve as a bridge between the patients and communities and the healthcare system (Ndou et al., 2013). CHWs also act as lay counsellors, organise and run campaign programmes to mobilise community members for the health services and provide health care at household level. However, the roles and responsibilities of CHWs and the focus of their work may be altered, based on the community needs and the type of diseases threatening the community at a particular time. However, the roles and responsibilities of CHWs can be summarised as follows: CHWs create a voice for the people and serve as a bridge between patient, communities and health system; act as lay counsellors; run campaigns and programmes that mobilise communities for health services; target household coverage for health care; and, fulfil the identity-related needs of individuals (Mhlongo & Lutge, 2019).

CHWs have been in existence worldwide for many years in order to deal with different health issues on the frontline, yet very little is known about their experiences and the challenges they encounter when performing their day-to-day activities. Many programmes were developed to train CHWs to deal with the different health needs and challenges that a particular country, state or community is faced with at a particular time. However, very few of these countries recognise CHWs as healthcare personnel within their health systems. They remain undefined and unsupported, while providing care in the community. Major steps have been taken by the WHO to explore and promote a sustainable CHW model, and to develop strategies and programmes to ensure that CHWs are recognised in health care systems globally (Schneider & Lehmann, 2016).

The WBOTs were introduced to the Julesburg area in 2013 in response to the government’s community-based focus on the quadruple burden of diseases initiative, which includes chronic diseases. The initiative required CHWs to refocus and adjust some of their activities in the community, which may have increased their workload and the roles and responsibilities of their work. The researcher was interested in understanding the experiences of CHWs and the approaches they use to cope with challenges when working in their work environment, with respect to workload, work focus, roles and responsibilities. This study focussed on uncovering the experiences the CHWs shared as they practice their day-to-day activities during the care of clients with chronic illnesses. The study was conducted in Limpopo Province, Mopani District, in the Julesburg Local Area of the Greater Tzaneen Municipality. The study provided an opportunity to the CHWs to voice what is not voiced in their daily reports. The study revealed both common and different experiences from the different villages.

1.3 PROBLEM STATEMENT

The increase in chronic illnesses, along with healthcare provider shortages in the rural areas of the Limpopo Province, has generated the need for CHWs in these rural areas. The South African national CHW programme was implemented through WBOTs since 2013 in the Limpopo Province. However, the roles, responsibilities of CHWs and interactions with clinic staff are still not well understood by both the clinic staff and CHWs themselves. These challenges were also observed by Doede, Allen, Gray Herbst, Hlungwani, Ramakuela, Xie and Campbell (2014). Their findings identified resource scarcity, inadequate clinic-patient partnerships in the management of NCDs and poor collaboration between professionals and CHWs in exercising their roles and responsibilities. This situation is similar to the one currently faced by the clinic staff and CHWs in the Julesburg area. The increase in the number of patients with chronic illnesses in the rural communities of Julesburg, the ill-defined roles and responsibilities of CHWs, the large number of households allocated to the teams and the distances CHWs travel between households often result in CHWs not meeting their daily expected targets and visits. This situation could have negative impacts on both the CHWs and the communities they serve particularly patients with chronic connditions. The researcher wanted to explore the experiences CHWs could be facing when performing their work in the Julesburg area.

1.4 LITERATURE REVIEW

A review of the literature is important in order for the researcher to gain insights into the topic being researched. The review guides the researcher on what research has been done so as to avoid repeating the same studies. A literature review also helps the researcher to become aware of the challenges that were faced by other researchers (Brink, 2011). A comprehensive literature review for this study will be presented in Chapter 2.

1.5 AIM OF THE STUDY

The aim of this study was to explore the experiences of CHWs in the care of patients with chronic illnesses in Julesburg Local Area of the Greater Tzaneen Municipality.

1.6 OBJECTIVES OF THE STUDY

The objectives of this study were:

1.6.1 To explore the experiences of community health workers in caring for patients with chronic illnesses in the Julesburg community.

1.6.2 To explore the views of community health workers regarding solutions to the challenges that they face in the care of patients with chronic illnesses in the Julesburg community.

1.7 RESEARCH QUESTION

The following research question was posed: ‘What are the experiences of community health workers in the care of patients with chronic illnesses in the Julesburg community?

1.8 RESEARCH METHODOLOGY

The study used a qualitative research approach to explore the experiences of CHWs while caring of patients with chronic illness in the Julesburg area. Qualitative research methodology is the systematic collection, organisation and interpretation of textual information using an inductive approach to generate insights (Brink & Van der Walt, 2013). The details of this approach will be discussed in Chapter 3.

1.9 SIGNIFICANCE OF THE STUDY

The findings of this study could, potentially, identify experiences of CHWs and their work with chronic patients that otherwise would not have been known. The findings could identify some of the barriers that prevent CHWs from sharing their personal experiences of their work. The findings may assist in the improvement of the work environment of CHWs, as the findings will be shared with relevant health professionals. This will assist in bringing about change and improving the quality of life of CHWs. Policymakers could use the findings and change the traditions that hinder the quality of work undertaken by the CHWs. Further details of the findings will be discussed in Chapter 5.

1.10 OUTLINE OF THE CHAPTERS

Chapter 1: In this chapter, the researcher will introduce the study background and the deployment of CHWs in the community because of the burden of diseases. The researcher will describe the experiences of CHWs while caring for the patients in the community. The aims, objectives, definitions of concepts and the significance of the study were also be covered in this chapter. The next chapter discusses the literature review in details.

Chapter 2: In Chapter 2, Literature review. The researcher reviewed the literature on different studies of the topic at hand.

Chapter 3: In Chapter 3, the researcher outlined the research methodology used in the study, the research design, research setting, population, sampling, data collection and analysis.

Chapter 4: The presentation and discussion of the results of the study were covered in this chapter.

Chapter 5: In Chapter 5, the researcher presented a summary of the findings, along with the conclusions and recommendations based on the findings.

1.11 SUMMARY

Many people worldwide are affected by chronic illnesses. These illnesses increase the challenge of healthcare provider shortages in many countries, particularly in the rural areas of low- and middle-income countries. The Limpopo Province, one of the rural provinces of South Africa, experiences an increase in chronic illnesses, along with healthcare provider shortages. These challenges generate the need to extend the scope of work of CHWs to include chronic illnesses in rural areas and clinics through WBOT deployment. The CHWs were regarded as a solution for alleviating the burdens in these healthcare facilities; however, their roles, responsibilities and interactions with clinic staff were not clearly defined for both clinic staff and the CHWs themselves. This led to confusion and conflict. This study aimed to explore the experiences of CHWs in the care of patients with chronic illnesses in Julesburg Local Area of the Greater Tzaneen Municipality. This study afforded the CHWs an opportunity to reflect on their contribution to the prevention of disease and the promotion of health, as well as to value the importance of their work in strengthening the healthcare facilities. In this chapter, an overview of the study and discussed the problem statement, aim, objectives and significance of the study. In Chapter 2, the literature review is discussed, based on relevant information from a global perspective, a Sub-Saharan Africa perspective and a local perspective.

CHAPTER TWO: LITERATURE REVIEW

2.1 INTRODUCTION

In Chapter 1, the researcher presented an overview of the study. A review of the literature is important in order for the researcher to gain insights into the topic being researched. This review guided the researcher on what research had been done so as to avoid repeating the same studies. It also helped the researcher to understand the challenges that were faced by other researchers when they were conducting their own studies. The following electronic databases were used: Google Scholar; Science Direct; Scopus' EMBASE; ERIC; Medline; Web Science; EBSCO Host; PubMed; and, African Journal Online. Chapter 3 discussed the research methodology of the study.

In this chapter, the researcher will discuss the historical background relating to CHWs, global experiences of CHW programmes, a Sub-Saharan perspective of the lived experiences of CHWs and the South African perspective of the lived experiences CHWs.

2.2 HISTORICAL BACKGROUND TO COMMUNITY HEALTH WORKERS

The CHW concept surfaced more than 50 years ago as a strategy promoting the use of community members to render basic healthcare services to address the growing shortage of health workers in low-income countries. There are many programmes and experiences throughout the world of community-based initiatives, where trained community members work in their own communities to assist members of these with their health needs. CHWs can either be men or women, young or old, and literate or illiterate individuals who are trained to perform certain health promotion, prevention and healthcare duties. In many instances, CHWs are not paid, or they are paid in kind or paid meagre salaries, which often demotivates them or makes it difficult for them to continue their services. The issue of CHWs being volunteers or being remunerated in some form remains controversial and has negative impact on the CHWs worldwide (Maher & Cometto, 2016).

Although CHW programmes in many countries have been in existence since the 1980s, most of them were not sustainable as they often targeted a particular health problem and, once the problem had passed, the programme disappeared, leaving CHWs not knowing what to do (WHO, 2007). Another challenge that CHWs face is, when there is an outbreak or a health concern, they are considered important, because they work on the frontline and often receive the least amount of attention, education, capability-building and remuneration. In addition, when there is global pandemic, a great deal of pressure is placed on CHWs to go out into the community and actively seek out those people who have been infected. They carry their burden like a mother does, because they go out there and look after their communities, even when it is difficult to do so (Africanews, 2021).

CHWs are necessary in healthcare systems to fight against the burden of diseases and to ensure that global strategies become successful. Many countries, including South Africa, failed to meet some of the targets set by the eight MDGs that focussed on the prevention of disease and the promotion of health. Failure to meet the MDG targets led to the development of the Sustainable Development Goals (SDGs) and the need for innovative approaches to meet these goals. The SDGs were adopted by all United Nations member states in 2015 as a universal call to take action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030 (Ballard, Bancroft, Nesbit et al., 2020).

To achieve the seventeen SDGs, the United Nations member states agreed on the need to invest in community-based health workers; to implement a comprehensive and coordinated effort to scale up effective interventions; and, to achieve universal health coverage and scale. All of these initiatives require CHWs, as many countries experience health professional shortages. In addition, WHO, 2016, recognises that addressing population needs for the SDGs requires a more sustainable and responsive skills mix, harnessing the potential of CHWs in inter-professional primary care teams. This led to the birth of the WBOTs in primary care facilities and a calling for the integration of these cadres into the health system. The arrival of HIV and the SARS-CoV-2 coronavirus (COVID-19) both increased the need for CHWs in many countries. CHWs play a pivotal role in fighting the pandemic, especially in countries with less resilient health systems (Ballard et al., 2020).

However, the level and type of CHW engagement with COVID-19-related activities depends on their skill and ability, as well as the interest level of CHWs to participate in various activities, and the level of transmission of COVID-19 in a specific community (CDC, 2021). The CHWs assist in screening and referring patients, as well as providing health education to the community households. It is, therefore, important to select and train the CHWs with the aim of universal coverage to all citizens in all communities. The CHWs should work with the government clinics in order to ensure a continuum of care. Ongoing training needs be done to keep the CHWs up-to-date with the latest trends (CDC, 2021).

2.3 GLOBAL EXPERIENCES OF COMMUNITY HEALTH WORKERS' PROGRAMMES

CHWs have been in existence worldwide for many years; deployed to deal with different health issues on the frontline. However, very little is known about their experiences and the challenges they encounter when doing their greatly appreciated work (Rosenthal et al., 2010). In many instances, they provide their services with no remuneration and sometimes work without anyone noticing them because their work is undertaken in a home environment. Many programmes have been developed to train CHWs to deal with different health needs and challenges that particular countries, states and communities are faced with at a particular time. However, very few of these countries recognise CHWs as healthcare personnel within their health systems and CHWs remain undefined and unsupported, while providing much needed care in the community. Major steps have been taken by the WHO to further explore and promote a sustainable CHW model, and implement strategies and programmes that ensure that CHWs are recognised by the healthcare systems, globally (Schneider & Lehmann, 2016). A study conducted in London by Findley and Matos (2015), indicated that CHWs provide care to both local and foreign individuals who reside in the local community. The experiences of CHWs are very different, depending on where they are globally, with studies providing different results, depending on the geographical setting.

A study undertaken in USA found that CHWs have been employed around the world since the 17th century to address a shortage of nurses and doctors in vulnerable communities by promoting primary healthcare services (Valesky, 2011). The CHWs provided care to immigrants who were coming to USA, who did not have access to basic health needs, thus helping them to overcome obstacles such as stress, strains and lifestyle changes that contributed to them feeling homesick (Findley & Matos, 2015).

2.4 THE SUB-SAHARAN PERSPECTIVE OF THE LIVED EXPERIENCES OF COMMUNITY HEALTH WORKERS

In a study conducted in Addis Ababa, Ethiopia, Maes (2016) emphasised the importance of the training of CHWs. The study focused on the increasing need for trained CHWs to deal with the quadruple burden of diseases, globally. The role of CHWs also indicates how their contributions at a micro level directly influence policymaking and practice at higher levels in the field of global health. The findings of the Maes study indicated that many of the challenges that community health workers face in their day-to-day activities are embedded in larger social, economic and political contexts, which raises the call for further research into their labour and the health systems they inhabit. The study emphasised the importance of trained CHWs; what motivates them is to improve the quality of life and health of the marginalised people; their passion to help other people; and, what makes the work of CHWs unique (Maes, 2016).

A study conducted in Western Kenya concluded that CHWs are potential enablers of care engagement for patients with chronic diseases. CHWs facilitated the linkage and engagement for proper disease management (Rachlis, Naanyu, Wachira, Genberg, Koech & Kamene, 2016). Experience based on their daily activities caused CHWs to become skilled agents of change.

A study conducted by Seutloali, Napoles and Bam (2018) found that CHWs in Lesotho had an adequate understanding of their roles and responsibilities regarding health promotion. However, the changes in disease burden resulted in a shift in roles, which affected their health promotion practice and experience. The perceived successes of the CHWs in this study included increased access to healthcare services and reduced mortality rates in the communities they served. The challenges faced by CHWs included their demotivation to carry out their work because of a lack of, or inconsistent, financial incentives, as well as a lack of supplies and work overload, which compromised the quality of their work and limited their community involvement. Health promotion is one of the PHC services functions that are successfully practised in Sub-Saharan African countries with its health problems.

In a study conducted in Northern Uganda, CHWs were reported to have complained about the physical and financial constraints associated with the care they were providing to children with nodding syndrome (Nakigudde, Mutamba, Bazeyo, Musisi & James, 2016). Furthermore, this study found that there was a need to incorporate community-based psychosocial and mental healthcare services for the caregivers into the national health system response (Nakigudde et al., 2016).

A study conducted in Ethiopia and Mozambique identified challenges faced by CHWs that interfered with their day-to-day activities. The challenges identified included poor salaries (stipend); lack of support; frustrations and distress; poor relationships with beneficiaries (patients); and, a lack of recognition by the healthcare services (Maes & Kalafonos, 2013).

2.5 SOUTH AFRICAN PERSPECTIVE OF THE LIVED EXPERIENCES OF COMMUNITY HEALTH WORKERS

According to the Medical Research Council (MRC), South Africa suffers from a quadruple burden of diseases that requires a comprehensive approach. This approach must include the services of CHWs, who would be responsible for changing lifestyles at community level National Council of Provinces (NCOP, 2016).

A study was undertaken at Khayelitsha in South Africa in order to explore the CHWs' knowledge and experience of hypertension and diabetes gained over their period of service. The study found that, although some CHWs had worked for more than 4 years, they lacked knowledge about hypertension and diabetes due to the substandard and haphazard training that they received (Tsolekile, Schneider & Puoane, 2018). A study of the lived experiences of family caregivers who take care of children with intellectual disabilities in a rural community, concluded that there was lack of support systems for, and no relief care available to CHWs leading to physical and mental fatigue, as well as social isolation of CHWs (Raphadu, Maritz & Van Rensburg, 2015; WHO, 2018).

A study undertaken in Gauteng dealing with homelessness as a health issue, and its effect on the spread of HIV, found that the experiences of CHWs in this area revealed deep frustrations and distress (Phiri & Perron, 2012). In addition, a study in the rural Eastern Cape concluded that home intervention services provided a potential model for the re-engineering of the PHC services, with health prevention and health promotion being two of the responsibilities of CHWs. The CHWs within the continuum of the healthcare system are seen as the foundation for improving the quality of life in the household (Le Roux, Le Roux, Mbewu & Davis, 2015).

2.6 SUMMARY

Although CHWs have been in existence for many years, there are many challenges in respect of recognising their contribution to the healthcare system and to dealing with pandemics. There is still a need to explore the CHWs lived experiences. In the following chapter, the researcher will deal with the chosen research methodology. The methodology chosen for this study was the qualitative study approach, where the experiences of CHWs were explored using focus group discussions, as well as the one-on-one interviews with the key informants.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 gave a detailed description of the literature used in this study. This chapter discusses the research approach and methodology that was used to conduct the study. This study used a qualitative research approach whereby the exploratory, descriptive and contextual designs were implemented to gather valuable information related to the CHWs' experiences when performing their duties and responsibilities in the Julesburg community.

3.2 RESEARCH APPROACH AND DESIGN

A qualitative research approach is the focus of studies that aim to explore meaning, or to describe and promote an understanding of human experiences. Qualitative research approach is the systematic collection, organisation and interpretation of textual information, using an inductive approach to generate insights expressed in the language of the researched (Brink, 2011).

An exploratory, descriptive and contextual design was used to explore the experiences of CHWs in the care of patients with chronic illnesses in Julesburg Local Area. Exploratory and descriptive design focuses on the qualitative aspect of meaning, experiences and understanding. This research design explores human experiences through the descriptions provided by the people involved, and is used to gain insights into a problem or a subject (Brink, 2011).

In this study, exploratory design was used to explore the human experiences of the participants through the descriptions provided by the CHWs. Focus-group discussions (FGDs) and key informant interviews (KIIs) were conducted to allow the researcher to explore the experiences of CHWs; highlighting their work and identifying any challenges that they may face during the provision care of community members.

A descriptive study design refers to research studies in which phenomena are described or the relationships between them are assessed (Brink, 2011). In this study, descriptive design was used to enable the researcher to describe the experiences of CHWs and to explore ways in which CHWs cope with identified challenges and workloads during the performance of their duties.

Contextual design is a structured design that provides the methods used to collect data about participants in their own area, and to interpret and consolidate that data in a structured way. Contextual design takes the natural contexts in which individuals or groups function into account, in order to provide an in-depth understanding of their experiences and challenges (Creswell, 2013). This study was contextual because it was conducted in a specific area called the Julesburg community. In this study, the CHWs were studied in the healthcare facilities they operate from.

3.3 STUDY SETTING

Julesburg is a rural area situated in the Greater Tzaneen Municipality, in the Mopani District of Limpopo Province. It is divided into five wards and eighteen villages. The wards are named 22, 25, 26, 28 and 29. The villages are Sedan, Mulati, Bonn, Mafarana, Gavaza, Burgersdorp, Julesburg (Calies, Hoveni, Rhulani, Bordeaux, Khwetji), Tours, Mogapeng, Ofcolaco, Rita, Zangoma, Lefara and Mhangweni and are under the leadership of different chiefs and indunas. Julesburg, with a population of 17 490, is divided into five communities namely, Calies, Hoveni, Rhulani, Bordeaux and Khwetji.

Julesburg often referred to as Julesburg Local Area. The CHWs are distributed as follows: Carlota clinic: 23; Carlota Jamela clinics: 15; Mogapeng: 6; Tours: 2; Zangoma: 6; and, the Julesburg Community Health Centre (CHC): 7, with an average of 3210 patients visiting the clinics every month. There are a total of 59

CHWs attached to the clinics in the local area, reporting to these clinics and the CHC. CHWs in the Julesburg area are responsible for an average of 250 households and 50 clients with chronic illnesses. However, the number of allocated households can increase or decrease, depending on community migration within and outside of the community; staff turnover; and, with the employment of new CHWs or when volunteers offer their services. In one month, an average of 1 925 clients visit the clinics to collect their chronic illness medication for hypertension and diabetes mellitus (see Annexure A).

3.4 POPULATION OF THE STUDY

Population is defined as the entire group of persons or objects that are of interest to the researcher, or a group of persons who meet the criteria that the researcher is interested in studying (Brink, 2011). The population of this study was all the clinics and the CHC in Julesburg, along with the 59 CHWs and six WBOT leaders working in the Julesburg area.

3.5 SAMPLING

According to Creswell and Poth (2018), sampling refers to the process of selecting participants from a defined population or group to participate in a research project. Sampling is a way of identifying and choosing individuals and groups that will produce believable descriptions of the information needed to answer the main research question or describe the phenomenon the researcher wants to study. Sampling in qualitative research should produce sample sizes that are large enough to obtain sufficient data to describe the problem or phenomenon that the researcher wants to study and to address the research questions (Creswell & Poth, 2018).

3.5.1 Sampling frame

Purposive sampling was used to select CHWs for the FGDs. Purposive sampling is also known as judgment, selective or subjective sampling; a sampling technique whereby a researcher uses their own judgment to choose members of a population to participate in the study (Creswell & Poth, 2018). CHWs from all the 5 clinics formed part of the study sample. A target sample for the FGDs was 18 to 24 CHWs (based on a total of six to eight CHWs per group), while the five supervisors (outreach team leaders) participated in the KIIs. A total of eight (8) FGDs were conducted with a total of fifty-six (56) CHWs.

3.5.2 Inclusion criteria

According to Creswell (2013), the term inclusion criteria refer to the characteristics that the potential participants must have in order to participate in a study. In this study, the following criteria were used to recruit participants: all CHWs working in the Julesburg community who were attached to the clinics and the CHC in this area, had been working for a year or more; were caring for patients with chronic illnesses in their allocated households; and available during the time of the study.

3.5.3 Exclusion criteria

Exclusion criteria are characteristics or features of the potential study participants who meet the inclusion criteria, but disqualified because they presented additional characteristics that could interfere with the success of the study or increase the risk of an unfavourable outcome (De Vos, Strydom, Fouché & Delport, 2011). All CHWs working in the Julesburg community that were attached to the clinics and CHC, caring for patients with chronic illnesses in their allocated households and unavailable during the time of the study were excluded from the study. They were excluded from the study, because they were on training and therefore not having sufficient experience except for exposure to their profession during practical. Some CHWs were excluded, because the had just completed their training and did not, have the required experience to make a meaningful contribution to the study.

3.6 PILOT STUDY

A pilot study is a small study to test data collection instruments using a few people to determine whether the tool would yield the expected results before the larger research study commences. The aim of a pilot study is to test the research instrument and to make changes, where necessary, before the real data collection commences (Brink, 2011).

A pilot study was conducted before the main study to assess whether the KII and FGD questions are understandable and answerable. This assisted the researcher to review questions and to discard confusing and poorly worded questions. The piloting was conducted with a group of six CHWs at the Dan clinic. Data collected from the pilot study were analysed, but did not form part of the study. The results of the pilot study were used to improve the data collection instruments and make them more reliable.

3.7 DATA COLLECTION

Data collection is the process of gathering information used to answer the research question. Data collection was undertaken by employing eight FGDs with CHWs from the six clinics. A total of fifty-six (56) CHWs participated in the study and in the KIIs with five WBOT leaders, using the FGD and KII guides, respectively. The use of FGDs and KIIs allowed for the triangulation of methods and data, which increased the credibility and validity of the results. During data collection, the researcher allowed participants to talk about the issues at hand. When participants moved outside the issue at hand, the researcher brought them back to the discussion without them noticing. During data collection, emotions observed were recorded.

Triangulation involves the use of multiple data collection methods to develop a comprehensive understanding of the problem or phenomena at hand. Triangulation is also viewed as a qualitative research strategy used to test validity through the convergence of information from different sources (Creswell & Poth, 2018). In this study, triangulation was used based on data collected from the FGDs and from KIIs with CHWs and WBOT leaders and their supervisors, respectively. This approach was employed in order to increase the credibility and validity of the results.

3.7.1 Focus group discussions

A focus group discussion is described as a group discussion with people who have been selected because they share certain characteristics that are relevant to the study or topic to be researched. Focus groups comprise a group of diverse people who participate in an open discussion to share their views on a specific problem or issue. During the conversation, the researcher poses a set of questions to the participants, who are free to interact with each other. All the opinions of the participants are noted down to be used later to draw conclusions (Brink, 2011). FGDs were used as they provided support to participants through group interaction, strengthening communication and enhancing representativeness through multiple voices (Linda, Mtshali & Engelbrecht, 2013). In this study, FGDs were conducted with the CHWs in order to discuss their experiences with respect to the care of patients with chronic illnesses. The FGD guides for CHWs were developed in English and translated into Xitsonga because the FGDs with CHWs were conducted in Xitsonga. This allowed the participants to share their experiences and express themselves using the language in which they were most comfortable. The guides for the FGDs are included as the annexures E and F. Probing questions were used in order to obtain full information and clarity, where necessary. The FGDs were conducted in a safe environment, free from noise and interruptions. Audio recordings were used to capture all information and contributions from the participants.

3.7.2 Key informant interviews

Key informant interviews are interviews that are conducted with people who have a special position in the target population and possess special knowledge that can shed additional light on the problem that is being investigated (Brink, 2011). Key informants contribute a perspective on a phenomenon or situation. They are usually not the research participants or target group, but provide information about the participants that expands the researcher’s understanding of, and insights into, the experiences of the target group (De Vos et al., 2011). In this study KIIs were conducted with WBOT leaders who were working very closely with the CHWs and who may have had additional information about their (CHWs) experiences in their work environment as supervisors. The KIIs were undertaken in English (Annexure

G). However, participants were allowed to respond in the language they were most comfortable with. Probing questions were used in order to obtain full information and clarity, where necessary. The KIIs were conducted in a safe environment, free from noise and interruptions. Audio recordings were used to capture all information and contributions from the participants.

3.8 ETHICAL CONSIDERATIONS

The research proposal was presented to the departmental review committee and was approved for submission to the School of Health Care Sciences' Research Ethics Committee. After approval by this committee, the proposal was submitted to the Faculty of Health Sciences for approval, which was obtained. Ethical clearance for the study was then requested and obtained from the Turfloop Research Ethics Committee (TREC) of the University of Limpopo. The approval certificate can be found in Annexure K. The ethical principles and guidelines of the university were followed throughout the study. The research findings of the study are not linked to any of the participants.

3.8.1 Permission to conduct the study

The researcher conducted data collection after receiving an ethical clearance certificate from TREC and after obtaining permission from the Limpopo Department of Health. Permission to collect data at the healthcare facilities and from the participants was requested and obtained from the Limpopo Department of Health. The letter from the department was submitted to the health district in order to get permission to access to the participating healthcare facilities and research participants (Annexure C).

3.8.2 Voluntary participation and information sheet

Voluntary participation is the situation where research participants exercise their free will in deciding whether to participate in a study or not. This right is protected and enforced by international law, national law, and research or scientific codes of conduct (Creswell & Poth, 2018).

In this study, all participants were provided with information about the study, its purpose and its objectives, before formally consenting to participate in this study. The participants were informed that their participation in the study was voluntary and that there would be no monetary incentives attached to their participation. The participants were informed of their right to withdraw from the study at any stage, if they so wished or if they felt uncomfortable during data collection activities; noting that they would not be penalised for withdrawing from participation in this study. This information sheet can be found in the first part of the Annexure I and was handed to the participants. After sharing the information, the researcher allowed time for the participants to ask questions.

3.8.3 Informed consent

Informed consent in qualitative research is when potential participants are given information about the study and related information that enables them to voluntarily make a decision on whether or not to participate in the study (Creswell, 2013).

Written consent was obtained from all the participants, which the participants signed after the researcher had discussed the study with them and provided them with information about the study. The participants were informed that their participation was voluntary and that they were, therefore, not forced to participate in the study. Those who agreed to participate in the study were asked to sign an informed consent form, which can be found in the second part of Annexure I.

3.8.4 Confidentiality and anonymity

Confidentiality refers to steps that the researcher takes to protect the identity of participants from being discovered by others, to ensure the protection of the participants' private information. However, confidentiality in FGDs cannot be guaranteed (Creswell, 2013; De Vos et al., 2011). The researcher requested all participants not to repeat what was discussed in the FGDs to others or to discuss any of the deliberations in the FGDs among themselves outside of the designated room. To ensure confidentiality in this study, the signed consent forms of participants were kept separate from the collected data, in different locked drawers, to ensure that no one, including the researcher, could link the consent forms to the collected data. All electronic data were encrypted and protected with passwords. During data collection, no names were used to ensure that the recorded voice information could not be linked to the identities of the participants.

Anonymity means that neither the researcher, nor other any other person, whether associated with the research project or not, would be able to identify the participants, because the collected data does not contain any information that could identify the participants (Brink, 2011). In this study, the researcher ensured that the names, addresses, facility and other identifying information were not recorded anywhere in the collected data. For both the KIIs and FGDs, unique numbers were used to identify the participants and the healthcare facility. During FGDs, participants referred to each other as sister or mama, which was replaced with unique sequential numbers during transcription of the data.

3.8.5 Privacy

Privacy in qualitative research means that participants have both a right and a responsibility to protect and control access to their private information, information that they do not wish to reveal to the researcher. In other words, no participant should ever be forced to reveal information to the researcher that the participant does not wish to reveal (Brink 2013). As this study was about experiences, participants were informed that they should not discuss private information that they were not ready to discuss. They were also told that they should not feel pressured to reveal such information.

To maximise privacy, the KIIs were held in a room that allowed for privacy, with no interference and disturbances and only the participant and researcher were present. The FGDs were conducted in a designated room with only the participants and researcher, as the facilitator of the discussions, present. During FGDs, participants were asked to refer to each other by pseudonyms to ensure that their real names were not recorded on the voice recorder. The participants were asked not to divulge private and sensitive information during the discussions. The researcher ensured that private and sensitive information was treated with the greatest sensitivity and was kept confidential. The researcher requested the group to do the same. If any of the participants discussed sensitive and uncomfortable experiences and, as a result, required professional assistance to deal with this, the researcher undertook to acquire assistance from the clinic manager to access the required professional support for the participant. All information collected was kept safe and locked away from unauthorised individuals.

3.8.6 Harm

Creswell and Poth (2018) describe harm in research as potential risks of or negative physical, psychological, social, legal and economic outcomes as a result of participation in the conducted study. It is important that researchers protect and secure the wellbeing of the participants to avoid harm, be it physical, emotional, social or spiritual, during data collection (Brink, 2011). There was potential for harm during data collection when undertaking KIIs and FGDs with the participants, which could include emotional breakdowns during the discussions. In case of emotional breakdown, the researcher sought assistance, through the clinic managers, from professional social workers with the necessary skills to support the participants in the facility. If any questions stirred up emotions in the FGDs or KIIs, the discussions were temporarily paused to allow emotions to settle before discussions were resumed. When a participant wanted to be excused from the study, the discussions were terminated. When the researcher felt that the discussions could cause psychological harm, the researcher referred the participants to counselling and further management by the relevant professional, through the clinic manager.

3.8.7 Bias

Bias in qualitative research occurs when a researcher tries to influence the results of the study in order to get the results that the researcher wants (Creswell, 2013). In this study, the researcher used KII and FGD guides with semi-structured questions and probes to ensure that the collected information reflected the experiences and perceptions of the participants, not that of the researcher. During both methods of data collection, the questions were asked in a similar manner to ensure that all participants in each method were exposed to a similar environment that did not interfere with, or influence, their answers and the discussions. A voice recorder was used to ensure that the information collected was exactly what the participants had said, which was verified by listening to the recorded information.

3.9 DATA ANALYSIS\

Data analysis is the process of systematically searching for and arranging the collected data into themes and sub-themes that increase the researcher's understanding of the phenomenon under investigation. In the data analysis process, the researcher uses inductive reasoning processes to interpret the data and structure the meanings derived from data (De Vos et al., 2011).

All data collected were transcribed from the tape recordings, verbatim. Data in the local language was translated into English and analysed. The transcriptions were analysed individually to identify similarities, differences and relationships. The transcriptions were then grouped into categories. The categorised data were then grouped into themes and sub-themes. The analysis approach followed the eight steps proposed by Tesch (Creswell & Poth, 2018) as indicated below:

3.9.1 Getting a sense of the whole

All the verbatim transcriptions were read carefully and notes were made, where necessary.

3.9.2 Read all data collected

All interesting and important points were written down. Quotes were identified, and similar responses were identified.

3.9.3 Picking the interesting topics

Clustering similar topics was undertaken and the topics were arranged into major or unique thoughts. The topics were selected in order to understand the underlying meaning, rather than the substance. Similar responses were grouped into themes and sub-themes.

3.9.4 Coding all data applying selective coding

This step involved going back to data in order to abbreviate topics as codes and codes were written next to the appropriate segment of the text.

3.9.5 Generation and descriptions of categories and themes

Descriptive wording for the topics was used to turn them into categories; all the while looking for ways to reduce grouping topics that relate to each other.

3.9.6 Grouping of interrelated themes

This step involved making a final decision on the abbreviation for each category and writing the codes alphabetically.

3.9.7 Assembling data

Data were assembled into material that belonged to each category in one group in order to undertake the preliminary findings.

3.9.8 Recoding

Based on the preliminary findings the themes were recoded**.** This last step was guided by the preliminary findings. The collected data were given to a neutral person to re-code. Areas where there were differences in coding were discussed and consensus reached. A letter attached from the coder is attached as Annexure J.

3.10 TRUSTWORTHINESS

Trustworthiness is defined as the degree to which others are convinced that the findings of a study can be trusted. Trustworthiness is used in the assessment of the validity and reliability of qualitative data (Creswell & Poth, 2018). In this research, the following criteria of trustworthiness were used: dependability, conformability, credibility and transferability, and are discussed below.

3.10.1 Dependability

Dependability refers to the consistency and reliability of the study findings and the degree to which the study procedures are documented to allow someone outside of the study to follow the processes that the researcher used for the study. Dependability is important in this study because it established whether the findings of this study are consistent and repeatable (Creswell, 2013; Creswell & Poth, 2018). Dependability in this study was ensured by conducting data collection as planned, using the data collection tools correctly and by audio recording the discussions. The audio recording and other materials which were collected, such as the field notes, were kept safely so that they could be compared to the final research report in order to ensure the trustworthiness of the research report. In this study, all material was used, for example transcripts, expressions and notes. The study identified experiences that otherwise would not have been known about CHWs and their work with chronic patients. The study also identified some of the barriers that prevent CHWs from sharing their personal experiences in their work. The findings obtained in this study could assist in the improvement of the working environment for CHWs. They will be shared with the relevant health professionals that could help bring about change or improve the quality of life of CHWs. Policymakers could use the results of this study to change some of the traditions that hinder the quality of work undertaken by the CHWs.

3.10.2 Conformability

Conformability refers to the objectivity of study during data collection and data analysis (Creswell & Poth, 2018). Data collection was conducted in a room that allowed for privacy, with no disturbances. All participants were exposed to the same questions and given enough time to respond. In the FGDs, all participants were given an opportunity to respond to the questions. Hearing that there were different participants taking part in the discussions assisted the researcher during the transcription of data. Conformability was ensured by providing proof of data collected, the transcripts of the audio being made available and direct quotes from the participants. A language expert was used to translate the data collection tool and transcription from one language to the other.

3.10.3 Credibility

Credibility refers to the extent to which a study and its results are believable and appropriate, with particular reference to the level of agreement between the participants and the researcher. Credibility is established by using data triangulation, multiple analyses and member checks (De Vos et al., 2011). The researcher ensured that the correct methodology was followed when collecting the required data. This was done to ensure that there was prolonged engagement with participants, and that all participants were treated equally, each participant was given enough time to respond to the topic being discussed. The findings of the study were shared with the participants by conducting feedback workshops to give them an opportunity to validate the findings. During data analysis, a neutral coder was used to check whether their findings are similar to those of the researcher.

3.10.4 Transferability

Transferability is the degree to which the result of qualitative research can be generalised and transferred to other concepts or settings. Transferability is synonymous to generalisation or external validity. Transferability is established by providing the readers with evidence that the research study's findings could be applicable to other contexts, situations, times and population. The researcher cannot prove that the research study findings were applicable (Schloemer & Schröder-Bäck, 2018). The focus group discussions and in-depth interviews provided a thick description of the experiences and challenges of CHWs. The collected data were available to readers and other researchers to access and use to conduct a secondary analysis. Data were recorded on audiotape to ensure that the participants' narratives were captured in their original format. During analysis, the researcher requested someone with experienced in research to read randomly selected transcripts and identify major themes and categories so that readers may have a clear picture of data.

3.11 LIMITATION OF THE STUDY

Some FGD participants found it difficult to voice their opinion freely in the presence of other participants with whom they may normally not have shared important information. This might have interfered with the quality of the information obtained. The time invested in getting the relevant people to participate and conducting the study could have been wasted. There is also the possibility that the participants because of the sensitive of the information withheld valuable information. Some participants could have been hesitant to answer some of the questions despite the assurance on confidentiality.

Although participants were assured that all information discussed during the FGD is confidential, they were not completely satisfied with this and they were reluctant to discuss work-related issues with their seniors present. Creating an atmosphere for useful discussion could be challenging because some debates were intense conversations. Lastly, although the researcher had practiced conducting FGDs several times, it was sometimes challenging to manage the participants' views smoothly in order to generate worthwhile insights. In addition, peer pressure seemed to have influenced some participants and their responses since the group knew each other. Some of the participants may have been uncomfortable sharing some of their personal experiences. Other participants were not free to share their experiences, especially the challenges that they came across at work related to their leaders, because their future development in their job was dependent on their supervisors.

3.12 SUMMARY

In this chapter, the researcher outlined the methodology used to collect and analyse data. A qualitative approach was used to guide this study. An exploratory, descriptive and contextual design approach was used in five clinics and one CHC. Purposive sampling was used to select CHWs for the FGDs. A total of eight FGDs with CHWs from the six clinics were held. A total of fifty-six (56) participants took part in the study and the KII with five WBOT leaders. After data collection, data analysis started and themes were developed. These will be discussed in the next chapter. In the next chapter, the researcher will present the results obtained from the study, the themes obtained from the analysis of the data, and an interpretation and discussion of the findings.

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF RESULTS

4.1 INTRODUCTION

In the previous chapter, the methodology that was used to collect and analyse the data was discussed. In the current chapter, the results obtained from the research, which investigated the CHWs' experiences when caring for clients with chronic illnesses are discussed. The findings will be discussed as follows: demographic characteristics of the participants; followed by the themes and subthemes that were developed. The demographic details of the participants are presented in tables and graphs.

The results obtained from eight FGDs and five KIIs dealing with CHWs and their experiences and with CHW supervisors, respectively are discussed. The experiences of CHWs when caring for patients with chronic illnesses and challenges related to their work were analysed into themes and sub-themes. Tech's thematic analysis was used to analyse the collected qualitative data. The following themes were developed: roles and activities of CHW in the care of chronic illness patients in the community; challenges in the caring of chronically patients relate to time and workload; challenges encountered during the care of chronic patients; and motivation and job satisfaction.

4.2 DEMOGRAPHIC CHARACTERISTICS OF THE PARTICIPANTS

Table 4.1 indicates the demographic information of the participants for the FGD and KIIs.

Table 4.1: Demographic Characteristics of the Participants

Categories of participants	**Community health workers FGD participants**		**Supervisors KII participants**		**Total**	
	Frequency	**Percentage**	**Frequency**	**Percentage**	**Frequency**	**Percentage**
No of participants	56	91.94	5	8.06	61	100
Age distribution of participants						
Categories of participants	**Community health workers FGD participants**		**Healthcare professionals KII participants**		**Total**	
Age	Frequency	Percentage	Frequency	Percentage	Frequency	Percentage
30-35	7	12.5	1	20	8	13.11 26
36-40	6	10.71	1	20	7	11.48
41-45	14	25	1	20	15	24.59
46-50	16	28.57	1	20	17	27.87
51-55	10	17.86	0	0	10	16.39
56-60	3	5.36	1	20	4	6.56
Total	56	100	5	100	61	100
Mean age	45.46		43.8		45.33	
Gender						
Female	55	98.21	4	80	59	96.72
Male	1	1.79	1	20	2	3.28
Total	56	100	5	100	61	100
Educational background/qualification						
Grade 6	1	7.14	-	-	1	7.14
Grade 10	6	10.71	-	-	6	10.71
Grade 11	20	35.71			20	35.71
Grade 12	29	51.79	5	100	34	55.74
Professional nurses with PHC			3	60	3	60
Social worker	-	-	1	20	1	20
Dietician	-	-	1	20	1	20
Designation						

Community Health worker	56	100		-	56	100
WBOT supervisor	-	-	2	40	2	40
OPM (Facility Manager)	-	-	2	20	1	20
OTL (Team Leader)	-	-	1	40	2	40

4.2.1 Categories of the participants

This study was a qualitative research approach that explored the experiences of CHWs when caring for patients with chronic illnesses in the Julesburg area of the Greater Tzaneen Municipality. A total of five clinics and one CHC participated in the study. As indicated in Table 4.2, of a total of sixty-one (61) participants, 91.94% (56) were CHWs and 8.06% five (5) participants were supervisors from the participating clinics and the CHC in Julesburg. The supervisors comprised two (2) WBOT leaders, one (1) facility manager (operational manager), one (1) dietician and one (1) social worker. The CHWs participated in eight FGDs that were conducted in the participating healthcare facilities. The CHWs were the target of the study, and shared their experiences while caring for patient with chronic illness. The key informants who participated in the one-on-one KIIs shared their knowledge of the CHWs and their work, as well as information that might not have been shared by the CHWs during the FGDs.

WBOT leaders had to be assigned professional nurses with passion to work 70% of their time in the community and 30% of their time at the healthcare facility. Their role is to supervise CHWs and to respond to all referrals from, and challenges faced by, the CHWs. WBOT leaders also facilitate weekly meetings and weekly in-service training on site, as well as in the facilities (South African National Department of Health [DOH], 2018). Allied staff was included in this study as Key informants, in this study it was the social worker and the dietician. The dietician works closely with the CHWs in nutritional issues and the Social worker with psycho-social support. In this study KIIs were done with one (1) facility manager (OPM), two (2) professional nurses WBOT leader, one (1) dietician and one (1) social worker.

4.2.2 Age distribution of the sample

Table 4.1 indicates that the age group of participants ranged from 30 to 60 years of age, with only eight (8) participants who could be classified as youth, representing seven (7) CHWs and one (1) supervisor. The majority (80.33%) of the participants were aged between 36 years and 55 years. Only four (4) (6.56%) participants were between 56 and 60 years old, as indicated in Table 4.2. The mean age of the participants was 45.33 years. This confirms that majority of both CHW and supervisor participants were in the age ranging between 30 and 60 years of age. as noted from the mean age. According to Gamede (2021), the age distribution data from the South African Nursing Council (SANC) in 2018 indicated that 29% of registered nurses/midwives and 29% of enrolled nurses in South Africa were between the ages of 40 and 49 years. In addition, 34% of enrolled nursing auxiliaries, who usually make up the majority of trained CHWs, are aged between 40 and 49 years, which are similar to the mean age of the CHWs in this study. This indicates that CHWs are aging and that there is a need for better attraction and retention strategies in order to attract younger CHWs to clinics in the Julesburg area (Gamede, 2021).

4.2.3 Gender distribution

The majority of the participants (96.72%), a total of fifty-nine (59), were female, and two (2) (3.28%) were male, one of which was a CHW and one a supervisor, as indicated in Table 4.2. The gender distribution of the participants reflects the gender demographics of healthcare workers and CHWs in clinics and non-government organisations working with the sick in the community. In South Africa, the provision of healthcare in clinics is mainly undertaken by female healthcare workers, particularly in rural areas and among low income groups. Additionally, many of these healthcare providers are of a mature age, hence, the large number of female healthcare workers, both CHWs and supervisors, in most of the healthcare programmes, including the clinics, where this study was conducted. The gender distribution in this study is also reflected in the South African population statistics and, in particular, in the Limpopo Province, where there are more women. According to O'Neill (2021) in 2019, South Africa's female population amounted to about 29.7 million people, while the male population of the country amounted to 28.86 million people.

4.2.4 Educational qualification

A total of the CHWs twenty-nine (29) (51.79%) of the participants had Grade 12, followed by twenty (20) (35.7%) with Grade 11. Six (6) (10.71%) participants passed Grade 10 and one (1) (7.14%) had passed Grade 6. When the Primary Health Care Re-Engineering Model was introduced, the minimum entry level into the CHW programme was Grade 8. These CHWs were recruited with the aim of applying the recognition of learning (RPL). Those that were not yet trained were called community caregivers (CCGs). However, none of them were given priority over another based on qualification when it came to remuneration. They all received same stipend and they all undertook the same level of work, with the same degree of supervision and the same in-service training. In this study. One of CHW among those with Grade 6 had not received been training at the time of this study.

All the supervisors had the necessary professional qualifications and registered with the appropriate professional bodies. All supervisors had Grade 12 and a tertiary level three professional qualifications.

4.2.5 Designations

The designations of the participants were according to the position they occupied in the healthcare facility and/or WBOT team during the time of the study. Fifty-six (56) CHWs that participated in the study indicated their designation as CHW. Among the participating supervisors, two (2) indicated that they were WBOT leader male and female, one (1) indicated her designation as facility manager and two (2), the social worker and the dietitian, indicated that they were supervisors. All participants completed the interviews.

4.2.6 Types of training CHWs received

Figure 4.1 indicates the training that the CHW participants received in the six participating healthcare facilities. They all received 69 days of home-based care training, initially; they were then given an opportunity to undertake anciliary health care training at levels 1, 2 and 3, after which they received a nationally recognised certificate. The CHWs then undertook and orientation to the re-engineering model training course for 20 days, followed by treatment adherence training. Lastly, all the CHWs undertook skills development training for 5 days.

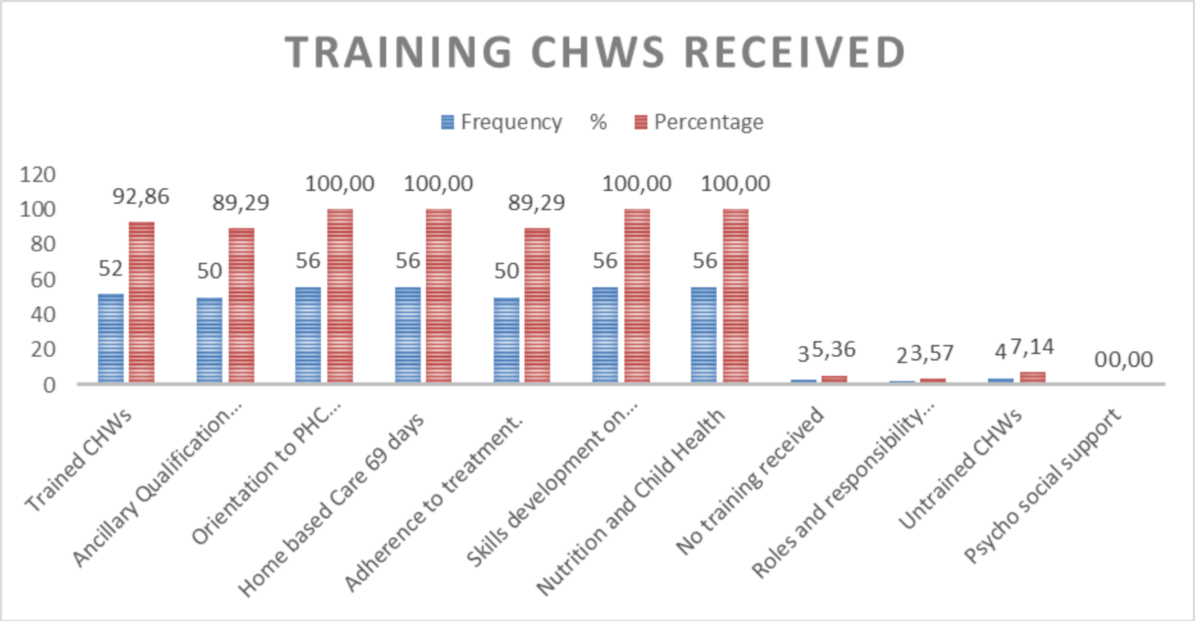

Figure 4.1: Types of Training CHWs Received

Fifty-two (52) CHWs regarded themselves as trained CHWs, while only four (4) regarded themselves as untrained. In order to provide the necessary care to patients in the communities, all CHWs were trained in the following areas and programmes: home-based care, 69 days; adherence to treatment; nutrition and child health; psycho-social support. Almost all of the participants (50) had undertaken the ancillary training at levels 1, 2 and 3; orientation to PHC re-engineering phases 1 and 2; and, skills development on ward-based primary healthcare outreach teams (WBPHCOT) training. The majority (50) of the participants were not trained in the roles and responsibilities of the ancillary qualification at any level; in the orientation to PHC re-engineering at any phase; and, in skills development on WBPHCOT. Six (6) of the participants were of the view that they were not trained in some of the other skills, as indicated in Figure 4.1. According to National Department of Health, CHWs must have NQF level 4 upon recruitment. The employer must ensure continuous occupational qualification development for CHWs to the level of team leaders and managers (Jinabhai, Marcus & Chaponda, 2015).

4.2.7 Work experience accumulated by CHWs

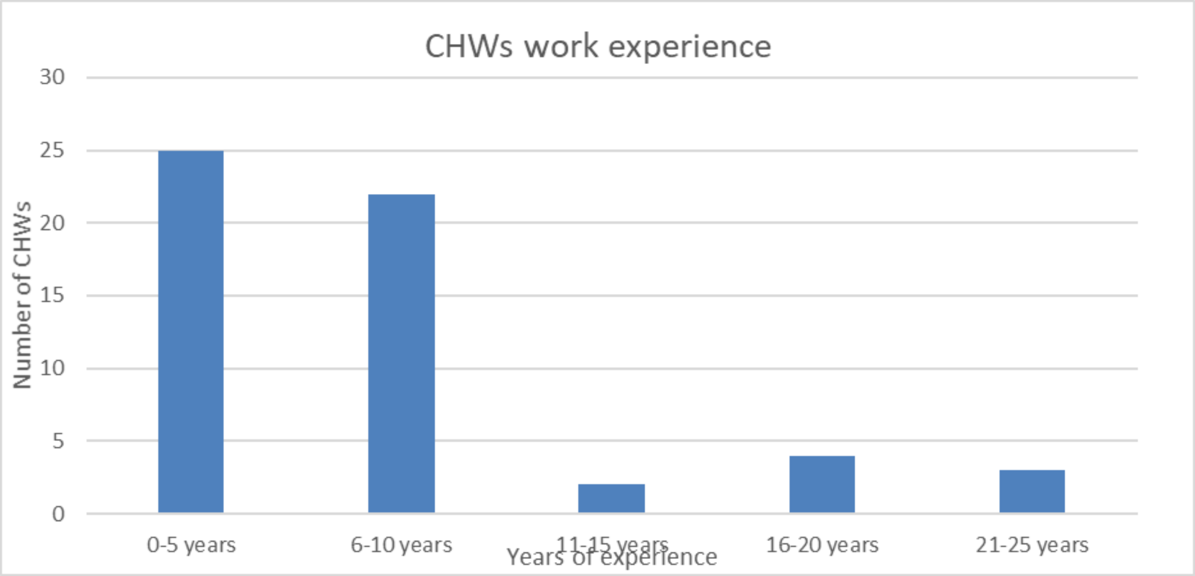

Figure 4.2: Number of Years Working as a CHW in the Current Community

The majority (89.79%) of the participants had worked as CHWs for fifteen years and less. Only six (6) CHW participants had worked for between 20 and 25 years. All the supervisors had less than six years of experience working with CHWs. In other words, the CHWs had more experience in community work than their supervisors. This is sometimes one of the biggest challenges faced by new managers, who have to lead CHWs with more experience in their work and community. Directing employees can be the most difficult part of being a supervisor, particularly when they have little or no experience of that particular work. It is, therefore, important for supervisors to learn quickly what CHWs are expected to do and successfully accomplish and their goals as a supervisor. As supervisors of CHWs in the community, they must be trained and skilled in team building, problem solving, delegation, motivation and performance review (Ray, 2018).

It is important that supervisors of CHWs provide the CHWs they supervise with regular performance reviews. Supervisors of CHWs require a set of skills that many people new to the position lack. These skills include managing the behaviours and reactions of staff and members of the community and learning to manage their own personal stress, to ensure that these stressors do not interfere with community work. It is also important that CHW supervisors encourage productivity among CHWs and learn how to encourage productivity within the team, motivating them as team members. Equally so, it is important to have regular meetings with peers and co-workers to ask for help, when necessary. It is also important for a supervisor to learn to ask for help from peers and co-workers (Ray, 2018).

4.2.8 Number of households allocated to each of the participating CHWs

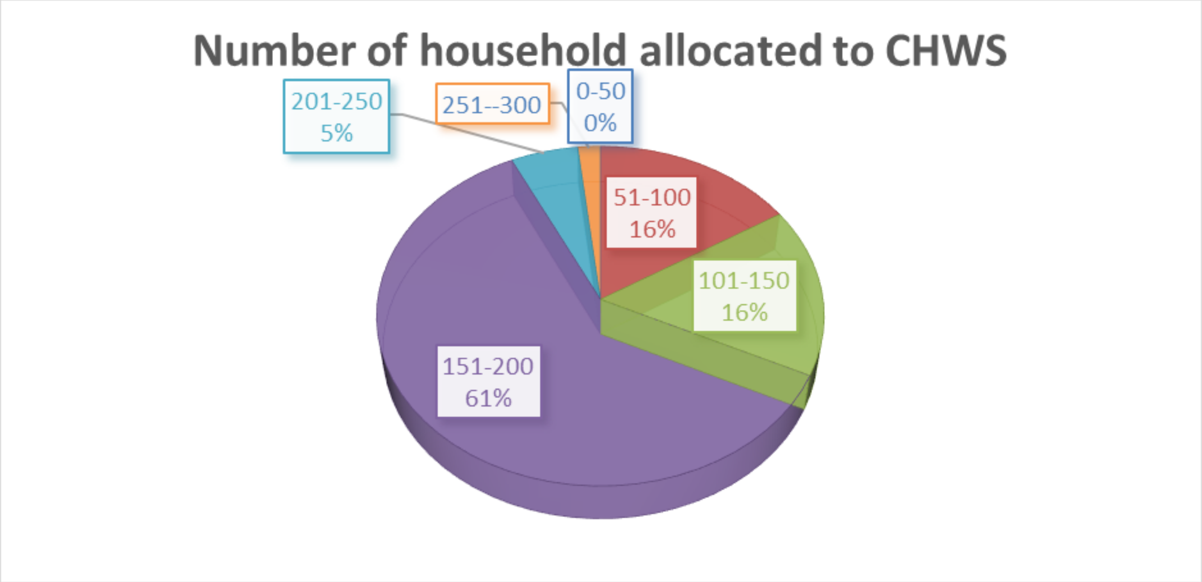

Figure 4.3: Number of Households Allocated to Each of the Participating CHWs

According to the WHO (2018), CHWs should take responsibility for 250 households each within their communities. Among the participating CHWs, only 5% (34) of had the required number of households, between 201 and 250; followed by 5.36% (3) responsible for between 251 and 300 households that they were required care for.

Sixteen per cent of the participants were responsible for between 151 and 00 households, while two groups of nine members each (16.07%) had participants who were responsible for between 101 and 150 households and 151 to 200 households, respectively. However, the number of households seen per month depends on the type of needs in the households and the number of clients to be traced.

4.2.9 Number of households allocated to each participating CHWs

Although South Africa has a long history of CHWs, a number of constraints and competing priorities continue to exist. CHWs are a bridge between the community and the healthcare services. They continue rehabilitating patients after discharge from hospital, to ensure that they recover fully in community. They also act as the cornerstone of the South African WBOT initiative, CHWs continue to promote health and link their communities to healthcare facilities, in spite of a lack of employment, limited resources and low wages (Murphy, Moolla, Kgowedi, Mongwenyana, Mngadi, Ngcobo, Miot, Evans & Pascoe (2021).

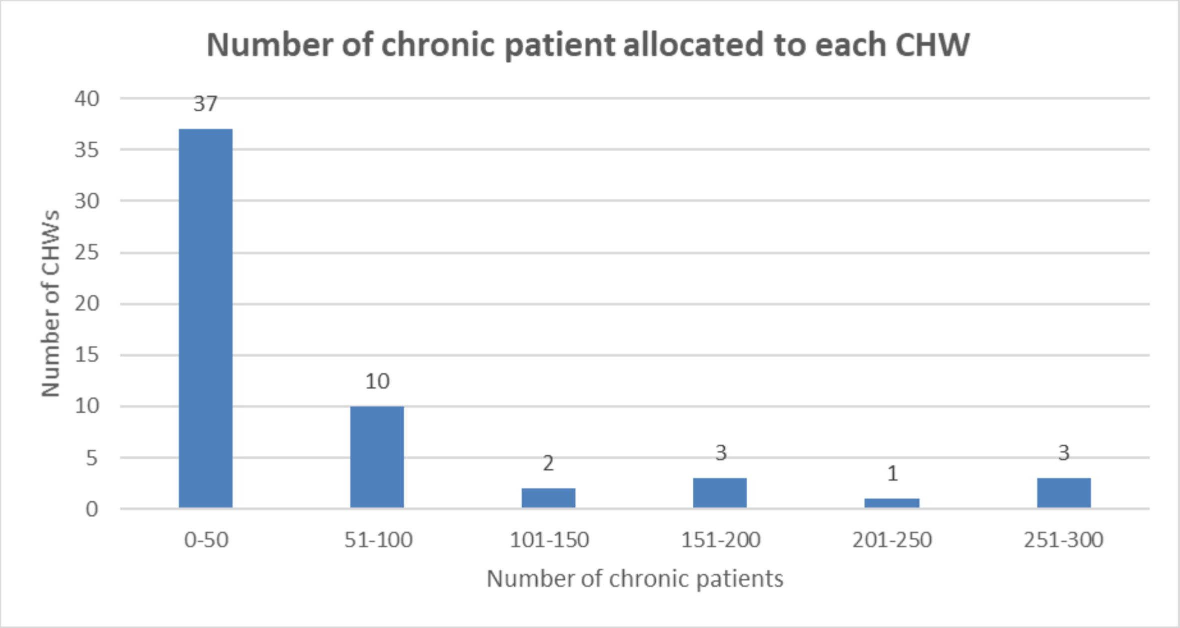

Figure 4.4: Number of Chronic Patients Allocated to CHWs

In this study, despite other community work, the CHWs were allocated community members with chronic illnesses to look after. A total of thirty-seven (37) CHWs were allocated between zero and fifty patients; followed by ten (10) participants who were allocated between 51 and 150 community members with chronic illnesses. Five CHWs were allocated between 151 and 300 community members with chronic illnesses to take care of.

According to Jinabhai, Marcus and Chaponda (2015) CHW activities must involve working with defined families, groups and individual learners. However, in many communities, CHWs are allocated 250 families and 50 and above patients with chronic conditions, making it difficult for them to reach the goals set according to their plan, because some patients might need closer care as a result of their condition.

4.2.10 Number of households each participating WBOT supports

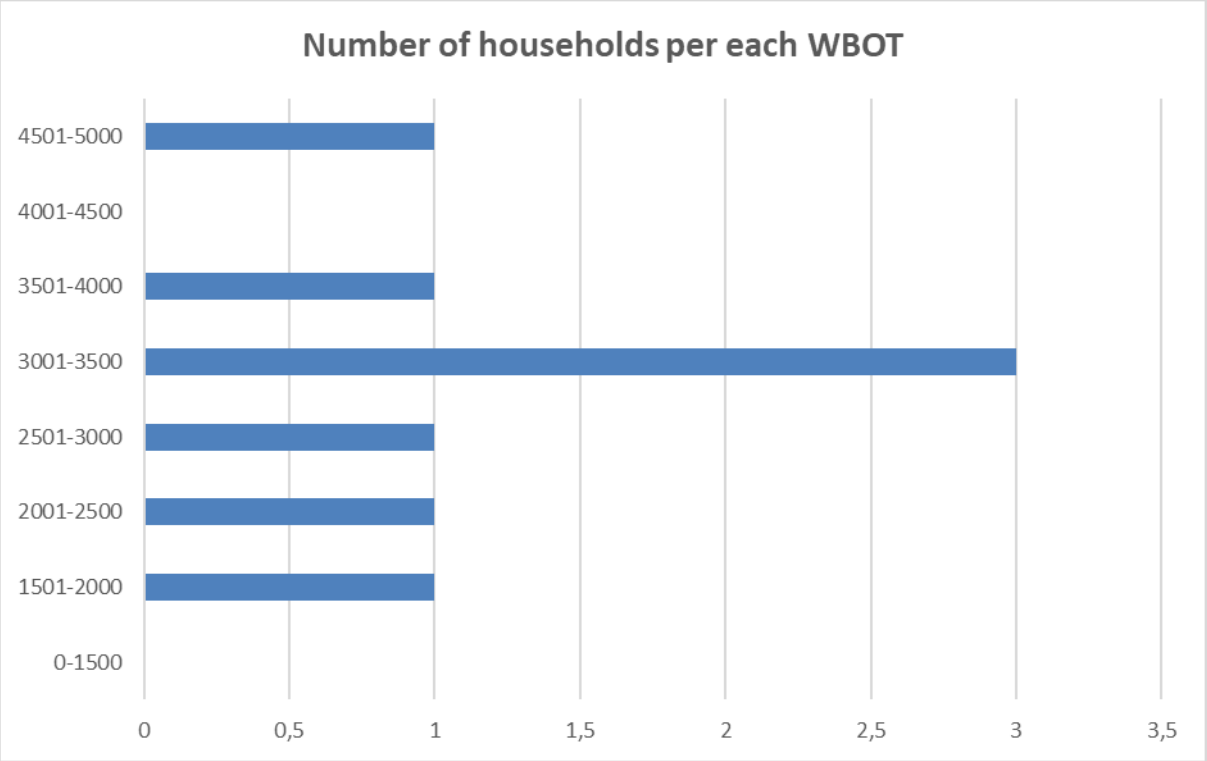

Figure 4.5: Number of Households Allocated per WBOT

A total of three (3) WBOTs had between 3 001 and 3 500 households under their care. There were only two (2) teams that had more households than this team; one team had between 3 501 and 4 000 households to take care of, while the WBOT with the largest number of households to take care of were allocated between 4 501 and 5 000 households. The three (3) WBOTs had fewer than 3 000 households to take care of.

According Jinabhai, et al. (2015), the work allocated to a WBOT is defined according to areas, not according to people and communities. In reality, the extent of health care provided may be beyond the individual patient, since there could also be family members who are ill. Therefore, WBOTs must provide services to people in their homes, extending health care to remote, rural and marginal populations who may find it difficult to access services at facilities because of their physical location or social position. The WBOT must extend health care to people who are homeless, who abuse substances, who engage in sex work or who are on the margins of society in other ways. They must extend the focus of care beyond health conditions and diseases.

According to the WHO, WBOTs are meant to assist health systems to conceptually, structurally and functionally fulfil their comprehensive PHC goals; with a strong focus on epidemiological household registration and community diagnosis tasks. WBOTs are meant to identify “at risk” individuals, families and communities; follow-up on patients; and, attend to pregnant women, new mothers and babies. WBOTs should be linked to, but not be part of, clinics and other healthcare services. WBOTs were supposed to be health services in a district that would continue to provide largely curative, bio-medical clinical services. Thus, WBOT members should become fully functional, additional health cadres, with semi-autonomous functions and shared responsibilities that would concentrate on the prevention diseases and promotion of health (Jinabhai et al., 2015).

4.2.11 Number of WBOTs and CHW per team in each clinic

Table 4.2: Number of WBOTs and CHWs per Team in Each Participating Clinic

Number of CHW allocated to each WBOT	
Number of CHW per team	**WBOT**
0-2	0
3-4	1
5-6	2
7-8	3
9-10	1
11-12	1
Total	8

Table 4.2 shows that the participating clinics had eight (8) WBOTs with the number of CHWS ranging from three (3) to twelve (12). The number of WBOTs and CHWs in each team varied. One clinic had no WBOT during the focus group discussions. The second team on the table with one (1) WBOT had only has three (3) and four (4) CHWs in the team. The third clinic had two (2) WBOTs with between five (5) and six (6) CHWs in each. The fourth clinic had three (3) WBOTs with CHWS seven (7) to eight (8) CHWs per team. The fifth clinic had one (1) WBOT with the number of CHWs in the team ranging from seven (7) to eight (8) and the last WBOT had the largest number of CHWs, at between eleven (11) and twelve (12) CHW members.

Table 4.3: Average Number of Clients with Chronic Illness Allocated to Each Participating CHW

Average number of clients with chronic illness allocated to each participating CHW		
Clients	**Frequency**	**Percentage**
0-50	-	-
51-100	56	100
101-150	-	-
151-200	-	-

201-250	-	-
251-300	-	-
Total	56	56

All participants indicated that they were responsible for fifty-six (56) patients with chronic illnesses.

Table 4.4: Average Number of Clients Referred to the Clinic by the Participating CHWs per Month

Average number of clients referred to the clinic by participating for further management by CHWs		
Average number	**Frequency**	**Percentage**
0-50	54	96.43
51-100	2	3.57
101-150	-	-
151-200	-	-
201-250	-	-
251-300	-	-
Total	56	100

Fifty-four (54) CHWs indicated that they refer between zero (0) and fifty (50) clients to the clinic in a month for further review and management. Two (2) of CHWs indicated that they refer between fifty-one (51) and one hundred (100) patients to the clinic per month for further review and management.

4.3 THEMES AND SUB-THEMES OF THE STUDY

The analysis of the collected data led to the identification of themes and sub-themes. Themes are features of participants' accounts characterising particular perceptions and/or experiences that the researcher sees as relevant to the research question. They are developed through a systematic process of coding, examining of meaning and provision of a description (Creswell & Poth, 2018). Table 4.5 shows the themes and sub-themes developed from the collected data that were developed and used to answer the research question. These themes and sub-themes are discussed in detail below.

Table 4.5: Themes and subthemes developed from the collected data

THEME	SUB-THEME	RESPONSES
Experiences related to CHWs' roles and activities in the care of chronic illness patients in the community	Providing Health Promotion	Promoting healthy Lifestyle, practicing personal and environmental hygiene, encouraging healthy eating, avoiding fatty foods and lots if sugar, exercises, collecting medication every month X9 Promoting Chid Health X2 Victim empowerment X1
	Adherence to treatment	- Making sure the patients are taking treatment correctly the right at the right time – treatment adherence X11 - Referral and Tracing of defaulters X2
	Providing care	- Caring for HIV clients providing on going counselling X5 - Care of mental illnesses X1 - Maintaining confidentiality Allowing patient and family members to report anything without fear that their secrets will be spread to the community members X3 - Counselling X1 - Ante natal Care X1 - Screening X2
Challenges in the caring of chronic illness patients relate to acceptability of CHWs in the community, time and workload Work planning	Families shifting responsibilities In the care of patients with chronic condition.	- Families shifting responsibilities, they expect CHWs to bath patients, to feed to clean and change soiled - When you arrive they leave you and report to the patient that your nurse is here. - Patient taking chronic medication but you find the patient without food X1 - Patient sharing medication. - Only when they have a bedridden patient they think of us and they need our services". - Chronic patients abusing us by requesting us to collect treatment for them and bring home for them because they don't want to go to the clinic or hospital to get Corona
	Acceptability in the community	- No! Sometimes we arrive at the household and identify some challenges and we spend a lot of time in the one household than it was anticipated X3 - We rush work so we can have time to write reports at the facility X1 - The community undermines us - Stigma we were called AIDS people now we are called corona people - Chronic patients abusing us by requesting us to collect treatment for them and bring

		home for them because they don’t want to go to the clinic or hospital to get Corona - We experienced stigma, we were refused entry in the household, name calling “people with corona” - We are not accepted in our communities and their families anymore. Some even lock their gates and some leave dogs to chase us. - Only when they have a bedridden patient they think of us and they need our services”. - We have now experience the stigma that AIDS CHWs suffered. When we walk in the street we are now called corona people. People call their children off the street when we pass through. - When we were going around screening households or when we give education people were not taking it seriously until they have a family member with a confirmed Covid 19 Positive. - Fear of contracting the disease, as we are not having enough PPEs, only 1 mask per day , sometimes no masks are available
	Trust and teamwork in the health system	- Sometime we are not accepted in our communities because of don’t trust us. - Sometimes is because they are worried about confidentiality if the tell you their problems. - Lack of confidentiality and trusting relationship among team members. - No! When we have TB Patients we have to see the patient every day and might be staying far from where I planned to visit, makes it difficult to complete my tasks for the day. This affect my report. -
Working relationships	Relationship with colleagues at the clinic	- There is good relationship. with the clinic staff, there is team work. X4 - People are not the same, some are treating us well and some are treating us badly X3 - Not given enough PPE only 1 mask per day and without sanitizer refill some time. X 15 - Poor information dissemination. - We experienced stigma, we were refused entry in the household, name calling, people with corona. - Less reports on chronic patients, no more reaching the targets.
	Relationship with the WBOT	- “At first it was not good, we use to be in groups gossiping reporting one another, but it was addressed by our Team leader, now we are one family”.X3

	team and fellow CHWs	- We share problems, we assist each other, meeting weekly on Fridays to bring report and share challenges amongst ourselves and help each other with finding solutions before we report to the Team leader x4 - We assist each other as a team when we have a problem patient or family. - One day we decided to have a scenario ,one of us had a problem with convincing a woman to be referred to the clinic ,and her health continuously deteriorated, she shared the problem with us, we all went to visit her, one introduced herself as a Social Worker from the clinic, the other one introduced herself as a Professional Nurse from the clinic and then our colleague informed her that we came to see her , then she allowed us to talk to her and she finally agreed, she was then referred to the clinic and was found to be having TB then she started taking treatment and completed and since then she was no more difficult and her health improved . - We share health care provision information and advises via phones X1.
	Stakeholder relationships in the community	- Stakeholder relationships in the community - Always good with our ward Councillors, CDW (Community Development Worker, Police, Indunas, Teachers, Pastors and Social Workers. X15 - “My ward councillor always involves me, she refers people with health problems, she calls me anytime she meets a health issue and I also call her when I need her help.” - I don’t have a good relationship with my Ward Councillor I don’t think she even know what I do in the community. X1 - We experienced stigma, we were refused entry in the household, name calling, people with corona. - Less reports on chronic patients, no more reaching the targets - Time to trace defaulters was replaced by household screening and referral of clients for testing - When we were going around screening households or when we give education people were not taking it seriously until they have a family member with a confirmed Covid 19 Positive. - Fear of contracting the disease, as we are not having enough PPE , only 1 mask per day , sometimes no sanitizer .no glove no aprons no disposable hand towels, airtime to report urgently if we find a suspicious of corona.

Motivation and commitment to render care to patients with chronic illnesses.	Motivation and commitment	- Passion, love for our own people X8 - Commitment to serve the Nation X5 - Knowledge that we gain every day, we are skilled X10 - To look after a bedridden patient and see the patient recovering x2 - Passion, love for our own people X8 - Commitment to serve the Nation X5 - Achievement of goals, when you see a bedridden patient recovering, when you discharge a TB patient, when you have less defaulters, the graph of lost to follow or missed appointments going down X10 - Knowledge that we gain every day, we are skilled X10 - Achievement of goals, when you see a bedridden patient recovering, when you discharge a TB patient, when you have less defaulters, the graph of lost to follow or missed appointments going down X10 - To look after a bedridden patient and see the patient recovering x2 - After motivating someone to go for HIV test and see the patient accepting and finally start on ART x2 - I get satisfied when I visit a sick patient and he agree to eat, if the patient refuses to eat I feel so bad it affects me personally like I fail to assist him/her. - I get satisfied when someone appreciate my work"x3 - "I get fulfilled when I have a good relationship with families and clients" x1 - "Commitment to work as a team makes me happy" x1 - "I get satisfied by convincing patients to stick to one clinic and adhere to treatment". X1 - Brining peace amongst neighbours after gossiping when I am doing my work and I intervene until the matter is resolved x 1 - After motivating someone to go for HIV test and see the patient accepting and finally start on ART x2 - I get satisfied when I visit a sick patient and he agree to eat, if the patient refuses to eat I feel so bad, it affects me personally like I fail to assist him/her.
Suggestion on ways to improve their working conditions and productivity	Ways to improve their working conditions and productivity	- To be permanently employed unlike on contracts for 6months - To have benefits like pension contributions, UIF, sick leave and annual leaves - To have salary increase, the stipend not enough for the work they doing. - To have more health Education - To have T-shirts with messages teaching about the chronic illness management. X1 - If we can be role models practising what we preach x1

		- More campaigns at schools and everywhere x2 - Teaching the community not to hide sick people in the home, so that we can save more lives by early - Assessments and early referral for early detection - To have bags for caring our stationery, to have umbrella, BP meters and Glucometers, gloves, Masks and sanitisers\.
	Suggestions in managing their plans and time in the performance of their duties	- To have T-shirts with messages teaching about the chronic illness management. X1 - If we can be role models practising what we preach" x1 - More campaigns at schools and everywhere x2 - Teaching the community not to hide sick people in the home, so that we can save more lives by early assessments and early referral for early detection - To have bags for caring our stationery, to have umbrella, BP meters and Glucometers, gloves, Masks and sanitisers.
	Suggestion on ways to improve productivity	- To recruit CHWs where there is a need, review of households, new stands, extensions leading to increased number of household per CHW - To involve the stakeholders - To provide on-going In-service and refresher courses - To provide Transport for the programme to improve supervision - To review the clocking system, since they are staying far from the clinic and work far from home - Provision of means of communication with cell phones, airtime and access to data.

4.3.2 Theme 1: Experiences related to CHWs' roles and activities in the care of chronic illness patients in the community

The CHWs described their roles and activities in relation to the care of chronically ill patients as providing health promotion, adherence to treatment and the provision of healthcare. However, the supervisors of CHWs described the role of CHWs as improving patient care in a manner that is of benefit to the supervisor and interdisciplinary team. Sub-themes of Theme 1 were identified and will be discussed below. Similarly, Tsolekile, Puoane, Schneider, Levitt and Steyn (2021) are of the view that the role of CHWs with respect to NCDs at household level must include health promotion, education about diet, exercise and lifestyle. Screening for overall cardiovascular disease risk (health promotion) and, in particular, for diabetes and hypertension, foot care (healthcare) and, an integrated approach to adherence support (adherence to treatment) must also be included. Furthermore, at community level, CHWs who focus on chronic diseases must organise campaigns and support groups, and promote action on risk factors related to diet and exercise. This is slightly different from the experiences of the participants in this study. According to the CHWs, campaigns are organised and conducted nationwide in the community by the national and provincial department, with minimal participation of the local clinics and CHWs. Their role is mainly to recruit participants to the different venues where the campaigns take place.

Ingram, Doubleday, Bell, Lohr, Murrieta, Velasco, Blackburn, Sabo, Guernsey de Zapien and Carvajal (2017) argued that the roles and activities of CHWs in this care patient with chronic illnesses are tailored to meet the unique needs of the communities they serve. A CHW's role depends on factors such their education, training, lived experience and experience working with specific populations. CHWs have a significant impact on chronic disease outcomes within primary care examined using electronic health records on patients who are collecting chronic medication correctly and those who are lost to follow-up. Community health workers have the responsibility to trace and bring back to the clinic patient that are have defaulted.

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According to the Rural Health Information Hub (RHIH), the role of CHWs is to address the health needs of the vulnerable groups in the community, including those with chronic illnesses, and advocate for underserved communities and individuals to receive services and resources to address their health needs. CHWs provide informal counselling, health screenings and referrals, and build capacity in the community to address local health issues. The CHWs also collect information that informs healthcare services and stakeholders about the performance of their programmes and policies.

4.3.1.1 Sub-theme: Providing health promotion

During focus group discussions, a number of CHWs indicated that their role in health promotion was to promote healthy lifestyles (12); to promote the practice of personal and environmental hygiene (15); to encourage healthy eating (4); to promote the avoidance of fatty foods and excessive sugar consumption (22); to promote exercise (5); and, to collect medication every month (9). Three (3) participants mentioned promoting chid health (2) and victim empowerment (1).

One of the participants in the focus group discussion indicated that:

> *Our role is to connect chronic patients who are a vulnerable group with the healthcare services and healthcare providers, help patients access healthcare and social service systems to get assistance for their needs and to help them manage their condition. We also provide care necessary when they are at home and community.*

Some CHWs, during the FGDs, and their supervisors, during the KIIs, indicated that CHWs do not only concentrate on the chronic illnesses, they also provide health promotion interventions to the entire household. CHWs observe, assess, screen and make decisions through referrals and health education. They are able to incorporate healthy lifestyle programmes in their work, assist communities and families to practice personal and environmental hygiene, encourage healthy eating and encourage families to avoid fatty foods and excessive sugar consumption. They encourage their chronic patients to exercise, collect medication every month and encourage adherence to treatment regimes.

Some of the supervisors indicated that CHWs understand that chronic illness will complicate if patients do not follow healthy a lifestyle. CHWs do not leave the house without teaching the occupants about a relevant health promotion topic. Health promotion is successful as CHWs say that they start with relationship and rapport building. During health promotion, the CHWs say that they do not leave the house without talking about the impact of Corona, stressing hand washing skills, practising social distances, proper wearing of masks and dealing with the signs and symptoms of the disease.

4.3.1.2 Sub-theme: Adherence to treatment.

It is currently recognised that CHWs are frontline public health workers who are becoming increasingly integrated into the healthcare system for the prevention, treatment and control of chronic disease. In particular, CHWs have demonstrated their ability to improve medication adherence in underserved populations. They have improved adherence to treatment among TB patients, people living with HIV and those suffering from other chronic disease. However, their services have not been used in the treatment of mental illness. The involvement of CHWs mental health could benefit patients and prevent severe mental illnesses (Allen, Sugarman & Wennerstrom, 2017).

According to the WBOT supervisors, clinics have a lost to follow-up client schedule. This is a list drawn and printed on weekly basis that CHWs refer to in order to trace those people who have stopped attending the clinic, in other words are lost to follow-up, in their areas. CHWs are given the list of names, telephone numbers and physical addresses in order to trace those lost to follow-up and refer them back to the clinic. Their target is to return at least three lost to follow-up patients per week. CHWs must provide adherence support to those patients who are not yet lost to follow-up by encouraging them to take medication correctly, that is, the right dose and at the right time, and reminding them of the date for their next check-up. CHWs do this so as to reduce the rate of defaulting and the lost to follow-up clients:

> *Some when they defaulted especially youth we find them and they promise, they even take your phones numbers and never come, some patients you find*

> *that the family do not take care of them you find the patient not clean and not having something to eat and they tell you there is no food their bank cards with loan sharks then I report to the social worker.*

In relation to their role with respect to tracing the loss to follow-up patients, during FGDs one CHW, indicated that:

> *The weekly schedule is showing us who has defaulted from the area that I work, it is difficult because some patients hide the information and they hide reasons why they defaulting, will tell you they went to the pastor and he has prayed for her and he no more need medication.*

One CHW described some of the challenges they encountered when tracing defaulters as follows:

> *Some give wrong address and wrong contact numbers when they register and the name is the only thing you know and when you see the name in the list is the one you know, and when I go and verify sometimes they leave the dog to scare you. Sometimes, because you don't know them, one will tell you the person is not home yet she is the one talking to you.*

During an FGD, another CHW indicated that:

> *I encourage them to taking their treatment by disclosing to them, that I am also on chronic treatment. I carry my own treatment and take in front of them. One day I took my treatment in front of them and my colleague who is not on any chronic treatment she also them she took hers before coming here and they believe and start adhering to their own treatment. During health talks we teach them not to share treatment, some pill containers look the same but they have different names.*

4.3.1.3 Sub-theme: Providing care

The third role and responsibilities of CHWs identified by the CHWs was that of providing care at community level. As one of the participants indicated that:

> *Another activity for CHWs is providing on going counselling, for an example those that have been newly diagnosed with HIV and started on Antiretroviral treatment including counselling of any problem. Sometimes we identify mental illnesses and if found in the household we refer for further assessment and treatment. All these activities are rendered while maintaining confidentiality. Allowing patient and family members to report anything without fear that their secrets will be spread to the community members.*

Another CHW responded:

> *When I am in the household I check also the medication that the patient is taking and asked how she/he is feeling like one day the patient was telling me she is always sleepy and when I checked the patient was taking double dose of treatment because the new box was different to the old one. We assist them in collecting treatment but encourage them that the following month she must go to the clinic when she is taking treatment I make sure she swallowed I talk with her, I remind her to always wash hands with water and soap and give health talk including about corona including children in the family making sure they also wash hands.*

A response from a professional nurse (WBOT Leader):

> *As their team leader I make sure there is teamwork. I make sure they work according to their scope of practise when providing care to the patient. I work as a messenger between them and community and again between CHWs and the clinic nurses. I am very happy to work with them we are now doing well with lost to follow and I make them feel free to share anything with me. They need my support.*

A response from another CHW:

> *All pregnant women we make sure they start booking from as early as 6 weeks, encouraging them by telling them the benefits and risks involved if they book late. A day after every antenatal visit at the clinic I also visit her and provide care.*

Another CHW indicated:

> *To young mothers in the community we go an extra mile showing them how to care for their babies, save, how to buy basic food, we advised them like they are our children. We have our colleague amongst us who is adopting orphans and she takes care of them in her home from her own love for children. When you ask her who is this child she always says no is my sister's child yet she is not related to her.*

Another CHW indicated:

> *In one family there was a bed ridden old man who was looked after by her daughter, she could not bath her and we take it upon ourselves to bath him even on weekends until he passed on.*

The CHWs also indicated that becoming a CHW requires a person who loves people and always understands their challenges:

> *You must always picture yourself in their boots and that will give you energy to do your work. As CHW you must not listen to negative talks in the community you must always remember your roles and responsibilities that they have taught us and that you are not alone you have your colleagues who are also ready to help you.*

Another CHW added:

> *Being a CHW it means becoming part of the team meaning that previously we were working in parallel, nobody cared what the other one was doing. I now understand why some people stopped doing this job.*

According to Salud (2014), good CHW must have the following qualities:

- CHWs need to be empathetic in order to do their work with respect;
- They need to be resourceful and willing to help others;
- They need to be able to build relationship with the community they are working with; and,

- They must have a desire to help other and personal strength and courage to face challenging situations. A good CHW must be respect and treat all people with respect.

The qualities mentioned above are important and, in this study, although they have not been mentioned, the participants in describing their work indicated that they have empathy and respect for their patients, families and communities. Based on the available data, the participants in this study appear to be trusted members of their community, working towards empowering the community, the family and their patients with chronic diseases through health promotion and health education. As indicated by their supervisors, the CHWs in this study have been shown to be successful at increasing health outcomes for their communities because they understand the cultural norms of their communities and know how to deal with them. There is also evidence that shows that the CHWs in this study have built team spirit among themselves, and the skills required when working in WBOT and clinic teams (Salud, 2014).

During a KII, one of the supervisors indicated that their role as supervisor was to provide guidance and supervision. However, this supervisor described the roles of CHWs as follows:

> *It means promoting a relationship that of client/healthcare worker relationship. Their main role is referral and tracing of patients who defaulted and return them to the facilities.*

Interestingly the same supervisor later indicated that she also learned a great deal from working with CHWs:

> *Supervising CHWs and getting into the community was a milestone in my development. I learned a lot while being a team leader. To me it is a great opportunity, because I discovered a lot of things in the community which I did not know. There were a lot of people who were not interested in coming to the clinic and who needed health care services.*

One supervisor was worried about the lack of recognition of CHWs by the healthcare system in South Africa, besides the work they are doing:

> *All CHWs activities must be complete, the basic need of clients from antenatal care, postnatal care, child health care, youth, acute and chronic to psycho social support. The CHW is managing all issues in the household from personal hygiene to managing chronic illnesses as well as bed ridden clients. CHWs are responsible to all members of the family. In all the different conditions they follow screening tools which guide them when to refer. With all these activities CHWs do not see themselves as an important source to Health Promotion. With the impact of COVID-19 the CHWs undergoes stigma and stress, they do not see value in the work they do. All received scales, Blood Pressure machines, umbrellas, bags and raincoats and stationery as once off. CHWs also received cell phones with data with an added responsibility of registering old people for COVID-19 vaccines.*

According to USAID (2013), the role and activities of CHWs in the care of chronic illnesses in the community. namely provision of health promotion, encouraging adherence to treatment and providing care, may increase the CHWs roles and functions. This may lead to the inclusion of monitoring, evaluating and preparing community health reports; facilitating planning activities at community level; mobilizing the community and other stakeholders; advocating and mobilising resources for community health activities and facilitating, training and developing community. However, CHWs receive little or no recognition; hence they are treated as volunteers and paid meagre salaries with no additional benefits. There is a need for authorities to recognise their work as healthcare professionals and include them as another cadre of healthcare workforce. This will improve patient care, benefitting the patients, supervisors, the interdisciplinary team and the healthcare services.

4.3.2 Theme 2: Challenges in the caring of chronic illness patients relate to community acceptance, time and workload and planning

This second theme is related to challenges faced when caring for chronic ill patients The subthemes here are acceptability of CHWs in the community; Families shifting responsibilities and unsupportive in care of the patients, insufficient time to complete planned tasks; working plan challenges; and, distance between households in the community.

4.3.2.1 Families shifting responsibilities and unsupportive in care of the patients

Some of the participating CHWs were of the view that some families with chronic patient are shifting responsibilities. These families expect CHWs to bath and feed patients, change soiled linen and clean their rooms, without the family's assistance. Sometimes, when the family is busy assisting the patient and a CHW arrives, they stop what they are doing and tell the patient that their nurse has arrived. Sometimes the family sometimes does not even wait to give the CHW a report about their patient. They use the presence of the CHW as an opportunity to visit friends or malls or and do shopping.

Some of the FGD participants were of the view that families do not want them in their homes they just tolerate them because they have bedridden patients. They also raised a concern that some families give patients with chronic illnesses medication but they do not give them food. However, it is not clear whether there is food in the house or the family just choose not to share the available food with the patient.

South Africa is one of the countries with increasing food security. Many families cannot afford buying food and have to depend on neighbours and subsistence farming. In 2020 food insecurity in South Africa was estimated at 16% meaning that 9.34 million people might sleep without food or have food just enough to sustain them because of poverty (IPC, 2021). It is therefore paramount that CHWs must try and get more information about Hungary patients and refer them to the appropriate services for assistance.

Some FGD participants indicated that some of their patients are abusive

> *Chronic patients abusing us by requesting us to collect treatment for them and bring home for them because they don’t want to go to the clinic or hospital to get Corona*

During FGDs, the participants indicated that they have weekly individual plans to deal with the chronic patients allocated to them that are approved by their supervisors. Challenges in the caring for these patients relate to time and workload. *Some of the participants indicated that:*

> *We are able to manage our time by planning which household to visit and when. It is difficult to manage time, because sometimes we meet difficult issues in the households and you spend more time than you planned assisting the family to deal with their challenge, as such we fail to finish what we had planned to do for the day.*

Another challenge that CHWs face is the distance between households because travelling distances interferes with their plans for the day. Sometimes they need transport to visit the next family and they have to wait for a taxi those only moves on to the next destination when it is full of passengers. During the FGDs, some participants indicated that:

> *When we have a new TB Patients we have to see the patient every day and might be staying far from where we planned to visit, it makes it difficult to complete your tasks for the day, because you have to walk long distances or get a taxi if you have money.*

According to USAID (2015), there are numerous factors that impede from providing, or assist CHWs to provide, effective services to chronic patients, according to their plans. These barriers are the result of a lack of knowledge and competency in managing chronic patients in the community. Some CHWs do not know how to perform their assigned tasks, while other CHWs are not able to perform assigned tasks because of problems relating to workload and time. Many CHWs are not willing to perform their assigned tasks for different reasons, including the COVID-19 pandemic that has affected many communities in the country. It is, therefore, important that all CHW programmes take these barriers into consideration during planning to stop the programmes from failing to reach their goals and objectives.

4.3.2.3 Sub-theme: Acceptability of CHWs in the community

Although CHWs are were introduced in many countries and communities as part of the healthcare system, in some communities, CHWs are not them as expected, for a variety of reasons. Some CHWs were found to be unacceptable to their communities because of a lack of confidentiality and trust. Some CHW programmes were not acceptable because the communities did not trust their government's reasons and purposes for introducing the programmes. Some community members discovered that the CHWs in their community were not trustworthy and that the CHWs gossiped about their patients and the condition with other community members (Singh, Cumming & Negin, 2015).

Some participants in this study were of the view that it took time for some of the CHWs to be accepted because the programmes they were working on dealt with diseases that were unacceptable to their communities; they gave examples of such diseases as TB and HIV/AIDS. Some CHWs who worked on these programmes before joining chronic illness teams indicated that:

> *It took time for us to be accepted by the affected families and communities at large because they did not understand TB and HIV/AIDS.*

Another CHW said:

> *We were called names – 'Chaivy' or 'AIDS' and often stigmatised because we were dealing with HIV/AIDS and TB patients. We had to device means to assist the affected families without raising the communities' attention. e.g., not using our uniform w and back entrances. When we were walking in street people will just close their gates. Sometimes when you greet them they will just keep quiet and point at the affected families or even say stop greeting us we are not AIDS families.*

All the CHWs in the FGDs indicated that their programme was easily acceptable because they were dealing with chronic illnesses that are well known in their communities. Families with a newly diagnosed patient would call CHWs from the street, without hesitation. However, all of this ceased with the arrival COVID-19. The virus challenged the acceptance of CHWs in their communities, and interfered with the care of chronic patients and performance of their duties in the communities. The trust relationships that were built over years disappeared immediately. It was indicated that the community became hostile towards CHWs and all healthcare workers:

> *We are not accepted in our communities and their families anymore. Some even lock their gates and some leave dogs to chase us.*

Another participant indicated that:

> *Only when they have a bedridden patient they think of us and they need our services.*

While yet another participant indicated that:

> *We have now experienced the stigma that AIDS CHWs suffered. When we walk in the street we are now called corona people. People call their children off the street when we pass through.*

4.3.2.4 Sub-theme: Trust and teamwork in the health system

The participants were of the view that trust was built on individual experiences and perceptions of the services provided by the CHWs. They indicated that WBOT members were more trustworthy because they were educated, knowledgeable and received adequate training regarding the work that they were doing. The supervisors also indicated that they were satisfied with work, reports and feedback received from the communities about CHWs.

However, the arrival of COVID-19 affected that trust and teamwork, not only in the community, but also within the WBOTs and their relationship with the clinics. Trust is essential to build an effective team because it provides a sense of safety. COVID-19 and its impact made team members to feel unsafe with each other and exposed to vulnerabilities.

As result of COVID-19, reports on chronic patients decreased and CHW could no longer reach their target patients. Time to trace defaulters was then replaced by household screening and referral of clients for testing for COVID-19. One of the participants indicated that:

> *Fear of contracting the disease, as we are not having enough Personal Protective equipment (PPE,) only 1 mask per day, sometimes no sanitizer, no gloves no aprons no disposable hand towels, airtime to report urgently if we find a suspicious person worsen the lack of trust between CHWs and health professionals.*

Another participant indicated that:

> *In the community when we were going around screening households or when we give health education about COVID-19 people were not taking us seriously because the trust they had on us was no more. They started taking it seriously when they started having family member or neighbour with a confirmed COVID-19 positive.*

In order to rebuild teamwork in WBOT and trust in the community, there is a need to ensure that all decisions made with respect to the care for chronic patients take the patients, families and communities into account as part of the team. According to the WHO (2012), an effective team *in healthcare provision has the different health providers relevant to the needed care as team members, including the patients. Team members communicate with each other and merge their observations, expertise and decision-making responsibilities in order to optimise patient care. An effective community-based team comprises the WBOT team, the patients, their families and their communities.*

4.3.3 Theme 3: Working relationships

The working relation theme is divided into three subthemes, namely relationships with colleagues at the clinic, relationships with the WBOT members and fellow CHWs, relationships with the chronic patients and their families, and stakeholder relationships in the community.

A working relationship is described by some authors as a relationship where time is spent with both colleagues and service users during working hours. This relationship is often referred to as a professional relationship. Working relationships are based on adhering to the policies, procedures and the agreed ways of working of an organisation. They are also bound by the conditions of employment and codes of practice, and the health worker is accountable for any mistakes or errors made (Perry, Zulliger & Rogers, 2014). Working relationships, with respect to CHWs, means their relationships with colleagues, patients, communities and stakeholders. A good CHW working relationship requires well-designed, functional support and interaction between the CHWs and the health systems, and should involve community-based health services. Hence, it is important for the CHWs to build good working relationships with the community leaders, communities, patients and their families, which are essential for effective community health services (Hodgins, et al., 2013).

According to the CHWs, the working relationship question should specify the working relationship with the employer. All CHWs in the FGDs insisted on starting the discussion with the challenges the faced that related to the employer. The following is what they said:

> *We want to be permanently employed unlike on contracts for 6 months sometimes we are not sure that we are adding value to the community. Is the government also seeing us as important or not, because we are always not sure we will be contracted again each time the contract ends. To have benefits like other employees if the government sees us as adding value to the community we are serving, benefits like pension contributions Unemployment Insurance Fund (UIF), sick leave and annual leave.*

All the eight groups mentioned something like this first.

Another employer-employee challenge was indicated thus:

> *It seems nobody cares about our mental wellness. We come across serious situations in the community but there is no debriefing to help us cope. Sometimes we really feel as outsiders. We fail to understand why they talk about us and the need to get more CHWs just to make them suffer? They all get their salaries but we get a stipend. We also know that there are other CHWs that get nothing because they are considered to be volunteers. These CHWs leave their families to go and assist very sick people in the community and save the government's money but getting free labour. This is unfair and it is the violation of our rights particularly the rights of women as the majority of us are women.*

4.3.3.3 Sub-theme: Relationship with colleagues at the clinic

CHWs are often considered by their colleagues in the clinics as lay health advocates who help to mitigate health disparities, while building trusted patient–provider relationships. Some clinics staff does not see the need to build a working relationship with CHWs as they do not consider them to be their colleagues. In this study the CHWs were happy and satisfied with the working relationship they had with their colleagues in the clinics. However, some of the participants indicated that not all clinic staff treated them well.

Four of the CHWs indicated that:

> *There is good relationship with the clinic staff, there is team work.*

A group of three participants indicated that they did not support this view, saying that:

> *People are not the same, some are treating us well and some are treating us badly.*

According to the supervisors, they have a good working relationship with the CHWs because the CHWs are committed to their work. They said that:

> *CHWs work as delegated responsibly. They are available when you need them. They know their clients with chronic illnesses and they assist in correcting collected wrong information from patients and family members. They work as a team in managing to handle some challenges in the community and give feedback.*

4.3.3.4 Sub-theme: Relationship with the WBOT and fellow CHWs

The CHWs understand their responsibility within the working relationship as bridging and providing cultural mediation between communities and health and social service systems; providing culturally appropriate health education and information to the communities and providing culturally appropriate health education and information to the communities. In their view, their working relationship with WBOT members was not always comfortable. Three participants indicated that:

> *People are not the same, some are treating us well and some are treating us badly.*

However, the majority of the FGD participants indicated good relationships among CHWs:

> *At first it was not good; we used to be in groups gossiping reporting one another, but it was addressed by our Team leader, now we are one family.*
>
> *We share problems, we assist each other, meeting weekly on Fridays to bring report and share challenges amongst ourselves and help each other with finding solutions before we report to the team leader.*
>
> *We assist each other as a team when we have a problem patient or family. One day we decided to have a scenario. One of us had a problem with convincing a woman to be referred to the clinic and her health continuously deteriorated, she shared the problem with us. We all went to visit her. One introduced herself as a social worker from the clinic, the other one introduced herself as a professional nurse from the clinic and then our colleague informed her that we came to see her, then she allowed us to talk to her and*

> *she finally agreed to visit the clinic. She was then referred to the clinic and was found to be having TB then she started taking treatment and completed and since then she was no more difficult and her health improved.*
>
> *We share health care provision information and advice via phones when one of us has forgotten something necessary for the patients' needs"*

During the interviews with the supervisors, two indicated that:

> *At first it was not good; we use to be in groups gossiping reporting one another, but it was addressed by our team leader, now we are one family.*
>
> *We share problems, we assist each other, meeting weekly on Fridays to bring report and share challenges amongst ourselves and help each other with finding solutions before we report to the team leader.*

The arrival of COVID-19 caused them to realise that they were not valued to the same extent as the other healthcare providers. The CHWs were unhappy, as indicated in the following quote:

> *We are not given enough PPE only one mask per day and without sanitiser refill some time and sent out into the community to screen people and refer those suspected of COVID-19. During this period there was also poor information dissemination as the supervisors were allocated elsewhere.*

Some supervisors were concerned that the CHWs sometimes over stepped the boundaries, as one indicated:

> *They sometimes fail to identify where they should not intervene, but refer to the relevant team member example to the social worker or to the dietician. Crossing the boundaries which might hinders their relationships with their clients with chronic illnesses. Example promising them to receive disability grant before they know if they do qualify and later refer them to the social worker who is not responsible in approving a grant.*

4.3.3.5 Sub-theme: Stakeholder relationships in the community

According to some of the supervisors, the CHWs offer interpretation and translation services; provide culturally appropriate health education and information; help people access the care that they need; provide informal counselling and guidance on health behaviour; advocate for individual and community health needs; and, provide direct services such as first aid and blood pressure screening. Therefore, CHWs are important in building lasting relationships with the community leaders.

During FGDs, the majority CHWs indicated that they had good relationships with the stakeholders in their community. They said that:

> *We always have good relationship with our ward councillors, CDW [community development worker], police, indunas, teachers, pastors and social workers in our communities.*

Another CHW indicated that:

> *My ward councillor always involves me, she refers people with health problems, she calls me anytime she meets a health issue and I also call her when I need her help.*

However, one of the participants indicated that:

> *I don’t have a good relationship with my ward councillor I don’t think she even know what I do in the community.*

This statement raises questions about the community entry process that was used to introduce this CHW in his community. This type of relationship is discouraging and may lead to the resignation of this CHW.

The supervisors indicated that their role in stakeholder relationship was that of providing support to the CHWs. Below are some of their inputs:

> *Our role as supervisors is to provide on-going support and guidance in the community*

(Sentiment expressed by four key informants).

> *We are also involved in problem solving and receiving referrals from CHWs to further manage the problem,*

(Sentiment expressed by four key informants).

> *Capacity building through spot teaching, in-service trainings, through work integrated learning.*

(Sentiment expressed by three key informants).

One supervisor indicated that *'We promote acceptance of CHWs within the facility and communities' but did not mention how this was achieved.*

Another supervisor indicated that *'She acts as a messenger between patients and CHWs, or between staff and CHWs'.*

The majority of the supervisors indicated that they *'Allow good working relationships, respect, and allow delegation among their team members'.*

According to the Department of Health (2018), the role and responsibilities of WBOT supervisors are to: provide overall supervision of WBOT activities in their catchment area, ensure high quality and timely implementation of community-based activities by the CHWs in their catchment area, build and maintain strong cooperation with the community stakeholders to keep them informed and actively involved in community health activities, build and ensure strong partnerships with health facilities in their catchment area, and ensure safe and accurate use/storage of working kits/tools provided to the CHWs.

The WBOT supervisor must advocate for underserved individuals or communities to receive services and resources to address health needs. They must collect data and relay information to stakeholders to inform programmes and policies. The supervisors must also provide and build capacity among CHWs to conduct informal counselling, health screening and referrals. They must also build community capacity to recognise and address health issues as early as possible (DOH, 2018).

4.3.4 Theme 4: CHWs Motivation and commitment to render care to patients with chronic illnesses

Although it is recognised worldwide, and within South Africa in particular, that CHWs make a valuable contribution to the healthcare services of a country, many CHWs render their services as unpaid volunteers, are paid in kind or are given a stipend, which is way below the value of the job they do. During the performance of their duties in the community, CHWs face many challenges that are sometimes ignored by their supervisors and employers. The two themes, namely experiences related to CHW's roles and activities in the care of chronic illness patients in the community; challenges in the caring of chronic illness patients, relate to time and workload. Work planning and working relationships indicate some of the challenges that CHWs face in the line of duty. Theme 4 highlights some of the ways in which CHWs deal with challenges and find solutions to them.

4.3.4.3 Sub-theme: CHWs motivation and commitment

The participants indicated that their self-motivation and commitment to their work, which the majority of the participants started doing as volunteers without a stipend, is what keeps them doing their work, in spite of all the challenges they encounter. Eight (8) CHWs indicated that:

> *Our passion, love for own people motivates us every day to go to works besides any challenge we are facing at work.*

Another five CHWs indicated that a commitment to serve the nation made them continue working:

> *To me I would say the knowledge we gain every day and we become more skilled every day has helped us to work hard.*

(Sentiment expressed by ten CHWs.)

Another CHW said that:

> *Knowledge that we gain every day, we are skilled. We underwent a lot of training and we are still that capacitated even now.*
>
> *Achievement of goals, when you see a bedridden patient recovering, when you discharge a TB patient when you have fewer defaulters.*

During the FGDs, a group of CHWs indicated some satisfaction and excitement when they were speaking about graphs going down, which was viewed by four (4) participants as a good motivation for them to continue working:

> *The graph of lost to follow or missed appointments is some facilities going down it gives that feeling of achievement. Seeing the positive feedback of the number of clients traced and came back to the facility and continuing to take their treatment makes you feel that you have saved a lot of lives.*
> *To see a bedridden patient now being ambulatory, those who were have recovered and those that the family lost hope went back to normal life.*
>
> *To see a sick patient who was being fed and see her now eating well without assistance.*

Another FGD participant indicated that:

> *"Passion for the job, committed to serve our own communities, most of us act as ambassadors of chronic illnesses, and we are on treatment and sharing with others the importance of Treatment adherence makes many people to want to live longer with their chronic conditions".*

Some participants indicated that they were motivated when the community, patient, colleagues and supervisors show appreciation for their work:

> *I get satisfied when someone appreciate my work*

(Sentiment expressed by three FGD participants).

> *I get fulfilled when I have a good relationship with families and clients”*

(Sentiment expressed by one FGD participant).

> *Bringing peace amongst neighbours after gossips and conflicts when I am doing my work and I intervene until the matter is resolved.*

(Sentiment expressed by one FGD participant).

The findings of studies undertaken in South Africa and other in countries showed motivators similar to those found in this study. Colvin, (2013) argued that financial incentive is one of many influences on the motivation of CHWs to perform their responsibilities. In the CHWs’ view, the real motivators are non-material incentives, particularly indirect non-material incentives such as the degree to which the environment is supportive of CHWs and the degree to which the health system functions effectively. Lack of appropriate incentives, with resulting high rates of staff turnover, are common in large-scale CHW programmes and are costly in terms of actual cost to replace CHWs, also in terms of the performance of the CHW programme. Most of the CHWs were poor women from marginalised communities, the incentives they received, no matter how small, made them feel that they received some form of recognition for the work that they do. CHWs were motivated by intrinsic factors, like making a difference and community appreciation, as well as non-monetary incentives, such as promotion to another level; acquisition of management skills; participation in capacity building and support for educational advancement.

According to Akintola and Chikoko (2016), many countries experience attrition among CHWs that threatens the realisation and sustainability of community-based health programmes, including the WBOTs in South Africa. Colvin, (2013), highlighted the causes of turnover among CHWs as inadequate and irregular pay, lack of family support, retirement, upgrading of health posts and lack of time to do their work.

The sources of motivations were from CHWs themselves, families and the community. At the individual level, CHWs were predisposed to volunteer work and applying the knowledge gained to their own problems and those of their families and communities. Families and communities supplement other sources of motivation by providing moral, financial and material support, including service fees, supplies, money for transportation, help with farm work and assistance with CHW tasks. Government and its development partners provided motivation in the form of stipends, potential for permanent employment; materials, training, and supervision are also motivators for CHWs for continuing with their work (Colvin, 2013).

4.3.5 Theme 5: Suggested solutions for dealing with CHWs challenges in the performance of their duties

Sub-theme: CHWs' suggestion on ways to improve their working conditions and productivity

The participants suggested that their supervisors and employers should work towards the improvement of their plans and working conditions to ensure that, as CHWs reach their goals, they gain satisfaction with their work. The CHWs indicated that satisfaction is gained through the improvements they see in their patients and in communities; seeing the graphs of the loss to follow-up going down and how TB patients are being cured. In their view, some of the plans they use are not realistic and do not take into consideration the distances travelled, the seriousness of the condition of some of the patients and challenges that they face in the families and communities during their performance of their duties.

The CHWs also indicated that they want to be permanently employed, rather than having the six month contracts, as is currently the case, which caused them to doubt whether their contribution to the healthcare system and to the community is really appreciated, or even adds value to patient care. The short contracts also cause the CHWs to feel anxious, particularly during the last two months of their contract because they do not know whether their contracts will be renewed or not. They believe that some of these anxieties also influence their work in the community:

> *Sometimes we are not even sure that we are adding value to the community.*

> *We wonder if the government is seeing us as important or not, because we are always not sure we will be contracted again each time the contract end.*

The participants' main request was to be permanently employed in order to enjoy employee benefits like all other employees in the Department of Health. The benefits mentioned were to have a salary not a stipend, pension contributions, and contributions to the Unemployment Insurance Fund (UIF), sick leave and annual leave. These were the first issues that participants in all eight FGDs wanted to discuss when the FGD discussions started.

All participants in the eight groups mentioned that:

> *To have benefits like other employees if the government sees us as adding value to the community we are serving, benefits like pension contributions, UIF, sick leave and annual leave and salary increase. The stipend is not enough for the work we are doing. Sometimes we knock off late, and sometimes we go assist the patient even on weekends. We have families to support and children to send to school.*

Another issue raised was:

> *If we can have T-shirts with messages teaching about the chronic illness management, as well uniform and name tags to make us look professional, trustworthy and respectful in the community could change the attitude of the community. Also, to have bags caring our stationery, umbrella, BP meters and Glucometers, gloves, masks and sanitisers would also be helpful and decent".*
> FGD participants.

Although there is general agreement, globally, those CHWs play an important role in addressing the inequities in health care access; their salaries remain an issue in many countries. However, in order to keep CHWs motivation levels high, to retain them in the system and to ensure productive services, CHWs working conditions and salaries must be addressed urgently in many countries. Good working conditions, transportation and adequate salary packages could facilitate and improve the performance of CHWs in many communities, including the Julesburg Local Area (Agarwal, Abuya, Kintu, Mwanga, Obadha, Pandya & Warren, 2021).

One of the participants also indicated:
If we can be role models practising what we preach. We cannot advocate condom use and we don't practice safe sex. If I refer women for pap smear I must be able to explain what to expect or how the procedure is done. How do I refer someone for HIV testing and yet I don't know my own HIV status? I have never had a pap smear, who knows I could be having cancer"

This statement raises some concern about the WBOT programme. It seems the programme does not look after its employees. It is possible that some CHWs joined thinking that they will also benefit health wise. It is important for the programme to rethink ways of ensuring that their employees are healthy and are not spreading diseases in the communities for example TB.

> *We need to do more campaigns at schools and everywhere, there is a need to give information to our youth, on their health but we once have BP machines and scales. They were very useful, but they are no longer working if we can have them it would be good.*

The participants suggested that their supervisors and employers should work towards the improvement of their plans and working conditions to ensure that CHWs reach their goals and derive satisfaction with their work. They indicated that their satisfaction level depends on the improvement they see among their patients and in their communities, for example, seeing the graph of the loss to follow-up going down and TB patients getting cured. The CHWs also want to be permanently employed, rather than having the six month contracts that are currently given to them, which makes them doubt whether their contribution to the healthcare system and the community is really appreciated or even adds value to patient care. The CHWs want to be treated with respect and be seen as colleagues when they are in the healthcare facilities or at an event where they are among other health professionals.

The experiences they had during COVID-19 made them realised that they were not considered as healthcare workers. No one cared about their safety, but they were expected to be at the frontline of identifying the COVID-19 in the communities.
Three participants during FGD expressed the following:

> *Provision of PPE in the facility is a problem especially the masks and sanitizers we do not have enough, you are given one per day and during the day you feel that you need to change and there is no extra one. I was once in trouble for taking sanitiser without being given, but because they were telling me to wait for someone and I was getting late, so I just grabbed and refilled my bottle and left, the following day I was accused of stealing sanitizer. This is not very respectful indeed and clear that we are not part of the health working force.*

> *If the community leaders could teach the community not to hide sick people in their homes, so that we can save more lives by early assessments and early referral for early detection.*

Another suggestion was to have a car dedicated to community service in each community that could always be available for going around and assisting CHWs when they required help. In their view, this could save lives because patients could receive assistance on time. In addition, providing the transport to the programme could improve supervision.

> *Supervision is none exists in real sense where the OTL will leave the facility and directly assist the CHWs in the community. To release OTLs from other duties in the facility and leave them to concentrate on supervision and capacity building for the CHWs in the community.*

> *There is also a need to review the clocking system, since some of us are staying far from the clinic and work far from home. You have to spend money to clock at the clinic and spend again to the community where you work.*

> *Sometimes because of the distances between houses I have to still pay to travel between households.*

During the KIIs, the supervisors raised the issue of lack of debriefing sessions for the CHWs. They felt debriefing sessions would boost the morale of CHWs and help mitigate the stressful situations they work under:

> *Debriefing sessions for CHWs are never done. It would boost their morale. The need for debriefing sessions planned for the CHWs on quarterly basis to release them on the burden they are caring and problems they facing in their work and community are never done. Nobody follows this up.*

According to Jaskiewicz and Tulenko (2012), in order to improve productivity among CHWs, supervisors must ensure that they are given a manageable workload by drawing up realistic plans for each week, with a realistic number of household visits, tasks and clients in an organised manner within a reasonable distance. CHWs need adequate supplies and equipment must be readily available. The supervisors and staff members in the collaborating clinics must support and respect the CHWs as part of the healthcare team. The supervisors must ensure that CHWs are accepted in all the communities allocated to them by ensuring that they conduct a proper community entry process. By so doing, all the CHWs would be able to function more productively and contribute to effective community-based healthcare services in their communities (Jaskiewicz & Tulenko, 2012).

4.3.6 Sub-theme: Participants' suggestions for managing their plans and time in the performance of their duties.

The CHWs indicated the following as issues that must be avoided by their supervisors to ensure that the CHWs achieve their goals in accordance with their weekly plan. One of the participants indicated that:

> *We use a daily plan not seeing all household though we are sometimes called somewhere not planned which distract the planned program.*
>
> *Time may exceed the planned time due to unforeseen circumstances. We are sometimes expected to work in the clinic screening and that reduces the time that we spend in the community.*

The following should be avoided by the managers to ensure that CHWs achieve their goals:

> *We rush work so we can have time to write reports at the facility, because we still have to visit other households.*
>
> *It is helpful in some households to stay longer, in some households you meet an old woman staying alone, with no one to talk to, when I arrive there I engage her in story telling asking her about how they were living long ago, making her feel important and appreciating their culture, when I leave the house, she looks happy and full of smiles than when you came in.*
>
> *Time is not enough if in the household you have identified issues to be addressed.*

The following were suggested to deal with some of these challenges:

> *We should not be allocated to do screening at the clinic before going to the community. They must avoid delaying us by making us wait for transport while doing other duties in the clinic that do not form part of the goals that we must achieve that week.*
>
> *The supervisors must allow us to manage our time and ensure we start in the community as per our plans to ensure that our patients must trust us because we inform them that we make appointments. It is bad when we do not honour our own appointment times.*

> *Since most of us work in our own communities going to the clinic that is outside my community to clock wastes my time that I should be spending in my communities. The supervisors must devise a way that people working in their own communities must clock maybe at the Traditional authorities to avoid wasting time and not achieving the goals of our weekly plans.*

The discussions of the themes and sub-themes in this study indicates that CHWs are aware of their roles and responsibilities as frontline public health workers. However, they are increasingly becoming integrated into the healthcare system which takes them away from some of their roles and responsibilities in the community which displeases them, because they often fail to reach their goals and all activities in their plans. This diversion from their work also affect their reports and graphs. They are aware that their roles and responsibilities are on prevention, treatment and control of all disease not just chronic diseases but the entire household. They encourage healthy lifestyle programmes in their work, assist communities and families to practice personal and environmental hygiene, encourage healthy eating and encourage their chronic patients to exercise, collect medication every month and encourage adherence to treatment regimes.

However, sometimes they are not accepted in the community and families based on the community and families' understanding of the diseases and pandemic. They sometimes suffer stigmatisation and hostilities from both the communities and families. Another challenge they have is that is that families stop assisting and even neglect their family members once CHWs are available in their communities.

In their work CHWs feel they receive little or no recognition by their employers and other healthcare workers. The lack of recognition, and unfair employment conditions affect them and cause dissatisfaction among CHWs. There is a need for authorities to recognise their work as healthcare professionals and include them as another cadre of healthcare workforce.

4.4 SUMMARY

In this chapter, the findings of the study, which was undertaken using quantitative analysis to analyse the demographic characteristics of the participants, expressed in graphs and figures. The qualitative data was analysed into themes and sub-themes, and discussed with relevant data used as a control. The findings show that the CHWs were not satisfied with their employment conditions and were feeling restricted in their attempts to achieve their goals, because of allocation of tasks that were not in their weekly plan. However, they show great motivation and commitment to continue working in their community and see people’s lives change for the better or get healed.

CHAPTER FIVE: SUMMARY OF THE FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This is the concluding chapter of the report. In this chapter, the researcher presents a summary of, and conclusion to, this study conducted at the Julesburg clinics and CHC. The experiences of CHWs and challenges they encounter when caring for patients with chronic illnesses in the Julesburg community are discussed in detail. A summary of the findings and inferences are illuminated with respect to experiences and challenges are summarised in this chapter.

5.2 SUMMARY OF THE STUDY

The study was a qualitative exploratory, descriptive and contextual design that focussed on the qualitative aspects of meaning, experiences and understandings the work CHWs are involved in. The aim of this study was to explore the experiences of CHWs in the care of patients with chronic illnesses in Julesburg area of the Greater Tzaneen Municipality. The study had two objectives, namely to explore the experiences of CHWs in caring for patients with chronic illnesses in the Julesburg community and to explore the views of CHWs regarding solutions to the challenges that they face in the care of patients with chronic illnesses in the Julesburg community.

This study design allowed for the exploration of the experiences of, and challenges faced by, CHWs through the descriptions provided by the people involved in order to gain insights into a problem at hand. A total of fifty-six (56) CHWs participated in the study in five FGDs with CHWs and five KIIs with supervisors, using FGD and KII guides, respectively. Data collected were divided into two groups. Demographic data analysed quantitatively represented with tables and graphs. Qualitative data was analysed using the eight steps proposed by Tesch, which resulted in the development of the five themes and sub-themes that were discussed in details in the previous chapter.

The analysis of the qualitative data was done and themes and sub-themes identified. The results obtained from the eight FGDs and five KIIs with CHWs and CHW supervisors, respectively, will be discussed. The experiences of CHWs in caring for patients with chronic illnesses and challenges related to their work were analysed into themes and sub-themes. Tech's thematic analysis was used to analyse the collected qualitative data. The first theme that emerged concerned the roles played by CHWs when providing health promotion, ensuring adherence to treatment among patients with chronic illness and providing care to these patients in their homes and in the community. This theme was followed by a theme regarding the challenges related to time, workload and planning faced by CHWs in the care of patients with chronic illnesses patients. The third theme that emerged was related to working relationships with colleagues, WBOTs and stakeholders in the community. The fourth theme to emerge was the motivation and commitment of CHWs towards the care of chronically ill patients. The final theme was related to the suggestions made about solutions to the challenges related to the performance of their duties, which included ways to improve their working conditions and productivity, and suggestions of ways to manage their plans and time in the performance of their duties. A detailed discussion of each theme was presented in Chapter 4.

5.3 CONCLUSIONS

The conclusions to the study were drawn using the objectives of the study.

To explore the experiences of CHWs in caring for patients with chronic illnesses in the Julesburg community.

The CHWs described their roles and activities in relation to the care of chronic illness patients as providing health promotion, adherence to treatment and provision of healthcare. CHWs also provide informal counselling, health screening and referrals, as well as building capacity in the community to address local health issues. They are able to incorporate a healthy lifestyle programme in their work; assist communities and families to practice personal and environmental hygiene; encourage healthy eating; and, encourage families to avoid fatty foods and excess sugar consumption. They encourage chronically ill patients to exercise, collect their medication every month and adherence to treatment regimes.

With respect to adherence to prescribed medication, CHWs have demonstrated their ability to improve medication adherence in underserved populations. They have improved adherence to treatment among TB patients, people living with HIV and other chronic disease. However, their services have not been used in the treatment of mental illness.

Another important aspect is that CHWs are aware that they are trusted members of their communities and are, therefore, able to work towards empowering the community, family and their patients with chronic diseases through health promotion and health education interventions. Their success in improving health outcomes in their communities is because they have a good understanding of the cultural norms of their communities and know how to deal with them.

However, they are times when the community is hostile towards them, for example if community entry is not properly carried out by the supervisor or when they do not trust the CHWs with their confidential information. They are sometimes stigmatised and prevented from doing their work when there is a new condition that they do not understand and have fear that the CHWs might bring it to their families.

CHWs have had experiences that make them feel unimportant and not needed. They were tasked to be the front-line workers during COVID-19 by identifying infected people in the community, however, they not provided with sufficient PPEs and sanitisers.

To explore the views of CHWs regarding solutions to the challenges that they face in the care of patients with chronic illnesses in the Julesburg community.

To explore the views of CHWs regarding solutions to the challenges that they face in the care of patients with chronic illnesses in Julesburg community

The participants suggested that their supervisors and employers should work towards the improvement of their plans and working conditions to ensure that CHWs reach their goals and derive satisfaction with their work. They indicated that their satisfaction is linked to the improvement they see among their patients and in their communities, for example, seeing the graph of the loss to follow-ups going down and TB patients being cured.

The CHWs want to be permanently employed, rather than having the current six months that makes them doubt whether their contribution in the healthcare system and community is really appreciated or even adds value to patient care. They want to be treated with respect and be seen as colleagues when they are in the healthcare facilities or participating in any event where they are among other health professionals.

Another suggestion made by the CHWs was to have cars dedicated to community services. In their view, this could save lives because patients can receive assistance in time. By providing transport to the programme, supervision of their activities could be improved because their supervisors could undertake more spot checks.

The time allocated for each household according to the plan is not sufficient if in the household there are issues that need to be addressed. The supervisors must allow CHWs to manage their time. This would ensure that they start their work in the community as per their own plans to ensure that their patients trust because they always honour their appointments.

There is a need for supervisors to ensure that CHWs are accepted in the communities allocated to them by ensuring that they conduct a proper community entry processes are followed properly.

5.4 RECOMMENDATIONS

- Healthcare services must ensure that CHWs receive recognition as they are always used as the frontline workers when there is a health need.
- Arrangements should be made to absorb CHWs into the health system as they go through extensive training, yet they are only paid a stipend and given a six-month contract. They should be provided with appropriate working conditions, with all the benefits.
- There is a need to consider CHWs as team members in healthcare facilities and they need to earn salaries for the work they are doing in the community. In order for countries to reach their seventeen SDG targets and to deal with pandemics, they need to work hard to incorporate CHWs into their teams.
- There is a need for authorities to recognise the work done by CHWs as healthcare professionals and to include them as another cadre of healthcare workers. This would improve patient care, benefitting the patients, supervisors, the interdisciplinary team and the healthcare services.
- Some CHWs do not know how to perform their assigned tasks. It is, therefore, important that all CHW programmes provide continuous teaching to ensure that CHWs are up-to-date with new conditions and medications for chronic patients.
- It is important to improve the working relationships between CHWs and other healthcare workers and within the WBOT to ensure that all healthcare providers on adhere to the policies, procedures and the agreed ways of working.
- In addition, supervisors should always remember that a good CHW working relationship requires a well-designed, functional support and interaction between CHWs, the health system and community-based health services. Hence, it is important for the CHWs to build good working relationships with community leaders, communities, patients and their families, which are essential for the provision of effective community health services, as indicated by Perry et al. (2013).

5.5 SUMMARY

In Chapter 5, the researcher presented a summary of, and conclusion to, the study conducted at Julesburg clinics and CHC. The study explored the experiences and challenges faced by CHWs by conducting FGDs with the CHWs to obtain the descriptions provided by the people involved in order to gain insights into the problem. The conclusions drawn from the study were made with reference to the objectives of the study. Some of the conclusions indicate that CHWs are trusted and respected in the community. However, when the community is not sure of the programme that they are working on or fear of the disease or pandemic the programme is addressing they sometimes become hostile. It is therefore important for the supervisors of the programme to conduct proper community entry processes for the success of the programme and safety of the CHWs. As CHWs are frontline health workers they need to be treated with respect and their employment condition of service need to be improved. The recommendations presented, if taken seriously, could improve the working conditions of CHWs.

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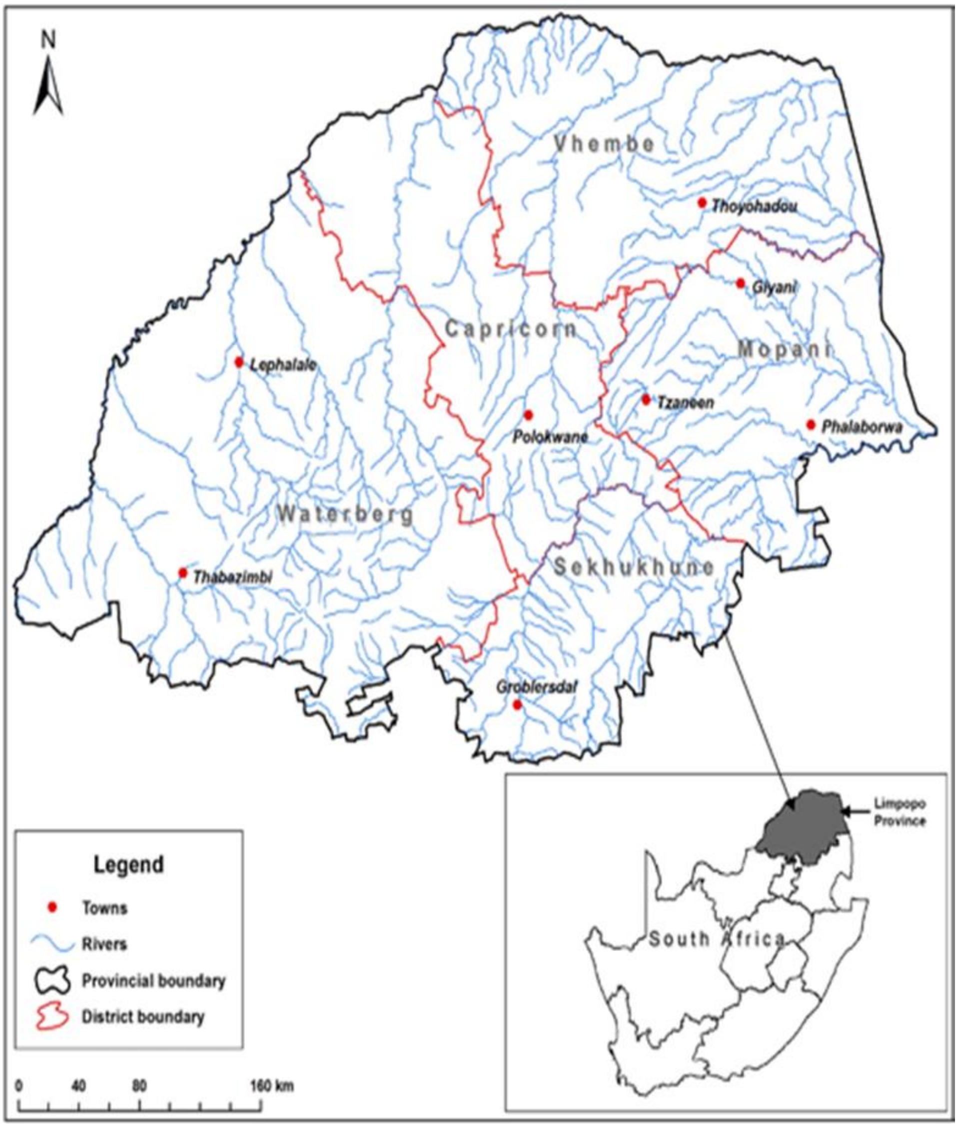
ANNEXURE A: MAP OF JULESBURG IN MOPANI DISTRICT, SOUTH AFRICA



MAP OF JULESBURG IN MOPANI DISTRICT


Julesburg
Hovheni Primary School
Roman Catholic Church
Come Back
Home Church
Google

ANNEXURE B: GANTT CHART

YEAR 2021	**J**	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**
Presentation submission to (SREC)			x									
Turfloop Research & Ethics Committee				X								
Identify Study site												
Department of Health Permission		x										
Pre-test and Data Collection		x										
Data processing and Analysis			x									
Report Writing				x								
Presentation of First Draft to report to Supervisors				x								
Submission for External Exam				x								
Correction from External examiner				x								
Final Submission				x								

ANNEXURE C: LETTER TO SEEK PERMISSION FOR RESEARCH

P. O. Box 289
LETABA
0870

Department of Health
Mopani District
0826

RE: APPLICATION TO SEEK PERMISSION TO CONDUCT A STUDY

Dear Sir/Madam

TITLE: COMMUNITY HEALTH WORKERS EXPERIENCES WHILE CARING FOR PATIENTS WITH CHRONIC ILLNESSES IN JULESBURG LOCAL AREA, MOPANI DISTRICT IN LIMPOPO PROVINCE, SOUTH AFRICA

8

I Tintswalo Johanna Mashele, Persal NO 80612989 a Professional Nurse working at RTC Mopani as a Master Trainer hereby request a permission to conduct a study as part of my learning requirement. I am currently a student in University of Limpopo, 2nd year Masters of Public Health 2017/2018. The study site will be Julesburg Local area including the pre-test at Dan clinic. I am intending to do my data collection around May/June 2020.

AIM OF THE STUDY

The aim of this study is to explore and assess the community health worker's experiences while caring for patients with chronic illnesses.

OBJECTIVES OF THE STUDY

- To describe the experiences of community health workers in caring for patients with chronic illnesses in the Julesburg community.
- To describe community health workers' views regarding solutions to the challenges that community health workers face in the care of patients with chronic illnesses in the Julesburg area.

Thanking you in advance

Mashele T.J

Contact no: 0784215012/082878153

Supervisor: Prof XT Maluleke

University of Limpopo

Contact No :015 268 4113

ANNEXURE D: THE FOCUS GROUP DISCUSSION GUIDE

SECTION A: DEMOGRAPHIC DETAILS OF PARTICIPANTS

INSTRUCTIONS TO PARTICIPANTS

RECORD THE ANSWERS BY MAKING A CROSS ON THE APPROPRIATE RESPONSE/S OR BY WRITING THE ANSWER IN THE SPACE PROVIDED.

PLEASE CROSS ONLY THE RESPONSE THAT IS CORRECT TO YOU.

THE COMPLETED FORM WILL BE COLLECTED BEFORE YOU START WITH THE FGD.

NO	QUESTIONS	ANSWERS
1.	How old were you on your last birthday?	Age completed in years:
2.	What is your date of birth	Date/Month/Year:
3.	How would you classify yourself in terms of gender	Male Female Other(specify)
4.	How would you classify yourself in terms of race	African White Coloured Indian Other (Specify)
5.	What is your nationality?	South African Citizen Non - Citizen)Other (Specify)……………………
6.	Qualification/s	
7.	Designation	

8.	Were you trained as a CHW?	Yes [ ] No [ ]
9.	When were you trained as a CHW?	
10.	When did you start working as a CHW	
11.	No. of years working as a CHW	
12.	When did you start working in Julesburg?	
13.	Name of your WBOT team	
14.	Name of WBOT team leader	
15	Name of the clinic your WBOT is attached to	
16	Name of the community you are working in.	
17	Number of household allocated to you	
18	Number of chronic Clients allocated to you.	

SECTION B

FOCUS GROUP DISCUSSION GUIDE

Role of CHWs in relation to chronic illnesses Management

1) What health activities are you engaged in a household with chronic clients?
2) What other activities are you involved in?
3) What do you think is our role in chronic illnesses management?
4) Do you think you are given the opportunity to play that role?
5) How long have you been a CHW in this area?
6) How do you relate with the clinic staff?
7) What are your experiences in dealing with chronic clients?
8) How do you explain your working relationship with other community stakeholders?

Probe for motivation

1) What motivates you to keep doing your work?

2) How would you describe your relationship with other CHWs?
3) How do you relate with other CHWs during daily activities?

Probe on referrals, supervision, supplies, reporting, etc.?

What challenges do you encounter during your day to day work and how do you manage them?

Disease burden of chronic illnesses?

1) What training activities have your and other CHWs received?
2) What were you trained on?
3) What is your view about this training?
4) What challenges are you encountering in your work?
5) What are the highlights in your work?

Probe concern

If given the opportunity what questions would you like to ask the Government officials and/or health care Providers about health care delivery in relation to chronic illnesses care?

Probe for challenges and solutions to challenges.

1) What is your view of the community's use of your service?
2) What opportunities exist for the CHWs in caring for patients with chronic illnesses?
3) What are the constraints in relation to the care of chronic illnesses?
4) What do you commonly address relating to healthy lifestyle?
5) How are the CHWs encouraged to take part in Health Service Delivery?
6) What challenges do you experience with family members?
7) How do you handle an emergency (share experience and how it was managed)?
8) What do you think should be done to improve you working?
9) What else do you want to share which I did not ask?

Thank you for your valuable time and your participation.

ANNEXURE E: THE FOCUS GROUP DISCUSSION GUIDE (XITSONGA)

XIYENGE: A. VUXOKOXOKO BYA VANGHENELERI VA SWILAVISISO

SWILERISO SWA VANGHENELERI

KOMBISA HI XIHAMBANO EKA NHLAMULO YA WENA KUMBE U TSALA NHLAMULO EKA NDHAWU LEYI SIYIWEKE.

KOMBISA HI KU BA XIHAMBANO EKA NHLAMULO LEYI NGA YONA EKA WENA

FOMO LEYI NGA TSARIWA YI HELA, YI TA TEKIWA HINGA SI SUNGULA SWIVUTISO.

NO.	XIVUTISO	NHLAMULO
1.	U na malembe mangani	
2.	Lembe leri unga velekiwa hi rona	Siku/Nhweti/ Lembe
3.	xana u wanuna kumbe wansati	Wanuna Wansati Swinwana(nyika vuxokoxoko)
4.	Xana u muhlovo mani ku ya ri rixaka	Mu-Africa Wo basa Mukhaladi Mundiya Swinwana(nyika vuxokoxoko)
5.	Umu aka tiko rini	Mu South- Afrika Muaka-tiko rinwana
6.	Tidyondzo leti u tithwaseleke	

7.	Renke ya wena a ntirhweni I yini	
8.	U swi thwaserile ku va CHW	Ina [ ] / EE[ ]
9.	U swi dyondzele rini ku va CHW	
10.	U sungurile rini ku tirha tani hi CHW	
11.	malembe lawa u tirheke tanihi CHW	
12.	U sungule rini ku tirha eJulusberg	
13.	Vito ra xiyenge xa wena xa WBOT	
14.	Vito ra murhangeri wa wena wa WBOT	
15.	Vito ra Kliniki leyi WBOT ya wena yi tirhelaka ka yona	
16.	Vito ra muganga lowu u tirhelaka ka wona	
17.	Nhlayo ya mindyangu leyi unga vekeriwa ku yi fikelela nhweti na nhweti	
18.	Nhayo ya vavabyi vo phaka maphilisi nhweti na nhweti lava unga vekeriwa yona	

SECTION B FOCUS GROUP TRANSLATED TO XITSONGA

Role of CHWs in relation to Chronic Illness

Xana migingiriko ya nwina emindyangwini leyi mi nga na lava hanyaka hi maphilisi?

Yinwana migingiriko ya nwina kwala ndyangwini hi yini xana?

Xana mintirho ya nwina ya nkonka hi yini a ku pfuneni ka rihanyu ra lava hanyaka hi philisi

Xana mivona mi vona mi na nkarhi wa ku ringanela ku pfuna emindyangwini lava hanyaka hi maphilisi?

Mina hi malembe mangani mi ri ka ntorho lowu?

Mi hanyisananjhani na vatirhi va le kliniki?

Hi swihi leswi mi hlanganaka na swona loko mi ri ntirhweni eka vanhu lava hanyaka hi maphilisi

Mi nga ndzi byela yinihi vuxaka bya nwina na vatirhi vanwana e ku pfuneni mindyangu leyi, xikombiso Social worker, Nhduna, muchanselara, Thicara, va NGO Health Inspectara vanwana na vanwana emugangeni wa nwina.

Probing Questions

Incini lexi mi susumetaka kuva mi ya mahlweni ni ntirho wa nwina?

Mi nga byi hlamusela njhani vuxaka bya nwina na vatirhi kuloni va le migangeni wa nwina?

Minga hlamusela njhani vuxaka bya nwina hi matirhelo ya nwina ya siku na siku

Probe on referrals, supervision, supplies, reporting etc

Hi yihi minthlonthlo leyi mi hlanganaka na yona na swona mi swi kotisa ku yini ku hundza e ka yona?

Disease burden of Chronic illness

Hi yihi mintirho leyi u yi thwaseleke loko mi ri ntirhweni wa nwina

Ti tihi tidyondzo leti mi ti kumeke loko mi ri ntiirhweni ?

Hi wahi mavonele ya nwina eka tidyondzo navuswikoti leswi mi swi kumeke a ntirhweni wa nwina?

Minthlonthlo ley mi hlanganaka n yona e ku dyondzeni hi yihi?

Hi swihi leswi mi tibumabumaka hi swona entirhweni wa nwina?

Probe Concern

Hi swihi leswi mi nga tsakelaka ku vutisa va Ndzawulo ya rihanyu va rhangeri n ava endli va milawu mayelana ni mahlayiselo ya vanhu lava hanyaka hi maphilisi?

Probe for challenges and solution to challenges

U nga vula yini hi mavonelo ya wena hi ku vuyeriwa ka vanhu lava hanyaka hi maphilisi emugangeni wa wena hi vukona bya wena bya wena?

Hi kwihi k vuyeriwa loku u ku kumaka e ka ntirho wa wena ni vanhu lava hanyaka hi maphilisi

Hi swihi swirhalanganyi leswi nghenelelaka entirhweni wa wena?

Hi swihi leswi mi dyondzisaka vanhu lava hanyaka hi maphilisi mayelana ni rihanyu lerinene

U hlohloteleka njhani entirhweni wa wena ku va ni rihanyu lerinene?

Hi yihi minthlonthlo leyi u hlanganaka na yona ku huma eka va ndyangu va vanhu lava hanyaka hi maphilisi?

Xana u endleyini loko u hlangene na nghozi emugangeni? (Ahi tweni lava tsakelaka ku hi byela leswi va humeleleke ni leswaku va endle yini e ka xiyimo xa nkarhi wolowo)

Hi ku on aka nwina, ku nga endliwa yini ku antswisa matirhelo ya nwina

Hi swihi swinwana mi lavaka ku bula hi swona ng aka ni nga swi vutisangi?

Ndzi khensa nkarhi a nwina na ku ku tinyiketela ka nwina ku va xiphemu xa mbulalaburisa lowu

ANNEXURE F: KEY INFORMANT INTERVIEW GUIDE

Interview number:				
Demographic Information of the Participants				
Age	23-29	30- 35	36- 45	46 -60
Designation	Team Leader	OPM	Dietician	Social Worker
Number of Years in working in this Position(Tick where appropriate)	0-2	3-5	5-10	10 and above
Facility				
No of years working with CHWs	1	2	2 – 3	4 - above
Members of your WBOT team				
Number of community health workers in your team				
Average number of household per CHW in your team				
Average number of clients with chronic illnesses				
Average No of Clients referred by CHWs	100	100-200	300-400	400-500
No of Household your team support is supporting				
Training received	None	59days	Phase 1	Phase 2

related to Community Health worker Training		Home based Care	Reengineering	Reengineering
Time interview started				
Time finished				
Duration				
Date				

SECTION B: KEY INFORMANT QUESTIONS

Can you please share with me how you became a WBOT team leader and what it means to be a team leader? Probe What do you like most about being a WBOT leader? What do you like least about being a WBOT leader?
What is your role as the WBOT team leader? Probe How would you describe your working with CHWs?
In your view, what motivates your team in their work? Probe What motivates CHW in doing their work? What motivates you to do your work.
How would you describe the relationship of your WBOT team and the clinic you are attached to? Probe

What is your relationship as the team leader with the clinic you are attached to?
How would you describe your relationship as the WBOT team leader and the team? Probe: How would describe your relationship with each member of your team? How would describe your relationship with CHWs
What challenges do you encounter in your role as a WBOT team leader?
What challenges do you think your WBOT team encounter in the community?
What challenges do think your CHWs encounter in the community? Probe What challenges do CHWs encounter when working with clients with chronic illnesses In your view, how do they deal with the identified challenges? In your view, do they deal with these challenges adequately? Why? How do you assist them in dealing with those challenges?
What challenges do you encounter during your day to day work and how do you deal with these challenges? Probe: In your view, how should these challenges be prevented? If you were given an opportunity to organise the WBOT team and ensure their effectiveness in the community, please share with me how you would go about it? How would you reorganise the CHWs work to ensure effectiveness and better health outcomes?
What motivates you to keep doing your work?
Thank you

ANNEXURE G: INFORMED CONSENT FORM

TITLE: COMMUNITY HEALTH WORKERS EXPERIENCES WHILE CARING FOR PATIENTS WITH CHRONIC ILLNESSES IN JULESBURG LOCAL AREA CLINICS, MOPANI DISTRICT IN LIMPOPO, SOUTH AFRICA.

RESEARCHER: Mashele T.J
MPH STUDENT
SUPERVISOR: Prof XT Maluleke

PURPOSE

As trained Community Health worker, I am inviting you to share your experiences for the period you have been caring for patients and the household members with chronic illnesses. The purpose of this research is to have an insight of your experiences as most of your time you work independently. Although the study will not benefit you directly, the information obtained may help in improving the working conditions of Community Health Workers.

RISKS

There should be no risks or discomfort during the research to you during sharing your experiences. The research will be conducted in an office on a one on one interview session with the researcher. You will have chance to talk freely in the language of your choice Sesotho, Xitsonga or English. Voice recordings will be done by me and later put in writing for analysis purposes, in a language that you will be comfortable with.

TIME COMMITMENT

The group discussion will take not more than 1 hour during the time, at the facility you are working with. There will be no remuneration for participating in the study.

ANONYMITY AND CONFIDENTIALITY

The researcher will personally keep a record of who participated in the study. I will keep the voice recordings together with the transcripts of the tapes. Your name will not be on the tape or transcriptions of those tapes, so the data will not be linked with your name. Your name will not be revealed when the study is reported or published. If quotations will be in the report, a pseudo name will be used for an example Mrs X.

VOLUNTARY CONSENT AND OPTION TO WITHDRAW

Your participation is totally voluntarily. You are not forced to participate. You have the right to withdraw anytime if you feel like doing so without repercussion or penalty even in the middle of the discussion.

APPROVAL

The study has been approved by the appropriate committee of the University of Limpopo. The Department of Health is informed.

MY CONTACT INFORMATION

If you have any question about the study or about participating in the study, please feel, free to contact me (Mashele Tintswalo Johanna)
Cell phone no. 078421 5012/0828781543
Email address tintswalom@gmail.com
Facebook Johanna Mashele

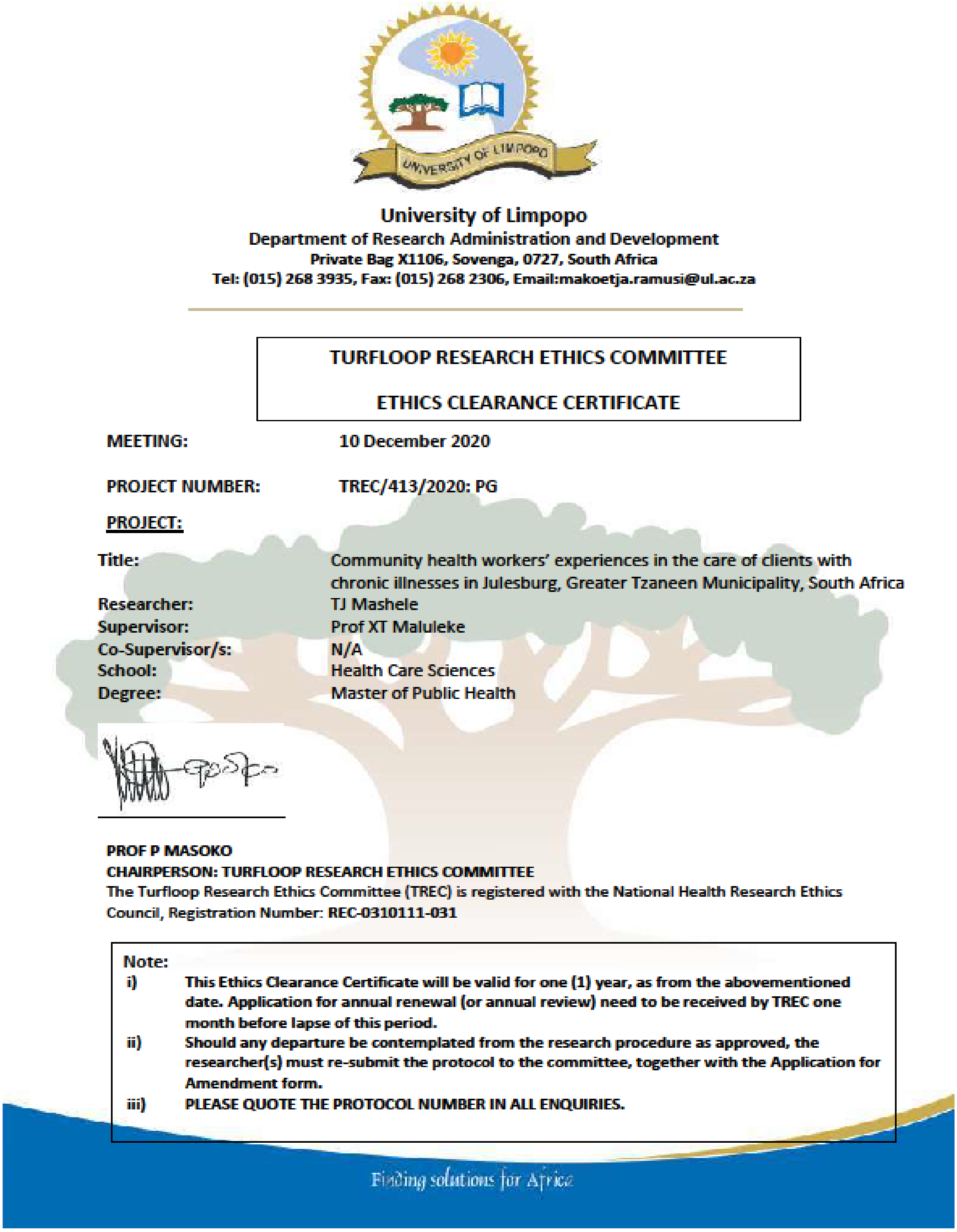
I have discussed the above points with the participants. It is my opinion that the participant understands the risks, benefits, and obligations involved in participating in this study.

…………………………………………. ……………………………….
Researcher Signature Date

I, the undersigned, fully understand that my participation in this study is voluntary and that I may refuse to participate or withdraw m consent band stop participating at any time without penalty. I am aware that the researcher will use an audio-voice recorder during the discussions or interviews.

I hereby freely consent to take part in this study.
………………………………….. ……..................................
Participant Signature Date

ANNEXURE H: ETHICS CLEARANCE CERTIFICATE



University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email:makoetja.ramusi@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 10 December 2020

PROJECT NUMBER: TREC/413/2020: PG

PROJECT:

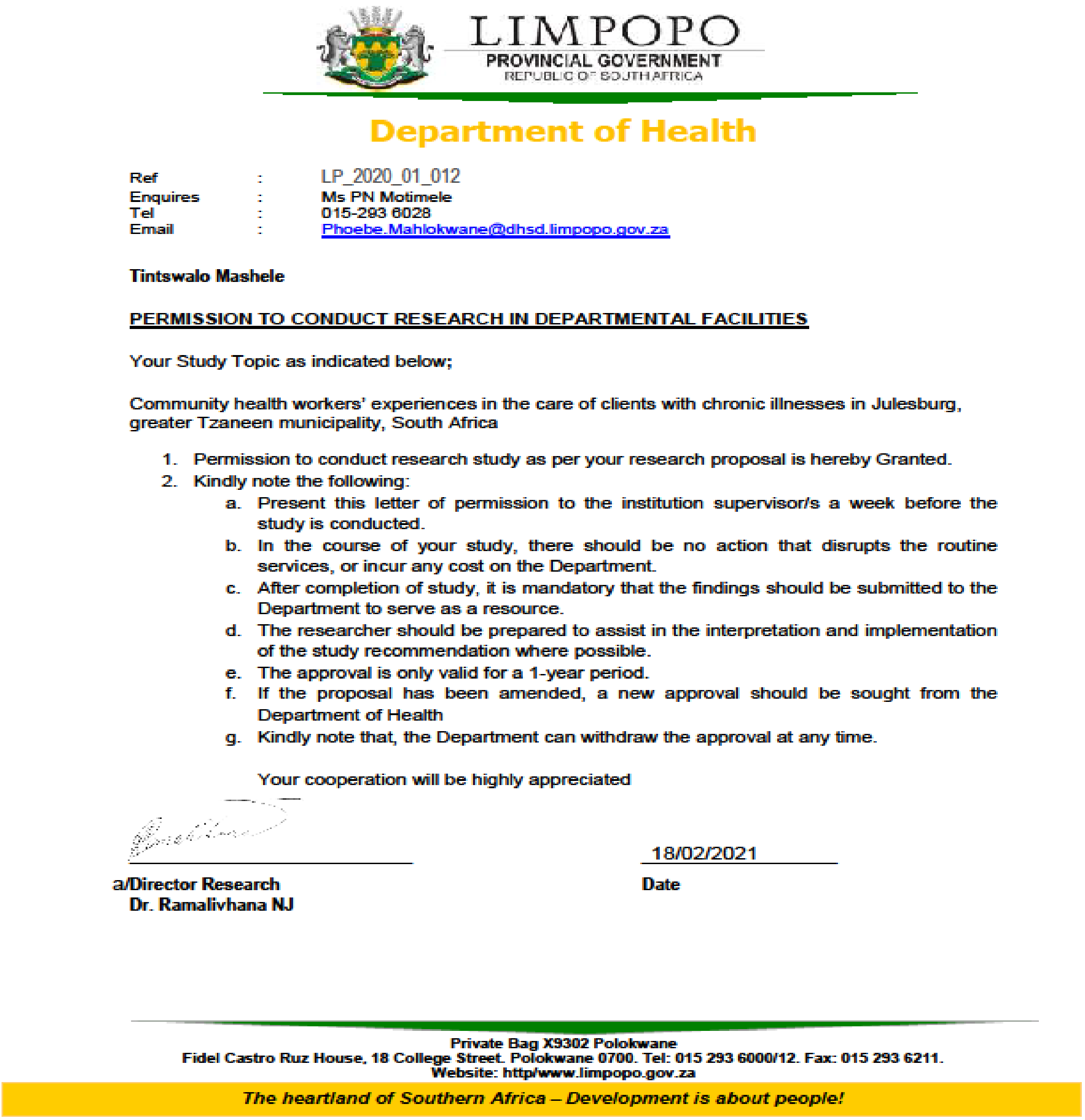
Title:	Community health workers' experiences in the care of clients with chronic illnesses in Julesburg, Greater Tzaneen Municipality, South Africa
Researcher:	TJ Mashele
Supervisor:	Prof XT Maluleke
Co-Supervisor/s:	N/A
School:	Health Care Sciences
Degree:	Master of Public Health

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE
The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: REC-0310111-031

Note:
- i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**
- ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**
- iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

ANNEXURE I: PERMISSION LETTER TO CONDUCT THE RSEARCH FROM THE DEPARTMENT OF HEALTH



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

Department of Health

Ref	:	LP_2020_01_012
Enquires	:	Ms PN Motimele
Tel	:	015-293 6028
Email	:	Phoebe.Mahlokwane@dhsd.limpopo.gov.za

Tintswalo Mashele

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

Community health workers' experiences in the care of clients with chronic illnesses in Julesburg, greater Tzaneen municipality, South Africa

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
    a. Present this letter of permission to the institution supervisor/s a week before the study is conducted.
    b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
    c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    e. The approval is only valid for a 1-year period.
    f. If the proposal has been amended, a new approval should be sought from the Department of Health
    g. Kindly note that, the Department can withdraw the approval at any time.

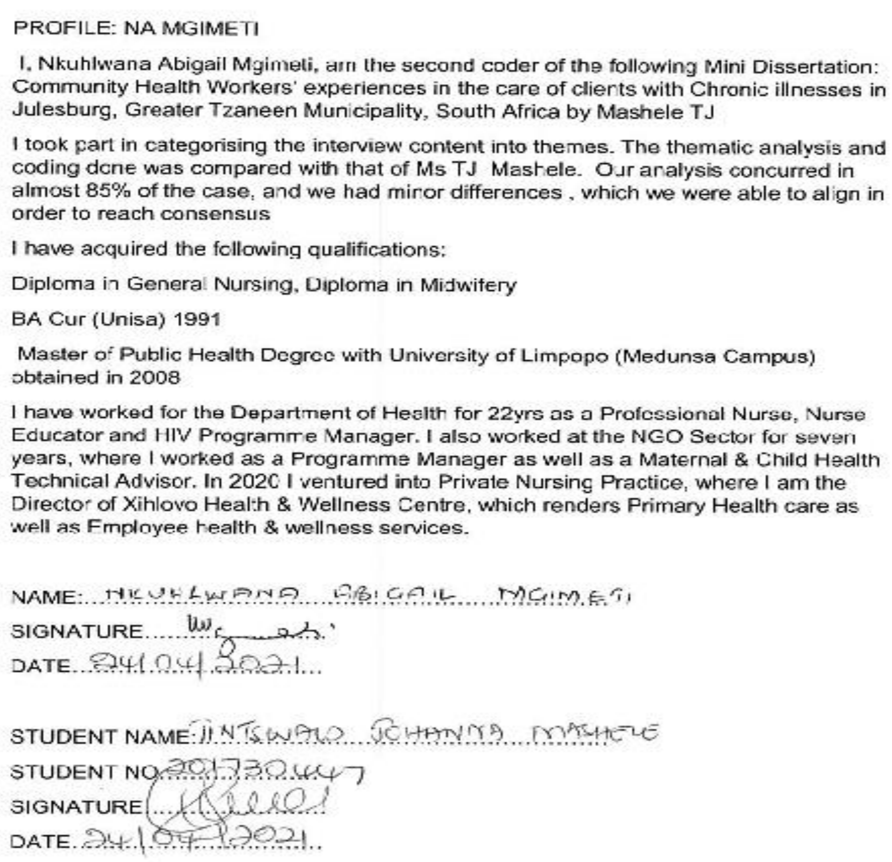
Your cooperation will be highly appreciated

18/02/2021

a/Director Research
Dr. Ramalivhana NJ

Date

ANNEXURE J: LETTER FROM THE EXTERNAL CODER



PROFILE: NA MGIMETI

I, Nkuhlwana Abigail Mgimeti, am the second coder of the following Mini Dissertation: Community Health Workers' experiences in the care of clients with Chronic illnesses in Julesburg, Greater Tzaneen Municipality, South Africa by Mashele TJ

I took part in categorising the interview content into themes. The thematic analysis and coding done was compared with that of Ms TJ Mashele. Our analysis concurred in almost 85% of the case, and we had minor differences , which we were able to align in order to reach consensus

I have acquired the following qualifications:

Diploma in General Nursing, Diploma in Midwifery

BA Cur (Unisa) 1991

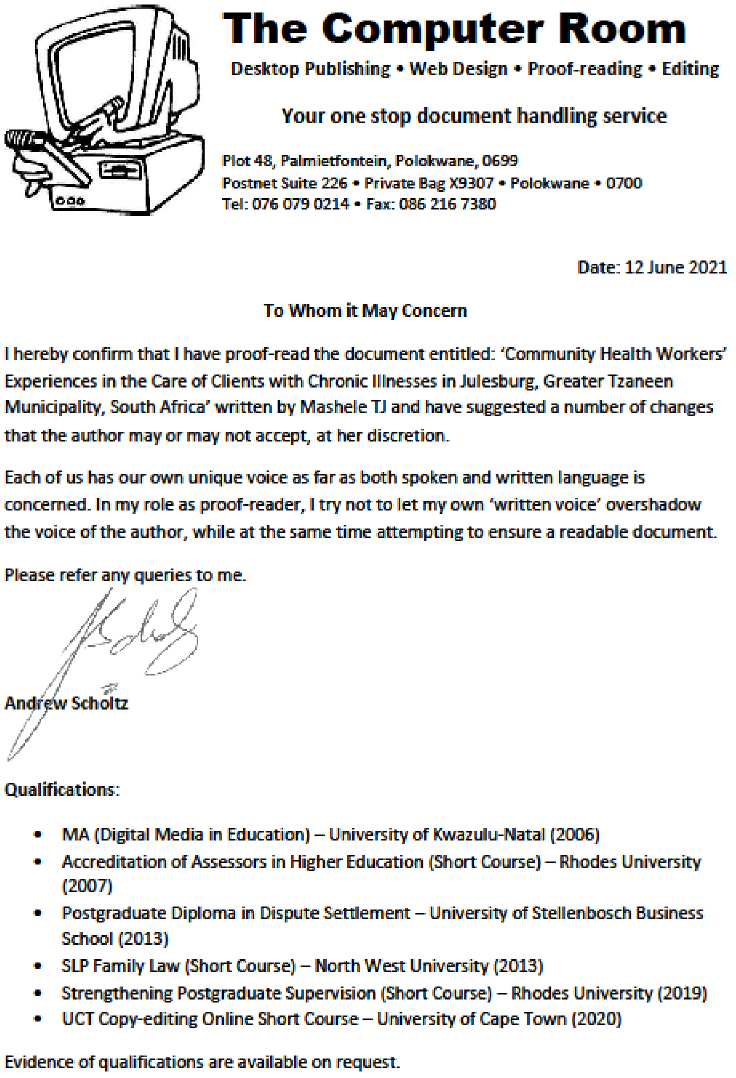
Master of Public Health Degree with University of Limpopo (Medunsa Campus) obtained in 2008

I have worked for the Department of Health for 22yrs as a Professional Nurse, Nurse Educator and HIV Programme Manager. I also worked at the NGO Sector for seven years, where I worked as a Programme Manager as well as a Maternal & Child Health Technical Advisor. In 2020 I ventured into Private Nursing Practice, where I am the Director of Xihlovo Health & Wellness Centre, which renders Primary Health care as well as Employee health & wellness services.

NAME: NKUHLWANA ABIGAIL MGIMETI
SIGNATURE
DATE 24/04/2021

STUDENT NAME: TINTSWALO JOHANNA MASHELE
STUDENT NO 201730447
SIGNATURE
DATE 24/04/2021

ANNEXURE K: LETTER FROM THE LANGUAGE EDITOR



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Date: 12 June 2021

To Whom it May Concern

I hereby confirm that I have proof-read the document entitled: 'Community Health Workers' Experiences in the Care of Clients with Chronic Illnesses in Julesburg, Greater Tzaneen Municipality, South Africa' written by Mashele TJ and have suggested a number of changes that the author may or may not accept, at her discretion.

Each of us has our own unique voice as far as both spoken and written language is concerned. In my role as proof-reader, I try not to let my own 'written voice' overshadow the voice of the author, while at the same time attempting to ensure a readable document.

Please refer any queries to me.

Andrew Scholtz

Qualifications:

- MA (Digital Media in Education) – University of Kwazulu-Natal (2006)
- Accreditation of Assessors in Higher Education (Short Course) – Rhodes University (2007)
- Postgraduate Diploma in Dispute Settlement – University of Stellenbosch Business School (2013)
- SLP Family Law (Short Course) – North West University (2013)
- Strengthening Postgraduate Supervision (Short Course) – Rhodes University (2019)
- UCT Copy-editing Online Short Course – University of Cape Town (2020)

Evidence of qualifications are available on request.