UNIVERSITY OF THE WESTERN CAPE

Title: Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering Primary Health Care services.

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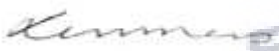
Declaration

I declare that "Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering Primary Health Care services" is my own work, that has not been submitted for any degree or examination in any other university and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Lynette Louisa Temmers

Signed: 

Date: 11 November 2019

Acronyms and Abbreviations

PHC	Primary Health Care
CHWs	Community Health Workers
NPO	Non-Profit Organisations
CBS	Community Based Services
OM	Operational Managers
WCDoH	Western Cape Department of Health
WHO	World Health Organisation
SDG	Sustainable Development Goals
UHC	Universal Health Care
SDH	Social Determinants of Health
FGD	Focus Group Discussions
KII	Key Informant Interviews
NHI	National Health Insurance
WBPHCOT	Ward-based Primary Health Care Outreach Teams
VHV	Village Health Volunteer
ASHAS	Accredited Social Health Activists
BRACS	Building Resources Across Communities

Definition of key terms

Community health workers are defined by the WHO (2016, 8) as "Community health workers should be members of the community where they work, should be selected by communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organisation, and have shorter training than professional workers."

Non-profit organisations (NPOs) refer to an organisation "established for public purpose" and "the income and property which are not distributable to its members accept as reasonable compensation for services rendered" (Western Cape Government 2009, 1).

Collaboration will be defined and used as an agreement between different sections both private and public, to work with each other to improve health (Public Health Agency of Canada, 2016; Ullah et al., 2006).

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Abstract

Background

Community health workers (CHWs) are integral to improve Primary health care (PHC) coverage, utilising their unique skills within the community to make services accessible and equitable. PHC is the cornerstone of the National Health Insurance (NHI) Bill for the provision of Universal Health Care (UHC). The Department of Health (DOH) in the Western Cape, South Africa, has set priorities and requirements for the provision of funding to Non-profit organisations (NPOs) for forming coalitions with the Health Department to deliver various aspects of health care. The post-2015 agenda of the Sustainable Development Goals (SDGs) are underscored by a strong sense of intersectoral collaboration to work together to attain sufficient and sustainable progress. Collaboration between CHWs and PHC facilities is important in aligning goals and activities to ensure a comprehensive and sustainable approach to ensuring UHC. However, there is little evidence documented on the experiences of CHWs performing the activities agreed upon and how they collaborate with PHC facilities to deliver PHC services to achieve the SDGs by 2030.

Methodology

This study aims to describe the factors that influence collaboration between CHWs and PHC facilities in delivering PHC services in a rural sub-district. A qualitative explorative study design was employed to provide an in-depth description of the factors influencing collaboration, as perceived by CHWs. Two data collection techniques were utilised in this qualitative inquiry: focus group discussions (FGDs) and key informant interviews (KIIs). Three FGDs consisting of four to five participants, totaling thirteen (13) CHWs, were conducted. Six KIIs were conducted with the Community based service (CBS) district programme coordinator, the CBS sub-district programme coordinator, the two NPO supervisors, and the two operational managers respectively. Data was analysed manually using a thematic analysis approach. Ethical standards and rigour were applied throughout the research process.

Results

The study findings indicated a discrepancy in the understanding of the roles and responsibilities of CHWs among PHC facility staff. These discrepancies create a barrier between CHWs and the PHC facilities. The lack of formal accreditation for CHWs and a compatible salary impact how CHWs are perceived by PHC staff. They do not perceive them as valuable team members and are often seen as subordinates. These negative attitudes influence their self-image and self-worth within their work environment and therefore, how they relate to staff at PHC facilities. Supervision practices are ineffective, with poor support from PHC facilities. The health system factors further affect the credibility of CHWs within the community, which directly impacts PHC services.

Conclusion

Collaboration efforts were found to be poorly implemented, leading to fragmented service delivery. The factors influencing collaboration need to be addressed to ensure that the barriers to effective collaboration and coordinated action of PHC services, can be resolved.

Key words: Community Health Workers, Non-profit Organisations, Sustainable Development Goals, Community Based Services, Primary Health Care, Department of Health, Collaboration, National Health Insurance, Rural District, Focus Group Discussions.

Chapter 1: Introduction

1.1 Background

The Alma-Ata Declaration of 1978 proposes a shift in focus from predominantly curative services to that of disease prevention and health promotion, and cites intersectoral action as integral for a comprehensive PHC service (Beard & Redmond, 1979). During the apartheid era in South Africa, non-whites were denied access to basic health services and minorities attempted to provide health care despite the segregation and disparities enforced by the political regime (Kautzky & Tollman, 2008; Li, Maillacheruvu & Mcduff, 2014). The need for knowledgeable nurses, capable of rendering PHC services was identified, and nurses were trained to take ownership of this service (Kautzky & Tollman, 2008). With the liberation of South Africa in 1994, the National Department of Health (NDOH) envisioned the implementation of PHC to address health inequities (Kautzky & Tollman, 2008).

In 2019, the NHI Bill adopted in South Africa, aims at providing quality and equitable health care to everyone (Naidoo, 2012; South African National Department of Health, 2017). This includes health access to all populations, including those marginalised due to social circumstances, and the provision of a comprehensive package of care at an affordable cost to all people (National Department of Health, 2017). The implementation of the NHI Bill preambles a re-engineering of PHC service delivery. CHWs currently form part of front line health providers and facilitates access to PHC within communities (Sanders & Lehman, 2007). For the implementation of the NHI Bill, health systems must be strengthened to accommodate the population at the community level within the public health sector. Health system strengthening would require reorienting funds to ensure a sustainable funding mechanism to implement and maintain quality, available, and accessible PHC services.

The Western Cape Department of Health (WCDoH) provided guidelines for the implementation of the three streams of PHC re-engineering, which supports the NHI objectives (South African National Department of Health, 2018). These streams include: School Health, District Based Specialist Teams, and Ward Based PHC Outreach Teams (WBPHCOT) (Pillay & Barron, 2011; Sanders et al., 2017). The NDOH has adopted the WBPHCOT programme as a strategy to achieve UHC. The WBPHCOT strategy was first rolled out in 2011 where provinces were given the freedom to implement it at their own discretion but this lead to uncoordinated

implementation and action (Sanders et al, 2007). The revised policy framework was launched in 2017 to facilitate the extension of PHC services at community and household level (National Department of Health, 2018). The revised policy does not make provision for the resources needed to implement the WBPHCOT programmes to achieve the SDGs for UHC. The policy also does not consider the impact of CHWs employed by the NPO sector and how this will affect PHC services considering current practices. WBPHCOTs comprise of a multi-disciplinary team lead by a nursing sister, and include CHWs who work in designated households within geographical areas within the community (Pillay & Barron, 2011; Sanders et al., 2017). This is in line with the goal of Healthcare 2030 to provide households with access to a CHW (Western Cape Government Health, 2014). Healthcare 2030 focusses on facilitating a holistic approach to wellness by strengthening PHC and CBS (Western Cape Government Health, 2014). The establishment of WBPHCOTs is integral to provide support for PHC service delivery in preventing disease and facilitating access to services (Sanders et al., 2017).

Primary level care is the first point of contact the community has in accessing health care and is based on the principle of equity (Payne et al., 2017; Schaay & Sanders, 2008). CHWs have been extensively used to increase coverage of services to marginalised communities to improve access to PHC (Haines et al. 2007). CHWs serve as the link between the community and the formal health sector, making PHC accessible to disadvantaged and hard to reach communities (World Health Organisation (WHO), 2018). CHWs are integral in the achievement of PHC objectives in areas with TB/HIV prevalence, and to ensure maternal and child health (Bhutta, Lassi & Pariyo, 2013; Tshitangano & Olaniyi 2018).

CHWs' main focus is health promotion and the prevention of illness, where a professional nurse serves as the intermediary between CHWs and the PHC facility, while ensuring that their goals are aligned with PHC facilities (Sanders et al., 2017; Pillay & Barron, 2011). Thus, CHWs are essential in improving PHC coverage with their unique skills within the community, making services accessible and equitable, which is the cornerstone of the NHI policy.

The Western Cape Province has opted to continue with contractual agreements with NPOs for CHWs, despite the uptake of CHWs in the government sector in other provinces (Schneider & Nxumalo, 2017). The DOH in the Western Cape has set priorities and requirements for the provision of funding to NPOs for forming coalitions with them to deliver various aspects of

health care (WCDoH, n.d.). The services provided by NPOs include intermediate care, home and community-based care, community mental health, nutrition projects, providing a preventative service in high transmission area projects, NPO driven wellness centres, and facility-based counselling (WCDoH, n.d.).

In the Western Cape Province, NPOs are required to apply for funding through a formal application, outlining the activities to be performed and expected budget requirements associated with the activities (WCDoH, n.d.). A contractual agreement is agreed upon between the NPO and DOH based on the proposed health needs with funding requirements that include reports, specifically: monitoring and evaluation, financial reports, and quarterly performance reports (WCDoH, n.d.). CHWs and PHC facilities are expected to adhere to the requirements outlined in the contractual agreement and are thus dependent on each other to perform the activities outlined in this partnership. To facilitate this partnership and provide an effective PHC service that will improve the overall health of populations as envisaged in the SDGs requires coordinated efforts by both sectors.

The post-2015 agenda of the SDGs are therefore underscored by a strong sense of intersectoral collaboration to work together to attain sufficient and sustainable progress (Nunes, Lee & O'Riordan, 2016; Stibbe, Reid & Gilbert, 2018). The SDG 3, with its focus on healthy living and the promotion of well-being, address and encompass targets related to PHC activities (Nunes, Lee & O'Riordan, 2016). To achieve progress in health and sustainable development that addresses the social determinants of health (SDH), collaboration with other sectors is needed (Nunes, Lee & O'Riordan, 2016).

Collaboration between CHWs and PHC facilities is important in aligning goals and activities to ensure a comprehensive and sustainable approach to health issues. However, there is little evidence documented on the experiences of CHWs performing the activities agreed upon and how they collaborate with PHC facilities to deliver PHC services with the objective of achieving the SDGs by 2030.

1.2 Problem statement

Collaborations between NPOs and PHC facilities are important to ensure that their goals and activities are aligned to provide a comprehensive approach to addressing the health issues of the community. Currently, NPO activities and PHC services are coordinated through the following fora: meetings, referral systems, monthly and quarterly reports, and feedback meetings. However, anecdotal evidence suggests that these sectors are actually working parallel to each other instead of working together and setting common goals. This lack of collaboration for integrated and operational action has hampered the achievement of the SDGs (Nunes, Lee & O'Riordan, 2016). The absence of effective collaboration and coordination of PHC services (with other sectors/with the NPO) have a negative impact on the achievement of SDG 3 for health and the promotion of well-being, and SDG 19 that proposes partnerships to achieve goals for interactions with other sectors that facilitates sustainable PHC activities (Stibbe, Reid & Gilbert, 2018).

1.3 Significance of the study

The results of the study will provide valuable insight into the collaboration between CHWs and PHC facilities in the public health sector, which is not a well-established field of inquiry. Within the context of Healthcare 2030 and the proposed NHI, the findings of the study can be used to facilitate evidence-based planning and provide guidance on the development of action plans on how to incorporate and collaborate with CHWs employed by the NPO in the achievement of PHC service delivery. More specifically, the study can be used to develop suggestions for practical guidelines to implement effective and efficient collaboration between CHWs and PHC facilities. On a macro level, the study contributes to providing insights into an anticipated policy on information sharing and planning, integration, and supporting CHWs in the health system to improve PHC service delivery.

1.4 Outline of the research

The thesis consists of seven chapters and numerous appendices used during the study. Chapter one contains the introduction to the study, the problem statement, and the significance of the study. Chapter two discusses the literature relating to intersectoral collaboration between the public health sector and NPOs. In addition, the literature gives a critical review of the factors that is known to affect collaboration with specific reference to CHWs and PHC facilities. Chapter three provides an outline of the methodology, describing the research aim and objectives, study design, participant selection, data collection, and analysis. Furthermore, it describes how rigour was applied throughout the study. The ethical principles considered are touched on in chapter four. The fifth chapter reports on the results, using verbatim quotes to substantiate the findings. Chapter six discusses definitive themes that emerged in the findings and how it relates to previous studies and the implications thereof. Chapter seven concludes the study by relaying recommendations based on the study findings. Lastly, the appendices include the informed consent forms, the interview guides used, the code book, and the ethical clearance received.

Chapter 2: Literature review

This chapter is a review of the current knowledge on intersectoral collaboration and how it relates to CHWs and the PHC facilities. It provides a comprehensive view of the factors known to influence collaboration and its impact on the provision and access to PHC services.

2.1 Primary health care

The PHC approach addresses the growing burden of disease in low and middle-income countries, enabling progress towards UHC for the achievement of the SDGs (Ozano et al., 2018). The objectives of PHC are to provide essential health care through prevention, promotion, cure, and rehabilitation with a holistic approach within communities, thereby making health accessible, affordable, and equitable for all (Walley et al., 2008). PHC requires different sectors to collaborate with each other for the provision of an integrated service that treats the patient as a whole within the context of his community and his unique circumstances (World Health Organisation, 2017).

UHC gives all people in a population the opportunity to access good quality and cost-effective health care, leading to productive populations which will ultimately improve the economy of countries (World Health Organisation, 2017). Through the implementation of PHC, access to UHC is enabled, facilitating the development of healthy countries with supportive environments for the population (National Department of Health, 2017; World Health Organisation, 2017).

The United Nations adopted the SDG goals which aimed at improving the "social, environmental, and economic dimensions" within populations (Nunes, Lee & O'Riordan, 2016:01; World Health Organisation (WHO), 2018). As proposed by the Alma-Ata Declaration, successful PHC implementation requires working with other sectors (Nunes, Lee & O'Riordan, 2016; Walley et al., 2008). This will ultimately result in achieving UHC and SDG 3 which relate to health and wellbeing.

In South Africa, the proposed implementation of the NHI Bill is aimed at addressing the social and health inequities faced by many South Africans as a result of the previous apartheid regime, and making PHC more accessible (Marten et al., 2014). UHC can only be achieved by sustained support and consistent economic funding by all countries (Marten et al., 2014).

However, it has become apparent that the health sector alone cannot address the growing burden of disease and the involvement of other sectors is needed to address the SDH (Anaf et al., 2014).

2.2 International experience and overview of CHW Programme

CHWs have been used extensively to increase coverage to marginalised communities as frontline health workers to improve access to health care (Haines et al., 2007; Payne et al., 2017). They extend PHC services within the communities to individual households. CHWs have diverse roles both locally and internationally, are indigenous to their communities, and have minimal to no formal training (Bhutta, Lassi & Pariyo, 2013). CHWs have been used in the private and public sectors, as well as in NPOs for the achievement of their goals. CHWs' primary roles are derived from the objective of their funder or employer (Schneider, Hlophe & Van Rensburg, 2008).

Brazil improved its PHC coverage to 70% of the population (WHO, 2008) by extending PHC services to hard to reach and impoverished areas, and concurrently reducing the burden on higher-level care for PHC conditions (Marten et al., 2014). Whereas in India, the government has committed themselves to provide financial support for the extension of both primary and secondary health care with the expansion of PHC, making health services more accessible and affordable within the country to achieve UHC (Lahariya,2018; Marten et al., 2014).

In Malawi, CHWs were initially tasked to assist with a cholera outbreak, but with the declaration of Alma-Ata, they were assigned to provide basic healthcare services within the communities, focusing on prevention, promotion, and rehabilitation (Smith et al., 2014). In addition, tasks were regularly amended to include clinical roles such as family planning, dispensing medications, and nutritional programmes for children, all of which are tasks within the scope of higher level cadres for which additional training was provided (Smith et al., 2014). In Bangladesh, CHWs improved DOTS (directly observed treatment, short course) coverage to 90-95%, increased tuberculosis case detection rate from 24% to 32%, and achieved a treatment success rate of 84% (Ullah et al., 2006).

Remuneration for CHW programmes is dependent on donor-funded or international donors/ domestic resources. These are often short-term funding that lacks stability and are unable to sustain programmes for extended times (Dahn et al., 2015). Donor funding is usually specified for specific interventions (Dahn et al., 2015). There is a long debate on CHW remuneration

whether they should be paid or volunteers (Singh et al. 2015). The Building resources across communities (BRAC) CHWs in Bangladesh has been compensated with incentives while Accredited social health activists (ASHAs) from India are paid according to specific health related activities done in the community (Singh et al. 2015). A definitive link has been made between remuneration and motivation to fulfill certain roles (Singh et al. 2015).

A volunteer CHW programme in India received incentives which included occasional monetary compensation subsidised by government, which collapsed due to inconsistent funding and growing expectation from CHWs for competitive remuneration (Sanders & Lehman, 2007; WHO, 2016). In a study including India, Bangladesh, and Pakistan donor funding was only approved for NPOs that had links with the formal health sector (Batley & Rose, 2011) to accomplish shared goals (Huxham & Vangen, 1996).

Various roles have been attributed to CHWs according to the priorities of their funder or the need from government, such as health promotion and prevention, adherence, screening, linking facilities with the communities, providing support to communities, data collection, the treatment of basic clinical conditions, and advocating for the community (Olaniran et al.,2017). NPOs are largely dependent on donor funding thus much of their priorities are focused on delivering services requested by the funder, or government, while still being able to function within their own boundaries (Batley & Rose, 2011). However, NPOs can also pose a threat to government, as these organisations often has a dual responsibility within the community in rendering services as well as campaigning for the needs of the community (Batley & Rose, 2011).

NPOs have been used specifically to support the government in service provision and extend coverage due to their closer relationship with communities (Batley & Rose, 2011; Rosenberg, Hartwig & Merson, 2008; Shipton, Zahidie & Rabbani, 2017). NPOs are considered to be more successful in achieving targets and expanding coverage through their community orientated relationship (Batley & Rose, 2011; Huxham & Vangen, 1996). In addition, NPO's are considered effective in bridging the gap in health services the public sector is unable to provide (Ejaz, Shaikh & Rizvi, 2011; Shipton, Zahidie & Rabbani, 2017). Their success is attributed to their role within communities, creating ownership of initiatives, and implementation of projects initiated and supported by the community (Sanders & Lehman, 2007).

CHWs were found to be effective when they have a regulatory framework guiding their roles and responsibilities (Kok et al., 2015). In addition, when a clear understanding of CHW roles exist, it was found that PHC staff was able to utilise them appropriately, complementing existing services rendered by the PHC facility (Payne et al., 2017; Sips et al., 2014).

A clear understanding and appropriate utilisation of CHWs lead to improved retention of patients and reciprocal referrals between CHWs and facilities, enabling an interconnectedness and continuity of care in various countries (Doede et al., 2017; Payne et al., 2017; Sips et al., 2014). Continuity of care can only be achieved if there is an understanding of the roles and expected responsibilities between the sectors that is based on a relationship conducive to collaboration (Kates et al., 2018).

With clear boundaries and specific responsibility on service delivery, NPOs in Pakistan and India ensured effective linkage between the CHWs and health professionals, thereby improving utilisation of PHC services (Brinkerhoff, 2003). The authors expressed the need for accountability and openness so that common goals can be explored and responsibility for specific roles between the NPO and public sector can be clarified to improve PHC services (Ejaz, Shaikh & Rizvi, 2011).

2.3 Overview of the CHW Programme in South Africa

In South Africa, two main types of funding mechanisms exist for CHWs: government and donor funds. The government fund mechanism is a contractual agreement which describes the package of care between the NPO and public health sector that formalises the partnership for CHWs working in the health sector (Daniels, Clarke & Ringsberg, 2012; WCDoH, n.d.). This contract allows for the allocation of funds for CHWs to receive a stipend as either generalist or specialist health workers, as set out in the national CHW policy (Sanders & Lehman, 2007; Schneider, Hlophe & Van Rensburg, 2008).

Daniels, Clarke & Ringsberg (2012), found that there were mixed results on employment of CHWs in South Africa where provision is made by the government to fund NPOs employing CHWs. Government support NPOs with administrative and stipend funding, but the policy does not make allowances for competitive benefits similar to the formal sector (Daniels, Clarke & Ringsberg, 2012). Concurrently, NPOs would lose the financial investment of these funds if the

government were to withdraw their funds. A suggestion was made to shift the focus to capacity building of NPOs and in this way strengthen financial support for CHWs (Daniels, Clarke & Ringsberg, 2012).

Consistent funding from established international donors have improved access to PHC and service delivery, specifically in the area of HIV/AIDS within South Africa (Schneider, Hlophe & Van Rensburg, 2008). These external agencies allocate funds for very specific purposes which has not always been aligned with local PHC goals and therefore, could not be used to address the underlying healthcare issues, as the funder priorities needed to be considered (Schneider, Hlophe & Van Rensburg, 2008). In areas where the NPO is well embedded and sustained within the community with secure funding, projects have proved to be more effective and sustained (Daniels, Clarke & Ringsberg, 2012; Nxumalo, Goudge & Thomas, 2013).

In South Africa, CHWs have both generalist and specialist roles related to the required needs of the nine different provinces of the country. Koon, Goudge & Norris (2013) differentiate between generalist and specialist roles by the training CHWs receive and their job responsibilities. Generalist have longer training with a wide range of responsibilities and specialist have short disease specific or population specific training (Koon, Goudge & Norris, 2013). In Kwazulu-Natal Province, CHWs have been incorporated by the government sector where their roles include ART adherence and care for patients at their homes. In addition, their roles are often extended to other roles such as cooking or cleaning at the home to ensure that patients remain healthy to take medication (Mottiar, Lodge & Group, 2018). Contrary to Kwazulu-Natal Province, in Limpopo Province the CHWs' duties include working within the clinics to accommodate staff shortages and their responsibilities are extended to include blood tests, screening and adherence for TB patients, prevention, and education (Mottiar, Lodge & Group, 2018). However, poor role clarification between PHC facility staff and CHWs lead to poor utilisation of services and attrition of CHWs in South Africa, thereby affecting service delivery (Sanders & Lehman, 2007; Sips et al., 2014).

CHWs often feel as though their contribution towards PHC services are not acknowledged by staff working in PHC facilities and these attitudinal challenges affect how motivated and cooperative personnel are to engage with each other in collaborative activities (Morley & Cashell, 2017; Tshitangano & Olaniyi, 2018). Other personal factors known to affect effective

liaising with one another are trust, empathy, and respect (Anaf et al., 2014; Morley & Cashell, 2017).

The WBPHCOT Policy Framework makes provision for 6-10 generalist CHWs to be part of a team that is responsible for an allocated ward of households. They are supervised by a nursing practitioner and affiliated to a PHC facility (South African National Department of Health, 2018). Unfortunately, implementation of the strategy lacks coordinated support and action from governments, experiences health system challenges, lacks resources and guidance on how to facilitate liaison between CHWs and PHC facilities (Sanders et al, 2007).

2.4 Intersectoral collaboration in delivering PHC services

Coordination between team members facilitates successful partnerships and joint decision making, due to their accumulated knowledge and insights from working together (Morley & Cashell, 2017). The WHO (2017) supports intersectoral collaboration to improve health outcomes and ensure equitable distribution of health services. The collaboration of a wide array of stake-holders provides a comprehensive and sustainable approach to addressing the SDH that impacts health outcomes (Adeleye & Ofili, 2010; Rosenberg, Hartwig & Merson, 2008). Intersectoral collaboration can be used as a strategy for the implementation of PHC services (Chircop, Bassett & Taylor, 2015). This requires that funding be procured for intersectoral collaboration to sustain NPO partners, to encourage advocacy for political and social support, to implement the necessary technological and infrastructure support, to maintain an environment for collaborative practices, and evidence based policies to be implemented (Chircop, Bassett & Taylor, 2015). However, despite sectors working together, there is an unwillingness to take ownership and responsibility, rendering collaboration efforts ineffective (Adeleye & Ofili. 2010).

Collaboration is engaging in coordinated efforts through sharing information and activities where sectors share ownership and responsibility (Morley & Cashell, 2017). This coordinated action, facilitates improvement in health outcomes and quality of care (Morley & Cashell, 2017). In addition, for collaboration efforts to be effective, government support is essential and policies, structures, and leadership must be aligned to encourage coordinated actions (Rosenberg, Hartwig & Merson 2008).

2.5 Factors influencing collaboration

The next section will discuss factors influencing collaboration and their effect on collaboration. The factors explored are health system factors such as organisational structures, supervision, and training. Following this, are enablers for integration into the health system such as policies, mutual sharing of information, and accountability.

2.5.1 Health system factors

2.5.1.1 Organisational structures

Organisational structures between team members can disrupt their interaction with each other as both can vary in terms of what their expectations and level of responsibility within the organisation is (Anaf et al., 2014; Morley & Cashell, 2017). These are worse when differences exist in salaries, positions of authority, procedures, and general processes followed by each individual in the team (Morley & Cashell, 2017). In a study in Cambodia on challenges CHWs experience, they feel more supported and respected for their contribution to health care when governments show support for them and they are seen as part of the team (Ozano et al., 2018). The expectation and reality of CHWs are often to function on the boundary of the health system within households and communities as lowly aides for PHC facility staff (Sanders & Lehman, 2007; Sips et al., 2014; Tulenko et al., 2013).

In Tanzania, an intervention on formal linkage mechanisms between the health sector, CHWs, and ADDO (Accredited Drug Dispensing Outlet) for maternal and child health, emphasised the importance of building a relationship with other sectors to improve access to services and reduce maternal and newborn mortality (Dillip et al., 2017). The implementation of formal interactions between these sectors facilitated improved communication and understanding of each other's roles, which allowed them to work together to compliment services, which in turn improved access to services (Dillip et al., 2017).

In addition, in a qualitative review and a study done in South Africa respectively, it was found that when CHWs are stationed within public health facilities it aided in them being more accessible and visible to staff and the communities where they work, improving communication between them and allowing the formal sector to see them as part of the health system (Payne et al., 2017; le Roux et al., 2015).

2.5.1.2 Supervision

A systematic review showed that a gap exists in the literature on effective approaches to supervision that would enhance CHW confidence in their abilities and role within the public health system (Scott et al., 2018). Both studies in India and Tanzania found that despite regular meetings and supervision to improve collaboration and interactions and linkages made on multiple levels, these are not sufficient and a formal procedure on discussions on role clarity and responsibilities between supervisors and CHWs is required for effective collaboration (Dillip et al., 2017; Srivastava et al., 2016).

The WBPHCOT policy framework and strategy used in South Africa, prescribes supervision of CHWs by a nurse (National Department of Health, 2018). This is often met with resistance, as staff in PHC facilities may already feel overburdened due to weak health systems with staff shortages and therefore, do not provide adequate supervision (Sanders & Lehman, 2007). Supervision in the NPO is provided by nursing coordinators in the Western Cape in South Africa (Sanders et al., 2017). A review on the effectiveness of CHW programmes by Shipton, Zahidie & Rabbani (2017), report less productivity by CHWs due to poor support and supervision practices.

2.5.1.3 Training

Training empowers CHWs with skills that add to their trustworthiness in communities (Scott et al., 2018). A study comparing different countries provided evidence demonstrating CHW programme effectiveness in improving health outcomes where CHWs had been assigned tasks related to maternal and child health (Haver et al., 2015). These programmes were successful due to the support of government who collaborated to align CHW training with PHC, and streamlining services for common goals and targets (Haver et al., 2015). CHWs were thus integrated into the health system and operated as part of the PHC team in achieving their targets.

2.5.2 Enablers for integration into the public health system

2.5.2.1 Policy

Legislation and policies supporting CHWs as a cadre, working in collaboration with the public health sector, is required for effective PHC service delivery and collaboration with PHC facilities (Kok et al., 2015). Integrating CHWs into the public health system allows them to work as part

of the multidisciplinary team who are tasked with making PHC services more accessible within communities (Haver et al., 2015; Schneider, Hlophe & Van Rensburg,2008; WHO, 2017). Tulenko et al. (2013) call on coordinated mechanisms of partnerships between NPOs and the public sector to make CHW programmes sustainable and integrate them into national health care systems. They proposed that governments direct their attention to formalising CHWs as a cadre with accredited, standardised training with occupation specific job specifications to facilitate uptake into the public health system (Siemon, Shuster & Boursaw, 2015; Tulenko et al., 2013).

Chircop, Bassett & Taylor (2015), identified a need for policies guiding the practical implementation of intersectoral collaboration between the NPO and government sector for the achievement of PHC.

2.5.2.2 Mutual sharing of information

For effective collaboration, both the NPO and government should participate in information sharing, monitoring, and planning processes to build on activities with each other whereby both sectors function as partners in the collaboration process, being able to fulfil both mutual and individual targets (Batley & Rose, 2011; Brinkerhoff, 2003; Ejaz, Shaikh & Rizvi, 2011; Srivastava et al., 2016). However, this is not the case, as is evident from a qualitative study in India where NPOs were required to submit their data and reports, but were not included in collaborative review of the data or concurrent planning between government and the NPO as mutual stakeholders (Brooke-Sumner, Lund & Petersen, 2016; Srivastava et al., 2016). Ullah et al. (2006), argue that engaging in shared activities that are aligned with both the priorities of the NPO and the government can help to sustain programmes and improve outcomes.

Furthermore, a qualitative study in India on linkage between the NPO and the government sector concluded that an unequal partnership existed, as government engaged in unilateral decision making on planning and policies which the NPO had to adhere to despite sharing feedback and resources with government (Srivastava et al., 2016). The expectation was that they remain passive participants in the partnership and were not included in mutual planning with government (Srivastava et al., 2016). This is similar to current practices in the Western Cape, South Africa, where the NPO is required to submit monthly and quarterly reports to the DOH on the services rendered by CHWs in the area of PHC, but is not included in planning or information sharing.

In South Africa, the lack of communication and trust between the NPO and the DOH is highlighted in the limited information which is shared with the NPO who is expected to give regular feedback to the DOH (Brooke-Sumner, Lund & Petersen, 2016). This lack of trust resulted in poor interaction with one another, which was further influenced by the absence of formal structures guiding collaboration and the difference in priorities from the two sectors (Brooke-Sumner, Lund & Petersen, 2016).

An environment that is conducive to teamwork between CHWs and staff at PHC facilities enhances patient care and service delivery (Allen et al., 2015). Sustaining this working relationship requires regular, structured interactions where both sectors share and discuss mutual matters to improve health outcomes (Allen et al., 2015; Brooke-Sumner, Lund & Petersen, 2016).

2.5.2.3 Accountability

Facilitators to collaboration are formal structures such as policies, circulars, and documented guidelines that could be followed and adhered to by each of the stakeholders, holding everyone accountable for their roles (Anaf et al., 2014). These policies guide and support both structures, involves sharing of resources which is cost-effective, includes supervision and accountability where both the NPO and government take responsibility for decisions and actions undertaken (Ullah et al., 2006).

To facilitate responsibility and ownership of collaborative initiatives, Tulenko et al. (2013), express the need for the public sector to take the lead in ensuring that goals and strategies are aligned with national policy frameworks that will guide sectors in working together. (Brooke-Sumner, Lund & Petersen (2016), reiterate the need for an organisation to take the lead in the collaboration process to facilitate coordinated action. Contrary Morley & Cashell (2017), define collaboration as a partnership, suggesting that there is a contribution from both sides and that they share equal responsibility.

Adeleye & Ofili (2010), emphasise the need for intersectoral collaboration as proposed by Alma-Ata for effective PHC to address health issues, but acknowledge that in practice there is a lack of accountability by the different sectors, which leads to poor outcomes.

Chapter 3: Methodology

3.1 Introduction

The following section will discuss the aims and objectives of the study, as well as the methodology applied to ensure rigour in this qualitative study. In the methodology, it describes the processes followed to identify the population, sampling, data collection, and analyses.

3.2 Research aim

To explore the factors influencing the collaboration between CHWs and the PHC facilities delivering PHC services in Cape Agulhas Sub-district, Western Cape.

3.3 Objectives

- To explore the current roles and responsibilities of CHWs employed by an NPO delivering PHC services,
- To explore the expected roles and responsibilities of CHWs employed by an NPO delivering PHC services,
- To describe the challenges experienced by CHWs employed by an NPO in delivering PHC services,
- To explore the relationship between community health workers working for an NPO, NPO supervisors, and PHC facility staff,
- To explore the institutional and contextual hindrances and enablers for collaborative integration of CHWs into PHC facilities.

3.4 Study design

A qualitative explorative study was used to provide an in-depth description of the factors influencing how collaboration is experienced between CHWs and PHC facilities (Jack, 2006; Lambert & Lambert, 2013).

During qualitative studies, people are able to express their views and individual realities as they perceive and experience it (Baum, 1995). Through a qualitative approach, the researcher was therefore able to gain a deep understanding from the CHWs on how they experience collaboration processes with PHC facilities, what they perceive to be the challenges and facilitators to collaboration, and what and how they interpret their relationship and interactions

with PHC staff (Robson, 2002). The researcher was able to understand and interpret multiple realities with an emphasis on the specific contexts within which it occurred.

3.5 Setting

The population of Cape Agulhas is estimated at 35,331 consisting of 11,321 households (Western Cape Department: Health, 2017), in the rural Overberg region in the Western Cape. The Western Cape is one of the nine provinces in South Africa. The percentage of early school leavers who do not complete Grade 12 has escalated from 23.7% in 2015 to 27.1% in 2016. These are attributed to unemployment, poverty, teenage pregnancies, households with minimal or no incomes, and indigent households (Western Cape Department: Health, 2017). Within Cape Agulhas there is an increase in access to sanitation, refuse removal, electricity, and housing compared from 2011 to 2016 (Western Cape Department: Health, 2017). However, there are still households who struggle with these basic needs, as the decline in access to piped water from 99.3% in 2011 to 93.2% in 2016 shows (Western Cape Department: Health, 2017). There are also still areas on the outskirts of the towns with informal housing whose basic needs are not met.

PHC services for HIV, TB, child health, and maternal health have shown improvements in access and targets from 2014 to 2016 with only teenage pregnancies showing a rise from 8.3% to 10.5% (Western Cape Department: Health, 2017). More people have been registered for both ART and TB treatment (Western Cape Department: Health, 2017). There are three towns that have a PHC facility that provides daily services and there is one district hospital for the Cape Agulhas area. In two towns they have satellite clinics and there are two mobile clinics that service the farms. Concurrently, emergency services in Cape Agulhas are on par with the rest of the Overberg, but access considering the distances to travel in rural areas remains a challenge (Western Cape Department: Health, 2017).

3.6 Study population

The population identified for the study consisted of CHWs and key informants who work with and have key information on the interactions between CHWs and PHC facilities in the Cape Agulhas sub-district. The study is comprised of five (5) study populations:

1. Community health workers in a sub-district. There are 31 CHWs in the Cape Agulhas sub-district working for a local non-profit organisation and being supported by the Department of Health.
2. Clinical nurse supervisors. There are currently two who are employed by the NPO.
3. Community based service (CBS) district programme coordinator. There is only one employed by the Department of Health for the Overberg Region.
4. Community based service (CBS) programme coordinators. There are currently three in the Overberg Region, one per sub-district.
5. Operational managers. There are four operational managers across the PHC clinics of the Cape Agulhas sub-district.

3.7 Sampling

Purposive sampling was used to select the participants from the different populations described above to provide insight and detailed descriptions on how they experience and understand the collaboration between CHWs and the PHC facilities to deliver PHC services (Ritchie, Lewis & Elam, 2003).

Stage 1: Selection of sub-district

Cape Agulhas sub-district was selected, as the researcher is familiar with the area, she is employed there, and it thus allowed for easy access.

Stage 2: Selection of towns

Bredasdorp and Napier are two of the five towns comprising the rural Cape Agulhas sub-district. The two towns were selected, as the biggest part of Cape Agulhas population is derived from Bredasdorp, and Napier has similarities with the other towns. Of the Cape Agulhas population, 50% reside in the Bredasdorp area while 13.7% reside in Napier. They have similar demographic community profiles and health care services as the surrounding smaller towns. They are also the towns with the biggest concentration of CHWs, with fifteen (15) and six respectively.

Stage 3: Selection of CHWs

Twelve CHWs were selected from Bredasdorp and divided into two groups of six based on the inclusion criteria. At the time of the first FGD, one of the CHWs withdrew due to personal

reasons and only five participated. With the second FGD, one of the CHWs were ill and another did not attend therefore, only four participated.

In Napier there were only five CHWs employed at the time of the third FGD and one CHW was ill, and thus only four participated.

Inclusion criteria:

- Only those CHWs who have attended a one-year training course presented by the Department of Health
- Those who attended training during 2017
- Those who have had at least two years' experience working as CHWs
- Availability of CHWs

Exclusion criteria:

- CHWs who have less than two years' experience working for the NPO
- CHWs working outside Bredasdorp or Napier

Stage 4: Selection of NPO supervisors

NPO nursing supervisors comprise of only two for the sub-district and both were included, as one supervisor works in Bredasdorp and the other renders services in the four smaller towns. Thus, no sampling was conducted.

Stage 5: Selection of CBS programme coordinator

The CBS programme coordinator is the representative from the DOH district office and as there is only one, no sampling was conducted.

Stage 6: Selection of CBS coordinator

The CBS coordinator from Cape Agulhas sub-district was selected as there is only one coordinator per sub-district. Thus, no sampling was conducted.

Stage 7: Selection of operational managers

The operational manager from Bredasdorp (only one) and Napier (also only one) was selected. There is only one operational manager in each town and therefore, no sampling was needed.

3.8 Data collection

Two data collection techniques were utilised in this qualitative inquiry: focus group discussions (FGDs) and key informant interviews (KIIs). The FGDs were conducted with the CHWs, and the KIIs with the CBS district programme coordinator, the CBS programme coordinator for Cape Agulhas, the two NPO supervisors, and the two operational managers. In total, three FGDs consisting of between four to five CHWs each, and six KIIs were conducted.

Data collection was predominantly done in Afrikaans, which is the predominant language spoken in the area, and translated to English during transcription. One FGD consisted of an isiXhosa speaking participant who was proficient in both Afrikaans and English. She preferred to express herself in English which the other participants could also understand.

The researcher purposively sampled those participants who can provide rich information on the study and used appropriate prompts to gain an in-depth understanding of how they perceive and experience intersectoral collaboration (Saunders et al., 2018). Data saturation was achieved when no new information, and subsequently no new themes, emerged from the interviews and FGDs (Saunders et al., 2018).

Data collection commenced in March 2019 and finished in June 2019. Initial contact was made in March when the researcher introduced the research topic and the process to follow during data collection to all selected participants. The researcher audio recorded the interviews and all recordings were transcribed. The transcript from the first FGD was shared with the thesis supervisor to check for completeness and advice on the process.

Focus group discussions

A total of three FGDs were done, two in Bredasdorp and one in Napier. The researcher confirmed an acceptable time, date, and venue to conduct the three FGDs in the two areas with NPO supervisors, and then confirmed the agreed upon time, date and venue with the CHWs two days prior to data collection. A reminder was sent to the NPO supervisor who had daily contact

with the CHWs a day prior and again the morning of the FGDs, using SMS notification. In preparation for the FGDs the two recorders that were used to make audio-recordings of the interviews, were pre-checked and charged to ensure no electronic malfunction. At the start of each FGD, the consent forms and FGD confidentiality binding form was agreed to and signed. The researcher emphasised the confidentiality of the session, safe storing of recordings, and how anonymity and confidentiality will be maintained.

A FGD interview guide was utilised (Appendix 9) to facilitate discussion with members in the group and in this way acquire a wide range of information (Kitzinger, 1995). The FGD interview guide comprised of five open-ended questions which were designed to elicit participant discussions and the exploration of the collaborative processes followed by both the CHWs and PHC staff (Kitzinger, 1995). The FGD guide was used to encourage a discussion on their perceptions of their roles and experiences, opinions, and feelings on what others perceive their roles to be, and their expectations and challenges. The FGD allowed participants to use the group dynamics to comfortably share their views on how they interact with the PHC clinics in the Cape Agulhas sub-district, which provided an opportunity for the expression of multiple views and interpretations (Baum, 1995).

Key informant interviews

Key informant interviews were conducted with the two NPO supervisors, the CBS coordinator (sub-district level), the CBS district coordinator, and the two operational managers. The time, date, and venue for the interviews were arranged with individual key informants and confirmed via a confirmation letter or email. Consent forms were signed before the KII commenced. Audio-tapes of interviews were made and interviews were transcribed verbatim (Legard, Keegan & Ward, 2003). Face-to-face interviews were conducted, enabling the researcher to immediately clarify their perceptions, opinions, and experiences in working with CHWs while exploring deeper than just the surface (Legard, Keegan & Ward, 2003). The researcher ensured that the interviewee was relaxed and comfortable to share experiences by being friendly, maintaining good eye-contact and avoiding leading questions. By establishing this rapport with the key informants it allowed the participants to openly express their feelings and opinions (Legard, Keegan & Ward, 2003). At the end of each interview, the researcher wrote down observations

and the main ideas expressed to add to rigour and prevent researcher bias. The researcher also kept a journal of research decisions made and noted the reasons why (Appendix 18).

A key informant interview guide was developed and translated to Afrikaans for each of the key informants (Appendix 11, 13, 15). The individual interview guides were specifically tailored for each key informant relating to the specific contributions they can make to the study from their perspectives and interactions with CHWs. For example, the operational managers were able to provide information specifically related to operational processes between CHWs and the PHC facilities, while the CBS coordinator was able to report on feedback mechanisms between CHWs and PHC facilities. The KII gave a variety of views and build on the FGDs of the CHWs (Legard, Keegan & Ward, 2003).

3.9 Data analysis

A thematic coding analysis approach, as proposed by Gibbs (2012), was used to analyse the data: familiarisation, coding, identifying themes, defining and naming themes, and finally integration and interpretation.

3.9.1 Familiarisation

The researcher initially made notes on her impressions after each FGD and KII. She then listened to the audio recordings before manually transcribing and translating the data from Afrikaans to English, after which she read the transcripts to familiarise herself with the data (Gibbs, 2012). The researcher was able to write down her initial understanding and meanings from repeatedly reading through the transcripts.

3.9.2 Coding

The researcher coded sections of texts that expressed a specific opinion, concept or behaviour as expressed by CHWs and KI by manually highlighting the sections on the printed transcripts and adding a descriptive code in the margins (Gibbs, 2012). The coding process involves adding meanings to each code (Robson, 2002). A separate code book was created that describes and explains the codes, and this ensured the constant application of the codes (Appendix 17). A master copy of the original transcript was kept to ensure that data source within the context of the transcript remains accurate.

3.9.3 Identifying themes

The researcher continued by categorising similar codes together and identified patterns to see what themes emerge from these categories (Gibbs, 2012). The researcher systematically reviewed and re-assessed the themes. New themes were then created by analysing patterns and links between them.

3.9.4 Defining and naming themes

These themes were named providing an overarching theme that describes the main idea of the grouped themes. Following this process, the researcher reviewed the revised or new themes to ensure that it is reflective of the data and that each individual theme is supported by data.

3.9.5 Integration and interpretation

Clear meanings was derived from the final themes and allowed for interpretation of data to draw conclusions from it and provide insights on the research question (Gibbs, 2012). This enabled the researcher to use the collected data to explain the factors that influence CHW and PHC facility collaboration.

3.10 Rigour

Rigour adds scientific value to the research design and results through the meticulous process undertaken by adhering to the standards set out for qualitative studies (Robson, 2002). Using precise and extensive methods add to the quality of qualitative research (Cypress, 2017). Rigour in this study was achieved through establishing trustworthiness, credibility, reflexivity, and transferability (Malterud, 2001).

3.10.1 Trustworthiness

Polit and Beck (2014), describe trustworthiness as referring to the quality of the study through the methods used during the research process. McCarthy et al. (2018), using Lincoln and Guba's (1985) model, concur that trustworthiness can be maintained through credibility, dependability, confirmability, and transferability. Rigour in this study was thus achieved through establishing credibility, being reflexive, and providing thick descriptions for transferability.

3.10.2 Credibility

Credibility was achieved by demonstrating that the findings are truthful (Shenton, 2004). McCarthy et al. (2018), follow Lincoln and Guba's (1985), criterion for achieving credibility.

They suggest that the researcher should be familiar with the subject being investigated, the organisations involved, and the participants. The researcher is employed by the DOH and familiarised herself with the service level agreement between the NPO and DOH, the scope of practice of participants and KI, and lastly current collaborative practices between them.

Creswell and Miller (2000), define triangulation as the systematic process of developing common themes within the data and confirming this through comparisons. Two types of data triangulation were used: data source and data methods (McCarthy et al., 2018; Shenton, 2004). Data source triangulation was applied by collecting data from CHWs and key informants from both the DOH and the NPO. The KIs of the DOH were from the PHC facilities, and both sub-district and district level and was able to substantiate the views and experiences of CHWs (Shenton, 2004). Triangulation was also done through two different methods of data collection methods employed, namely FGDs and KIIs.

Member checking refers to the researcher checking participants' responses with them. During FGDs and KIIs the researcher summarised the main ideas or confirmed with participants if her understanding of their responses reflected the true meanings as they had intended it, to ensure an accurate account of their views, opinions, and feelings (McCarthy et al., 2018; Shenton, 2004). In this way, the researcher attempted to derive a concise understanding of the experiences and perceptions of CHWs and how they work with PHC facilities within their contexts.

In applying a rigorous study design, the focus in qualitative studies is on credibility, which provides sufficient descriptions and information that make the results of the study believable. To achieve this, the researcher continuously linked the aim and research question to the sampling, methods used, data collection, analysis, and interpretation to ensure quality throughout the process.

Credibility was ensured by using the following mechanisms: systematically conducting the different processes, using method triangulation, and establishing trustworthiness in the data. To be systematic, the researcher provided detailed accounts of the sample selection, data collection and analysis processes. This detailing of methodology enhances the dependability adding to trustworthiness, enabling the use of similar processes by other researchers (Shenton, 2004).

The researcher made a master copy of the data and assigned codes to each transcript. Codes were assigned to participants to ensure their anonymity. The data was copied onto a USB and the researcher's work computer with an encrypted password, only known to the researcher.

Thematic coding was done and the supervisor checked for appropriate coding and correct interpretations. Furthermore, the findings include verbatim transcripts to support the themes in the findings (Creswell & Miller, 2000). This systematic process provides a scientific base from which inferences were drawn to give this qualitative enquiry credibility (Malterud, 2001).

3.10.3 Reflexivity

The researcher endeavored to be reflexive throughout the research process, through regular reflection (Creswell & Miller, 2000; Malterud, 2001). To address researcher bias, a journal was kept detailing feelings, opinions, and own beliefs during the research process. According to Malterud (2001), an awareness of the researcher's own pre-conceptions and opinions on a phenomenon adds to richness of the data.

Before each FGD and KII the researcher declared her position as she is employed by the DOH and works within PHC facilities, as well as with CHWs in the community. She also documented her impressions and feelings after each FGD and KII which allowed her to acknowledge her own opinions regarding collaboration processes between both CHWs and the PHC facility staff. Declaring her position and documenting her experiences enhances the rigour of the research study. The researcher documented changes in the research process and the reasons attributed to it, and continued to be reflexive throughout (Shenton, 2004). Through this process of reflexivity, the researcher was able to understand how her feelings and opinions could influence her understanding and perception of the data, and was able to acknowledge and be aware of this during interpretation of the data.

3.10.4 Transferability

When thick descriptions are provided findings can be applied to similar contexts and populations by others (Shenton, 2004). The rich descriptions of the research setting, how each participant fits into the PHC domain, experiences, and perceptions of both the KI and CHWs and the research process provide context specific information enhancing the trustworthiness of the study (Creswell, & Miller, 2000; Malterud, 2001). This allows for transferability to similar contexts

where the findings could be used to improve collaboration between CHWs and PHC facilities (Shenton, 2004). Concurrently the researcher set out to provide detailed descriptions of participants, the setting and context information to allow for comparisons to similar contexts. The findings can be applied by others from these detailed descriptions to decide how useful the information is within their own settings (Polit & Beck, 2014).

Chapter 4: Ethical considerations

Ethical approval was obtained from the Biomedical Research Ethics Committee at the University of the Western Cape. In addition, permissions were requested from the Western Cape Department of Health National Health Research Database via their link: http://nhrd.hst.org.za., using the online application before data collection commenced. The researcher proceeded to request permission from the Overberg District Department of Health, Cape Agulhas Sub-District Management Committee where the study was conducted, and the Child and Welfare Bredasdorp NPO with whom the CHWs are currently employed, via email informing them regarding the study and requesting permission to conduct the study.

All participants for the FGDs were contacted via their supervisor and an information session was done where their permission for participation in the study was requested. KIs were informed via email and the information sheet was sent. The researcher explained that their participation was voluntary and they may withdraw at any time without any repercussions. The participant information sheet (Appendix 1), which was also translated into Afrikaans, which is the prevalent language spoken by participants, contained information on the purpose of the study and outlined the data collection process that would be followed and how information would be analysed and findings shared. The information sheet was distributed amongst the participants upon their agreement to participate in the study. The researcher ensured that they all understood the process as outlined on the information sheet and invited participants to ask questions to clarify any uncertainties in simple terms and in their preferred language. All participants were requested to sign the informed consent sheet in their preferred language (Appendix 5).

The researcher ensured that all participants understood that their participation was voluntary and ensured that they were aware and agreed to being audio-recorded. The researcher ensured the participants that every effort will be made to ensure confidentiality but explicitly stated the risks as they were a small sample working in a small area and that the risk existed that they could be identified in this way. In addition, for the FGDs, a mutual confidentiality agreement translated to Afrikaans (Appendix 7) was developed and participants were requested to provide written consent for a non-disclosure of information shared during the session, agreement. With any human interaction there is a potential for discomfort. Participants were informed that should a

situation arise where discomfort is experienced, they will be referred to the social worker at the Child and Family Welfare NPO in a confidential manner.

The FGDs and KIIs were audio-taped and the recordings were immediately transferred to a USB flash drive and a copy was stored on the researcher's work computer, which was password protected. The researcher was the only person who had access to the computer password and identification key identifying participants. The identifying codes that were used during data collection and analysis were kept in a file on the researcher's computer. These codes were consistently used and where participant's names or references that could make them identifiable on recordings were used, these were excluded. The hard copies of the transcripts were printed for analysis and stored with the USB in a locked safe. After six months the hard copies will be shredded and the information on the USB and hard drive of the computer will be permanently deleted.

Written reports will be distributed to the stakeholders of the NPO and DOH for dissemination of findings and recommendations. The researcher plans to discuss the findings of the study with participants and initiate future discussions on collaboration with them and the identified stakeholders.

Chapter 5: Findings

5.1 Introduction

This chapter presents the findings of the FGDs with CHWs and KIs. A description of the study participants and their main function is provided in the socio-demographic profile of the CHWs. It contains the various roles CHWs perform and the role misconceptions that exist. The factors influencing collaboration is identified and suggestions for future collaborative efforts are presented. Table 1 describes the main responsibilities of the CHWs and KIs and their function within their organisations.

Table 1: Main responsibilities of participants as specified by DOH

Community health workers (CHWs)	Members of a community who are trained to provide health promotion, illness prevention, and rehabilitative care in communities. They are expected to assist clinics in providing services to people in outlying areas, within communities, within households. (In the Western Cape they are employed by Non-profit organisations and started working full days in September 2019.)
Non-profit organisation coordinators (NPO coordinator)	Professional nurses working as direct supervisors for CHWs and resort under the NPO. Responsible for the combined statistics and final reports required at sub-district level.
Operational managers (OM)	Operational managers of PHC facilities and liaises with CHWs through NPO coordinators. Facilitates and reports on the PHC services in their geographic areas.
Community based service district programme managers (CBS district programme manager)	Facilitates the CBS programme for the Overberg area for the DOH.
Community based service sub-district programme managers (CBS sub-district manager)	Facilitates the CBS programme in Cape Agulhas/Swellendam sub- district and directly liaises with the NPO, NPO coordinators, and serves as the link to the DOH.

Table 2 depicts the socio-demographic profile of CHWs. All study participants were female; however, there is one male CHW in the study population who declined to participate in the study. All the CHWs reside within the same low socio-economic areas within the communities where they render services.

Table 2: Socio-demographic profile of CHWs

Participants	
CHWs	14
Male CHWs	0
Female CHWs	14
Age	
22-30	3
31-40	4
41-50	5
51-65	2
Highest qualification	
Grade 7	2
Grade 8	1
Grade 9	1
Grade 10	2
Grade 11	1
Grade 12	7
Years employed as a CHW	
2-5 years	6
6-10 years	5
11-13 years	3

5.2 Role of CHWs

The following section will outline the main roles CHWs identified and the role misconceptions.

5.2.1 Routine roles

There are various roles CHWs are expected to perform as part of the service level agreement between the DOH and the NPO. The CHWs reported that they conduct a range of routine tasks. This included tasks relate to screening, washing, wound care. Here they elaborated on their daily routine and the services they provide in the community.

"Mondays, Wednesdays and Fridays it's washes and wounds that we do, Tuesdays and Thursdays it's screening. Tuesdays it's always condom day by us and that depends what we must still do in-between," (FGD 3).

They also explained their role at the alternative dispensing sites for chronic medication where they check vital signs under supervision of their NPO coordinator.

"We do blood pressure, the observations we do, we screen them at the same time for TB and we write it in the folder so the time the patient gets to the Doctor, then he has his blood pressure and stuff," (FGD 3).

Moreover, they expressed their health promotion role and the systematic process they follow in screening households.

"…at the first house, maybe there's five people in the house, three children and a mother and a father. Then I must talk about women's health to the mother, to the man I am now going to talk about men's health, and then I am going to, if the three children are under aged, then I am going to talk about the RTHB (Road to Health Book) *and so TB* (tuberculosis) *and other type of questions come too,"* (FGD 1).

Educator

CHWs described how they educate households on caring for patients and teaching them various skills, thereby transferring their skills to the community.

"…this is what we learn, we must teach the people in the house how to wash the people (referring to the patients*), we must teach the people in the house how to give the tablets* (to the patients), *we do adherence, we do all those things,"* (FGD 2).

The NPO coordinator confirmed this role as educators, specifically in creating awareness on risk factors and when action needs to be taken, or when to access the PHC facility.

"So now they don't go to just wash people anymore, it is more about the education of the people and the lifestyles of people, so I expect them to screen, and to refer children and refer adults to the clinic because they are empowered to do it and then they must also take part in campaigns, we work with the clinics there, with the school nurse and all of those things really is to train people," (NPO1).

Defaulter tracing

They reported that they are responsible for following up TB defaulters, ante-natals and children who are due for immunisations or follow-up appointments at the clinic who did not arrive.

"…now they give the pages and pages of recalls….and then we go and look for all those people in one day, and so they reach their targets too," (FGD 2).

The NPO coordinator concurred the process whereby patients who did not arrive for scheduled appointments involving preventative or curative services at the clinic, is followed up in the community by the CHWs.

"They want the carers to go and look up the people who don't come to the clinic regularly, the people who don't fetch their tablets on time or children for immunisations. They usually give us a list, the children who are behind for immunisations and then each one gets an amount that they must go look up and they also refer then. They say Sister wants you to come to the clinic and give them a referral letter," (NPO1)

Participation in PHC facility activities

CHWs participate in communal activities, events or health days with the PHC facilities under the guidance of the NPO coordinator. CHWs elaborated on various activities they engaged in with PHC staff.

"…then we do school health and with the clinic's events (cough), *outreaches, campaigns…yes. But at events, most of the time we just take people's blood pressure or so, unless it's door-to-door"* (FGD 2).

They included activities they did in PHC facilities at chronic days where patients with chronic illnesses (illnesses lasting more than 3 months) such as arthritis, hypertension, diabetes, asthma waited to receive their medication.

"Yes, we do the foot examinations, we wash it in a small bath and all those types of things, right here in the clinic…we each get a place, very comfortable ne (CHWs laugh and nod in agreement) *and we do the weight, BMI everything,"* (FGD 2).

The NPO coordinator explained how the CHWs assist the PHC facility in the TB room.

"…we have three people who had a special training for TB, and they are in cooperation with that staff nurse (who works with the TB patients) *so they always follow up on Tuesdays and Thursdays who must get sputum pots, who they must follow up or if I need to know something about TB, I can just ask them,"* (NPO 1).

Extension of PHC facility

The PHC facility staff understands that CHWs are an extension of their service and is there to help and support them within the community to reach those patients who do not attend the clinics and follow-up those patients that require care in the community.

"...they motivate people to go for pap smears and identify who is due and available for a pap smear so that we can hit our targets," (OM 2).

PHC facilities require CHWs to identify people in the community that they are unable to reach to achieve their targets and provide PHC services to the population. They therefore, expect CHWs to work on the periphery and help them to reach their targets.

"The contracted one (the NPO) *must provide the service outside so that the target, the national targets from let's say er women's health or child health or whatever can be achieved,"* (CBS 2).

5.2.2 Misconceptions on roles

Working hours

The community's perception of the role of CHWs and their expectations often entails services which are not part of their role and impacts their personal lives. One of the most common misconceptions is working hours, as CHWs only work half days, enabling them to meet their personal needs and work demands.

"…we work half a day; the people come to your house in the afternoon. For me, personally, I am a mother and a father for my kids that time. I can't still deal with you if I am busy with homework with my kids," (FGD 2).

The CHWs expressed their concern at the expectations from the community to provide services over weekends that they feel obliged to assist.

"…yes, we now don't work on a weekend but the people expected it from me, sometimes the patient that I have now, I have done him on a weekend, but I stopped it because they can get someone from the family to do it," (FGD 2).

Community members also expect CHWs to be available to assist with emergencies at night whether it is in their scope of practice or not.

"…and I tell them, I can't leave my children at night to go and help someone and then it's someone having a stroke or a heart attack and I am not trained to help with that." (FGD 2).

The PHC staff reported an awareness of some of the difficulties CHWs experience in the community with regard to their working hours and the expectation the community has of them to perform health-related tasks.

"I think sometimes they make misuse of them quite a lot because some of them… er they only work half days at the moment, some of them are called in on Saturdays or Sunday, in the late afternoon, so I think they are also seen as an extension of the clinic," (OM 1).

Personal resources

Another misconception in the community is the expectation that CHWs must provide support to meet the patient's basic needs.

"…you already knew, that if you go into that house, you must have a R5 in your pocket for electricity, you must make sure there's a bar of soap in your bag, and you must make sure that if there is no bread for the lady to drink her tablets that you can quickly run to buy a bread…" (FGD 1).

Home based care vs. community health care worker

There were also misconceptions about the services they provide and how the service has evolved with its focus on wellness and empowering the community. PHC facilities tend to continue with the CHW service as they had initially been introduced to it.

"…so we don't take the medication to the patient's house anymore…but the clinic still refers patients that we must take the meds to the home…now they create the impression that I don't want to do it because they tell the patients, just go to the Sister (the coordinator) *and she will organise everything,"* (NPO 1).

5.3 Factors affecting collaboration with PHC facility staff

The following factors emerged on CHWs' collaboration with PHC facility staff: training, remuneration, referrals, role of the supervisor, challenges experienced with supervision, sharing of information, PHC staff attitudes, CHWs self-image, and access to appointment slots. Other factors include environmental hazards CHWs encounter and lastly their suggestions on how collaboration can be improved.

5.3.1 Training

The CBS manager explained the process followed for CHWs who attend training to successfully complete training.

"…tests were done and went up to the training provider, people who failed had to redo, they got three chances to redo," (CBS 1).

The CBS manager responsible for coordinating and facilitating the training reported how the different levels of education of CHWs affect the level at which the training and statistics is presented to them. Furthermore, the entry-level for CHWs who have been employed as CHWs for a prolonged period was much lower.

"The fact that everyone is not yet at the same scholastic level trained, makes that everyone is not functioning at the same level and that might have a small influence on how they specifically do statistics and understand the training…sometimes they don't understand the definitions so well and that shows as they will regularly make mistakes," (CBS 2).

However, despite the challenges experienced, the CBS manager reported a good pass rate for all the CHWs.

"They have gone through various courses and they have passed it and received certificates for it and they even get identified as CHW level," (CBS 2).

CHWs feel that the training they received improved their knowledge, understanding and ability to perform their roles confidently. They described their experiences of how they had been able to implement and use the skills acquired in training.

"Like for example, if I come to a mother and she is breastfeeding and she tells me the child is not getting full… I didn't know it's the foremilk that is the child's water that he must get and the stronger he drinks the more it will come through. So, the course broadened my knowledge, so for me it was tops," (FGD 1).

*"The training is divided into different criteria, so basically if a person walks into the house you will know what to do," (*FGD 1).

For those who had not received the full course, they felt confident that what they had learned in the refresher course was sufficient to make them competent.

"We don't know everything in detail but we go on as we have learned in the refresher," (FGD 3).

5.3.2 Remuneration

The issue of remuneration had repercussions for the nature of the collaborative relationship as it affected both the NPO coordinators and the CHWs. For instance, the CHWs expressed dissatisfaction with their salaries.

"I don't know what they think of us. They see us as nothing and now they make our money also nothing," (FGD 1).

"They (referring to PHC staff) *get a government salary and we don't. We get that little"* (FGD 3).

Furthermore, upon reflection, they reported an increase in workload while their salaries remained the same.

"Before, the job was only to wash people and wound care. Now I sit with a file and I must do a daily report of my patients every day…" (FGD 1).

They elaborated on the type of work that they do and the fact that uniform allowance does not cover their expenses considering that they work outside and their clothes and shoes last for a limited time.

"Yes, when I buy shoes, there's no more money for clothes, if you buy clothes, there's no money for shoes," (FGD 1).

The coordinators also commented on the current system of a petrol allowance, that they need to claim and how it impacts them financially.

"I drive out petrol, I have used over R6000 petrol already this month and I am not getting any petrol money this month. March April you don't get petrol money, so I don't have any money left," (NPO 2).

5.3.3 Referrals

It was reported that verbal referrals were received from PHC facilities to the NPO coordinators which is not the norm but accepted as a referral method for patients who need to be seen by CHWs in the community.

"I do not always get referrals on paper like you are supposed to get, I have made peace with it already…it gets done verbally which is not right, but it's just one of those things you have to accept," (NPO 2).

NPO coordinators facilitate all referrals for CHWs. They delegate the referred patients to individual CHWs.

"Actually, our duties come through Sister (NPO Coordinator) *and the referrals too. From patients that come out of the hospital, like the babies that the hospital phones we must go and visit, but it comes directly from the hospital to Sister and then Sister gives it to us or phone us,"* (FGD 2).

The referral process was explained as follows:

"We give our referrals to them, to the coordinator….and then there is a referral file that we use to refer the patients," (OM 2).

The NPO coordinator will check that referrals have been followed up and CHW visits recorded to ensure continuity of care.

"So, if I get a referral or a request then I go to the people (CHWs)*…write down who you are going to…they have their papers and all their stuff together so if the sister of the clinic ask, then they can show them,"* (NPO 2).

CHWs reported that referrals were mostly a one-sided approach where they were expected to motivate people to make use of the PHC services but seldom received any feedback on patients once they have attended the facilities which made continuity of care difficult.

"…they never call us in to talk about the patient; sometimes we don't even know what they said because the patients can't always tell you, you know. Then you must just go on, unless Sister (NPO coordinator) *tells you something else to do,"* (FGD 1).

The long waiting time for an appointment date due to crowded clinics mean that CHWs are dependent on their interpretation of the patient's condition without really understanding the full scope of the patients' problems. All referrals also need to be done through their coordinator.

"I feel a bit that when a patient is referred from the hospital he must be helped immediately so that he can get better sooner and especially when the patient goes, I am his carer, the uncle goes tomorrow, I can go with because Wednesday when you go wash the uncle then you know exactly how to move the patients arm, his leg like this…" (FGD 1).

5.3.4 Role of the supervisor

CHWs are currently supervised by the NPO coordinator who is a professional nurse. NPO coordinators facilitate the operational roles of CHWs and are tasked with their supervision. They also offer personal support and guidance to the CHWs when needed.

"…I also helped her when her husband died, to sort out her things and so forth" (NPO 2).

In addition, they also offer clinical support. It was reported that the NPO nursing coordinator supervises the work the CHWs do in the community by accompanying the CHWs and assisting them when they experience difficulties with patients in the community.

"…or we ask Sister (the coordinator) *how we must make, she helps us a lot by telling is what to do or she goes with us to the people that we have a problem with,"* (FGD 2).

The NPO coordinator confirms how they offer support and guidance on clinical issues within households.

"Every week we go to a patient and then we get together at a certain time and then I discuss some things with them so they also learn," (NPO 2).

Within WBPHOTs, it was envisioned that the OM at the PHC facilities should lead and provide support to the rest of the team. Within Cape Agulhas, the NPO coordinator is solely responsible for CHW supervision and the OM for staff within the facility.

"…so they fall under the coordinator and she sees that they do the follow-ups from us or referrals or children, we won't be able to still go out too, so she will come back to us if we have a problem and sort it out with the CHW," (OM 1).

5.3.5 Challenges experienced with supervision

The CHWs expressed contrary views on the type of supervision they receive and what they expect. The NPO coordinator supervises them and assists them with referrals but they expressed a need for more practical support in the community at the patient's homes.

"…I feel the first day, if it's a wound, or if I say there's worms coming out of the leg, now I don't know why there are worms…..I don't know why, then she does not go with (CHWs shaking their heads in agreement) *or say, but I am going with you then you can show me the leg…then tomorrow you know what to do,"* (FGD 3).

This encouraged the other CHWs to comment.

*"I was told I have a wound patient (*patient who has a wound*), I had to figure it out myself, an experienced CHW showed me, not the coordinator,"* (FGD 3).

In response, the CBS manager identified the challenge that exists in the rural areas where NPO coordinators are often expected to work across a few towns which makes more regular support and supervision difficult.

"They have the most important role…that is supervision, monitoring. Besides patient care, formulation of a care plan, they must then ensure a patient is allocated to a CHW, they must also ensure a CHW is allocated a geographic area within which they work. And supervision, that direct supervision of the CHW, walking with them, working with them, doing screening, that's an area where difficulties are because we are in the rural sector and our coordinators work across towns, you will find that one town will have an NPO coordinator once a week," (CBS 1).

5.3.6 Sharing information

The NPO coordinator is expected to have a weekly meeting with the PHC facility and compile a written report on the meeting for the DOH. These meetings are initiated by the NPO coordinator, occur informally, and are often affected by the demands of the PHC facilities.

"There is a month to month meeting but this is for the manager's uhm, in the clinic, the operational manager and the coordinator. Yes, so all the problems now get discussed between them," (OM 1).

"…you don't really give feedback from the meetings…it's a very informal meeting that is held…" (OM 2).

The NPO coordinator takes responsibility for, and checks on referrals and which of the defaulters or recalls CHWs had to follow up on and if they had arrived at the PHC facility. She then compiles a list of all those who had not arrived and resends these to the CHWs to follow up on.

"I go on a Friday for example, then I go to the clinic and I go to the Sister that works with the babies and then I say we had these referrals, have they arrived yet. And so too with the other sisters if we get referrals from them," (NPO 1).

The CBS coordinator in the area serves as an intermediary between the NPO and PHC facilities when they encounter difficulties and supports the NPO when grievances cannot be resolved.

"…your CBS coordinator also plays a role in liaison and where there is, especially where there are new things and where there are challenges in terms of communication between the NPO coordinator and your facility, your CBS coordinator is part of the DOH personnel and that person goes in together with the NPO coordinator to ensure that the facility understands or to negotiate for the NPO sector," (CBS 1).

The NPO must compile monthly reports for the DOH where they report on CHW specific statistics as well as statistics relating to PHC.

"Through the reports they give, that they receive from the NPO coordinator, the NPO sends me a monthly report and uhm, a quarterly report that is a requirement, then we will measure if they are delivering the service as we requested…no, we do not require reports on CHW work from the facilities but they call us if they feel they are not doing their job," (CBS 1).

Contrary to the abovementioned, CHWs reported that some of them have minimal to no direct contact with the clinics.

"That is the problem…we have no contact," (FGD 3).

Within the CBS programme, the CBS manager at sub-district level are responsible for coordinating the NPO service level agreement and ensuring that both the NPO and DOH officials

understand and know their role in this collaboration. The CBS manager shared that they have encountered PHC staff that is unaware of what the work plan for CHWs entail, despite their efforts at transparency and information sharing.

"…because I also find that whatever is discussed at management level doesn't filter down to the OM (operational manager) *the PHC manager has always been invited to the NPO coordinator meetings in the sub-districts. There has been a few attendance…haphazardly attending and not every quarter…the info is maintained at one level and it doesn't filter down,"* (CBS 1).

5.3.7 PHC staff attitudes toward CHWs

CHWs feel that the staff at facilities do not see them as part of the health team and treat them like they would any other patient attending the facility although they are attending on behalf of their patients.

"…then you get there to make the patient's appointment and they have all these attitudes, just tells us to stand at the back in the line. They must just understand that just like they have work, we do too," (FGD 3).

The CHWs related experiences where staff have been disrespectful in how they address them or not acknowledged them as part of the team.

"…then she will tell me straight, there isn't dates yet come again, come this afternoon. For me it's I'm going the extra mile for a patient…and then I am specifically making the appointment so the patients can organise with someone to push them to the clinic this afternoon," (FGD 1).

The coordinator confirmed that PHC staff attitude is a barrier in service provision.

"There is good communication between the coordinators and the clinic but not with the carers, they (PHC staff) *just don't think they are good enough, some of them is just like that…"* (NPO 2).

"They give even less attention to them (referring to CHWs), *they will just say I am busy, I can't go look now,"* (NPO 1).

PHC staff is aware that CHWs perceive them to have a negative attitude towards them.

"…they feel almost as if the nursing staff look down on them and think that their work uhm is not of such a good quality er so they feel… they feel when they come in by the clinic they can see on the staff's facial expressions that they think they aren't really nurses…" (OM 1).

5.3.8 CHWs self-image

The CHWs often felt unappreciated especially in relation to the PHC facilities.

"…we don't feel like we are part of them because you don't get treated right inside here," (FGD 2).

This has an effect on their self-esteem and their perception of how others view them as was evident in the following responses.

"*...they treat us too badly, for example, see how I look, its broken and stuff* (gestures to her own clothes which is faded and shoes broken). *No one is going to take me seriously if I turn up like a scarecrow! It just doesn't work that way,"* (FGD 1).

Within the community, they recalled experiences where they have been the recipients of derogatory opinions and disrespectful treatment.

"…they don't always understand what we do, that is why they call us streetwalkers or bum washers (laughing) *because they don't understand the rest of the work,"* (FGD 1).

"…sometimes you get scolded very angrily, but you must go in there," (FGD 3).

This is confirmed by the NPO coordinator who feels that they are not respected because the community does not see them as a professional cadre.

"Yes, and they look down on them and now when I go in (into the home), *they see I have epaulettes on and then they sing a different tune ...it's almost like, they are not nurses, they are not trained and now they* (patients) *want to say, do it like this and this,"* (NPO 1).

Another factor that influences collaboration is the PHC facilities understanding and appreciation for the services rendered by CHWs in the community despite difficult circumstances.

"I suppose the weather is also a big thing they have to walk everywhere," (OM 1).

"They really take our hand; we need them in the community. We already have a big workload, if we still had to go out in the community, we would lose lots of patients along the way, our defaulter rates would be much higher," (OM 2).

CHWs expressed the need to receive recognition and be respected for the work they do in the community for their part in prevention, promotion, and treatment. They felt disrespected at the way their referrals are treated and felt like their competence was questioned when their referrals are questioned by non-clinical staff.

"I feel that when I give a referral for a specific illness, then I feel that person shouldn't need to be asked 110 things (at reception) *because I have already explained in the referral* (for the Sister) *what it is for,*" (FGD 2).

They also feel that they need to be able to make a direct referral to the clinic without permission from the NPO coordinator first.

"So, I can't just go knock on the sister's door and say Sister (PHC sister), *this thing* (pressure sore) *is getting bigger, can Sister come look or can I quickly bring the patient. No, I must go to Sister* (coordinator) *and she must go to the clinic sister…"* (FGD 1).

CHWs expected acknowledgement and recognition for their work. They expressed that they expected appreciation for their role in achieving targets and was very specific in that they want this recognition from PHC facilities as they feel they do not acknowledge or value their role in PHC.

"There wasn't really any appreciation shown or recognition for what we have been doing, they basically, how do you say? The people didn't really come to the clinic and we got and motivated the people in the community…but when the certificates and stuff got given, I mean, they could at least have said thank you to us or invited us to enjoy a cup of tea with them," (FGD 2).

CHWs felt that they were integral in the attainment of targets and PHC facilities would not reach their targets without their work in the community.

"Yes, we are good for their work outside, we are responsible for that, so if we don't do the work, they don't get their inside er statistics, numbers won't be reached because we are the people who bring that numbers in through the referrals from outside to inside," (FGD 1).

CHWs further expressed their disappointment at the lack of inclusion in PHC facility celebrations or recognition when targets e.g. as with events or campaigns have been reached, and they had participated in the attainment of the targets.

"…we are separate. And we have a few, like HIV day, they took photos, had the red HIV t-shirts and they took photos. We weren't in the newspaper, but they were. And we were standing right there. We helped to make the day a success and get lots of people to come and test," (FGD 1).

5.3.9 Access to appointment slots

CHWs reported frustration at the operating systems of the clinic. Specifically, the long waiting times at reception and the procedure they must follow to make appointments for patients as they experienced it as cumbersome and time-consuming.

"I have to walk from Hugo Street, it is as you come into Bredasdorp so when I walk from here (NPO Office where they sign in) *to the clinic then I already only get out of the clinic at half past ten because reception feels I must stand at the back of the line just to find out when must the aunty* (patient) *see the doctor because the aunty can't walk any more to come herself,"* (FGD 1).

The appointment system at the clinics specifically for services for which the CHWs are responsible to refer people from the community is also a barrier in service delivery. They reported that because there is no designated appointment slots for patients they refer, patients must return for appointments on an alternative date which often leads to non-compliance of patients as they do not return for appointments.

"Like the pap smears. If you refer someone for a pap smear, or they give another date and the patient must come again, the patient is not coming again, that I can guarantee, that person is not coming again," (FGD 2).

This makes them lose credibility in the community.

"The people say we are wasting their time because when we refer them to the clinic the door gets closed in their faces (meaning it figuratively)*,"* (FGD 3).

5.3.10 Environmental hazards

CHWs expressed fear for their safety and that of their families as they felt obligated to allow patients to come to their homes to facilitate adherence to treatment.

"We also put our lives in danger, like with TB people that you can't go to because they work so now, they come to your house at six in the morning to take their pills, your children are in the house! And there's no other time because if they don't come to your house, they are not going to drink the pills," (FGD 2).

This prompted another CHW to respond with her experience.

"I have had to go and stand at the canteen (shebeen), (CHWs all laugh) *you laugh, at the beginning but then I must get him lunch time, then he must now drink his pills, so he can get better otherwise he doesn't drink his pills,"* (FGD 2).

"Or you go to their house the morning, they know they must get their pills, they are not there. They walk around and now you must go find him," (FGD 2).

They are often faced with other problems that are beyond their control as the OM reported.

"…but where they come, they have to walk to, so on cold rainy days they have to walk and I think that influences their work…and the social circumstances of people are not always nice and when they go in, it's not always nice for them…" (OM 2).

CHWs feel that PHC facility staff do not understand the environmental hazards that come with working in the community and that they expect them to fulfil their roles without consideration for their environment which is not always conducive.

"They don't realise that sometimes we have to go in difficult circumstances; it was for the TB sister, a recall…when I got there so the boyfriend didn't know about his girl that is sick and then he walked behind me with a scissor, insisting I tell him what tablets she is taking," (FGD 1).

Within the communities where they work at the homes of patients, they are often met with dangers that pose a risk to their own safety and are dependent on their ability to ensure their safety.

"Once we also went into the informal settlement…luckily we got her (gestures towards one of the CHWs) *she knows lots of people in the informal settlement…then it was just pangas and knives and axes, my nerves!"* (FGD 1).

These environmental hazards can prevent them from delivering a service to patients.

"I also cannot go to another patients house; he has a bulldog this big (indicates big with her hands) *that dog jumps over the gate just so,"* (FGD 2).

5.4 Suggestions to improve collaboration

The CHWs expressed the need for open communication with PHC staff on a regular basis and not just through their coordinators, to improve relationships and working together as a team. The CHWs provided a list of possible suggestions to improve their interaction with PHC facilities.

The first suggestion is to have an introductory meeting.

"…even if we can just all get together at the beginning of the year, you know, then we all know where we stand with each other…" (FGD2).

The second is to have planned meetings once a month with the CHWs and PHC staff.

"We are going to see if we can have a meeting with all the role players and the staff and uhm if we can do it on a more regular basis because like I say, it is usually only the coordinator and the operational manager who talk to each other and the rest don't really get any feedback," (OM 2).

A third suggestion is for the coordinator to spend a day a week at the clinics. The operational managers suggested ways to improve communication between themselves and the CHWs.

"I think maybe if the coordinator had an office here (in the clinic) *and meet on a Monday so she can work out that office…give them a space where they can put their stuff…and have a basis and*

get a chance to be in the clinic…they really see what is going on…they will actually feel more part of the clinic," (OM 1).

A fourth suggestion is for the operational manager at each facility to be knowledgeable of the work plan of the NPO and what the service level agreement entails clarifying the roles of all organisations.

"So we've also decided that we will take it further, that we will go in, besides my quarterly meetings, that myself and the deputy director of Comprehensive Health, that the two of us will go in on sub-district level and meet with the OM so really if they say that they do not know the package of service then I really question that…" (CBS 1).

Chapter 6: Discussion

6.1 Introduction

This chapter presents a critical reflection on the findings of the study. The discussion centers around the key findings that include the roles and responsibilities of CHWs, supervision practices, the application of Maslow's hierarchy of needs to CHWs, health system factors that influence how PHC facilities and CHWs collaborate, and how collaboration relates to CHWs within the PHC domain.

6.2 Roles and responsibilities

The study findings indicated a discrepancy in the understanding of the roles and responsibilities of CHWs among PHC facility staff. There is an expectation from PHC staff that CHWs should perform duties that are not part of their allocated roles, as indicated in their package of care agreement with DOH. This finding is similar to various studies where roles of CHWs were not clearly defined and understood, leading to conflict and a lack of recognition for CHWs' contribution in service delivery (Doherty & Coetzee, 2005; De Jong, 2015; Tsolekile et al., 2014). Without clear roles, unrealistic expectations exist that affects collaboration and PHC outcomes.

The findings indicated that the community had an expectation that CHWs be available outside their working hours. This is similar to the ASHAs in India who are expected to work long hours and sacrifice much of their private time providing a health service to the communities despite poor remuneration (Tripathy, Goel & Kumar 2016). Despite the proven progress made with CHW programmes in both low-income and high-income countries, the response to the grievances of CHWs often remain unmet by government or programme managers (Abdel-All et al. 2019).

Role ambiguity is further embedded with the different accountability structures within which they work; they work within the PHC domain but are formally employed by an NPO (Tulenko et al., 2013). Furthermore, the public health sector formalised health worker cadres through job descriptions; however, for CHWs working in the NPO sector the roles of CHWs are often adjusted to the needs within the health system (Doherty & Coetzee, 2005), and not necessarily

aligned with a designated job description. This adds to the confusion regarding what roles CHWs are expected to perform causing misunderstandings and strain between CHWs and PHC staff.

6.3 Supervision

Supervision of CHWs is primarily the responsibility of the NPO coordinator who also serves as an intermediary between CHWs and PHC facilities. This study found that NPO coordinators provide limited supervision and that the manner in which it was done, was not facilitating growth that would equip CHWs with improved skills and continuous learning. The lack of appropriate supervision practices impacts the quality of services rendered and the motivation of CHWs to participate in a collaborative relationship with their supervisor (who is their link to PHC facilities) which affects their relationship with PHC facilities.This is similar to a study done in Mozambique in Africa where poor outcomes were reported due to inefficient supervision, as supervisors were not equipped with the skills needed to provide appropriate supervision that would facilitate mentoring (Ndima et al., 2015).

In the systematic review by Bhutta , Lassi & Pariyo (2013) , the approaches to supervision in Bangladesh and Thailand were reviewed. Bangladesh has a more supportive approach with structured guidelines on how supervision must be implemented. Supervisors are trained on how to provide supervision, have specific and regular meetings guided by a supervision tool and they use data to address problem areas with the BRACS CHWs (Bhutta, Lassi & Pariyo, 2013). They have practical engagement within the community and assist with tasks to facilitate mentoring. Appropriate supervision leads to improved outcomes and quality care. Contrary, in Thailand, the Village Health Volunteer (VHV) have a supervisor at sub-district level where the lead VHV is responsible for facilitating the service locally and is responsible to guide them (Bhutta, Lassi, Pariyo, 2013). Therefore, to facilitate improved outcomes in health, supervisors must be trained with the necessary skills, have an attitude that facilitates coaching and be willing to interact with CHWs in a way that is conducive to growth.

Supportive supervision that encourages personal development is required, enabling CHWs to become more knowledgeable and skilled (Shipton, Zahidie & Rabbani, 2017). The literature supports the notion that it is not only whether or not supervision is provided but, it is about the type of supervision provided that is directly linked to CHWs' effectiveness in the community (Assegaai & Schneider, 2019; Austin-Evelyn et al., 2017).

Furthermore, the barriers to supervision identified in the study, which included lack of time, large geographical areas, and conflicting work schedules were similarly identified in a review on CHW supervision as the challenges that can be addressed through peer supervision or alternative supervisory support (Crigler, Gergen & Perry, 2013). The challenge of providing adequate and regular supervision to CHWs can therefore be dealt with by changing the approach to a more beneficial one using some of the strategies that proposes task assistance and emotional support which creates a mentoring environment and encourages the integration of CHWs into the health system..

6.4 Application of Maslow's hierarchy of needs to CHWs

Maslow's hierarchy of needs is based on the theory of motivation. In his theory, he surmises that humans are motivated by the five levels mentioned in his hierarchy of needs and that this drive to fulfil our needs, is what motivates us and our behaviour (Maslow ,1970). The needs are the physiological needs, security needs, social needs, self-esteem needs and lastly self-actualisation (Maslow, 1970). In his five stage hierarchy, lower level needs must first be achieved which refers to our most basic needs as humans and as we grow we develop a need for the higher level needs to be met. This theory was applied to the CHWs as we can draw on it to understand the needs that CHWs expect to be met within their working environment and how it affects their behaviour and ultimately how they collaborate with the PHC facility staff (Jerome, 2013).

6.4.1 Physiological need

In Maslow's hierarchy of needs, physiological needs are the most basic needs that must be satisfied to enable CHWs to have an adequate income to sustain themselves and their families (Maslow, 1970). The findings suggest that despite CHWs receiving a stipend, they continue to face financial challenges. In addition, they have the dual challenge of being part of the impoverished communities where they work and feel obligated to use personal resources to support their patients. In their study on the use of personal resources by CHWs in South Africa, Sips et al. (2014), suggest that CHWs pose an economic risk to themselves through this practice, which in turn affects their motivation and commitment to their work (Maslow, 1970).

6.4.2 Safety and security

The next need Maslow described is that of safety and security. This need is based on people feeling safe and secure within their environment (Maslow, 1970). The findings showed that

CHWs experience safety risks within their work environment that make them feel unsafe and threatened. Similar findings on daily safety risks CHWs are exposed to were experienced by home-based caregivers employed by an NPO responsible for HIV care in an urban area in Cape Town, South Africa (Ramuhaheli & Erasmus, 2012). Furthermore, CHWs must renew their contracts annually and therefore, have no assurance of employment. For CHWs to cooperate in sustainable and successful collaboration practices, basic needs such as safety and security must first be addressed (Jerome, 2013).

6.4.3 Social needs

Moving higher in the hierarchy of needs are the social needs characterised by the interaction with staff that facilitates a culture of acceptance and belonging (Maslow, 1970). The findings demonstrate the lack of acceptance and belonging experienced by CHWs by their colleagues within PHC facilities. This is further exacerbated by the absence of a professional relationship between them and PHC facility staff (Benson & Dundis, 2003; Jerome, 2013). CHWs expressed the lack of support from PHC facility staff and are dissatisfied with their relationship, which affects their cooperation performing the various tasks required for PHC service delivery.

In addition, the findings reflect that CHWs are not perceived by PHC staff as valuable team members but instead seen as subordinates. These results are substantiated by Morley and Cashell (2017), who found that CHWs feel inferior to PHC staff as they are not acknowledged as part of the health team. Similiarly, a study in Malawi of Health surveillance assistants (HSA), reports that professional cadres often see CHWs as a threat as they do some of the tasks previously allocated to them (Perry et al. 2014). The role of the CHW must be clearly defined by management structures to ensure that they feel accepted as part of the team and valued for their skills (Perry et al. 2014). This lack of belonging creates a barrier on the interaction between CHWs and PHC facility staff which impedes effective and outcome based services.

CHWs in Cambodia reported on the attitude and perceptions of the communities where they work (Ozano et al. 2018). Due to the CHWs health promotion role within the community, education toward lifestyle changes is a core component. This is met by resistance from the community as they find it difficult to comprehend due to their traditions, culture or education levels (Ozano et al. 2018). The community therefore do not respect their knowledge or skill level and this can negatively impact collaboration between CHWs and PHC facilities as the

community do not treat or see CHWs with the same respect and the prevention work of CHWs is ineffective. In turn, PHC staff may not see CHWs as assisting them as their work does not lighten their workload within facilities.

6.4.4 Self-esteem

Self-esteem is seen as a higher order need by Maslow and is achieved by the recognition received that makes people feel valued and appreciated (Maslow, 1970). The findings showed that CHWs are not being included in reward systems or acknowledged for their role in the attainment of PHC tasks or goals. This lack of sharing in the achievement of PHC facilities creates a barrier making interaction between CHWs and PHC facilities strained, as CHWs feel their contribution is not valued and they are not being respected as health workers. The results build on existing evidence of studies done in Brazil and South Africa respectively showing a lack of recognition by professional staff that led to CHWs' impact and value in the community diminishing (Grossman-Kahn et al., 2018; Schneider & Nxumalo, 2017). When employees feel their contribution is not relevant, their self-esteem is affected and this has a negative effect on their work, as they do not feel valued in their organisation (Jerome, 2013).

6.4.5 Self-actualisation

CHWs did not participate in planning and decision making of PHC related activities. They are used to implement decisions and interventions as planned by DOH, but are not consulted when these services are being planned and developed. CHWs in Brazil encountered similar issues as they were not included in decisionmaking and planning (Grossman-kahn et al. 2018). They felt they had a valuable contribution to make and would improve services. Grossman-Kahn et al. (2018), reiterate that CHWs should be active members of the team to facilitate coordinated outcomes. Governments should draw on the insights of CHWs to assist with planning as they are familiar with their communities and have first-hand knowledge of what interventions will be accepted and appropriate in their communities (Ozano et al. 2018). Maslow's hierarchy of needs maintains that for staff to be motivated and to reach the highest level, their needs for self-development and growth must be met (Jerome, 2013). Their participation in planning and decision making will encourage continuous self-growth and allow them to be content in their work (Jerome, 2013).

6.5 Health system factors

CHWs are key in ensuring access to PHC services as they can encourage the community to make use of PHC services and are instrumental in how the community perceive and access PHC services (Grossman-Kahn et al., 2018). The findings suggest that the operational issues within PHC facilities affected the community's trust in CHWs causing them to lose their credibility in the community. These results build on existing evidence of a study done in Brazil, where CHWs were similarly incorporated into PHC services and poor participation of CHWs in operational and planning activities impacted their trustworthiness in the community, making it difficult for them to perform their duties such as referrals for PHC services (Grossman-Kahn et al., 2018; Ozano et al., 2018).

A key problem that emerged in the findings were long waiting times and the lack of appointments for patients referred by CHWs. Similarly, Grossman-Kahn et al. (2018), found that when CHWs encounter these health system barriers, it restricts their services within communities as PHC services are not accessible and available for their referrals. Scott et al. (2018) suggests integration of CHW programmes in health systems to improve CHW confidence and awareness of PHC facility procedures and changes.

CHWs also reported on the challenges of liaising with staff on patient issues which would improve their effectiveness in the community. The findings indicate that collaboration regarding patients is primarily from CHWs as they screen and refer patients from the community, but there is a lack of reciprocal feedback. This one-sided attempt at collaboration on patient issues is confirmed by multiple studies where CHWs reported the lack of sharing of information on patients from the PHC facility staff (Tsolekile et al., 2014; White, Govender & Lister, 2017).

6.6 Collaboration

The findings showed that current collaborative practices are ineffective and that CHWs and PHC facilities continue to work parallel to each other. Collaborative activities exist with the NPO coordinator attending meetings with PHC facilities whilst the CHWs continue to have minimal contact with PHC staff. Literature advocates meetings with CHWs as a group and not only with the coordinator (Findley et al., 2014).

Findley et al. (2014) reported CHWs in the USA were integrated into the multi-disciplinary team by initiating participation of CHWs in their multidisciplinary meetings and discussions as any other member of the team. The integration led to clear roles, improved communication amongst team members with CHWs, and team members developing an appreciation for the contribution CHWs can make to patient care (Findley et al., 2014).

Research studies support collaboration between members of the health teams and CHWs and their value as members of the team for positive patient outcomes (Findley et al., 2014; Franklin et al., 2015; Grossman-Kahn et al., 2018). In their review on collaborative teamwork between CHWs and nurses, the importance of a comprehensive understanding of individual roles and working together for mutual goals, was identified (Franklin et al. 2015).

For effective collaboration, CHWs must be integrated into the public health system. This will facilitate accountability by both sectors through their closer interaction with each other which will clarify responsibilities and enhance understanding of both sectors' contribution (Kim et al., 2017; Scott et al., 2018). CHWs need the support of other sectors to ensure the sustainability and credibility of their programmes (Scott et al., 2018).

Chapter 7: Conclusion and Recommendations

7.1 Conclusion

In conclusion, this qualitative study discussed intersectoral collaboration between CHWs and PHC facility staff and identified factors that influence this collaboration. Collaboration efforts were found to be poorly implemented, leading to fragmented service delivery. The study findings emphasised the misconception within the PHC system on roles and responsibilities of CHWs that directly impact both the relationship between the sectors and accountability of the programme. The health system factors identified affect the credibility of CHWs within the community, which directly impact PHC services. The lack of integrating CHWs within the health system through accredited training from an academic instituition, adequate remuneration, and participation in PHC clinical and administrative planning further divides CHWs and PHC facility staff. The study highlighted the lack of recognition and respect CHWs encounter from the PHC staff, which hampers coordinated activities and team work. Collaborating with different sectors, as proposed by the WHO and the Alma-Ata Declaration, is necessary if UHC is to be achieved.

7.2 Recommendations

- The use of CHWs within the health sector has proved essential in the achievement of UHC. A market related financial package in accordance with their job expectations that reflects their job demands, training, level of knowledge, and skills is suggested. This would require budgetary provision, especially considering the renewed focus on PHC with the NHI Bill.
- There is a need for both the community and PHC facility staff to be re-educated regarding CHW roles and responsibilities, and how services can complement each other. Community leaders should be approached to collaborate with them to assist in educating the community. This will allow for coordinated activities and better use of resources. With defined roles, both sectors will have a clear understanding of their scope of practice.
- Workshops can be facilitated between PHC facility staff and CHWs that will address attitudinal barriers.
- Although progress has been made in training, CHWs are not acknowledged as part of the professional team. Recognition and formal certification, defining them as a professional

cadre, will ensure clear structures on their expected knowledge and skill level and they will gain the respect of colleagues.

- For supervision to be effective, suggestions are made for regular supervision within the field and for supervisors to be trained to provide supportive and mentoring supervision that facilitates personal and professional growth. PHC operational managers should also be trained supervisors to accommodate for the long distances in rural communities. Implementation of a supervision tool and alternative supervisory methods such as peer or community support should be considered. Their interaction with CHWs will allow an opportunity for learning and competency for both sectors.
- Accountability structures for PHC facilities for the different wards within which the CHWs work must be developed, as they are essentially responsible for the geographical area CHWs provide services to. This must facilitate continuity of care instead of compartmentalising patients.
- Regular informal and formal opportunities must be created to share information at all levels of care between CHWs and PHC facilities. This would mean that CHWs must be included as any other staff member in clinical discussions.
- Both PHC facilities and NPO (including CHWs) must be included in reciprocal feedback processes and reports must be made available at all levels. This would allow for a formal process of liasing between the NPO and PHC facilities that allows the NPO sector to have a more active role in collaboration.
- Recognition awards and incentives must include CHWs.

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Appendix 1: Information sheet: community health workers

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E-mail: soph-comm@uwc.ac.za

Project Title: Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering primary health care services.

What is this study about?

This is a research project being conducted by L. Temmers a MPH student at the University of the Western Cape. We are inviting you to participate in this research project because you can provide the study with the best understanding of your work as a community health worker. The purpose of this research project is to explore how community health workers and Primary Healthcare Clinics in Cape Agulhas work together. We are interested in your opinions in this regard.

The purpose of this study is to describe and explore the collaboration between Community Health Workers employed by an NPO (Non-profit Organisation) like Child and Welfare South Africa and Primary Health Care facilities (clinics) in the Public Health Sector. The findings of this study can be used to develop suggestions on how to improve collaboration between clinics and CHWs. Furthermore, the findings can be used to develop a policy on information sharing and planning between clinics and CHWs and how to support each other to improve their services.

What will I be asked to do if I agree to participate?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify.

You will be asked to sign consent to participate in the research study. I will do a group interview (Focus Group Discussion) with you. The group will have 5 other community health workers with you. It will be done at the Child and Welfare Office in Bredasdorp. With your permission, I will make an audio-tape recording of the interview. It should last about one hour. The questions will be about your work, how you work in the community and with the clinics. The focus will be on understanding how you see things. I am interested in what you think and understand.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To protect your confidentiality, your name will not be used during the interview and pseudonyms will be used. A code will be assigned to you which will be used on all the data collected. The researcher will be the only person who will have knowledge on which code is assigned to you and will be the only person who has access to this information.

To ensure your confidentiality, the researcher will keep the identification key containing your real name in a safe at her home. The data collected will also be kept in this safe and only the identification code will be used on all paperwork. On the computer where data will be stored, all the files will be protected with passwords.

If we write a report or article about this research project, your identity will be protected.

This study will use focus groups therefore the extent to which your identity will remain confidential is dependent on participants' in the Focus Group maintaining confidentiality.

What are the risks of this research?

There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. You may feel uncomfortable or judged talking about your work in this context and it may bring about an emotional response. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a social worker at the NPO (Child and Welfare) for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about collaboration processes between CHWs and the public sector (clinics). We hope that, in the future, other people might benefit from this study through improved understanding of the processes involved in CHWs employed by NPO's working with the Primary Health Care facilities and that this information can be used to facilitate good working relationships between CHWs and the clinics.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify. There is no remuneration for taking part in the study.

What if I have questions?

This research is being conducted by Lynette Temmers from the University of the Western Cape. If you have any questions about the research study itself, please contact Lynette Temmers at: 0658603125/ 0284241167 at Otto Du Plessis Hospital**.**

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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Appendix 2: Inligtingsgsblad: gemeenskapsgesondheidswerkers

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Projek Titel: Faktore wat die samewerking tussen gemeenskaps gesondheidswerkers en Primêre Gesondheidsorg fasiliteite beinvloed in primêre gesondheidsdienste.

Waaroor gaan die studie?

Hierdie is ‘n navorsingsprojek wat deur L.Temmers verbonde aan die Universiteit van Wes Kaapland gedoen word. Ons nooi u uit om deel te neem aan die studie omdat u die studie met die beste begrip van u werk as gemeenskaps gesondheidswerker kan gee. Die doel van die navorsing is om die samewerking tussen gemeenskapsgesondheids werkers en Primêre gesondheidsorg Klinieke te verken. Ons stel belang in wat u dink.

Die doel van die studie is om te beskryf en verken hoe gemeenskaps gesondheid werkers in diens van nie-winsgewende organisasies soos Kinder en Gesinsorg Suid Afrika en klinieke saamwerk in die Publieke gesondheidsorg sektor. Die resultate van die studie kan gebruik word om voorstelle te maak oor hoe om samewerking tussen klinieke en Gesondheidswerkers te verbeter. Verder kan die resultate ook gebruik word om ‘n beleid te ontwikkel oor hoe klinieke en gemeenskapsgewondheids werkers inligting kan deel, saam kan beplan en reël, en mekaar kan ondersteun om almal se diens te verbeter.

Wat sal van my verwag word indien ek deelneem?

U deelname aan die studie is volkome vrywillig. U mag kies om deelname te weier. Indien u besluit om deel te neem aan die studie, mag u enige tyd onttrek. Indien u besluit om nie deel te

neem aan die studie of as u enige tyd besluit om te onttrek, sal u hoegenaamd nie gepenaliseer word of enige voordele verloor wat u andersins in aanspreking sou voor gekom het.

U sal gevra word om toestemming te teken vir deelname in die navorsingstudie. Ek sal ‘n onderhoud met u in ‘n groep doen (FoKus Groep Bespreking). Die groep sal bestaan uit 5 ander gemeenskapsgesondheidswerkers. Die onderhoude sal by Kinder en Gesinsorg se saal in Bredasdorp gedoen word. Ek sal ‘n oudio-opname (klank) van die onderhoud doen.Dit behoort ongeveer ‘n uur lank te wees. Die vrae sal handel oor u werk, hoe u in die gemeenskap en met die klinieke werk. Die fokus sal wees om te verstaan hoe u dinge sien. Ek stel belang in hoe u dit verstaan en wat u dink.

Sal my deelname in die studie konfidensieel gehou word?

Ek onderneem om u identiteit te beskerm. Om te verseker dat niemand weet wat u bydrae is, sal u naam nie gedurende die onderhoud genoem word en sal skuilname gebruik word. ‘n Kode (nommer) sal aan u toegeken word en op al die versamelde data gebruik word in plaas van u naam. Slegs die navorser sal kennis hê oor wie watter kode toegeken is en sal die enigste persoon wees wat toegang tot die informasie sal hê.

Om u te verseker van konfidensialiteit sal die navorser die identifikasie sleutel wat u regte naam en kode nommer bevat, in ‘n kluis by haar huis opsluit. Die versamelde data sal ook in die kluis gehou word en slegs die identifikasie kode nommer sal op alle papierwerk gebruik word. Op die rekenaar waar die data gestoor word, sal al die lêers beskerm word met ‘n wagwoord.

Indien ons ‘n verslag of artikel oor hierdie navorsings projek skryf, sal u naam nooit genoem word.

Hierdie studie maak gebruik van fokusgroep besprekings dus is die mate waartoe ons u identiteit konfidensieel kan hou, afhanklik van die ander deelnemers in die fokus groep om konfidensialiteit te behou.

Wat is die risikos verbonde aan die studie?

Daar mag dalk risikos wees a.g.v. deelname aan die studie.

Alle interaksies tussen mense en praat oor self of ander dra ‘n seker hoeveelheid risiko saam. Ons sal egter steeds die risikos verminder en u onmiddellik help indien u enige ongerief, emosioneel of andersins, gedurende die proses van u deelname in die studie ervaar. Waar nodig, sal ‘n verwysing na ‘n toepaslike maatskaplike werker by Kindersorg vir verdere hantering en intervensie gedoen word.

Wat is die voordele van die studie?

Die studie is nie ontwerp om u persoonlik te help, maar die resultate mag die navorser help om meer oor samewerking prosesse tussen gemeenskaps gesondheidswerkers en primêre gesondheidsorg fasiliteite (klinieke) te leer. Ons hoop dat ander persone in die toekoms sal voordeel trek uit die studie deur verbeterde begrip van die prosesse betrokke in samewerking tussen gemeenskaps gesondheidswerkers in diens van nie-winsgewende organisasies (Kindersorg) en klinieke en dat hierdie inligting gebruik kan word om goeie werksverhoudinge tussen gemeenskaps gesondheidswerkers en klinieke te fasiliteer.

Moet ek deelneem aan die navorsing en mag ek enige tyd ophou deelneem?

U deelname aan die studie is volkome vrywillig. U mag kies om deelname te weier. Indien u besluit om deel te neem aan die studie, mag u enige tyd onttrek. Indien u besluit om nie deel te neem aan die studie of as u enige tyd besluit om te onttrek, sal u hoegenaamd nie gepenaliseer word of enige voordele verloor wat u andersins in aanspreking sou voor gekom het. Daar is geen vergoeding vir deelname aan die studie.

Wat as ek vrae het?

Die studie word gedoen deur Lynette Temmers verbonde aan die Universiteit van Wes Kaapland. Indien u enige vrae het oor die navorsing, kontak L.Temmers by 0658603125/ 0284241167 by Otto Du Plessis Hospitaal**.**

Indien u enige vrae het aangaande die studie en u reg as ‘n deelnemer aan die navorsing of indien u enige probleme ervaar verwant aan die studie wil aanmeld, kontak asb :

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Appendix 3: Information sheet: key informants

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E-mail: soph-comm@uwc.ac.za

Project Title: Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering primary health care services.

What is this study about?

This is a research project being conducted by L. Temmers a MPH student at the University of the Western Cape. We are inviting you to participate in this research project because you have first-hand knowledge on collaboration between community health workers and the Public primary health care facilities.

The purpose of this study is to describe and analyse the collaboration between Community Health Workers employed by an NPO (Non-profit Organisation) and Primary Health Care facilities in the Public Health Sector. The findings of this study can be used to develop suggestions for practical guidelines to implement for effective and efficient collaboration between Community Health Workers and Primary Health Care facilities. Furthermore, the findings can be used to develop a policy on information sharing and planning integration and supporting CHWs in the health system to improve PHC service delivery.

What will I be asked to do if I agree to participate?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify

You will be asked to sign consent to participate in the research study. I will do a face to face individual interview with you at a time and place acceptable to you. With your permission, I will make an audio-tape recording of the interview. It should last about one hour. The questions will be about your work, how you work with community health workers, how you see them and the barriers and facilitators you see in the execution of their duties. The focus will be on understanding how you see things. I am interested in what you think and understand.

Would my participation in this study be kept confidential?

The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, your names will not be used during the interview and pseudonyms will be used. A code will be assigned to you which will be used on all the data collected. The researcher will be the only person who will have knowledge on which code is assigned to you and will be the only person who has access to this information.

To ensure your confidentiality, the researcher will keep the identification key containing your real name in a safe at her home. The data collected will also be kept in this safe and only the identification code will be used on all paperwork. On the computer where data will be stored, all the files will be protected with passwords.

If we write a report or article about this research project, your identity will be protected.

What are the risks of this research?

There may be some risks from participating in this research study.

All human interactions and talking about self or others carry some amount of risks. You may feel uncomfortable or judged talking about your work in this context and it may bring about an emotional response. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a social worker at the NPO for further assistance or intervention.

Due to the small population size it may be possible for others to identify you within our sub-district but the researcher will make every effort to maintain confidentiality and will at no time confirm your identity to anyone.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about collaboration processes between CHWs and the public sector (clinics). We hope that, in the future, other people might benefit from this study through improved understanding of the processes involved in CHWs employed by NPO's working with the Primary Health care facilities such as clinics and that this information can be used to facilitate good working relationships between CHWs and the clinics. I hope to use the findings of the research to implement strategies within our sub-district that can be used to improve collaboration to improve services.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify. There is no remuneration for taking part in the study.

What if I have questions?

This research is being conducted by Lynette Temmers from the University of the Western Cape. If you have any questions about the research study itself, please contact Lynette Temmers at: 0658603125/ 0284241167 at Otto Du Plessis Hospital**.**

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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Appendix 4: Inligtingsblad: sleutel informante

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Projek Titel: Faktore wat die samewerking tussen gemeenskaps gesondheidswerkers en Primêre Gesondheidsorg fasiliteite beinvloed in primêre gesondheidsdienste.

Waaroor gaan die studie?

Hierdie is 'n navorsingsprojek wat deur L.Temmers verbonde aan die Universiteit van Wes Kaapland gedoen word. Ons nooi u uit om deel te neem aan die studie omdat u eerstehandse kennis het van interaksie en samewerking tussen gemeenskaps gesondheidswerkers en primêre gesondheidsorg kan gee. Die doel van die navorsing is om die samewerking tussen nie-winsgewenede organisasies en die primêre gesondheidsorg fasiliteite in Kaap Agulhas te beskryf. Ons stel belang in u opinies in die verband.

Die doel van die studie is om die samewerking tussen gemeenskaps gesondheid werkers in deins van nie-winsgewende organisasies en publieke primêre gesondheidsorg fasiliteite te beskryf en analiseer. Die bevindinge van die studie kan gebruik word om voorstelle te ontwikkel vir praktiese riglyne om te implimenteer vir effektiewe en doeltreffende samewerking tussen gemeenskaps gesondheid werkers en primêre gesondheidsorg fasiliteite.Verder kan die bevindinge ook gebruik word om 'n beleid te ontwikkel aangaande die deel van inligting, beplanning, integrasie en ondersteuning van gemeenskaps gesondheid werkers om primêre gesondheidsorg dienslewering te verbeter.

Wat sal van my verwag word indien ek deelneem?

U deelname aan die studie is volkome vrywillig. U mag kies om deelname te weier. Indien u besluit om deel te neem aan die studie, mag u enige tyd onttrek. Indien u besluit om nie deel te neem aan die studie of as u enige tyd besluit om te onttrek, sal u hoegenaamd nie gepenaliseer word of enige voordele verloor wat u andersins in aanspreking sou voor gekom het.

U sal gevra word om toestemming te teken vir deelname in die navorsingstudie. Ek sal ‘n semi-struktureerde onderhoud met u voer. Onderhoude sal gedoen word by ‘n ooreengestemde lokaal. ‘n Oudio-band sal gemaak word van die onderhoud. Dit behoort ongeveer een uur lank te wees. Die vrae sal handel oor u werk, hoe u met gemeenskap gesondheidswerkers werk, hoe u hulle sien en die hindernisse en fasiliteerders in die uitvoer van hul pligte. Die fokus sal wees om te verstaan hoe u dinge sien. Ek stel belang in wat u dink en verstaan.

Sal my deelname in die studie konfidensieel gehou word?

Die navorser onderneem om u identiteit en die aard van u bydrae te beskerm. Om u anonimiteit te verseker, sal u naam nie gedurende die onderhoud genoem word en sal skuilname gebruik word. ‘n Kode sal aan u toegeken word en op al die versamelde dat gebruik word. Slegs die navorser sal kennis hê oor wie watter kode toegeken is en sal die enigste persoon wees wat toegang tot die informasie sal hê.

Om u te verseker van konfidensialiteit sal die navorser die identifikasie sleutel wat u regte naam bevat, in ‘n kluis by haar huis opsluit. Die versamelde data sal ook in die kluis gehou word en slegs die identifikasie kode sal op alle papierwerk gebruik word. Op die rekenaar waar die data gestoor word, sal al die lêers beskerm word met ‘n wagwoord.

Indien ons ‘n verslag of artikel oor hierdie navorsings projek skryf, sal u identiteit beskerm word.

Wat is die risikos verbonde aan die studie?

Daar mag dalk risikos wees a.g.v. deelname aan die studie.

Alle menslike interaksies en praat oor self of ander dra ‘n seker hoeveelheid risiko saam. Ons sal egter steeds die risikos verminder en u onmiddellik assisteer indien u enige ongerief, psigies of andersins, gedurende die proses van u deelname in die studie ervaar. Waar nodig, sal ‘n

verwysing na ‘n toepaslike maatskaplike werker by die nie-winsgewende organisasie vir verdere hantering en intervensie.

Weens die klein populasie mag dit moontlik wees vir ander om u te identifiseer in ons sub-distrik maar die navorser sal alles in haar vermoë doen om konfidensialiteit te handhaaf en sal onder geen omstandighede u identiteit met enigeen bevestig.

Wat is die voordele van die studie?

Die studie is nie ontwerp om u persoonlik te help, maar die resultate mag die navorser help om meer oor samewerking prosesse tussen gemeenskaps gesondheidswerkers en primêre gesondheidsorg fasiliteite te leer. Ons hoop dat ander persone in die toekoms sal voordeel trek uit die studie deur verbeterde begrip van die prosesse betrokke in samewerking tussen gemeenskaps gesondheidswerkers in diens van nie-winsgewende organisasies en primêre gesondheidsorg fasiliteite en dat hierdie inligting gebruik kan word om goeie werksverhoudinge tussen gemeenskaps gesondheidswerkers en klinieke sal fasiliteer.

Moet ek deelneem aan die navorsing en mag ek enige tyd ophou deelneem?

U deelname aan die studie is volkome vrywillig. U mag kies om deelname te weier. Indien u besluit om deel te neem aan die studie, mag u enige tyd onttrek. Indien u besluit om nie deel te neem aan die studie of as u enige tyd besluit om te onttrek, sal u hoegenaamd nie gepenaliseer word of enige voordele verloor wat u andersins in aanspreking sou voor gekom het. Daar is geen vergoeding vir deelname aan die studie.

Wat as ek vrae het?

Die studie word gedoen deur Lynette Temmers verbonde aan die Universiteit van Wes Kaapland. Indien u enige vrae het oor die navorsing, kontak L.Temmers by 0658603125/ 0284241167 by Otto Du Plessis Hospitaal**.**

Indien u enige vrae het aangaande die studie en u reg as ‘n deelnemer aan die navorsing of indien u enige probleme ervaar verwant aan die studie wil aanmeld, kontak asb :

Dr. Verona Mathews

School of Public Health

University of the Western Cape

Private Bag X17

Bellville 7535

vmathews@uwc.ac.za

021 959 2809

Prof Uta Lehman

School of Public Health

Departementele hoof

Universiteit van Wes-Kaapland

Privaatsak X17

Bellville 7535

soph-comm@uwc.ac.za

Prof Anthea Rhode

Dekaan van die Fakulteit Gemeenskap en Gesondheidwetenskappe

Universiteit van Wes-Kaapland

Privaatsak X17

Bellville 7535

chs-deansoffice@uwc.ac.za

Appendix 5: Consent form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Title of Research Project: Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering primary health care services.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I agree to having the interview audio-taped. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. Should you have any questions regarding this study, you can contact the researcher : L. Temmers at 0658603125/ 0284241167 at Otto du Plessis Hospital.

Participant's name……..

Participant's signature…….

Date……

Appendix 6: Toestemmingsvorms

UNIVERSITEIT VAN WES-KAAPLAND

Privaatsak X 17, Bellville 7535, Suid-Afrika

Tel: +27 21-959 2809, Faks: 27 21-959 2872

E-pos: soph-comm@uwc.ac.za

Titel van navorsings studie: Faktore wat die samewerking tussen gemeenskaps gesondheidswerkers en Primêre Gesondheidsorg fasiliteite beinvloed in primêre gesondheidsdienste.

Die studie is aan my verduidelik in taal wat ek verstaan. My vrae oor die studie is beantwoord. Ek verstaan wat my deelname sal behels en ek neem deel uit my eie vrye wil en my eie keuse. Ek gee toestemming dat ‘n oudio opname van die onderhoud gedoen word. Ek verstaan dat my identiteit nie bekend gemaak sal word. Ek verstaan dat ek myself enige tyd kan onttrek van die studie sonder om ‘n rede te verskaf of vrees vir negatiewe gevolge of verlies van voordele. Indien u enige vrae aangaande die studie het, kan u die navorser kontak by L. Temmers by 0658603125/ 0284241167 by Otto du Plessis Hospitaal.

Deelnemer naam……..

Deelnemer Handtekening…….

Datum……

Appendix 7: Focus group confidentiality binding form

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Title of Research Project: Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering primary health care services.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone by the researchers. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits. I understand that confidentiality is dependent on participants' in the Focus Group maintaining confidentiality.

I hereby agree to uphold the confidentiality of the discussions in the focus group by not disclosing the identity of other participants or any aspects of their contributions to members outside of the group.

Participant's name……..

Participant's signature……..

Date……

Appendix 8: Fokus groep konfidensialiteit bindende vorm

UNIVERSITEIT VAN WES-KAAPLAND

Privaatsak X 17, Bellville 7535, Suid-Afrika

Tel: +27 21-959 2809, Faks: 27 21-959 2872

E-pos: soph-comm@uwc.ac.za

Titel: Faktore wat die samewerking tussen gemeenskaps gesondheidswerkers en Primêre Gesondheidsorg fasiliteite beinvloed in primêre gesondheidsdienste.

Die studie is aan my verduidelik in taal wat ek verstaan. My vrae oor die studie is beantwoord. Ek verstaan wat my deelname sal behels en ek neem deel uit my eie vrye wil en my eie keuse. Ek verstaan dat my identiteit nie bekend gemaak sal word. Ek verstaan dat ek myself enige tyd kan onttrek van die studie sonder om 'n rede te verskaf of vrees vir negatiewe gevolge of verlies van voordele. Ek verstaan dat konfidensialiteit afhanklik is van die deelnemers in die fokus groep bespreking.

Hiermee stem ek in om konfidensialiteit van die besprekings in die fokus groep te handhaaf deur nie die identiteit of enige ander aspekte van hul bydrae met persone buite die groep te deel.

Deelnemer naam……..

Deelnemer handtekening……..

Datum……

Appendix 9: Interview guide: FGD CHWs

1. What are your ages?
2. How long have you been working in this community?
3. Describe what your work entails/ what you do
    - In the community?
    - In the clinics?
    - What does the clinics expect from you?
    - What do you expect from them?
    - What types of reports/ feedback do you give to your supervisors?
    - What type of reports feedback do you give to the facility?
4. Explain to me the type of training you need to be a CHW?
    - How do you use your training?
    - How does the training help you to do your job?
    - How does the training prepare you to talk to the community?
    - How does the training prepare you to speak to the facility staff?
5. Describe your experiences as a CHW
    - Who do you have to work with, tell me about the role players?
    - How do you work with the clinics?
    - Tell me about the type of meetings you attend? And with clinics?
    - How do you plan the health services?
    - How do you get resources?
    - Who talks to you about the client?
    - What is your relationship with staff?
6. What is the type of things that influences how you do your job?
    - What makes it easier, and more difficult?
    - If it is a private matter? A work related matter? (e.g. Appointment for client?)
    - How are your issues with leave, sick days or salaries sorted out?

Appendix 10: Interview guide: FGD CHWs (Afrikaans version)

1. Hoe oud is julle?
2. Hoe lank werk julle in die gemeenskap?
3. Beskryf vir my wat u werk behels, dit wat jy doen.
    - In die gemeenskap?
    - Wat doen julle by die kliniek?
    - Wat verwag die klinieke van julle om te doen?.
    - Wat verwag julle van die klinieke?
    - Watter tipe verslae/ terugvoering moet u gee en aan wie?

4. Verduidelik vir my wat behels die opleiding wat mens benodig om ‘n gemeenskaps gesondheidswerker te wees.
    - Hoe gebruik julle julle opleiding?
    - Hoe help die opleiding julle om julle werk te kan doen?
    - Hoe help die opleiding wat julle ontvang julle om met die gemeenskap te praat?
    - Hoe help die opleiding julle om met die kliniek personeel te kommunikeer?

5. Beskryf u ervaringe as ‘n Gemeenskaps gesondheidswerker.
    - Met wie moet u saamwerk, vertel my van die mense met wie u werk?
    - Hoe werk u saam met die klinieke?
    - Vertel my van die tipe vergaderings wat julle bywoon. En met die klinieke?
    - Hoe beplan u wat om te doen.
    - Hoe kry u u toerusting?
    - Vertel watter tipe verhouding het u met die personeel van die kliniek?

6. Watter tipe dinge beinvloed hoe julle julle werk doen?
    - Wat maak dit makliker, en moeiliker?
    - As dit ‘n privaat geleentheid is?
    - Werksverwant is?
    - Hoe word u probleme met verlof, siek dae en salarisse uitsorteer?

Appendix 11: KI: Supervisors (NPO)

1. Describe how you work with CHWs.
    - What do the CHWs expect from you?
    - What do you expect from them, and from the clinic?
    - What do they (clinics) expect from the CHWs?
    - Describe what feedback mechanism you have. With CHWs, to the NPO, clinics?
    - How do you receive feedback?

2. Elaborate on the training CHWs receive.
    - How does the training help them to do their job? And you?
    - How does the training help them to laisse with the NPO and the clinics?

3. What are the things that influences/affects how CHWs do their job?
    - Why? How does it affect them?
    - How do you address/handle this, with the NPO, and with the facility?

4. Describe the relationship between CHWs and Clinics.
    - Tell me about your meetings.
    - How do you know which primary healthcare activities to focus on?
    - How do you ensure that you have resources to do your job?
    - How do you/ CHWs participate in planning activities?
    - How do you/ CHWs participate in monitoring?
    - Do you feel that CHWs opinions are important in facilities? Why, why not?

5. What influences how CHWs do their job?
    - With CHWs?
    - With staff at facilities?

Appendix 12: KI: Supervisors (NPO) (Afrikaans version)

1. Beskryf hoe u werk met Gemeenskap Gesondheidswerkers (GGWs).
    - Wat verwag hulle van u?
    - Wat verwag u van hulle, en van die kliniek?
    - Wat verwag die klinieke van die GGWs ?
    - Beskryf watter terugvoer prosesse daar bestaan. Vir GGWs? Nie-winsgewende organisasie (NWO), klinieke?
    - Hoe ontvang u terugvoering?

2. Brei uit oor die opleiding wat die GGWs ontvang.
    - Hoe help die opleiding hulle om hul werk te kan doen? En vir u?
    - Hoe help die opleiding hulle om met die NWO en die klinieke te skakel.

3. Wat beinvloed hoe GGWs hul werk doen?
    - Hoekom? Hoe affekteer dit hulle?
    - Hoe hanteer u dit, met die NWO? En met die klinieke?

4. Beskryf die verhouding tussen GGWs en die klinieke.
    - Vertel my van u vergaderings.
    - Hoe weet julle watter tipe primêre gesondheidsorg aktiwiteite om op te fokus?
    - Hoe verseker u en GGWs dat u die nodige toreusting het om u werk te kan doen?
    - Hoe neem u deel aan beplannings aktiwiteite?
    - Hoe neem u deel aan monitering?
    - Voel u dat GGWs se opinies belangrik is in fasiliteite? Hoekom, hoekom nie?

5. Wat beinvloed hoe GGWs hul werk doen?
    - Met mekaar of ander GGWs?
    - Met kliniekpersoneel?

Appendix 13: KI: PHC operational managers

1. Describe what CHWs do in your area.
    - How do they help with services?
    - What reports / statistics/ feedback do you expect from them?
    - In your opinion, how do you see them fit into the PHC system?
    - What would you like CHWs to do?
    - Where do you think they can be used? Inside/ outside the facilities? Why? How?
    - In your opinion, what can they do during campaigns and outreaches?

2. How do you work with other role players?
    - What type of interaction do you have with CHWs?
    - In what ways do you communicate with CHWs?
    - How do you experience working with CHWs?
    - How do they participate in meetings?
    - How do they participate in events?
    - How do they participate in PHC activities?

3. What type of reward or performance systems do they have in the Dept. of Health?
    - Who participates in it? Anyone from outside the facilities?
    - How does nomination work?
    - Other role players

4. What influences how CHWs work in your area? How?

Appendix 14: KI: PHC operational managers (Afrikaans version)

1. Beskryf wat moet die gemeenskaps gesondheidswerkers doen in u area.
    - Hoe help hulle die diens?
    - Watter verslae/ statistieke/ terugvoer verwag u van hulle?
    - In u opinie, hoe pas hulle in die primêre gesondheid sisteem?
    - Wat verwag u van die gemeenskaps gesondheidswerkers?
    - Waar en hoe dink u kan hulle gebruik word? Binne of buite fasiliteite? Hoekom, hoe?
    - In u opinie, wat kan hulle doen met veldtogte en uitreike?
2. Hoe werk u met ander rolspelers?
    - Watter tipe interaksie het u met gemeenskaps gesondheidswerkers?
    - Op watter manier kommunikeer u met gemeenskaps gesondheidswerkers?
    - Vertel my van u ondervinding van werk met gemeenskaps gesondheidswerkers.
    - Hoe neem hulle deel aan vergaderings?
    - Hoe neem hulle deel aan funksies/aktiwiteite?
    - Beskryf hul deelname aan primêre gesondheidsorg aktiwiteite.

3. Watter tipe beloning of prestasies sisteme is daar in Dept Gesondheid?
    - Wie neem deel daaraan? Net dept Gesondheid persone of enigeen van buite die fasiliteit?
    - Hoe werk die nominasie van persone?
    - Ander rolspelers?

4. Wat beinvloed hoe gemeenskaps gesondheidswerkers werk in jul area? Hoe?

Appendix 15: KI: Community based service managers

1. Describe how you work with CHWs.
2. What do you see as the roles of CHWs?
    - What do you think about the expectations from CHWs from government?
    - What factors contributes to effective service delivery for you? By CHWs?
    - What factors is a barrier for you in service delivery?

3. Elaborate on the training CHWs receive?
    - How do you think it prepares them in their day to day work?
    - How do their learned skills match expectations? From themselves? From clinics?
    - How do you think it prepares them to face barriers/problems?

4. Elaborate on the contractual agreement between NPO and Dept. Of Health?
    - Share how it is being implemented
    - How do they liaise with each other?
    - How do they support each other?
    - Describe the processes involved in monitoring. In your opinion, how effective is it?

Appendix 16: KI: Community based service managers (Afrikaans version)

1. Beskryf hoe u werk met gemeenskaps gesondheidswerkers.

2. Wat sien u as die rol van gemeenskaps gesondheidswerkers?
   - Wat dink u van die verwagtinge van die staat van gemeenskaps gesondheidswerkers?
   - Watter faktore dra vir u by tot effektiewe dienslewering? Deur gemeenskap gesondheidswerkers?
   - Watter faktore is ‘n hindernis vir u ten opsigte van dienslewering?

3. Brei uit oor die opleiding wat gemeenskaps gesondheidswerkers kry.
   - Hoe dink u berei dit hulle voor vir hul dag tot dag werk?
   - Hoe pas die aangeleerde vaardighede by die verwagting van hulle? Van hulleself? Van klinieke?
   - Hoe dink u berei dit hul voor om hindernisse/probleme te oorkom?

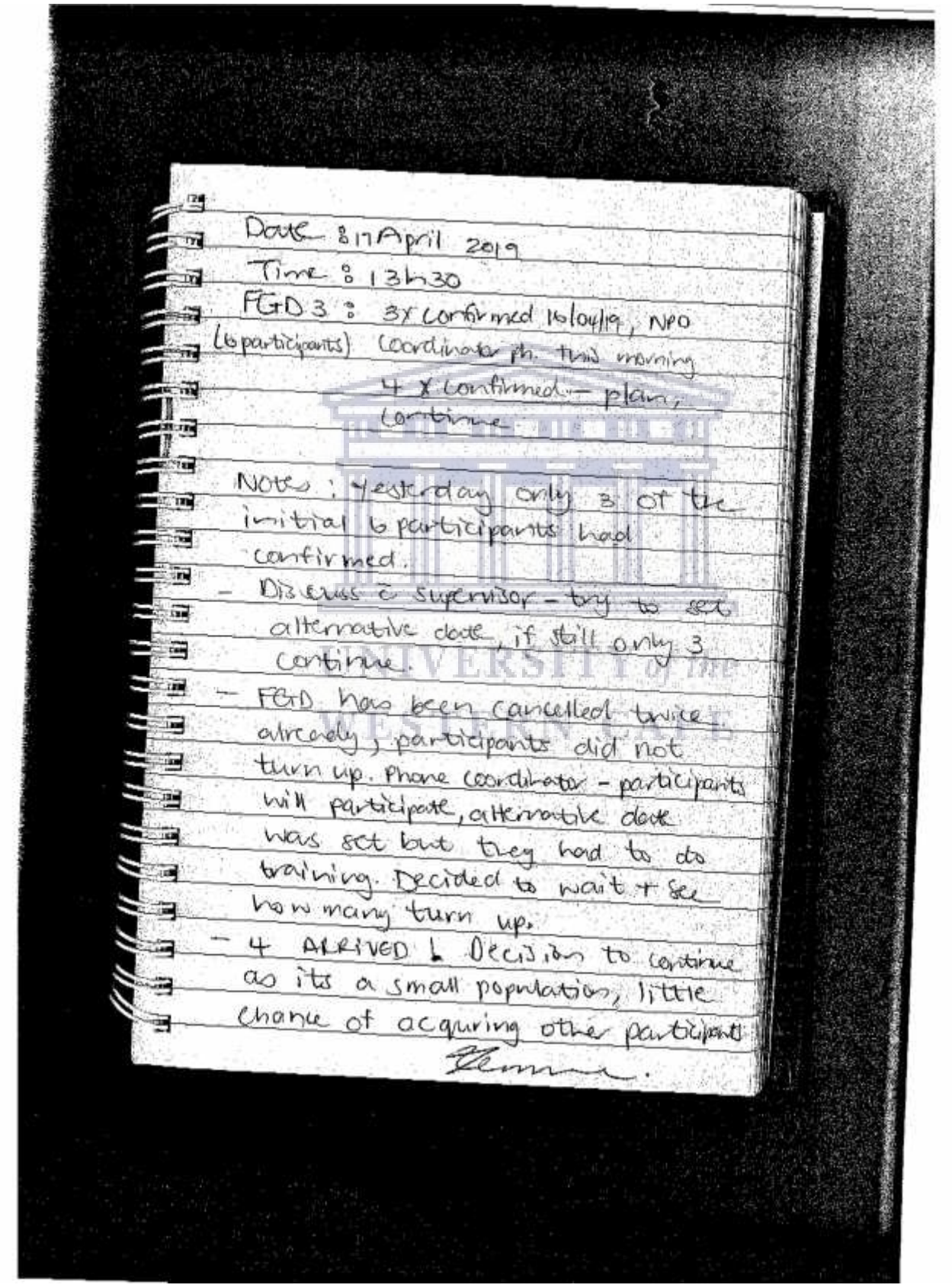
4. Brei meer uit oor die kontrak tussen die nie-winsgewende organisasie en Dept van Gesondheid.
   - Deel hoe word dit implementeer.
   - Hoe skakel die hulle met mekaar?
   - Hoe ondersteun hulle mekaar?
   - Beskryf die prosess betrokke met monitering. In u opinie, hoe effektief is dit vir u?

Appendix 17: Code book

Codes	Description
Activities with clinics	Any interaction and common activities between CHWs and PHC facilities
Activities in communities	Activities CHWs perform in communities (as part of their roles)
Activities	
Roles or responsibilities	Activities CHWs and PHC staff see as part of their jobs
Health promotion	Activities done by CHWs to promote healthy living in communities – part of roles
Tasks CHWs take responsibility for	Other tasks CHWs do that is not part of their job but important to help the community to keep healthy
Referrals	Referral process followed by CHWs and PHC staff, referrals to CHWs, from CHWs, interaction on referrals
Training	The type of training received by CHWs, both formal and informal
Supervision	Supervision received by CHWs – all activities related to supervision of CHWs
Attitude CHWs	CHWs way of looking at PHC facilities and staff
Attitude PHC staff	PHC way of looking at CHWs
CHWs feelings	Feelings expressed by CHWs relating to themselves
Planned collaboration	Ideas and opinions on how to improve collaboration
Community expectations and opinions	What the community expect from CHWs
PHC facility expectations	What the PHC staff expect from CHWs

Expectations from CHWs	What CHWs expect from PHC facilities What CHWs expect from the NPO
CHWs perceptions	How CHWs perceive PHC staff and their roles
Remuneration	Salaries – expectations and opinions
Professional body	CHWs as a cadre
CHW education level	Opinions on how level of education of CHWs affect presentation of training
Planning	How CHWs plan activities
Recognition	Feelings and opinions on acknowledgement of CHWs
Relationships between CHWs and PHC	The type of connection between CHWs and PHC staff, day to day interaction with each other, how they related to each other
Impact of CHW effectiveness	Activities that show CHWs effectiveness in communities
Leadership	Opinions on leadership and accountability for activities
Inclusion	Participation in planning activities
Proposed activities to improve collaboration	Activities suggested to improve collaboration with each other
Confidence	Opinions and feelings on competency by CHWs
Resources	Various resources and its availability to CHWs
NPO relationship with CHWs	How CHWs experienced their relationship with the NPO
PHC appreciation for CHWS	Comments, ideas, support by PHC in appreciating CHWs part in PHC

Appendix 18: Journal entry



Date: 17 April 2019
Time: 13h30
FGD 3: 3x confirmed 16/04/19, NPO (6 participants) Coordinator ph. this morning
4 x confirmed – plan; continue

Notes: Yesterday only 3 of the initial 6 participants had confirmed.
- Discuss c supervisor – try to set alternative date, if still only 3 continue.
- FGD has been cancelled twice already, participants did not turn up. Phone coordinator – participants will participate, alternative date was set but they had to do training. Decided to wait + see how many turn up.
- 4 ARRIVED & Decision to continue as its a small population, little chance of acquiring other participants

Appendix 19: UWC ethics approval

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 4111/2948
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E: research-ethics@uwc.ac.za
www.uwc.ac.za

06 March 2019

Ms L Temmers
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM19/1/4

Project Title: Factors influencing the collaboration between community health workers and the public primary health care facilities in delivering primary health care services.

Approval Period: 15 February 2019 – 15 February 2020

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The permission to conduct the study must be submitted for record purposes.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

BMREC REGISTRATION NUMBER -130416-050

Appendix 20: Approved permission letter: sub-district

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2809 Fax: 27 21-959 2872

E-mail: soph-comm@uwc.ac.za

Dr Du Toit

Department of Health

Sub-District Office (Cape Agulhas and Swellendam Area)

18 Drostdy Street

Swellendam

Sub- District Management Team

RE: Permission to conduct research study in the Cape Agulhas Sub-District

Dear Sir

Title of the project: Factors influencing the collaboration between Community Health Workers and the Public Primary Health Care Facilities in delivering primary health care services.

This is a research project being conducted by Lynette Temmers affiliated with the University of the Western Cape as part of a Masters in Public Health degree. I want to request permission to interview 4 people in the Department of Health working in the Overberg Region. The interviews will be face to face interviews and will take approximately one hour.

This study aims to explore and describe the factors that influence collaboration between CHWs and PHC facilities in delivering PHC services. Attached is the proposal of my research, a copy of the study information sheet and a copy of the consent form that will be completed by the participants prior to participating in the research study.

This research has been approved by the University of the Western Cape's Biomedical Research Ethics Committee. REFERENCE NUMBER (BMI 9/1/4). Please find attached the ethical approval letter from our Biomedical Research Ethics Committee at the University of the Western Cape (UWC).

If you agree, kindly supply your full name and signature below and return the signed form in the enclosed self-addressed envelope. Alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging your consent and permission for me to conduct this research study.

Approved by:

Name and title	Signature	Date
JP du Toit		13/3/12

If you require any further information, please do not hesitate to contact me at:

Tel: 028 4241167; Mobile: 0658603125; Fax 0862411115, E-mail: 9301390@myuwc.ac.za

Thank you for your time and consideration in this matter.

Yours sincerely,

Lynette Temmers

Should you have any further questions regarding this study please contact:

Prof Uta Lehmann

Director: School of Public Health

University of the Western Cape

Private Bag Xl 7

Bellville 7535

Tel.• +27 21-959 2809 Fax: 27 21-959 2872 E-mail:
soph-comm@uwc.ac.za

OR

Prof Anthea Rhoda

Dean of the Faculty of Community and Health Sciences

University of the Western Cape

Private Bag Xl 7 Bellville 7535
chs-deansoffice@uwc.ac.za

Appendix 21: Approved permission letter: Western Cape Department of Health

Western Cape Government
Health

HEALTH IMPACT ASSESSMENT
HEALTH RESEARCH SUB-DIRECTORATE
Health.Research@westerncape.gov.za
tel: +27 21 483 0866; fax: +27 21 483 9895
5th Floor, Norton Rose House,, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201903_017
ENQUIRIES: Dr Sabela Petros

University of Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7535

For attention: Mrs Lynette Temmers

Re: **Factors influencing the collaboration between community health workers and the public primary health care facilities in delivering primary health care services**

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact **Dr J Du Toit on 028 514 8400** to assist you with any further enquiries in accessing the following sites:

Bredasdorp Clinic

Napier Clinic

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. By being granted access to provincial health facilities, you are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of your project. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR M MOODLEY

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 05-06-2014