



RESEARCH ARTICLE

Sustaining the National Health Insurance Scheme in South Africa: The Roles and Challenges of Community Health Workers

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Abstract:

Background:

The provision of universal health coverage is acknowledged as a priority goal for healthcare systems globally. In South Africa, the National Health Insurance system has been endorsed as a funding model for the provision of universal health coverage for South Africans. Community Health Workers have contributed to better universal health coverage outcomes in many countries. A study in India revealed that coverage of health care practices is positively correlated with the knowledge level of Community Health Workers. In South Africa, there is a difference in the duration of training of Community Health Workers in different provinces, especially in Vhembe District.

Objective:

This study aimed to assess Community Health Workers' knowledge regarding their roles and describe their challenges within the context of National Health Insurance.

Methods:

Qualitative design was used to collect data from 33 participants who formed five focus groups comprising six to eight members each. Ethical principles of research such as permission, informed consent, voluntary participation and anonymity were observed. Data was analysed using thematic data analysis technique guided by Tesch open coding method.

Results:

The findings revealed that Community Health Workers lack adequate knowledge regarding the roles they are expected to play within Ward Based Outreach teams. Some of the challenges they face include transportation to clients' homes and poor reception in households.

Conclusion:

A review of the South African Qualification Authority health promoter unit standards is recommended coupled with the mentorship of Community Health Workers by retired nurses to help them understand their roles better.

Keywords: Community health workers, National Health Insurance, Roles, Knowledge, Challenges, South Africa.

1. INTRODUCTION

December 12, 2017, marks the anniversary of the first United Nations resolution, calling countries to provide universal health care coverage by 2030 [1]. According to the World Health Organisation [2], shortage of health workers is highlighted as one of the key constraints to achieving the universal health care coverage globally. Thus, since the

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1978 Alma Ata conference, Community Health Workers (CHWs) are being increasingly advocated as potential solutions to overcoming shortfalls of healthcare professionals worldwide, particularly in lower-middle income settings [3]. Community health work was introduced in South Africa as home-based care in the 1940s, focusing on the home care of HIV/AIDS patients [4]. Evidence from countries such as Brazil, India, *etc.*, demonstrate that services offered by CHWs have helped in the decline of maternal and child mortality rates; and have also assisted in decreasing the burden and costs of Tuberculosis (TB) and Malaria worldwide [1].

The south African government introduced National Health Insurance (NHI) as a funding system supporting the provision of universal health care for all [5]. The provision of universal health care services in South Africa is facilitated by the adoption of Primary Health Care (PHC) re-engineering strategy with its 4 pillars, which include among others Ward Based Outreach Teams (WBOT). The CHWs form part of the six members of WBOT. For decades, the South African Healthcare system has been clinic and hospital based [4]. The idea of PHC re-engineering is about taking health out of the facility to the community, with emphasis on health promotion and disease prevention [6]. Thus, the PHC re-engineering model proposes a population-based approach for the delivery of PHC services to the uninsured population using CHWs as part of the formal structure of the health team, as a bridge between the providers of formal health services, community services, social agencies and vulnerable populations within the communities. In South Africa, CHWs are seen as a valuable means of providing effective and contextually appropriate services both in urban and rural settings [7].

CHWs in South Africa are people from the communities without a formal professional training or degree, who have been selected, or, who have volunteered to perform functions related to healthcare delivery [8]. This job is usually taken up by females in their thirties and forties [9]. Some of these CHWs only hold the Matriculation (Grade 12) certificate – an evidence of completion of secondary education, while others do not complete secondary school (Mottiar & Lodge, 2018). However, many of them receive some form of training in health care by completing the National Certificate in home-based care (NQF level 1). With this qualification, they are able to perform different roles within their communities as health care providers [10]. In the healthcare profession tier, CHWs are one of those at the lowest class because of their low level of education, the type of work they do and their meagre income [11]. Belonging to a low social class has been associated with a reduced ability to control one's environment, an increase in psychological stress and vulnerability to physical and mental illnesses; thus, it is understandable that many CHWs also suffer from chronic diseases like hypertension and diabetes [11, 12].

According to the Department of Social Development; South Africa had about 72 839 CHWs in health and social development sectors in 2011 alone, with various training, titles and roles such as home-based carers or community caregivers (49 042); lay counsellors (15 206); adherence counsellors (2 010); DOT supporters (2 740); peer educators (3 478); TB defaulter tracers (93); High Transmission area workers (109); hospice workers (143); and mentors (18). These CHWs are distributed across all provinces of South Africa with the highest number in Kwazulu-Natal (17 677), followed by Limpopo (8 443), then Mpumalanga (8431); and lowest in Northern Cape (2 431); Free State (3 194 and Western Cape (3 816) [13].

Regarding their roles in the era of PHC re-engineering and National Health Insurance, the Provincial guidelines for the implementation of WBOT toolkit illustrate that CHWs are expected to provide information, education and support for healthy behaviours and appropriate home care; carry out community assessment; conduct household assessment and identify those at risk and high risk; provide psychosocial support; identify and manage minor health problems; support screening and other programmes; and support continuum of care [14].

Initially, all CHWs perform their roles voluntarily and were not being paid. However, provincial governments eventually took up the responsibility of paying them hourly either through Non-Governmental Organizations (NGOs) or directly [9]. Most of them receive a meagre stipend at an average rate of R21.50 per hour or less and work 8 hours daily for 5 days in a week; most do not receive the stipends regularly, while some do not receive it at all [9, 10]. Many of them consider this stipend as grossly inadequate because they needed to use transport to get to the households within the communities where they work on a daily basis [10]. Without a nationally standardized salary rate, CHWs at different provinces receive different treatments in terms of stipends and most of them do not work under specific job contracts; thus, their job interests are not protected [10]. Apart from inadequate stipends, CHWs are also faced with other challenges, especially lack of recognition like other health professions and a lack of real opportunity to grow their careers within the CHW system; this results in emotional distress and a subsequent desire of many of them to pursue another more recognized career in health discipline, like Nursing [10]. This implies that many CHWs have reached their threshold of coping with the stress posed by their works and they could no longer adapt with the workload without a

proportionate remuneration [15].

CHWs in Vhembe District of Limpopo Province of South Africa attended various training programs with varying learning outcomes [16]. Yet, most of them usually refer the majority of health needs identified from the community to the local clinic without attempting to address them. The reasons for not attempting to address the identified health needs were not clear. Tsolekile, Schneider & Puoane in a study, which assessed CHWs' roles, training and knowledge about diabetes mellitus in Khayalitsha, Cape Town, revealed that CHWs training is unstandardized and not aligned to the stipulated roles [12].

“Some attended 69 days training offered by government employed nurses at a local health centre; others attended 59 days training offered by government employed nurses at a local clinic; some attended Ancillary Health training at Nchebeko skills consultancy (Pty) Ltd for 1 year; others attended Ancillary Health training at Nchebeko skills consultancy (Pty) Ltd for 2 years; some attended Ancillary Health training at Nchebeko consulting for only 3 years”.

In South Africa, a variety of 1 year CHWs' training programs with various learning outcomes are registered with the South African Qualification Authority (SAQA) namely National Certificate: Community Work NQF level 2: ID 64749; National Certificate: Community Work NQF level 3: ID 64769; ID 64749; Further education & Training Certificate: Community Health work, NQF level 4: ID 64697; General education & training certificate: Ancillary Health care, NQF level 1: ID 49606; Further education and training certificate: Child and youth Care work, NQF level 4: ID 60209; Further education & Training Certificate: Public Awareness promotion of dreaded diseases & HIV/AIDS, NQF level 4: ID 74410. The learning outcomes of these program are not similar and not aligned to the CHWs' roles outlined in the Provincial guidelines for the implementation of WBOT tool kit [16], except for Occupational Certificate: Health promotion officer, NQF level 3: ID 94597 [17], which is the most current replacing 64749 and 64769.

A worldwide case study identified a similar trend, where a range of CHW programmes have a different mix of typology with varying learning outcomes and training duration, training provided by various service providers, training aligned to varying roles [1]. This discovery suggests that a possible role of knowledge deficit exists among CHWs, who received training of varying duration in Vhembe district. The CHWs are the public's first point of contact with the health care system. The public's first impression of CHWs should instill confidence in the health care system. Performing their roles as expected might market the healthcare system well to the general public. However, performing the role as expected depends on knowledge of such roles. It is not clear if CHWs know their roles. In order to be sure, this study emanated to assess CHWs' knowledge regarding their roles, so that if gaps exist, CHWs should be thoroughly trained to strengthen their capacity in relation to the roles stipulated in the provincial guidelines [14].

Since the beginning of the South African NHI pilot projects and PHC re-engineering strategy in 2012, many studies were conducted in other pilot sites (Eastern Cape, Western Cape, and Kwazulu Natal provinces of South Africa) to describe the roles, experiences and impact of CHWs in re-engineering of PHC [7, 18 - 23]. However, no study was conducted to assess the CHWs' knowledge of their roles and describe challenges they face when performing their roles within the context of National Health Insurance. This study may assist district health managers and WBOT managers to realise areas of role knowledge deficit upon which, more emphases is needed if improvement of the quality of services rendered by CHWs is something to go by. The aim of this study was thus to assess the CHWs' knowledge of their roles and describe challenges they face when performing such roles within the WBOT context of PHC re-engineering and NHI.

2. MATERIALS AND METHODS

This study adopted a qualitative approach using an exploratory and descriptive design which is contextual. Qualitative study design was found appropriate to give a detailed picture and understanding [24] about the knowledge level of CHWs regarding their roles in their daily line of work within the WBOT context of PHC re-engineering. Challenges relating to their daily work activities was also explored qualitatively. The exploratory design enabled the researcher to explore the knowledge level of CHWs regarding their roles and describe challenges using their own Tshivenda language. The contextual design helped the researcher to capture data from CHWs in the field through conversations with them while they work; letting their work and the issues they encounter guide the interview [25].

2.1. Study Setting

The study was conducted in three rural villages of Vhembe district. Vhembe district is one of the NHI pilot sites within the Limpopo province in South Africa. This district is made up of four local municipalities, namely Makhado,

Collins Chabane, Musina and Thulamela. The three rural villages are located in Thulamela municipality [26].

Thulamela Local Municipality occupies 5 834km²; and is situated in Thohoyandou between Malamulele and Ha-Lambani areas [26]. Thulamela municipality population of 497 237 occupies 216 villages cared for by 216 registered NPOs including Village 2, Village 1 and Village 3 CHWs [13]. The CHWs in these Non-Profit Organisations (NPOs) receive R1, 500.00 monthly stipend.

2.2. Population and Sampling

There are about 1874 CHWs in Vhembe district database, which is kept by the department of Health and Social Development [27]. The three-targeted villages are served by 47 CHWs employed by NPOs registered with the Department of Social Development. Thus, the target population for this study was all 47 CHWs serving the three villages. Convenience sampling technique was used to invite all 47 CHWs, though only 33 attended the first informal discussion meeting, which was meant to negotiate participants' informed written consent. Convenience sampling made recruitment of participants easy as all prospective participants who attended the first informal discussion meeting tendered their written consent as a way of agreeing to participate in the study. Thus, through convenient sampling, the study was cheap to implement as an individual participant was not followed at their own homes [28].

Participants were distributed as follows: 13 from Village 2, 6 from Village 1 and 14 from village 3. All these participants had a secondary school education coupled with more than 7 years' experience working as CHWs. Participants had received various health care training of varying duration as stated in preceding sections.

2.3. Potential Harm and Benefits of the Study

There were no inherent physical, psychological or disclosure risks associated with participation in this study. Participants' identifying details were not revealed to ensure confidentiality and privacy. Thus, answers cannot be associated with a particular village or individual.

2.4. Informed Consent

An information sheet which explained the purpose and benefits of the study was prepared in English and translated into Tshivenda. The CHWs from three rural villages were met for the purpose of recruitment at Village 2. Potential participants were advised to withdraw at any time when they felt uncomfortable to continue with the discussions. Participants were also told that data gathered during the focus group discussions would be published in accredited journals or presented at national or international conferences in such a manner that will not link the information to them. Potential participants were allowed time to ask clarification questions, after which, they were requested to sign consent forms. All 33 CHWs agreed to participate in the study and signed informed consent forms.

2.5. Data Collection Method and Procedure

Six data collection meetings were held in Village 2 where CHWs met with the researcher on monthly basis since 2017 April including the recruitment of participants meeting. Data was collected through semi-structured individual written narratives and five Focus Group Discussions (FGD). Through the individual narratives, each participant is able to express his/her opinions, while the focus group discussion times provide the participants with necessary mutual support to express their feelings which may be common to the group, but which some individuals may find embarrassing to narrate [29]. Kitzinger has noted that focus group discussion is a good way of obtaining information from marginalized or oppressed individuals because it gives them a chance of interacting with others who are experiencing a similar challenge with them, they feel safe and are usually more willing to consent to such studies and express their minds [29]. These two methods of data collection were both adopted to neutralize the bias of having focus group discussion only where the minority voices of those who may disagree with some issues could be silenced [29].

Each focus group comprised of 6-8 members. The FG1 comprised of CHWs who received 59 days training (7); FG2 comprised of CHWs who received 69 days training (6); FG3 comprised of CHWs who received 1 year training (8); FG4 comprised of CHWs who received 2 years training (7) and FG 5 comprised of CHWs who received 3 years training (6).

Using semi-structured narrative guide, the researcher asked CHWs in each of the five FGs two questions in line with study objectives at each meeting, namely "*What are your roles as CHWs within the WBOT context of PHC re-*

engineering; and “*What are the challenges you come across in your daily line of work within the WBOT context of PHC re-engineering?*” The questions were asked in Tshivenda for clarity. The researcher instructed CHWs to individually describe their answers to each research questions on a plain sheet of paper called individual written narratives. Individual written narratives were identified by means of a code, which was made up of the FG number and participants’ initials for anonymity and confidentiality. These narratives are kept under lock by the researcher.

The FG discussion meetings facilitated information sharing among focus group members to consolidate the focus group responses to research questions. Each CHW brought individual written narrative to the focus group discussion meeting for reference. Each group nominated a scribe and a group leader. The leader asked group members in each of the five FGs two questions in line with study objectives, namely “*What are your roles as CHWs within the WBOT context of PHC re-engineering;* and “*What are the challenges you come across in your daily line of work within the WBOT context of PHC re-engineering?*” Referring to their individual written narratives, group members shared roles and challenges. The shared roles and challenges were captured on flip charts by the scribes in each FG. All flip charts did not bear participants’ name or their villages. For identification purposes, the flip charts were named after the FG numbers *e.g.* FG1, FG2, FG3, FG4 and FG5 to ensure anonymity and confidentiality of participants. One CHW was selected from each FG to present to the researcher on behalf of the FG the agreed roles and challenges captured in the flip charts. During the presentation, the researcher recorded the explanations of the roles and challenges verbatim as field notes.

2.6. Data Analysis

The Tshivenda field notes were translated back to English by the researcher. Analysis of the English field notes was guided by Tech’s open coding method discussed in Creswell [30]. The researcher read through all of the field notes interpreting each one of them carefully in order to identify what was said about the common roles and challenges. Themes emerged from the consolidated FG discussed roles and challenges on flip charts; whereas individual written narratives and explanations given by the presenters regarding the FG discussed and agreed on roles and challenges provided participants’ quotes.

2.7. Trustworthiness of the Study Findings

Quality of the findings was ensured through the use of Guba and Lincoln’s criteria cited in Creswell [30, 31], namely credibility, transferability, confirmability and dependability. To ensure that the study findings are true and accurate (credibility), roles and challenges stated in individual narratives in respond to the research questions were adopted by focus groups before they were consolidated as field notes [32]. Transferability was ensured through the provision of a complete description of the research methods and interpretation of the research findings in the study report [33]. In order to ensure that the findings are based on participants’ responses and not any potential bias or personal motivations of the researcher (Confirmability), an audit trail by colleagues highlighted every step of data analysis that was made and a rationale for the decisions made [32]. To ensure dependability, an inquiry by a colleague from another university revealed that the findings are consistent and could be repeated [32].

3. RESULTS

Findings of this study are presented under two objectives. The first objective assessed the knowledge of CHWs regarding their roles within the WBOT context of PHC re-engineering; whereas the second objective described the challenges of CHWs within the WBOT context of PHC re-engineering.

3.1. Knowledge Level of CHWs Regarding Their Roles Within the WBOT Context of PHC Re-engineering

About nine themes aligned to the CHWs roles stated in the guidelines [14] emerged from data analysis under this objectives namely, community profiling, health education, DOT support, basic home nursing, referral, encourage drug adherence, tracing defaulters, general assistance, monitoring (Table 1):

Table 1. The role of CHWs within the wBOT context of PHC re-engineering.

Objectives	Themes	Sub-Themes
The roles of CHWs	1. Community profiling	House to house visits House-hold members recording. Identification of physiological and social problems.
	2. Health education	Individual education and advice Community education and advice School learners' education and advice.
	3. Support for DOT	Supervising the taking of TB and HIV treatments. Reporting challenges to the clinic.
	4. Basic home nursing care	Bathing clients discharged from hospital Cleaning households Cooking for the sick
	5. Referral	Social problems reported to social workers Physiological problems reported to the clinic nurses Referral forms
	6. Encourage drug adherence	General encouragement
	7. Tracing defaulters	Loss to follow-up tracing General encouragement Collection of treatments from clinics on clients' behalf
	8. General assistance	Lack of basic needs such as Social grants, Houses, Food, Identity documents, and Birth certificates reported to appropriate stakeholders
	9. Monitoring	Social grant abuse reported to social workers

Regarding the role of CHWs within the WBOT context of PHC re-engineering, FG presenters mentioned the following:

Theme 1: Community Profiling

All FGs participants unanimously mentioned that they collect data from the households. They said,

“We go house to house visiting the households that are allocated to us. Asking the number of household members staying there. Asking for the name of the head of the family. Asking if there is anyone who is sick in the family. Asking if there is any social problem for which assistance is needed (presenters representing FG1, FD2, FG3, FG4, and FG5).

Theme 2: Health Educating Community Members

All FGs participants mentioned that they educate people in communities and households.

“Educating people in households and communities about dangers of risky lifestyles; and advising them to lead a healthy lifestyle full of exercises” (presenters representing FG1, FD2, FG3, FG4, FG5).

Theme 3: Supporting DOT

All FG participants mentioned DOT support as one of their roles. They said,

“Clients on TB and HIV treatments needs supervision to adhere to their treatment. Each CHW is allocated a number of such clients by the clinic. Ensuring that they have taken their medications is one of the roles of CHWs (presenters representing FG1, FG2, FG3, FG4, and FG5).”

Theme 4: Basic Home Nursing Care

All FG participants mentioned basic nursing care as one of their roles within the WBOT context of PHC re-engineering. They said, “All patients discharged from hospitals, who are still in need of care are allocated to CHWs. Visiting allocated clients at their household to bath them, clean, cook and helping them with anything necessary is one of the roles of CHWs (presenters representing FG1, FD2, FG3, FG4, FG5).”

Theme 5: Referral

All FG participants mentioned referral of clients to clinic as one of their roles in PHC re-engineering. They said,

“Going around the households in the community, trying to identify health needs is one of the roles of CHWs. Those that are found to have social problems, are referred to social workers by CHWs; those that are found to have physiological problems, are referred to clinics by CHWs; a clinic referral form is completed by CHWs, which the client

takes along to the clinic (presenters representing FG1, FD2, FG3, FG4, and FG5).”

Theme 6: Encouraging Treatment Adherence

FGs 3, 4 and 5 participants mentioned encouraging treatment adherence as one of their roles within the WBOT context of PHC re-engineering, they said

“Encouraging people to continue taking their treatments irrespective of the side effects is the role of CHWs, because the side effects are less valuable compared to the benefits of treatment (presenters representing FG3, FG4, and FG5)”

Theme 7: Tracing Treatment Defaulters

FGs 3, 4 and 5 participants mentioned tracing defaulters as one of their roles within the WBOT context of PHC re-engineering. They said,

“Those who do not follow-up their treatments are traced and visited at their homes; and encourage to go to the clinic to replenish. Where necessary e.g. in a case of disabled and elderly people, their treatment is collected from the clinic on their behalf and delivered at their homes (presenters representing FG3, FG4, and FG5).”

Theme 8: General Social Assistance

All FG Participants mentioned general social assistance as one of their roles within the WBOT context of PHC re-engineering. They said,

“Helping people get social grants, houses, walking aids, food, identity documents and birth certificates etc.” When a probing question was asked as to how do they do that? *They said “By identifying serious basic needs in the communities and contacting the relevant officials on behalf of the clients to request for service (presenters representing FG1, FD2, FG3, FG4, and FG5).”*

Theme 9: Monitoring

FG5 participants mentioned monitoring as one of their roles within the WBOT context of PHC re-engineering. They said, *“Reporting social grants abuse and requesting for their stoppage (FG5)”*. When a probing question was asked as to where do they report grant abuse and request stoppage, they said *“The social worker who is based at the clinic is given a report” (a presenter representing FG5).*

3.2. Challenges Faced by CHWS Within WBOT Context of PHC Re-Engineering and NHI

Four themes and sub-themes emerged during analysis, namely socio-economic and demographic challenges; non-adherence to medication and health advice; non-recognition by clients and other members of the health team (Table 2).

Table 2. The challenges faced by CHWs within the WBOT context of PHC re-engineering.

Objective	Themes	Sub-Themes
The challenges faced by CHWs	1. Socio-economic and demographic challenges	CHWs Walking long distances to clients' homes CHWs performing two roles for one small stipend Clients not having food while expected to take medication regularly Clients not following-up their medications Stock shortages at clinics
	2. Non-adherence to medication and health advice	Clients sharing medications Clients drinking alcohol Clients not adhering to prescribed diabetic diet Clients refusing to take medication
	3. Poor reception in Households and non-recognition as other members of the health team	Not allowed to use screening tools to assess clients Not being accepted at clients' homes Clients refusing to sign CHWs records of household visit
	4. Mentally illness stereotypes	Mentally ill clients abuse by family members

Regarding the *challenges* CHWs face in their line of work within the WBOT context of PHC re-engineering and NHI, FG presenters mentioned the following:

Theme 1: Socio-Economic and Demographic Challenges

All FGs complained of transport and communication challenge and said:

“We work in villages that are about 10km far from one another. For an example, from Village 2 or Village 1 to Mangondi or Tshififi. We often use the little stipend of R1 500.00 to pay for R20. 00 transport daily to ferry us to clients’ homes” (presenters representing FG1, FD2, FG3, FG4, FG5).

We use our cell phone to contact the team leader and other staff at the clinic. If no phone, we walk to the clinic to report.

All FG participants were not happy that WBOT members are also home based carers performing WBOT activities only on Mondays and Fridays; and home based care work on Tuesday till Thursday; and reporting to both the Community Based Organisation(CBO) and WBOT leaders. All CHWs complained that the stipend is too little, and said *“can you imagine carrying out two responsibilities (WBOT on Mondays and Fridays; and Home based care from Tuesday-Thursday) but earning very small stipend of R1 500.00 from CBO? It is not fair because the activities are not very similar. It is not easy working in the communities because sometimes not allowed by the CBO manager to go and do WBOT activities. Some clients do not have food, yet they are expected to take their chronic medication regularly (Presenters representing FG1, FD2, FG3, FG4, FG5)”*

All FGs complained that clients do not follow-up their medication on time, citing lack of transport money as a reason for lack of treatment follow-up. They said *“clients do not follow-up their medications on time. They often say they did not have money for transport (presenters representing FG1, FD2, FG3, FG4, and FG5)”*

All FGs complained about shortage of medications at the clinics. They said *“there is a shortage of medications at clinics.” (Presenters representing FG1, FD2, FG3, FG4, FG5)”*

Theme 2: Non-Adherence to Medication and Health Advice

All FGs complained of clients refusing to take medication, while some do not take their medication at the prescribed time. They said,

“What is more painful is when clients stop taking treatment preferring herbs, olive oils and prophets. Some clients who get medicines from the clinics do not drink them, those who drink them do so at wrong times” “Some clients share medications with friends and relatives because they think their illnesses are the same. Some clients use alcohol to swallow treatment, some do not adhere to diabetic diet (Presenters representing FG1, FD2, FG3, FG4, FG5).

Theme 3: Poor Reception in Households and Non-Recognition as Members by Other Members of the Health Team

The FG5 complained that clients refuse to sign record of household visit, and that some household do not welcome them, they said *“some clients do not allow us to enter their homes; others refuse to sign for us record of our visit to their homes”* when a probing question was asked as to what are the reasons given by members of visited household when they refuse to sign the record? They said *“members of the visited households say that they can’t sign for us when they did not allow us into their homes” (a presenter representing FG5)”*

All FGs indicated that they are not allowed by district managers to use screening tools such as blood pressure measurement tool, temperature measurement tool, weight measurement tool, height measurement tool, blood sugar tool etc. nor to conduct a wellness campaign at a school. They said, *“We are not allowed to check clients’ temperature, blood pressure, weight and height, not to give health education at schools. District managers tell us that nurses are just lazy to do their job” (presenters representing FG1, FD2, FG3, FG4, and FG5)”*

Again, they do not tell us what happened when we referred clients to them at the clinics.

Theme 4: Mental illness Stereotypes

The FG4 was challenged by a mentally ill client who continually beats her son terribly. the presenter said, *“Some clients share medications because they think their illnesses are the same., There is one client who beats her son terribly every time”* when a probing question was asked to say, what you do about these cases, she said, *“We refer such cases to the clinic (presenter representing FG4)”*

4. DISCUSSION

The aim of this study was to assess the knowledge level of CHWs regarding their roles and describe the challenges facing CHWs within the WBOT context of PHC re-engineering and NHI pilot environment. In order to improve the

quality of services rendered by this cadre, CHWs should know their expected roles. In order to enhance the performance of their roles, CHWs' knowledge gaps should be identified and challenges addressed.

4.1. The Knowledge Level of CHWs Regarding Their Roles Within the WBOT Context of PHC Re-Engineering

The analysis of data revealed that CHWs in the era of PHC re-engineering and NHI pilot at Thulamela Municipality mentioned their roles to include community profiling, monitoring, general assistance, tracing defaulters, improved drug adherence, referral, basic nursing care, support for DOT and health education (Table 2). These perceived roles are similar to those performed by CHWs in Cape Town [7] and Gauteng Sedibeng health posts [34].

In this study, participants mentioned that their role includes visiting households, asking the number of household members staying there, asking the name of the head of the family, finding out if there is anyone who is sick or having social problems in need of social services. Though they termed this role community profiling, what the participants were referring to was in fact household assessment according to the Provincial Guideline for the implementation of the three streams of PHC Re-engineering [14]. This means that CHWs are not clear as to what does the role community profiling entail. None of the individual participants nor the FGs mentioned comprehensive household assessment, which suggest that CHWs did not know what this role is called irrespective of the duration of their training. In addition, though they mentioned some of the activities performed under the comprehensive household assessment, they did not exhaust the list, which might mean that their knowledge of this role is deficient. The Provincial Guideline for the implementation of the three streams of PHC Re-engineering describe community profiling as one of the activities to be performed during community assessments and mobilization around community needs and resources [9]. However, none of the individual participants nor FGs mentioned community assessments and mobilization around community needs as one of their roles, which might mean that when they do community profiling, they do not understand it fully. Thus, their knowledge of this role is also inadequate irrespective of the duration of training. Jinabhai, Marcus and Chiponda (2015) in a study conducted to rapidly appraise WBOTs highlighted that CHWs' training programs are not well linked to formal qualifications or WBOT competencies and scope of work or roles. On the contrary, in a study conducted in Kwazulu-Natal by Khuzwayo and Moshabela, respondents demonstrated insightful knowledge and understanding of services provided by WBOTs or roles [6].

Findings in this study indicate that participants never mentioned support screening in schools and early childhood development centres as one of their roles. On the contrary, the Gauteng CHWs at the Sedibeng Health posts conduct basic health screening [34]. Similarly, Khuzwayo and Moshabela highlighted that WBOTs in Kwazulu-Natal assists in early detection and intervention of health problems and illness, though the extent of assistance is not clear, whether it involve the use of screening tools or not [6]. According to the core competencies associated with their roles stipulated in the provincial guidelines on the implementation of WBOT, CHWs should use screening and assessment tools (blood pressure machine and blood sugar machine) to assess individuals for risk of chronic health problems [13]. In addition, CHWs are expected to conduct developmental assessment for children. Developmental assessment of children is done by weighing children's weight and height, which are screening tools.

During the FG discussions, participants in this study indicated clearly that they are not allowed to use screening tools such as blood pressure measurement tool, temperature measurement tool, weight measurement tool, height measurement tool, blood sugar tool *etc.* In addition, they are not allowed to give health education at a school. The district believes that such screening tools should be used by nurses and not CHWs. This confusion leaves CHWs not clear about their screening role irrespective of the duration of training. In addition, this study revealed that CHWs are not well accepted in communities. Austin-Evelyn advised that monitoring clients' temperature, blood pressure and weight would enhance CHWs' acceptance in communities [22]. According to him, many members of the community are currently buying and using such screening tools, yet they are not trained, which means that CHWs who have undergone some training would use the screening tools more accurately than the general members of the community [22].

During FG discussions CHWs persistently indicated that they refer any identified health and social problem to appropriate stakeholders. None of them ever mentioned it as their role, to identify and manage minor health problems such as rendering basic first aid and treating minor ailments in the home and communities. This omission suggest that CHWs are not aware that identification and management of minor health problems such as rendering basic first aid and treating minor ailments in the home and communities is their role in WBOTs. In addition, the provincial guideline for the implementation of WBOT expects CHWs to manage minor childhood illnesses using oral rehydration therapy and continuous feeding; manage common health problems that affect persons with disability and the elderly including foot

care, mobility and dietary interventions [14]. On the contrary, CHWs in Gauteng Sedibeng Health posts attend to minor ailments in communities [34].

Though the roles of CHWs are clearly stipulated in the Provincial guidelines for the implementation of WBOT *e.g.* provision of post-trauma counselling *etc.*, coping mechanisms and general psychosocial counselling was never mentioned in this study during the FG discussions as one of the roles of CHWs within WBOT. Though one of the CHWs mentioned it as a challenge that she often report to the clinic a mentally ill mother who often beats her son severely. Additionally, CHWs in this study mentioned non-adherence to diabetic diet as a challenge that they often refer to the clinic, which suggest that they do not know that it is their role to provide psychosocial counselling to motivate clients to adhere to treatment and health advice. Similarly, CHWs in Gauteng and Kwazulu –Natal also never mentioned psychosocial counselling support as the role of WBOTs, which suggest that generally CHWs are not aware that providing psychosocial counselling is one of their roles in WBOTs [6, 34]. The conclusion is that CHWs in Vhembe district are not aware of their general psychosocial counselling support role. Despite their lack of knowledge of their roles, Tsolekile, Puoane, Schneider, Levitt & Steyn still believes that CHWs roles transgress those that clients could find at a health facility [35].

4.2. The Challenges of CHWs Within the WBOT Context of PHC Re-Engineering and NHI Pilot

Analysis of data revealed that CHWs are often faced with socio-economic and demographic challenges in their line of work. Lack of transport and money to pay for such transport to visit clients who reside long distances from clinics is the most common challenge CHWs face almost on daily basis in their line of work despite that they are considered part of the health system. Nxumalo et al, warn that without a system that is able to provide support, CHWs are not able to provide comprehensive services to households [20]. In addition, clients also lack money to pay for transport to honour treatment replenishment follow-ups. Several studies that are specific to diseases clearly show that transport costs is a prominent challenge deterring South African clients from attending clinic visits regularly with interruptions to treatment when they run out of medication [36] and adhere to prescribed behaviour including recommended diet [37]. Non-adherence to bot treatment and health advice was identified in this study as one of the challenges faced by CHWs in their daily line of work. Similarly, Languza, Lushaba, Magingxa, Masuku & Ngubo alluded to unreliable financial support challenge among CHWs [38]. Nxumalo et al highlighted similar challenges in Gauteng and Eastern Cape [20].

Other challenges include poor reception in households. These problems were identified on several occasion in previous South African studies [4, 7, 20, 22, 39]. According to Nxumalo et al, often CHWs come across health needs for services, which they are not able to provide, leading to poor reception in households [15]. Similarly Palazuelos, Ellis, IM, Peckarsky, Schwartz, Farmer, & Mitnick emphasize the importance of beneficiaries to have trust in the services provided by CHWs; According to them, people tend to associate CHWs with the state and its health system, and lack of trust in government levelled at the CHWs [40]. Francis and Edmeston highlighted that poor trust in state services is pervasive in South Africa, particularly among poor communities; and that in response to a neglected and deteriorating PHC and clinic services, people routinely bypass these services [41]. Thus, generally, CHWs function in an environment where households have little reason to be confident in their services. Among the challenges health care workers face, is their lack of capacity to response to community needs [20]. Similarly this study revealed that CHWs' capacity is challenged when faced with a mental ill client.

4.3. Practical Implication

Currently, Jinabhai, Marcus & Chaponda highlights that the training program given to WBOTS is not well linked to stipulated WBOTs competencies and roles or scope; and does not take into account the gaps in knowledge and skills [4]. However, the scope of roles outlined in the provincial guidelines for the implementation of WBOT threatens to overwhelm CHWs daily work activities [14]. This scope may be equivalent to learning outcomes of a health promotion degree programme. Thus, expecting two crash training courses of 10 days each to cover the scope as planned by the government would leave CHWs with knowledge deficit pertaining to their roles. Transport and financial challenges, deter South African clients from attending clinic visits regularly with interruptions to treatment when they run out of medication [36] resorting to unorthodox medication such as roots and leaves of indigenous plants or oils and/or water from prophets; not adhering to prescribed behaviour including recommended diet [37].

5. RECOMMENDATIONS

In order to improve CHWs' knowledge of their roles, a review is needed on the SAQA unit standards for the most

current CHW qualification called health promoter (ID 94597), so that any curriculum that will be developed based on this qualification may cover all roles stipulated in the guidelines. Mendenhall, De Silver, Hanlon, Petersen, Shidhaye, Jordans, Luitel, Ssebunnya, Fekadu, Patel, Tomlinson, & Lund emphasize adequate training of CHWs in preparation for a task-sharing where mental health care should also be provided by CHWs to improve access to mental health care in Low Middle Income Countries so that CHWs should be able to provide service for all health needs they come across to improve their reception in households [42]. Nxumalo suggests mentorship of CHWs by retired nurses to strengthen their role capacity to respond to community needs [34]. CHWs are advised to aim at re-building household trust by establishing personal relationships with their clients, spending time with them and providing simple care of the kind that might be administered by kin and neighbours in other contexts [3]. In addition, service providers need to be contracted to develop a procedure handbook containing step by step information on how to perform CHW roles such as identification and management of minor health problems, support screening in schools, provision of psychosocial support, and conducting community assessments. Nxumalo suggested a physical structure of the health post to provide a base for the CHWs reducing long distances to be travelled by both patients and CHWs thereby minimizing transport costs and financial burden [34].

CONCLUSION

The CHWs at Thulamela municipality are doing a very good work of extending the arm of formally trained health professionals to the rural areas. However, this study concludes that CHWs do not know some of the roles they are expected to play within WBOT such as identification and management of minor health problems, support screening in schools, provision of psychosocial support, and conducting community assessments. In addition, CHWs are faced with several challenges in their line of work such as transport, lack of finance, poor reception in household and non-recognition as members by other members of the health team, which makes it difficult for them to carry out their mandated roles.

ETHICAL APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval to conduct the study was obtained from the University of Venda Research Ethics Committee (Project No: SHS/18/PH/23/2307).

HUMAN AND ANIMAL RIGHTS

No animals/humans were used for studies that are the basis of this research.

CONSENT FOR PUBLICATION

Written informed consent was obtained from each participant before data collection.

CONFLICTS OF INTEREST

The authors declare no conflict of interest, financial or otherwise.

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