

**EXPERIENCES AND CHALLENGES OF AN INTERPROFESSIONAL
COMMUNITY OF PRACTICE IN HIV AND AIDS IN TSHWANE DISTRICT,
SOUTH AFRICA**

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ABSTRACT

Collaboration amongst stakeholders remains a central tenet to achieving goals in planning, implementation, monitoring and evaluation of HIV and AIDS prevention and care strategies. This paper describes the experiences of members of a health care team who joined efforts to collaborate and form a community of practice (CoP) in HIV and AIDS. Qualitative, exploratory case study methods were used. Twenty-six participants were interviewed. Transcripts from the interviews were subjected to the thematic framework of data analysis. Based on the analysis, three themes emerged as impacting on collaboration and these were: the understanding and expectations of being a CoP member; professionalism and ethics within the CoP and collaboration in HIV and AIDS care. The key findings were that the understanding and expectations from the CoP varied. Ethical principles including respect, trust and confidentiality were identified as key tenets of collaboration and were expressed in various ways. The expectations of being a CoP member, the ethical principles within the CoP all impacted in differing ways on how they collaborated. The implication of this study suggests that consultation during inception and throughout the process, clarification of roles, transparency and respect are cardinal points in professional relationships.

Key words: HIV, AIDS, Interprofessional collaboration, Community-of-Practice, Professionalism, South Africa

INTRODUCTION

*Together we can*¹ is one of the catch phrases found on South African billboards promoting Human Immune Deficiency Virus (HIV) prevention and care. This catch phrase captures the fact that no single discipline or individual can effectively tackle HIV and AIDS (Acquired immune deficiency syndrome) challenges. Interprofessional collaboration remains a pivotal process in both the service delivery and the management of HIV and AIDS especially in South Africa as the epidemic escalates and affects all generations. With the numbers of people living with HIV and AIDS (PLWHA) increasing due to improved HIV care (UNAIDS, 2012) their needs are also becoming complex due to the chronicity of the disease and patients getting older. Globally, South Africa has one of the highest number of PLWHA , as 5.6 million people are infected, with women dominating the statistics (UNAIDS, 2012). One fifth of South African women in their reproductive years are living with HIV and AIDS bringing the issue of children's health into the discourse. To effectively address the challenges brought by various issues in a number of settings, CoPs have been initiated. Collaborators of the process need to have the spirit of mutual engagement with community of practice (CoP) members sharing repertoire of communal resources and using them appropriately to achieve shared goal(s) of the community (Lathlean & Le May, 2002).

The conceptualisation of a CoP is based on social learning theory and include people who share a common purpose, learn how to be effective and improve performance (Wenger, 2006). Wenger, McDermott and Snyder (2002) emphasised that CoP members share concerns, sets of problems, a passion and expertise in the area of practice. CoPs complement existing structures, galvanise knowledge sharing, learning and change in addition to the use of cross functional teams and being customer and product focused units so as to attain outcomes (Wenger & Snyder, 2000; National Center for the Dissemination of Disability Research, 2005). Members volunteer to be part of the CoP. However it can be challenging for diverse agencies, professional and consumers to work together due to different perspectives, knowledge and experiences.

The concept of the CoP has been applied to a number of settings including organisations, government, education and social development (Wenger, 2006). In the higher education sector CoPs strive to work and engage with a variety of communities (Andrew, Tolson & Ferguson, 2008) and in this context CoP needs among other things, education and social welfare professional membership. While educators need to provide programmes that will

mitigate the low literacy level, social welfare will intercede where social ills such as poverty persists and ensure that there is access to social and food security (DoH, 2007). In health care, CoPs have been a means of organisational knowledge sharing and improving care. Currently CoPs are regarded as complementary workforces (Wenger, 2011) adding value to task shifting and the completion of tasks (Nickols, 2003). These CoPs need to collaborate for knowledge and skills sharing.

Literature indicates that CoPs as professionals often have inadequate information relating to interprofessional collaboration (D'Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; Willumsen, 2008; Willumsen & Hallberg, 2003; Hjalmarson, Ahgren & Kjölrsrud, 2013). It is suggested that interprofessional CoPs are an empowered workforce where collaborative work, communication and ownership occur (Andrew et al., 2008). These individuals create an environment of inclusiveness where new ideas, methods of improving the practice and ways of sustaining such groups are shared. Through their involvement in collaborative efforts members learn new ways of technology and they use evidence that was collaboratively searched. CoP groups go through various stages such as potential, coalescing, maturing, stewardship and transformation (Wenger et al., 2002). During these stages, basic elements exist on how the group members can generate knowledge and share it.

However, the majority of CoPs experience various problems such as poor communication in terms of establishment and facilitation of the organisational processes related to patient care (Maguire & Hardy, 2013). In addition, members fail to realise that serving in multidisciplinary teams assist in reducing complexities that impact on collaboration and partnership in HIV and AIDS (Maguire & Hardy, 2013). More recently, researchers argued that multiple organisational and individual identities may conflict with one another (Pratt & Foreman, 2000; Maguire & Hardy, 2013).

The results from a Canadian study conducted among university health students on perceptions of interprofessional collaboration interventions yielded positive results. The results indicated that there were significant improvements in attitudes, equality in care provision and team work (Curran, Mugford, Law, & MacDonald, 2005; Willumsen & Hallberg, 2003). In addition, Andrew et al. (2008) in their study on community of practice in nursing concluded that the quality and the complexity of the work done can be promoted

through collaboration with service providers, university based academics and researchers (Hesjedal, Hetland & Iversen, 2013).

CoPs informally exist in South Africa. As an example, the rollout of antiretroviral therapies (ART) in South Africa led to training of health care workers for HIV and AIDS care in multidisciplinary teams (El-Sadar & Abrams, 2007). The extensive HIV training and mentoring activities provide healthcare workers in sub-Saharan Africa with new knowledge and opportunities for professional growth (El-Sadar & Abrahms, 2007). The need for task shifting by training professional nurses to initiate ARTs and inclusion of lay workers to support patients to comply with ARTs was also implemented. Pharmacists and medical doctors were trained to support nurses prescribe and initiate ARTs so as to increase access to ARTs. This resulted in interprofessional collaboration and increased the focus onto patients (Bridges, Davidson & Tomkowiak, 2011) as interprofessional teams seek to understand patients' compliance to ARTs.

It is evident that collaboration and partnership are required to enhance continuity and sustainability of HIV and AIDS health promotion programmes (Bridges et al., 2011; Probst & Borzillo, 2008; Wenger et al., 2002). The tenets of collaboration include building relationships, maximising existing strengths and building a sense of commitment to the project (Harper et al., 2004). The secondary tenets include learning from each other, generation of new knowledge, growth and sustainability and being involved in new tasks (Bridges et al., 2011).

BACKGROUND

In response to the required collaborative service delivery in the rollout of ARTs and the growing problem of malnutrition, in 2010, academics from two universities in the Tshwane district, South Africa came together to develop a CoP. They developed the HIV and Malnutrition CoP, composed of university lecturers, nurse practitioners and social workers, pharmacists, dietician, support workers and medical doctors. Membership was voluntary, organised and co-ordinated by the first author of this paper, who invited potential members to the first meeting which was held in 2010. Twenty two members first came together and they were all working in HIV and AIDS and malnutrition service contexts.

This group was called a 'CoP' as it resembled the characteristics of a CoP as members were established professionals with shared interest in HIV and AIDS related malnutrition or were working with HIV and AIDS patients. The members agreed to share models of good practice, knowledge and research evidence through workshops, consensus meetings, emails, seminars and training/capacity building. Some members also discussed work-related challenges over the telephone. They had a common purpose which included enhancing partnership working, and reducing the professional boundaries and power that was inherent in the professional group involved in HIV and nutrition care. Through the CoP, the capacity of members would be developed so they are better able to respond to public health and professional challenges brought on by HIV and AIDS and malnutrition. Capacity building in our CoP followed planned activities that were developed based on identified needs in order to empower members with knowledge and skills that could assist in addressing challenges experienced in practice '(Department for International Development, 2013 ; UNEP, 2002). Some of the capacity building activities included understanding research, sharing evidence and experiences from practice, how to implement research evidence, leadership and computer skills. The members discussed challenges to their professional values as a result of working with PLWHA . Some of the challenges mentioned included staff shortage which compromised time and quality of care, negotiation of power with other professionals and limited opportunities for staff development.

This CoP was funded by the University-based Nursing Education in South Africa with the aim of strengthening collaboration and capacity building of health care workers in Tshwane district. They were expected to accomplish their allocated tasks/assignments within the expected time frame. Lastly, members were also responsible for sustaining partnerships and active participation within the CoP.

Stigma and confidentiality are the two interwoven concepts that were key tenets of our CoP as Genrich and Brathwaite (2005) remind us that patients living with HIV experience stigma and discrimination. Confidentiality was therefore a key ethical principle that needed to be ensured and applied in all cases. Additionally, CoP members belonged to professional bodies that expected them to observe key ethical principles when dealing with HIV and AIDS and discussing challenges faced at work. The experience of AIDS-related stigma has been discussed in various studies (Kalichman & Simbayi, 2003; Herek, Capitano & Widaman 2003; UNAIDS, 2000b). These studies emphasise how HIV-related stigma can be

symbolically expressed in different ways. This is witnessed in South Africa where some people are reluctant to test for HIV due to fear of discrimination (DoH, 2007). This belief among professionals and patients impact on the ways routine test are offered, thus leaving many people untested as they fear the potential of a positive diagnosis and possible stigmatisation.

Despite the development and strengthening of other sectors by CoPs, such as in the South African educational systems (Hall, 2010) there has been limited understanding of the challenges faced by CoP members working in the South African health systems. This paper explores the experiences and challenges faced by members of the University initiated HIV and AIDS malnutrition CoP in Tshwane. The paper discusses some learning points to overcome these challenges for future collaboration and improvement of care delivery.

METHODS

We employed a case study approach that focused on an HIV and malnutrition CoP in Tshwane district, South Africa (Yin, 2012).

Sample

Twenty six participants were interviewed and most were members of the CoP from its inception in 2010. They included nurses (n=6), lecturers (n=4), nursing students from the two universities (n=3), support workers (n=3), lay counsellors (n=7) Dietician (n=1), Medical Doctor (n=1) and Social Worker (n=1). Most participants were females (n=22) and few men (n=4). This is not surprising as the caring profession in South Africa and elsewhere is dominated by women (South African Nursing Council, 2012).

Convenient sampling was used so as to recruit professional participants whose organisations were affiliated to HIV service provision and were in the CoP database. Participants were chosen because they were CoP members and had some 'insider' knowledge about the CoP. Participants were telephoned by the research centre manager who arranged convenient times and places for the interview. Participants voluntarily agreed to participate and signed the informed consent form before taking part in the interview. The interview guide explored their roles, experiences of being members of the CoP and recommendations of how to improve the functioning of their CoP.

Data collection

We employed semi-structured interviews as we were interested in understanding how CoP members interpret their experiences, how they construct their worlds, and what meanings they attribute to their experiences (Merriam & Bogdan 2009) of being members of the HIV and AIDS and Malnutrition CoP. All semi-structured interviews were conducted with the aid of an interview guide to collect data. The interviews lasted between 45 minutes to an hour. However, some members of the CoP were trained in qualitative data analysis, and they were involved in analysing the transcripts and validating the findings.

Data analysis

All interviews were recorded and transcribed verbatim. The transcripts were then subjected to thematic framework analysis as outlined by Ritchie and Spencer (1994). Thematic framework analysis follows five steps of analysing interview transcripts which are familiarisation, identifying a thematic framework, indexing, charting, mapping and interpreting.

Ethical considerations

The research protocol was reviewed by the University Ethics Committee who granted ethical approval.

FINDINGS

Three themes emerged which from the analysis ('understanding and expectations'; 'professionalism and ethics' and 'collaboration in HIV and AIDS care') are described in turn below.

Understanding and expectations

The understanding of the concept of CoP varied and was complicated by different understandings of the word 'community'. These complexities created blurred boundaries between being members of the CoP and being member of the Tshwane community. Participants also used the term 'community oriented practice' interchangeably with the term community of practice.

This raised further questions about what was meant by the word 'community' as others saw the goal of their CoP as focused at working in community settings:

“When we move out of the lecture room, hospital and ward...to concentrate on the community [...] actually we are implementing the theory that we have gained from class onto the community” (P21 lecturer).

There was a connection between the community they serviced and their CoP. Some said that they were keen to assist their CoP by gathering information from the ‘community’ to aid research. The issue of developing research skills was very important. As an example, some saw their CoP membership as an opportunity for self-development. As noted, “I was hoping to further my studies after our first meeting with them” (P9 nurse).

Some ideally believed that the CoP should have involved “working with the community and all the stakeholders”. However, not all stakeholders were involved and the particular exclusion of traditional healers from CoP membership was seen as problematic and they said:

“...the community of practice only includes academics and health workers which exclude other stakeholders...why did they exclude other professionals from its inception? ...why did they not include the people living with HIV?” (P5 nurse)

However, the shortage of qualified specialists in social work, nutrition and psychology made the sustained involvement of these professionals problematic as often they worked alone with very limited support. Others saw the role of the CoP as teaching members of the community about HIV:

“The role of the CoP is to go out there and reach as many people as possible, teach them, and show them how they can relate” (P13 student).

For this CoP, teaching was focused on building the capacity of members and there were occasions when they saw the CoP as separate from the community it served creating a ‘them and ‘us’ situation.

Professionalism and ethics

One of the themes that came up strongly was about their understanding of professionalism and ethics amongst CoP members. Participants discussed these issues emphasising on principles such as respect, distributive justice and beneficence including values such as trust and honesty in working relationships.

Participants spoke about working relationships and expressed that although their CoP was intended to foster collaboration, there was lack of readiness among members to collaborate due to factors such as inability to share information, tasks and the lack of trust among different professionals. On the issue of sharing information, one participant said:

“The staff at ART is used to working independently. They are not prepared to share information with us. Although we try to help, we feel we are always left in the dark as we don’t know their challenges”(P4 lecturer).

There were also limited opportunities for learning together about research. The participants indicated that the nature of relationship between the members, initiation mechanisms and recruitment strategies used to attract members contributed to the limited opportunities. Participants reflected on professional boundaries as these created complex senses of belonging to the CoP that were in tension, with other identities as they belonged to the CoP, yet felt like ‘outsiders’ particularly when it came to demonstrating knowledge about ‘research’ and they said:

“I want to be part of the CoP. I want to be involved in the proposal writing and conducting research. I don’t want to be given report. I blame my institution for not releasing us to attend meetings regularly”(P11 nurse).

Members wanted more involvement in conducting research and not to be just presented with reports. Research processes brought about different power bases where some members felt that they were being ‘pushed’ as one participant confirmed:

“...we need to demystify research. In terms of the university, their interest is the number of researchers and number of publications made. So if they come and push research and the nurses are thinking, what’s this? I think we need participatory research where nurses are included in data gathering process and writing and one day they see their names on publication”(P26 lecturer).

This was a result of power dynamics:

“At times I sense the power dynamics that is playing on us. Like when we sit in the meeting the professors and academics should not be above us as we are equals. I think we need to bridge that gap and work towards the common goal (P19 nurse).

The issue of commitment also came up and some participants felt that their CoP was not functioning well due to lack of commitment, expressed as non-attendance of meeting:

“Nurses don’t show interest on what they are doing. They are short staffed and they see workshops and meetings as a waste of time”(P3 lay counsellor).

Attending meeting was perceived by others as a waste of time, given their heavy workloads and that they as professionals were already informed about the workings of the HIV in the body and one put it this way:

“I feel that information given to us as nurses must rather be given to the community not to me” (P23 student).

Despite these challenges some participant’s statement communicates hope for future positive outcomes. Improving attendance of meetings was perceived to be a measure of commitment. Having hope in meeting the imagined aims of their CoP was also reflected upon:

“Because we had our objectives but then we never adhered to any of them and could not attend the meetings as well so we did not reach our objectives. But we noticed that is really pulling us down so we decided that from this year we are going to start on a high mode” (P25 lecturer).

Some members involved in initiating this CoP reflected that they did not have set aims and objectives. Despite the lack of formal aims and objectives, they noted:

“We were thinking of exploring a new strategy that will attract people to come for meetings. We have not decided how we are going to address it; and maybe they did discuss the new strategy in the meeting that I could not attend” (P1 doctor).

The unmet expectations were often due to issues of communication breakdown for example, in the invitation of the hospital members to join the CoP. The participants said:

“There was a misunderstanding between the CoP organisers and the hospital management, the university were not upfront with them on who to attend the meetings. The matrons ended up using rotational allocation and this is where the breakdown in communication occurred” (P18 nurse).

The next section discusses the implications of their expectations, professionalism and ethics in collaborative work in HIV and AIDS care for service users in Tshwane, South Africa.

Collaboration in HIV and AIDS care

Collaboration within HIV and AIDS and malnutrition multidisciplinary teams was said to be the key to successful processes of dealing with the negative impacts of the epidemic.

Participants aspired to collaborate with others and discussed who should ideally have been included in the CoP and put it this way:

“The way I understand it...is that they are all working with the community...they are involved with the entire stakeholder: trauma, mother and child, reproductive health, CTOP and yes the topics are interrelated” (P1 doctor).

The statement above indicates that some members from trauma, mother and child, reproductive health and Choice of Termination of Pregnancy (CTOP) should form part of the CoP. It was also important to include dieticians in the CoP:

“We do have dieticians in the hospital who are very dedicated. They give information to the health care workers and to the patients” (P6 lay counsellor).

Others spoke that the CoP should work across institutions and include other professionals:

“...the greatest need is to have a group that is composed of social workers, dieticians, psychologists, doctors and even clients and traditional healers” (P17 dietician).

Participants further aspired for more involvement of colleagues within their teams.

The CoP should include ward staff and various stakeholders so as to meet given goals:

“It is clinical practitioners in the wards, the academic staff even people from PHC, people from the ART clinic, the CTOP clinic working together to reach a goal”(P15 social worker).

Others aspired to work with school head teachers, particularly to help promote better sexual health outcomes and combat high rate of pregnancies, HIV and AIDS and STI. This would involve working in schools and being part of the school ‘timetable’ so as to be effectively engage with others.

In such cases it was important to work together with the school principal.

“...make sure that I engage the school principal if we target the schools to give information to the school children regarding the prevention of HIV, sexually transmitted diseases as well as prevention of unwanted pregnancies”. (P4 lay counsellor).

One participant indicated that her role was to interact and be involved with communities with the aim of providing HIV and AIDS information. This was evidenced as:

“My role is to interact with the communities. I should get involved with them; they must know what HIV is; how to protect themselves from being infected. They must know ways of dealing with this HIV if they get infected ” (P6 lay counsellor).

DISCUSSION

This CoP though constituted within formal university settings, operated informally, resulting in lack of clarity about its meanings. The meanings varied from ‘working on’ to ‘working with’ the community, raising a number of question such as when is a CoP and when is it not? From our data members had to negotiate their complex identities of being affiliated to the CoP due to their professional credentials as well as being members of the community they serviced. Members of the CoP had to ‘swing’ in between these identities within their ‘communities’. The CoP was identified as a ‘CoP’ when members shared the ideals and aspirations of their CoP (Wenger et al., 2002). These aspirations, in particular professional development, learning about research, exploring new practices and sharing models of good

practice created a sense of belonging to the CoP (Probst & Borzillo, 2008; Wenger et al., 2002) . These aspirations were realised when members were consulted and worked together as an example, during the research reported in this paper. Members were keen to be involved and actively worked together within and across organisations addressing key objectives of the research project with the objective of a reaching a common goal.

However, stigma, confidentiality and power created different forms of subjectivities and affiliations to the CoP. Stigma and confidentiality made it problematic to share detailed information about experiences of working with PLWHA who were also facing nutritional challenges. For professionals living with HIV, the lack of trust amongst their peers limited the disclosure of their own HIV status. This impacted on team work as often teams, particularly within clinic settings had to cope with absenteeism due to ill health, and not knowing how to support their peers within the context of living with HIV. The community of practice in Tshwane had not come up with a strategy of how to negotiate professional confidentiality within the context of HIV and AIDS for nurses, doctors and allied health care workers, who held powerful positions within the health care system (UNAIDS, 2000b).

Furthermore CoP members seemed not to have streamlined their outcomes towards sharing knowledge and learning from each other as there was a lack of acknowledgement of collective competencies (Wenger, 2006). The different levels of knowledge about research created power imbalances that resulted in different forms of belonging to the CoP. CoPs have historically been construed as ‘places’ for learning (Wenger, 2006) and members saw an opportunity to learn and develop their skills. Some CoP members thought that the Cop will be a springboard for studying for further degrees at the university. Members perceived the reservations in knowledge sharing particularly in research skills (Bridges et al., 2011), by academics as a way of maintaining academic power and *status quo* (Probst & Borzillo, 2008). Members felt left out as most of the topics involving research were often planned without them. Words like ‘them’ and ‘us’ attested to the strategic positioning within the CoP as some participants negotiate the complexities of professionalism, power, stigma and confidentiality. Furthermore it was also difficult for members to imagine themselves as a ‘community’ and they referred to the community as composed of people who were in need of their professional service. The challenges were much more so as the universities and the hospitals were structures that functioned in the community they served, raising questions about the negotiation of power outside their practices.

The inclusion and exclusion criterion that has guided the initial recruitment of CoP members raised questions about working with other stakeholders who had been excluded from the CoP. As an example, the inclusion of academics and nurses whilst excluding other such as traditional healers was seen as problematic. Traditional healers remain the sole culturally accepted, holistic healthcare service that is available and accessible to all Africans (Dennill et al., 2008). Traditional healers should be part of the collaborative team when dealing with HIV and AIDS and malnutrition issues (King, Balaba & Kaboru, 2004). UNAIDS (2000a) emphasised that collaboration with traditional healers is vital in the care of people with HIV and AIDS in Sub-Saharan Africa who should form part of HIV programme. Despite the increasing availability of ART, the vast majority of African people continue to consult traditional healers for the treatment of HIV-related conditions and other common diseases. In South Africa traditional healers were consulted as first health providers by 70% of patients (Puckree et al., 2002). This exclusion of PLWHA was problematic given the global and local initiatives of involving PLWHA in planning, education and implementation of projects about them. The concept of 'working with' captured the notion of participation and active involvement of community groups as strategic partners (Dennill et al., 2008). Importantly, participants were focused on working with service-users in line with their professional code of conduct (Jooste, 2009). There was an ongoing negotiation of identity and cultural meaning to mention a few as the CoP was still developing as a social learning system (Wenger, 1998).

This study contains a number of limitations. The study was limited to in the inclusion of other professionals such as doctors and psychologists. These members play a significant role in addressing the impact of HIV and AIDS and the management thereof. Only two doctors were part of this CoP. In addition, the normal establishment of a group took place within a short period of time. The norms of starting a group were observed but not contextualised with members. The stages of CoP (potential, coalescing, maturing, stewardship and transformation) were difficult to achieve fully due to inconsistency in attendance of CoP meeting by the members.

CONCLUDING COMMENTS

Findings from this study attest to the importance of taking extra care when establishing a CoP that addresses HIV and AIDS and malnutrition issues, so as to ensure that the CoP is true in nature and name. It also highlights the importance of transparency, ownership and effective communication, throughout the development of a CoP. Importantly, educational systems

should address the professional silos that typify the health and social care education. It is therefore important to integrate health and social care models in the development and capacity building of HIV practitioners. Interprofessional collaboration should be an integral part of the education system in South Africa, so as to enable district programme managers to translate the priorities of national programmes, often outlined under national HIV and AIDS strategic plans, into district HIV and AIDS and malnutrition plans, based on community needs and priorities (Pervilhac, 1997). Clarity is needed on the meanings of collaboration within this cultural context. Finally we recommend interprofessional learning at undergraduate and postgraduate levels. This practice continues even though the National Strategic Plan for HIV, STIs and TB (DoH, 2012) reiterate the need for interprofessional teams especially when caring for PLWHA as they need wellness programmes for physical and mental health.

Note

1. For more information see: <http://www.togetherwecan.org.uk/>

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Declaration of interest

The authors declare no conflicts of interest. The authors were responsible for the writing and content of this paper.

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