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EXPERIENCES OF WARD BASED COMMUNITY HEALTH CARE WORKERS REGARDING THE UTILISATION OF PATIENTS SCREENING TOOLS IN FETAKGOMO-TUBATSE SUB-DISTRICT, LIMPOPO PROVINCE

by

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ABBREVIATION / ACRONYM	**MEANING**
AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
HIV	HUMAN IMMUNE VIRUS
NHI	NATIONAL HEALTH INSURANCE
NDOH	NATIONAL DEPARTMENT OF HEALTH
NCD	NON-COMMUNICABLE DISEASES
NPO	NON-PROFITABLE ORGANIZATION
USA	UNITED STATES OF AMERICA
WBPHCOT	WARD BASED PRIMARY HEALTHCARE OUTREACH TEAM
WBCHW	WARD BASED COMMUNITY HEALTH WORKERS
WHO	WORLD HEALTH ORGANIZATION

DECLARATION

I, **Elelwani, Malau** declare that the study **"Experiences of Ward Based Community health care Workers regarding the utilization of patients screening tools in Fetakgomo-Tubatse sub-district, Limpopo province**

is my work, that all sources that I have used or quoted have been indicated and acknowledged using complete references, and that this work has not been submitted for any other degree at any other institution.

Elelwani Malau	:	. *MALAU.E*.....
Date Signed	:	04 December 2022

DEDICATION

I dedicate this thesis to the people who were instrumental in supporting me

Throughout the course of my study:

- My son Bohlale Thabang Junior for his patience and for always understanding my lack of support due to a tight study schedule.
- My wonderful husband, for your support financially, emotionally, and mentally, may God bless you more.
- Thank you to my mother and father-in-law for their Support

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“I thank The Almighty God for giving me the power and strength to overcome Challenges and empowering me to complete the study.”

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ABSTRACT

Background: Screening of patients in the community is important and is a commonly used indicator to detect, prevent and treat abnormal changes. Two examples of these changes are elevated blood pressure or a rise in blood sugar which could develop into a disease. Ward Based Community Health Workers work in a community using different screening tools, such as a household screening tool, a non-communicable disease screening tool, and maternal and child screening tools. These are used to check whether the patients are taking their medications, as well as motivate patients to receive care. After screening patients in the community, the Ward Based Community Health Workers refer them to primary health care.

Aim: To explore the experiences of Ward Based Community Health Workers when utilizing the patient's screening tools.

Methods: A qualitative exploratory descriptive phenomenological research design study was utilized in this study. These were used to explore and get an in-depth understanding of the experiences of WBCHW regarding patient screening tools. The study was conducted in three clinics in the Fetakgomo-Tubatse sub-district, Limpopo Province. About, twenty three trained Ward Based Community Health Workers were selected using non-probability purposive sampling methods. Three focus discussion groups with six participants in clinic one, five in clinic two and twelve in clinic three were conducted. Semi-structured interview questions were used to collect data from the trained Ward Based Community Health Workers. Data was analysed using Colaizzi phenomenological method. Trustworthiness was established using strategies that ensured dependability, credibility, transferability, and conformability.

Results: Four themes and 16 sub-themes were identified from the study, which were: Positive experiences of WBCHW regarding the utilization of patient screening tools; Challenging experiences of WBCHW regarding the utilization of patient screening tools; Coping experiences of WBCHW regarding the utilization of patient screening tools; and Recommendations of WBCHW regarding the utilization of patient screening tools.

Keywords: Experiences, Patients, Screening tools, Utilisation, Ward Based Community Health Worker

CHAPTER 1
OVERVIEW OF STUDY

1.1 INTRODUCTION

This study focuses on the Ward Based Community Health Workers (WBCHW), who are employed to work in a community using different screening tools, such as a household screening tool, a non-communicable disease screening tool, and a maternal or child screening tool. The main purpose of these workers is to check whether the patients are taking their medications, motivating them, or sharing knowledge. Thus, they also refer the patients to health and social facilities to receive care. WBCHW provide a means of bridging the gap between health facilities and the community. This is valuable in rural areas where communities are underserved and patients have to travel long distances to seek medical care.

The Community Health workers are supposed to screen each household member by using an appropriate screening tool, such as diabetes and hypertension screening tool, based on the target group. After screening, the workers will make appropriate referrals and provide health education without being judgmental. In this study, the researcher explored the experiences of Ward Based Community Health Workers when utilizing the patients screening tool in the Fetakgomo-Tubatse sub-district, Limpopo province. The chapter covered the overview of the study, introduction and background, research aims, questions and objectives of the study. The purpose and significance of the study are discussed with a brief description of the methodology used in the study.

1.2 BACKGROUND

The programme of Ward Based Community Health Workers originates from China (Mhlongo & Lutge 2019). The author indicated that in the 1920s doctors in China used to walk barefoot to reach the communities and offer the health care services that the WBCHW are offering today. Since then, many countries including South Africa adopted and implemented the programme as part of a health initiative designed to achieve universal health care, particularly in poor under-resourced countries.

This follows the initiative made by the World Health Organization (WHO 2017) that planned the package of essential non-communicable disease interventions for primary healthcare facilities. This package is to be utilized by WBCHW all over the globe. As a result, an engagement with the local community facilitators was arranged for training WBCHW in the use of assessment tools.

The training aimed to link the health care service and the community to meet the target of at least 50% of eligible individuals receiving treatment and counselling through early detection. Thus, helping to manage various diseases including non-communicable conditions. Management of various diseases was attested by various studies conducted in China, Brazil, and Iran (WHO 2017). These studies have shown that using Community Health Workers can expand the health outcomes of the population they serve (WHO 2017). Based on the above findings by the WHO and experiences from other countries, South Africa developed the primary health care re-engineering framework, and strategy, using WBCHWs who serve to support the distribution of primary health care service within the context of National Health Insurance (Mhlongo & Lutge 2019). The Ward Based Primary Health Care Outreach Team (WBPHCOT) was developed on pre-existing community home-based care, established by a non- government organization that was started years ago to substantiate the care done by primary health care nurses. This provided minimal health care in the homes of the community and included the promotion of environmental as well as personal hygiene, care of HIV patients and their nutritional status.

Around 2008, it expanded to a screening of patients and identifying those at risk of chronic conditions, to refer them to primary health care facilities. The WBPHCOT was built and launched in December 2011, mandating the WBCHW community to provide quality health care to the community (Schneider, Besada, Sanders, Daviaud & Rohde 2018). The main aim of appointing them was to reduce the burden caused by quadruple diseases, such as non-communicable diseases which include diabetic mellitus and hypertension. Diabetic mellitus accounts for more than 40% of adults, with hypertension accounting for more than 50% of the condition globally, including South Africa (Fairall, Folb, Timmerman et al., 2016).

Regardless of the appointment and training of WBCHW, the International Diabetes Federation (IDF) estimated that 2.28 million people were living with diabetes and close to 70% (>8millon) people of 45 years and older were hypertensive, with treatment coverage at 27.5% in South Africa in 2016 (Paxton & Rheedre 2018). The researcher working as a primary health care nurse has observed the same trend of the increase in the number of people suffering from these two conditions. Daily, two to three people are diagnosed with either hypertension or diabetic mellitus with more than 150 patients who collect their diabetic or hypertensive drugs every month. although the two non-communicable diseases are preventable with lifestyle modification. Hence the focus of this study was on the two non-communicable diseases (hypertension and diabetic

mellitus). As such, the researcher decided to conduct the study on the experiences of WBCHW regarding the utilization of screening tools, since the two conditions are avoidable if detected earlier at Fetakgomo-Tubatse in Limpopo Province.

Despite the promises of the Ward Based Community Health Workers screening patients to improve programme outcomes. There are several key barriers and challenges to WBCHW's successful implementation in health care services. In Brazil it was found that community members does not value the work of community health workers (Grossman-Kahn, Schoen, Mallett, Brentani, Kaselitz & Heisler 2018). They are regarded as low-status and healthy community members and some chronically ill individuals often do not see the need for regular CHW visits (Grossman-Kahn et al., 2018). In Pakistan, studies found that there is a delay in stipend payment of CHW which led to resentment and resistance to work (Hodgins, Kok, Musoke et al. 2021).

An evaluation of community health extension workers (CHEW) tasked with providing family planning education in Nigeria found that CHEWs did not know about several family planning methods such as intrauterine devices (IUD), (OlaOlorun & Tsui, 2020). In South Africa analysis of data from other studies revealed WBCHWs are often faced with socio-economic challenges in their line of work where by WBCHWs travels a long distance and pay for transport to visit patients who reside far from the clinic (Tshitangano & Olaniyi 2018).

In Limpopo most of the WBCHW is generally poor with a low level of payment that limits their ability to access basic sites, WBCHW reported that sometimes they have to pay from their own pockets to help their patients for transport to go to a clinic, placing further strain on their households (Jobson, Matlakala and Naidoo, 2019).

1.3 PROBLEM STATEMENT

WBCHW were employed to conduct household screening, promote overall health, facilitate an appropriate referral for health, and provide adherence support for people on medications and social support as needed for individuals or households (Murphy, Moolla, Kgowedi et al, 2021). The Primary Health Care facilities are supposed to support the WBCHW programme in their areas.

The researcher as a Primary Health Care nurse working with WBCHW, observed that they become overwhelmed by their wide range of tasks, especially following instructions on the

completion of their patients' screening tools which resulted in poor performance and workload. The researcher also received informal reports from some of them that they experienced challenges in utilizing the provided patient screening tools when visiting households. This frustrated them and affected their functionality. In addition, the researcher discovered that in the area where they are providing health care, the District Health Information system statistics indicated that the leading cause of death is Non-Communicable Diseases such as diabetes Mellitus and hypertension. Death from the two conditions stands at 40% in females and 34% in males (Department of Health 2015).

As such, the findings of the study conducted by Schneider et al. (2018) amongst WBCHW pointed out difficulties they experienced in screening patients. Some of the experiences indicated were socio-cultural barriers, lack of resources, and challenging working environments (Schneider et al. 2018), resulting in 2.28 million people living with diabetes while 8 million are living with hypertension in South Africa. Again, in the area where the researcher worked, more than 150 people collected their diabetic and hypertensive treatment with two to three newly diagnosed adults and children with these two conditions (Department of Health 2015).

As such, the researcher conducted this study to explore the experiences of WBCHW in the utilization of screening tools, particularly as they were appointed to reduce the burden of non-communicable conditions and to increase the life expectancy of all people in South Africa. The available data may be used to develop strategies to improve utilising patient screening tools by WBCHWs in the Fetakgomo-Tubatse sub-district, Limpopo Province.

1.4 RESEARCH AIMS

This study aims to explore the experiences of the WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province.

1.5 RESEARCH QUESTIONS

What are the experiences of WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province?

1.6 RESEARCH OBJECTIVES

To explore and describe experiences of WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province.

1.7 DEFINITION OF KEY TERMS

1.7.1 Ward Based Community Health Worker

Works in the community providing care, promoting health, screening for any health risks, and referring the patient to the clinic for further screening if needed (Murphy et al, 2021). In this study, the WBCHW is a member of the community who is trained and appointed by the National Department of Health to screen conditions such as hypertension and diabetes to prevent, promote and provide basic medical health care within their community.

1.7.2 Screening tool

The household screening tool and hypertension and diabetes screening tool are utilised by the WBCHW to ask questions to find out if there is any health or social development-related problems with the community members (Lewin, 2018). In this study, a screening tool is used by a trained WBCHW to assess community members' conditions such as discovering diabetes and hypertension in their household.

1.7.3 Experiences

This refers to the information that one has gone through in life and from being in a lot of different situations (Cambridge Dictionary, 2021). In this study, experiences refer to WBCHW's actual knowledge and direct personal participation regarding the utilization of a patient's screening tool.

1.7.4. Patient

Refers to a person who is receiving medical care (Cambridge Dictionary, 2021).In this study the patient refers to the people who are screened ,seeks medical attention and cared for by WBCHW in community.

1.7.5 Utilization

This refers to the act of using something in an effective way (Dictionary,2021).In this study the WBCHW uses the different screening tools for instance diabetic and Hypertension screening tool to screen the patients from in the community

1.8 SIGNIFICANCE OF THE STUDY

The findings of the study might help to improve the health of the community at large. If the challenges faced by WBCHW are attended to, their working conditions will also improve. Their work will contribute to the promotion of good health and the prevention of diseases in the country. The rate of non-communicable diseases (hypertension and diabetes) will be reduced as patients will be diagnosed and referred timeously to the relevant primary health care services. The health system which included primary health care nurses will have less of a burden treating patients with non-communicable diseases. Early identification of patients with non-communicable diseases will result in less money to be utilised in treating patients; hence this will help to improve the economy of our country.

1.19. RESEARCH DESIGN AND METHODS

A qualitative exploratory descriptive phenomenological research design was used in this study, in which the researcher tries to understand the experiences and responses or reactions of WBHCW regarding their experiences in the utilization of non-communicable disease screening tools (Flick, 2018). The researcher puts aside the researcher's feelings and beliefs, to explore the experience of WBCHW regarding the utilization of the patients' screening tool. The goal of the exploratory method in this study was to explore the experience of ward based community health workers regarding utilising the patients screening tool in the Fetakgomo-Tubatse sub-district, Limpopo province. The descriptive method aimed to describe the experience of the ward based community health workers when utilising the patients' screening tool.

Ethical clearance and Permission to conduct the study were issued by the University of Pretoria Ethics committee and the Limpopo provincial department of health. Participants consented to participate in the study by signing the consent form (Annexure C). The study was conducted at the Fetakgomo-Tubatse sub-district clinics, in Limpopo Province. The target population of this study was all trained WBCHW from the Madiseng Satellite Clinic, Dilokong Gateway Clinic and HC Boschoff clinic. In the study, an estimated sample of forty (40) trained Ward Based Community Health Workers were selected using convenience sampling methods. They were divided into three (3) focus groups, as per three selected clinics. However, only twenty three (23) participants formed part of this study. A focus group interview guide with semi-structured interview questions was created, see Annexure B. Probing questions were asked where necessary. Participants' demographics were primarily captured during the interviews. Data analysis involves the systemic organising and synthesis of research data that is, the sifting, charting, and sorting of data according to key issues and themes (Polit & Beck, 2018). After the

focus group discussion, the researcher briefly analysed and reflected on the data obtained using Colaizzi method. These analyses influenced the next interview in terms of the probing question asked, see chapter 3 for a full details of research design and methods.

1.10. THE ORGANISATION OF CHAPTERS

The chapters of this dissertation will be organised as follows:

Chapter One: Overview of the study

The chapter provides an outline of the study where the background, significance of the study, research objectives, questions and aims are discussed.

Chapter Two: Philosophical assumptions, methodology and design

This chapter provides a detailed description of the research's philosophical assumptions, and paradigms while focusing on descriptive, exploratory, and phenomenological designs.

Chapter Three: Data analysis and presentation of research results

In this chapter, the focus is on the description of how themes from the findings were developed and presented.

Chapter Four: Discussion of the main findings, implementations, recommendations, limitations, and conclusion.

The chapter discusses a summary of the study about research findings, implementation, recommendations, and study limitations.

1.9 CONCLUSION

This chapter highlighted the orientation and the overview of the study about the experience of Ward Based Community Health Workers regarding applying the patients screening tools in the Fetakgomo-Tubatse sub-district, Limpopo province. An outline of the problem statement, the significance of the study, the research design and the organisation of chapters was provided. The next chapter outlines the philosophical assumptions and research methodology.

CHAPTER 2

PHILOSOPHICAL ASSUMPTIONS, RESEARCH DESIGNS AND METHODOLOGY

2.1 INTRODUCTION

Chapter 1 provided an overview of the study. This chapter discussed the paradigm and research methodology, which is qualitative, explorative, descriptive and phenomenology design. The experiences of Ward Based Community Health Workers regarding consuming patients' screening tools were explored and described qualitatively. This chapter also explored the population, sampling, measures to ensure trustworthiness and method used for data collection and analysis**.**

2.2 RESEARCH PARADIGMS

A paradigm is an entire collection of beliefs, values and techniques shared by the members of a given community. It consists of hypothetical ideas and practical procedures that a group of experts adopted to fix the world with its language and terminology (Holloway & Galvin, 2016). The researcher used an objectivism paradigm as a research perspective approach to enable the researcher to understand the meaning that people give to everyday life experiences (De Vos, 2017). During data collection, the study focused on several experiences of a phenomenon given by participants (ward based community health workers). The study also focused on several accounts that result in a deeper understanding of the whole phenomenon, which was based on the experiences of WBCHW regarding using patient screening tools.

2.3 PHILOSOPHICAL ASSUMPTIONS

Philosophical assumptions are principles that are accepted as being true based on logic or custom, without a proof (Polit & Beck, 2018). Qualitative research centres a holistic approach to the research process. Whereby choices in methods and methodology are informed by a philosophical belief system (Leavy, 2018; Coates,2021). The philosophical assumptions statement provides a discussion of the paradigm or worldwide guiding of the research project. In this study, it is assumed that an understanding of Ward Based Community Health Workers' experiences regarding screening patients can contribute to providing knowledge, skills, and support to enable them to take care of the patients.

2.3.1 Ontology assumptions

Ontology assumptions are concerned with the nature of reality and presence (Holloway &

Galvin, 2016). According to De Vos & Fouche, 2017 ontology refers to the life world of a subject that can be discovered objectively. This research firstly focused on ontology questions which were based on the nature and reality of the experiences of the WBCHW regarding the utilization of patient screening tools and how this impact WBCHW morale. Secondly, how do WBCHW respond to these experiences in their work?. The researcher believes that for WBCHW to screen patients in the community, the government must provide them with screening tools and in turn, the WBCHW must utilise them. The researcher conducted this study, to explore the experience of WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province.

2.3.2 Epistemology assumptions

Epistemology assumptions are the theory of knowledge and are concerned with the question of what counts as valid knowledge (Holloway & Galvin 2016). Epistemology is defined as the relationship between the inquirer and those being studied (Polit & Beck, 2018). The study focused on exploring the experiences of WBCHW regarding the utilisation of the screening tool. In this regard, the benefits of interacting with WBCHW gave the researcher a better opportunity to know and understand the worker's daily activities and working conditions.

2.3.3 Methodological assumptions

Methodological assumptions refer to the values and ideas on which researchers base their procedures and plans or methods (Holloway & Galvin 2016). According to Polit and Beck, 2018, Methodology is the way researchers construct, collect, and analyse the research questions. Research methodology helps the researcher to obtain data through multiple sources, for example, questionnaires, face-to-face interviews, and focus group discussions. The methodology helped answer research questions and objectives. Therefore, the researcher used a qualitative, exploratory descriptive phenomenological design to construct human experience through intensive dialogue with persons who are living the experience (LoBiondo-Wood & Haber 2017). The researcher's goal was to explore the experiences of WBCHW regarding the utilization of the screening tool through a focus group discussion. The researcher set aside the researcher's experiences, perceptions, and biases to ensure objectivity in the conduct of the study and the conclusions that were drawn.

2.4 RESEARCH DESIGN

The research design refers to a set of logical arrangements from which perspective researchers can select one suitable design for their specific research goals (De Vos, Fouche, 2017). Blaikie (2018) formulates a research design as an integrated statement and justification for more technical decisions involved in planning a research project. The study was conducted through qualitative exploratory descriptive phenomenological research design in which a researcher understood the experiences responses or reactions of people to a specific phenomenon (Flick, 2018). The researcher puts aside the researcher's feelings and beliefs, to explore the experience of WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo province.

2.4.1 Qualitative research design

Qualitative design is a general, interactive, subjective, and naturalistic research approach used to describe life experiences, culture, and social processes from the perspectives of the participants (Grey, Grove, and Sutherland, 2017). Qualitative research design is the choice of the researcher and actions that determine and create the research strategy that best suits the research goals (De Vos & Fouche', 2017). Smith, Gelling, Haigh, Barnason, Allan and Jackson (2018) added that qualitative research studies provide the theoretical and clinical nursing community with great awareness of the needs, perspective and understanding of those getting and providing health and social care. The qualitative research design facilitated an in-depth understanding of the lived experiences of WBCHW regarding the utilisation of the screening tool. The qualitative design was used because it can distribute data and results that reflected the research questions and ensemble the research purpose.

2.4.2 Exploratory Design

An exploratory design is conducted to gain insight into a situation, phenomenon, community or individual (De Vos, 2017). According to Burns and Grove, (2015) exploratory studies are designed to increase the knowledge of the field of study and to provide the researchers with information needed to achieve the purpose of this study. This allowed Ward Based Community Health workers to express their experiences regarding utilising the patients screening tools as, little information about the experience of Ward Based Community Worker utilizing the patient screening tool in the Fetakgomo-Tubatse sub-district, Limpopo province, was known. It also helped the researcher to answer the research questions of the study.

2.4.3 Descriptive Design

The descriptive design presents a picture of the specific details of a situation, social setting, or relationship, and focuses on “how” and “why” questions (De Vos, 2017). The purpose of descriptive design is to communicate accurately the extent, variations, and importance of a situation regarding the phenomenon being studied (Tappen, 2017). The researcher, therefore, begins with a well-defined subject and conducts research, to describe the experiences of a Ward Based Community Health Worker regarding utilizing the patient’s screening tools accurately. The reason for the description was to provide answers to the research questions and presents what was happening on the ground.

2.4.4 Phenomenological design

Phenomenological design is defined as a strategy in which the researcher identifies the essence of human experiences about a phenomenon as described by participants and focuses on the meaning of the lived experiences of participants (Holloway & Galvin, 2016). De Vos and Fouche,’(2017) regard the phenomenological study as a study that describes the everyday experiences and social actions of a subject. The researcher recorded the everyday lived experiences of WBCHW (participants) regarding the utilization of patients screening tools. The researcher used the phenomenological approach to provide a suitable research strategy and restrict the researchers’ biases as well as those of the participants and research in an open-minded way. The four strategies used by phenomenologists were outlined below:

Phenomenological involves the following steps:

2.4.4.1 Bracketing

The term bracketing is when the researcher’s preconceptions, attitudes, values and beliefs are held in abeyance to ensure that they do not prejudice the description of a phenomenon (De Chesnay, 2014). Bracketing is also a process of pointing out and holding preconceived beliefs about the phenomenon (Polit & Beck, 2018). In this study, the researcher sets aside all the beliefs about the situation that the researcher is studying.

2.4.4.2 Intuiting

In this step, one begins attempting to grasp the uniqueness of the phenomenon by comparing and contrasting it to a related phenomenon or examining similarities and differences, and it also involves phenomenological seeing, looking and listening to the phenomenon (De Chesnay, 2014). According to Polit and Beck, 2018, the researcher tried to understand the lived experience of

the participants. The intuition process helped the researcher to understand and become immersed in the study.

2.4.4.3 Analysing

This step involves the general examination of the structure of the phenomena according to the component and their configuration (De Chesnay, 2014). Thus, analysing is when the data collection is focused on creating materials by recording naturally occurring interactions (De VOS, Fouche, 2017). The research worked with rich descriptive data and common themes in analysing data as stated by participants.

2.4.4.4 Describing

According to De Chesnay (2014), this phase begins in silence and is born out of perplexity and frustrations in the face of the phenomenon one is trying to describe and it provides unmistakable guideposts to the phenomenon. The researcher tries to understand every concern, a full report of the findings in combination with how data was collected, captured, and analysed (Polit & Beck, 2018). The aim of this final step in this study was communication by offering different, critical descriptions a written and verbal form as transcribed from the voice recorder and field notes.

2.5 CONTEXT SETTING

The study was conducted in the Limpopo Province, which is one of the rural provinces situated in the North East corner of South Africa. The Limpopo Province has a population of 5.5 million people and 290,521 households. Limpopo has five districts consisting of Capricorn, Vhembe, Mopani, Waterberg, and Sekhukhune with 22 sub-districts. The Sekhukhune district consists of Elias Motsoaledi, Ephraim Mogale, Makhuduthamaga and the Fetakgomo-Tubatse sub-districts. In Fetakgomo-Tubatse there is the Burgersfort clinic, Mecklenburg Gateway Clinic, Selala Clinic, H.C Boshoff Health Centre, Dilokong Gateway Clinic, Madiseng Satellite Clinic and Riba Clinic. This location was chosen on the basis that it has consistently retained WBCHW since 2012 and has the greatest number of households (125 361) in any other sub-district.

In this study, only three clinics from the Sekhukhune district in the Fetakgomo-Tubaste were chosen: Dilokong Gateway Clinic, Madiseng Mobile Satellite Clinic, and the HC Boschoff clinic. These are situated between Madagshoek and Mashamthane consisting of a population of 25 900 people.

A total of 83 WBCHW got trained in 2017 to serve at the Dilokong Gateway and Madiseng Clinics, the HC Boschoff clinic whereby, 46 WBCHW serves Dilokong gateway clinic, 29 WBCHW serves

Madiseng clinic and 8 serve the HC Boschof clinic. Thus, these WBCHWs were trained to screen community members in the community they served, to reduce the risk and burden of diseases in the villages. WBCHW were allocated 270 households to register and to do follow-ups on them after registration. Hypertension and diabetes are prevalent diseases in this area. Up to 59.3% of people in the Fetakgomo-Tubatse sub-district are diagnosed with diabetes and hypertension every year.

2.6 TARGET POPULATION

The population consists of the individual to whom the researcher can gain access and who has the appropriate knowledge and experiences (Holloway & Galvin, 2016). The population is all elements that meet the criteria for inclusion in the study in which the researcher is interested (Flick, 2017). The populations of this study were all trained WBCHW from the Fetakgomo-Tubatse sub-district, Limpopo province and utilising patient screening tools.

2.6.1 Sampling method and sample size

Sampling is a process of selecting a portion of the nominated population to represent the whole population of the study (McCrae and Purssell, 2016). The researcher sampled clinics before sampling the participants. Consequently, the Fetakgomo-Tubatse sub-district has 22 clinics and only 3 clinics which are Madiseng, Dilokong Gateway, and the HC Boschoff Health Center were selected. These clinics were chosen due to a greater number of household populations and high numbers of patients diagnosed with diabetic mellitus and hypertension. Yet, these clinics have a huge number of WBCHWs who were trained and have been rendering screening services since 2012. A non-probability purposive sampling method was used to select the clinics and participants. Non-probability sampling implies that there is no way of ensuring that each member of the population could be selected (Polit & Beck, 2017). A Purposive sampling method was chosen based on the researcher's knowledge of the population and was used to hand-pick sample members, inclusion criteria are created based on the judgment of the researcher (Botma, Greeff, & Mulaudzi 2017). Therefore, in the study, forty (40) trained Ward Based Community Health Workers were sampled purposively as the researcher knew that they knew about the phenomenon under study. When the researcher used the sampling method, the researcher described inclusion criteria (Holloway & Galvin, 2018).

2.6.2. Inclusion criteria

Inclusion criteria state which particular people are included in the research (Holloway & Galvin,

2016). Therefore, the following inclusion criteria of WBCHW were used in this study:

- Those working in a WBPHCOT programme linked to Dilokong Gateway Clinic, Boschoff Health Center, and Madiseng Satellite Clinic in Fetakgomo-Tubatse, Limpopo.
- Those who have undergone Primary Health Care Outreach programme training for fifty-nine (59) days;
- Those who have been trained in phase one and two of the WBPHCOT programme;
- Those with a year or more experience rendering this programme; and
- Those who agreed to be part of the study.

Therefore, all WBCHW who do not meet the inclusion criteria was excluded from the study.

2.6.3. Gaining access to the research setting

Successful accessibility to research setting is determined by the researcher's ability to build and maintain relationships and agreements with gatekeepers and participants (De Vos, 2017). In this regard the researcher requested permission to gain access of Ward based Community Health Workers through the University of Pretoria, Provincial Department of Health and Primary Health Care Outreach, an Executive officer of Fetakgomo-Tubatse sub-district and the facility managers of the clinic were used to recruit participants in the study. Permission was also requested from the team leader from Ward based primary health care outreach teams (WBPHCOT). The team leader was the one who contacted the WBCHW which falls under her line of work. The WBCHW were informed about the date, time, and location of the study.

2.6.4. Selection and recruitment of participants

The researcher gained access to the participants through negotiation with the facility managers and the WBPHCOT team leaders of three clinics. The WBCHW were contacted in advance and made aware of the title and purpose of the study. The researcher also informed them about the dates, times, and locations. Participants were selected according to the inclusion criteria and the researcher avoided pressurising the participants. Thus, leaflets of the study were given to the participants (Annexure D). Those who were willing to participate were interviewed through focus group discussion

2.6.5. The Pilot study

The term pilot study is conducted to determine whether the intervention will work in other words, "to see if the beast will fly" (De Vos, Fouche', 2017). According to Holloway and Galvin, (2016),

pilot testing is a small trial run of a research interview. In this study the pilot testing was conducted a week before the commencement of the main study with eight WBCHW. These WBCHW were excluded from the main study. The reason was for the researcher to learn on how to conduct a focus group discussion. It was also to identify if the method is suitable for the study. The main question “What were your experiences when using the diabetic and hypertensive screening tool on patients in the community?. Sub-questions were also asked to probe further. The WBCHW understood the questions. In the pilot study, no challenges were encountered with the content of the questions. The research question was clear and understood and the spontaneous response prompt from WBCHWs.

2.7 DATA COLLECTION

Data collection is the selection and construction of visual material for analysing and understanding phenomena, social fields, and independent shared experiences (Barrett & Twycross, 2018). The aim is to reach the material that allows for constructing generalised statement by analysing and comparing several phenomena (Flick, 2018). The researcher used a focus group interview to collect data. Three focus groups were conducted with 23 participants. The first one with 6 participants, the second one with 5 participants the third one with 12 participants. During the focus group discussion, participants were tape-recorded and field notes were written. The steps followed during data collection are described below.

2.7.1 Preparation of the focus group

A focus group is a group of people sharing certain characteristics, for example, a similar professional background or sharing similar experiences (Barrett and Twycross, 2018). A total of twenty three (23) WBCHW participated in the focus group discussion. They were divided into three focus groups. Twelve participants from the Dilokong gateway clinic. Twenty were from Madiseng clinic and eight were from the HC Boschof clinic. The data collection was conducted on different dates in each clinic. The WBCHW were contacted in advance and made aware of the title and purpose of the study. The researcher also informed them about the dates, times, and locations. The researcher wrote a letter to the Fetakgomo-Tubatse sub-district for permission to use the home- based care structure hall at Driekop as a venue to conduct each focus group. The researcher approached one of the Professional nurses to be a research assistant in advance to scribe and record the focus group discussions for all three clinics. To ensure a relaxed environment, refreshments were arranged for participants in the focus group. The dates were scheduled on Fridays because WBCHW does not work on Fridays. They

usually have meetings and so the researcher had an opportunity to meet them without disturbing their work. A focus group interview guide (Annexure B) was used to guide the discussion.

2.7.2 Conducting a focus group

The researcher welcomed the participants and introduced herself. The research assistant, and participants also introduced themselves. The WBCHW who meet the inclusion criteria signed a consent prior to the focus group. The roles of the use of an audio-recorder and scribing were explained to the participants and they all verbally agreed for the recordings. Data was collected in a safe private area free of noise where participants were audible and recorded.

To ensure equal participation a semi-circle seating arrangement was used during the discussion. Ground rules relating to the use of mobile phones and ensuring that one person speaks at a time were emphasised. Codes such as participant A were assigned to participants so that they avoid using their names as a means of ensuring anonymity.

A reminder of the right to pull out from the research at any point and to report any feelings of distress was noted. Semi-structured interview questions were asked. The central question asked was, **What were your experiences when using the diabetic and hypertension screening tool on patients in the community?** Participants were allowed time to process the question and were spontaneous in responding. Probing questions to obtain more detail and clarity on the participants' experience were asked. The focus group discussion lasted for 40-45 minutes, and data were collected for four weeks. Participants were reminded to keep the discussion confidential. The researcher/facilitator did not express her biases or assumptions during the focus group discussion. When a participant feels comfortable with the facilitator. There was transparency while interacting. As such, participants were comfortable about disclosing their experiences regarding utilising the household screening tool.

According to Polit and Beck (2018), field notes are notes taken by the researcher as unstructured observations in the field. Field notes should be written during the interviews as a record of the researcher's impressions (De Vos, 2016). A written account of the occurrence that was heard, seen, felt experiences, and thoughts during the course of the focus group discussion is vital. Participants were notified that the field notes will be taken during the discussion. The researcher delegated the research assistant to write the field notes. In this study, field notes assisted the researcher to identify and interpret feelings, ideas, and impressions of WBCHW about their experiences of the topic.

A variety of technical devices are available for recording behaviour and events, making the

analysis or categorising of data at a later stage (Polit & Beck, 2017). In this study, a tape record was the most suitable device. The tones of participants about their experience were captured successfully and it did not intimidate them as a researcher had explained that it would be used. The researcher operated the tape recorder and the WBPHCOT team leader wrote field notes.

Three focus group discussions were conducted until data saturation was reached, which is a point where no new information was obtained from the study participants.

2.7.2.1. Communication skills

The following communication skills were used during the focus group discussion:

- **Listening**

  Being a good listener is the most important skill for in-depth interviewing, and it is not important not to interrupt when participants are telling their stories (Polit &Beck, 2018). A facilitator is expected to be able to have quality information during the interview, gain a better understanding and encourage participants to talk more (De Vos, Fouche', 2017). The researcher showed interest by nodding and leaning forward as participants were talking about their experiences.

- **Probing**

  Probing is a technique to persuade the participant to give more information about the issue under discussion (De Vos, 2017). Polit and Beck (2018) define probing as eliciting more useful or detailed information from a participant in an interview than was volunteered in the first reply. The researcher used a probing technique to deepen a response to a question, to increase the richness of data being obtained and to give cues to the participants about the level of a response that is desired.

- **Clarifying**

  Clarify means an explanation or more details that make something easier to understand (Cambridge Dictionary, 2021). This embraces a technique that will be used to get clarity on unclear statements (De Vos, 2017). The researcher ensured that participants understood the questions clearly and accurately.

- **Paraphrasing**

  Most importantly, paraphrasing is a process that involves a verbal response when the researcher enhances meaning by stating the participants' words in a different form, but with the same meaning (De Vos, 2017). According to Cambridge Dictionary (2021) paraphrasing is to express the meaning using different words, for clarity. The researcher used this technique

to ensure clarity and accurate capturing of information from the participants.

- **Silence**

According to the Cambridge dictionary (2021), silence is a period without sound or complete quiet. Silence gives time for reflection and gathering thoughts and feelings (De Vos,2017). In the study, silence was used to give the participant time to recall their lived experiences regarding utilizing the patient's screening tools.

- **Empathy**

Empathy means the ability to share someone else's feelings or experiences by imagining what it would be like to be in that person's situation (Cambridge dictionary, 2021). Empathy is to emotionally understand what other people feel and see things from their point of view (De Vos, 2017). This skill was used when participants express their painful experiences.

- **Minimal verbal response**

A minimal verbal response is a verbal response that correlates with occasional nodding (De Vos, Fouche', 2017). According to Cambridge Dictionary (2021) Minimal verbal response positive facial expression or nodding of the head such as ''Uh-huh'' and ''I hear what you are saying''. The researcher used ''mm-mm' 'yes, I see to show the participants that the researcher was listening.

- **Summarising**

Summarising to express the most important facts or ideas about something or someone in a short and clear form (Cambridge Dictionary, 2021). The summary has a structuring function and stimulates the participants to give more information (De Vos, 2017). The researcher summarsies the participant's ideas, thoughts and feelings verbalised so far to see if the researcher understood what he or she was saying.

2.8 DATA ANALYSIS

The purpose of data analysis is to discover, communicate and bring order to the data collected (Polit & Beck 2017). Data analysis aims to make logic of abundant information that accrued during an investigation (De Chesnay, 2016). Several techniques are available for data analysis when using a phenomenological method (LoBiondo-Wood & Haber, 2017). Morrow, Rodriguez, King, (2015) suggests a series of seven steps. The researcher applied those steps during data analysis by reading the participants' narratives to acquire a feeling of their ideas, and to understand them fully. After reading, significant statements to identify keywords and sentences relating to the phenomenon under study was extracted. Meanings for each of these significant

statements were formulated. This process was repeated across participants' stories, and recurrent meaningful themes were grouped. Similar information was integrated resulting in main themes, themes, and sub-themes (see chapter three). The categorised information and verbatim transcripts of focus group interviews were given to the independent coder for further confirmation and modification.

2.9 TRUSTWORTHINESS

Trustworthiness is a step of sureness qualitative research has in their data, measured using credibility, transformability, and dependability (Lincoln & Guba 1985).). In this study, the following criteria were used as described by (Lincoln & Guba 1985).

2.9.1 Credibility

This is the alternative to internal validity, in which the goal is to demonstrate that the inquiry was conducted in such a manner as to ensure that the subject has been accurately identified and described (Lincoln & Guba 1985; De Vos 2017). The researcher asks if there is a match between research participants' views and researchers' reconstruction and representation of them. The strategies to enhance credibility are prolonged engagement, persistent observation, and peer debriefing. The researcher invested enough time, established trust in the WBCHW, kept the inquiry honest and identifies elements relevant to the study. Credibility was again ensured by submitting analysed data and verbatim transcripts to the independent coder.

Strategies to enhance credibility are as follow:

- **Prolonged engagement:**

Lincoln and Guba (cited in Polit & Beck, 2018) explained a prolonged engagement in the field as the investment of sufficient time in data collection. According to Korstjens and Moser (2018), prolonged engagement is investing sufficient time to become familiar with the setting and context, to test for misinformation, to build trust, and to get to know the rich data. The researcher stayed in the focus group discussion for sufficient time. Each focus group discussion took 40-45 minutes to develop an in-depth understanding of the phenomenon.

- **Persistent observation:**

Polit and Beck (2018) explain peer observation as a continuous confirmation of the accurateness of data and themes with the participants before the conclusion of the research findings. According to Korstjens and Moser (2018), persistent observation is feedback on data, interpretations, and conclusions to members of those groups from whom data were originally obtained to strengthen the data, because the researcher and respondents look at data with a different eye. The

researcher went back to the participants to confirm data the collected and interpretation for the participants' input. The tape was played back to the participants for comments.

- **Peer debriefing:**

Peer debriefing is defined as a discussion with peers not involved in the research (Botma et al., 2017). Peer debriefing involves having discussion sessions with peers to review and explore various aspects of the inquiry as a way of making data trustworthy (Polit & Beck, 2018). Colleagues who understand the nature of the study were invited to review the study regarding experiences, insight, and analyses. The peer debriefing contributes to the researcher's honesty.

2.9.2 Dependability

This is the alternative to reliability in which the researcher attempts to account for changing conditions in the phenomenon chosen for study as well as changes in the design created by an increasingly refined understanding of the setting (Lincoln & Guba 1985). According to De Vos and Fouche (2017), the researcher asked whether the research process is logical, well-documented and audited. As such, the researcher systematically documented the process and products of this study to allow verification through an audit. In this study, the researcher gave the field notes, and transcriptions to an independent coder who have not participated in the study, to analyse and interpret. The transcribed data was handed to the supervisor to recheck and ensure that all findings are supported by data from the participants. The findings proved to be internally coherent. Generalising could not be considered in the study as the study was limited to three clinics in Limpopo province.

2.9.3 Conformability

Conformability is a final construct, in which study results are derived from the characteristics or experiences of participants and study context is not biased (De Vos 2017). Lincoln and Guba (1999) stress the need to ask whether the findings of the study could be confirmed by another. The major strategy for establishing conformability is again an audit trail consisting of the following: Raw data, data reduction and analysis, data reconstruction reduction and synthesis and process notes (De Chesnay, 2014). The researcher's audit recordings were helpful as a part of the audit trail and also served as a reminder. In this study, an independent coder was provided with research data and consensus was reached on the categories, sub-categories, and themes. The researcher ensured that feedback was given to participants regarding emerging interpretations and participants' reactions were obtained.

2.9.4 Transferability

Lincoln and Guba (1999) propose this as the alternative to external validity, in which the burden of demonstrating the applicability of one set of findings to another context rests more with the investigator who would make the transfer than with the original investigator (De Vos, 2017). The researcher provided enough information for the reader to determine the findings were transferable to another context.

2.10 ETHICAL CONSIDERATIONS

Ethical consideration is a classification of moral values concerned with the step to which research procedures adhere to the study participants' professional, legal, and social obligations (Polit and Beck, 2018). The researcher received permission from the Research Committee of the Faculty of Health Sciences of the University of Pretoria and the Department of Health Research Committee of Limpopo Province. The researcher also received permission from the Primary Health Care Departments at the selected clinics. The researcher observed the following ethical considerations:

2.10.1 Recruitment

The recruitment period is an essential and often difficult phase and the research deadline can lead some researchers to coerce people into participating. People must be are free and feel that they are free to refuse participation in research (Gaudet and Robert, 2018). As such, the researcher avoided pressuring participants and they were given leaflets about the study (Annexure B).

2.10.2 Informed consent

Informed consent means the research participants are fully knowledgeable about the research and their voluntary agreement to be part of the study (Holloway & Galvin, 2016). The best way isto prepare a shared contract, which explains the purpose of the research, the expectation from the participant, and the procedure with the data (Flick, 2018). Before commencing with the focus group discussion. The researcher gave verbal information to the participants followed by written informed consent (Annexure D). The participants have an absolute right to withdraw at any time.

2.10.3 Anonymity and confidentiality

In this study, confidentiality means researchers keep confidentiality that the participants do not

wish to disclose to others and anonymity is guaranteed and a promise is given identities will not be revealed (Holloway & Galvin, 2016). Anonymity and confidentiality are classic promises made to research participants in social research and concepts often contemplated together (Flick, 2018; Gaudet et al., 2018). Anonymity is the safest means of protecting the participant's information and when there is no linkage of participants to their data and during data transcription all information on the audio tape, which participants to data collection. The names of three clinics were indicated as Clinic 1, 2 and 3 and these allocations are known by the researcher only. All participants responded anonymously based on the code that corresponds to the participants. The true identity of participants is corresponding to each code known by the researcher. Thus, to ensure confidentiality, participants recorded-audio, saved them in a password-locked computer and that only the researcher have access to these records. The participants were assured that the audio records will be used for this study research and nothing else. Participants were assured verbally and in writing in the informed consent that the information they provide will not be used against them during the study and in the future.

2.10.4 Respect for a person

Respect for a participant was sustained. The researcher explained to the participants the purpose of the study. The participants were informed about their rights and their right to ask questions. They were also informed that they can withdraw from the study at any stage.

2.10.5. Benefits

The research was in nature non-experimental, therefore there was no harm or discomfort experienced by participants. The researcher was prepared to terminate the study if the study will result in any harm to the participants.

2.10.6 Measures to minimise the spread of coronavirus

WHO declared Coronavirus an international pandemic in March 2020. During the same month, President Ramaphosa also declared it a national disaster in South Africa. This disaster led to lockdown restrictions which included citizens staying or working from home, social distancing and practising basic hygiene to minimise the spread of coronavirus.

In this study, the researcher followed the principles and regulations by ensuring social distancing by seating participants one (1) meter apart from each other. The researcher also supplied the group members with new masks and hand sanitisers to use during the focus group discussion.

The researcher's assistant screened every participant before entering the hall by using a COVID-19 screening tool. If any unwell signs and symptoms are noted, then that participant will be referred to a nearby clinic with an individual screen form for further investigation.

2.11 CONCLUSION

In this chapter, the research design and method were discussed in detail. Population and sampling, data collection and data analysis were described. Trustworthiness was discussed in detail. Details of the focus group were presented. The next chapter discussed data analysis and presentation of the results of the study

CHAPTER 3

PRESENTATION OF RESULTS AND INTERPRETATION

3.1 INTRODUCTION

This Chapter presents the results and interpretation of the data collected according to the methodology presented in the previous Chapter. Data was collected using a focus group from three clinics with 40 participants. The responses were received from 23 participants. The three Clinics comprise Clinic 1 with 6 participants, Clinic 2-6 participants and Clinic 3 had 12 participants in the focus group. The total number of participants was 23 for the study. Thematic analysis was used to analyse and interpret the data. This aided in determining themes for the study and categories with subthemes for each theme. The results are presented with tables and graphics to show the theme, category, and sub-theme. The objectives of the study were to explore and describe the experiences of WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province. Participant's demographics and experiences are summarised in table 3.1:

DEMOGRAPHICS

Table 3.1: Demographical information of participants

Variable	Category	Counts
Clinic	Clinic 1	6
	Clinic 2	5
	Clinic 3	12
Age	29-34 years	1
	35-39 years	1
	40-44 years	12
	45-49 years	4
	50-54 years	5
Level	59 DAYS-PHASE 1&2	11
	59 DAYS-PHASE 1	8
	59 DAYS	4
Experience	2-7 years	19
	8-12	2
	13-17	2

Most participants were between 40-44 years old (12) followed by five participants between the 50-54 age group. Eleven participants were in phase1 and 2 while eight were in phase 1. Most participants had between 2-7 years of experience working in the clinics while fewer had 13-17 years of experience.

3.2. FINDINGS

Four main themes and sixteen sub-themes identified from this study.

3.2.1 Framework of themes and sub-themes

Table 3.1 displays the themes and sub-themes identified during the data analysis. The themes and sub-themes were identified. The themes highlighted positive experiences of WBCHW regarding the utilization of patient screening tools, challenging experiences of WBCHW regarding the utilization of patient screening too ls coping experiences of WBCHW regarding the utilization of patient screening tools and recommendations of WBCHW regarding the utilization of patient screening tools.

Table 3. 1. SUMMARY OF THEMES AND SUB-THEMES

THEMES	SUB-THEMES
Positive experiences of WBCHW regarding the utilization of patient screening tools	○ Facilitates comprehensive household assessment
	○ Facilitates identification of risk factors and symptoms for referral
	○ Facilitates identification of specific disorders
	○ Facilitates health education
	○ Facilitates clients' acceptance/ awareness of potential health problems
	○ Promotes trustworthiness and evidence of WBCHWs' contribution
	○ Guides WBCHWs' actions and workflow
	○ Enhances clients' compliance
	○ WBCHW-related challenges (limited scope of practice and recognition)

Challenging experiences of WBCHW regarding the utilization of patient screening tools	○ Client-related challenges (inadequatecooperation with screening)
	○ Client-related challenges (distrust WBCHWs)
	○ Resource-related challenges (non-availability of screening tools and medication)
Coping experiences of WBCHW regarding the utilization of patient screening tools	○ Alternative solutions to compensate for problems with screening tools
Recommendations of WBCHW regarding the utilization of patient screening tools	○ Sufficient and applicable screening tools and resources
	○ Capacitation of WBCHWs
	○ Improved conditions of service

3.2.2 Presentation of the findings

Each theme and sub-themes are presented as indicated in table 3.1.

3.2.2.1: Positive experiences of WBCHW regarding the utilisation of patient screening tools

A positive experience of WBCHW regarding the utilization of patient screening tools facilitates comprehensive household assessment. WBCHW can identify specific disorders, risk factors, and symptoms for referral and give health education. This makes clients gain awareness of health potential problems and promotes trustworthiness and evidence of WBCW's contribution. Therefore, it guides WBCHWs' action, and workflow and enhances the client's compliance the following sub-themes as indicated in table 3.3 above were identified:

- **Facilitates comprehensive household assessment**

The community health workers are assigned 270 households to monitor yearly. Their role is to facilitate the comprehension of household assessment which helps them identify any problems in the households through screening them. Participants reported that household and diabetic screening helped them to identify the shortage of food and nutritious food in the household.

> **FG1-P2**: *"this screening tool helps us when we are in the household asking them to the point where we can ask them about food. It can show if in that house they might be having a shortage of food"*.

FG1-P2: "*when we have entered a household asking them about the diabetic screening tool, it can show us that in this home they have a shortage of nutritious foods".*

A participant expressed that screening in households helps identify ill patients. Thus, it provides them with the ability to give patients health education, and the importance of going to the clinic or hospital and CHW also issue a referral letter to the community member.

FG3-P1: "*when we go to the community and screen the community members at home, it helps us to find very ill patients or bedridden patients, and we can give them health education about the importance of going to hospitals or clinics for consultations, we also give them a referral letter to go to the nearest clinic /hospital".*

Participants reported that when they screen the community household, they identify unemployed members who are sick. They referred them to the dieticians and the social worker to help the community with food packages.

FG3-P7: "*...when we screen for households sometimes we find the other community member unemployed, and they are sick so we refer them to social workers and dieticians"*

The other participant expressed that community health workers can develop a relationship with community members by becoming open when CHW uses a screening tool patients talk about every problem every patient has in the household.

FG2-P4*: "a patient becomes open when asking him/her to use the screening tool because he/she can see that we are not only focusing on him/her alone. He/she can tell us about everything".*

Another participant added

FG2-P2: "*I still repeat that they become open to tell you everything*".

Participants reported that by using a screening tool during household visits CHW can get information about the number of sick and vulnerable patients in the household.

FG2-P10: "*we can get information. Just like to know how many people there are in the household. How many are those who are sick and also those who are needy, it assists us with such kind of information".*

In addition to other participants: FG2-P6: "*we can also ask them at home to share their story so that tomorrow may be able to help them knowing their problem. To tell them about their disease".*

The findings of this study show that using a screening tool have a positive impact on both the community health workers and the community members. The community members can be open and express their feelings about their sickness and share their problems with the community health worker in the household. The community health workers can identify the problem and sickness during household visits. Therefore, it requires them to intervene and act by referring the patient to the multidisciplinary team depending on the problem and condition of the patient, for example, to the social workers, dietician, clinic, and hospital.

- **Facilitates identification of risk factors and symptoms for a referral**

The majority of participants indicated that the positive experiences of WBCHW regarding the utilisation of patient screening tools facilitated the identification of risk factors and symptoms for a referral. Screening patients with screening tools help the CHW to understand the extent of the problem, and so that they can be referred to the clinic or hospital.

Participants indicated that screening helps them understand what the person is suffering from and can decide whether to refer or not and prevents assumptions and makes the screening tools useful and helpful indicated by the following participants.

FG1-P6: "*another thing you can be able to understand is if the person might be having diabetes or what? Then you can refer the person to the clinic so that they may be sure if is diabetes, using that screening tool. I may assume that the patient might be having diabetes, then after I have assumed based on his/her signs, I refer him/her to the clinic or hospital to be sure if it was it that I may know how to assist him/her*."

FG1-P8: *"I see it being very significant when I am having this screening tool, we can distinguish the diseases of our patients, so that I may be able to know whether this one needs to be referred or not".*

FG1-P2: *"I chose a column of CHW action; our screening tool can help us when we are in the community. Our screening tool was able to help us identify many people in our community who were just living with many signs until we entered and refer them to the*

hospital so many were helped."

FG1-P7: *"on hypertension and diabetes, this screening tool assists in a way that many people do not know what the signs and symptoms of hypertension and diabetes are. When we are asking them some questions we end up knowing that this one might be remarkably close to being visited by diabetes based on the signs. We are then able to send him/her to the clinic to check if indeed he/she has it or what."*

FG2-P1: *"yes, like when a person with hypertension tells you that he/she overheats and sometimes dizzy, and that, you can suspect that he/she might be having hypertension then you refer him/her to the clinic to check if he/she does not have high blood".*

One of the participants indicated that these prevent guessing what the problem is and provide correct information for proper decision-making.

FG2-P11: "*I see that screening tool being useful because you will find that someone in the household might be having signs but not knowing what the problem might be. So when you are having the screening tool reading for that person he/she will be helped and the person ends up telling you that you see signs 1, 2, 3. Then you can talk to that person and tell him/her to go to the clinic to be checked. Because we know since we are working with people when he/she tell us tells maybe it is high blood because they feel dizzy and so forth. The only thing you can tell him/her is to go to the clinic so that you will know what your real problem might be*."

One of the participants indicated that when a person has signs of either diabetes or hypertension, they get referred to the clinic.

FG2-P6: "*CHW action, when I see that the person has signed, I can refer the person to the clinic".*

Participants indicated that screening helps them to encourage others to monitor their health.

FG-P12: *"it assists us in a way that as we go on entering households old people of 50 years and older according to my view, I think we might encourage them to check their blood pressure sometimes so that they can know where their blood pressure is".*

FG3-P2: *"This screening tool helps us because we can screen household, diabetes and hypertension signs of the community members if they have any signs and refer them to*

the clinic earlier before complications".

The findings of this study show positive experiences of WBCHW regarding the utilisation of patient screening tools that facilitated the identification of risk factors and symptoms for a referral. Screening patients with screening help the CHW to understand the extent of the problem so that they can be referred the clients to the clinic or hospital for further investigations. Participants indicated that screening helps them understand what the person is suffering from and can decide whether to refer or not and prevents making assumption throws that screening tools were extremely useful and helpful. Using screening tools prevents guesswork in the problem and provides correct information for proper decision making and easier to associate with the disease. The CHW gained confidence in encouraging community members to monitor their health properties.

- **Facilitates identification of a specific disorder**

The majority of participants indicated that the positive experiences of WBCHW regarding the utilisation of patient screening tools facilitated the identification of specific disorders using guidance, asking relevant questions, quick results, and knowledge to differentiate the kind of diseases.

One of the participants indicated that screening tools work as a guide.

> **FG1-P1:** *"This screening tool guides us. Even when we are busy using it in the households we can try to see if a patient signs fall under hypertension or diabetes."*

One of the participants indicated that screening tools help CHW to ask relevant questions.

> **FG1-P9***: "My experience is that it helps us not to ask questions that are not there, but only those that relate to diabetes".*

One of the participants indicated that screening tools provide instant results.

> **FG2-P2:** *"Even me with the screening tool I can show many diseases. Then you can know that today, I found this number for hypertension and diabetic this number."*

One of the participants indicated that screening tools work in line with the signs of the disease being tested.

FG3-P7: "*The screening tools help us a lot because you can find who have signs of hypertension without them, knowing it could be hypertension*"

One of the participants indicated that screening tools provide knowledge to differentiate between hypertension and diabetes results for a referral.

FG3-P4: *"When we use the screening tool for diabetes and hypertension, when we screen the community member we can differentiate between the signs of hypertension and diabetes so it helps us to know what we are referring the patient for*".

This study found that the positive experiences of WBCHW regarding the utilisation of patient screening tools facilitated the identification of specific disorders by guiding the clients on which signs fall under hypertension or diabetes, asking clients relevant questions to ensure they get referred accordingly and that clients can receive quick results and know their status of which disease is positive or negative, also the knowledge acquired to differentiate the kind of diseases it is that the client is suffering from.

- **The facilitation of health education**

The majority of participants indicated that the positive experiences of WBCHW regarding the utilisation of patient screening tools facilitate health education through teaching about diabetes and hypertension; guiding the community on how to read the results after checking diabetes and hypertension, creating awareness, making a follow-up, advise them on a healthy leaving such as exercise, diet, and educate the community on the signs of diabetes and hypertension.

One of the participants indicated that screening tools assist in teaching about the diseases related to diabetes and hypertension.

FG2-P12: "*they are immensely helpful to us especially when we are in the field asking patients some questions and also ticking. It also assists in teaching about diseases related to diabetes and hypertension*."

One of the participants indicated that screening tools help reading the guiding participants on how to read diabetes and blood pressure results.

FG1-P12: "*it helps us in a way that when we have entered the households. We read for them so that they can know, for example, if he/she has diabetes or high blood will know what he/she must eat or not to eat even to exercise. Then when I have this screening tool*

I show him/her and read to him/her saying, if you want your blood pressure to be controlled you must do the following then I read to him/her. Is see it being helpful in that way. To know if you fall under diabetic or hypertension even what to eat and what not to eat."

One of the participants indicated that screening tools help in awareness

FG2-P4: "*you find that my diabetic patient still has a problem of eating too much, so you must make him/her aware through education that a diabetic patient does not eat too much food at the same time. You must eat a small amount of food but frequently so, no eat an excessively big porridge because that will cause a problem in your body*."

FG2-P2: "*on the risk factors, when we are there with our patients as they spoke, we can make them aware and educate them that starting to use things that are bad, just like smoking may worsen their disease and warn them that they must not smoke and drink alcohol things like that*".

In addition…

FG2-P3: "*a hypertension patient on the risk factor, when we arrived to them we give them health talk that they should not eat too salt and fats so that the blood pressure cannot be higher".*

One of the participants indicated that screening tools help in making follow up

FG2-P10: "*on CHW action, we must always make follow up, to find out if our patient does things the way we taught them to do so. Just like those with high blood follow all their instructions even those with diabetes that they reduce eating too and eat rightfully*."

One of the participants indicated that screening tools help when advising on healthy leaving such as exercising, and diet

FG2-P1: "*we can also encourage them to do exercise when they have those signs and not just sit and relax*".

FG2-P12: "*this screening tool helps us in a way that, even though some of these things I did not see, we also tell the patients to have vegetable and fruit gardens at home*".

The following participants indicated that screening tools help in educating the community on the signs of diabetes and hypertension:

FG2-P5: "*When we arrive at the household if there is a patient with hypertension we also give health education to the family the patient stays with for example to avoid putting salt when they cook the patients food, we teach them the diet of a hypertensive patient and the lifestyle modification of the patient*".

FG2-P8: "*we can tell them those with high blood on the danger signs, we can tell them that whenever you feel headache, overheating and also vomiting you must go to the clinic so that they can check your blood pressure if it might be high or maybe if he/she doesn't know if he/she has it they can check him/her and tell him/her*".

FG3-P7: "*after the screening, we can also give them health education for example person with signs of hypertension is not supposed to eat salty and oily food. They are supposed to also exercise. They should also stay in a clean environment even when they wake up. They are supposed to open the window and clean the toilets and wash hands to avoid germs contaminations and other sicknesses*"

The facilitation of health education was through teaching about diabetes and hypertension; guiding the community on how to read the results after checking diabetes and hypertension, creating awareness, making follow-ups, advice on healthy living such as exercise, and diet, and educating the community on the signs of diabetes and hypertension.

- **Facilitates clients' acceptance/ awareness of potential health problems**

The majority of participants indicated that the positive experiences of WBCHW regarding the utilisation of patient screening tools facilitate acceptance/ awareness of potential health problems. Awareness relating to acceptance, identification of the risk factors, helping our household patients, help required, measures to be taken on the signs of chronic conditions, knowledge regarding the signs of diabetes and hypertension and alert about the sign and symptoms of diabetes and hypertension.

Participants indicated that acceptance is facilitated by the knowledge of learning their screening results.

FG1-P11: "*this screening tool also assists us, because in the households what I have experienced in our community is that most of them, they tell themselves and relying on things like, when you have diabetes or hypertension is because of heredity. so even if he/she has it, just because he/she never heard about anyone having those diseases in*

the family then the person ends up not accepting that he/she has it. So when we arrive in the household and started screening him/her and find that some of the signs are there which are on the screening tool, it can make our work easy."

Participants indicated that having a screening tool facilitates awareness since once patients know the status of the results helps in managing lifestyle changes.

FG1-P3: "*I think this screening tool, according to how the questions are written, helps me, for example, if I am a smoker I can be able to leave smoking"*.

Participants indicated that screening helps identify the risk factors as indicated by one of the participants.

FG1-P12: "*the screening tool assists me on risk factors like an example, our grandparents in the households, our grandparents just wake up and sit under the tree and do not go anywhere. When I come with the screening tool and start asking him/her if she has frequent urination. The time when she/he will be going to urinate frequently she/he will discover that she/he might be having a problem."*

Participants indicated that screening helps the community in knowing whether they have hypertension

FG1-P1: *what I was able to experience or see, is that this screening tool is able to help our household patients. Sometimes, a person might be having hypertension or diabetes without realising it. So, according to the signs when I explain them to him/her the signs for diabetes are this and that for high blood is this and that. Then a person ends up revealing that he/she has a problem, while she/he did not realise and go to the clinic earlier.*

Participants indicated that provision of help on what steps to take should the results or if they are found with diabetes or high blood.

FG1-P10: *on our screening tool, while we are doing a household visit, the one for high blood, I am able to discover a lot of things because some find that they did not know that they have high blood signs. While we are busy teaching them and asking questions they end up being open and telling us everything about themselves, that I feel this and that. Then we can see that these people need help if a situation is like this, and what*

measures to be taken.

Participants indicated that screening helps with Understanding the signs of a chronic illness

> **FG3-P1**: Diabetes and hypertension help the patients to know the signs of chronic conditions
>
> **FG3-P4:** "*the screening tool helps patient to know the signs of diabetes and hypertension it also helps the patient to not take the signs lightly so he/she could go to the hospital if they are any signs of sickness"*

One of the participants shows that screening help with an alert about the sign of diabetes and hypertension.

> **FG3-P6:** *"These screening tools also help us so the community members can be alert about the sign and symptoms of diabetes and hypertension, and it can also direct the community member on how to live a better lifestyle".*

This study found that positive experiences of WBCHW regarding the utilisation of patient screening tools facilitated acceptance/ awareness of potential health problems. Awareness facilitated was based on acceptance, identification of the risk factors by the WBCHW, help given to the household patients, and awareness of measures to be taken on the signs of chronic conditions, and the knowledge received regarding the signs of diabetes and hypertension and alert about the sign and symptoms of diabetes and hypertension.

- **Promotes trustworthiness and evidence of WBCHWs' contribution**

The majority of participants indicated that the positive experiences of WBCHWs regarding the utilisation of patient screening tools promote trustworthiness and evidence of WBCHWs' contribution. Having screening tools provided evident results and helps the community to do something about it since they will have knowledge of what is going on in their health; Creates some level of trust, promotes openness and patients are able to tell the CHW everything

Participants indicated that having screening tools provided evident results and helps the community to do something about it since they will have knowledge of what is going on in their health

> **FG1-P5:** *"it assists in a way that when we have entered into a household having the tool with us. With asking questions and looking in it is not like just entering there having nothing*

except just talking. This is, because sometimes when we just talk they end up not taking, what we are telling or asking them. Thus, now in other households some have started hypertension and diabetic treatment and left it. They are now becoming vegetables or hit by a stroke. They are unable to stand they do not have a wheelchair. So it helps us that when to ask them to have the tool they are able to stand."

In addition, another participant said,

FG2-P9: *"this screening tool helps in a way that it able to be served as proof that in this day or date, I entered and spoke with them about diabetes and hypertension diseases".*

Participants indicated that having screening tools creates some level of trust

FG1-P5: *"this paper we will be explaining to them that it is coming from the government and it also has a stamp for the department they become satisfied, is not like talking about having nothing with us. When we talk to them having nothing they feel like we are just lying to them and sometimes they chase us out of their homes."*

Participants indicated that having screening tools promotes openness

FG1-P5: *"When we have a document that has a departmental stamp we show and tell them that we are truly sent they become open to us and tell us everything".*

In addition, another participant said,

FG2-P2: *"when I am having the screening tool going to the community, when I arrive there they see that these papers are from the hospital they become open. Even me with this household I am able to record my daily work."*

Participants indicated that having screening tools helps in putting together a reliable report for feedback.

FG2-P6: "*we are able to have a report of what we went to do in that household, at which date? When? We tick and are able to take out those tools*."

The study found that the positive experiences of WBCHWs regarding the utilization of patient screening tools promoted trustworthiness and evidence of WBCHWs' contribution. Having screening tools provided evident results to clients. It helped the community to do something about

it since they have knowledge of what is going on associated with their health. The positive experiences of WBCHW regarding the utilization of patient screening tools promoted trustworthiness and evidence of WBCHWs' contribution created some level of trust and promoted openness and patients were able to tell the CHW everything about what they were feeling.

- **Guides WBCHWs' actions and workflow**

The majority of participants indicated that the positive experiences of WBCHWs regarding the utilization of patient screening tools guide WBCHWs' actions and workflow in understanding what the signs are for and make their fieldwork simplified and easier. Screening tools facilitate relevant questions to ask patients and work as a guide.

Participants indicated that screening tools help the CHW to differentiate what the signs are for.

> **FG1-P4:** *"this screening tool also assists us on the people, some of them their signs, when we are in there speaking with them we eventually know what the signs might be for. As we will be looking there while the patient is speaking, we are then able to assist him/her."*

The participant indicated that screening tools make the CHW work easier

> **FG1-P11**: *"I am participant 11, when I am using this screening tool it makes my work easier, when I am going to ask the patient some questions even the patient becomes open to answer the questions that I will be asking him/her".*
>
> Another participant said regarding simplifying the work
>
> **FG2-P11:** *"I see it being useful as it simplifies our work. Like as they already spoke that when you get the house to house having it you are able to save time. Because you just read and the patient gives you an answer then you are busy ticking."*

The participant indicated that screening tools facilitate relevant questions to ask patients.

> **FG1-P11**: *"when I say easy, I mean the questions that I will be able to ask, for example, asking that question like do you urinate frequently things like that? Then he/she is able to answer me."*

The participant indicated that Screening tools provide good guidance on how work should be done

> **FG1-P6:** *"maybe if it were a report I would comment at the end or I put a signature and write the date. According to me is something just a guide on how I should do the work in the working place."*

The participant indicated that Screening tools reduce workloads as they work efficiently.

> **FG3-P7**: *"The household, hypertension and diabetes screening tool are very important to us as community health workers, it reduces our workload because we were asking all the questions about signs and symptoms while referring to the screening tool, and I immediately know quickly that a person is having what kind of sickness".*

This study revealed that the positive experiences of WBCHWs regarding the utilization of patient screening tools guided WBCHWs' actions and workflow in understanding what the signs are for and makes their fieldwork simplified and easier. Screening tools facilitated to ask of relevant questions to patients and worked as a guide to the WBCHW team in executing their mandate properly.

- **Enhances clients' compliance**

A majority of participants indicated that the positive experiences of WBCHW regarding the utilisation of patient screening tools to guide the patients on how medication can be taken for compliance and prevent defaulting. Screening tools help CHW to guide about the importance of taking medication and avoid defaulting treatment, providing patients with advice in taking treatment, screening tools also helped in managing the side effects of the medication by providing patients with advice on how taking can be treated.

One of the participants indicated that screening tools help CHW to guide the patients on how medication can be taken.

> **FG2-P6**: "*Which are risk factors, it helps us also in assisting them on how to take their pills at the same time*".

Participants indicated that screening tools are important for taking medication and avoiding defaulting treatment

> **FG2-P12**: "*The importance of taking medications and avoiding defaulting treatment. This is because hypertension and diabetes are lifelong chronic diseases, which is what we teach them when we go to the fields*."

Participants indicated that screening tools help CHW in providing patients with advice in taking treatment.

> **FG2-P12**: "*I am adding on the medication information, We give them advice to take their treatment on time, for example, if the patient is used to taking treatment at 7h00, he/she should take treatment at 7h00 if is 08h00 or 09h00, they should take it as, usual, some*

medication is taken in the morning and some at night.

Participants indicated that screening tools manage after effects of medication

> **FG3-P2**: "*If I find the patient saying that the medication is making them dizzy. As a CHW, I would start asking questions. If the patient ate food before taking medication. Sometimes you can find that the patient has just taken light food and when they take medication, the medication finds that what the patient has eaten is weak the medication will cause dizziness. As a CHW we much find from a patient about taking food before drinking medications*."

The study revealed that the positive experiences of WBCHW regarding the utilisation of patient screening tools were used as a guide for the patients on how medication can be taken and comply so that defaulting can be prevented. Screening tools helped CHW to guide the importance of taking medication and avoid defaulting treatment, providing patients with advice in taking treatment. Screening tools also helped in managing the after-effects of medication in providing patients advice on how treatment can be taken.

3.2.2.2 The challenging experiences of WBCHW regarding the utilization of patient screening tools

The challenging experiences of WBCHW regarding the utilization of patient screening tools expressed by participants were divided into WBCHW-related challenges which encompass the limited scope of practice and recognition, Client-related challenges which were inadequate cooperation with screening and distrust WBCHWs, and Resource-related challenges which covered non-availability of screening tools and medication.

- **WBCHW-related challenges (limited scope of practice and recognition)** Challenging experiences of WBCHW regarding the utilization of patient screening tools are associated with the limited scope of practice, and recognition by the government, healthcare colleagues and clients. WBCHW indicated that they know their scope of practice but in reality, they work above the scope of practice for the activities that they are not recognised for. It was also apparent that the WBCHW are frustrated by the workload and has not been recognised by the government for the work done. The participants expressed frustrations and workloads.

> **FG3-P2:** "*As a community, health worker, I work too much work because I am a counsellor. I give counseling to community members. I am also a teacher because children when I usually screen ask me questions on health, then I help them. I am also a pharmacist I distribute patients medication at home. I am also a psychologist a solves*

problems of the community members, but after this workload, the government does not even recognise us. and too much work we are doing for the community because our salaries never increase. We always sign contracts and are not absorbed permanently, but the department wants to report every month."

During the group discussion, some participants indicated that their scope of practice is limited, about nine participants were recognised by their healthcare colleagues. They reported that the EMS staff when picking up patients that they referred ask them for information that they know very well that they are not allowed to practice, because they not performing certain activities due to the scope of practice.

FG2-P2: *"The EMS ambulance will ask what the problem with the patient is, they even ask for the BP readings of the patient, and you will find that we don't have the blood pressure readings of the patient because we don't have the BP machines*".

They also reported that their work is not fully recognised by the people they provide healthcare to, especially if their monitoring is not backed up by the use of an apparatus such as a blood pressure screening machine and glucometer machine.

FG1-P3: "...*but sometimes we come across those who want devices that we can use to check them, for example, the BP machine and glucometer that is when they will really believe in our work. We screen then they are open, but because they are not the same some prefer to see us having something in our pocket to show that he/she might be having diabetes*."

In addition,

FG2-P4: "*When we walk throughout the households is doing the screening for diabetic and hypertensive, some end up requiring that we should come with BP machines so that they may see the ratings of their blood pressure. Because they are no longer going to clinics these patients, even when they went there no one take them BP, like those who take their monthly treatment. When they arrive at the clinic they just collect their treatment and come back*."

FG2-P7 shared the same sentiments: *"in other houses/homes when we screen them when we start introducing ourselves they will ask us if we are having BP machines and scales, the also ask if we have treatment for headaches, so we tell them how we work. However, they also ask questions that need hospital answers and it becomes difficult for*

us to screen them."

FG37 added**:** *"yes, but the patients insist that we should have the BP and scale when we come to screen them"*

The information shared here suggests that the scope of work for WBCHW needs to be clarified and congruent with the training provided.

- **Client-related challenges (inadequate cooperation with screening)**

Client-related challenges were identified and described as inadequate cooperation with screening. Participants indicated that the challenges they faced when visiting the clients are that clients withhold information. At times they lie, resist to respond questions, refuse to provide personal information, refused to be screened and not want to participate in the counselling sessions, etc. The following quotes confirm challenges caused by the inadequate cooperation of the clients.

FG1-P11: "*we mostly come across them; there is this patient who does not want to give you information. You are busy screening a person he/she just denies some of the things but you are able to see that they are there. Which means that they withhold information and also that which you might have found on him/her*."

FG2-P2: ..."*even though sometimes they lie to us, we have to ask them questions*".

FG3-P9: "*The challenge I had when I was screening hypertension, household and diabetes was the head of family, especially, when I was using a household screening tool. We have to write the names of the head of family, phone numbers and ID number. So, some of the household members would refuse to give us the ID number and the phone number saying they are private details*."

FG3-P6: "*Most of the community members refuse to be screened when we enter their homes they go out. Most of them are sick, even when I try to give them health education and counselling they do not want to listen to us. They tell you that they have medical aid membership. Thus, I can see them they are sick, but they deny the screening, especially, men are the wants who do not want to be screened*."

> **FG3-P1:** "*Some other day when I went screening another family they were refused to be screened and there was a very ill patient in that family, they called me when the patient started to complicate and I find that the patient was gasping, it was a difficult challenge for me*".

Apparently, some, of the clients are rude and undermining the WBCHW and boosting about consulting the other healthcare providers that they feel are better than WBCHW.

> **FG3-P9**: "*Sometime when screening the community member they say that they have their own private doctors when he/she gets sick they will go to their private doctor, so I felt undermine as a community health worker because we are working for the government*".

Another participant revealed that they are not safe when visiting clients in their households because they are exposed to dangerous situations like finding dogs in patients homes.

> **FG3-P7**:"*When using the screening tool we have challenges is not all the community members that want us to enter their homes, some houses we find dogs outside they call the dogs on us. Sometimes when we enter their homes they do not respond to our greetings or respond to any of the questions we ask when we screen them*."

The unwillingness to share information by the clients to the CHW made it difficult for the team to write a clean report that is communicative. This will result in poor recording of information by the nurses at the hospital, thereby providing wrong interventions and treatment.

- **Client related challenges (distrust WBCHWs)**

Ward Based Community Health Workers experiences challenges from clients, whereby clients do not trust them to be from the healthcare services. They suspect them as robbers when they approach households. Participants reported that there are instances when clients will run away when they see them coming. Some family members hide n ill patient from CHW, some see them as a threat to spreading Covid-19. Some of the clients even verbalises that they don't see any benefit from CHW.

> **FG1-P5:** *"when we go there not having anything, saying we are sent by the department verbally so.it is as if we are lying, we are there to rob or cheat them and that we are only*

there just to get our payment through them. Many say is only through them that we are paid".

FG2-P6: *"Some of the challenges when we go to the households, for hypertension and diabetes screening, some families run inside their houses and they will say those who disclose about people's conditions have arrived, or when you get them at home they will say they are visitors, they don't want to see us and we can't enter their house without their consent"*

FG3-P5: *"when we go for household screening to some families you can find that they are hiding a very ill patient, that's why when we come to their homes they don't want us to enter their place, they assume that we will tell other community members about that patient sickness, they don't trust us".*

FG3-P1: "*now that there is a pandemic of covid-19 when we go to screen the community members' hypertension and diabetes they usually say we are spreading covid-19 to them*"

FG3-P4: "*When we screen the community members they sometimes tell us that they don't benefit anything from us because we don't give them food, so there is no need of screening them because at the end of the day we won't give them anything, and they say CHW are the AIDS People*".

- **Resource-related challenges (non-availability of screening tools and medication)**

Drawing from the discussions in focus groups. It was also obvious that the WBCHW are experiencing challenges related to the non-availability of screening tools and medication. The non-availability of the screening tools was referred to as the lack of photocopying machines, the lack of stationery and a shortage of screening tools resulting with the WBCHW using their money to photocopy so that they can look professional and respected by the clients.

FG-P11: "*we do not have a photocopy machine; we make copies of this screening tool by ourselves. This means the day that I will not having money I will not be using it*

because would not have copied it."

FG2-P3: "*When we screen the patients you will find that we only have five screening tools and it limits our work, we only screen those five families', because we don't have a photocopy machine"*

FG3-P5: "*Another challenge we have is the shortage of screening tools our photocopy machine was broken. We use the notebooks while referring to the phone screening tools when screening the patients for household diabetes and hypertension."*

FG3-P1: "*To add to what participant 5 has said, the departments of health send us the screening tools to the phone and they want us to use our money to print screening tools, it makes our work difficult because we don't have money to print the screening tools, that's why we use our notebooks"*.

Regarding a lack of stationery and shortage of the screening tools the participants mentioned that:

FG1-P11: "*so the time I do not have, it means work will not be able to move. It is a stationery problem."*

FG1-P6: "*I go back to what participant 11 has highlighted, it takes us back that our work seems to be of no value because of these papers. I mean the screening tools. They are the ones that give us dignity when working with them in the community. So, when you start removing papers from a notebook it seems like you are not serious about your work*."

The shortage of medication was also included as a challenging experience. The participants highlighted the following:

FG2-P3:" *The challenge is the shortage of medication. Whereby, sometimes patients are given a high dose of medication and told to cut the tablets in half. Patients just taken e overdose. This is because they are lazy to cut the tablets, which is the challenge I experienced."*

In addition,

FG2-P2:" *The challenge that I had is about medication, patients give us their chronic forms to collect treatment at the Dilokong gateway. Sometimes, I find their medications out of stock at the clinic. So, I keep the chronic form until I get medication at the clinic,*

and the patient will say can I get the medication for her at the hospital I do not have money to go to the hospital. So, I keep the chronic form with me until the medication is issued at the clinic."

3.2.2.3 Coping experiences of WBCHW regarding the utilisation of patient screening tools

The findings show that participants have developed means for them to cope with the shortage of screening tools resources, which are addressed below.

- **Alternative solutions to compensate for problems with screening tools** Participants indicated that alternative solutions to compensate for problems with screening tools are to provide the WBCHW with money to get screening tools in the nearest hospitals if clinics do not have or provide them with money to print and photocopy since they do not have photocopy machines. The following quotes show the WBCHW compensate their money to make copies of the screening tools.

> **FG2-P3**: "*When we screen the patients you will find that we only have five screening tools and it limits our work, we only screen those five families, because we don't have a photocopy machine".*

> **FG1- P11**: *"We make copies of this screening tool by ourselves. This means the day that when I do not have money, I will not use it, because I would not have copied it*."

> **FG1-P11**: *"So the time I don't have, it means work won't be able to move. It is a stationery problem".*

In addition, the other participant indicated that having screening tool gives them dignity when they are working and shows the seriousness of their work.

> **FG1-P6**: *"I go back to 11, it takes us back that our work seems to be of no value because these papers, I mean the screening tools. They are the ones that give us dignity when working with them in the community. When you start removing papers it seems like you are not serious with your work".*

> **FG3-P5**: "*Another challenge we have is a shortage of screening tools photocopy machine is broken, so we use the notebooks while referring to the phone screening tools*

when screening the patients for household diabetes and hypertension".

FG3-P1: "*To add on what participant5 has said, the departments of health send us the screening tools to the phone and they want us to use our money to print screening tools, it makes our work difficult because we don't have money to print the screening tools, that's why we use our own notebooks".*

3.2.2.4 Recommendations of WBCHW regarding the utilisation of patient screening tools

The participants recommended that there should be sufficient and applicable screening tools as well as resources, and that WBCHW should be capacitated as well as improving conditions of services in which the WBCHW functions.

- **Sufficient and applicable screening tools and the resources**

Majority of participant indicated that they need screening tools and resources such as stationary to prevent having problems while in the field.

Participants expressed the need for stationary.

FG1-P11 "*According to me, this screening tool is fine. At least what they can try is to supply us with stationery so that we won't have problems when doing the work in the field*"

FG1-P12 "*Yes, I agree, according to me the clinic that is next to hospital I think must be the one to assist us with stationery*".

FG1-P1 *"I think all clinic should help us with stationery, if they lack they can ask from the hospital if they are available*".

FG3-P4: "*We need our department to supply us with diabetes, hypertension and household screening tools, because we don't have enough money to photo copy this tool, and so that our job can be much easier and community members can have trust on us, they don't take us serious when we use our note books*".

Some of the participants even recommended that the screening tools should be according to the type of illness they are monitoring. Participants expressed the need for screening tools not to be the same, but each to be directive based on the illness that they are assessing.

FG2-P2: "*We would like the screening tool to be separated; we should have the screening tool of diabetes separated from hypertension screening tool so our work can be much*

simpler and easier",

FG2-P4: "*We need the supply of more screening tools, or maybe they can send the screening tool for hypertension household and diabetes in our phone so we can keep on reminding ourselves on how to screen the patients*".

Another participant suggested that they should be supplied with apparatus to screen high blood pressure and Glucose to confirm the presence of hypertension and Diabetes in their clients.

FG3-P5: "*BP machines and glucose machine so that after screening the community members when we find signs of hypertension and diabetes we can confirm through this machine, before referring the patients to hospital, also so that the patients can be satisfied and have trust in us as community health workers*".

- **Capacitation of WBCHWs**

The focus group responses presented the need for training WBCHWs on communicable diseases such as hypertension and diabetes, or/and have workshops and awareness campaigns so that they learn more on them. The training is also required on how to use the apparatus used to screen and monitor patients.

FG2-P12: "*I think they can improve our knowledge about screening of household hypertension and diabetes through workshops, so we can have a better understanding, and so that the department can also update us on the chronic diseases screening tools*".

Training on how to use the blood pressure machines is also required.

FG2-P4: "*We would like our department to supply us with Blood Pressure machines and train us how on to use a Blood pressure machine so that after screening signs of hypertension we can check the community member to confirm if they have hypertension and refer them to the hospital*".

Another participant added that:

FG2-P3: "*We need training on hypertension and diabetes screening and we also need training of hypertension and diabetes machine training and also supply as with the machines so we can check the community members after screening*".

In addition, to training and workshop on the use of apparatus another participant suggested campaigns to educate communities about WBCHWOT in order to improve trust.

> **FG3-P6**: "*I suggest the department to do campaigns about how we work as the WBCHWOT so that the communities have trust on us and understand our role*".

The results show that visitation by management when household visits are done can strengthen better supervision. Participants also alluded to support from expert such as social workers.

It was also highlighted that it is necessary to have some unplanned visits by management when conducting household visit. Participants believed that this could enhance better supervision and acknowledgement of challenges experienced by the team.

> **FG3-P2**: "*We would want our Outreach Team Leader to come visits us when we screen households, hypertension and diabetes of the community members, so they can supervise us in the job we are doing, so that they can see the challenges we are facing*"

Expert support such as a Social worker was also recommended by the participants, because of the social related problems that are identified in families.

> **FG3-P2**: "*When we screen community members for hypertension household and diabetes, some problem needs social workers, so we need our social workers to support us when we call them for help to visit certain families that have social problems*"

- **Improved conditions of service**

Participants responses have shown the need for improved conditions of service. These include salary increase, transport allowances, Uniform, and Working time schedule.

Participants requested improvement on working conditions related to salary increase.

> **FG3-P6:** "*We would like our Department to increase our salaries so that we can feel motivated to work more and to improve our work*"

Another participant felt that transport allowance will motivate them to visit other households in areas that they can't reach by just walking.

FG3-P5: "*When we screen our community members the section we are working in are far apart and we walk so when we arrive at the houses we are already tired, we need transport allowance, or transport because where we are working is a long distance and is far apart*".

Some suggested to be permanently employed by the department of health.

FG3-P1: "*We need Department of health to absorb us permanently so that we can also get the benefits of a government worker, so our children cannot suffer when we are dead, and so that it can motivate us to do quality job*".

Uniformity in what the WBCHW were wearing was suggested in the form of allowance or as a supply.

FG3-P6: *"We are asking our government to supply us with uniform or uniform allowances we can screen the community member with confidence and so that community can recognise us as CHWs when screening them".*

Other participants raised the issue of working hours. The participant felt that they are working long hours but they are on a contract and they are not paid well.

FG3-P 8: "*The time of coming at work is 07H00 and we knock off at 16H30. I mean the time to go screen the patient for household diabetic and hypertension is 07H00 and knock off at 16H30. We work hours of permanent staff but we are on contract. Thus, maybe the government can get consider reducing our hours of work*".

3.3 Conclusion of the chapter

In this chapter, the findings in the study were made through thematic analysis and were discussed. The researcher used an objectivism paradigm as a research perspective approach to enable the researcher to understand the meaning that people give to everyday life experience (De Vos 2017). Quotations from objectivism transcript of interviews with WBCHW were used for study findings. They expressed their experiences when using the diabetic and hypertension screening tool on patients in the community Chapter Four follows with the conclusion, recommendations, and the contribution to the body of knowledge, limitations, and a summary of the study.

CHAPTER 4

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

In chapter three the researcher presented and interpreted the study findings supported by quotes from WBCHW who participated in the FGDs. Chapter four discusses the findings supported by the literature.

The objectives of the study were to explore and describe the experiences of WBCHW regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province.

4.2 DISCUSSION OF FINDINGS (THEMES AND THEIR SUB-THEMES)

The discussion follows the framework that presented and interpreted the findings, thus according to themes and subthemes. Four themes were identified from the study.

4.2.1 Positive experiences of WBCHW regarding the utilization of patient screening tools

The study results revealed that a positive experience of WBCHW regarding the utilization of patient screening tool facilitates comprehensive household assessment. About eight sub-themes emerged from this theme. The study found that the positive experiences facilitated comprehensive household assessment, facilitates identification of risk factors and symptoms for referral, facilitated identification of specific disorders, facilitated health education, facilitated clients' acceptance/ awareness of potential health problems, promoted trustworthiness and evidence of WBCHWs' contribution, Guide WBCHWs' actions and workflow and enhanced clients' compliance, supported by Perry, et al, (2017), and Tshitangano and Olaniyi (2018) studies.

- **Facilitates comprehensive household assessment**

The findings of this study show that using a screening tool have a positive impact to both the ward-based community health workers and community members. The community members were able to be open and express feelings about their sickness and share their problems with the ward-based community health worker in the household. Ward based community health workers were able to identify the problem and sickness during the household visits which required them to

intervene and act by referring the patient to the multidisciplinary team depending on the problem and condition of the patients, for example, to social workers, dietician, clinic, and hospital. WBCHWs are the world's most promising health workforce as they use screening tools in order to identify various conditions to reduce the burden of disease from serious, readily preventable, or treatable conditions (Perry et al, 2017). They are the first point of contact between health service clients and providers, linking communities to the health system.

Screening tools facilitate a comprehensive household assessment which assisted WBCHWs to identify important information regarding their clients and their households. As such Khuzwayo and Moshabela (2018) study highlighted that when WBCHWs uses screening tool it assists in early detection and intervention of health problems and illness. Tshitangano and Olaniyi (2018) conducted a study on WBCHW indicating that the Provincial guidelines for the implementation of WBOT toolkit illustrate that CHWs are expected to use screening tools when providing appropriate home care as such conducting household assessment assisted them in identifying other risk factors related to conditions such as cancer apart from diabetic and hypertensive diseases (Scott, Beckham, Gross, Pariyo., Rao, Cometto & Perry 2018; Tshitangano & Olaniyi, 2018). As such the use of screening tools which facilitates comprehensive assessments will assist in early detection of other conditions which might facilitate early referrals to the next level.

- **Facilitates identification of risk factors and symptoms for referral**

The findings of this study show positive experiences of WBCHWs regarding the utilization of patient screening tools which facilitated the identification of risk factors and symptoms for referral. Screening patients with screening tools helps the WBCHWs to understand the extent of family members' problems so that they can refer the clients to the clinic or hospital for further investigations. Participants indicated that screening helps them understand what the person is suffering from and can decide whether to refer or not and prevents making assumptions which shows them that screening tools were useful. Using screening tools prevented guess work of what the problem is and provide correct information for proper decision making and easier to associates the signs of the disease.

The findings of the study were supported by Marques, Sarmento, Martins and Nunes (2015) where it stipulated the guidelines for performance of community health care workers as they were to refer people with presumptive signs and symptoms of various conditions for diagnosis and related treatment to hospitals or clinics. The effectiveness of WBCHWs to pre-screen people

for high-risk factors and other conditions is a first step to subsequently increasing screening that requires high- level of referral (Perry, Zulliger, Scott et al., 2017). In line with the study findings of Ramukumba (2019) screening tools enable them to identify signs and symptoms of diseases and refer accordingly. Similar to the study of Scott et al, (2018), the researchers indicated that, WBCHWs assist with appropriate utilization of screening tools and make referrals to the next level. Referrals to the next level of care will assist patients to get prompt treatment and care as such complications are prevented.

- **Facilitates identification of specific disorders**

This study found that the positive experiences of WBCHWs regarding the utilization of patient screening tools facilitated identification of specific disorders through guiding the clients on which signs falls under hypertension or diabetes. Asking clients relevant questions to ensure they get referred accordingly, and that clients are able to receive quick results and know their status of which disease is positive or negative, and also the knowledge acquired to differentiate the kind of diseases it is that the client is suffering from. Similar to the findings of this study, Hodgins, and Kok (2021) reported that WBCHWs are engaged in the identifying specific disorders through the screening tools where they discovered other signs of conditions such as tuberculosis (TB), chronic diseases (especially hypertension, diabetes, and mental illness). Tshitangano and Olaniyi (2018) conducted a study indicating that the Provincial guidelines for the implementation of WBOT toolkit illustrate that WBCHWs are expected to provide appropriate screening to the community, conduct household assessment in this way they identify clients at risk of other conditions. Cooper, Messow, McConnachie, Freirre, Elliot, Heard, Williams and Morrison (2018) concurred with the current study findings by indicating that early identification of specific disorders might assist in the prevention of mental disorders as the client with signs of depression might be identified during screening and be refereed for psychological counselling early. Therefore, screening tools facilitate identification of specific disorder to prevent high risk complications.

- **Facilitates health education**

The findings of this study revealed that the use of screening tool facilitated the need for health education. The findings of the current study indicated that WBCHWs guide family members on how to read the results after checking and recording their blood glucose and blood pressure. WBCHWs give families advice on a healthy living style such as exercising, diet, and educate the

community on the signs of diabetes and hypertension so that they can be aware and act early. The World Health Organization, (2020) in line with this study results suggested the provision of health education by WBCHWs as a first point of contact. Similar to the findings of the current study, Schneider et al. (2018) indicated that WBCHWs facilitate health education to families through teaching about diabetic mellitus and hypertension as a condition. The authors also highlighted that WBCHWs conduct screening and health-promotion programmes in schools and early childhood development centers, working in partnership with school health teams and outreach teams in educating school children and their families. Ramukumba (2019) supported that WBCHWs participates in various health promotions campaigns, organised by the health facility, these involved screening for TB, cancer, male circumcision, physical activity for elderly, adherence clubs and school health promotion. Giving health education can assist the community and family members as they will have knowledge of various diseases conditions and on how to prevent them from occurring hence increasing their life expectancy.

- **Facilitates clients' acceptance/ awareness of potential health problems**

This study found that positive experiences of WBCHWs regarding the utilization of patient screening tools facilitated acceptance/ awareness of potential health problems. Awareness was based on identification of the risk factors by the WBCHWs, helps when given to the household patients, and awareness on measures to be taken on the signs of chronic conditions, and the knowledge received regarding the signs of diabetes and hypertension. The findings of this study were supported by the World Health Organization (2020) which indicated that screening of patients by health care professionals through history taking facilitated awareness of the sign and symptoms that the patient was presenting with. Puente-Maestu, Calle, Rodríguez-Hermosa et al., (2016)) supported by indicating that patient education and screening also plays a critical role in facilitating patients' acceptance of their diagnosis and understanding behavioural changes required for active participation in treatment. In support of the findings, Puente-Maestu, Calle, Rodríguez-Hermosa et al., (2016) conducted a study that indicate that a key factor for taking full advantage of advanced medical treatments in today's health care environment is the ability of the patients and their families to be aware of their condition, understand health and accept medical information. Therefore, acceptance and awareness of potential problems around families can assist them in changing bad habits, e.g., a smoker will stop smoking to prevent worsening of both hypertensive diseases of prevention, diabetic mellitus to complicate to cardiovascular conditions.

- **Promotes trustworthiness and evidence of WBCHWs' contribution**

The study found that the positive experiences of WBCHWs regarding the utilization of patient screening tools promoted trustworthiness and evidence of WBCHWs' contribution. Having screening tools provided evident results to the clients and helped the community to do something about it since they have knowledge of what is going on associated with their health. The positive experiences of WBCHWs regarding the utilization of patient screening tools promoted trustworthiness and evidence of WBCHWs' contribution created some level of trust, and promoted openness and patients were able to tell the WBCHWs everything of what they were feeling. As such, the findings of Hodgins et al, (2021) indicated that communities need to have a realistic understanding of the WBCHWs' roles and their programme, to be involved in a transparent process for selecting WBCHWs for their communities and to have the opportunity to participate in the WBCHWs' programme to build a mutual understanding and relationship between them. Mundeva, Snyder, Ngilangwa and Kaida (2018) study suggested that without a more understanding of how clients experience and engage with their WBCHW, we may be missing critical information about how to make these programs more effective, how to meet the needs of individuals, families, and communities, and how to ensure that shared decision-making is a reality in health programs.

Therefore, the World Health Organization (2020) indicated that behaviour change communication and community mobilisation was done to ensure that community buys into the idea of being assisted by WBCHWs which might aid in the mutual trust between the families, communities and the WBCHWs. On the contrary, Scott et al. (2018) indicated that community trust and respect can be eroded if WBCHWs experience frequent stock outs or do not have access to the supplies needed. Trustworthiness in the use of screening tools will assist WBCHWs as they will not miss critical information about the condition of the patient as such proper care can be given to the patient in time.

- **Guides WBCHWs' actions and workflow**

The WBOT program plays a critical role in extending PHC services to community and household level and making health accessible in terms of distance and information**.** The program assisted WBCHWs' actions and workflow through the provision of screening tools as such this study

revealed the positive experiences of WBCHW regarding the utilization of patient screening tools which guided them in understanding what the signs are for and makes their field work simplified and easier. Nelson and Madiba (2022) supported the findings of the current study by indicating that the screening tool guides WBCHWs teams to promote good health, prevent ill health and through a variety of interventions including referrals based on the concept of a healthy community a healthy family, a healthy individual, and a healthy environment. Screening tools facilitated relevant questions to be asked from clients and worked as a guide to the WBCHW team in executing their mandate properly (Nelson & Madiba, 2022). Ormel, Kok., Kane et al, (2019) has suggested WBCHWs should be supported by the health system should guide their workflow through the screening tools, even when they are not formal cadres. Vaughan, Kok, Witter and Dieleman (2015) further supported by indicating that WBCHWs are the first point of contact between health service clients and providers, linking communities to the health system as such they deliver a wide range of promotive, preventive services by using a screening tool. WBCHWs are also in the unique position of being able to bring insights about community health to higher-level health workers. Therefore, the screening tool can be used as guide for WBCHWs workflow so they know can how to act about the condition of the patients.

- **Enhances clients' compliance**

The study revealed that the positive experiences of WBCHWs regarding the utilization of patient screening tools was used as a guide for the patients on how medication can be taken and comply so that defaulting can be prevented. Screening tools helped WBCHWs to guide patients on the importance of taking medication and avoid defaulting treatment. In line with the results of this study, screening tools also helped in managing the side effects of medication in providing patients advice on how diabetic treatment can be taken (McSharry, McGowan, Farmer & French, 2016). The same authors further recommended that to Improve linkage to treatment, support to be offered when initiating treatment to maintain patient outcomes, including treatment adherence (Mcsharry et al, 2016). Engaged clients in their treatment and offering support through follow-ups as done by WBCHWs promotes patient compliance to treatment and a greater degree of treatment satisfaction (Prinjha, Ricci-Cabello, Newhouse & Farmer, 2020; Lauffenburger, Barlev, Sears, Keller, McDonnell, Yom-Tov, Fontanet, 2021). In support of the findings, Soleymani, and Wallace-Bell (2018) indicated that enhanced engagement is associated with positive treatment outcomes, for example, screening patients, session attendance and homework compliance. As screening tools enhance clients‘ medication compliance, they will further assist in the prevention of the patient’s condition complications, hence promoting the quality of the patients’ lives.

4.2.2 Challenging experiences of WBCHW regarding the utilization of patient screening tools

The challenging experiences of WBCHW regarding the utilization of patient screening tools expressed by participants were divided into WBCHW-related challenges which encompass a limited scope of practice and recognition, Client related challenges which were inadequate cooperation screening and distrust WBCHWs, and resource-related challenges.

- **WBCHW-related challenges (limited scope of practice and recognition)**

This study revealed that the challenging experiences of WBCHW regarding the utilization of patient screening tools related to a limited scope of practice and recognition. These findings are in line with the findings from the previous studies. In the study conducted in South Africa, which scope of practice for WBCHW was found to be extremely narrow (Doherty, Kroon, Rhoda, Sanders 2016). Findley, Matos, Hicks, Campbell, Chang and Reich (2014) emphasised that it is important to identify an appropriate scope of practice, just like it is done with members of any other profession. The current study participants raised concerns about their working conditions. They expressed frustrations about the healthcare activities they provide to the households and the lack of recognition by the South African government. The same information was shared by the participants in the study that was conducted in California on confronting the potential of community health worker certification for workforce recognition and exclusion (Kissinger, Cordova, Keller, Mauldon, Copan & Rood 2022). Tshitangano and Olaniyi (2018), study supported by indicating that district health managers and WBCHW managers should realise areas of role knowledge deficit upon which, more emphases are needed to improve the scope of practice and quality of services rendered by WBCHWs.

Ramukumba (2019) discovered that the main issues on the scope of practice and recognition seemed to revolve around being used to extend the work of nurses, 'unstable contracts' and stipends that are often delayed or never received. This reflects calls to recognise the expertise of WBCHWs (Scott et al. 2018). Therefore, WBCHW scope of practice is clear and includes all the basic activities that are required when referring a client to other healthcare providers their recognition will expand within clinical organisations and communities. The South African government needs to recognise WBCHW contributions and increase their professional security by legitimating their training.

- **Client related challenges (inadequate co-operation with screening)**

The WBCHWs experience challenges when screening the clients in their households. The issues related to inadequate co-operation by the clients and family members were highlighted by the participants. It is important to obtain additional information during household screening, however, in the current study, the clients and family members seemed to have a tendency of refusing WBCHWs access to the households or intentionally hide the necessary and important information. This makes it difficult for the team to write a clean report that is communicative. In line with our findings, the study conducted in five rural districts in KwaZulu-Natal, South Africa reported that community members are reluctant to disclose sensitive information during the household screening, especially if WBCHWs are not trusted to maintain confidentiality (Grant, Wilford, Haskins, Phakathi, Mntambo & Horwood 2017). Hence, in the study conducted in Kenya, the participants pointed out that the family members share information freely to the WBCHWs that visits the clients regularly because they have developed a supportive and trusting relationship (Oliver, Geniets, Winters, Rega & Mbae (2015).

Similar to our findings, attitudes of the community members, families and clients were reported as a challenge for the WBCHW to carry their work efficiently (Oliver et al. 2015). In the study that investigated instructive roles and supportive relationships of clients during their engagement with community health workers in a rural South African home visiting program, it was found that without a more nuanced understanding of client conditions through screening and adequate information WBCHWs may miss critical information about the clients' condition, which leads to mis diagnosis and treatment (Laurenzi, Skeen, Coetzee et al., 2021).

- **Client related challenges (distrust WBCHWs)**

The findings show that WBCHWs in Fetakgomo-Tubatse sub-district, Limpopo province are not trusted by their households. Thus, the clients and family members were reported to be impolite to the WBCHWs when trying to reach-out for them. Similar to these findings, in the study that explored the acceptability of WBCHWs conducting household visits to mothers and infants during pregnancy and after delivery, it was found that WBCHWs are not trusted by community members (Grant et al. 2017). The community members in the same study reported that WBCHWs could not be trusted because they are not professional enough to maintain confidentiality of the households' issues. According to Oliver et al. (2015), mistrust can arise when communities suspect CHWs are withholding resources.

Sharma, Harris, Lloyd, Mistry & Harris (2019) highlighted that the WBCHWs and clients should have a trusting relationship, which enables WBCHWs to serve as a liaison/link/intermediary between health/ social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. In addition, Oliver et al. (2015) highlighted that the trust is needed for clients to share sensitive or troubling issues with WBCHWs. Moreover, Nxumalo, Goudge & Manderson. (2016), argue that WBCHWs have the potential to build the trusting relationship with the clients themselves through proper interaction. Cervantes, Robinson, Steiner and Myaskovsky (2022) are of the opinion that a proper interaction includes understanding and respecting culture and language of clients since information can be easily obtain through local language. The issue of trust is clearly important, with the implication that distrusting relationship causes more burden on the health and social systems in the community.

- **Resource related challenges (non-availability of screening tools and medication)**

The work of WBCHWs' involves screening clients for diseases, monitoring those who are on chronic medication, assisting clients to take medication, identifying households with social challenges, reporting and referrals. The screening tools designed by the department of health are used to guide them on what to assess and record, however, WBCHWs in this study reported that they struggle to get the screening tools and stationery in general. They also reported insufficient medication for the clients. All of this impede their work, to the extent of using their money to photocopy screening tools in order to be recognised by the clients as professionals. A case study with CHWs in Kenya identified similar challenges, whereby lack of forms and medication were reported (Oliver et al. 2015).

In support, the study that investigated the barriers to the implementation of the Ward-Based Outreach Team Program in Nkangala district, Mpumalanga Province, South Africa, identified that there is inadequate provision of resources (Nelson & Madiba 2020). According to the same authors, the district receives inadequate budget to run the program, which results with running short of equipment and screening tools. Confirming that WBCHWs in South Africa experience resource-related challenges, Nxumalo et al. (2016) added that WBCHWs receives insufficient supplies to run day to day work during household visits.

According to Scott et al. (2018), the frequent stock outs or do not have access to the supplies needed experienced by the WBCHWs to carry daily activities is one of the reasons the community

do not trust and respect WBCHWs. Consequently, despite the long existence of programmes in South Africa, there are still many challenges to optimal implementation, including limited resources (Murphy et al, 2021). These inadequate resources of screening tools are not unique to WBCHWs, but also affect the local health facilities to which they are attached (LeBan, Kok & Perry 2021). Putting together all these issues related to limited resources the work of WBCHWs is immensely affected. Although, it is understood that resources are always likely to be limited in low-income settings, it is important to look into the program and prioritise supplying resources that will allow WBCHWs to carry their day to day activities without experiencing challenges.

4.2.3 Coping experiences of WBCHW regarding the utilization of patient screening tools

The findings show that since, the WBCHWs experience challenges with the utilization of screening tools for long, they suggested alternative solutions to deal with these issues.

- **Alternative solutions to compensate for problems with screening tools**

The results of the study revealed that alternative solutions to compensate for problems with screening tools as coping experiences of WBCHW regarding the utilization of patient screening tools is for the government to refund the money they use to photocopy the screening tools or provide a stipend for them to access screening tools in the hospitals. These results are supported by the study that developed a model for a point of care testing for non-communicable disease diagnosis in resource-limited countries (Malcolm, Cadet, Crompton & DeGennaro 2019).

The participants in this study, coped with the challenges through writing down important information for screening references in their note books, paper, referral form or transfer the information in the screening tool when stationary was available. Regarding accessing the screening tools in the hospital, they use their money to get the screening tools at the nearest hospital or photocopy there in bulk. In line with the results of this study it was discovered that lack of adequate financial resources was the main challenge for WBCHWs to sufficiently screen and monitor the households (Nelson & Madiba 2020).

Sometimes participants indicated that they could take from their stipend money to pay for travelling cost which makes the job unbearable. The study on contextual factors affecting the integration of community health workers into the health system in Limpopo Province, South Africa stressed transport issues, whereby the WBCHWs took from their wallets to get access to the services in order to assist the clients (Jobson et al. 2020). Oliver et al. (2015) reported the same

results.

Finance allocation to the work performed by WBCHWs seems to be a big issue. The lack of money affects both the quality and the quantity of the services offered by the WBCHWs. Although the WBCHWs in the current study developed alternative solutions to compensate for problems with screening tools, this might hurt the program. Therefore, the researchers advocate for a dedicated budget allocation to run the program smoothly.

4.2.4 Recommendations of WBCHW regarding the utilization of patient screening tools

The participants recommended sufficient and applicable screening tools and resources; capacitation of WBCHWs; and an improved condition of service as a means to improve challenges with utilization of patient screening tools.

- **Sufficient and applicable screening tools and resources**

Screening tools and resources such as a stationary or working tools are needed while visiting and providing care in households. Ramukumba (2019) study supported that sufficient screening tools will enable the WBCHWs to register households in allocated wards and to identify vulnerable individuals and families. These resources are a serious need since not having them provided is associated to risk factors such as clients distrust and suspected robbers or clients running away or avoiding giving correct personal details and openness to be screened. In support, evidence guides on health policy and system support to optimise community health worker programmes for HIV, TB and malaria services, emphasises optimal supply of information materials such as screening tools for a successful WBCHWs work (World Health Organization 2020). If there are enough resources such as sufficient and applicable screening tools the WBCHWs will perform their work without difficulties.

- **Capacitation of WBCHWs**

This study discovered that there is a need for training on how to use the screening tools, in particular to communicable diseases such as hypertension and diabetes, through workshops and awareness campaigns. It is important for WBCHWs to know how to conduct households visit using designed screening tools and report using the tool. Nelson and Modiba (2020) reported that although, most of the WBCHWs had undergone Phase 2 training, their study participants revealed that the training of diabetes and hypertension screening tools was inadequate. Inadequate

training may lead to WBCHWs feeling that they are not outfitted enough to complete the screening tool forms. This notion is supported by the study that reported on the CHWs at the dawn of a new era (Carpenter, Musoke, Crigler & Perry 2021). numerous other authors indicated that proper initial and continuous training of WBCHWs is a necessity (Giugliani C, Zulliger 2020; Schaaf, Warthin, Freedman, Topp 2020). Scott et al, (2018) continuous training increases WBCHWs knowledge and skills and can positively influence WBCHWs motivation, job satisfaction, and performance.

The findings further show a recommendation for visitation by supervisors when household visits are done. The findings of Scott et al, (2018) concur that supervision during household visits is critical for the effectiveness of WBCHWs. Hence, Westgate, Musoke, Crigler & Perry (2021) argue that supervision is essential for optimising performance and motivation of community health workers. The reason been that supervisors can identify what WBCHWs are experiencing in the field and help them to acquire other critical elements needed from the health system such as an adequate supply of screening tools (Kok, Vallieres, Tulloch, Kumar, Kea, Karuga & Ndima 2018). Several studies have shown that regular supervision motivates WBCHWs to improve via confidence in performing their duties (Ludwick, Turyakira, Kyomuhangi, Manalili, Robinson & Brenner 2018; Nsibande, Loveday, Daniels, Sanders, Doherty, Zembe, 2018)

Despite supervision of WBCHWs been highly recommended by many authors, there is common supervision related challenges reported over and over in the literature. In the study by Perry (2020) lack of transport as a common barrier to visit households for supervision of WBCHWs was reported. In another study, lack of funds to pay for travel expenses and lack of transport for supervisory field visits as well as lack of appropriate tools and support to conduct supervision were also reported to be an obstacle for supervising WBCHWs (Westgate et al. 2021). Lowane, Shilubane & Lebese (2022) highlighted the need of transport for the clinic sisters to reach some household areas in order to guide and supervise the CHWs.

Capacitation of WBCHWs through providing training on the use of screening tools and by regularly supervising them when visiting households will boost their confidences and produce better results in screening households.

- **Improved conditions of service**

This study participants also recommended that the conditions that they operate under, needs to

be improved. It was discovered that WBCHWs conditions of service in the households is not favourable. They are not getting paid for the services they offer, but only receive a stipend which they still share with households through photocopying screening tools when they lack. The unfavourable work environment can easily affect the performance WBCHWs, moreover, it is important to improve it. The study that conducted a desk review of articles and reports on working conditions, revealed that to increase CHWs productivity and effectiveness, there should be enough supplies to carry out their tasks (Jaskiewicz & Tulenko 2012). The same authours reported there is also a need to support and recognition from the formal health system.

Scott et al, (2018) advocate for the improved financial remuneration, believing that it can reduce attrition among WBCHWs and help motivate them in their work. In addition, Ramukumba (2019) is of the opinion that WBCHWs have enough experience to be formally integrated into the healthcare system and given permanent positions with a salary. Hence, the study that analysed services provided by CHWs within urban districts in South Africa, alluded that they contribute toward the universal access to care (Thomas, Buch & Pillay 2021).

Therefore, it is critical to look at the conditions that WBCHWs work and improve on what they are going through to increase productivity in achieving Sustainable Developmental Goals.

4.3 Conclusion of the chapter

In this chapter, the findings in the study were discussed in relation to the available literature. Chapter 5 presents the recommendations, limitations, and summary of this study.

CHAPTER 5

CONCLUSION, RECOMMENDATIONS, LIMITATIONS, AND SUMMARY

5.1 INTRODUCTION

The previous chapter was on the discussion of the findings and literature control. This chapter draws conclusions, recommendations and limitations of the study based on the research findings regarding participants' experiences. The aim of this study was to explore the experiences of the WBCHWs regarding the utilization of patient screening tools in the Fetakgomo-Tubatse sub-district, Limpopo Province.

5.2 CONCLUSION OF THE FINDINGS

The objective of the study was to explore and describe experiences of WBCHWs regarding the utilization of patient screening tools in Fetakgomo-Tubatse sub-district, Limpopo Province.

From the findings of the study, the researcher came up with four themes and sixteen sub-themes which were indicated below.

5.2.1 Positive experiences of WBCHWs regarding the utilization of patient screening tools

In this study, it was evident that screening tools assisted WBCHWs as it facilitated a comprehensive household assessment where the WBCHWs had identified other problems apart from hypertension and diabetic conditions. Furthermore, risk factors and symptoms of diabetic and hypertensive conditions were identified from other family members who were not suffering from the two mentioned conditions which necessitate for referral to the clinic. A screening tool has assisted the WBCHWs to give health education to the household members based on the risks factors identified, which made clients to be aware and accept their health problems. Furthermore, screening tools promoted trustworthiness between WBCHWs, families and the community as it provided evidence of WBCHWs' contributions. Guided by the screening tools WBCHWs' actions and workflow became simpler and easier as such, they were able to advise diabetic and hypertensive patients on health living style to prevent and manage their conditions. Screening tools further assisted the WBCHWs to enhance clients' engagement and acceptance of their condition and to comply with their treatment which produced a positive treatment outcome.

5.2.2 Challenging experiences of WBCHW regarding the utilization of patient screening tools

Findings of this study confirmed that WBCHW faced challenges related to a limited scope of practice by lacking required information about screening the patients' conditions and recognition by the department of health. Client inadequate co-operation and distrust towards WBCHWs made it difficult for the WBCHWs to use the diabetic and hypertension screening tools which might cause complications on the client's conditions. Non-availability of screening tools and a shortage of medication has impacted on an unsuccessful implementation of WBCHWs program.

5.2.3 Coping experiences of WBCHWs regarding the utilization of patient screening tools

Regardless, of WBCHWs role to utilize the screening tool. The WBCHWs have coping mechanisms to try and find a solution to improve the quality of their work and program. Thus, as such findings of this study revealed that WBCHWs use their money to photocopy screening tools, which impact negatively on the quality of their work.

5.2.4 Recommendations of WBCHWs regarding the utilization of patient screening tools

WBCHWs recommended the need to have sufficient screening tools in order to screen the patients for diabetes and hypertension to reduce high risk conditions and burden of diseases. This will enable them screen and referred patients timeously to the relevant primary health care facilities which in turn will improve the health of the community at large. Furthermore, Capacitating the WBCHWs will increase their confidence and will motivate them to improve quality health services. It was evident from the findings that improving their working conditions and increasing their incentives will encourage them to implement quality work free from any destruction.

5.3 RECOMMENDATIONS

Based on the findings of the study the following recommendation were made to enhance the utilization of screening tools by the WBCHWs tools in the Fetakgomo-Tubatse sub-district, Limpopo Province. These recommendations might assist in the provision of quality health care thus reducing the quadruple burden of diseases in the community.

5.3.1 Recommendation to the nursing practice

- Department of health to conduct short courses and in-service training for the WBCHWs to enrich their knowledge about the screening of other conditions.
- The Department of Health needs to acknowledge the WBCHWs as permanent members, through this recognition, the WBCHWs will be able to become full -time workers also be regarded as professionals so that their profession can be developed and advanced.
- The Department of Health to recognise WBCHWs and consider them for nursing assistance training as the work of nursing assistance is more or less the same with WBCHWs, for example, screen through taking history and taking vital signs using apparatus (Blood Pressure machines, height, scale, mid upper arm circumference tape).
- The Department of Health to supply the WBCHWs with sufficient resources, which includes screening tools, extra for transportation, kit bags with Blood Pressure machines, Glucose machines, Mid upper arm circumference tapes, umbrellas, and Photocopy machines to make their work much easier and simpler.
- The Department of Health to make the screening tools online so that WBCHCWs can have easy access to the tool and they must be provided with data to retrieve the tools.
- Directorate to conduct an awareness campaign about the role of WBCHWs for the WBCHWs to have access to the families when they conduct screening to the community.

The recommendation to the public

- The hospital liaison officer to work with traditional leaders to make the community awareness about the role of WBCHWs in order for the WBCHWs to have access to the families when they conduct screening to the community.

Recommendation for further researcher

- Further researches can be conducted regarding challenges faced by WBCHWs when utilizing other screening tools and exploring the relationship between the WBCHWs with the community or nurses.

5.4 LIMITATIONS

- The study was not funded hence the researcher used her resources to conduct the

research as such this study was conducted one sub-district.

- The study was conducted in Fetakgomo-Tubatse sub-district. Other Sub-district in Sekhukhune were not included, therefore, the study cannot be generalised to other WBCHWs in Sekhukhune district and the whole province.

5.5 SUMMARY OF FINDINGS

The findings of this study revealed that WBCHWs had a positive experience when utilizing screening tools as such, screening tools facilitated comprehensive household assessments. Through the identification of risk factors, specific disorders and symptoms were identified which necessitated the patient's referral to the clinic. Screening tools facilitate the acceptance of clients and awareness of potential health problems. Furthermore, the utilization of screening tools by WBCHWs assisted to promote trustworthiness. Finding further revealed that screening tools guide WBCHWs' workflow and action to be taken when the family member is having signs and symptoms of certain disorders.

The results of this study highlighted that screening tools assist WBCHWs to facilitate health education and enhance client compliance to treatment. Challenging experiences of WBCHW regarding the utilization of patient screening tools were related to a limited scope of practice and recognition. The findings of this study indicated that a shortage of screening tools and medication causes distrust towards WBCHWs and inadequate cooperation with the screening of the family members in the households. Despite the shortage of resources WBCHWs compensate their finances to run their programmes. In this study WBCHWs recommended that sufficient resources and applicable screening tool together with capacitation of WBCHWs will improve their working conditions of service.

5.6 The conclusion of the study

This chapter focused on the conclusion, recommendations, limitation, and summary of the research. The researcher conducted this study at the Fetakgomo-Tubatse District among WBCHWs who were serving three clinics. The participants were sampled using purposive sampling methods and forty WBCHWs participated in the study through FGDs. Qualitative exploratory descriptive phenomenological research design was used, and data was analysed using Colaizzi methods where four themes and fourteen sub-themes emerged from the study. The findings of the study were presented and supported by the study participants through quotes and the literature.

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UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

ANNEXURE A:

APPLICATION LETTER FOR PERMISSION TO CONDUCT RESEARCH

P.O.BOX 1039
STEELPOORT
1133

Department of Health
Private Bag X9392
Polokwane
0700

Dear Sir/Madam

Request to conduct research

I am a professional nurse working at the Dilokong Gateway Clinic. I am currently studying at the University of Pretoria for my Master's Degree in Health Studies.
I am writing to you to request permission from the Department to conduct research in the Fetakgomo-Tubatse sub-district.

As it has been observed, Ward Based Community Health Workers function in the communities providing services to the patients in their homes. One of their roles is to screen patients and link patients at risk to Primary Health Care, through referrals. The health workers are facing challenges in utilising the patient's screening tools due to a lack of materials or resources. It has also been noticed the health workers have a varied workload and do not receive much incentive.

I propose that an interview be done through the focus group to collect data and information. This gathering of information will be treated with the utmost confidentiality.

I would appreciate it if my request were considered favourably.

Yours faithfully

Malau Elelwani

ANNEXURE B: FOCUS GROUP INTERVIEW GUIDE

CENTRAL QUESTION TO BE ASKED DURING THE FOCUS GROUP SESSION:

What were your experiences when using the diabetic and hypertensive screening tool on patients in the community?

Based on the above-mentioned question the following research sub-questions will be utilized as a guide:

- How do you perceive your role within the community?
- What is your view about the household, hypertension, and diabetes screening tool?
- What are the biggest challenges you are facing when screening households, hypertension, and diabetes in the community?
- What improvements do you believe would help you to fulfil your role as a Ward Based Community Health Worker?

ANNEXURE C: LEAFLET AND INFORMED CONSENT

PARTICIPANTS INFORMATION

TITLE OF THE STUDY:

EXPERIENCES OF THE WARD BASED COMMUNITY HEALTH WORKER REGARDING UTILIZING PATIENTS SCREENING TOOLS IN FETAKGOMO-TUBATSE SUB-DISTRICT, LIMPOPO PROVINCE.

DATE:

1. INTRODUCTION

You are invited to take part in this research study. I am doing this research for master's in nursing at the University of Pretoria. Two Ward Based Outreach Team Leaders will assist the researcher as scribers and recorders of the conversations in each focus group discussion. Your names will not be revealed. This information leaflet is to help you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. If you have any questions regarding this study, please do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about what we will be discussing during the focus group discussion. Your participation is appreciated and important for professional development in the field of health studies.

2. WHAT IS THE PURPOSE OF THE STUDY?

The purpose of the study is to explore the experiences of Ward Based Health Workers regarding the utilization of patient screening tools in Fetakgomo-Tubatse, Limpopo Province.

3. WHAT IS EXPECTED OF YOU DURING THIS STUDY?

You will be requested to participate in a focus group interview that will be facilitated by the researcher. You will meet the researcher at the Home Based structure hall in Driekop. The researcher will ensure that the chosen place is comfortable and private. All participants will be interviewed through focus group discussions which will last 40-45 minutes. You will be asked about your opinion about your experiences as a Ward Based Community Health worker regarding

utilizing patient screening tools. You will be expected to talk while the tape is recording the conversations. These will be used as a reference during the data analysis. All information that will be recorded will be used only for the study. As soon as the data has been analyzed the recorded information will be stored for a minimum 0f 15 years without being destroyed or deleted.

4. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

The researcher will seek approval from the research ethics committee of the University of Pretoria, Faculty of Health Science. Should you need any clarity on ethical approval, please feel free to contact the Research Ethics Committee at the Faculty of Health Science, University of Pretoria's office:012-356-3084/012-356-3085, Email: Manda.Smith@up.ac.za.

5. WHAT ARE THE RIGHTS OF PARTICIPANTS IN THIS STUDY?

Your participation in this study is entirely voluntary and you can refuse to participate or withdraw at any time without any reason.

6. WHAT IF ANY OF THE STUDY PROCEDURES RESULT IN DISCOMFORT AND RISK?
Since the study is related to your experiences, you might experience discomfort. If this happens you are requested to report any uneasy feelings, so that they can be handled by sending you to the psychologist as soon as possible.

7. WHAT ARE THE POSSIBLE BENEFITS OF THE STUDY?

The study will benefit you as Ward Based Community Health Worker as it provides us with information about your experiences regarding working conditions in the Ward Based Primary Health Care Outreach Team services in Fetakgomo-Tubatse. The research will lead to improvements in policy development, promotion of the general health status of the community and better working conditions.

8. CONFIDENTIALITY

Due to the nature of the focus group, confidentiality cannot be guaranteed because participants will listen to each other's discussions. The information after the focus group discussion will be kept safe and will not be used for any other purpose except for research. There will be no names and addresses attached to the research report.

9. DURATION OF FOCUS GROUP IN THE STUDY

The study will take 40-45 minutes of focus group discussion.

10. HOW LONG WILL THE DATA BE STORED?

The research data and documents will be maintained for a minimum of 15 years from the commencement of this study.

11. SOURCE OF ADDITIONAL INFORMATION

Should you have any questions during the study, please contact the researcher.
Researcher E. MALAU (0605701774)
Supervisor DR IT RAMAVHOYA

Co-supervisor: DR MM RASWESWE

CONSENT TO PARTICIPATE IN THIS STUDY

I have read and understood the information before signing the consent form. The content and meaning of the information have been explained to me. I have been allowed to ask questions and am satisfied that the answers are clear and satisfactory.

I hereby volunteer to take part in this study.

STATEMENT OF CONSENT TO BE AUDIO TAPED

I understand that Audio records will be taken during the study statement.
Choose Yes or No by inserting your initial in the relevant box
I agree to be audio recorded
YES

☐

☐
NO

Participant's name……

Participant's signature…… Date……

Researcher's name ……

Researcher's signature……Date……

Witness name…….

Witness signature…….. Date…….

ANNEXURE D: LETTER OF ETHICAL APPLICATION APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Faculty of Health Sciences **Research Ethics Committee**

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

8 October 2020

Approval Certificate

New Application

Ethics Reference No.: 167/2020

Title: Experiences of ward based community health workers regarding the utilization of patients screening tools in Fetakgomo-Tubatse sub-district, Limpopo province.

Dear Ms E Malau

The **New Application** as supported by documents received between 2020-09-01 and 2020-10-07 for your research, was approved

by the Faculty of Health Sciences Research Ethics Committee on 2020-10-07 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year and needs to be renewed annually by 2021-10-08.
- Please remember to use your protocol number (167/2020) on any documents or correspondence with the Research

Ethics Committee regarding your research.

- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. If a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

_

Dr R Sommers

MBChB MMed (Int) MPharmMed PhD

Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of
Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African
Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

Research Ethics Committee
Room 4-60, Level 4, Tswelopele Building
University of Pretoria, Private Bag x323
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Tel +27 (0)12 356 3084
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www.up.ac.za

Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE E: LETTER OF ETHICS RENEWAL APPROVAL

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences

Institution: The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.

- FWA 00002567, Approved dd 18 March 2022 and Expires 18 March 2027.
- IORG #: IORG0001762 OMB No. 0990-0278 Approved for use through August 31, 2023.

Faculty of Health Sciences **Research Ethics Committee**

13 April 2023

Approval
Certificate
Annual Renewal

Dear Ms E Malau,

Ethics Reference No.: 167/2020 – Line 3

Title: Experiences of ward based community health workers regarding the utilisation of patients screening tool in Fetakgomo-Tubatse sub-district,Limpopo province

The **Annual Renewal** as supported by documents received between 2023-03-28 and 2023-04-12 for your research, was approved by the Faculty of Health Sciences Research Ethics Committee on 2023-04-12 as resolved by its quorate meeting.

Please note the following about your ethics approval:

- Renewal of ethics approval is valid for 1 year, subsequent annual renewal will become due on 2024-04-13.
- Please remember to use your protocol number (167/2020) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, monitor the conduct of your research, or suspend or withdraw ethics approval.

Ethics approval is subject to the following:

- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

On behalf of the FHS REC, Dr R Sommers
MBChB, MMed (Int), MPharmMed, PhD
Deputy Chairperson *of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria*

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health)

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Fakulteit Gesondheidswetenskappe
Lefapha la Disaense tša Maphelo

ANNEXURE F: LANGUAGE EDITING LETTER

Unit C Mankweng 0727
081 5666 755
rightmovemultimedia@gmail.com
Researcheditors882@gmail.com
karabokonyani@gmail.com

12 December 2022

TO WHOM IT MAY CONCERN

This editing certificate verifies that this research proposal was professionally edited for Malau Elelwani

Thus, it is meant to acknowledge that I, Mrs K.L Malatji a professional Editor under a registered company RightMove Multimedia, have meticulously edited the Dissertation from the University of Pretoria. Title: EXPERIENCES OF WARD BASED COMMUNITY HEALTH CARE WORKERS REGARDING THE UTILISATION OF PATIENTS SCREENING TOOLS IN FETAKGOMO-TUBATSE SUB-DISTRICT, LIMPOPO PROVINCE.

Sincerely,

Mrs K. L Malatji

ANNEXURE G: EXAMPLE OF FOCUS GROUP TRANSCRIPT

Facilitator: Good Morning

Participants: Good morning mam

Facilitator: Thank you for honoring our meeting

Facilitator: My name is_I'm a focus group facilitator today and I will be asking you some questions related to your experiences regarding the utilisation of patients screening tools during household visits , I'm not alone__will be our moderator, Ms Elelwani Malau will be the scriber. So she will be taking some notes as we are talking don't be offended, she is noting your responses down. We are asking to record the meeting because, sometimes we can miss important information if we don't record. I believe that you already signed the concern forms that you want to participate in this study. Can I hear from the participants?

Participants replied: yes

Do you agree to be part of this study? And signed the forms that Elelwani gave you?

Participants replied: yes

Facilitator: thank you

Facilitator: Did Ms Malau explain that we are not going to use your names?

Participants replied: yes

Facilitator: did she give you numbers, that each of you has his/her own number?

P**articipants** replied: yes

Facilitator: okay when we speak or if you want to speak, Elelwani will raise her hand then I will see you in there, then she will tell which number has raised a hand. Even you when you stand up to talk first tell us your number. Then if someone want to say something or add after another participant do not call him/her by name use the number.

Participants replied: yes

Facilitator: okay, we have already agreed on language, we will mix. Our study is talking about screening tools that you are using for hypertensive and diabetic assessments in the households. Are you familiar with it?

Participants replied: yes

Facilitator: Okay you are familiar with it, you really know it and you are using it?

Participants replied: yes

Facilitator: Another thing is your biographical data.

Facilitator: What are your experiences regarding the use of screening tools during household visits? The very same documents that you said you know it and you are familiar with it. If you want to answer please raise your hand and start by telling us your number.

Scriber: participant number 11

Facilitator: okay participant 11 you can talk

Participant 11; I am participant 11, when I am using this screening tool it make my work easier, when I am going to ask the patient some questions even the patient becomes open to answer the questions that I will be asking him/her.

Facilitator: so it makes your work to be easy, when you say easy what do you really mean?

Participant 11: when I say easy I mean the questions that I will be able to ask, for example maybe asking that question like, do you urinate frequently things like that? Then he/she is able to answer me.

Facilitator: okay, you mean the patient is able to answer the question that you asked him/her?

Participant 11: yes, questions those that are on the screening tool

Facilitator: okay, thank you. Is there anyone who wants to tell us how he/she feels when using the screening tool?

Participant 6: participant 6 another thing you can be able to understand if maybe the person might be having diabetes or what? Then you can refer the person to the clinic so that they may be sure if really is diabetes, using that screening tool.

Facilitator: okay so, participant 6 you are saying the screening tool makes you know the disease? Did I understand you well?

Participant 6: that I may assume that the patient might be having diabetes, then after I have assumed based on his/her signs I refer him/her to the clinic or hospital to be sure if it was it that I may know how assist him/her.

Facilitator: okay, thank you. Is there anyone who wants to add? Can I hear from participant number 2?

Participant 2: participant 2, this screening tool help us that when we are in the household asking them to the point where we are able to ask them about food. It is able to show if in that house they might be having shortage of food.

Facilitator: can you repeat?

Participant 2: participant 2,when we have entered a household asking them about diabetic screening tool, it is able to show us that in this home they have shortage of nutritious foods.

Facilitator: ooh okay, does ithave other questions which are not only about hypertension and diabetes?

Participant 2: yes

Facilitator: okay, thank you. What are your experiences when using hypertensive and diabetic screening tool on patients? Who want to answer it? When you have entered a household having this paper, what happens while busy using it? What happen?

Scriber: participant 1

Participant 1: what I experienced or see, is that this screening tool is able to help our household patients, sometime a person might be having hypertension or diabetes without realizing it, so according to the signs when explain them to him/her that signs for diabetes is this and that for high blood is this and that. Then a person end up revealing that he/she has a problem, while didn't realize and go to the clinic earlier.

Facilitator: thank you participant number 1. Do we have another one whowants to try to answer this question? Can I hear from participant number 9? What are your experiences when using this screening tool document?

Participant 9: Participant number 9, my experience is that it helps us not to ask questions that are not there but only those that relate to diabetes.

Facilitator: okay, this means you do not ask questions that are irrelevant? It assists you not to ask questions that have nothing to do with their diseases?

Participant 9 replied: yes

Facilitator: okay, do we still have anyone who want to talk about his/her experiences when using the tool?

Scriber: participant 11

Participant 11: this screening tool also assists us, because in the households what I have experienced about our community is that most of them they tell themselves and relying things like, when you have diabetes or hypertension is because of heredity. so even if he/she have it, just because he/she never heard about anyone having those diseases in the family then the person end up not accepting that he/she has it. So when we arrive in the household and started screening him/her and finding that some of the signs are there which are on the screening tool, it is able to make our work easy.

Facilitator: okay, thank you. Another question is that, what are your views about this screening tool? When looking at the screening tool, what do you think? Is there anyone who wants to tell us what does he/she think about when looking at it? Isn't it that you are the ones using it?

Participants replied: yes

Participant number 3: I think this screening tool, according to how the questions are written it helps me, for example if I am a smoker I can be able to leave smoking, but sometimes we come across those who want devices that we can use to check them, for example BP machine and glucometer that is when they will really believe that it is working. We screen then they are open, but because they are not the same some prefer to see us having the something in our pocket to show that he/she might be having diabetes.

Facilitator: okay, thank you participant 3. Do we have another one who will add?

Scriber: participant 5

Participant 5: I think it assist in way that when we have entered into a household having the tool with us and asking questions looking in it is not like just entering there having nothing except just talking with your mouth, because sometimes when we just talk they likely end up not taking what we tell them. And now in other households some have started hypertension and diabetic treatment and left it, they are now sitting down being hit by stroke. They are unable to stand they don't have wheelchair. So it helps us that when ask them having the tool they are able to stand.

Participant 5: this paper assist to explain to them, it comes from the government and it also have a stamp for the department they become satisfied, is not like talking having nothing with us. When we talk to them having nothing they feel like we are just lying to them and sometimes they chase us out of their homes.

Facilitator: oh, they do chase you away?

Participants replied: yes

Facilitator: do they chase you when trying to fill the form, or they just chase you not to entertheir homes?

Participant 5: when we go there not having anything, saying we are sent by the department verbally so.it is as if we are lying, we are there to rob or cheat them and that we are only there just to get our payment through them. Many say is only through them that we are paid. When we have a document that have a departmental stamp we show and tell them that we are truly sent they become open to us and tell us everything.

Facilitator: okay, alright thank you. Thank you participant 5.

Participant 9: this screening tool helps in a way that it able to be served as a proof that in this day or date I entered and spoke with them about diabetes and hypertension diseases.

Facilitator: to be a proof? When you say to be a proof, what do you mean?

Participant 9: a date will be written that in this day we entered and spoke with them and screened them for hypertension and diabetes.

Facilitator: does it have dates?

Participant 9: yes we write dates

Facilitator: do you write a name as well?

Participant 9: yes

Facilitator: okay, alright thank you. Before I proceed is there anyone who want to respond?

Participant 4: can I please add on the one that participant 3 already spoken? When we walk throughout the households doing the screening for diabetic and hypertensive, some end up requiring that we should come with BP machines so that they may see the ratings of their blood pressure. Because they are no longer going to the clinics these patients, even when they went there no one take them BP, like those who take their monthly treatment. When they arrive at the clinic they just collect their treatment and come back.

Facilitator: okay, participant 4 you are talking about checking their blood pressure by the machine?

Participant 4: yes

Facilitator: so how do you check the BP? Do you take blood pressure on every patient? What is happening? How come you decide to take one BP through the machine?

Participant 4: I am talking about patients who collect their chronic medication monthly

Facilitator: oh okay, it is clear. Alright.so your views, here I want know your views about this tool when screening the patients in the households?

Scriber Participant 8

Participant 8: number 8, I see it being very significant when I am having this screening tool, we are able to distinguish the diseases of our patients, so that I may be able to know that this one need to be referred or not.

Facilitator: so in other words you are saying this paper assist you to confirm the patient that need to be referred further?

Participant 8: yes

Facilitator: participant 8 can I hear your answer?

Participant 8: I am talking about the screening tool, I am saying it is able to help as a community healthcare worker, so that when I enter household I may be able to differentiate my patients and know things that are suitable for them differently so.

Facilitator: okay, alright thank you. We are still on the views, anyone who want to talk?

Participant 1: this screening tool guides us. Even us when we are busy using it in the households we are able to try to see if a patient signs falls under hypertension or diabetes.

Facilitator: okay so participant 1, you say when you are busy using it in the households, you are also able to see where you fail? Is it how I understand or?

Participant 1: no, I am saying we are able to assume that based on how he/she explain his/her signs might be falling under hypertension or diabetes.

Facilitator: okay, thank you. The next question is, on the paper, you are the ones using it, right? It has many parts, there is this other one called disease……, criteria, risk factors, warning signs or symptoms and the other one is community healthcare action. On the columns, there are 5 columns. On these 5 columns each of you should tell us what how each column assists or restrain.

Participant 2: I chose a column of CHW action; our screening tool is able to help us, when we are in the community. Our screening tool was able to help us identify many people in our community who were just living with many signs, until we entered and refer them to hospital so many were really helped.

Facilitator: thank you, is there anyone who wants to talk about another column or add on the CHW action? We never heard anything from participant 12

Participant 12: the screening tool assists me on the risk factors column, like example our grandparents in the households, our grandparents they just wake up and sit under the tree and not go anywhere. When I come with the screening tool and start asking him/her, if she has a frequent urination. The time when she/he will be going to urinate frequently she/he will discover that she/he might be having problem.

Facilitator: okay, alright. We thank you participant number 12. Can we hear from participant number 4?

Participant 4: this screening tool also assists us on the people, some of them their signs, when we are in there speaking with them we eventually know what the signs might be for. As we will be looking there while the patient is speaking we are then able to assist him/her.

Facilitator: okay, thank you participant number 4.can we hear from participant number 7?

Participant 7: this screening tool assist that in a way that as we are busy screening and asking different questions, we find that there is a pregnant somebody who doesn't go to check up even children who are not being taken to check up by certain reasons.

Facilitator: okay, you are talking about the views?

Participant 7: yes

Facilitator: okay about pregnancy, diabetes and hypertension what are your views?

Participants 7: on hypertension and diabetes, this screening tool assist in way that many people don't know what the signs and symptoms of hypertension and diabetes are. When we are asking them some question we end up knowing that this one might be very close to be visited by diabetes based on the signs. We are then able to send him/her to the clinic to check if indeed he/she has it or what.

Participant 10: participant 10,on our screening tool, while we are doing house hold visit, the one for high blood, I am able to discover lot of things because some you find that they didn't know that they have high blood signs. While we are busy teaching them and asking questions they end up being open and tell us everything about themselves, that I feel this and that. Then we are able to see that these people need help if a situation is like this, what measures to be taken.

Facilitator: thank you participant 10, can we go to the other question? What are the difficulties experienced when using hypertensive and diabetic screening tool? Are there any problems that you come across when using this screening tool?

Scriber: Participant 11:

Facilitator: let's hear from participant 11

Participant 11: we mostly come across them; there is this patient who doesn't want to give you information. You are busy screening a person he/she just deny some of the things but you are able to see that they are there.

Facilitator: so participant 11, the problems that you come across, I am trying to understand, alright? There are patients who don't want to give information or there are those who just deny what you discovered or identified?

Participant 11: they withhold information and also that which you might have found on him/her.

Facilitator: previously you said some refuse to give information. Am I correct?

Participant 11: Yes and when you look at that person and check on the screening tool some of them you that they are there on him/her but a person just refuse.

Facilitator: okay, is there other one who want to add on the problems that you come across when using the screening tool?

Participant 9: some of them they to comply on the dates that they are given to collect their treatment.

Facilitator: can I ask again? When you say they don't follow dates, what are those dates for? because you're the one who goes to them, is it? do you make appointments when you go to them?

Participant 9: yes, to some we make appointments.

Facilitator: then when you visit for follow up, what is happening?

Participant 9: I will go again if I happen not to find them

Facilitator: okay, is a follow up thing?

Participants: yes

Facilitator: okay, thank you participant number 9. Is there anyone who still want to share the problems regarding screening tools and household visits?

Participant 2: the problems that we come across when we are in the community having the screening tool is that, when are screening them, you find that the signs and symptoms on them are there. The problem that we come across is that, you find that a person has insufficient finance and find that a clinic is little bit far and fail to travel. On that case you will hear him/her asking if a have money to pay for his/her transportation, then you find that I also don't have it then the person will not be able to go to the hospital. You will end up looking for money to pay for his/her transportation.

Facilitator: now you're talking about lack of transport after referrals?. There comes a problem of not having a car to transport them to the hospital and others don't have money?

Participant 2: yes, yourself end up making a plan that this person reach there with your money?

Facilitator: ooh, okayI hear you participant number 2. Is there anyone who also has a problem? Or have experienced a problem?

Participant 5: I add on what number 2 has spoken. Some when we arrive in the households, and starting checking if their time to drink their treatment has arrived, the person will just refuse to take treatment before us, saying he/she does not have food and again saying this tablets makes him/her to cough. Then when you trying to know why not having food, reply by saying I don't get social grant I don't have a child, I don't get child social grant. I cannot drink them. While a patient has rights then we are unable to force him/her treatment we leave him/her.

Facilitator: ooh, you also give them medicines?

Participant 5: we collect them at the hospital and give them in their homes, and then the following day we go and check if they drink in time, or what?

Facilitator: after you gave them the medication, do you write in the screening tool, or what is happening? Because we really want to know about the paper.

Participant 5: we don't write in the screening tool, we write in our books when we go to check if they are correctly taking the treatment.

Facilitator: ooh okay, I was asking if we may not talk too much about this one, it will be for another day. Today we look too much on the screening tool. Lets firstly talk about the screening tool, we will see the other problems on another day. Maybe there might be someone who may desire to do the study on that. Thank you participant number 5. Is there anyone who wants to speak? Before he/she speak, where do you get the screening tool? Who do give you the screening tool to use it?

Facilitator: participant 11

Participant 11: we make copies of this screening tool by ourselves. This means the day that I will be not having money I won't be using it because wouldn't have copied it.

Facilitator: not having money, what do you mean?

Participant 11: not having money, because for me to have a copy it means I might have used my money to make the work.

Facilitator: okay, meaning you must make copies yourself?

Participants replied: yes

Facilitator: with your own money?

Participants replied: yes

Participant 11: so the time I don't have, it means work won't be able to move. It is a stationery problem.

Facilitator: stationery problem?

Participants replied: yes

Facilitator: is there anyone who also have a stationery problem amongst you?

Participants replied: all of us

Facilitator: then what happens when there is no stationary?

Participant 11: when we come across this kind of challenge, as we carry some books, when one is left we write those questions in the books. Then you will screen the patient using your book.

then the time you have money, you take the information from the book and put it on the screening tool.

Facilitator: How do you manage to write more than one patient in one book?

Participant 11: is a paper, I remove some papers.

Facilitator: ooh , you remove a blank paper?

Participant 11: yes I remove a blank paper, then I write, I remove one page and enter one house and start screening them when I am done I remove another enter another household. The time I get money I make copies and take the information to the screening tool.

Facilitator: okay, I hear you participant 11.can we hear from others. we are still on the problem of shortage of screening tool, I want to hear how others solve this problem.

Participant 6: I go back to 11, it takes us back that our work seems to be of no value because these papers, I mean the screening tools. They are the ones that gives us dignity when working by them in the community, so when you start removing papers it seems like you are not serious about your work.

Facilitator: okay, thank you, thank you participant 6,. Is there anyone who wants to add on the screening tools shortage issue? Isn't it that you all have a screening tool problems?

Participants replied: yes

Facilitator: someone says she is using a paper, the other one says she is tearing a paper from the book, the others are saying they make some copies. Is there anything else apart from the mentioned?

Participant 1: to be honest they have spoken on our behalf, all that they have said is what we are doing

Facilitator: oh , you are doing the same thing all of you?

Partipants replied? yes

Facilitator: is it participant number 1?

Participant 1: yes

Facilitator: okay, thank you. I think we should proceed now. We heard about your emotions, your views, we heard the problems that you come across; we heard about all the good experiences that you come across.

Facilitator: So from all the discussions what are your suggestions? What do you want to be improved? what is it that you think will make your work easy when using this screening tools?

Participant 11: according to me, this screening tool is fine. At least what they can try is to supply us with stationery so that we won't a problem of doing the work in the field.

Facilitator: where should this stationery come from? According to you where do you think you can get the stationery from?

Participant 11: from clinics, because we are working with clinics.

Facilitator: oh, you work under clinics?

Participant 11: yes, we work under clinics.

Facilitator: according to my knowledge, you work under different clinics, is it?

Participant 11: yes

Facilitator: you find that you have 5 clinics that you are working under, for example.in these 5 clinics, which one should provide you with these scripts?

Participant 11: the one that has a hospital.

Facilitator: the clinic that has a hospital:

Participant 11: yes, it must be helped by the ones nearby.

Facilitator: okay, I hear you, apart from the stationary what else should be improved and how?. Participant 11 said the clinic next to the hospital is the one she thinks can supply with stationer. Do you all think it should be the clinic next to the hospital?

Participants replied: yes

Facilitator: do you all think so?

Participant 12: it is participant 12, yes, according to me the clinic that is next to hospital I think must be the one to assist us with stationery.

Facilitator: Why do you choose the one next to the hospital?

Participant 12: the reason is that, even if in the clinic they might be having shortage on that day, they can ask them for us at the hospital since it will be nearer.

Facilitator: okay, I hear and understand. Do you meet at one clinic every day?

Participant 11: no, we don't meet at one clinic. Everyone have their own clinic. if there is no stationery for example. As we are now having a stationery problem but we try to push work even if we don't have stationery, as I have explained that we are using papers. If there is no stationery, they will be using paper in the meantime waiting for stationery. So that work won't stop but proceed.

Facilitator: yes, we don't want to use papers that are without stamp, the ones you remove from the books. We trying to figure how we can solve this issue.

Participant 1: I think all the clinics should help us with stationery, If they lack they can ask from the hospital if they are available.

Participant 11: I think they should add date for us

Facilitator: add what?

Participant 11: date

Facilitator: alright, so add the date on the column.

Facilitator:. we still have 5 minutes 4 minutes now that we can use to wrap up and talk if you feel like we left something, just tell us what we have left out.

Participant 6: is it not possible that we can talk about other things except screening tool?

Facilitator: yes but for now we talk about the experiences regarding screening tools. Other things we can talk about outside the meeting

Facilitator: If there is nothing about screening tools I am truly grateful, I thank you. Know that the information you shared with us we take it very serious you may see it being published so don't be surprised when you see it, your names won't appear because we don't want these information to be traced back to anyone. We are really thankful. Have a good day, alright?

Participants replied: yes

Facilitator: Can the moderator and scriber remain.

Facilitator: Please stop, stop recording.